Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

BOARD OF DIRECTORS PUBLIC MEETING

5 November 2025

10:00 GMT Europe/London

Trust Board Room and via Teams

AGENDA

1. STANDING AGENDA ITEMS

Darren Best, Chair

REFERENCES

Only PDFs are attached

00. Board Agenda Public Nov 25 DRAFT.pdf

Board of Directors Meeting held in Public
Agenda

Board of Directors Board meeting held in public Venue: Trust Board Room, St Nicholas Hospital and Via Microsoft Teams		Date: Wednesday 5 November 2025 Time: 10:00am – 12:30pm	
	Item	**Lead**	
1.	**Standing agenda items**		
1.1	Welcome and Apologies for Absence	Darren Best, Chair	Verbal
1.2	Confirmation of quoracy and declarations of Interest	Darren Best, Chair	Verbal
1.3	Minutes of the meetings held 25 July 2025	Darren Best, Chair	Enc
1.4	Action Log and Matters Arising from previous meeting	Darren Best, Chair	Enc
1.5	Integrated Performance Report (Quarter 2)	Ramona Duguid, Chief Operating Officer	Enc
2. Strategic Ambition 1 – Quality care, every day			
2.1	Quality and Performance Committee Quarterly Assurance Report	Louise Nelson, Committee Chair	Enc
2.2	Mental Health Legislation Committee Quarterly Assurance Report	Emma Moir, Committee Chair	Enc
2.3	Care Quality Commission final assessment reports - Older People's Wards – final report - CQC action plan update	Sarah Rushbrooke, Executive Director of Nursing and Therapies	Enc
2.4	Safeguarding Adults and Children Annual Report 2024/25	Sarah Rushbrooke, Executive Director of Nursing and Therapies	Enc
	Break – 5 minutes		

3. Strategic Ambition 2 – Person led care, where and when it's needed			
	No items for the period		
4. Strategic Ambition 3 – a great place to work			
4.1	People Committee Quarterly Assurance Report	Brendan Hill, Committee Chair	Enc
4.2	Resident Doctors 10-point plan	Rajesh Nadkarni, Deputy Chief Executive and Medical Director	Enc
5. Strategic Ambition 4 – sustainable for the long term, innovating every day			
5.1	Resource and Business Assurance Committee Quarterly Assurance Report	Emma Moir, Committee Chair	Enc
5.2	Finance quarterly report (Quarter 2)	Chris Cressey, Interim Executive Director of Finance	Enc
5.3	Annual Plan delivery 2025/26 Mid-Year Review Report (including quality priorities)	Ramona Duguid, Chief Operating Officer	Enc
6. Strategic Ambition 5 – working for, and with our communities			
6.1	Charitable Funds Committee Report	Vikas Kumar, Committee Chair	Enc
6.2	Health inequalities quarterly report	Lynne Shaw, Executive Director of People and Organisational Development	Enc
7. Governance and Regulatory			
7.1	Audit Committee Assurance Report	Robin Earl, Audit Committee Chair	Enc
7.2	2024 / 25 Annual – Safety, Security and Resilience Report (Including EPRR Core Standards Assessment)	Ramona Duguid, Chief Operating Officer	Enc
7.3	Board Assurance Framework / Risk Management Report	Debbie Henderson, Director of Communications and Corporate Affairs	Enc
8. Any other business / items for information			
8.1	Chair's update	Darren Best, Chair	Enc

8.2	Chief Executive report	James Duncan, Chief Executive	Enc
8.3	Questions from Governors and the public	Darren Best, Chair	Verbal
Date of next meeting Wednesday 28 January 2026, St Nicholas Hospital Board Room and via MS Teams			

1.1 WELCOME AND APOLOGIES FOR ABSENCE

Darren Best, Chair

1.2 CONFIRMATION OF QUORACY AND DECLARATIONS OF INTEREST

Darren Best, Chair

1.3 MINUTES OF THE MEETING HELD WEDNESDAY 25TH JULY 2025

Darren Best, Chair

REFERENCES

Only PDFs are attached

1.3 Board in public minutes DRAFT 25.07.2025.pdf

Minutes of the Board of Directors meeting held in Public
Wednesday 23rd July 2024
Trust Board Room, St Nicholas Hospital and via Microsoft Teams

Present:
Darren Best, Chair
Brendan Hill, Non-Executive Director and Vice-Chair
Michael Robinson, Non-Executive Director and Senior Independent Director
Robin Earl, Non-Executive Director
Louise Nelson, Non-Executive Director
Rachel Bourne, Non-Executive Director
Vikas Kumar, Non-Executive Director

James Duncan, Chief Executive
Ramona Duguid, Chief Operating Officer
Chris Cressey, Interim Executive Director of Finance
Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance
Jonathan Richardson, Digital Advisor to the Board of Directors

In attendance:
Debbie Henderson, Director of Corporate Affairs and Communications / Trust Secretary
Kirsty Allan, Corporate Governance Manager / Deputy Trust Secretary
Gemma Pattison, Deputy Director of Workforce and OD
One member of the public was in attendance
One Governor was in attendance

STANDING AGENDA ITEMS

1.1 Welcome and apologies for absence
Introductions took place and Darren Best welcomed Gemma Pattison, Deputy Director of Workforce and OD attending in the absence of Lynne Shaw, Executive Director of Workforce and Organisational Development. Apologies also received from Rajesh Nadkarni, Deputy Chief Executive / Medical Director.

1.2 Confirmation of quoracy and Declarations of Interest
All Board members present and there were no declarations of interest to note.

1.3 Minutes of the meeting held 30 April 2025
Minutes of the meeting held 30th April 2025 were considered.

Approved: Minutes of the meeting held 30 April 2025 were approved as an accurate record.

1.4 Action Log and Matters Arising from the previous meeting.
There were no actions due for review and no matters arising.

1.5 Integrated Performance Quarterly Report
Ramona Duguid referred to the report which reflects several positive developments during May, particularly in the following areas:

- **Clinical Supervision and Psychiatric Liaison**: Continued focus and performance improvements have been noted in these areas, with sustained progress aligning with strategic priorities. These remain key strengths in the Trust's clinical delivery.
- **Out of Area Placements**: The Trust has successfully maintained the improvements seen in May, which is especially significant given the concerning position reported in April. This

demonstrates effective intervention and monitoring, contributing to better patient outcomes and resource management.

- **Clinically Ready for Discharge**: Although the Trust remains off-track overall, there has been a noticeable improvement within the Adult Acute Pathway, where ongoing improvement work is beginning to translate into progress across Rehabilitation and Young People's Pathways. These areas continue to pose challenges, but the emerging trends suggest that targeted efforts are starting to yield results.

Following detailed deep dives, targeted recovery plans have been implemented to address the proportion of patients with a safety plan in place, as well as to improve trajectories related to Rights at the point of detention. Both areas are now showing early signs of improvement. Additional focused work is underway to analyse and respond to June's performance position, ensuring continued progress. Supportive work is being undertaken with the Gateshead Early Intervention in Psychosis (EIP) Team in response to ongoing concerns regarding the timely commencement of treatment within 14 days. This has been a consistent area of underperformance over the past 6–12 months. Ramona highlighted this as a key area of focus, and efforts are being made to address the underlying issues and improve compliance with the standard.

There has been a continued focus on crisis performance, particularly within the critical 24-hour response window. An additional summary of this performance has been included in the enclosed report to ensure visibility and accountability. Ramona advised there remains a sustained emphasis on reducing 4-week waits, with ongoing collaborative work alongside North East and North Cumbria Integrated Care Board (NENC ICB) colleagues to improve the neurodevelopmental pathway. A comprehensive and detailed report outlining timelines and progress for both adults and children and young people will be presented to the September meeting of the Quality and Performance Committee.

Sarah Rushbrooke drew the Board's attention to the significant focus over the past six months on reducing the most restrictive forms of intervention. Notable improvements have been observed in the use of Mechanical Restraint Equipment (MRE) and Prone Restraint. However, it was noted that there has not yet been an overall reduction in the total number of restraint incidents. Sarah referenced the shift away from prone restraint towards the use of safety pods, which represent a less restrictive and more therapeutic approach. Additionally, work has commenced in recent months on the categorisation of incident reporting related to restrictive practices. A series of workshops have been held to review and refine reporting mechanisms, benchmarking against other Trusts in the region. Sarah advised that future reports will be more comprehensive, clearly evidencing the shift from most to least restrictive practices. Sarah also highlighted the continued positive feedback from patients regarding their sense of safety, with consistent above-target performance in patient experience metrics over the past 12 months.

Gemma Pattison mentioned a key focus has been placed on improving both appraisals and sickness absence. Trajectory plans are being developed for appraisals, and deep dives are being conducted within the Group structure. Targeted discussions have taken place regarding teams which require more intensive support. Innovative approaches are being considered to meet trajectory targets, including the introduction of group appraisals that incorporate well-being conversations. In terms of training, there has been improvement across the majority of areas highlighted in the report. Additionally, autism and learning disability training has now been included, and communication has been circulated to staff to raise awareness of this training opportunity.

James Duncan highlighted the need for the Quality and Performance Committee to consider the current position regarding restraint, seclusion, and assaults. It was noted that a trajectory for these areas is not currently in place and will need to be considered, while ensuring that this enables the right emphasis on patient safety.

Louise Nelson queried the 4-week wait metrics, specifically focusing on individuals who are struggling to access services. Clarification was sought on how these individuals are being supported, and what learning is being captured from these experiences. It was noted that there remains a need for greater clarity on how these actions are translating into measurable improvements. The importance of understanding the impact of interventions, rather than just the activity, was emphasised.

Ramona Duguid informed the Board that additional information on community wait performance both locally and nationally will be presented during the Board Development session following the formal meeting. Ramona noted that, in relation to certain waiting time metrics, such as over 52-week waits, the Trust is among the best-performing organisations. In the areas of mental health and learning disabilities, the Trust is performing well, although some organisations are achieving slightly better outcomes. Ramona also referred to ongoing work around outcomes recording and the importance of accurately managing “clock stop” and “clock start” processes. This is a key area of focus, as it is closely linked to both data quality and the clinical processes in place within teams.

Ramona highlighted that one of the significant challenges remains demand and capacity, particularly within the neurodevelopmental pathway for both adults and children and young people. Louise raised a question regarding neurodevelopmental waits for children and young people, specifically asking how the Trust is working with voluntary sector organisations to enhance the experience and support for those currently on waiting lists. Ramona explained that some of the support being provided by third sector organisations has not been commissioned or subcontracted directly by the Trust, instead, it has been put in place by Place-based ICB commissioners, with a focus on early help, support, and intervention for individuals awaiting assessment or treatment.

Darren Best referred to the core area of work around neurodevelopmental waiting times, which aligns with the NHS 10-Year Plan. He queried whether the ICB, which holds overall responsibility, is actively coordinating this work, or whether the Trust is independently managing various pieces of work. Ramona advised that multiple initiatives have emerged from different areas to address local needs and provided assurance that the Trust is working collaboratively with the ICB to improve coordination. A key objective is the development of standardised pathways for accessing care and treatment which includes ensuring that all providers are aligned in how they support individuals, particularly those transitioning between community and secondary care services with the overall aim to define a consistent and agreed pathway for the North East and North Cumbria region. This work is being taken forward with strong clinical involvement and engagement from key partners in primary care. Following a query from Darren regarding timescales, Ramona confirmed that the matter has been raised with the ICB, with a follow-up meeting scheduled for 18th August to agree on the way forward. Ramona acknowledged that full implementation of a pathway change could take up to 12 months, given the need to manage individuals already on the waiting list, accommodate new referrals into the service, and support people transitioning out of secondary care. Ramona emphasised that making these system-wide shifts will be crucial, alongside meaningful engagement with individuals with lived experience and collaboration with third sector partners.

Rachel Bourne noted that the recovery information regarding CYPS waiting times is primarily focused on the neurodevelopmental pathway with waiting times for mental health and learning disability services remaining significantly below target and queried whether the pathway changes and recovery approach also encompass mental health and learning disability pathways. Ramona explained that a significant proportion of children and young people experiencing waits over 100+ weeks are those transitioning into adult services. She also noted that other specific care and treatment pathways are represented within the long-waiting cohort associated with the neurodevelopmental pathway.

Regarding financial performance, Chris Cressey explained that further work is ongoing with the ICB in relation to the medium-term plan, particularly focusing on block contracts. He highlighted that inconsistencies are emerging between the level of resource identified and expenditure across the various services delivered in each PLACE area. These discrepancies are beginning to reveal variations not only in the investment made with CNTW but also in the investment levels across the wider patch. As part of the medium-term planning process, work is being undertaken with the ICB to better understand what constitutes appropriate investment across services and geographies.

Vikas Kumar spoke about the importance of understanding impact and driving meaningful change. He highlighted concerns within the voluntary sector, noting that some organisations continue to receive funding despite not adapting to changing demographic needs. He emphasised the need for the Board to seek assurance that investment is being directed where it can have the greatest impact. This

includes reviewing how funding is allocated within the voluntary sector to ensure it aligns with current and future needs and supports the delivery of meaningful outcomes.

Darren Best thanked everyone for their contributions and raised a key question for those engaged in discussions with the ICB asking how we ensure quality checks of partners involved. James Duncan added that the voluntary sector is often not well commissioned in line with its needs. He noted a lack of clarity around objectives, metrics, and the capacity to collect meaningful data. He emphasised that the development of the NHS 10-year plan particularly its focus on Neighbourhood Health presents a significant opportunity. Through improved commissioning and planning, there is potential to better understand and meet the needs of the population, ensuring investment delivers maximum benefit.

Rachel Bourne raised concerns about the high levels of bed occupancy and asked what plans are in place to address this. Ramona outlined a range of ongoing work particularly targeting patients with a length of stay exceeding 60 days. She explained that a deep dive is being conducted across all ward areas with rates of length of stay of 60 days at discharge at 20% and above. Specific initiatives are underway to improve patient pathways and enhance multidisciplinary team (MDT) working. This includes evaluating the effectiveness of 7-day service arrangements for clinical teams operating in those wards. Ramona also referred to earlier discussions around patients who are clinically ready for discharge, noting that rehabilitation and older adult services face particular challenges. Addressing delays in transitioning patients to more appropriate care settings is seen as a key factor in reducing overall bed occupancy.

Darren raised the issue of patients who are clinically ready for discharge, referencing a recent news piece by the ICB that highlighted the challenges faced by individuals with learning disabilities and autism who remain stuck in the system. He noted that the stories shared were unfortunately familiar and mirrored issues seen nationally. The piece was praised as a strong example of journalism, and Darren welcomed the growing interest from local authorities across the region particularly in relation to children and young people's services. He acknowledged some of the challenges the Trust is currently facing on certain wards and asked the Board to consider whether enough is being done to apply pressure on social care, local authorities, and other partners to drive progress. He questioned whether there may be an opportune moment to do more in this space.

On the topic of restrictive practice, Darren expressed appreciation for the proposal to provide a more detailed breakdown to support better understanding. He raised concerns about how restrictive practices are currently being recorded, noting that this has implications for the Trust's performance and how it is perceived both regionally and nationally. He requested an update on what is being done, why it is being done in that way, and how it might be improved. He asked that this item return to the Board in November to ensure the Trust can clearly explain how restrictive practice is being recorded and managed.

Finally, Darren welcomed the innovative approaches being taken to appraisal, commending the shift in mindset from simply identifying problems to actively seeking solutions. He noted that appraisal, sickness absence, and training have been longstanding challenges, and expressed support for the kind of thinking that aims to address these issues constructively.

ACTION: An updated to be provided at November's Board meeting on Restrictive Practice focusing on the issues outlined in the minutes.

RECEIVED: The Board received the Integrated Performance Quarterly Report

2. STRATEGIC AMBITION 1 – QUALITY CARE, EVERYDAY

2.1 Quality and Performance Committee Report

Louise Nelson referred to the report, which summarised the work of two committee meetings held in May and July. She explained that the committee continues to review the Board Assurance Framework (BAF) risks, focusing on four key risks. In relation to risk 2510, the committee reviews the Integrated Performance Report (IPR) at each meeting and uses it to guide focused quality discussions, as outlined in the report.

Louise highlighted the relevance of the OPEL Framework and its implications for the Trust as a mental health provider. She also noted that the committee had undertaken a detailed review of the CQC's 'must do' and 'should do' actions, with a particular focus on risk 2512 concerning patient safety culture, this includes oversight of the Patient Safety Incident Response Framework (PSIRF). The committee is working to draw together themes from various reports and recommendations to ensure a cohesive and comprehensive approach to addressing them. She emphasised that the committee is increasingly asking Executives not only to describe what is being done, but also to clearly articulate the specific actions, identify who is responsible, and explain the outcomes or responses.
In relation to BAF risk 2543, Louise noted that further work is required to consolidate the various transformation models to ensure a clear and consistent direction of travel, as the current approach can feel fragmented.

Finally, Louise praised the Trust's research activity, describing it as person-centred and impactful. She highlighted the breadth of research examples provided and the positive influence this work is having across the organisation.

RECEIVED: The Board received the Quality and Performance Committee report.

2.2 Mental Health Legislation Committee Report.
Michael Robinson reported that the Committee met once during the reporting period in July. The Committee continues to provide assurance that appropriate systems, structures, and processes are in place to ensure compliance with Mental Health Legislation. At present, there are no Board Assurance Framework (BAF) risks directly linked to the Committee however, the Committee is actively monitoring the progress of the Mental Health Bill through Parliament to assess any potential implications. While there is currently no BAF risk aligned to the Committee, it was noted that the final form of the Mental Health Act legislation changes could have significant implications for the Trust's daily operations.

Corporate risks were reviewed and assigned to the Steering Group. These included areas such as recruitment, appraisal, and training of members of the Hospital Managers Panel, which currently comprises approximately 50 individuals. Notably, for the first time, the panel includes two members from ethnic minority backgrounds, an encouraging development that opens opportunities for further diverse recruitment.

The Committee reviewed the training provided to panel members and discussed the introduction of a new appraisal process. This will include annual self-assessment, three-yearly observation-based appraisal and five-yearly formal appraisal. Michael explained that this structure aligns with practices in other Trusts and reflects the current appointment terms (initial five years, with the possibility of a further five-year term). Final approval of this appraisal framework is pending at the next Steering Group.

A challenge remains in ensuring sufficient numbers of panel chairs of the 50 current members, only 10 are chairs. While all panel members are accepted on the understanding they may chair in future, the role is demanding. The Committee continues to encourage members to step into chairing roles where possible. Michael also referenced the Moon case, which concerns the employment status of panel members. Legally privileged advice has been shared with all trusts, and this may necessitate changes to current systems and processes in due course. The Committee has maintained a focus on the rights of patients, particularly in relation to Community Treatment Orders (CTOs) and the completion of Forms A and B concerning capacity and consent to detention. Signs of improvement have been noted within the Trust, though ongoing monitoring will continue.

James Duncan noted that the Mental Health Act Bill is expected to be published in the autumn. He emphasised that, once published, the Board will need to dedicate time to reviewing the Bill in detail, particularly in the context of the NHS 10-Year Plan and the development of the Trust's own 5-Year Strategic Plan. The forthcoming legislation is anticipated to have significant implications for the organisation's operations and strategic direction.

ACTION: Board to dedicate time reviewing the Mental Health Act Bill once published

RECEIVED: The Board received the Mental Health Legislation Committee Report.

2.3 Care Quality Commission Final Assessment Reports (Community Services and Older Peoples Wards – high level feedback)

Sarah Rushbrooke informed the Board that the Care Quality Commission (CQC) conducted an assessment of the Trust's community-based mental health services in February 2025. The Board received early sight of the draft report and was made aware of the areas under review. The final report was published on 18 June 2025.

The assessment resulted in a change to the Trust's overall rating from 'Outstanding' to 'Requires Improvement'. Four of the five domains were downgraded, with the exception of Responsive, which remained rated as Good. The CQC identified two breaches of regulation:

- **Regulation 17** – relating to governance, with specific areas of concern outlined in the report.
- **Regulation 18** – relating to staffing.

A comprehensive action plan has been developed in response and was outlined in the enclosed presentation to the Board. Progress against this plan will be monitored through the Quality and Performance Committee, in line with standard governance processes. Sarah provided assurance that several areas of significant concern have already been addressed. For example, training in learning disability and autism is now mandatory, and immediate progress has been made where possible.

Sarah also reported on a separate three-day CQC assessment of older people's wards, undertaken in June 2025. As part of the usual inspection process, multiple sites across all localities were visited, and families, service users, and carers were interviewed. Initial high-level feedback was received in June in the form of a letter from the inspection teams, based on verbal feedback and without triangulated data. The report highlighted several areas of positive practice, alongside areas requiring improvement, particularly regarding behaviours and approaches observed on some wards. These concerns have been reviewed and addressed with immediate effect. All actions arising from this assessment will also be monitored through the Quality and Performance Committee.

Rachel Bourne raised concerns regarding the quality of care plans, noting that this issue has been consistently highlighted through feedback and incident reporting. While the Trust is committed to improving care planning, Rachel questioned how the Board can be assured that the planned improvements will lead to demonstrable enhancements in the quality of care plans. Sarah confirmed that prior to the recent inspection, a series of workshops had been held focusing on care planning, particularly within inpatient services. Following recent feedback from the CQC, this work has now been extended to include community services. Sarah expressed confidence that the Trust will be able to make significant improvements through a multidisciplinary approach, which has already been identified and will be brought forward to the Quality and Performance Committee for oversight and assurance.

Darren Best referred to the revised draft action plan currently under review and commended the team for the significant effort made to improve the quality of the action plan and the clarity of target dates which is essential for driving accountability and progress within the organisation. The revised plan provides stronger assurance against the identified targets and timelines.

RECEIVED: The Board received the Care Quality Commission Final Assessment Reports (Community Services and Older Peoples Wards – high level feedback).

3. STRATEGIC AMBITION 2 – PERSON LED CARE, WHEN AND WHERE IT IS NEEDED

3.1 Yewdale Ward – progress update report

Ramona Duguid referred to the report which provides an overview of the current position and pace of change regarding Yewdale Ward. The report summarised the extensive work undertaken since the last submission to the Board in April, including collaboration with ICB colleagues following their review

of the process, as outlined in the paper. The report also captured the outcomes from the ICB Service Change Advisory Committee, shared with the Trust the previous week and an update from the Health Overview and Scrutiny Committee (OSC) meeting held in Cumbria, also the previous week.

Ramona explained that the ICB has requested the Trust to maintain a continued focus on reducing out-of-area placements, continue working with North West Ambulance Service on patient transfers, strengthen the travel impact assessment and provide regular updates on progress relating to improvements in community and crisis care.

Sarah Rushbrooke referred to the comprehensive Quality Impact Assessment in place for Yewdale, which outlines all mitigations to support patients and manage acuity on the ward. She confirmed that regular updates are being provided on patient status, staffing, and discharges, and expressed confidence that there is a strong focus on the quality of changes being implemented.

James Duncan reported on his attendance at the OSC meeting, where discussions acknowledged the Trust's progress, and the safety and quality issues associated with Yewdale. However, concerns remained regarding the impact on the population of West Cumbria and a long-standing perception of insufficient engagement at an early stage in shaping future services. There was particular interest in the implementation of Hope Haven and its potential benefits for the region. Following correspondence between the OSC and the ICB, the Trust received a letter from Levi Buckley, Director responsible for Mental Health at the ICB, which included the following key statement: "On the basis of the feedback from the committee and the findings of the independent review, I am not identifying any further significant impediments to the Trust progressing to the next stage of its reconfiguration plan." James explained that Levi has also written to the local MP. The Trust will formally respond to the issues raised, particularly around the travel impact assessment, and will continue to work with the ambulance service to address these concerns.

James emphasised that the Trust's focus now is on managing the safe transition of the service to Carlisle Clinic and the closure of Yewdale, with patient safety and quality at the forefront.

Darren Best asked whether a defined date had been set for when there would be no more patients on Yewdale. James confirmed that no further admissions are taking place and that discharge arrangements are being managed on an individual basis, with the final closure date to be determined by the Quality Impact Assessment and patient needs.

Darren noted that the closure of Yewdale has been a significant issue for the Board, involving engagement, consultation, and quality and safety concerns and given the importance of this transition, and requested that if there are still patients on Yewdale by 31 August, a further update be brought to the Boards attention. Darren commended the Executive Team on the work that has been undertaken to date.

RECEIVED: The Board received the Yewdale report.

4. STRAEGIC AMBITION 3 – A GREAT PLACE TO WORK

4.1 People Committee Report

Brendan Hill referred to the report and highlighted several key areas of focus for the People Committee. Brendan confirmed that the change in status of learning disability and autism training from high priority to mandatory reflecting a shift in how the training is prioritised rather than a response to a specific target. This change ensures greater consistency and compliance across the Trust.

He noted the importance of the Work Growth Accelerator Hub, a regional initiative in partnership with CNTW, which is particularly relevant given that mental health remains the leading cause of staff absence. The Committee continues to receive updates on a wide range of initiatives, and Brendan praised the team's strong track record in supporting staff health and wellbeing, which remains of high quality. Brendan discussed ongoing work to strengthen the appraisal process, including exploring how appraisals can be linked to incremental pay progression. He emphasised the need for a broad and

inclusive approach to appraisals that captures the full scope of staff contributions, while reinforcing that appraisals are a fundamental part of working within the Trust.

Brendan raised concerns about recent national changes to immigration policy which are likely to impact a number of Trust staff. He noted that extensions to work visas are now unlikely, and the Trust is proactively engaging with affected individuals to prepare for these changes. The Committee received the Equality Diversity and Inclusion report, which provided good assurance. Brendan also referenced the work of the Freedom to Speak Up Guardians, noting that the Trust currently has four Guardians. He continues to meet with them quarterly to review their work and the themes emerging from staff feedback. While the Guardians are becoming more embedded in their roles, Brendan challenged the Committee to consider how their insights are triangulated with other sources such as CQC reports and management feedback to ensure that concerns raised are being addressed effectively and translated into action.

James Duncan addressed the ongoing scrutiny of national immigration policy by the People Committee, emphasising the profound and far-reaching impact it is having. He noted that the effects are not limited to the individuals directly affected by visa restrictions but also extend to their families and wider teams. Many staff have made significant life decisions, including relocating families to the UK, and the implications of these policy changes are both personal and organisational. The Trust continues to work closely with affected staff to provide support during this challenging period.

Darren Best echoed James' comments, acknowledging the legal requirement to comply with national legislation, but also stressing the importance of aligning with the Trust's values. He posed a key question for the People Committee: Are we truly treating and supporting people in the best possible way, in line with our values? Darren suggested this should be a point of assurance for the Committee. Darren also reflected on a recent meeting with the Freedom to Speak Up Guardians, describing it as a positive and supportive discussion. The Guardians are working well as a collective, dividing responsibilities and supporting one another, however, they also reported experiencing challenges related to management structures, attitudes, and behaviours. Darren urged the People Committee to look more deeply into the updates received from the Guardians, asking are the Guardians able to carry out their roles in the way the Board expects, are they being supported by managers appropriately, if not, what actions are being taken to address this. Darren emphasised the importance of ensuring that the Freedom to Speak Up function is not only operational but also empowered and respected across the organisation.

Gemma Pattison provided assurance to the Board regarding the support being offered to staff potentially affected by recent changes to immigration policy. She confirmed that she and Lynne Shaw have been holding individual health and wellbeing sessions with impacted staff, recognising the significant personal and family-related implications of these changes. Gemma noted that further changes to immigration rules were implemented on 22 July and acknowledged that additional changes may follow. In preparation, the Trust has been working closely with Group Directors to assess potential workforce implications. James Duncan added that members of the Staff Cultural Diversity Network have been actively involved in this work. He commended their dedication, noting that many of them may also be personally affected by these policy changes, yet continue to engage constructively with the Trust to support others.

Darren Best raised the issue of staff survey engagement, noting that the Trust's overall completion rate in the previous year was below expectations. He requested that the People Committee provide assurance at the next Board meeting on the actions being taken to improve engagement for the 2025 staff survey. He also suggested reviewing the timing and volume of other surveys to avoid survey fatigue, which may be contributing to lower participation including the quarterly pulse survey. Gemma confirmed that conversations are underway with leadership teams to support improved survey completion rates, this includes a detailed review of local data and the use of triangulation to identify areas where additional support is needed, particularly for team and ward managers.

ACTION: People Committee to seek further assurance on:

- **Leadership and management support for Freedom to Speak Up Guardians.**
- **Actions being taken to improve completion rates for the 2025 staff survey.**

RECEIVED: The Board received the People Committee Report.

4.2 Equality, Diversity and Inclusion Annual Report 2024/25
Gemma Pattison noted that the report had been reviewed and approved by the People Committee and is aligned with statutory requirements for publication. The report includes key metrics and updates on the Trust's work in relation to the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and the Gender Pay Gap, highlighting the progress made and areas for continued focus.

Rachel Bourne drew attention to a particularly stark finding of over 50% of staff from ethnic minority backgrounds do not believe the Trust is an equal opportunities employer. While the data shows some improvement, she emphasised that this figure remains deeply concerning especially given that programmes are already in place to support progression. Rachel asked if the Trust is doing enough as an organisation to demonstrate our commitment to these groups of staff. Darren Best thanked Rachel for the challenge and acknowledged that many large public sector organisations face similar issues. He stressed the importance of continuing to hold the organisation to account in this area. James Duncan added that the demographic profile of the Trust's workforce has changed significantly over recent years, alongside shifts in the surrounding population. He noted that this evolution brings new challenges, including differing cultural expectations and perceptions of management. While he was encouraged to see that the metrics are moving in a more positive direction but acknowledged that disparities remain and require deeper understanding.

Darren requested that comparative data from other Trusts be reviewed to provide further context and benchmarking for the Trust's performance in these areas to be fed through to the People Committee for review.

ACTION: Comparative data from other Trusts relating to the % of staff from ethnic minority backgrounds who do not believe the Trust is an equal opportunities employer to be reviewed by the People Committee.

RECEIVED: The Board received Equality, Diversity and Inclusion Annual Report 2024/25

4.3 Raising Concerns / Whistleblowing Report
Gemma Pattison presented the report, noting an increase in the number of reported cases since the last reporting period. However, she clarified that this increase is consistent with the same period in the previous year, indicating a stable trend rather than a new escalation.

The report outlines ongoing work across the organisation, with a particular emphasis on the importance of compassionate leadership. Gemma highlighted that the leadership development programme, discussed earlier in the meeting, is a key enabler in shaping the right culture. This is especially relevant considering feedback from the Freedom to Speak Up Guardians, who have reported mixed experiences some staff feeling safe to raise concerns, while others do not.

This theme also emerged in the recent bullying survey, reinforcing the need to embed compassionate leadership principles throughout the organisation. Gemma emphasised that creating a culture where staff feel safe, supported, and empowered to speak up is vital to the success of the leadership programme and the wider organisational culture.

Michael Robinson raised concerns regarding confidentiality and asked how information from Freedom to Speak Up (FTSU) cases is communicated effectively across the organisation while maintaining discretion. Gemma acknowledged the importance of this issue and noted that, with the expansion to four Freedom to Speak Up Guardians, further work is underway to strengthen how learning from concerns is captured and shared. Gemma confirmed that an individual feedback questionnaire will be introduced for those who have raised concerns which will help the Trust better understand both the actions taken in response to concerns and the perceived outcomes from the perspective of the individual. Gemma added that insights from these questionnaires will inform future Board reports,

enabling the organisation to reflect on learning, improve processes, and ensure that staff feel heard and supported throughout the process.

RECEIVED: The Board received the Raising Concerns / Whistleblowing Report

5. STRATEGIC AMBITION 4 – SUSTAINABLE FOR THE LONG TERM, INNOVATING EVERYDAY

5.1 Resource and Business Assurance Committee (RaBAC) Report

Brendan Hill referred to the ongoing service developments in West Cumbria, highlighting the Committee's role in reviewing financial reporting and sustainability. Significant pieces of work continue to be brought to RaBAC prior to Board consideration. Regular updates are being received on the CEDAR programme, the New Hospital Programme, estates returns and the premises model.

As the CEDAR programme nears completion, attention is turning to future planning. One key area remains outstanding relating to Bamburgh, which is expected to be completed by summer.

Key issues persist around medium-term planning, particularly in managing workforce and WTE (Whole Time Equivalent) usage. This will be a central focus of RaBAC's business going forward. While in-year performance remains a reporting priority, there is increasing emphasis on medium and long term sustainability planning. Financial forward planning and WTE usage in relation to the evolving Model of Care and Support are recognised as key cost drivers for the Trust.

The Committee also reviewed corporate efficiencies and service changes, including a detailed discussion on the Strategic Case for Change for adult acute inpatient services in West Cumbria, ahead of its submission to the Board.

James Duncan reported that substantial work on acute inpatient services in West Cumbria was completed last week. The Trust is now undertaking a Gateway 4 Review, the national standard for evaluating public projects. This will be presented to RaBAC to provide assurance on project delivery.

Digital developments have been a part of RaBAC's remit however, it was agreed that digital should no longer fall within RaBAC's Terms of Reference once the Digital Committee is established by year-end.

Jonathan Richardson provided an update on the Digital Maturity Assessment, which is conducted annually across all organisations. The assessment shows stability and improvement in strategic planning and workforce readiness, but further progress is needed in leadership, engagement, digital medicines, and cyber security. The establishment of the Digital Committee, supported by Non-Executive Directors with digital expertise, is expected to positively impact future assessments.

Darren Best noted that this meeting is taking place ahead of the Governors meeting scheduled for tomorrow, where it is hoped that the appointment of two new Non-Executive Directors will be formally approved following a successful recruitment process. If approved, the Board will benefit from having Non-Executive Directors with a digital background, strengthening its expertise in this area. Further discussions are also underway regarding the potential appointment of a non-voting Associate Non-Executive Director to bring additional specialist knowledge to the Board. However, Darren emphasised the importance of securing the Governors' approval for the two new Non-Executive Directors as a priority before progressing further.

Darren Best mentioned the Boards intention to establish a dedicated Digital Committee by the end of the calendar year. This will involve reassigning certain agenda items currently under the remit of the RaBAC and Q&P Committees to form the foundation of the new Digital Committee.

Darren indicated that a formal recommendation regarding digital governance will be presented to the Board in September and as part of the Digital Business Case, discussions are ongoing with the Chair of NTW Solutions to ensure alignment between the Trust's overarching digital strategy and the proposals being developed by NTW Solutions. Darren emphasised it is essential that the Board has clarity on the Trust's digital direction, and that any external proposals are consistent with and

supportive of the Trust's digital ambitions. The Digital Committee will play a key role in monitoring progress and ensuring strategic coherence going forward.

RECEIVED: The Board received the Resource and Business Assurance Committee Report.

5.2 Finance quarterly report (Quarter 1)
Chris Cressey presented the Quarter 1 financial report, confirming that the Trust submitted its end-of-quarter return to the ICB, showing a surplus of £2.9m. This is £4.1m ahead of plan, primarily due to the early receipt of land sale proceeds originally forecast for later in the financial year. The report also outlines the staffing position, noting an over establishment of 36 posts at the end of Quarter 1 however, this reflects a continued positive reduction when viewed against trend analysis. Supporting data in the report shows that as of June 2024, the Trust has fewer staff in post compared to the same period last year. Variations across clinical areas are being actively managed, with ongoing engagement to support workforce planning.

A key issue raised was the need for financial recovery planning within clinical areas, given the over-establishment in Quarter 1. This will require further action in Quarters 2–4 to ensure delivery of the Trust's financial plan. Financial recovery discussions will be embedded within the well-led meetings held with the Executive team at the end of each quarter, and recovery plans will be reviewed by RBAC for assurance.

Chris confirmed that the Trust is forecasting delivery of its financial plan, which includes £30m of financial savings. Of this, £7.8m is now identified as non-recurrent mitigation rather than recurrent savings, as originally planned. These mitigations will support the Trust's financial position in 2026/27 and contribute to strengthening the underlying position through the medium-term financial plan.

For the first time, the national Month 3 submission required Providers to report their underlying financial position. The Trust submitted a £33m deficit, reflecting the broader national picture and the shift towards medium-term and 10-year financial planning. Organisations are expected to develop at medium term financial plan, with detailed guidance anticipated later in the year to support submissions by the end of the calendar year.

The report also identifies financial risks and outlines mitigations under development. One area of focus is the financial pressure associated with inpatients who are clinically ready for discharge. Internal and external discussions with the ICB are ongoing to address this issue. From a capital perspective, the Trust remains on plan. An update on the capital position will be brought to the September meeting. At the end of Quarter 1, the Trust held £27.5m in cash and is expected to maintain a positive cash position throughout the financial year.

Rachel Bourne queried the increase in agency spend and asked whether there is a reliance on non-recurrent funding to return to plan by year-end, or if this is embedded within the medium-term financial plan.

Chris responded that agency pressures are being experienced in various parts of the organisation. However, these are being actively managed as part of the financial recovery programme. He noted that the planning guidance for the year includes a target to reduce temporary staffing specifically, a 30% reduction in agency staff usage and a 10% reduction in bank staff. The current report indicates that the Trust is not yet meeting these targets, but it is expected that the financial recovery initiatives will help reduce temporary staffing spend over time. On the issue of non-recurrent funding, Chris explained that while such funding can help the Trust meet its financial targets in 2025/26, it does not address the underlying £33m deficit. Reliance on non-recurrent measures could exacerbate the deficit if recurrent savings schemes are not delivered, he emphasised that while the Trust expects to deliver the recurrent savings identified in the programme, these are unlikely to be fully realised within the current financial year.

Robin Earl referenced the discussions held this month through RaBAC and raised a challenge regarding the pace of progress, questioning whether the current approach allows sufficient time to recover the financial position within the available window. In response, Chris Cressey provided

assurance that financial recovery planning is already underway, operational discussions began in Month 2, with financial recovery meetings taking place across each clinical area. While a formally signed-off plan is still in development, defining specific actions required to impact the forecast, Chris confirmed that the groundwork and implementation activity are already progressing well.

Robin Earl inquired whether the Trust has forecasted when cash may become a concern. Chris advised that a detailed update will be presented to a future RaBAC and Board meeting at the end of Quarter 2. He noted that the observed reduction in WTE staffing levels is contributing positively to cashflow expectations, given that wages are the Trust's primary expenditure. It is hoped that this reduction will help support the Trust's cash position. At present, the Trust does not anticipate entering a negative cash position during the current financial year.

Darren Best confirmed receipt of regular Board updates regarding the overall regional financial position. He emphasised that improving the system's financial standing is now a more urgent and visible priority than ever before. Darren welcomed ongoing dialogue with the ICB regarding individuals who are clinically ready for discharge.

Referring to the table on page 3 of the report, Darren noted that staff numbers across the organisation have fluctuated significantly over the past year, with a peak observed in March 2025. He highlighted that the data does not yet reflect a sustained downward trend in staffing, raising concerns about the Trust's ability to meet financial targets aligned with the Model of Care and Support and People Plan.

James Duncan acknowledged the March staffing spike and reiterated the importance of maintaining a steady and focused approach. James stated that further reductions in workforce are planned to address gaps in Quarter 1. These are essential to keeping the year-end run rate on target. James also noted that substantial groundwork has been undertaken, which positions the Trust favourably. He welcomed the forthcoming details of the 10-year plan and highlighted that receiving a three-year allocation would mark a significant and positive shift not seen in recent years.

RECEIVED: The Board received the Finance quarterly report (Quarter 1)

5.3 NHS 10-year plan
James Duncan provided an update to the Board, referring to a recent report that requires further consideration in the context of the development of the 10-Year Plan. He highlighted ongoing work across the organisation and nationally with Neighbourhood Health initiatives, noting that early adopter sites are being identified. It is expected that three neighbourhoods will be proposed for inclusion by the ICB, with discussions currently underway in which the Trust is actively involved.

James emphasised the importance of being part of the early adopter programme, particularly in terms of delivery, and acknowledged that any additional funding is contributing to the creation of a network of learning. James welcomed the 10-Year Plans focus and continued emphasis on 24/7 mental health service models. He also referred to the development of Mental Health Emergency Departments, which the Trust is currently progressing.

6. STRATEGIC AMBITION 5 – WORKING FOR AND WITH OUR COMMUNITIES
No issues to report for the period.

7. GOVERNANCE AND REGULATORY

7.1 Audit Committee Assurance Report
Robin Earl referred to the report noting that the committee met three times between May and July. Two of those meetings focused on reviewing the draft and final Annual Accounts. Robin outlined the committee's review of proposed changes to two of the Board Assurance Framework risks following discussion at the Quality and Performance Committee:

- **Risk 2511 – Not meeting regulatory requirements:** The proposal is to increase the likelihood score, resulting in an overall risk score rising from 15 to 20.

- **Risk 2512 – Maintaining a positive learning culture:** The proposed likelihood score increase would raise the overall score from 12 to 16.

These proposals were discussed in detail, with the committee agreeing to recommend both changes to the Board for approval. Robin highlighted that the reassessment of these risks was prompted by recent findings of the Care Quality Commission (CQC) reports.

The committee also received a positive update on progress with the Patient Safety Incident Response Framework (PSIRF). With input from internal audit representatives, the committee was able to triangulate feedback and gain strong assurance around the implementation efforts.

Robin reported a notable reduction in overdue agreed actions arising from internal audit reports from 13 down to 6 which was welcomed. He noted that any overdue actions in future would lead to a request for direct updates from the responsible executive director.

Darren referred to the increase in scoring of risks 2511 and 2512, which were adjusted following inspections by the Care Quality Commission (CQC). He noted that while these risks were already known to the organisation, the CQC's findings prompted a reassessment based on a different interpretation of the associated evidence and impact. Darren raised a broader concern about the robustness of risk scoring for the remaining BAF risks and queried the extent to which the Board can be confident in the accuracy of current risk ratings, and whether external bodies such as the CQC or Health and Safety Executive (HSE) might evaluate these risks differently than the Trust has. He suggested this be formally considered by all relevant committees to reflect on whether, based on the controls and assurance in place, their current risk scores are appropriate and defensible.

Debbie Henderson commented on the committees' ongoing work in reviewing BAF risks and whether they are appropriately assessed and scored. She highlighted that a dedicated Board session is scheduled to take place in November which will include a review of the Trust's risk appetite which is set by the Board. Debbie suggested that this would provide the opportunity to review the BAF risks in light of any review of the overall risk appetite and the Board's collective understanding of risk management, particularly in terms of approaches, tolerance, and appetite. She stressed that this will be an important and constructive conversation for the Board.

APPROVED: The Board agreed the increase in scoring relating to risks 2511 and 2512.

RECEIVED: The Board received the Audit Committee Report.

7.2 Trust Annual Plan 2025/26 (and Quality Priorities for 2025/26) – for approval
James Duncan referenced the Plan which outlines the continuing efforts across all areas. He drew particular attention to the development of the Performance Framework, noting that it remains a key focus for the Executive Team. Their priority is to ensure that the framework is appropriately tailored to meet the organisation's needs, enabling clarity, alignment, and effective performance management.

APPROVED: The Board approved the Trust Annual Plan, aims and priorities for 2025/26 aligned to the Trust strategic ambitions (including the Quality aims and priorities for 2025/26)

7.3 Board Assurance Framework / Risk Management Report
Following the update provided under item 7.1, Debbie Henderson suggested that the Board consider aligning the BAF more closely with the Audit Committee Assurance report going forward. This recommendation aims to ensure consistency, oversight, and strengthen the overall assurance process across governance structures.

James Duncan reflected on risks 2510 and 2511, noting that while both relate to the organisation's ability to meet regulatory standards, the wording of each risk differs slightly. He suggested that this variation in phrasing may be contributing to the difference in risk scores. James recommended a review of the language used in both entries to ensure consistency and clarity, and to support accurate comparative assessment of risk severity. Again, Debbie suggested that this takes place as part of the November Board review of the Trust risk appetite and risk management processes.

RECEIVED: The Board received the Board Assurance Framework / Risk Management Report

7.4 NTW Solutions Limited – Board Terms of Reference – for approval
Debbie Henderson referred to the report and confirmed there were no updates to provide beyond the points highlighted in blue, which relate specifically to terminology.

APPROVED: The Board received and approved the NTW Solutions Limited Board Terms of Reference

8. Any Other Business

8.1 Chairs update
Darren Best referenced the relevant section of the report concerning Michael Robinson's upcoming departure from his role on 30th September. He formally requested the Board's approval for Louise Nelson to assume the position of Senior Independent Director and expressed his gratitude to Louise for agreeing to take on this important responsibility.

Darren also acknowledged that this was Michael Robinson's final public Board meeting, marking the end of his service with the Trust spanning over six years. He offered sincere thanks to Michael for his significant contributions, particularly stepping into the role of Senior Independent Director in January 2025 and chairing the Mental Health Legislation Committee emphasising that Michael's departure would be a notable loss for the Trust. Michael extended his thanks to all for their support throughout his tenure as Non-Executive Director and shared his best wishes for the future.

8.2 Chief Executive Report
For information.

8.3 Fit and Proper Persons Test annual update
For information which has been shared on the Trust website for completion. The update was previously approved by the June closed Board due to publication timescales.

8.4 Modern Slavery Statement 2025
For information which has been shared on the Trust website for completion. The statement was previously approved by the June closed Board due to publication timescales.

8.3 Questions from Governors and the public
None to note

Date and time of next meeting
Wednesday 5 November 2025, St Nicholas Hospital, Jubilee Road, Gosforth, NE3 3XT
Trust Board Room and live-streamed via MS Teams

1.4 ACTION LOG AND MATTERS ARISING FROM PREVIOUS MEETING

Darren Best, Chair

REFERENCES

Only PDFs are attached

1.4 BoD Action Log PUBLIC at November 2025.pdf

Board of Directors Meeting held in public

Action Log as at 5 November 2025

RED ACTIONS – Verbal updates required at the meeting
GREEN ACTIONS – Actions are on track for completion (no requirement for discussion at the meeting)

Item No.	Item	Action	By Whom	By When	Update/Comments
Actions outstanding					
24.09.25 (2.2)	Mental Health Legislation Committee Assurance Report	Board to dedicate time reviewing the Mental Health Act Bill once published.	Rajesh Nadkarni	TBC	Board date for discussion to be confirmed following publication.
04.12.25 (2.7)	Learning from deaths report	Inclusion of the following in the next scheduled report: - Visibility of specific areas - Analysis of inequalities, - Learning from reviews that are taking place - The collaborative work with the NENC ICB on suicide prevention - Information on 'near-miss' cases i.e., those people who could have, or almost did die by suicide, particularly those cases involving self-harm.	Rajesh Nadkarni	~~July 2025~~ January 2026	Deferred from July.
Completed Actions					
30.04.25 (5.1)	Resource and Business Assurance Committee report	Update on progress against the capital programme / Estate developments to be provided to a future Board meeting.	Chris Cressey	TBC	Complete – agenda item at September closed Board meeting

Item No.	Item	Action	By Whom	By When	Update/Comments
24.09.25 (4.1)	People Committee Assurance Report	People Committee to seek further assurance on: - Leadership and management support for Freedom to Speak Up Guardians. - Actions being taken to improve completion rates for the 2025 staff survey.	Brendan Hill / Lynne Shaw	December 2025	Actions forwarded to Lynne Shaw for inclusion on action log for People Committee.
24.09.25 (4.2)	Equality, Diversity and Inclusion Annual Report	Comparative data from other Trusts relating to the % of staff from ethnic minority backgrounds who do not believe the Trust is an equal opportunities employer to be reviewed by the People Committee.	Brendan Hill / Lynne Shaw	December 2025	Action forwarded to Lynne Shaw for inclusion on action log for People Committee.

1.5 INTEGRATED PERFORMANCE QUARTERLY REPORT (QUARTER 2)

Ramona Duguid, Chief Operating Officer

REFERENCES

Only PDFs are attached

1.5 IPR Quarter 2 Report - November 2025.pdf

Meeting	**Board of Directors Public Meeting**		**Agenda item: 1.5**
Date of meeting	Wednesday 5 November 2025		
Report title	Quarter Two 2025-26 – Integrated Performance Report		
Report Lead	Ramona Duguid – Chief Operating Officer		
Prepared by	Tommy Davies – Deputy Director of Transformation, Delivery and Performance		
Purpose	**For decision**	**For assurance**	**For awareness**
		x	
Report previously considered by	Executive Management Group (monthly reported version)		
Executive summary	The Trust Board of Directors approved a performance management framework for the delivery of a quarterly performance report that provides assurance on the Trust's performance each quarter. This report is the Quarter Two 2025/26 version and provides an update on the performance of the Trust's core measures linked to the strategic objectives set out in the Trust Strategy. For completeness, the report also includes the latest update of the NHS Oversight Framework, published in September 2025. The Trust is currently placed in Segment 4 based on the nine specific metrics outlined in this framework. Included within the report are the core areas performing well, areas of concern, and areas to watch in terms of potential to improve or risk of deterioration. The areas of concern include a summary of the actions being taken to improve performance. In line with the performance management framework, more detailed action plans have been developed to address these areas. At the back of the report is guidance on interpreting SPC (Statistical Process Control) charts and symbols, which enable the Trust to determine whether changes in performance are statistically significant or reflect expected normal variation from month to month.		
Detail of corporate/ strategic risks	**BAF Risk 2510** – Due to increased demand and capacity the Trust is unable to meet regulatory standards relating to access, responsiveness, and performance resulting in a risk to quality and safety of services. SA1 **BAF Risk 2511** – Risk of not meeting regulatory and statutory requirements of Care Quality Commission (CQC) registration and quality standards. SA1		

	BAF Risk 2512 – Risk of failing to maintain a positive safety learning culture resulting in avoidable harm, poor systems, process and policy, and identification of serious issues of concern. SA1 **SA2** Person-led care, when and where it is needed – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals. **BAF Risk 2543 –** Failure to deliver our transformation plans around the model of care to address issues relating to community and crisis infrastructures, and demand for inpatient provision which could compromise quality, safety, and experience of service users. SA2 **SA3** A great place to work – We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers. **BAF Risk 2540** - Risk of increased staffing costs from use of temporary staff impacting on quality of care and financial sustainability. SA3 **BAF Risk 2542** – Failure to develop a sustainable workforce model to recruit/retain/ and support the development of the right people with the right skills to deliver safe and effective services, our strategic objectives, and contractual obligations. SA3 **BAF Risk 2544** - Risk of poor staff motivation, engagement, and job satisfaction if issues affecting staff experience are not addressed including health and wellbeing support, inclusion and the ability to speak up. SA3 **SA4** Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled**.** **BAF Risk 2546** - Risk that restrictions in capital expenditure imposed regionally / nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments and infrastructure.
Recommendation	The Trust Board are asked to: • Note the contents of the Performance Report and to take assurance that appropriate actions are in place to address areas of underperformance and to maintain areas of strong performance.
Supporting information / appendices	None

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Trust Board of Directors

Integrated Performance Report

Patients | Quality | People | Person Led Care | Sustainability

Quarter Two – 2025-26 Report

(Reporting Data to Sep-25)

With YOU in mind

Trust Board of Directors Q2 25-26 - Key messages

Reporting Period: Sep-2025

What's going well?

Several safety measures have continued to improve or remain stable during Quarter 2 of 2025/26. In September, there were no MRE restraints recorded for the first time. Prone restraints have remained at a low level compared to previous years. Incidents of self-harm have reduced significantly over the past five months. The percentage of patients who say they "feel safe" has continued to improve and remains on target.

Our urgent and crisis care services continue to perform well, with all psychiatric liaison and crisis measures positioned in the first or second quartile nationally, benchmarked against 46 other Mental Health Trusts. Urgent crisis referrals seen within 24 hours have improved and were on target at the end of the quarter. Both psychiatric liaison wait time measures, 1 hour in Emergency Departments and 24 hours for wards, remained on target throughout the quarter. Very urgent crisis 4-hour response rates were in the second quartile but off target overall, at 51.3% in September.

Early Intervention in Psychosis wait times have improved significantly over the last quarter, reaching 85.5% against a 60% target.

Out-of-area placements have been at zero for the last two months of the quarter, representing an improvement on the previous quarter.

Training compliance - Information Governance, local induction, and web-based risk training has improved during the quarter, with all now on target.

What's of concern?

The NHS Oversight Framework contained in this report highlights some areas that require improvement and are causing the Trust to be in segment 4 for overall performance. These include sickness absence, the percentage of adult acute patients with a length of stay less than 60 days, and reference costs.

- Adult Acute – 60-Day Length of Stay: Plans are in place to reduce extended inpatient stays, including the Hospital to Home workstream and adoption of the 10 Key High Impact Actions.
- Sickness Absence: A trajectory has been agreed to reduce sickness absence across all teams by 1% by year-end. The Strategic Workforce Group is leading actions to deliver this reduction, including targeted support and interventions for teams with higher absence rates.
- Reference Costs: This data is based on 2023/24 figures. Reference costs have since improved in 2024/25, and improvement work is in place to reduce them further in 2025/26. Significant Trustwide plans are being developed to improve our overall financial position by March 2026.

Trust Board of Directors Q2 25-26 - Key messages

Reporting Period: Sep-2025

What's of concern? - continued

Clinically Ready Discharge (CRFD) rates deteriorated significantly towards the end of the quarter, particularly in September. There was a surge in pressure during September that affected these rates. From October, a new Clinically Ready for Discharge tiered monitoring process is in place as part of the Hospital to Home approach. This will enable a specific focus on patients who are ready for discharge, working across the system. Inpatient Rehabilitation requires the most focus to affect the overall CRFD position.

Community waits for CYPS, Adults, and Older Adults are off target, with no change in the trend over Quarter Two. The Trust benchmarks in the best quartile for adopting the new methodology for meaningful clock stops, and for Adults and Older Adults waiting over 104 weeks, which is currently zero. However, CYPS waits are in the lowest quartile. Average waits for Mental Health CYPS, Adults, and Older Adults have improved. However, meeting the new meaningful clock stop standard within four weeks remains a challenge, replacing the previous 18-week wait contacts methodology. The Monthly Access Oversight Group with CBUs is in place to focus on standardising processes and improving waiting times. CYPS waiting time performance is largely the result of increased demand within Neurodevelopmental pathways, and agreement has been reached with the ICB to restructure the commissioned service, enabling CNTW to focus only on those patients where they have a secondary care mental health or learning disability need.

What's worth watching?

All clinical staff priority training metrics have improved over the last 24 months since the introduction of training prioritisation. However, some have come close to the target and dipped slightly in the last quarter, including PMVA basic training, Adult and Paediatric Immediate Life Support, and Clinical and Suicide Prevention. Training is being closely monitored by the care groups to bring us on track across the next two quarters.

Appraisal rates have improved significantly throughout Quarter Two. If this improvement continues, the target will be met within a few months.

Over the last four months, assaults on patients have remained below the average and show a clear downward trend.

Long-Term Segregation and Prolonged Seclusion saw a slight uptick in September, although overall improvement has been seen over the last two years.

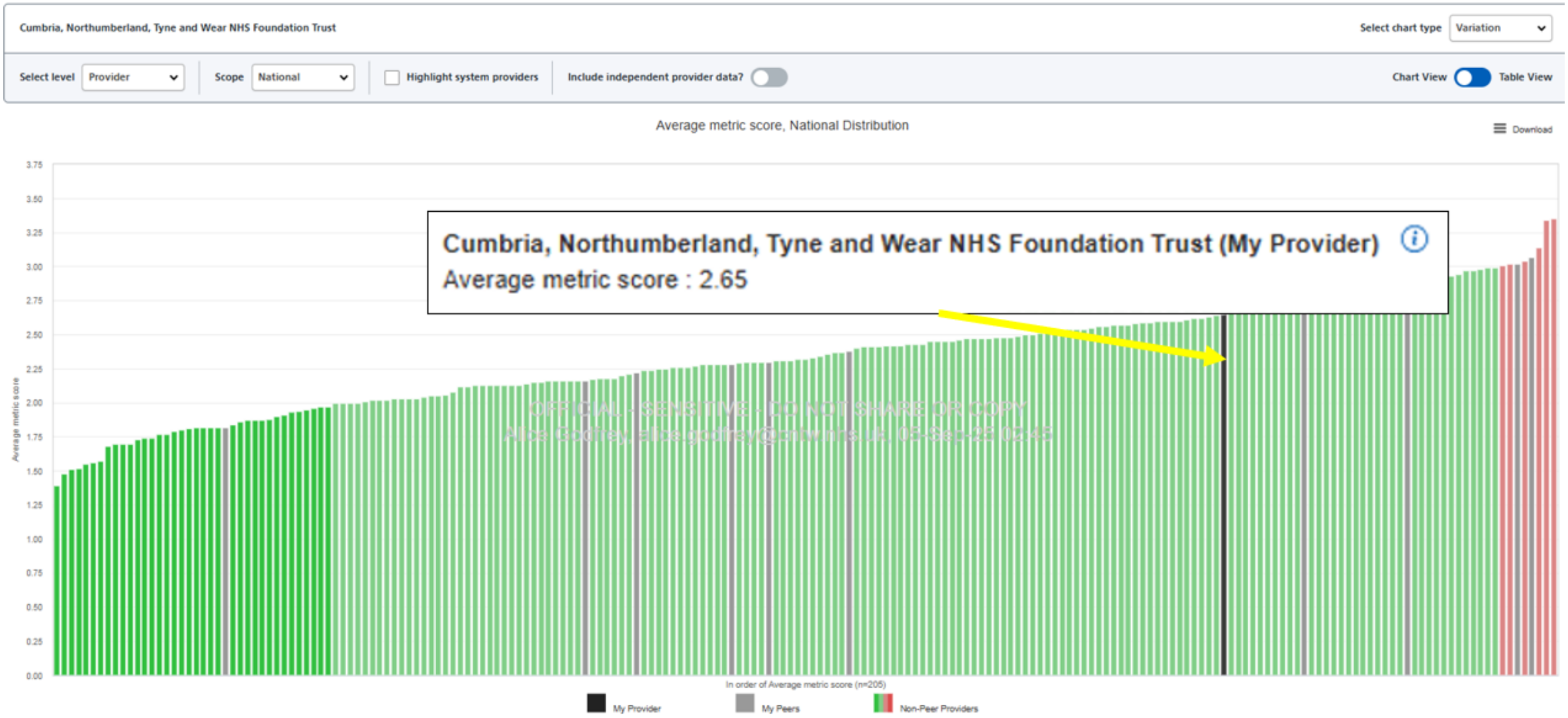
NHS Oversight Framework CNTW Q1 25/26 domain Scoring

Reporting Period: Sep-2025

Segments	Segment Domain	Measure	Data Period	Actual	Peer Median/ Mean	NOF Score domain	NOF score
Access to Services	3	Annual % change in the number of CYPS accessing NHS funded mental health services	Jun-25	**3.06% increase**	1.75%	3	**2.84**
Effectiveness and experience of care	4	CQC community mental health survey satisfaction rate score	Q1 25/26	**2**	*Not provided*	2	**2**
		Percentage of inpatients with a length of stay exceeding 60 days at discharge score	Jun-25	**29.8%**	23.1%	3	**3.43**
Patient Safety	2	NHS Staff Survey - raising concerns sub-score score	Q1 25/26	**6.70**	6.69	3	**2.9**
		Percentage of patients in crisis to receive face-to-face contact within 24 hours score	Jun-25	**72%**	51%	2	**1.73**
People and workforce	4	Sickness absence rate score	Mar-25	**6.53%**	5.60%	4	**3.66**
		NHS staff survey engagement theme score	Dec-24	**6.97**	7.02	3	**3.15**
Finance and productivity	2	Planned surplus/deficit	Apr-25	**0.39%**	0.00%	1	**1**
		Variance year-to-date to financial plan score	Jun-25	**2.67**	0.02	1	
		Relative Cost Difference	Mar-24	**112%**	101%	3	**3.17**
Overall	**4 of 4**					**Score**	**2.65**

NHS Oversight Framework – Q1 25-26 national distribution

Reporting Period: Sep-2025



Headline SPC performance measure summary

Reporting Period: May-2025

Target assurance

Variation	Consistently achieve	Achieve at Random	Consistently off target	No Target
Improvement			• % of patients with a Safety & Risk Management Plan • Appraisal rate	• Reducing incidents of self harm • MRE Restraints
Normal Variation	• Did you feel safe? • % PLT Ward referrals seen within 24hrs • EIP – Starting Treatment in 14 days	• How was your experience? (FFT) • How was the care we provided? • Active Inappropriate Out of Areas • % Adult inpatients discharged with LOS >60 days • % Older Adult inpatients discharged with LOS >90 days • Crisis % Very urgent seen within 4 hours • Crisis % Urgent seen within 24 hours • % PLT ED referrals seen within 1hr	• Sickness • Rights at point of Detention • Records of Capacity/CTT at point of detention • All staff WTEs against plan	• Prone Restraints • Long Term Seg & prolonged seclusion • Assaults on Patients • Assaults on Staff
Concern		• Adult & Older Adult Wards – Average Length of Stay (ALoS) Rolling 3 months	• Bed Occupancy • Clinically Ready for Discharge • % 4 week or less to treatment (WAAOP) • % Waiting 4 weeks or less to receive help (CYPS)	

Core Trust Integrated Outcome Measures - Summary Overview

Reporting Period: Sep-2025

	Ref	Indicator Name	Variation	Assurance	Performance	Target	Target Type	Risk Rating	Summary Narrative	Exec
Commitments	C01	How was your experience? (FFT)	Normal Variation	Achieve at Random	88.5%	90%	CNTW Std	Med (Monitoring)	Improved in the month	SR
	C02	How was the care we provided?	Normal Variation	Achieve at Random	89.3%	90%	CNTW Std	Med (Monitoring)	Deteriorated in the month	SR
	C03	Did you feel safe?	Normal Variation	Consistently Achieve	94.1%	90%	CNTW Std	Low (On Track)	Reported consistently above target	SR
People	P01	Sickness in Month	Normal Variation	Consistently Off Target	6.7%	5%	NHSE Std	High (Action)	No improvement, remains off target (excludes NTWS)	LS
	P04	Appraisal rate	Improvement	Consistently Off Target	81.6%	85%	CNTW Std	Med (Monitoring)	Improving and best performance in 24mths (excludes NTWS)	LS
	P05	% Clinical Supervision completed	SPC n/a	SPC n/a	88.1%	80%	CNTW Std	Low (On Track)	Performance is consistently above the target	LS
Quality Care	Q01	MRE Restraints	Improvement	SPC not applicable	0	n/a	n/a	Med (Monitoring)	No reported MRE restraints for the first time in 24 months	SR
	Q02	Prone Restraints	Normal Variation	SPC not applicable	13	n/a	n/a	Med (Monitoring)	Position deteriorated by 1 from August, remains within control limits	SR
	Q03	Long term segregation and prolonged seclusion	Normal Variation	SPC not applicable	12	n/a	n/a	Med (Monitoring)	Deteriorated in the month	SR
	Q04	Assaults on Patients	Normal Variation	SPC not applicable	136	n/a	n/a	Med (Monitoring)	No change in the month (136 reported August 2025)	RN
	Q05	Assaults on staff	Normal Variation	SPC not applicable	397	n/a	n/a	Med (Monitoring)	Significant improvement in the month (489 reported August 2025)	RN
	Q06	% of patients with a Safety & Risk Management Plan	Improvement	Consistently Off Target	90.8%	100%	CNTW Std	Med (Monitoring)	Position improved, continual improvement since April 24	RN
	Q07	Reducing incidents of self-harm	Improvement	SPC not applicable	922	n/a	n/a	Med (Monitoring)	Position improved in the month (1,004 reported August 2025)	RN
	Q08	Rights at Point of Detention	Normal Variation	Consistently Off Target	90.1%	100%	CNTW Std	High (Action)	Performance continues to fluctuate, 0.7% deterioration from August	RN
	Q09	Record of Capacity/ CTT at point of detention	Improvement	Consistently Off Target	85.3%	100%	CNTW Std	High (Action)	Remains consistently off target, deteriorated in the month by 8.6%	RN
Person Led Care	A01	Active Inappropriate Out of Area Placements	Normal Variation	Achieve at Random	0	0	NHSE LTP	Low (On Track)	There were no active Out of Area Placements at the end of September	RD
	A02	Bed Occupancy including leave (open beds on RiO)	Concern	Consistently Off Target	95.7%	85%	NHSE Std	High (Action)	Deteriorated in the month and remains above target	RD
	A03	% Adult inpatients discharged with LOS > 60 days	Normal Variation	Achieve at Random	28.4%	20%	CNTW Std	Med (Monitoring)	Deteriorated in the month and remains above target	RD
	A04	% OP inpatients discharged with LOS > 90 days	Normal Variation	Achieve at Random	41.2%	40%	CNTW Std	Med (Monitoring)	Improved in the month, reported above target	RD
	A05	Adult & Older Adult Wards - ALoS Rolling 3 months	Normal Variation	Achieve at Random	65.8	59.8	CNTW Std	Med (Monitoring)	Off target for the past 10 months	RD
	A06	Clinically Ready for Discharge (formerly DTOC)	Concern	Consistently Off Target	18.3%	7.5%	NHSE Std	High (Action)	Remains off track, highest position reported in 24 months	RD
	A07	Crisis % Very urgent seen within 4 hours (WAA&OP)	Normal Variation	Achieve at Random	51.3%	65%	CNTW Traj	Med (Monitoring)	40 out of 78 very urgent referrals seen within 4 hours	RD
	A08	Crisis % Urgent seen within 24 hours (WAA&OP)	Normal Variation	Achieve at Random	84.8%	85%	CNTW Std	Med (Monitoring)	373 out of 440, improved in month, 0.2% below target	RD
	A09	% PLT ED Referrals seen within 1 hour	Normal Variation	Achieve at Random	81.4%	80%	CNTW Std	Low (On Track)	Remains above the internal target	RD
	A10	% PLT Ward Referrals seen within 24 hours	Normal Variation	Consistently Achieve	94.9%	85%	CNTW Std	Low (On Track)	Reported consistently above the internal target	RD
	A11	% Waiting 4 wks or less to treatment (WAAOP)	Concern	Consistently Off Target	26.9%	75%	CNTW Traj	High (Action)	73.1% (1,776 of 2,431) have been waiting longer than 4 weeks	RD
	A12	% Waiting 4 wks or less to receive help (CYPS)	Concern	Consistently Off Target	8.2%	55%	CNTW Traj	High (Action)	91.8% (8,736 of 9,520 have been waiting longer than 4 weeks	RD
	A13	EIP – starting treatment in 14 days	Normal Variation	Consistently Achieve	85.5%	60%	CNTW Std	Low (On Track)	Reported consistently above target	RD
Sustainable	S01	Live within our means (I&E Surplus/Deficit £)	SPC not applicable	SPC not applicable	£0.6m	-£1.5m	n/a	Low (No Target)	£0.6m surplus at month 6, £2.1m ahead of plan due to land sale	CC
	S02	Income & Expenditure Forecast	SPC not applicable	SPC not applicable	£3.3m	£3.3m	n/a	Low (No Target)	£3.3m surplus reported with increased risk & recovery plans in place	CC
	S03	All staff WTEs	Normal Variation	Consistently Off Target	8,592	8,497	CNTW Traj	Med (Monitoring)	The Trust was 95 WTE over established at month 6	CC
	S04	Capital spend compared to plan (£)	SPC not applicable	SPC not applicable	£1.1m	£1.5m	n/a	Low (No Target)	The capital programme was behind plan at month 6	CC
	S05	Cash balance compared to plan (£)	SPC not applicable	SPC not applicable	£22.4m	£33.4m	n/a	Low (No Target)	The Trust cash balance is lower than plan at month 6	CC

Great Place to Work - Training

All Staff Priority Training Compliance %

Ref	Indicator Name	Variation	Assurance	Performance	Target	Target Type	Numerator	Denominator	Risk Rating
TA01	Information Governance	Concern	Consistently Achieve	92.0%	90%	CNTW Std	8,112	8,821	Med (Monitoring)
TA02	Corporate Induction	Concern	Consistently Achieve	95.9%	95%	CNTW Std	8,456	8,821	Med (Monitoring)
TA03	Local Induction	Improvement	Achieve at Random	95.4%	95%	CNTW Std	8,379	8,788	Low (On Track)
TA04	Safeguarding Adults Level 1	Normal Variation	Consistently Achieve	95.6%	85%	CNTW Std	1,520	1,590	Low (On Track)
TA05	Safeguarding Children Level 1	Normal Variation	Consistently Achieve	95.2%	85%	CNTW Std	1,513	1,590	Low (On Track)
TA06	Fire	Normal Variation	Consistently Achieve	90.0%	85%	CNTW Std	7,937	8,821	Low (On Track)
TA07	Equality & Diversity Introduction	Improvement	Consistently Achieve	95.4%	85%	CNTW Std	8,412	8,821	Low (On Track)
TA08	Health & Safety	Improvement	Consistently Achieve	95.4%	85%	CNTW Std	8,419	8,821	Low (On Track)
TA09	Infection Prevention & Control (IPC)	Concern	Consistently Achieve	93.2%	85%	CNTW Std	8,218	8,821	Med (Monitoring)
TA10	Moving & Handling Awareness Training	Improvement	Consistently Achieve	94.3%	85%	CNTW Std	8,316	8,821	Low (On Track)
TA11	Web Risk Register	Improvement	Consistently Off Target	84.2%	85%	CNTW Std	689	818	Med (Monitoring)
TA12	Oliver McGowan Mandatory Training	SPC not applicable	SPC not applicable	33.5%	n/a	n/a	532	1,590	Low (No Target)

Clinical Staff Priority Training Compliance %

Ref	Indicator Name	Variation	Assurance	Performance	Target	Target Type	Numerator	Denominator	Risk Rating
TC01	Clinical Risk and Suicide Prevention	Improvement	Achieve at Random	83.0%	85%	CNTW Std	3,343	4,029	Low (On Track)
TC02	Biopsychosocial at Risk Assess. & Safety Planning	Improvement	Consistently Achieve	92.4%	85%	CNTW Std	3,724	4,029	Low (On Track)
TC03	Resuscitation L2 Adult Basic Life Support	Improvement	Consistently Off Target	83.7%	85%	CNTW Std	1,565	1,869	Med (Monitoring)
TC04	Resuscitation L3 Adult Immediate Life Support	Normal Variation	Consistently Off Target	72.4%	85%	CNTW Std	2,459	3,395	High (Action)
TC05	Resuscitation L3 Paediatric Immed Life Support	Improvement	Consistently Off Target	75.6%	85%	CNTW Std	31	41	High (Action)
TC06	Resuscitation L2 Paediatric Basic Life Support	Improvement	Consistently Off Target	80.7%	85%	CNTW Std	482	597	High (Action)
TC07	PMVA Basic	Improvement	Consistently Off Target	79.9%	85%	CNTW Std	1,977	2,476	High (Action)
TC09	Engagement & Observation	Improvement	Achieve at Random	89.9%	85%	CNTW Std	2,941	3,273	Low (On Track)
TC10	Dysphagia Awareness	Improvement	Achieve at Random	91.7%	85%	CNTW Std	2,265	2,469	Low (On Track)
TC11	Autism Core Capabilities: Tier 1 & 2	SPC not applicable	SPC not applicable	61.0%	70%	CNTW Traj	3,960	6,496	High (Action)
TC12	Learning Disability Tier 1	SPC not applicable	SPC not applicable	50.9%	60%	CNTW Traj	3,306	6,496	High (Action)

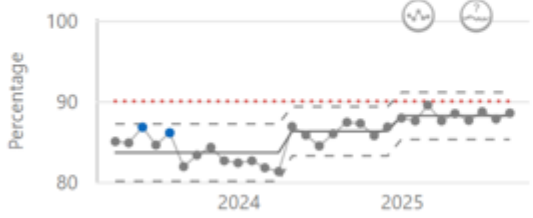
Commitments to our Carers and Patients

Reporting Period: Sep-2025

How was your experience? (FFT)

Med (Monitoring)

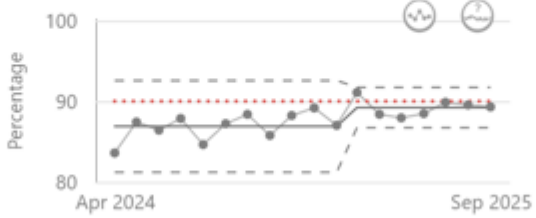
Ref: C01 September: 88.5% CNTW Std: 90%



How was the care we provided?

Med (Monitoring)

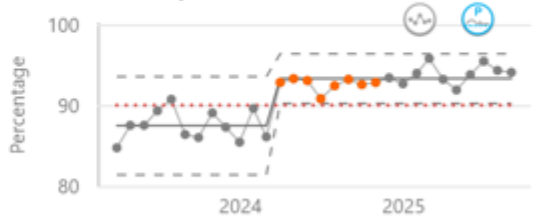
Ref: C02 September: 89.3% CNTW Std: 90%



Did you feel safe?

Low (On Track)

Ref: C03 September: 94.1% CNTW Std: 90%



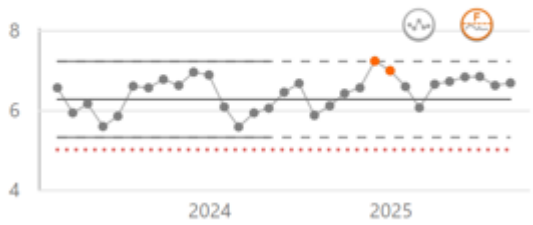
Great Place to Work

Reporting Period: Sep-2025

Sickness in Month

High (Action)

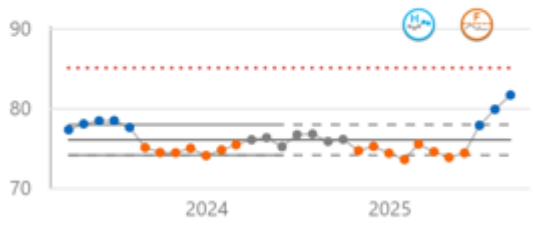
Ref: P01 September: 6.7% NHSE Std: 5%



Appraisal rate

Med (Monitoring)

Ref: P04 September: 81.6% CNTW Std: 85%



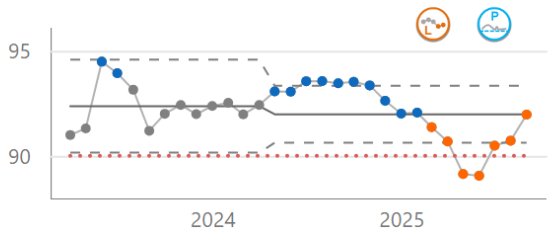
Great Place to Work – All Staff Priority Training Compliance %

Reporting Period: Sep-2025

Information Governance

Med (Monitoring)

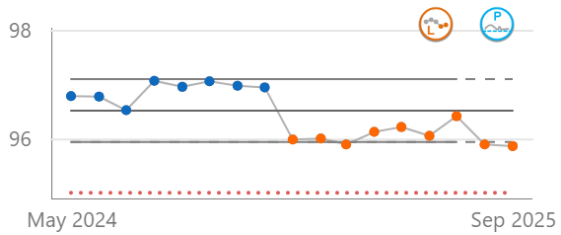
Ref: TA01 September: 92.0% CNTW Std: 90%



Corporate Induction

Med (Monitoring)

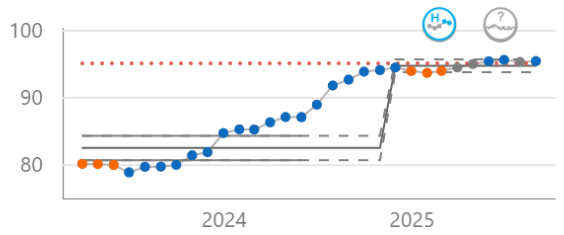
Ref: TA02 September: 95.9% CNTW Std: 95%



Local Induction

Low (On Track)

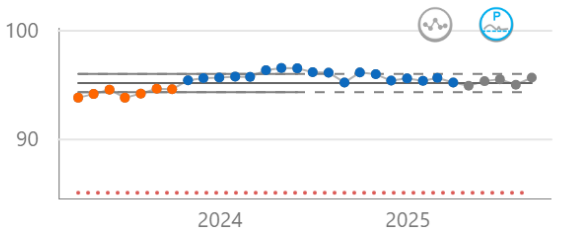
Ref: TA03 September: 95.4% CNTW Std: 95%



Safeguarding Adults Level 1

Low (On Track)

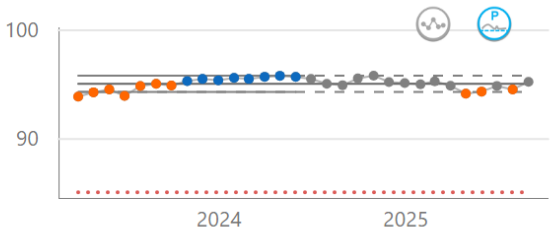
Ref: TA04 September: 95.6% CNTW Std: 85%



Safeguarding Children Level 1

Low (On Track)

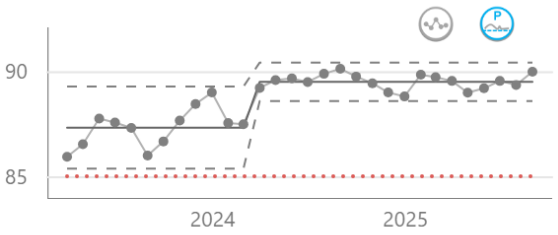
Ref: TA05 September: 95.2% CNTW Std: 85%



Fire

Low (On Track)

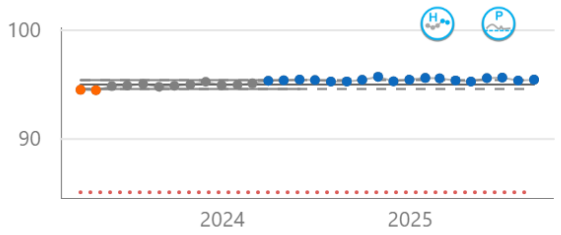
Ref: TA06 September: 90.0% CNTW Std: 85%



Equality & Diversity Introduction

Low (On Track)

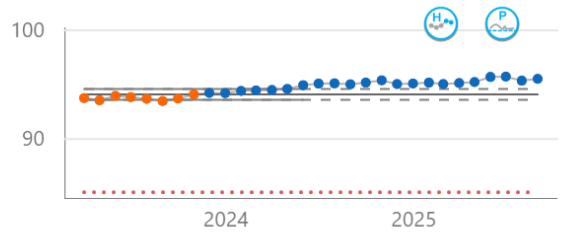
Ref: TA07 September: 95.4% CNTW Std: 85%



Health & Safety

Low (On Track)

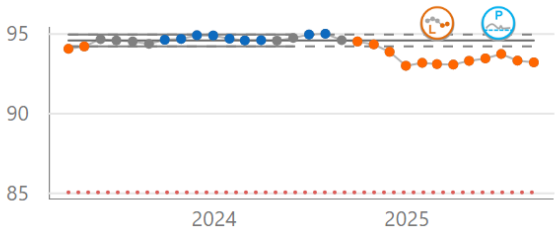
Ref: TA08 September: 95.4% CNTW Std: 85%



Infection Prevention & Control (IPC)

Med (Monitoring)

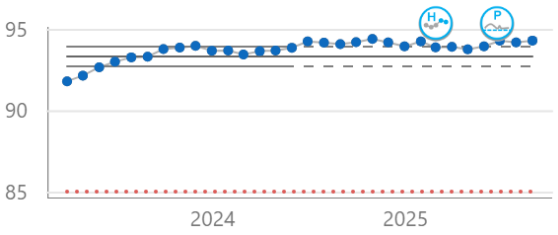
Ref: TA09 September: 93.2% CNTW Std: 85%



Moving & Handling Awareness Training

Low (On Track)

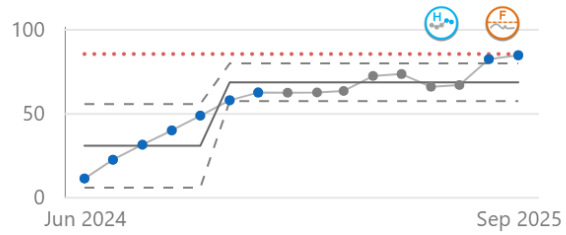
Ref: TA10 September: 94.3% CNTW Std: 85%



Web Risk Register

Med (Monitoring)

Ref: TA11 September: 84.2% CNTW Std: 85%



Oliver McGowan Mandatory Training

Low (No Target)

Ref: TA12 September: 33.5% Plan: n/a

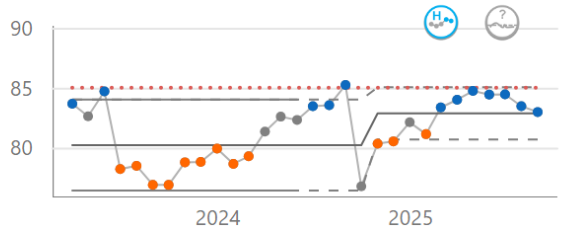
Great Place to Work — Clinical Staff Priority Training Compliance %

Reporting Period: Sep-2025

Clinical Risk and Suicide Prevention

Low (On Track)

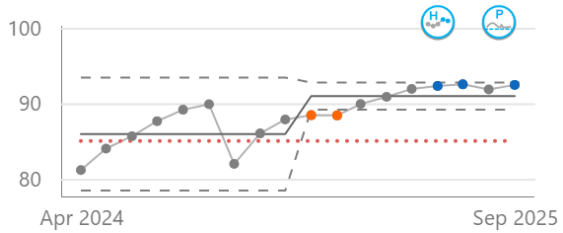
Ref: TC01 September: 83.0% CNTW Std: 85%



Biopsychosocial at Risk Assess. & Safety Planning

Low (On Track)

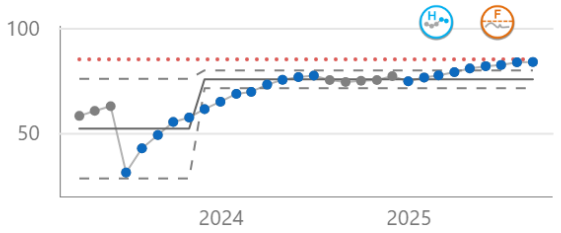
Ref: TC02 September: 92.4% CNTW Std: 85%



Resuscitation L2 Adult Basic Life Support

Med (Monitoring)

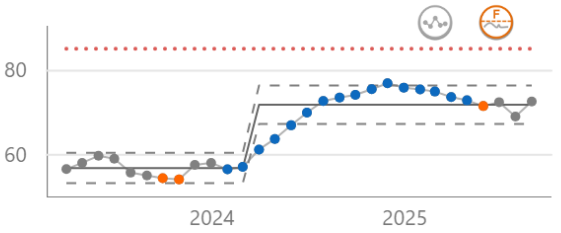
Ref: TC03 September: 83.7% CNTW Std: 85%



Resuscitation L3 Adult Immediate Life Support

High (Action)

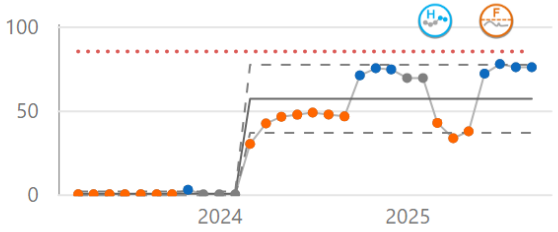
Ref: TC04 September: 72.4% CNTW Std: 85%



Resuscitation L3 Paediatric Immed Life Support

High (Action)

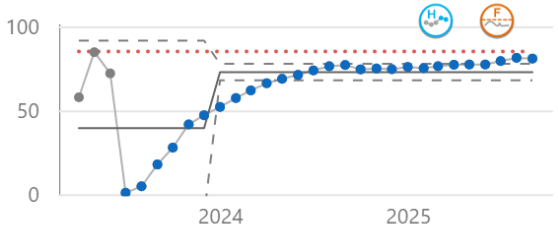
Ref: TC05 September: 75.6% CNTW Std: 85%



Resuscitation L2 Paediatric Basic Life Support

High (Action)

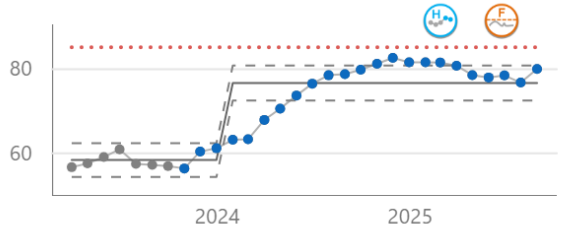
Ref: TC06 September: 80.7% CNTW Std: 85%



PMVA Basic

High (Action)

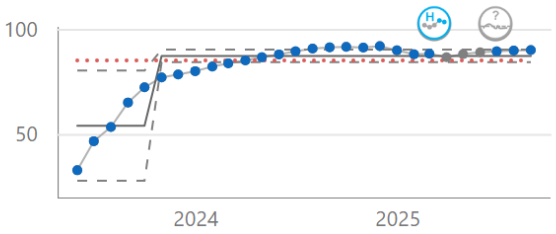
Ref: TC07 September: 79.9% CNTW Std: 85%



Engagement & Observation

Low (On Track)

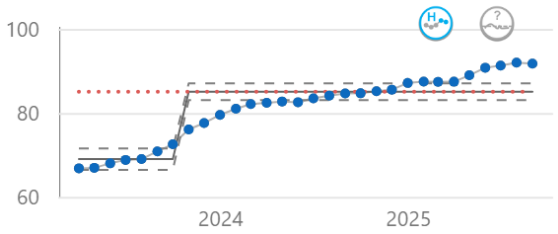
Ref: TC09 September: 89.9% CNTW Std: 85%



Dysphagia Awareness

Low (On Track)

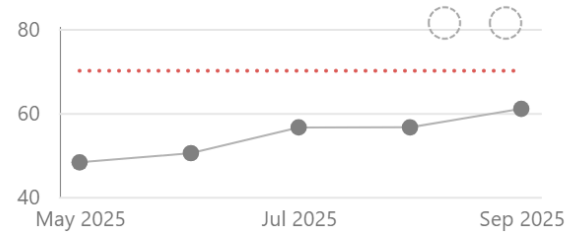
Ref: TC10 September: 91.7% CNTW Std: 85%



Autism Core Capabilities: Tier 1 & 2

High (Action)

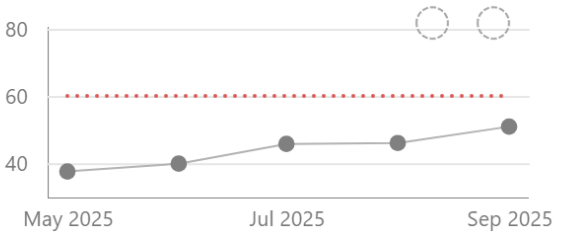
Ref: TC11 September: 61.0% CNTW Traj: 70%



Learning Disability Tier 1

High (Action)

Ref: TC12 September: 50.9% CNTW Traj: 60%



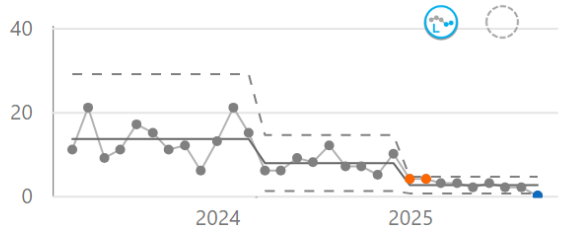
Quality Care, Every Day

Reporting Period: Sep-2025

MRE Restraints

Med (Monitoring)

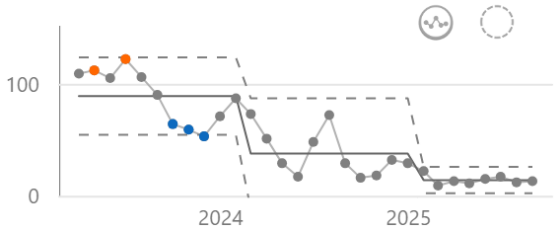
Ref: Q01 September: 0 Plan: n/a



Prone Restraints

Med (Monitoring)

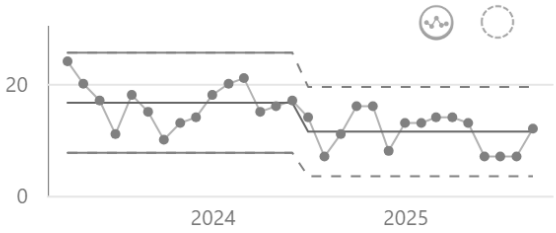
Ref: Q02 September: 13 Plan: n/a



Long term segregation and prolonged seclusion

Med (Monitoring)

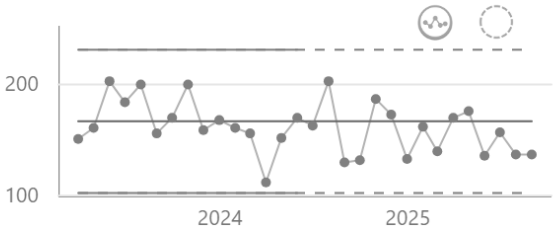
Ref: Q03 September: 12 Plan: n/a



Assaults on Patients

Med (Monitoring)

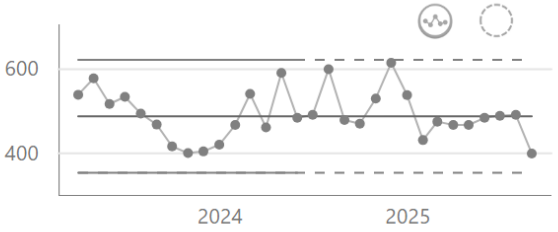
Ref: Q04 September: 136 Plan: n/a



Assaults on staff

Med (Monitoring)

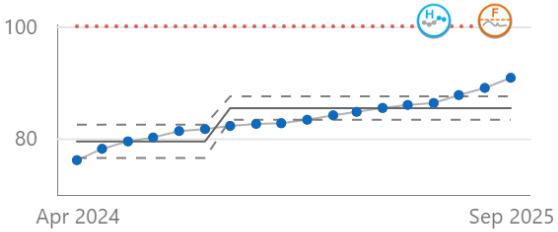
Ref: Q05 September: 397 Plan: n/a



% of patients with a Safety & Risk Management Plan

Med (Monitoring)

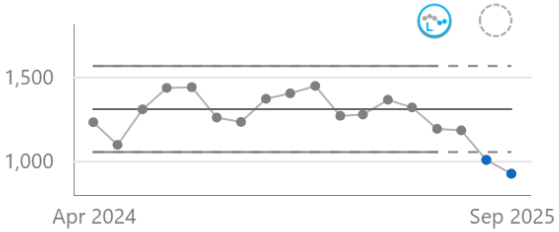
Ref: Q06 September: 90.8% CNTW Std: 100%



Reducing incidents of self-harm

Med (Monitoring)

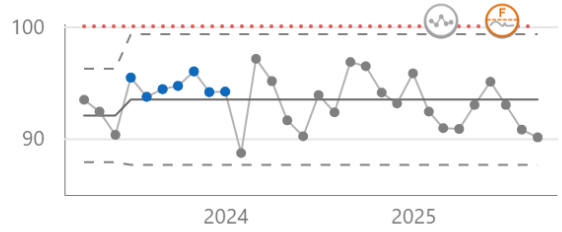
Ref: Q07 September: 922 Plan: n/a



Rights at Point of Detention

High (Action)

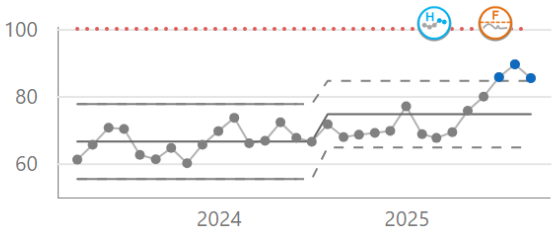
Ref: Q08 September: 90.1% CNTW Std: 100%



Record of Capacity/ CTT at point of detention

High (Action)

Ref: Q09 September: 85.3% CNTW Std: 100%



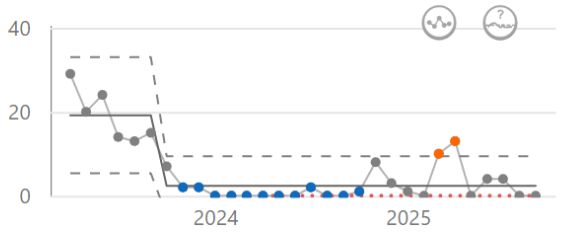
Person-led Care, when and where needed

Reporting Period: Sep-2025

Active Inappropriate Out of Area Placements

Low (On Track)

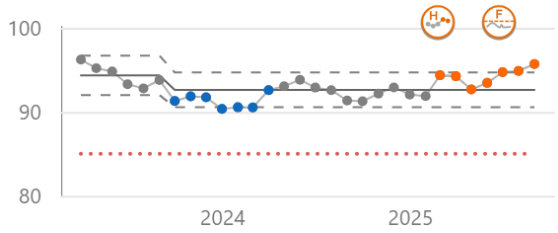
Ref: A01 September: 0 NHSE LTP: 0



Bed Occupancy including leave (open beds on RiO)

High (Action)

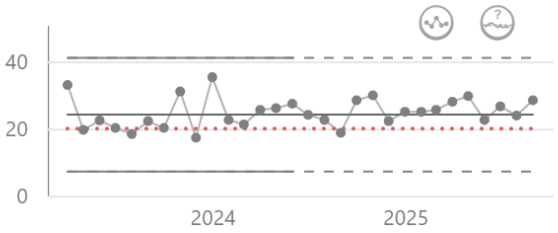
Ref: A02 September: 95.7% NHSE Std: 85%



% Adult inpatients discharged with LOS > 60 days

Med (Monitoring)

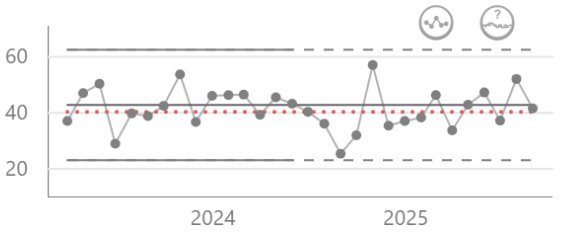
Ref: A03 September: 28.4% CNTW Std: 20%



% OP inpatients discharged with LOS > 90 days

Med (Monitoring)

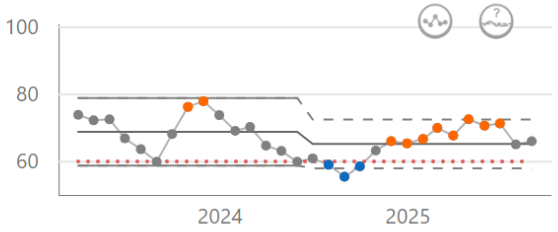
Ref: A04 September: 41.2% CNTW Std: 40%



Adult & Older Adult Wards - ALoS Rolling 3 months

Med (Monitoring)

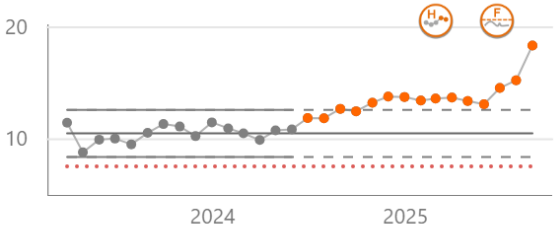
Ref: A05 September: 65.8 CNTW Std: 59.8



Clinically Ready for Discharge (formerly DTOC)

High (Action)

Ref: A06 September: 18.3% NHSE Std: 7.5%



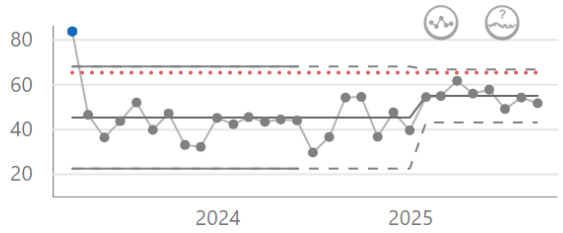
Person-led Care, when and where needed

Reporting Period: Sep-2025

Crisis % Very urgent seen within 4 hours (WAA&OP)

Med (Monitoring)

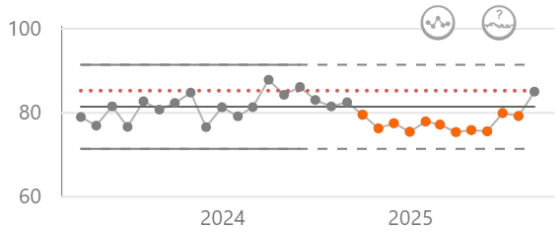
Ref: A07 September: 51.3% CNTW Traj: 65%



Crisis % Urgent seen within 24 hours (WAA&OP)

Med (Monitoring)

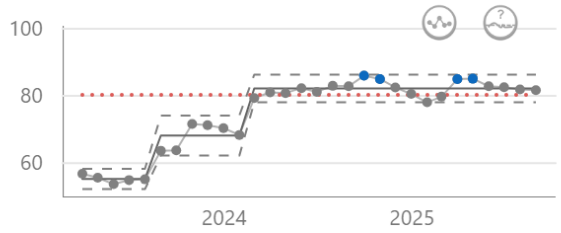
Ref: A08 September: 84.8% CNTW Std: 85%



% PLT ED Referrals seen within 1 hour

Low (On Track)

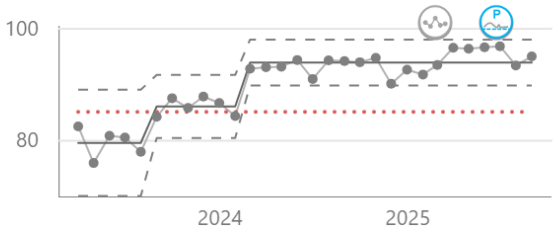
Ref: A09 September: 81.4% CNTW Std: 80%



% PLT Ward Referrals seen within 24 hours

Low (On Track)

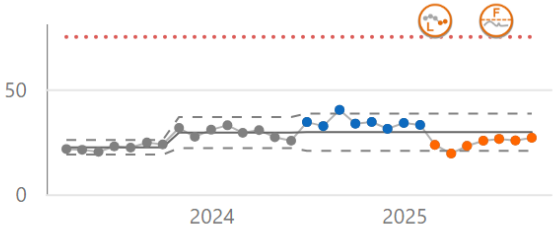
Ref: A10 September: 94.9% CNTW Std: 85%



% Waiting 4 wks or less to treatment (WAAOP)

High (Action)

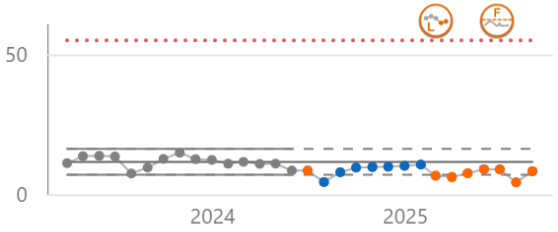
Ref: A11 September: 26.9% CNTW Traj: 75%



% Waiting 4 wks or less to receive help (CYPS)

High (Action)

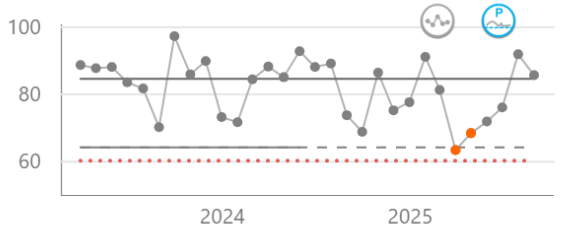
Ref: A12 September: 8.2% CNTW Traj: 55%



EIP – starting treatment in 14 days

Low (On Track)

Ref: A13 September: 85.5% CNTW Std: 60%



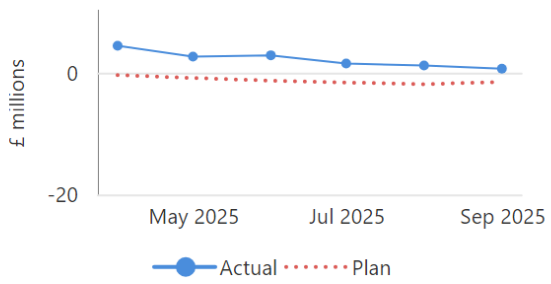
Sustainable for the Long Term

Reporting Period: Sep-2025

Live within our means (I&E Surplus/Deficit £)

Low (No Target)

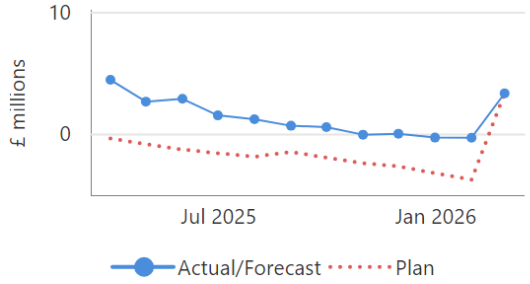
Ref: S01 September: £0.6m Plan: -£1.5m



Income & Expenditure Forecast

Low (No Target)

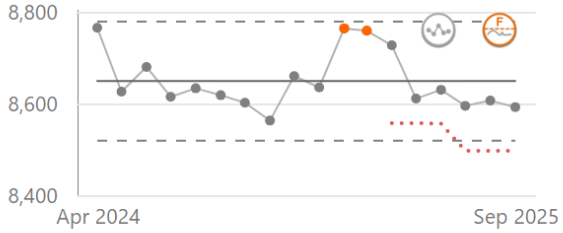
Ref: S02 March: £3.3m Plan: £3.3m



All staff WTEs

Med (Monitoring)

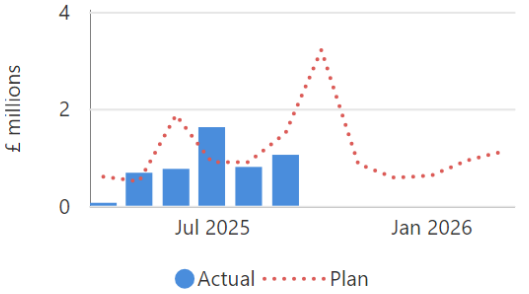
Ref: S03 September: 8,592 CNTW Traj: 8,497



Capital spend compared to plan (£)

Low (No Target)

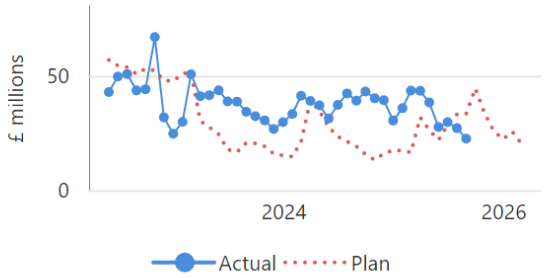
Ref: S04 September: £1.1m Plan: £1.5m



Cash balance compared to plan (£)

Low (No Target)

Ref: S05 September: £22.4m Plan: £33.4m



Interpreting summary icons

These icons provide a summary view of the important messages from SPC charts.

	Variation / performance Icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	**Normal Variation** Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	**Concern** Special cause variation of a CONCERNING nature.	**Something's going on!** Something, a one-off or a continued trend or shift of numbers in the wrong direction	**Investigate** to find out what is happening / has happened. Is it a one off event that you can explain? Or do you need to change something?
	**Improvement** Special cause variation of an IMPROVING nature.	**Something good is happening!** Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening / has happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Assurance icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	**Achieve at random** This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	**Consistently off target** This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	**Consistently achieve** This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Interpreting SPC charts

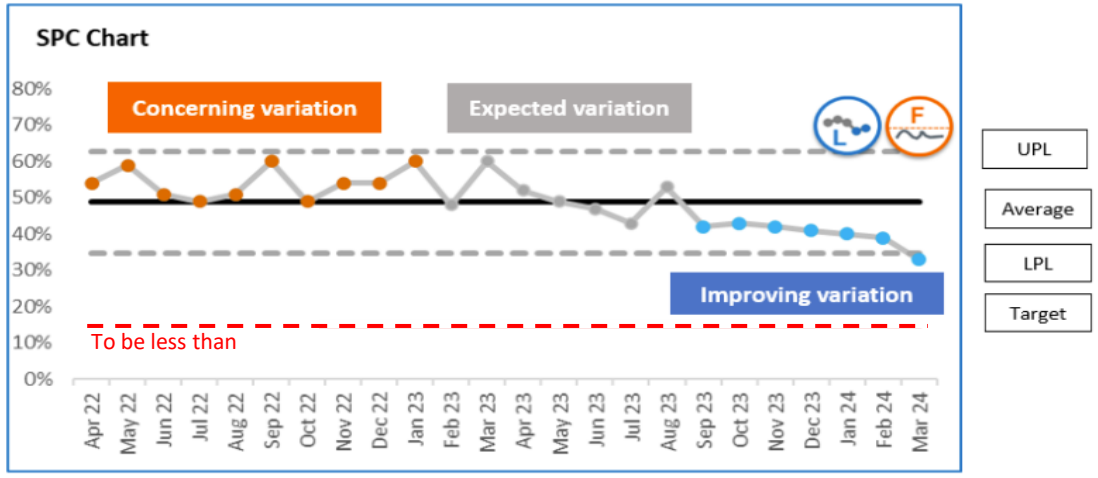
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated and improvement actions implemented

Blue – there is a pattern of improvement which should be learnt from

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable



The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard (the **red** line) can be achieved always, never (as in this example) or sometimes.

SPC charts therefore describe not only the type of variation in data, but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

Risk scoring process

Step 1

Guide to Risk scoring		Target Assurance		
		Consistently Achieve	Achieve at Random	Consistently off target
Variation	Improving	Risk: LOW	Risk MED	Risk MED
	Normal Variation	Risk: LOW	Risk MED	Risk: HIGH
	Concern	Risk MED	Risk: HIGH	Risk: HIGH

Step 2

Risk level is worked out using the SPC variation and target assurance in step 1. Then a step 2 test is applied.

- Is the metric something without a target such as safety incidents and we want to continue to monitor the actions
- A common-sense check of the SPC interpretation and risk may lead to a slight adjustment of the risk

Step 3

Risk score of med or high means that an exception report pages is added to the IPR with a full SPC graph, Care Group data breakdown, reasons for performance issue, list of actions and expected improvement timescales.

2. STRATEGIC AMBITION 1 - QUALITY CARE, EVERY DAY

Darren Best, Chair

2.1 QUALITY AND PERFORMANCE COMMITTEE QUARTERLY ASSURANCE REPORT

Louise Nelson, Committee Chair

REFERENCES

Only PDFs are attached

2.1 QandP Assurance report to Board - Nov 25.pdf

Report to the Board of Directors
5 November 2025

Quality and Performance Committee Quarterly Assurance Report
August 2025 – October 2025

1. Purpose

This report seeks to provide the Board with assurance of ongoing oversight of key areas of focus and risk undertaken by the Quality and Performance Committee. This includes an overview of the areas of focus, discussion and assurance and the Board Assurance Framework risks currently aligned to the Committee.

2. Quality and Performance Committee overview

The Committee receives assurance on the implementation and delivery of key performance, quality, safety strategies, programmes of work and systems. It also has oversight of patient and carer experience, including continued the focus on ensuring patient and carer involvement is embedded across the Trust. The Committee receives assurance in relation to systems and processes to ensure ongoing compliance with legislative frameworks including the Care Quality Commission, NICE guidance and other nationally agreed guidance relating to Clinical Effectiveness.

A representative from the North East and North Cumbria Integrated Care Board also attends meetings of the Committee. There have been two meetings of the Committee during the period August 2025 – October 2025. Meetings were held on 3 September and 8 October.

3. Board Assurance Framework risks within Committee remit

The Quality and Performance Committee is currently managing the following key risks on the BAF:

Risk descriptor	Risk score
Risk 2510 – Due to increased demand the Trust is unable to meet regulatory standards relating to access, responsiveness, and performance resulting in a risk to quality and safety of patient care.	4 (likely) X 4 (significant) 16
Risk 2511 – Risk of not meeting regulatory and statutory requirements of Care Quality Commission (CQC) registration and quality standards.	4 (likely) X 5 (major) 20
Risk 2512 – Risk of failing to maintain a positive patient safety learning culture resulting in avoidable harm, poor systems, process and policy, and escalation of serious issues of concern.	4 (likely) X 4 (significant) 16
Risk 2543 – Failure to deliver our transformation plans around the model of care which affects the quality and sustainability of services.	3 (possible) X 4 (significant) 12

4. Quality and Performance Committee focus August – October 2025

4.1 Assurance relating to risk 2510

This is predominantly received through the Integrated Performance Report which provides a summary of all performance metrics for the period. During the period, this has been supported with bespoke reports and discussions on key areas of focus.

At the September meeting, an update was provided detailing the processes for monitoring and escalating those patients who are clinically ready for discharge (CRFD). Patients who are CRFD remain in hospital due to barriers such as lack of housing and ongoing social care packages which are out-with the Trusts control. The issue is recognised as multifactorial and requires ongoing partnership with system-wide stakeholders to facilitate improvement. The significant financial implications were noted and the need for long term solutions to address the issue. From a quality perspective, the impact on patients was also recognised as well as the potential for distress and harm. The North East and North Cumbria representative on the Committee noted that the ICB were acutely aware of this as a multifactorial and complex issue and agreed to continue to feedback and escalate this further with the ICB.

At the September meeting, an update on Community Services waiting times was provided and included improvement in general performance over the past 12 months, however significant challenges remain specifically within the gender services pathways. An update following a planned deep dive on gender waiting times will be provided in the next quarterly report. The importance of working with partners was highlighted to ensure a unified approach to address the impact of long waiting times on service users.

As of October, Adult and older adult pathways remain a concern and the committee have received recovery plans with ongoing monitoring in place. The neurodevelopmental pathway remains challenged, and a trajectory plan is in development.

At the October meeting, the Committee noted a significant reduction in self-harm incidents, a previous area of concern for the Committee.

At each committee meeting, there is a quality focus / deep dive into an issue which is of particular interest to the Committee from an assurance perspective. The September meeting focused on the work to improve ligature assessments. The October meeting focused on the progress being made to implement the actions to address regulatory breaches placed upon the Trust following service-level inspections over the past 12 months. Further detail on these is provided in section 4.2 below.

4.2 Assurance relating to risk 2511

Significant work has been undertaken on delivering the actions required to address the regulatory breaches placed upon the Trust by the CQC during service-level inspections throughout 2024 and 2025. Service-level inspections have taken place in learning disability and autism services, community services, children and young people's services and older people's services.

A presentation and report were provided detailing the themes from our recent CQC inspection and the actions required to address breaches and areas of concern.

Following the Boards commitment to achieving no use of prone restraint and reducing MRE, trajectories have been set for all bed-based services.

Following concerns raised by the CQC that learning from incidents, complaints, and Freedom to Speak Up concerns were not being shared across CBUs and teams, there is now a standardised

group governance structure in place supported by new learning groups and expanded learning webinar. There is further work required to ensure the integration of the patient voice and improving thematic reporting of learning outcomes.

The Trust policy and guidance for lone working have been reviewed and a subsequent internal audit complete to provide an additional layer of assurance.

A quality focus/deep dive on the management of ligature risks at the September meeting. The update included the Trust's current position in relation to the assessment of ligature risks, a summary analysis of ligature related incidents, the draft compliance assessment against the CQC 2023 guidance and the work being progressed in the context of the CQC regulatory breaches. A new ligature assessment process has been piloted and the development of the community CERA (clinical environment risk assessment) will be implemented through a phased approach across community services. Ongoing work includes clarifying standards and auditing of the new processes.

The Trust has reviewed the processes across community services for referral and assessment. Caseload management has been undertaken and underpinned by implementation of a Trust policy to standardise the approach to waiting list management.

Learning disability and autism training is now mandatory for all staff, with compliance continuing to improve.

In relation to concerns raised by the CQC around privacy and dignity relating to same sex accommodation and sexual safety, evidence was provided via an audit and demonstrated compliance with national guidance and the CQC removed this breach from the final report. Despite this, the Trust still recognise the importance of the focus on sexual safety and the need for improvement and are working on clearer definitions and reporting of sexual safety incidents.

Although the Committee acknowledged the level of action taken to date to address the regulatory breaches, they will be a standing agenda item for all committee meetings to ensure oversight and assurance that actions remain on track for completion, as well as updates on evidence of impact. The Committee will use the quality focus agenda item to deep dive into any areas flagging as a concern, and any issues will be escalated to the Board if required.

The committee discussed the importance of identifying potential future breaches, acting on known issues with urgency, and reflecting on why some issues were not addressed before CQC intervention.

4.3 Assurance relating to risk 2512

Assurance in relation to a positive patient safety culture. is predominantly received through regular reporting of serious care reviews and independent investigations. The reports include learning from incidents and cases both locally and from a multi-organisational perspective.

In line with the national Patient Safety Incident Response Framework, the Committee receives and reviews all Patient Safety Incident Investigations (PSII). Six reports have been received during the period. The Committee approved the PSII outcome reports in terms of process and although learning was evident in all reports, the Committee will continue to review the ongoing, longer-term impact of the learning.

Although there were no new independent reports for the period, the committee noted that previous reports contained Board level actions/assurances. A review of such actions and a summary of learning from independent reports will be presented to the February 2026 meeting of the Committee as a quality focus.

The Committee received the Quality and Safety report in September which focuses on learning from incidents, restrictive practice, safeguarding and public protection and complaints and claims. There were no significant issues of concern to note.

4.4 Assurance relating to Risk 2543

There were no reports on the holistic overview of the work of the Trust transformation programmes and the development of the Model of Care and Support given the strategic nature of this and the responsibilities of all Committees, Executive Management Group, operational Groups and the Board. However, the Committee recognises that the cycle of business as it currently stands, and key areas of focus continue to reflect the actions required, within the Committees remit to enable delivery of the Model of Care and Support in the longer-term.

The Committee recognised the ability to deliver the transformational plans under the Trusts Model of Care and Support programme will require urgent action to develop the Trusts medium-term resource plan and Workforce Plan. The Committee asked that these be developed at pace.

An update on the Trust's Quality Aims and Priorities was provided and the alignment of these to the Trust's five strategic ambitions. The Committee will continue to receive updates on progress against achievement of the priorities throughout the year ahead.

4.5 Other issues and assurance received by the Committee

Safer staffing

Regular Safer Staffing reports continue to be reviewed by the Committee noting the ongoing challenges with high acuity, observation levels, and reliance on temporary staff, particularly in North Cumbria and Walkergate Park. It was noted that a recent internal audit provided a reasonable level of assurance. Action plans are in place at operational level to improve escalation, daily management, and support for staff decision-making regarding risk and temporary staff use.

The Committee discussed the link between safer staffing and the financial recovery plan, noting the current staffing model is unaffordable. The Committee requested the urgent development of a Trust Workforce Plan that aligns finance, workforce planning and the Trusts Model of Care and Support. The Committee recognised the need for triangulation of the People Committee, Resource and Business Assurance Committee and Quality and Performance Committee on increased understanding, and use of, benchmarking of reference costs, and the importance of rebasing inpatient units.

A request was made to improve the safer staffing report to have a stronger focus on the impact of staffing changes and how they relate to financial recovery and overall staffing numbers across wards.

NHS Provider Capability Board Self-Assessment

The Committee reviewed the draft NHS England Provider Capability Board Self-Assessment prior to consideration at the October Board development session. All Provider Trusts have been asked to complete the self-assessment against the six domains outlined in the NHS England Insightful Board guidance:

- Strategy, leadership and planning
- Quality of care
- People and culture

- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

The self-assessment was reviewed in the context of identifying any gaps associated with the business of the Quality and Performance Committee in relation to the stated domains. Due to tight timeframes issued by NHS England for completion of the assessment, gaps remained in relation to a number of domains at the time of reporting. For the purpose of this Committee, these related primarily to Domain 2 – quality of care and Domain 4 – access and delivery of services. These gaps were recognised by the Committee and were populated prior to submission to the Board development sessions held on 15 October.

CQC Well led inspection high-level feedback

The Committee noted the CQC initial high-level feedback following the well led inspection undertaken in September/October. It was recognised that the feedback was high-level at this stage, and the final full report was forthcoming. Discussions with the CQC continue to gain further clarity on some of the findings in the letter which will be shared at the open Board meeting in October. It was noted that there was reference to governance and the importance of ensuring a clear line of sight between operations and the Board. This includes being as robust as possible in terms of governance processes and this will be a continual focus for the Committee as part of its planning, agenda setting and reporting.

Medicines Optimisation and controlled drugs management and use

The Medicines Optimisation report was received covering the period January to June 2025. A review of rapid tranquilisation practices showed moderate risk and improved adherence to post-injection monitoring. Clozapine level monitoring showed good practice and the roll out of point-of-care, and reducing result times from days to minutes. Positive feedback has been received from clinicians and patients.

Risks relating to ADHD prescribing was noted and remains high due to GP collective action, with work ongoing with partners to refresh shared care guidelines. This risk was documented on the Corporate Rik Register and is reported as part of the Board Assurance Framework report to the Committee.

A report on the safe use and management of controlled drugs was provided for the period January to June 2025. The Trust medicines policy was updated to clarify handling of lost FP10 prescriptions, partly in response to incidents linked to GP collective action. The assurance report demonstrated good practice and low risk. The Clinical Audit plan continues to support the work around medicines management for an assurance perspective.

Nice guidance report

Three key risks were noted relating to the ongoing review of Nice Guidance 10 – violence and aggression, the pause in the review of ADHD guidance due to medication shortages, and the debate around waist circumference measurements for under-18s prescribed antipsychotics.

Lived experience report

The report provided detail on the activities led by the lived experience service, including Triangle of Care, service user and carer reference groups, the involvement bank, and the youth involvement bank. Whilst the report demonstrates the wide range of involvement activities, it does not yet show the impact of these. Work is ongoing to integrate lived experience data into

the quality and safety report to improve triangulation of intelligence with other metrics thereby improving the level of assurance and breadth to depth in reporting.

Caldicott and Health informatics

The Committee noted that the Trust met the standards required for the 2024-25 Data Security Protection Toolkit (DSPT) submission with external audit results amongst the highest in the region.

Reports for statutory escalation to the Board

The following reports were reviewed by the Committee prior to presentation to the November Board meeting. There were no significant issues to note for escalation alongside the reports:

- Emergency Preparedness Resilience and Response standards and Safety, Security and Resilience Annual Report (including Health and Safety Executive actions)
- Safeguarding and Public Protection Annual Report
- The Infection Prevention and Control quarterly Assurance Annual Report
- Positive and Safe Annual Report (not required for Board escalation – has been shared with the Board for information).

5. Ongoing areas of focus for the Committee

As well as standing items for regular review, the Committee will undertake specific oversight and review of the recovery plans in relation to waiting times and access, including the continuing work to review the neurodevelopmental pathway for children and young people, continue the reduction in the use of restrictive practice, approaches to managing, and progress against the CQC action plan to address the regulatory breaches in place.

Summary and recommendation

The Quality and Performance Committee has continued to operate within its terms of reference and ensure alignment of the cycle of business with the Board Assurance Framework and ensuring the continued focus on assurance of the actions being taken to address key risks to achieving the Trusts Strategic Ambitions.

The Board is asked to:

- Note the content of the report and seek further assurance on any issues where appropriate.
- Note the continuing focus on addressing the actions to close the regulatory breaches issued to the Trust by the CQC.
- Note the focus of the Committee on improving reporting to include earlier escalation of issues, timelines, ownership and impact. This is linked to the receipt of CQC regulatory breaches and the need for earlier intervention internally and pace to address issues of concern.
- Note the need for improvements to be made to the safer staffing report including the link between safer staffing and the financial recovery plan. This includes the urgency to develop a Workforce Plan aligned to the development of a medium-term resource plan and the Trust Model of Care and Support.

Louise Nelson
Chair of Quality and Performance Committee
November 2025

2.2 MENTAL HEALTH LEGISLATION COMMITTEE QUARTERLY REPORT

Emma Moir, Committee Chair

REFERENCES

Only PDFs are attached

2.2 MHLC Committee Assurance report to Board - Nov 25 FINAL.pdf

Report to the Board of Directors
5 November 2025

Mental Health Legislation Committee Quarterly Assurance Report
August 2025 – October 2025

1. Purpose

This report seeks to provide the Board with assurance of ongoing oversight of key areas of focus and risk undertaken by the Mental Health Legislation Committee. This includes an overview of the areas of focus, discussion and assurance.

2. Mental Health Legislation Committee overview

The Committee receives assurance that there are systems, structures and processes in place to ensure compliance with, and support to, the operation of Mental Health Legislation within inpatient and community settings. It ensures that any proposed changes to Mental Health Legislation are identified and monitored, and necessary changes made to practice comply with associated codes of practice and recognised best practice.

It ensures the Trust has in place and uses appropriate policies and procedures in relation to Mental Health Legislation and to facilitate the publication and guidance of the legislation to all relevant staff, service users, carers and managers.

There has been one meeting of the Committee during the period held on 8 October 2025.

3. Board Assurance Framework risks within Committee remit

Although there are currently no Board Assurance Framework risks aligned to the Committee, in July, the Committee reviewed the need for a risk relating to the impact of the changes to legislation set out in the Mental Health Bill. At that time, the Committee felt that the risks associated with this were being managed at the most appropriate level in the organisation but agreed to regular review on an ongoing basis.

In October, a Mental Health Bill Strategy Day took place at DAC Beachcroft attended by the Committee Chair relating to the forthcoming Mental Health Bill. Although the Bill has still not yet come into force, at its October meeting, the Committee agreed to draft a Board Assurance Framework risk relating to risks of impact on quality of care, workforce and service delivery as a result of the Bill. The risk will be drafted and circulated to the Committee for review by the end of October to be considered in the context of the November Board development session on risk and risk appetite.

4. Mental Health Legislation Committee focus October 2025

Panel members

The Committee discussed the outstanding action relating to panel members employment status. Advice was provided in privilege on approaches taken by other organisations regionally and nationally in terms of learning from implementation in response to the ‘Moon’ judgement (the ruling clarified the limitations on the powers of mental health panels, specifically the first-tier Mental Health Tribunal, when imposing conditions on a restricted patient who is conditionally discharged). It was confirmed that in the context of the feedback provided, the Trust will retain the current approach whereby panel members remain statutory office holders acting on behalf of the Hospital Managers under the Mental Health Act 1983.

The Committee recognised the work undertaken to increase panel member representation from ethnic minorities however, more targeted work is required to increase recruitment from these communities. The Committee asked that improvements be made to future reports in terms of the use of data (including benchmarking) and action plans to increase representation and targets around recruitment. This will also be linked to the Patient and Carer Race Equality Framework work.

Giving of Rights

An outstanding action was discussed regarding compliance with the giving of rights in relation to Community Treatment Orders. Issues of compliance have been discussed at operational level and a comprehensive discussion on 'Rights' will take place at the next meeting of the Mental Health Legislation Steering Group on 20 November 2025. A full update on the outcome of the discussions and progress on actions to improve compliance will be provided to the Committee in Quarter 1 2026/27.

Care Quality Commission (well led inspection, Mental Health Reviewer Visits and care planning)

In relation to care planning, issues regarding lack of personalisation of care planning have decreased. Issues remain around timeliness of care plans. This is a quality priority for the Trust for 2025/26 and will be subject to regular review at the Quality and Performance Committee. Mental Health Legislation Committee will continue to have appropriate oversight and assurance via CQC Mental Health Reviewer visit reporting.

The Committee received the CQC Mental Health Reviewer visit report and requested clarity in relation to themes, recommendations and action plans to resolve issues highlighted as part of the reviews, specifically in relation to Mental Health Legislation Committee.

The Committee noted the CQC initial high-level feedback following the well led inspection undertaken in September/October. It was recognised that the feedback was high-level at this stage, and the final full report was forthcoming. Discussions with the CQC continue to gain further clarity on some of the findings in the letter which will be shared at the open Board meeting in October. Although there no initial findings relating directly to the business of the Committee, references were made to governance and the importance of ensuring a clear line of sight between operations and the Board and being as robust as we can in terms of governance processes.

NHS Provider Capability Board Self-Assessment

The Committee reviewed the draft NHS England Provider Capability Board Self-Assessment prior to consideration at the October Board development session. All Provider Trusts have been asked to complete the self-assessment against the six domains outlined in the NHS England Insightful Board guidance:

- Strategy, leadership and planning
- Quality of care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

The self-assessment was reviewed in the context of identifying any gaps associated with Mental Health Legislation in relation to the stated domains. The Committee were satisfied that there were no gaps in relation to the business of the MHLC specifically.

5. Ongoing areas of focus for the Committee

A key theme from the discussion at the October meeting of the Committee was a need to review and refresh reporting into the Committee. This will include use of, and presentation of data, analysis, insight and benchmarking in all reports and clear information on high-level actions and plans for improvement, including timescales and ownership.

Reporting from the Mental Health Legislation Steering Group will be particularly important in terms of providing assurance to the Committee moving forward.

Summary and recommendation

The Mental Health Legislation Committee has continued to operate in line with its terms of reference and ensure focus on assurance of the actions being taken to address key issues in achieving the Trusts Strategic Ambitions.

The Board is asked to note the contents of the report and seek further assurance on any issues where appropriate.

Emma Moir
Chair of Mental Health Legislation Committee
November 2025

2.3 CARE QUALITY COMMISSION - FINAL ASSESSMENT REPORTS

Sarah Glacken, Executive Director of Nursing, Therapies and Quality Assurance

- Older People's Wards ? final report
- CQC action plan update

REFERENCES

Only PDFs are attached

2.3 CQC Core Service Improvement Plan v4.0.pdf

Meeting	Trust Board of Directors		**Agenda item: 2.3**
Date of meeting	Wednesday 5 November 2025		
Report title	To receive an update on the CQC Core Service improvement plan		
Report Lead	Sarah Glacken, Executive Director of Nursing and Therapies		
Prepared by	Vicky Wilkie, CQC Compliance Manager		
Purpose	**For decision**	**For assurance**	**For awareness**
		X	
Report previously considered by	n/a		
Executive summary	The Trust was notified on 5 August that the CQC would be conducting a 'Well-led' assessment under their new Single Assessment Framework between 30 September and 2 October. The CQC interviewed specific members of the leadership team and were keen to talk to staff and service users about their experiences. The Trust received high level feedback from this assessment by way of a letter on 3 October. On 1 October the CQC published the results from their assessments of wards for older people with mental health problems that took place in June. During September the report was received and reviewed for factual accuracy by the Trust prior to publication. The assessment looked at all five key questions and has been assessed as requires improvement overall (a change from good previously). On 18 August a four-day assessment of child and adolescent mental health wards commenced across two locations (Ferndene and Acklam Road Hospital). The Trust received initial high level inspection feedback by way of a letter on 27 August. At the time of writing this report the Trust had not received the draft assessment report. The Trust continues to progress with actions received following an assessment of community based mental health services for working age adults following CQC publication of assessment findings on 27 June. **Appendix 1** provides detail on the gaps in compliance and actions in place to improve the position.		
Detail of corporate/ strategic risks	Risk of not meeting regulatory and statutory requirements of Care Quality Commission (CQC) registration and quality standards.		
Recommendation	The Board is asked to: - **Note** the document and provide input on any gaps in terms of any other issues of concern, or additional areas of focus for the Board.		
Supporting information / appendices	www.cqc.org.uk/provider/RX4		

CQC Core Service Improvement Plan

Appendix 1

Breach of regulation	What have we done about it?	What still needs to be done?	Timescale for completion
Theme 1: Learning **Regulation: 17 Good governance**			
There was not a clear framework of what must be discussed at a team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.	Review of group and Trust level governance meetings undertaken and approved at Executive Management Group in June 2025. Group level Terms of Reference implemented in July 2025. Terms of Reference for group level learning finalised and 1st meetings held on 12 August 2025. The Trust learning and improvement webinars have been reviewed and will be aligned with the Trust Quality Priorities. Learning from individual Patient Safety Incident Investigations will also be presented regularly at webinars. Themes from completed reviews are included in learning governance and appropriate actions are taken to disseminate them. Hierarchy of learning has been incorporated into training around incident reviews and Patient Safety Incident Response Framework (PSIRF) awareness sessions that are delivered. Hierarchy of controls and interventions is now		**Action complete**

Breach of regulation	What have we done about it?	What still needs to be done?	Timescale for completion
	included in the Practice Guidance Note for completing Early Learning Reviews and After Action Reviews. Tools and techniques have been reviewed by the Safer Care team. Further review and enhancement of tools available will be included in the reviews of the PSIRF plan and policy in 2026.		
Theme 2: Environmental risk / concerns **Regulation: 12 Safety care and treatment**			
Environmental risk assessments submitted were not consistent across the bases, some were survey reports, others were ligature risk assessments completed to a varied standard and others were security risk assessments. The security risk assessments include the risk to staff in the environment. There were security risk assessments completed for 3/12 teams visited.	Standard for environmental assessments clarified in policy and practice and new Clinical Environmental Risk Assessment template for community areas in place. Programme of assessments using the new framework has commenced across community services. This will be coordinated over the next six months.	Assessments of physical condition of buildings to be carried out by NTW Solutions to assess current assets to prioritise capital expenditure and refurbishment. These inspections will include access of staff attack alarms and patient accessibility for community premises.	**31/03/2026**
Staff did not always assess risks to people's health and safety or mitigate them where identified. Oversight of ligatures was managed via several different documents, none of which instructed staff on how to safely manage the environment and where there were hot spots.	The Trust has considered the outputs from a ligature pilot using the CQC Ligature Point Recording template. This has been completed for all inpatient areas and considered at Executive Management Group. Based on incident data, this methodology will be adopted within female adult acute wards and inpatient CAMHS settings in the first instance.	Once the female adult acute wards and CAMHS wards have undertaken their assessments their experiences and risk impact will be reviewed for consideration of full implementation of the CQC template. If agreed a	

Breach of regulation	What have we done about it?	What still needs to be done?	Timescale for completion
		costed business case would be required. A bespoke ligature training package to be developed by Safety Team and CNTW Academy.	
There were environmental issues that had been reported and not acted upon despite audits of the environment being carried out.		A significant refurbishment project is underway on Oakwood to address several environmental concerns. The scheme will address the courtyard issues, anti-barricade doors and internal decoration and will be completed by March 2026.	
Theme 3: Staff safety **Regulation: 17 Good governance**			
The Trust were not fully implementing the Lone Worker Policy, with not completing the Lone Worker Risk assessments for staff.	Lone Working Policy and associated Practice Guidance Note has been reviewed and ratified. Commissioned an internal audit of management of lone working devices. Key findings including good practice and recommendations for actions were presented at Business Delivery Group.		**Action complete**
Theme 4: Assessment process and waiting times management **Regulation: 17 Good governance**			

Breach of regulation	What have we done about it?	What still needs to be done?	Timescale for completion
There was no formal process to assess risk whilst people were waiting for an assessment.	Standard assessment process has been confirmed and implemented across all EIP and Community Treatment Team in line with national approved assessments. New Practice Guidance Note (06 Allocation and Reallocation of Service Users) has been finalised and circulated to all relevant services and teams. Roll out of Referral Actions across community teams has commenced which will help track referrals, improve allocation decisions and provide transparency.		**Action complete**
Theme 5: Mental Health Act compliance **Regulation: 17 Good governance**			
There were gaps in recording in relation to reading and recording of rights in relation to individuals subject to a community treatment order (CTO).	Staff have been reminded of their obligations under the policy framework to ensure compliance and alignment with legal expectations and individuals rights. A number of training sessions were organised for clinical staff during July across community teams and medical forums.	CTO compliance is being monitored through the monthly Community Care Group Quality meeting and Mental Health Legislation Steering Group and will agree the assurance mechanism to enable closure by 31/12/2025.	**31/12/2025**
Referrals for a second opinion appointed doctor (SOAD) were not always completed in-line with recommendations stated in the MHA Code of Practice.	Staff have been reminded of their obligations under the policy framework to ensure compliance and alignment with legal expectations. An Initial Response Group has been set up in relation to SOAD referral compliance to review all	SOAD referral compliance is being monitored through Mental Health Legislation Steering Group and will agree the assurance mechanism to enable	

Breach of regulation	What have we done about it?	What still needs to be done?	Timescale for completion
	other solutions such as change in use of daily review of visual control board. Mental Health Legislation Steering Group have agreed to amend the internal compliance standard from eight to six weeks and an escalation process is in place when this is not achieved.	closure by 31/12/2025.	
Theme 7: Safety and quality metrics Regulation: 17 Good governance			
Learning disability and autism training was not mandatory and there were low levels of compliance.	Learning disability and autism training now mandatory for all clinical staff in accordance with Health and Social Care Act. Oliver McGowan training now mandatory for non-clinical staff. Training trajectories for improvement in place with clinical teams. Roll out of training and compliance to be monitored through care group and Trustwide performance meetings.		**31/12/2025**
Not all staff accessed training in drug and alcohol awareness.	Training Needs Analysis for community staff has been explored and agreed in relation to drug and alcohol awareness.	Task and Finish Group established to review addiction screening tool which is a national tool. This will then be taken to Trustwide Safety Group for approval prior to implementation and roll out.	
Training levels, supervision and appraisal	Teams consistently underperforming against	Internal audit due to be	

Breach of regulation	What have we done about it?	What still needs to be done?	Timescale for completion
levels were low in community services. Staff in older person's wards were not provided with the training and supervision required for their role.	training, appraisal and clinical supervision standards have been identified with clear actions to improve compliance.	completed at end of Q2 and outcomes and actions will be overseen by the Clinical Supervision Oversight Group reporting to Trustwide Strategic Workforce Meeting	
There were gaps in clinic room records.	Monitoring of clinic room temperatures has been reinforced with clinical teams with clear leadership roles to ensure compliance. Electronic solution to address human error with fridge / clinic room temperature monitoring has been approved by Trustwide Business Delivery Group.	Procured electronic process (MyKit Check) to standardise practice. Implementation to commence in December 2025.	
There were gaps in care records, with care plans and risk assessments not completed and up to date for all records reviewed.	Compliance with care planning and risk assessment metrics has been reinforced with clinical teams and are reviewed weekly to address areas of underperformance and non-compliance. Care planning, risk assessment and safety planning have been identified as Quality Priorities during 2025/26 with milestones agreed. Performance monitoring for compliance with care planning, risk assessment and safety planning has been enhanced across all community teams to achieve the required standard.		

2.4 SAFEGUARDING ADULTS AND CHILDREN ANNUAL REPORT 2024/25

Sarah Glacken, Executive Director of Nursing and Therapies

REFERENCES

Only PDFs are attached

2.4 Board November SAPP annual report 2024 - 25.pdf

Meeting	**Board of Directors**		**Agenda item: 2.4**
Date of meeting	Wednesday 5 November 2025		
Report title	Safeguarding and Public Protection Annual Report 2024/25		
Report Lead	Sarah Glacken, Executive Director of Nursing, Therapies & Quality Assurance.		
Prepared by	Claire Thomas, Deputy Director, Safer Care Peter Astbury, Associate Director Safer care		
Purpose	**For decision**	**For assurance**	**For awareness**
		X	
Report previously considered by	*Quality and Performance Committee – 8th October 2025*		
Executive summary	This annual report covers safeguarding activity from 1 April 2024 to 31 March 2025. It provides assurance that the Trust is meeting its statutory safeguarding responsibilities and demonstrates a strong commitment to collaborative safeguarding and public protection across all areas of its work. Key highlights include: • The Trust's Safeguarding and Public Protection team offers specialist advice, supervision, and oversight of safeguarding concerns. The Executive Lead for Safeguarding and Prevent during this period was Dr Rajesh Nadkarni, Executive Medical Director. • In the past year, 23 statutory reviews required Trust involvement. Learning from these reviews is shared across the organisation to inform practice and supervision, with bespoke training delivered as needed. • Major learning themes from statutory reviews in 2024/25 include: trauma-informed care, professional curiosity, multi-agency collaboration, application of the Mental Capacity Act, and the links between domestic abuse, substance use, suicide, and risk assessment. • The Trust continues to work effectively with partner agencies across eight Local Authorities and three Police forces, regularly attending key safeguarding forums. • Safeguarding and public protection incident activity decreased slightly (by 2%) compared to the previous year, reversing a trend of annual increases. This drop reflects an overall decrease in reporting rather than changes in specific areas or themes. • The report outlines progress in safeguarding the health and wellbeing of patients and carers, highlights ongoing development areas for the safeguarding team, and sets out		

	future priorities for the organisation.
Detail of corporate/ strategic risks	***SA1 – Risk of failing to maintain a positive patient safety learning culture*** *This risk relates to the possibility of avoidable harm occurring due to poor systems, processes, and policies, as well as the escalation of serious issues of concern. The report emphasises the importance of maintaining a robust safety culture to prevent such outcomes.*
Recommendation	*To Note*
Supporting information / appendices	N/A

Key Points to Note:

- The Trust Safeguarding and Public Protection Annual Report covers the period from 1st April 2024 to 31st March 2025.

- Safeguarding is fundamental to all work of the Trust. This report provides assurance that the Trust is fulfilling its statutory safeguarding responsibilities and demonstrates a strong commitment to working together within all aspects of safeguarding and public protection.

- The Trust has a Safeguarding and Public Protection team who provide specialist advice, supervision and oversight of reported safeguarding concerns and activity. The Trust Executive Lead for Safeguarding (Adult and Child) and Prevent during the reporting period was Dr Rajesh Nadkarni, Executive Medical Director.

- In the last 12 months there have been 23 statutory reviews commissioned by our partners which have required CNTW involvement. Learning from Case reviews is shared via relevant Trust, Locality and Service safety meetings and bulletins. It is used inform current practice and supervision and where required bespoke training sessions are provided to individual teams to review cases in more detail and to strengthen practice.

  Learning themes highlighted in published statutory reviews in 24/25 included:

  - Importance of trauma informed care / interventions
  - Importance of staff being professionally curious when working with vulnerable people to ensure robust safeguarding occurs.
  - Importance of collaborative multi-agency working / information recording & sharing
  - Knowledge and application of the Mental Capacity Act (MCA).
  - Links between Domestic Abuse, substance use and suicide / risk assessment and safety planning.

- The Trust are committed to ensuring that we continue to work effectively and collaboratively with all partners. We continue to work with all our partner agencies across the eight Local Authorities and three Police forces. We have continued to comply with our strategic responsibilities and are regular attenders within MAPPA, MARAC and PREVENT forums. The Trust has regular attendance at Adult Boards, Children Partnerships, Domestic Abuse Boards and many subgroups across relevant Local Authority areas.

- Safeguarding and public protection incident activity has decreased in 24/25 this bucks the trend where previously we had seen a year on year increase. The decrease between 2023/24 and 2024/25 was minimal at 2%, dropping from 19,403 incidents in 23/24 to 18,927 incidents this year. In Quarter 2 2024 following a review of safeguarding causes in relation to incident reporting to improve data quality, changes were made to the safeguarding cause groups staff could select when reporting a safeguarding incident. As a result, a direct comparison of cause group data is not possible however on review the decrease in 2024/25 shows an overall

decrease in safeguarding reporting rather than being related to of one area, cause group or theme.

- The report outlines the progress that has been made in safeguarding the health and wellbeing of patients and carers. It highlights areas where the safeguarding and public protection team are continuing to develop and offers an insight into the safeguarding priorities for the organisation.

Safeguarding and Public Protection Annual Report 2023/24

Contents

Introduction

This annual report gives an account of the safeguarding activity across Cumbria, Northumberland Tyne and Wear NHS Foundation Trust. The report covers the period April 2024 to March 2025. It demonstrates the Trust's commitment to protecting children, young people and adults at risk of harm across all service areas.

The purpose of this report is to provide assurance to the Board that the Trust is fulfilling its safeguarding responsibilities in line with the NHS England, Safeguarding accountability and assurance framework - Safeguarding children, young people and adults at risk in the NHS.

Safeguarding and Public Protection Team

The Trust has a Safeguarding and Public Protection (SAPP) team who provide specialist advice, supervision and oversight of reported safeguarding concerns and activity.

The Trust Executive Lead for Safeguarding (Adult and Child) and Prevent during this period was Dr Rajesh Nadkarni, Executive Medical Director.

There are now three substantive Named Professionals leading the SAPP team. One nurse, one Allied Health Professional (AHP), and one Social Worker, as well as one Named Doctor for Children. The Trust also has a Mental Capacity Lead who sits in the Mental Health Legislation team.

The Named Professional and Doctor posts have a key role in the management of safeguarding allegations against Trust staff, liaising with workforce, management and external partners as required, the Named Nurse and Doctor have a particular focus on Safeguarding Children (statutory obligation), while the AHP and Social Worker focus on Safeguarding Adults.

There are eight SAPP Practitioners (6.9 wte) and a Case Review Report Writer (1 wte). The team also includes a Safeguarding and Public Protection Development Officer and the Clinical Police Liaison Nurse who bring a variety of safeguarding and public protection expertise, skills, and experience. One of the SAPP practitioners also acts as a dedicated lead for Prevent. The Safer Care Administration Team support these staff.

The core functions of the SAPP team are:

- To provide clinical leadership in respect of safeguarding to support high quality safeguarding and public protection practice for children and adults
- To provide a "triage" service for all safeguarding and public protection concerns raised within the organisation to ensure the individual is safeguarded and effective safety plans are in place.
- Sharing learning from internal and external reviews of cases and best practice
- To provide support and advice on complex cases.
- To attend Multi Agency Risk Assessment Conference - MARAC (Domestic Abuse),

Multiagency Public Protection Arrangement - MAPPA (public protection) and Prevent (counter terrorism) multi-agency meetings on behalf of the trust.

- To attend in conjunction with clinical localities Safeguarding Adult Board (SAB) and Safeguarding Children Partnership (SCP) subgroup meetings.

- Provide strategic advice and leadership through the involvement in Safeguarding Practice Reviews, Safeguarding Adult Reviews and Learning Lesson Reviews.

- To provide challenge and scrutiny of safeguarding and public protection practice including the interface with statutory agencies.

- To provide oversight and development of policy and procedures.

- To provide strategic vision in respect of safeguarding and public protection.

- To provide high quality supervision and check that supervision delivered across the organisation is in line with evidenced based practice

- To support individuals working with adults at risk, to practice in adherence to the six safeguarding principles.

- To support positive working relationships with Police colleagues and application of Right Care, Right Person.

- The SAPP team aims to support all trust staff to keep children, young people and adults at risk, safe and to meet statutory obligations. We promote collective accountability in all that we do, working together to prevent all forms of abuse or neglect.

A commitment to safeguarding children and adults is evident at all levels within the organisation. The Trust has a clear and consistent structure in place to ensure scrutiny and challenge of safeguarding arrangements and consideration of the impact on the people who use services.

The Trust has a suite of safeguarding policies and associated practice guidance:

- Safeguarding Adults at Risk (CNTW(C)24)
  - Sexual Safety in mental health services (SA-PGN 01)
  - VIPs, Celebrities and Media Teams visiting CNTW (SA-PGN 02)

- Safeguarding Children Policy (CNTW(C)04)
  - Babies sharing beds with their mothers in hospital – Beadnell Unit, SGP (SC-PGN02)
  - Addiction Services- Pregnancy Pathway and Guidance (SC-PGN03)
  - VIPs, Celebrities and Media Teams visiting CNTW (SC PGN 04)
  - Working with Sexually Active Children under the age of 18 – Safeguarding guidance (SC PGN 05)

- Domestic Abuse Policy (CNTW(C)54)

- MAPPA (Multi Agency Public Protection Arrangements) and Public Protection Policy CNTW(C)25
    - Victims' Rights Under the Mental Health Act (MHA) (MAPPA-PGN-01)

- Management of Allegations Guidance (D-PGN-02) part of Disciplinary Policy

- Mental Capacity Act Policy (CNTW(C)34)
    - Assessing Capacity for Consent to Sexual Relations (MCA-PGN-01) Working with Sexually Active Children under the age of 18 – Safeguarding guidance (SC PGN 05)

Training

The Trust has aligned its training requirements for Trust staff to the intercollegiate safeguarding competencies.

Online safeguarding training is provided by E-Learning for Health (Health Education England) for levels 1 and 2. The Level 3 training continues to be delivered by the Academy and includes learning from local and national reviews.

Staff continue to have access to other safeguarding training from our partner agencies. Local training offers continue to be disseminated via the Trust Bulletins.

Safeguarding Level	Compliance % as of March 2025 *(target 85%)*
Adults Level 1	96.1%
Adults Level 2	93.8%
Adults Level 3	85.4%
Children Level 1	95.7%
Children Level 2	91.2%
Children Level 3	85.4%
Preventing radicalisation	92.1%

The NHS training and competencies framework updated in July 2025 outlines prevent training expectations in its training needs analysis section. Work has commenced to review those currently identified to complete this Prevent training to ensure it aligns with Trust training requirements 2025/26.

Supervision

The SAPP team is a small resource within this large organisation. We have therefore targeted this resource to provide greatest impact. The SAPP team (Named Professionals) continue to attend the Local operational Quality & Safety Meetings, with the aim of supporting leadership teams in identifying safeguarding concerns and next steps.

CNTW utilise the web-based reporting system, to report Safeguarding incidents. All incidents categorised as safeguarding are reviewed by SAPP practitioners daily. Advice

is provided to the clinical team in the management of the safeguarding concern. When a complex safeguarding concern is identified, the relevant SAPP practitioner will work with the Locality managers and clinicians and offer either one to one or group supervision in relation to the case. In certain cases, this supervision may be undertaken by the Named Professionals or Named Doctor.

The Named Professionals also advise on the management of internal staff allegations, alongside operational leads and workforce and ensure appropriate engagement with Local Authority Designated Officer (LADO) and Adult Safeguarding Concerns (ASC) processes occur.

The Named Professionals provide supervision to the SAPP practitioners, who in turn receive supervision from ICB Designated Nurses. The Named Doctor receives supervison from the Designate Doctor within the ICB.

Learning from Case Reviews

There continues to be a dedicated resource to support our Safeguarding Adult Boards, Children's Safeguarding Partnerships and Domestic Abuse Partnerships in completing and learning from Case Reviews.

In the last 12 months there have been 23 statutory reviews commissioned by our partners which have required CNTW involvement:

- 16 DARDR (Domestic Abuse Related Death Reviews)
- 7 SARs (Safeguarding Adult Reviews

Learning from Case reviews continues to be shared via relevant Trust, Locality and Service safety meetings and bulletins. It is a standing agenda item for the regular SAPP team meetings to inform current practice and supervision.

Learning is also shared in Trust forums such as Managers meetings where required and at the PSLIP (Patient Safety Learning Improvement Panel), bespoke training sessions are provided to individual teams to review cases in more detail and to strengthen practice.

Themes identified from published statutory reviews in 24/25 included:

- Importance of trauma informed care / interventions
- Importance of staff being professionally curious when working with vulnerable people to ensure robust safeguarding occurs.
- Importance of collaborative multi-agency working / information recording & sharing
- Knowledge and application of the Mental Capacity Act (MCA).
- Links between Domestic Abuse, substance use and suicide / risk assessment and safety planning.

In line with themes from learning from reviews below is work that was already underway within CNTW or work that has commenced as a result:

- CNTW was already committed to becoming a trauma informed organisation. Since

November 2023, it has had a dedicated lead. Over the year, the Trust has begun to develop and roll out training in different areas, with a plan to deliver to all Trust staff by the end of March 2026, including awareness training as part of Trust induction. Work to date and the longer term training plan has been shared with partners as part of our response to statutory safeguarding reviews.

- The importance of Professional curiosity continues to be highlighted as part of learning from statutory reviews, in response SANN (Safeguarding Adults National Network) produced a practitioner briefing that was shared widely within CNTW via the central SAPP team and CNTW Bulletin.

- A Domestic abuse training package has been developed, reflecting learning from local cases. It includes input from a CNTW clinician who has lived experience of the DHR/DARDR process from a family members perspective. This training is delivered to individual teams as required and Trustwide sessions are available throughout the year. The addition of a third named professional to the SAPP team has allowed specific Safeguarding subjects to be allocated so that Named Professionals can act as leads, one of our Named Professionals is the identified lead for Domestic Abuse. The lead is responsible for maintaining and updating the Domestic Abuse policy and considering updates to available training related to domestic abuse.

- CNTW's suicide risk prevention training highlights the correlation between Domestic Abuse and increased suicide risk.

- CNTW's co-occurring Mental Health and Substance use conditions policy highlights the correlation between suicide and substance misuse.

- The Trust MCA reviewed the learning themes around MCA and presented findings to the Trust PSLIP panel in 24/25. Informing the panel, that the trust has an executive lead with MCA responsibilities, that review and update of the MCA and DOLS policy has occurred and that the Trusts mandatory MH legislation training continues to be provided. Furter work had been undertaken to streamline MCA act documentation in the Electronic Patient Record system and that a dedicated MCA intranet page / resource was being developed (this is now live).

Our Commitment to Partnership Working

We are committed to ensuring that we continue to work effectively and collaboratively with all partners. We continue to work with all our partner agencies across the eight Local Authorities our Trust covers.

We have continued to comply with our strategic responsibilities and are good attenders within our MAPPA and MARAC forums. The Trust has regular attendance at Adult Boards, Children Partnerships and many subgroups across all relevant Local Authority areas. In 24/25, we have also seen the establishment of Domestic Abuse Strategic Partnership boards. Plans are in place to ensure representation at each DA board during 25/26.

The large geographical footprint of CNTW does present a challenge in the number of

safeguarding related meetings where Trust representation is requested. In 24/25 we commenced a review of our attendance and began discussions at Trust level. In 25/26 we will continue to work with the ICB to ensure we are targeting Trust resources appropriately and effectively, improving communication and joint working across the ICB and providers.

CNTW continues to participate in statutory safeguarding reviews providing scoping information, chronologies, Individual management reviews, participation in associated panel meetings and practitioner learning events. The Trust also participates in Learning reviews where cases do not meet the threshold of a statutory review process. Again, owing to the Trusts large geographical footprint CNTW are involved in a higher number of statutory reviews than some of our NHS partner organisations, this along with changes to statutory review requirements related to Domestic Abuse related Death Reviews (DARDR's), is presenting challenges from a resource and capacity perspective. As noted earlier the SAPP team has 1 WTE report writer to complete much of this work. We have raised this with ICB colleagues and will continue to monitor the situation.

CNTW now employ three Multi Agency Safeguarding Hub (MASH) practitioners, one based in Northumberland, one in North Tyneside (new post) and one in Sunderland. North East and North Cumbria ICB agreed recurring funding for the post in North Tyneside with the successful applicant commencing employment in May 2024.

Within the CNTW service area, we interact with three different Police Services, these being Northumbria, Cumbria and Cleveland (Lotus ward only). We also have a close working relationship with British Transport Police, who provide policing services for the Rail Network within the UK. On a national level we have a good working relationship with the respective North East & North West Counter Terrorism Policing Commands.

At a local level we continue to have a strong working relationship with Northumbria Police this is at Strategic and Operational Levels. Northumbria Police continue to support a dedicated mental health policing team within their Prevention Department.

Our working relationship with Cumbria Police had been more challenging during this year, following a decision by Cumbria Police to disband their dedicated mental health and street triage team from December 2024. This has impacted on day to day business as our dedicated points of contact have changed and engagement has been more varied across the Cumbria Policing area, however we continue to monitor this.

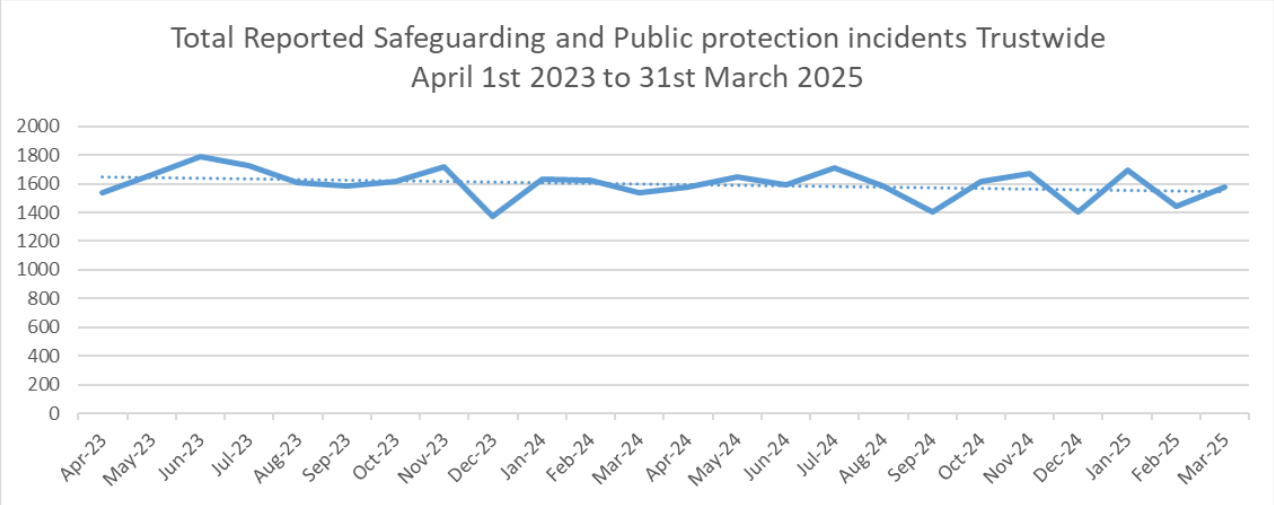
Whilst our involvement with Cleveland Police is limited, we have a good working relationship with their mental health leads and team. We have also been working hard to establish links within Durham Police, given the close links that our services have to that area.

Further work is required in 2025/2026 to review how Partnerships and Boards are supported in response to the Trust organisational restructure. In the interim those Directors who attended these retained the responsibility for ensuring attendance continues.

Overview of Safeguarding Incident Activity

Safeguarding and public protection incident activity has shown a slight decrease in 24/25,

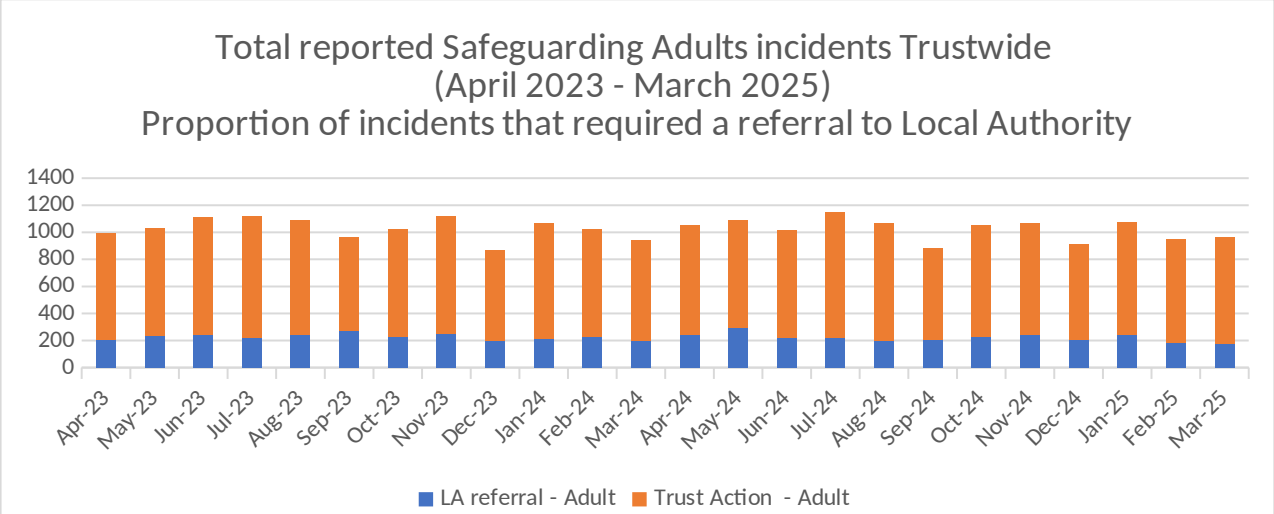
which is the first year of decrease after over 5 years of year on year increases.
The decrease between 2023/24 and 2024/25 was minimal at 2%, dropping from 19,403 incidents in 23/24 to 18,927 incidents this year.
During this reporting period a review of safeguarding reporting categories was undertaken to improve data quality. As a result, a direct comparison of cause group data is not possible however on review the decrease in 2024/25 shows an overall decrease in safeguarding reporting rather than being related to of one area, cause group or theme.

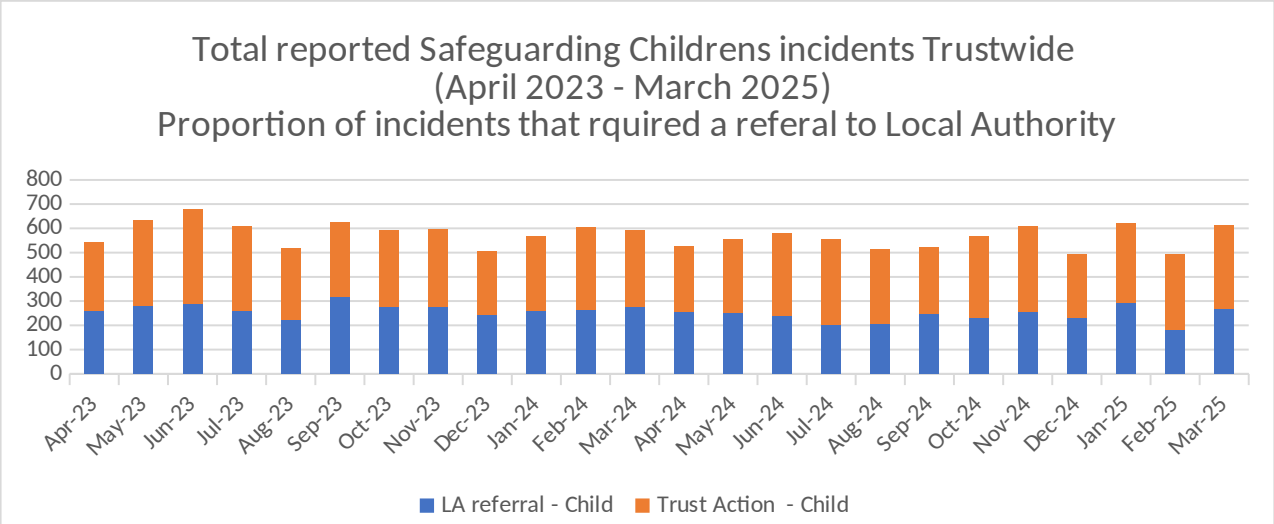


Despite the challenges of continued high volume and complexity during the year, the Trust continued to deliver upon the safeguarding agenda. We have remained dynamic in our approach to service delivery, adapting our processes and approaches to ensure we can not only meet demand but also maintain the quality of the safeguarding oversight, advice and supervision.

All Safeguarding incidents are triaged by Safeguarding Practitioners and guidance is given to the clinical teams for those incidents that meet the Local Authority reporting thresholds these need to be referred into the relevant Local Authority.

The graphs below show the proportion (in blue) of reported Safeguarding incidents for Adults and Children where a referral to the Local Authority was required.





Domestic Abuse and MARAC

All areas served by the Trust continue to hold weekly MARAC meetings. These are led by the Police. SAPP practitioners and MASH workers (where the roles exist), attend these to share relevant risk information to support the development of robust multi-agency risk assessments. Patient records are updated to indicate where an individual discussed is accessing CNTW services at the time of the MARAC.

Activity across the trust footprint has increased resulting in a higher number of MARAC meetings being held, to service the increasing demand agreements have been made in some areas with other NHS providers to share the workload of attendance.

The North Cumbria locality continue to report a higher incidence of domestic violence incidents, and this is reflected in the number of Domestic Homicide Reviews / Domestic Abuse Related Death Reviews where there are a significantly higher proportion of those reviews held within the Cumbria locality in comparison to other areas.

The ICB are currently undertaking a review of the MARAC process, how health link in and the outputs and effectiveness of MARAC participation from a health perspective. CNTW have participated in this review which is being led by the ICB's Director of Nursing for Safeguarding.

Public Protection and MAPPA

Safer Care and SAPP team continues to discharge Duty to co-operate (DTC) responsibilities on behalf of the Trust.

The Deputy Director Safer care attends MAPPA Strategic Management Board (SMB) for Cumbria and Northumbria areas. SAPP practitioners attend Level 2 and 3 meetings with support of operational services who attend for those cases where the service user is accessing services.

The Strategic Management Boards monitor compliance of duty to co-operate agency attendance at MAPPA meetings as a key performance indicator. Quarterly data is shared via SMB with latest data for Quarter 4 Northumbria indicating 100% attendance from CNTW at level 2 & 3 meetings. Cumbria SMB data highlighted 100% attendance at level 3 meetings and 95% attendance at level 2 meetings.

The MAPPA process within CNTW is under review to ensure there is a clear process for managing our MAPPA eligible service users that is fully understood by the responsible services. This will include a review of the incident data and rolling out training to the relevant services.

The conversion rate for referrals made for level 2 and 3 management accepted by the screening panel for CNTW remains low. The Safeguard and Public Protection Development Officer has reviewed our data. In 2023/24 our conversion rate for accepted referrals was 17%, 24/25 saw an improvement with 23% of MAPPA level 2 and 3 referrals accepted. Work is ongoing to introduce the MAPPA Q screening document into our MAPPA Policy and it is being shared with relevant wards (Secure Services), the main purpose of the MAPPA Q is a simple guidance and check document to aid practitioners decision making, based on all available risks to give them a more informed and balanced decision making process as to whether a Level 2/3 referral is necessary and appropriate. The MAPPA Q is widely used by the Responsible Authorities to assist in decision making.

PREVENT

The SAPP team continue to have a dedicated resource to support channel panels and in response to continued high volume requests from police and special branch.

CNTW data suggests that most referrals to PREVENT and Channel panel discussions have an extreme right-wing ideation but there are an increasing number which fall under the category of Mixed, Unclear and Unstable extremism (MUU). MUU individuals are often vulnerable and can be heavily influenced by online content, especially after high-profile acts of mass violence. Their fragmented beliefs, often include hatred and an adulation of mass killers, school shooters or serial killers.

For all areas covered by CNTW the most significant threat comes from Self-initiated terrorists (S-IT) (formerly known as Lone Actors). The actions of a S-IT are difficult to detect and deter. They can mobilise to action quickly using low sophistication methods of attack, using readily available items that require no specialist knowledge or training. Bladed or blunt force weapons are the most likely form of attack methods, including vehicles, which have also been used as ramming devices.

Evidence suggests that autism spectrum disorder (ASD) is overrepresented in lone actor terrorist samples, compared to the general population and this over representation is found within CNTW data. CNTW data for the period April 2024 to March 2025 records that 26% of the contacts have ASD as a confirmed diagnosis. This number increases to 38% if other neurodiverse conditions such as ADHD are included. 33% of contacts have no clear diagnosis but many of these individuals are on neurodevelopmental assessment waiting lists.

The implication for this over-represented group is a need to increase awareness and information around specific vulnerabilities and risk factors in this patient group, for parents, educational staff, and care professionals to help ensure detection of a person with ASD developing radical ideology which will minimise the risks of the exploitation and criminalisation of individuals with ASD.

Police Liaison and Involvement

The Clinical Police Liaison Lead (CPLL) has been an established role within the trust since 2014. It has adapted, developed and changed throughout this time to address local and national challenges. There is also a 0.4wte SAPP/Police Liaison role in Cumbria.

Since August 2024 we have also had a temporary post of Police Liaison Data Reviewer/Analyst to support in t Right Care Right Person (RCRP) incident monitoring.

The CPLL role is a central point of liaison with police colleagues where needed, and works closely with Northumbria, Cumbria, Cleveland and Durham Police. The CPLL also liaises with British Transport Police (BPT) and links into other national police services where relevant. This engagement with BTP about suicide on the rail network has resulted in our Trust being added to an alert scheme, which highlights deaths that have occurred within the CNTW service area. BTP leads also now flag people of concern who are attending railways.

As Emergency Services roles evolve, the CPLL role has adapted to liaise and support partner agencies to include regular contact with the Fire and Rescue Service, Ambulance Services and on occasion H M Coastguard. The CPLL also supports with liaison and multi-agency work within Emergency Department (ED) and with Local Authority (AMHP) colleagues.

During 2024/25 Police Liaison activities and involvement included:

- Monitoring the implementation of RCRP across the trust, reviewing all Police contact incidents via the web-based incident reporting system.

- Establishing learning from incidents of RCRP, and Police contact and ensuring that policy, training, and guidance reflects this and feeds back into services.

- We continue to develop and deliver appropriate training/awareness packages in CNTW and to Police in Northumbria and Cumbria, around the key areas in mental health and policing.

- Complex Case Risk management/public protection support and guidance is offered to teams, where Police are involved.

- Regular meetings with all police forces occur to identify areas of development and need, reviewing incidents and establishing joint learning where appropriate. Ensuring a joined-up approach.

- We review all incidents of police attendance on inpatient wards with Police. These reviews assist in identifying areas of learning and training and ensuring Police are

called to our wards only, when necessary, given the potential for higher use of force. There is a national requirement for these reviews to be undertaken.

- We work closely with Police around hate crime and incidents affecting CNTW staff and service users, increasing knowledge around this type of offending. Running a project across several sites with Northumbria Polcie, looking at educational intervention for service users who are offending in this way.

As noted earlier a temporary Police Liaison Data reviewer/analyst post started on 19th August 2024, this temporary post is due to end in November 2025. The post has allowed Safer Care to review all relevant incidents and establish a detailed database of incidents and activity to produce quality reports, and identify quality issues, for example process gaps linked to incidents involving a missing person. The role in turn has also allowed the CPLL time to provide more responsive support and advice to teams around police related incidents, crime reporting, as well as undertaking planned work to improve quality.

Right Care, Right Person (RCRP) has dominated the work in 23/24 and this continued in 24/25.

Between June 2024 until 31st March 2025, the Police Liaison Data Reviewer/Analyst has facilitated the review of 3133 incidents where police involvement was identified on an incident form. This work included review of **1141** incidents of Concern for Safety and **326** Missing Person (including AWOL) incidents.

Northumbria Police implemented RCRP in 2023 with changes to missing person reports and concerns for safety. Cumbria Police implemented RCRP mid-2024.

Northumbria Police have since developed a dedicated missing person investigation team, and we work closely with this team in relation to our missing service users and this has proved significant in improving communication and support for our teams. The benefits of this new process have been seen where we have had a complex missing service user investigation.

During this year there has been a much greater focus on monitoring, feedback and learning. This has been a continual and intensive task but has enabled us to be confident we are aware of issues early and that we can address them within teams and adapt our processes where necessary.

We've adapted our incident dashboard process to improve governance, recording what incidents we review and completing process maps and guidance for clinical teams. We are also regularly updating our dedicated intranet page on Police Liaison and RCRP.

Key Achievements during 2023/24

➢

- The Trust completed the Safeguarding Adults Audit CA-23-063.02 this year. The main objective of the audit was to ensure that CNTW clinicians follow the Trust reporting processes when a safeguarding adult concern is raised. Another objective was to provide assurance that any safeguarding concerns are dealt with promptly, with the involvement of CNTW Safeguarding and Public Protection

Team, to ensure the victim is safeguarded. The Audit outcome highlighted good practice and low risk.

- The CNTW Clinical Police Liaison Lead was presented with a commendation by Northumbria Police for their dedication, hard work and support on the roll out of RCRP.

- The CNTW Safeguarding and Public Protection PREVENT lead, was recognised with a Head of Department Commendation by the Head of Prevent. This award has been presented in recognition of his valuable support to Counter Terrorism Policing in the North East, his participation in Channel and Police Led Panels and the vital support he has offered to vulnerable suspects whilst in custody.

- Learning from local Child safeguarding Practice Reviews indicated that we needed to improve our assessment of the impact of parental mental health to children. In response to this the Keeping Children Safe Assessment within the electronic recording system was reviewed and updated, it's use is monitored via regular Healthcare Record audit.

- Domestic Abuse awareness sessions have been provided to teams Trustwide. Training is reflective of local DHR/DARDR learning.

- A Trustwide weekly question was developed to assess and improve domestic abuse awareness. This was an automatic pop up on accessing the trust intranet and included links to further information, briefings and policy. 84.45% of the Trust workforce demonstrated a robust understanding of Domestic Abuse and the appropriate actions to take to safeguard victims, with a further 7.92% identifying that they would seek appropriate advice and guidance from the SAPP team.

- The Safeguarding Adults, Safeguarding Children and Domestic Abuse polices were all updated during 24/25

Annual Workplan 2025/26

Key workplan focusses for 2025/26:

- Review and update further the Domestic Abuse training package to ensure that risk to self and the correlation between domestic abuse and suicide is given equal weight alongside the risk victims of domestic abuse face from perpetrators. DHR /DARD learning and a recent report from the Domestic Abuse Project found that the number of victims of domestic abuse who took their own lives in England and Wales surpassed the amount of people killed by their partner for the second year in a row.

- Domestic Abuse audit will be completed in 25/26

- SAPP will input into the Trust wide Bio-psychosocial risk assessment quality group to ensure that Safeguarding risks are fully considered when the tool is updated and evaluated.

- Review of the updated NHS Prevent Training and competencies framework to ensure CNTW's training offer is in line with national expectations.

- Review policy and practice guidance for managing MAPPA eligible offenders, ensuring embedded into induction for forensic pathway

- Work to review of the quality of referrals submitted for MAPPA will move forward with the introduction of the MAPPA Q screening document into our MAPPA Policy

- Safer Care will be continuing to monitor the high levels of Safeguarding reporting and reviewing the triage functions capacity to review all safeguarding incidents.

- Regular training sessions planned – RCRP, Crime reporting & Investigation. Continued training with Police on areas of Mental health and Policing.

- Publication of a Crime reporting and Criminal Justice System guidance booklet for staff and teams to guide them and encourage appropriate reporting and increase understanding of the system.

- Reviewing the Police Liaison Data Reviewer/Analyst as substantive post or look at how as trust we manage and provide assurances around RCRP/police activity across CNTW. Reviewing the Clinical Police Liaison Lead function and role depending on the aforementioned.

- SAPP to contribute to the implementation of the CP-IS (Child Protection Information Sharing) system which has a hard go live date of March 31st 2026.

Appendix 1 - Excerpt from the Safeguarding children, young people and adults at risk in the NHS - Safeguarding accountability and assurance framework

NHS England » Safeguarding children, young people and adults at risk in the NHS

Section 4.4 Health and Care Providers

All health providers, including provider collaboratives, are required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse in every service that they deliver.

Providers must demonstrate that safeguarding is embedded at every level in their organisation, with effective governance processes evident. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working. These arrangements include:

- The contractual requirements as laid out in Schedule 32 of the NHS Standard Contract
- Identification of a named nurse, named doctor and named midwife (if the organisation provides maternity services) for safeguarding children
- Identification of a named nurse and named doctor for children in care
- Identification of a named lead for adult safeguarding and a Mental Capacity Act (MCA) lead – this role should include the management of adult safeguarding allegations against staff
    - This could be a named professional from any relevant professional background
- Safe recruitment practices and arrangements for dealing with allegations against staff
- Provision of an executive lead for safeguarding children, adults at risk and Prevent
- An annual report for safeguarding children, adults and children in care to be submitted to the trust board
- A suite of safeguarding policies and procedures that support local multi-agency safeguarding procedures
- Effective training of all staff commensurate with their role and in accordance with the intercollegiate safeguarding competencies
- Safeguarding must be included in induction programmes for all staff and volunteers
- Providing effective safeguarding supervision arrangements for staff, commensurate to their role and function (including for named professionals)
- Developing an organisational culture where all staff are aware of their personal responsibilities for safeguarding and information sharing
- Developing and promoting a learning culture to ensure continuous improvement
- Policies, arrangements and records, to ensure consent to care and treatment is obtained in line with legislation and guidance

It is worth noting that provider accountabilities and responsibilities need to be considered in conjunction with professional accountabilities to the professional regulators.

3. STRATEGIC AMBITION 2 - PERSON LED CARE, WHERE AND WHEN ITS NEEDED

Darren Best, Chair

No items for the period

4. STRATEGIC AMBITION 3 - A GREAT PLACE TO WORK

Darren Best, Chair

4.1 PEOPLE COMMITTEE QUARTERLY ASSURANCE REPORT

Brendan Hill, Committee Chair

REFERENCES

Only PDFs are attached

4.1 People Committee Assurance report to Board - Nov 25.pdf

Report to the Board of Directors
5 November 2025

People Committee Quarterly Assurance Report
August 2025 – October 2025

1. Purpose

This report seeks to provide the Board with assurance of ongoing oversight of key areas of focus and risk undertaken by the People Committee. This includes an overview of the areas of focus, discussion and assurance and the Board Assurance Framework risks currently aligned to the Committee.

2. People Committee overview

There has been one substantive meeting of the Committee during the period. This was held on 10 September 2025.

3. Board Assurance Framework risks within Committee remit

The People Committee is currently managing the following key risks on the BAF:

Risk No.	Risk descriptor	Risk score
Risk 2542	Failure to develop a sustainable workforce model to recruit/retain/ and support the development of the right people with the right skills to deliver safe and effective services, our strategic objectives, and contractual obligations.	4 (likely) X 4 (significant) 16
Risk 2544	Risk of poor staff motivation, engagement, and job satisfaction if issues affecting staff experience are not addressed including health and wellbeing support, inclusion and the ability to speak up.	3 (possible) X 4 (significant) 12

The BAF risk target dates fall between end of September and December this year. A review of target dates will be included within the context of the November Board development session on risk management and risk appetite.

4. People Committee focus August – October 2025

4.1 Assurance relating to risk 2542

The Workforce Metrics performance report continues to inform the People Committee agenda on areas such as absence, training, induction, appraisal and recruitment as well as some of the metrics relating to culture such as exit data and staff surveys.

General workforce performance

In terms of workforce performance, there has been sustained improvement in compliance with individual training topics. A full review of training requirements will begin in quarter 3 with an update to the Committee in quarter 4. Compliance with clinical supervision and appraisal rates have also continued to improve reaching over 80% compliance via targeted approaches to areas of low compliance.

A report was received on Continuing Professional Development (CPD) allocations which showed full planned utilisation. The Committee discussed the need for more flexibility in CPD funding to better support workforce transformation and align CPD outcomes with service quality and staff development. Future reports will be improved to show clear alignment to transformation, talent and succession planning.

The Committee received the Medical Revalidation report which noting a 100% appraisal completion rate. Improvements were attributed to a new patient feedback system that helps doctors collect required feedback more efficiently. The report provided assurance on robust governance processes, strong engagement and a focus on diversity and culture, including trauma informed policy reviews and training. The Committee approved the report, under the delegated authority within its terms of reference, for submission to NHS England.

Sickness absence

Sickness absence remains higher than target and continues to be a key priority area for the operational teams. The regional Sickness Absence Group, Chaired by CNTW Executive Director of People and Organisational Development is collaborating with other regions, including adopting the NHS Productive methodology, which has shown positive results in the North West. Work is ongoing locally to address mental health-related absences, with benchmarking and improvement methodologies being explored.

Key hotspot areas in Cumbria in relation to recruitment and retention

An update was provided in relation to challenges in medical recruitment. The Committee noted that whilst robust systems are in place to manage vacancies, and a reduction in community vacancies has been seen, there is still pressure within inpatient services. This is particularly in the Cumbria footprint with pressures being managed by some use of medical agency staff.

Cumbria remains a key hotspot due to high turnover and recruitment challenges in unregistered healthcare assistant and registered nurse posts. Actions to increase recruitment efforts continue with a focus on candidates committed to living and working in Cumbria. Reliance on agency staff in crisis services remains a concern, though improvements had been evident. Recruitment issues in the Cumbria footprint continues to be subject to executive oversight and a future workshop deep dive on high turnover areas, including direct input from local teams to better understand on the ground experiences will be held at a future Committee workshop.

2025 General Medical Council National Training Survey

The results showed that the Trust is in the top 10% nationally for trainee satisfaction and just outside the top 5% for trainer satisfaction with key strengths in clinical supervision and workload allocation for resident doctors. Areas identified for improvement include handover processes, adequate experience and appraisal for trainers.

The national challenge of an oversupply of medical graduates without enough training posts was discussed in the context of the Trust stopping international recruitment to focus on increasing local training capacity. The need to align workforce planning for resident doctors with training and consultant workforce development was emphasised.

Development of a sustainable workforce plan

The Trust remains off target in relation to the Whole Time Equivalent reduction requirements aligned to the achievement of the Trust financial plan. Discussion regarding plans for financial recovery are also taking place at the Resources and Business Assurance Committee (RaBAC).

The recovery plan is focusing on addressing issues of overstaffing, analysis on the rationale for additional staffing relating to physical health appointments and reliance on use of temporary staff. The Trust aims to reduce bank and agency use where appropriate but noted that some areas need to remain over-established for safety reasons.

It is recognised that the absence of a Workforce Plan is a key issue for the Trust and the Committee and Board have asked that the plan be developed with pace. Workforce sustainability is being addressed across multiple committees, each with its own focus, i.e. RaBAC from a financial planning perspective, People Committee from a workforce planning and development perspective and Quality and Performance Committee from a safe service delivery and quality perspective. Triangulation of committee business will be important to ensure the continued focus on key areas of concern for the Trust, as well as avoiding duplication and having purposeful discussions with clear outcomes which are all aligned.

4.2 Assurance relating to risk 2544

Equality, Diversity and Inclusion (EDI)

The Committee received the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) Annual Report.

Regarding WRES, there continues to be disparities in staff experiencing bullying, harassment and discrimination from patients, relatives or colleagues. Actions to remove disparities in staff survey metrics include signing up to Unison's Anti-Racism Charter and using NHS Race Health Observatory and UNESCO tools. The Trust also has in place anti-racism initiatives including the Give Respect Get Respect campaign.

The Committee emphasised the importance of career progression for BME staff and moving beyond inclusive recruitment to supporting advancement within the organisation. The Committee discussed the increase in BME staff representation, now around 13%, mostly Band 5 and below, and how this will be considered as part of workforce planning. International recruits predominantly join as unregistered staff. Progression for BME staff is a Board priority and there were positive examples of BME staff on nurse apprenticeships and national schemes, but it was recognised that data may not be evident in the short-term.

Regarding WDES, similar issues were identified in people with disabilities experiencing bullying, harassment and abuse from managers and colleagues. Proposed actions to become more anti-ableist, including active bystander initiatives and a push to achieve Disability Confident Level 3 Status. A training/development session with the Board has been arranged to take place in January 2026.

Freedom to Speak Up

The Committee received the Freedom to Speak Up Self-Assessment Tool, developed by the National Guardian's Office, which included detail on the strengths and gaps in the Trust's speaking up arrangements. Key areas of focus relate to tackling barriers to speaking up, addressing detriment and further developing the speaking up culture.

4.3 Other issues and assurance received by the Committee

Annual Employee Relations report

Only two grievance cases were completed within the 30-day key performance indicator due to the complexity of cases. The Trust has revised and refreshed the new Resolution Policy and

process (previously Grievance process) to improve timeliness and seek to resolve issues at a local level before reaching the stage of formal grievance. Managers are now required to undertake mandatory training on the Resolution Policy, Disciplinary Policy and Health, Wellbeing and Attendance Policy to support cultural change. The Committee requested that future reports include actions to address the data which shows that BME staff are overrepresented in formal processes.

5. Ongoing areas of focus for the Committee

Over the next 12 months+, the Committee will continue to focus on:

- Oversight of the development of a sustainable Workforce Plan ensuring alignment to the development of a medium-term resource plan and planning for the delivery of change required through the Trust's Model of Care and Support.
- Key hotspot areas in Cumbria in relation to recruitment and retention.
- Progress against actions to reduce the levels of sickness absence.
- Deep dive into actions to improve and address recruitment issues, particularly in the Cumbria footprint at a future Committee workshop session.

6. Summary and recommendation

The People Committee has continued to ensure alignment of the cycle of business with the Board Assurance Framework and ensuring the continued focus on assurance of the actions being taken to address key risks to achieving the Trusts Strategic Ambitions.

The Board is asked to:

- Note the content of the report and seek further assurance on any issues where appropriate.
- Note the request to develop the Workforce Plan at pace.

Brendan Hill
Chair of People Committee
November 2025

4.2 RESIDENT DOCTORS 10-POINT PLAN

Rajesh Nadkarni, Deputy Chief Executive and Medical Director

REFERENCES

Only PDFs are attached

4.2 10 Point Plan to help improve the working lives of Resident Doctors.pdf

Meeting	**Board of Directors**		**Agenda item: 4.2**
Date of meeting	**Wednesday 5 November 2025**		
Report title	**10 Point Plan to help improve the working lives of Resident Doctors**		
Report Lead	**Dr Rajesh Nadkarni, Medical Director / Deputy Chief Executive**		
Prepared by	**Elaine Grant, Head of Medical Staffing, Workforce and Organisational Development**		
Purpose	**For decision**	**For assurance**	**For awareness**
	✓		✓
Report previously considered by	Due to the urgent nature of the communication from NHS England the report has not been considered by any of the Board Committees.		
Executive summary	NHS England has set out a 10 point plan to improve the working lives and conditions of resident doctors. The elements within the plan are as follows. 1. Improve workplace wellbeing for resident doctors. 2. Resident doctors receiving work schedules and rota information as per the requirements of the Rota Code of Practice. 3. Resident doctors being able to take annual leave in a fair and equitable way which enables well-being. 4. NHS Trust Boards appointing two named leads, a senior leader responsible for resident doctor issues, and a peer representative who is a resident doctor, both reporting to the Board. 5. Resident doctors not experiencing payroll errors due to rotations. 6. Resident doctors not unnecessarily repeating statutory and mandatory training when rotating. 7. Resident doctors being enabled and encouraged to exception report. 8. Resident doctors receiving reimbursement of course related expenses within four to six weeks of submitting their claims. 9. Reducing the impact of rotations on resident doctors' lives while maintaining service delivery. 10. Minimising the practical impact upon resident doctors to having to move employers when they rotate by expanding the lead employer model.		

	NHS England have stated that Trusts are expected to provide oversight of this work. They have stated that the outcome should be included in their annual report for accountability and progress. **Trust Response** Following the release of NHS England's guidance a working group was established within the Trust led by leaders within Medical Education. A Trust wide plan was developed, and this is included in Appendix 1. It has further been discussed with resident doctor representatives and the Local Negotiating Committee of the Trust who are in agreement with the suggested actions. Amongst the 10 actions, two are predominately the responsibility of the Lead Employer Trust or NHS England. Another action has already been implemented as the North East and Cumbria have a lead employer model which is now being recommended nationally within the plan. In relation to the other 7 actions a plan is being developed with Medical Education, Medical Staffing, NTW Solutions, Lead Employer Trust, resident doctor representatives, and Guardian of Safe Working.
Detail of corporate/ strategic risks	N/A
Recommendation	It is my recommendation that the assurance around progress of this plan is monitored by the People Committee, and it is appropriately sighted within Trust annual reports in due course. With regards to Action 4, I request the Boards support in the Executive Medical Director continuing to hold the role of senior leader responsible for resident doctor issues in the interim. In relation to the peer representation, we have requested expressions of interest from resident doctors. We will ensure that the successful candidate is included in providing assurance to the Board through the People Committee.
Supporting information / appendices	Appendix 1 – Action Plan

Appendix 1 – Action Plan

Point	NHSE Expectation	CNTW Action	Who Responsible?	Date to be completed	Actual date completed	Notes
1. Improve workplace wellbeing for our resident doctors Trusts are expected to take meaningful steps to improve the working environment for resident doctors. Issues will vary by location, so trusts can adapt implementation to reflect local needs and operational realities in these and other areas: • where possible, [provide designated on-call parking spaces] • the autonomy to complete portfolio and self-directed learning from an appropriate location for them • access to mess facilities, rest areas and lockers in all hospitals, including new builds • a 24/7 out-of-hours menu offering hot meals and cold snacks for staff	**Within the next 12 weeks every trust should:** Conduct a self-assessment of the feasibility of improving priority areas and develop action plans to address any gaps. This audit and subsequent plans must be approved by the trust's people committee or equivalent body. Trusts will be expected to provide updates for national reporting on progress.	We will work with NTW Solutions to scope out the feasibility of having designated parking spaces on each Trust hospital site. We will also liaise with acute Trusts where the resident doctors are on-call across the acute sites i.e. RVI/GHead. Continue to work with Estates colleagues to locate space for on-call rooms and too tired to travel rooms on the SNH site and to locate a mess room and too tired to travel room on the MWM/HWP site. Work with facilities staff looking at the current availability of hot and cold food out of hours and ensure access is available on all sites for resident	Medical Staffing/Estates/Facilities	20th November 2025		Northumbria sites also included for acute sites Hopewood park has a designated-on call spot, no other sites have this. On call parking needs to apply to DoC as well. While too tired to travel rules not in place taxis must be provided for these rotas for too tired to travel doctors after long days and nights (+taxi back to collect car if applicable) Food provisions: - RVI costa, Ferndene vending only sites with any hot food provision as far as we are aware - HWP cold vending, SGP cold vending, MWM cold

		doctors working out of hours.				vending, SNH cold vending as far as we are aware - Would also raise hot food needs to have options available across a range of dietary restrictions (e.g vegetarian, vegan, halal, gluten free)
2. Resident doctors should receive work schedules and rota information as per the requirements of the Rota Code of Practice	**From now**, and for all rotations going forward NHS England must provide at least 90% of trainee information to trusts 12 weeks prior to rotations commencing. **From now**, Trusts must use this information to ensure that resident doctors receive their work schedules at least 8 weeks in advance and detailed rotas no later than 6 weeks before the rotation begins. Where these standards are not met corrective action must be taken. Performance data must be submitted by trusts, and	Work in collaboration with the Lead Employer Trust to ensure all work schedules are issued to the LET in line with the code of practice (it is the responsibility of the LET to issue the work schedules to the Trainees) Work together as a region to ensure the data provided will be submitted	Medical Staffing/Lead Employer Trust	Ongoing		All of our rotas are issued within 6 weeks of the resident doctor commencing in post Concerns around whether full time work schedule will match rotas While this is LET responsibility (confirmed at LET LNC also) will require input from CNTW to amend.

	NHS England will monitor and report on national compliance across all stages of the process.	in a consistent way.				
3. Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing It is vital that leave is allocated in a way that meets individual needs while maintaining service delivery.	**Within 12 weeks, NHS England will:** conduct a review of how annual leave is currently agreed and managed for our resident doctors. This review will identify areas for improvement and lead to clear recommendations to ensure a more consistent, transparent and supportive approach across all trusts.	See paper re current process.	Medical Staffing / Clinical Supervisors / Resident Doctor Reps	20th November 2025 (patchwork Feb 2026)		We are implementing Patchwork Health from February 2026 which has a live rostering system allowing annual leave requests to be submitted via the rostering system app therefore removing the need for paper forms and e-mails. Patchwork looks like it will be a welcome upgrade on the process Specific workplace/rota challenges will be discussed as part of patchwork implementation working group that was agreed
4. All NHS trust boards must appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to the board	Within 6 weeks, trusts should: appoint a senior named lead for resident doctors' issues (where one is not already in place), and a resident doctor peer representative, to report to the board. **In September 2025, NHS England will**: publish a national role specification for the board lead.	Please see notes column. On receipt of the person specifications, we will request expressions of interest from our resident doctors and carry out an election process to select the resident	Medical Director/Guardian of Safe Working / Medical Staffing	9th October		Awaiting national person specifications. Dr Nadkarni as medical director has taken on the role of senior named lead in the interim. The representative who is to act as interim senior must attend GoSW and LNC

	The senior lead will formally take on this responsibility within an existing role, supported by a national role specification to be published by NHS England in September. The resident doctor lead will act as a peer representative and enable trust boards to hear directly from resident doctors themselves. They should be invited to attend board level discussions on issues which specifically relate to improving doctors' working lives. Boards should also ensure their executive teams engage directly with resident doctors to understand local working conditions and priorities. This should be supported by national and local data sources (for example, GMC/NET Survey), with improvement plans developed with the same rigour as staff survey responses.	doctor peer representative.				meetings (+ any other relevant meetings) so that they are kept abreast of resident issues as not happening at present. If unable to do so would likely need to consider an alternative board member who could facilitate this Would also note that if/when resident concerns are raised on issues are raised in which there is a COI it is essential these are declared and taken into account. There must be a mechanism to ensure these are appropriately flagged prior to discussions
5. Resident doctors should never experience payroll errors due to rotations Following a successful pilot that has reduced errors by half, we are extending the learning from this work to all NHS trusts.	**Within the next 12 weeks, every trust should:** Participate in the current roll out of the national payroll improvement programme and ensure that payroll errors as a result of	Appoint a Programme Improvement Lead to work with the national group and LET.	Lead Employer Trust / Elaine Grant – Head of Medical Staffing	20th November 2025		It is ultimately the responsibility of the LET to ensure that resident doctors are paid correctly however, Elaine Grant, Head of Medical Staffing has been nominated to be

	rotations are reduced by a minimum of 90% by March 2026. All organisations are required to establish a board-level governance framework to monitor and report payroll accuracy and begin national reporting as required.	Elaine Grant is the contact for CNTW to report payroll accuracy for Trust employees in relation to national reporting requirements.				the Trust contact for the national Payroll Improvement Programme and will work in collaboration with the LET in relation to this. National reporting to commence October 2025
6. No resident doctor will unnecessarily repeat statutory and mandatory training when rotating	**Within the next 12 weeks if they are not already doing so, every trust should:** Comply with agreements set out in the MoU signed by all trusts in May 2025 by ensuring acceptance of prior training. **By April 2026, NHS England will:** reform the entire approach to statutory and mandatory training with a revised framework as outlined in the 10 Year Health Plan for England.	Review the MOU signed in May 2025 to ensure we are following the agreement.	Medical Education/Lead Employer Trust	20th November 2025		The system of agreeing and using the Lead Employer Trust model of using specific CSTF e-learning modules for all resident doctors in the Northeast and North Cumbria was set up to accept prior learning in the typical stat & man topics, provided this training is up to date, and adopted and used by CNTW from approx. 2018.
7. Resident doctors should be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours	A new national Framework Agreement for Exception Reporting was agreed on 31 March 2025 and will be rolled out for implementation in due course. The changes agreed simplify the reporting process for resident doctors, ensure they are being fairly	Already partially in place at CNTW. Still need to work through some queries relating to conflict of interest, i.e. our Guardian has a trainee and ensure our processes are in	Medical Staffing/Guardian of Safe Working / Director of Medical Education / Resident Doctor representatives.	31st December 2025		Will need to agree a process through LNC for ERs over 2 hours.

	compensated for the additional hours they are required to work, and will support the safety of their working hours. We are committed to implementing these reforms as soon as practicable.	line with the new national guidance				
8. Resident doctors should receive reimbursement for course-related expenses within 4 to 6 weeks of submitting their claims We will transition nationally from an approach where expenses for approved study leave are reimbursed only after a resident doctor has attended a course/activity, to one where reimbursement is provided as soon as possible after the expense is incurred.	**Within the next 12 weeks every trust should:** Review their current processes to ensure they can reimburse resident doctors upon submission of valid receipts for all approved study leave-related expenses, including travel and subsistence.	N/A Fully managed by the Lead Employer Trust	Lead Employer Trust / Resident Doctors / Clinical & Educational Supervisors	20th November 2025		
9. We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery A review of how rotations are managed is now underway and is being led by the Department for Health and Social Care (DHSC) in conjunction with the British Medical Association (BMA). NHS England is working closely with the BMA to fully understand trainees' concerns and to find constructive and workable solutions to address their needs as a matter of priority.	Within 12 weeks, NHS England will: develop and launch suggested pilots of reformed rotational changes, while continuing to look at wider reform.	N/A – NHS England to take forward	NHS England	20th November 2025		
10. We will minimise the practical impact upon resident doctors of having to move employers when they rotate, by expanding the Lead Employer model	**By October 2025, NHS England will: develop a comprehensive and financially sustainable roadmap, underpinned**	N/A – the North East & Cumbria region already has a Lead Employer Model.		N/A		

NHS England is committed to extending the Lead Employer model to cover all resident doctors and dentists in training. This change will eliminate the need for trainees to change employers with each rotation, reducing duplication and administrative errors while improving continuity, efficiency, and the overall training experience.	**by a robust business case. This will include detailed recommendations on costing and funding, service catalogue requirements, and pricing models for national implementation. The roadmap will provide a clear framework for expanding Lead Employer arrangements across the system.**					

5. STRATEGIC AMBITION 4 - SUSTAINABLE FOR THE LONG TERM, INNOVATING EVERY DAY

Darren Best, Chair

5.1 RESOURCE AND BUSINESS ASSURANCE COMMITTEE QUARTERLY ASSURANCE REPORT

Emma Moir, Interim Committee Chair

REFERENCES

Only PDFs are attached

5.1 RABAC Board Assurance Report - Nov 2025 - FINAL.pdf

Report to the Board of Directors
Wednesday 5 November 2025

Resource and Business Assurance Committee Quarterly Assurance Report August – October 2025

1. Purpose

This report seeks to provide the Board with assurance of ongoing oversight of key areas of focus and risk undertaken by the Resource and Business Assurance Committee (RABAC). This includes an overview of the areas of focus, discussion and assurance.

2. Resource and Business Assurance Committee overview

The Committee receives assurances that the Trust has effective systems and processes in place to secure economy, efficiency and effectiveness in respect of all resources, supporting the delivery of the Trust's Strategy and Operational Plans. It examines current and emerging risks to delivery, the effective and efficient use of resources, and the long-term sustainability of the Trust.

There has been one meeting of the Committee during the period August 2025 – October 2025. This meeting was held on 10 October 2025.

3. Board Assurance Framework risks within Committee remit

The Resource and Business Assurance Committee is currently managing the following key risks on the Board Assurance Framework (BAF):

Board Assurance Framework risk	Risk score
Risk 2545 – Failure to deliver a sustainable financial position and longer-term financial plan, will impact on Trust's sustainability and ability to deliver high quality care.	4 (likely) X 4 (significant) 16
Risk 2546 – Risk that restrictions in capital expenditure imposed regionally / nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments and Infrastructure.	3 (possible) X 4 (significant) 12
Risk 2547 – Risk that the Trust's information and systems is at higher risk of being compromised leading to unknown vulnerabilities. This could lead to loss of, and/or public disclosure of, information and loss of access to critical systems.	3 (possible) X 4 (significant) 12

4. Resource and Business Assurance Committee focus August – October 2025

4.1 Assurance relating to risk 2545 – financial sustainability

In terms of financial planning, the Committee requested additional assurance in future reports of the evidence on delivering the efficiency plan and improving the cashflow plan for month 6 – month 12. The Committee noted the need to address the underlying deficit and provide assurance through clear, actionable plans for sustainability and escalation to the Board if adequate assurance is not received.

Regarding medium and long-term financial planning, the Committee highlighted their primary area of concern was financial sustainability over the next 2 – 3 years, whereby similar assurance will be required in future reports in terms of the detail around deliverability. The importance of working at pace to close the gaps on the development of the medium-term resource plan and workforce plan. It was noted that triangulation of Board committees will be important to ensure these plans as well as the Trusts Model of Care and Support are all aligned to ensure strong and clear decision-making in the organisation.

Following review of the BAF risk 2545, it was agreed that the controls, assurances and outstanding actions be strengthened. Assurance was provided at the meeting in relation to actions being taken but it was recognised that these are not currently reflected in sufficient detail in the BAF risk.

4.2 Assurance relating to risk 2546 – capital restrictions

The Committee noted and commended the work of all involved in the Trusts CEDAR Programme (Care Environment Development and Re-provision) following the final phase of the opening and redevelopment of the Bamburgh Clinic.

Future reports on the wider capital programme will include clarity on whether live schemes are on track for completion, any overspend, and any risks or issues for assurance.

4.3 Assurance relating to risk 2547 – vulnerabilities of digital information and systems

The Committee noted that the September Board of Directors approved the Business Case to transfer Digital Services to NTW Solutions Limited (the Trust subsidiary company).

During the past 12 months, Digital oversight has been delegated to the Resource and Business Assurance Committee through its terms of reference and cycle of business. Following the appointment of a Non-Executive Director with Digital expertise in September, a separate Digital Committee of the Board will be established formally in December and responsibility for digital oversight will transfer to the new Committee.

A final report on the transfer of Digital services will be submitted to the November meeting of the Resource and Business Assurance Committee in advance of the transfer of responsibility for assurance and oversight.

In relation to 2547 – risks relating to digital vulnerabilities and loss of, and/or public disclosure of, information and loss of access to critical systems. The Committee recommended that the likelihood scoring of the risk which currently indicates ‘possible’ be reviewed considering the current climate of cyber-attacks. Further detail on controls and actions to mitigate and reduce the impact on quality, safety, care and treatment would be beneficial. It was recognised that whilst the risk would be transferred to the Digital Committee when established, an update on this would be useful at the November meeting of the Resource and Business Assurance Committee in the context of the wider update on the Digital service transfer to NTW Solutions Limited.

4. Other issues and assurance received by the Committee

Provider Collaborative

During the past 12 – 18 months, oversight of the Trusts Provider Collaborative arrangements have been delegated to the Resource and Business Assurance Committee for oversight and assurance.

The Committee highlighted the need to improve assurance reporting relating to provider collaborative arrangements. A standing agenda item/report for key issues from the provider collaborative will be included for all future meetings. It was recognised that the Trust was in the process of appointing a substantive Executive Director of Finance to the Board and a further discussion on assurance reporting for provider collaborative arrangements would take place once the appointment was in place.

NHS Provider Capability Board Self-Assessment

The Committee reviewed the draft NHS England Provider Capability Board Self-Assessment prior to consideration at the October Board development session. All Provider Trusts have been asked to complete the self-assessment against the six domains outlined in the NHS England Insightful Board guidance:

- Strategy, leadership and planning
- Quality of care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

The self-assessment was reviewed in the context of identifying any gaps associated with the business of the Resource and Business Assurance Committee in relation to the stated domains. Due to tight timeframes issued by NHS England for completion of the assessment, gaps remained in relation to a number domains at the time of reporting. For the purpose of RaBAC, these related to Domain 5 – productivity and value for money and Domain 6 – financial performance and oversight. These gaps were recognised by the Committee and were populated prior to submission to the Board development sessions held on 15 October.

CQC Well led inspection high-level feedback

The Committee noted the CQC initial high-level feedback following the well led inspection undertaken in September/October. It was recognised that the feedback was high-level at this stage, and the final full report was forthcoming. Discussions with the CQC continue to gain further clarity on some of the findings in the letter which will be shared at the open Board meeting in October. It was noted that there was reference to governance and the importance of ensuring a clear line of sight between operations and the Board. This includes being as robust as we can in terms of governance processes and this will be a continual focus for the Committee as part of its planning, agenda setting and reporting.

Summary and recommendation

The Resource and Business Assurance Committee has continued to operate in line with its terms of reference and ensure alignment of the cycle of business with the Board Assurance Framework and ensuring the continued focus on assurance of the actions being taken to address key risks to achieving the Trusts Strategic Ambitions.

The Board is asked to note:

- The concerns of the Committee relating to delivery of the 2025/26 financial plan and the request for more detailed information on the actions required.
- The concerns of the Committee relating to the development of the medium-term resource plan to ensure financial sustainability and the request for improvement to future reporting in terms of clear actions, timelines and ownership.

Emma Moir
Resource and Business Assurance Committee Interim Chair
November 2025

5.2 FINANCE QUARTERLY REPORT (QUARTER 2)

Chris Cressey, Interim Executive Director of Finance

REFERENCES

Only PDFs are attached

5.2 Trust Board - M6 Finance Report - Final.pdf

Meeting	Board of Directors		Agenda item: 5.2
Date of meeting	Wednesday 5th November 2025		
Report title	Month 6 Finance Report		
Report Lead	Chris Cressey, Interim Executive Director of Finance		
Prepared by	Helen Lumsdon, Associate Director – Financial Reporting		
Purpose	For decision	For assurance	For awareness
		X	
Report previously considered by	Executive Management Meeting (27th October 2025) have received the Month 6 detailed finance report.		

Executive summary

Overall Financial Position

The Trust has reported a £0.6m surplus at Month 6 which is £2.1m ahead of the annual plan. While this is a positive variance it is masking overspends against plan, the year-to-date surplus includes the benefit from the sale of land at Northgate, phased into the plan towards the end of the year. Removing the benefit the Trust is £5.2m behind plan at Month 6. See the table below: -

	£m
Planned Deficit	(1.5)
Northgate Land Sale	6.6
Red Shale Provisions	0.7
Expected Surplus	5.8
Reported Surplus	0.6
Shortfall	**5.2**

The shortfall plan is from overspends in 3 areas, staffing over establishment, Out of Area Treatments (OATs) and pressures on delivering efficiencies. In addition, there are two key commissioning pressures arising from the impact of GP collective action on the Trust prescribing budget (forecast at £1.4m) and the impact of care packages for in patients who are clinically rehab for discharge (forecast impact of £2.8m)

Staffing Over Establishments

The Trust has been over established throughout the year, the over establishment has decreased to 18 in month 6. The table below show the over establishment for quarter 2 this year

	Month 6			Month 5	Month 4
	Budget	Actual	Variance	Variance	Variance
	WTE	WTE	WTE	WTE	WTE
Inpatients	1,755	1,861	106	122	108
Community	3,094	3,066	(28)	(17)	(25)
Specialist	1,900	1,929	29	45	30
Infrastructure	1,825	1,736	(89)	(56)	(37)
TOTAL	**8,574**	**8,592**	**18**	**94**	**76**

All groups have reduced the WTE pressure from month 5 to month 6. However in order to deliver against the originally agreed workforce and financial plan, the Trust needs to deliver a further 198 wte reduction. In addition to recover the shortfall in months 1-6 a further reduction of approximately 150 wte would be required. This is being addressed in the urgent recovery programme, and an updated plan for months 7-12 will be presented to RABAC in November, and updated monthly form that point.

OATS

The trust has experienced pressure from sending patients out of area in the first 6 months of the year. The Trust forecast includes a £1.2m overspend OATs budgets which is being offset by non-recurrent mitigations.

Efficiency

The trust has reviewed the efficiency programme and is forecasting to deliver the full £30.6m planned efficiency. The trust has identified areas within the original efficiency programme that will not deliver this year and identified offsetting mitigations. The revised delivery includes £9.5m of planned recurrent savings which will not deliver and are being offset by £9.5m of non-recurrent mitigations.

Commissioning pressures

GP collective action has resulted in patients previously being supported in primary care being transferred into CNTW services. This has resulted in staffing pressures but also a significant impact on the Trust prescribing budgets, where GPs will no longer prescribe antipsychotic or ADHD medication. The forecast pressure of the prescribing budget is £1.4m, but in reality this is a cost shift from the ICB prescribing budget to CNTW.

The Board are already aware of pressures arising from care packages to support in-patients who are clinically ready for discharge. The forecast impact of this £2.8m.

Both issues are now subject to formal escalation with the Integrated Care Board

Financial Delivery

The trust is forecasting to deliver the planned £3.3m surplus at the end of the financial year but remains reliant on non-recurring measures to deliver this. In order to improve the position the Executive team have put in place an urgent recovery programme, aimed at delivering staff reductions and non pay savings in the second half of the year. The urgent recovery programme contains a range of measures to recover a further £4.1m in savings.

Capital Expenditure

The table below shows the trust's planned capital programme.

Capital Programme	2025/26
	£'000
CEDAR	538
Newcastle Older Peoples Wards	4,953
Benton House	970
Backlog Maintenance	489
Sustainability	500
Carlisle Civic Centre	463
Omnicell Cabinets*	495
Equipment	100
IM&T	800
Minor Schemes	1,152
Bamburgh 136	1,200
Clozapine Clinic	375
Tyne Ward	131
PDC – Solar Energy Project	1,842
Desteaming – Prep Works	200
	14,208

*There is a £990k pressure to replace obsolete Omnicell cabinets of which 50% will be completed in 25/26 and 50% will be completed in 26/27. The commitment will be a pre commitment against the 2026/27 capital programme.

Cash Position

The Trust has a cash balance of £22.4m at the end of September, a decrease from the balance of 27.1m in August. The September balance is behind plan. The trust has received the land sale proceeds

	in Q1 rather than Q4 as included in the plan, however higher than planned revenue spend and reliance on non cash efficiency is having a detrimental impact on the cash position. The Trust provided a forecast cash balance of £13m at the of the financial year. The forecast cash position reflects a prudent assessment of cash balances. The reduction in forecast cash is based on using an increased level of non-cash transactions to offset in year overspending, and a risk that commissioners of the patients being treated in the Mitford Unit do not pay their invoices. The urgent recovery programme is intended to improve the cash position at the year end, but also ensure that the Trust is in a place to secure a sustainable run rate going into 2026/27. The Trust has increased the price of the Mitford service based on current costs and the Trust has begun the dispute process with the relevant commissioners, who are not paying the revised price. Commissioners are not disputing their obligation to pay so the trust will receive income. The dispute is based on the price. The risk is based on the proportion of the income relating to the increase. Full payment would increase the forecast trust cash balances to circa £16m, therefore depending on the agreement the range of impact is £12m (£4m - £16m).
Detail of corporate/ strategic risks	The two risks below are included on the risk register. Failure to deliver a sustainable financial position and longer-term financial plan will impact on the Trust's sustainability and ability to deliver high quality care. Restrictions in capital expenditure imposed regionally/nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments and infrastructure. A risk that the trust needs cash support in 2026/27 is being added to the trust risk register.
Recommendation	The Board is asked to; • Note the pressure on financial delivery from staffing over establishments, pressure on the OATS, pressure on delivery of the efficiency plan and commissioning pressures.

	• Note the required reduction in staff numbers to deliver the financial forecast in the remainder of the financial year. • Note the trust cash position, being aware the 2025/26 plan assumes a reduction in cash balances through the year to support delivery of the capital programme and maintaining the trust loan and PFI commitments. • Note that revised trajectories for the second half of the year, in line with the urgent recovery programme, will be taken to RABAC in November.
Supporting information / appendices	None – detailed analysis is provided to RABAC as a standard information pack. This analysis is not repeated here.

5.3 ANNUAL PLAN DELIVERY 2025/26 MID-YEAR REVIEW REPORT (INCLUDING QUALITY PRIORITIES)

Ramona Duguid, Chief Operating Officer

REFERENCES

Only PDFs are attached

5.3 half year 25-26 update.pdf

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Meeting	**Board of Directors Public Meeting**		**Agenda item: 5.3**
Date of meeting	Wednesday 5th November 2025		
Report title	(HY1) First Half Year 2025-26 – Strategic Objectives progress update		
Report Lead	James Duncan, Chief Executive		
Prepared by	Ramona Duguid, Chief Operating Officer Tommy Davies – Deputy Director of Transformation, Delivery and Performance		
Purpose	**For decision**	**For assurance**	**For awareness**
		x	
Report previously considered by	None		
Executive summary	The Trust has in place an annual plan for 2025/26 which sets out the delivery of key priorities for the year against the five strategic ambitions. In September 2025, the Board of Directors approved a performance management framework, which included a requirement to produce a mid-year progress report against delivery of the annual plan. This report provides an update as at Month 6 on progress against the specific priorities. Positive progress has been made across several of the priority areas, which are included in the report. The most significant challenge remains the Trust's underlying financial position, for which additional mitigations are being implemented to support improvement during the second half of 2025/26. The Chair and Chief Executive have now agreed a focus on the following priority areas in the second half of the year: • Financial delivery; • Staff engagement and staff survey response rates; • Delivery of a workforce plan which supports financial sustainability; • Delivery of CQC regulatory breach improvements; • Strengthening the functioning of Board Committees The Executive Team will review the wider annual plan for the second half of the year to re-prioritise, in order to ensure that the key agreed areas of focus can be delivered.		

Detail of corporate/ strategic risks	**BAF Risk 2510** – Due to increased demand and capacity the Trust is unable to meet regulatory standards relating to access, responsiveness, and performance resulting in a risk to quality and safety of services. SA1 **BAF Risk 2511** – Risk of not meeting regulatory and statutory requirements of Care Quality Commission (CQC) registration and quality standards. SA1 **BAF Risk 2512** – Risk of failing to maintain a positive safety learning culture resulting in avoidable harm, poor systems, process and policy, and identification of serious issues of concern. SA1 **BAF Risk 2543 –** Failure to deliver our transformation plans around the model of care to address issues relating to community and crisis infrastructures, and demand for inpatient provision which could compromise quality, safety, and experience of service users. SA2 **BAF Risk 2540** - Risk of increased staffing costs from use of temporary staff impacting on quality of care and financial sustainability. SA3 **BAF Risk 2542** – Failure to develop a sustainable workforce model to recruit/retain/ and support the development of the right people with the right skills to deliver safe and effective services, our strategic objectives, and contractual obligations. SA3 **BAF Risk 2544** - Risk of poor staff motivation, engagement, and job satisfaction if issues affecting staff experience are not addressed including health and wellbeing support, inclusion and the ability to speak up. SA3 **BAF Risk 2546** - Risk that restrictions in capital expenditure imposed regionally / nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments and infrastructure.
Recommendation	The Board of Directors are asked to: • Note the progress made against the delivery of this year's annual plan and priorities and to take assurance that appropriate progress has been achieved across the strategic ambitions during 2025/26. • Note the review of the remainder of 2025/26 to be undertaken in the context of refocus of our priorities for the second half of the year.
Supporting information / appendices	n/a

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Our five trust strategic ambitions: aims and priorities

(HY1) First Half Year 2025/26 - Update

With YOU in mind

Our five trust strategic ambitions: aims and priorities

(HY1) First Half Year 2025/26 - Update

Our vision

To work together, with compassion and care, to keep you well over the whole of your life.

Our values

We are honest and transparent...

because we want to be fair and open, and to help people to make informed decisions.

We are respectful...

because everyone is of equal value, is born with equal rights and is entitled to be treated with dignity. We want to protect the rights of future generations and the planet that sustains us all.

We are caring and compassionate...

because that is how we'd want others to treat those we love

Our strategic ambitions

Quality care, every day

Person-led care, when and where it is needed

A great place to work

Sustainable for the long term, innovating every day

Working with and for our communities

Strategic ambition 1

Quality care, every day

Strategic ambition 2

Person-led care, when and where it is needed

Strategic ambition 3

A great place to work

Strategic ambition 4

Sustainable for the long term, innovating every day

Strategic ambition 5

Working with and for our communities

Strategic ambition 1

Quality care, every day

Strategic ambition 1

Quality care, every day

Quality Aims

- To continue to develop and embed a positive and safe culture
- To improve physical health care
- To reduce levels of restrictive practice and violence and aggression
- To reduce levels of self-harm
- To improve the care of people with a severe and enduring mental illness

Quality Priorities

- Develop a consistent and evidence-based approach to risk assessment and safety planning across all services.
- Ensure safe and coordinated transitions between services.
- Improve the early recognition and response to deteriorating patients.
- Manage and reduce the risk of severe clozapine-induced constipation.
- Continue to improve sexual safety by reducing incidents and strengthening prevention and response.
- Promote care planning that is person-centred, co-produced, and informed by the multidisciplinary team.
- Strengthen communication with families and carers, ensuring they are actively involved in care decisions and when a patient deteriorates.
- Improve handovers of care across inpatient services.
- Improve therapeutic engagement and observation across inpatient services.
- Manage and reduce the risk of cardiorespiratory arrest caused by sedative medication.
- Support staff wellbeing through increased access to resources, compassionate leadership, and healthy workplace culture

Aims					Strategic ambition 1 **Quality care, every day** Priorities 2025/26
To continue to develop and embed a positive and safe culture	To improve physical health care	To reduce levels of restrictive practice and violence and aggression	To reduce levels of self-harm	To improve the care of people with a severe and enduring mental illness	
✓	✓	✓	✓	✓	Strengthen communication with families and carers, ensuring they are actively involved in care decisions and when a patient deteriorates
✓	✓	✓	✓	✓	Promote care planning that is person-centred, co-produced, and informed by the multidisciplinary team
✓	✓	✓	✓	✓	Develop a consistent and evidence-based approach to risk assessment and safety planning across all services
✓	✓			✓	Ensure safe and coordinated transitions between services
✓	✓				Improve the early recognition and response to deteriorating patients
✓		✓	✓		Continue to improve sexual safety by reducing incidents and strengthening prevention and response
✓	✓	✓	✓	✓	Improve ward handovers of care across inpatient services
✓	✓	✓	✓	✓	Improve therapeutic engagement and observation across inpatient services
	✓				Manage and reduce the risk of cardiorespiratory arrest caused by sedative medication
	✓			✓	Manage and reduce the risk of severe clozapine-induced constipation
✓		✓			Support staff wellbeing through increased access to resources, compassionate leadership, and healthy workplace culture.

Strategic ambition 1

Quality care, every day

Priority	HY2 Update 25/26
Continue to improve sexual safety by reducing incidents and strengthening prevention and response.	• Policies and trust guidance reviewed to ensure standards of behaviour are explicit. • Acceptable Language Framework developed in relation to sexual misconduct and acceptable behaviour for use within training & induction across the Trust. • Sexual Violence and Domestic Abuse lead appointed. • Thematic review of sexual safety incidents discussed at PSLIP. Further monitoring and learning through Trustwide Safety Group and Quality governance of care groups.
Improve handovers of care across inpatient services.	• Handover policy developed and presented to BDG with further improvements suggested, to be tested digitally as part of modernising policy and practice implementation across the Trust. • Shift Pattern consultation to increase time allocated for handovers completed and thematic review presented to Trustwide Business Delivery Group. • Digital solution being explored with other national Trusts.
Improve therapeutic engagement and observation across inpatient services.	• Engagement sessions held with service users to agree best practice principles for engagement and observations. • Policy review underway to align with national guidance and promote a one-page summary at Trust meetings. • Training content reviewed to ensure robustness, inclusion of trauma-informed approaches, and monitoring of standards. • Involvement in NHS England monitoring of practice (we are involved in submitting data to NHS England which will refine our processes further; all these comments are following discussion with relevant leads). • Monitor themes of engagement and observation as and if they emerge in Incidents.
Manage and reduce the risk of cardiorespiratory arrest caused by sedative medication.	• Thematic review undertaken in relation to serious incidents where sedative medication polypharmacy and cardiopulmonary arrest have been identified. • National, Regional and Local Safety Alerts received since 2020 which related to sedative medication were reviewed to establish Trust Compliance. • Current evidence being evaluated to identify any Trust specific actions for the future.

Strategic ambition 1

Quality care, every day

Priority	HY2 Update 25/26
Strengthen communication with families and carers, ensuring they are actively involved in care decisions and when a patient deteriorates.	• Work has begun on developing dashboards in relation to: Triangle of Care and Dialogue+ • PGN developed and included in Carer Awareness training. • Gap analysis has been undertaken to understand and address gaps in involvement groups with care groups.
Promote care planning that is person-centred, co-produced, and informed by the multidisciplinary team.	• 4 workshops held to design build of RiO Care Plan platform with good attendance from relevant professional and service users and dates agreed for implementation in Community and Specialist Care groups. • Enhanced training package being developed. • Bed Based Services – Care Planning documentation implemented electronically. • Community Services in the process of implementation.
Develop a consistent and evidence-based approach to risk assessment and safety planning across all services.	• Intranet page created to support effective risk assessment and planning which includes : o Repository of training materials holding four videos with more being designed. o Risk Champions established in all care groups and information on the intranet. o Monitoring of Biopsychosocial risk assessment and safety plan as part of Integrated Performance Report.
Improve the early recognition and response to deteriorating patients (bed-based services).	• Resuscitation Officer appointed • Provision of training to ensure this is robust in relation to : o adult and paediatric basic and immediate life support; o NEWS (early warning systems). • Digital approach (My Kit Check) to management of medical equipment designed and being piloted. • Monitor the impact through the Physical Health and Public Health Steering Group.

Strategic ambition 1

Quality care, every day

Priority	HY2 Update 25/26
Manage and reduce the risk of severe clozapine-induced constipation.	• Literature review of relevant evidence and regional/local/national guidance undertaken to inform updates to Trust guidance on the prevention, identification and management of clozapine-induced constipation are in line with best practice. • Qualitative feedback survey undertaken to understand existing primary care guidance, with limited engagement from GPs across the ICB, evaluation of this has now commenced. • Monitor the impact through the Physical Health and Public Health Steering Group.
Support staff wellbeing through increased access to resources, compassionate leadership, and healthy workplace culture.	• Flexible Working and flexible retirement options readvertised for awareness, support wellbeing and retain talent. • Review of Financial wellbeing resources underway with awareness sessions arranged for Q3, continuing into 2026. • Increased communications around available wellbeing benefits, initiatives and channels. • Successful funding bid from NHS Charities Workplace Wellbeing Programme. • Compassionate leadership programme commenced.

Strategic ambition 2

Person led care, when and where it is needed

Strategic ambition 2

Person led care, when and where it is needed

Aims

- Focussing on prevention and improving the front door
- Improving services for people receiving treatment in the community
- Improving services for people in the community with severe mental health needs and other complex needs
- Improving Services for people in the community with urgent needs
- Improving services for people who require additional treatment within Inpatient setting

Priorities

Successfully deliver and sustain the Hope Haven 24/7 Neighbourhood Health Centre as part of the government flagship Neighbourhood Health approach.

Delivery of partnership hub working across all other areas and embedding of Neighbourhood Health working.

Implementation of a new Psychosis Review and Community Clozapine Initiation Service (PRECCIS)

Develop Intensive Case Management to improve care for individuals with Severe Mental Illness.

Increase the numbers of patients accessing depot medication for SMI.

Reconfigure Inpatient services to optimise the estate to have the maximum impact on the quality and safety of patient care.

Develop, agree and progress the implementation of a new model of care for the Mitford Unit Autism Spectrum Disorder Inpatient Unit.

Reconfiguration of inpatient provision in West Cumbria.

Review of Learning Disability inpatient provision and reconfiguration.

Collaborate with TEWV, Primary Care, VCSE, and other partners to design a significantly different pathway for ADHD and Autism Spectrum Disorder needs.

Redesign and improve the pathway for specialist children and young people's eating disorder service.

Reduce waiting times for assessment and access to treatment.

Developing a strong interface between Crisis, Community, and Inpatient services to effectively meet patients' needs during a crisis, including admission pathway for UEC (community and emergency departments)

Improve UEC interface and alternatives for crisis support and intervention.

Management of frequent attenders.

Proactive support for patients who require effective discharge from inpatient care.

Aims					Strategic ambition 2 **Person led care, when and where it is needed**
Focussing on prevention and improving the front door	Improving services for people receiving treatment in the community	Improving services for people in the community with severe mental health needs and other complex needs	Improving Services for people in the community with urgent needs	Improving services for people who require additional treatment within Inpatient setting	**Priorities 2025/26**
✓					• Successfully deliver and sustain the Hope Haven 24/7 Neighbourhood Health Centre as part of the government flagship Neighbourhood Health approach. • Delivery of partnership hub working across all other areas and embedding of Neighbourhood Health working.
	✓	✓			• Collaborate with TEWV, Primary Care, VCSE, and other partners to design a significantly different pathway for ADHD and Autism Spectrum Disorder needs. • Redesign and improve the pathway for specialist children and young people's eating disorder service. • Reduce waiting times for assessment and access to treatment.
		✓			• Implementation of a new Psychosis Review and Community Clozapine Initiation Service (PRECCIS) • Develop Intensive Case Management to improve care for individuals with Severe Mental Illness. • Increase the numbers of patients accessing depot medication for SMI.
✓	✓	✓	✓	✓	• Developing a strong interface between Crisis, Community, and Inpatient services to effectively meet patients' needs during a crisis, including admission pathway for UEC (community and emergency departments) • Improve UEC interface and alternatives for crisis support and intervention. • Management of frequent attenders. • Proactive support for patients who require effective discharge from inpatient care.
				✓	• Reconfigure Inpatient services to optimise the estate to have the maximum impact on the quality and safety of patient care. • Develop, agree and progress the implementation of a new model of care for the ***Mitford*** Unit Autism Spectrum Disorder Inpatient Unit. • Reconfiguration of inpatient provision in West Cumbria. • Review of Learning Disability inpatient provision and reconfiguration.

Strategic ambition 2

Person led care, when and where it is needed

Priority	HY2 Update 25/26
Collaborate with TEWV, Primary Care, VCSE, and other partners to design a significantly different pathway for ADHD and Autism Spectrum Disorder needs.	• NENC ICB development of revised commissioning policy to support pathway changes into secondary care mental health services. Collaboration with TEWV remains strong in relation to revised clinical pathways for secondary care services. • Triage of existing waiting list demand will be required in line with the new policy and agreed clinical pathway in Q3.
Redesign and improve the pathway for specialist children and young people's eating disorder service.	• The Quality Improvement Group is established to oversee, guide, and implement improvements in the care pathways, service delivery, and clinical outcomes for children and young people diagnosed with disordered eating within the Trust. The group will focus on service evaluation, pathway development, innovation in models of care, and staff development to ensure high-quality, safe, and effective treatment.
Reduce waiting times for assessment and access to treatment.	• With no waits over 104 weeks for Working Age Adults and Older Adults, the trust benchmarks the highest in England for Mental Health Trusts and is top quartile for the implementation of the community transformation meaningful clock stop methodology. • As per the ADHD/Autism plan the long waits in these services continue to affect the overall CYPS waits but collaborative work on this with the ICB will reduce these waits.
Management of frequent attenders to inpatients	• There has been a focus on 46 patients with highest admissions. Following targeted work, 24 of the 26 had no admissions and the admission rate of the cohort in total dropped by 80% from 255 to 50 admissions.

Strategic ambition 2

Person led care, when and where it is needed

Priority	HY2 Update 25/26
Reconfigure Inpatient services to optimise the estate to have the maximum impact on the quality and safety of patient care.	• Several projects have completed and are progressing including Learning Disability and Autism inpatient care, and the closure of Yewdale as below. • Working Age Adults have successfully moved onto the refurbished Bamburgh Clinic at St Nicholas Hospital • Construction works at St Nicholas Hospital have commenced to re-provide Older Adults inpatients services off the Centre for Ageing Vitality.
Develop, agree and progress the implementation of a new model of care for the Mitford Unit Autism Spectrum Disorder Inpatient Unit.	• Clinical model and proposed operational model have been developed ahead of seeking approval on next steps with Executive Management Group and system partners. This will include the connectivity with learning disability inpatient provision where clinically appropriate.
Reconfiguration of inpatient provision in West Cumbria	• Yewdale ward in West Cumbria has closed, additional beds are available on the newly developed beds at the Carleton Clinic Site.
Review of Learning Disability inpatient provision and reconfiguration.	• Temporary changes approved to support the engagement on longer term options which will be operationalised in Q3. • Next phase of proposed changes will take place in November 2025 with the introduction of the Learning Disability in-reach and Transitions Team.

Strategic ambition 2

Person led care, when and where it is needed

Priority	HY2 Update 25/26
Successfully deliver and sustain the Hope Haven 24/7 Neighbourhood Health Centre as part of the government flagship Neighbourhood Health approach.	• Copeland residents can access mental health and wellbeing support from CNTW, Everyturn and Home Group, alongside practical advice on housing and benefits, physical health checks via Cumbria Health, community wellbeing activities via iCan and drug and alcohol support through The Well all working as one team providing services. • Four Temporary accommodation beds are open and a Virtual Safe Haven. • The Hope Haven Hub building will go live in the centre of Whitehaven in December.
Delivery of partnership hub working across all other areas and embedding of Neighbourhood Health working.	• The Trust are supporting the successful bid by Sunderland to become a government flagship for the Neighbourhood Health pilots for physical and mental health. • Each area is working with partners to build on the national guidance to introduce a Neighbourhood Health approach.
Implementation of a new Psychosis Review and Community Clozapine Initiation Service (PRECCIS) Increase the numbers of patients accessing depot medication for SMI. Develop Intensive Case Management to improve care for individuals with Severe Mental Illness (SMI)	• New posts recruited to for the clozapine clinic, accommodation will be ready for Jan-26 • Processes task and finish group set up to implement the new protocol for the clinic and identify SOPs (Standard Operating Procedures) and clinic build in RiO • A cohort of 375 patients who require assertive and intensive outreach in the community has been established using data for specific criteria and clinical team intelligence. • These patients will be targeted for key work with partners and community teams to manage the risk and support them to live effectively and safely in the community. This has including reducing DNAs (patients who did not attend) and a reduction in urgent and crisis referrals.

Strategic ambition 2

Person led care, when and where it is needed

Priority	HY2 Update 25/26
Developing a strong interface between Crisis, Community, and Inpatient services to effectively meet patients' needs during a crisis, including admission pathway for UEC (community and emergency departments)	• Hospital to Home Team launch October 2025. • Urgent care pathway in development linked to workforce plan for Community Treatment Teams, Crisis and access services such as Psychiatric Liaison Teams.
Improve UEC interface and alternatives for crisis support and intervention.	• Northumberland, North Tyneside and Newcastle safe havens are fully operational. West Cumbria has launched its virtual safe haven offer. • Mental Health Response Vehicle live in West Cumbria successfully supporting A and E diversions. • Acorn Unit crisis assessment centre operational for 136 assessments and Crisis assessment and Home Treatment • NHS 111 press 2 live Trustwide.
Proactive support for patients who require effective discharge from inpatient care.	• Hospital to Home model launch. • A patient tracker system has been implemented to target RAG (red, amber green rating) approaches. • A Tier system for patients who are Clinically Ready For Discharge from the Trust has also gone live so staff can focus the most relevant patients.

Strategic ambition 3

A great place to work

Strategic ambition 3

A great place to work

Aims

- Culture and leadership development
- Development of Workforce Plan
- Support the health and wellbeing of staff by providing early intervention support / reduce sickness absence

Priorities

- Roll out Leadership Programme (3 modules) and Clinical Support Worker Development Programme
- Map the current and future clinical support workforce requirements in line with organisational change, immigration policy changes.
- 1% sickness absence reduction across all operational and corporate areas
- Ensure that the legal framework is followed in all staff consultations and that appropriate support is put in place for staff as required
- Raise awareness across the Trust of the Sexual Safety Legislation and individual and collective responsibilities therein

Strategic ambition 3

A great place to work

Aims			Strategic ambition 3 **A great place to work** **Priorities 2025/26**
Culture and leadership development	Development of Workforce Plan	Support the health and wellbeing of staff by providing early intervention support / reduce sickness absence	
✓			Roll out Leadership Programme (3 modules) and Clinical Support Worker Development Programme
	✓		Map the current and future clinical support workforce requirements in line with organisational change, immigration policy changes.
	✓	✓	Ensure that the legal framework is followed in all staff consultations and that appropriate support is put in place for staff as required
		✓	Raise Awareness across the Trust of the Sexual Safety Legislation and individual and collective responsibilities therein
		✓	1% sickness absence reduction across all operational and corporate areas

Strategic ambition 3

A great place to work

Priority	HY2 Update 25/26
Roll out Leadership Programme (3 modules) and Clinical Support Worker Development Programme	• Roll out Leadership Programme. To date, Trust Leadership Forum members and 105 Team Leaders (Band 7+) have completed the priority modules with the remaining circa 400 staff booked to attend up to June 2026. • Roll out Clinical Support Worker Development Programme. Circa 100 staff have completed the programme with dates throughout 2026.
Map current and future clinical support workforce requirements in line with organisational change, immigration policy changes.	• Workforce planning. Workshops/discussions have taken place over the past 6 months to align plans to the model of care programmes. Workforce Plan to be in place by March 2026.
1% sickness absence reduction across all operational and corporate areas	• Trust continues to ensure that the legal framework is followed in all staff consultations and that appropriate support is put in place for staff as required.
Ensure that the legal framework is followed in all staff consultations and that appropriate support is put in place for staff as required	• Signed up to the Sexual Safety Charter. Raised awareness of the Sexual Safety Legislation and individual and collective responsibilities therein. Policies reviewed. Analysis of Sexual Safety cases at PSLIP (patient safety learning and improvement panel).
Raise awareness across the Trust of the Sexual Safety Legislation and individual and collective responsibilities therein	• 1% sickness absence reduction target across all operational and corporate areas. Action plan agreed at Executive Management Group. Targeted work commenced in areas with highest absence rates.

Strategic ambition 4

Sustainable for the long term, innovating every day

Strategic ambition 4

Sustainable for the long term, innovating every day

Aims

- To meet the Trust's statutory and mandated targets
- Deliver the analogue to digital shift
- Embed research into services and practice across the Trust
- Trust aim to reduce carbon emissions to 'net zero' by 2040

Priorities

- Deliver the Trust annual plan for 2025/26 as part of the North-East & North Cumbria ICB's financial plan to deliver financial break-even
- Develop our digital strategy to support the model of care
- Roll out paperless working in the last two remaining clinical services areas (Therapeutic Observations in Inpatients and Electronic prescriptions in the Community)
- Recognise and address the underlying financial pressure across services within the Trust and support the NHS development of Medium-Term Planning
- Green plan
- Ensure CNTW is a leader and an influencer in local and national research networks and partnerships

Sustainable for the long term, innovating every day

Aims				Strategic ambition 4 **Sustainable for the long term, innovating every day**  **Priorities 2025/26**
To meet the Trusts statutory and mandated targets	Deliver the analogue to digital shift	Embed research into services and practice across the Trust	Trust aim to reduce carbon emissions to 'net zero' by 2040	
✓				Deliver the Trust annual plan for 2025/26 as part of the North-East & North Cumbria ICB's financial plan to deliver financial break-even
✓				Recognise and address the underlying financial pressure across services within the Trust and support the NHS development of Medium-Term Planning
	✓		✓	**Develop our digital strategy to support the model of care**
	✓		✓	Roll out paperless working in the last two remaining clinical services areas (Therapeutic Observations in Inpatients and Electronic prescriptions in the Community)
		✓		Ensure CNTW is a leader and an influencer in local and national research networks and partnerships
			✓	Green Plan

Strategic ambition 4

Sustainable for the long term, innovating every day

Priority	HY2 Update 25/26
Deliver the Trust annual plan for 2025/26 as part of the North-East & North Cumbria ICB's financial plan to deliver financial break-even	• The Trust reported a £0.6m surplus year to date in month 6, this is £2.1m ahead of plan. The YTD position is supported by an earlier than anticipated sale of land. The forecast to the end of the financial year is for a £3.3m surplus in line with planned contribution to the ICB overall financial plan to deliver break even. CNTW is currently reliant on a higher than planned level of non recurrent support in 25/26 and urgent and emergency measures have been put in place to improve the financial position in the second half of 2025/26, and support the delivery of a sustainable revisit in 2026/27
Roll out paperless working in the last two remaining clinical services areas (Therapeutic Observations in Inpatients and Electronic prescriptions in the Community)	• The supplier of Rio, the Access Group, are undertaking an ambitious programme to redevelop the system. This redevelopment is based on Trust and user feedback. Electronic observations is one of the first developments, with CNTW inpatient staff fully engaged. The new module is expected to be available for release after November 2025 and will introduce significant improvements to recording both physical and therapeutic observations. This will reduce the paper used on inpatient wards, and the storage of paper in the Trust. • Following sign off of business case, a new system, CLEO, has been procured for community prescribing. CLEO will be used initially in the Adult ADHD service. This will reduce use of paper prescriptions as electronic transfer of prescriptions will be introduced directly from Trust to local pharmacy.

Strategic ambition 4

Sustainable for the long term, innovating every day

Priority	HY2 Update 25/26
Recognise and address the underlying financial pressure across services within the Trust and support the NHS development of Medium-Term Planning	• The Trust has identified the underlying financial pressure within services and is currently in discussions with the NENC ICB to confirm the status of income for future years to have a full understanding of the funding sources that will continue past 25/26. • Plans under development at Care Group Level to develop medium term plans for delivering long term sustainability within agreed income levels • Await planning guidance and associated resource allocation for 2026/27-2028/29
Develop our digital strategy to support the model of care	• The focus for Digital has been the delivery of the move to NTW solutions which completed at the end of September. • The Digital Strategy will now be reviewed to fully align to the 10-year plan
Ensure CNTW is a leader and an influencer in local and national research networks and partnerships	• CNTW's research profile is growing, with major funding secured for ARC NENC (£18m) and mood disorder trials (£2m) • CNTW is supporting HCP research careers through the NENC internship programme (£887k).
Green plan	• The Green Plan has been refreshed in line with national guidance and is being received by the Trust Board of Directors for sign off in November.

Strategic ambition 5

Working with and for our communities

Strategic ambition 5

Working with and for our communities

Aims

- Act as a system enabler and influencer
- Drive action to reduce health inequalities

Priorities

- Develop an effective partnership between TEWV and CNTW and support the Provider Collaborative to be successful.
- Engage with and support the 10-year plan, transforming how services are commissioned for patients.
- Support the Neighbourhood Health Models by engaging with partners to develop new and cohesive ways of working.
- Roll out the Patient and Carer Race Equality Framework (PCREF) across all marginalised groups.

Strategic ambition 5

Working with and for our communities

Aims		Strategic ambition 5 **Working with and for our communities**  **Priorities 2025/26**
Act as a system enabler and influencer	Drive action to reduce health inequalities	
✓	✓	Develop an effective partnership between TEWV and CNTW, and support the Provider Collaborative to be successful.
✓	✓	Support the Neighbourhood Health Models by engaging with partners to develop new and cohesive ways of working.
✓	✓	Engage with and support the 10-year plan, transforming how services are commissioned for patients.
✓	✓	Roll out the Patient and Carer Race Equality Framework (PCREF) across all marginalised groups.

Strategic ambition 5

Working with and for our communities

Priority	HY2 Update 25/26
Develop an effective partnership between TEWV and CNTW and support the Provider Collaborative to be successful.	• Joint meetings continue between the TEWV and CNTW Executive • Provider Collaborative Governance under review through Provider Collaborative Board
Engage with and support the 10-year plan, transforming how services are commissioned for patients.	• Following the 10-year plan, the Trust Strategy and Trust Model of Care has been refreshed. • Key areas being progress such as Neighbourhood Health Models at place, MHED (MH Emergency Department) plans, and the Hope Haven is also a national pilot for the new 24/7 Neighbourhood Health Centre.
Support the Neighbourhood Health Models by engaging with partners to develop new and cohesive ways of working.	• The Trust has engaged at each plan level regarding Neighbourhood Health Models working with partners of developing partnerships, hubs and closer working joined up around patients. • Sunderland are a first cohort national pilot.
Roll out the Patient and Carer Race Equality Framework (PCREF) across all marginalised groups.	• Analysis of Trust ethnicity data complete. • PCREF Plan agreed with representatives from marginalised ethnic and faith communities and published on Trust website. • PCREF governance structure established, providing oversight of PCREF plan implementation.

6. STRATEGIC AMBITION 5 ? WORKING FOR, AND WITH OUR COMMUNITIES

Darren Best, Chair

6.1 CHARITABLE FUNDS COMMITTEE REPORT

Vikas Kumar, Committee Chair

REFERENCES

Only PDFs are attached

6.1 Charitable Funds Committee Trustee Assurance report - Nov 25.pdf

Report to the Board of Directors
Wednesday 5 November 2025

Charitable Funds Committee Quarterly Assurance Report
August 2025 – October 2025

1. Purpose

This report seeks to provide the Board with assurance of ongoing oversight of key areas of focus by the Charitable Funds Committee. This includes an overview of the areas of focus, discussion and assurance associated with the Trust Chairty.

2. Charitable Funds Committee overview

The Committee is a statutory committee of the Corporate Trustee (Board of Directors) for the Trust Charity. The Charity is registered with the Charity Commission with Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust Board of Directors as the Corporate Trustee (as a unitary Board of Directors).

The aim of the Charitable Funds Committee is to undertake the routine management of the Charity, in accordance with the Trust's Scheme of Delegation, and to give additional assurance to the Corporate Trustee that charitable activities are within the law and regulations set by the Charity Commission for England and Wales. It does not remove from the Corporate Trustee the overall responsibility for stewardship of Charitable Funds but provides a forum for a more detailed consideration and management of all charitable activity within the Trust.

There has been one substantive meeting of the Committee during the period August 2025 – October 2025. This meeting was held on 22 October.

4. Issues relating to statutory and regulatory compliance and governance oversight

There are currently 51 Specific Funds and one General Fund (SHINE – Support, Hope, Inspire, Nurture and Empower). Three new funds have been opened during the period for NHS Charities Together Grant funding for Wellbeing, donation for Northgate, and legacy donation for St Nicholas Hospital.

Dormant funds

The Committee noted that there are funds which are not regularly utilised. An update will be provided to a future meeting on opportunities to utilise these dormant specific funds following discussions with the fund holders.

Charity expenditure activity

There have been 13 withdrawals from specific funds and 12 withdrawals from the SHINE fund during the period. The Committee noted the low numbers of applications to withdraw funds from the South locality and community services, and the Marketing and Charity team will undertake some targeted work in these areas to raise awareness of the funds available and support opportunities for use of funds and fundraising activity.

Draft Charity Accounts 2024/25

The Committee received the draft audited Charity accounts for 2024/25 and the quarter two (July – September) financial report. The External Audit team have raised no issues with regard to the

accounts audit. The final accounts will be presented for review at the Extra Ordinary meeting of the Audit Committee (the Charity Chair is a member of the Audit Committee) and an Extra-ordinary meeting of the Board in December.

5. Charity strategy and activity

Regional Charity Chairs collaboration

The Committee Chair is a member of the NHS Regional Charities Chair group. The group have engaged in discussions to create a Memorandum of Understanding focusing on the following four areas of commitment from each Trust charity. Charitable Funds Committees from all organisations in North East and North Cumbria have been asked to respond.

1. Collaboration through funding contributions/ring-fenced funding to support specific initiatives or building additional capacity.
2. Shared knowledge and experience on how committees operate including sharing of policies and process.
3. System-wide approach to lobbying and influencing.
4. Collaborative funding – targeting new moneys/funding opportunities in through collaborative bids.

The Committee agreed that whilst the Trust Charity would support 2 and 3 above, support for option 4 would be subject to capacity available within existing support functions. Regarding option 1, the Trust Charity is currently not in a position financially to support any central contribution requests at this time, and the Committee emphasised the importance of focusing on the Charity's impact locally. The Trusts response is aligned with responses from other NHS Trust Charities across the region.

A response will be provided to the regional group.

Approval process for bids via bid review meetings

The Committee continues to hold bespoke regular meetings to review and approve funding bids received. Expenditure is expected to increase, as always, on the lead up to the Christmas period and the Committee recognised the need for timely approvals of requests through the bid review meetings. The process has been strengthened to ensure it supports the charity and its impact through timely approvals of applications.

Delivery of the Charity strategy

An update was provided by the Marketing and Charity team on the charity and fundraising activity delivered during the period. This included an update on recent fundraising events, grant applications, website development, and community engagement initiatives, as well as future plans.

Successful fundraising activities included a golf day, the Great North Run, and the Northumberland Castle's half marathon, as well as grant applications such as the Greener Communities Grant and a £5,000 award from Movement for Good. The charity's website is nearing completion following user testing, and staff engagement.

The team have undertaken work to develop community and school partnerships with local schools. St Paul's Primary School in Sunderland have agreed to be our 'community link charity' and fundraise for SHINE as well building a long-term relationship with the Trust. The team supported by colleagues from our Children and Young People's services have also engaged in

discussions with the school, parents and carers of children about the importance of mental health and wellbeing.

Through a successful bid to NHS Charities Together, the Trust have secured a Workforce Well-being Grant Project. The criteria for applications are specific, and this bid focused on ‘supporting staff behind the process’. The project aims to support staff through the development of inclusive training linked to ensuring sexual safety, supporting staff through coronial processes and support for staff who have been involved in serious cases.

Summary and recommendation

The Board is asked to note the content of the report and seek further assurance on any issues where appropriate.

Vikas Kumar
Chair of Audit Committee
November 2025

6.2 HEALTH INEQUALITIES QUARTERLY REPORT

Lynne Shaw, Executive Director of People and Organisational Development

REFERENCES

Only PDFs are attached

6.2 Health Inequalities Update Trust Board November 2025.pdf

Meeting	Board of Directors Public Meeting		Agenda item: 6.2
Date of meeting	Wednesday 5 November 2025		
Report title	Health Inequalities Update		
Report Lead	Lynne Shaw, Executive Director of Workforce and OD		
Prepared by	Jane Welch, Health Equity Lead		
Purpose	For decision	For assurance	For awareness
		X	X
Report previously considered by	Health Equity Steering Group		
Executive summary	This paper provides an update on the agreed governance process for health inequalities work across the Trust. The paper also provides an update on the Trust's work to tackle health inequalities across five of the Trust's six priority areas of focus for this work. The six agreed priorities are: 1. Developing the CNTW Patient and Carer Race Equality Framework. 2. Implementing the Core20Plus5 for children and young people. 3. Developing CNTW's role as an anchor institution – tackling the wider economic and social determinants of wellbeing. 4. Digital inclusion and accessibility. 5. Morbidity and mortality – addressing poor physical health outcomes among our patient populations (including implementation of the Core20Plus5 for adults). 6. Equality, Diversity and Inclusion – continuing this work across the Trust. Progress updates relating to Priority 6 - increasing equality, diversity and inclusion across the Trust workforce - are not included in this paper and will be reported to Board separately via the People Committee.		
Detail of corporate/ strategic risks	N/A		
Recommendation	The Trust Board of Directors is asked to receive the report for assurance on the governance process for health inequalities work and compliance with the NHS England requirements relating to the Patient and Carer Race Equality Framework. The Board of Directors is also asked to receive this update report for awareness of the progress of other priorities areas.		
Supporting Information / appendices	Appendix 1: CNTW Patient and Carer Race Equality Framework Plan		

Health Inequalities Update
Board of Directors
Wednesday 5 November 2025

1. Governance

The Trust's Health Equity Steering Group provides strategic oversight of work to tackle health inequalities across the Trust. A detailed action plan is in place for each of the Trust's health inequalities priorities outlined above with progress against action plan objectives reported to the Health Equity Steering Group on a monthly basis. Risks and issues are reported monthly and escalated where appropriate.

The Health Equity Steering Group brings together senior colleagues from across the Trust who provide leadership to the six health equity priority workstreams. Work is underway to embed health equity programme delivery across the Trust's operational governance structure.

Trust Board will receive six-monthly updates on our work to tackle health inequalities, this will ensure senior leaders receive assurance across the entirety of our health equity programme which intersects with multiple areas of Trust business.

2. Workstream updates

2.1 Patient and Carer Race Equality Framework

NHS England requires all mental health Trusts to develop, publish and implement a plan to tackle racism and inequalities linked to ethnicity, faith and culture in our services. This plan is known as the Patient and Carer Race Equality Framework (PCREF) and must be co-produced in partnership with people from racially and culturally minoritised communities. Trusts are required to progress implementation of their PCREF Plan during the financial year 2025-26. PCREF implementation is included in the NHS Standard Contract and is regulated by the CQC. Progress to date:

- PCREF Steering Group established which oversees the implementation of our PCREF Plan. Membership includes local community representatives to support partnership working and joint decision-making.
- PCREF Action Plan in place to support implementation, with development and delivery of individual projects underway.
- Analysis of Trust ethnicity data completed to identify key areas of inequality and inform decision-making on priorities within our PCREF Plan.
- PCREF Plan (Appendix 1) agreed with community representatives and published on the Trust website, with priorities across inpatient, community, and corporate services.
- Series of engagement events held with representatives of marginalised ethnic and faith communities to discuss and agree PCREF priorities and approach.

Challenges to date include engaging patients and carers from minoritised ethnic, faith and cultural backgrounds in this work. A more detailed update focused on PCREF will be presented to the Board in due course.

2.2 Core 20 Plus 5 for Children and Young People

Core20Plus5 aims to support coordinated activity to reduce health inequalities at national and system level by defining a target population cohort and five clinical areas of focus where work to address inequalities should be accelerated. One of the five clinical areas of focus outlined in the Core20Plus5 for Children and Young People is improving access to mental health services for people aged 0-17 from different ethnicities, ages, sexes and areas of deprivation. Progress to date:

- Sub-group of specialist children's transformation group established to focus on health inequalities, with plans to expand membership to community colleagues across the Provider Collaborative. This will enable the group to better understand and address health inequalities faced by children across mental health services in our region.
- Profiling of CNTW and TEWV patients aged under 18 ordinarily resident in top 20% most deprived postcodes nationally is currently underway. This will enable us to better understand multiple disadvantage experienced by this patient group and will support the development of targeted action to improve access to care for this group in line with the Core20Plus5 framework.

2.3 Morbidity and Mortality

CNTW provides care to patient groups that are likely to experience significantly poorer physical health outcomes than the general population. For many of our patients, poor physical health outcomes are not inevitable. The Core20Plus5 for Adults defines five clinical areas of focus where work to address inequalities should be accelerated. Progress to date:

- The implementation of the Adults Core20Plus5 will be overseen by the Trust's Physical Health and Public Health Steering Group.
- Agreement to conduct a scoping exercise with a view to developing a targeted approach to the delivery of physical health checks for people living with Severe Mental Illness (SMI). The development of a tailored approach aims to ensure adult patients living in the top 20% most deprived postcodes experiencing multiple disadvantage have equitable access to physical health checks, taking steps to address the mortality gap for patients living with Severe Mental Illness.
- Profiling of CNTW adult patients ordinarily resident in top 20% most deprived postcodes nationally is currently underway. This will enable us to better understand multiple disadvantage experienced by this patient group and will support the development of targeted action to improve equitable access to physical health checks in line with the Core20Plus5 framework.

2.4 Digital Inclusion and Accessibility

In 2023, NHS England published a Digital Inclusion Framework which identifies five priority domains and actions for providers and NHS staff. In June 2025, the North East and North Cumbria Integrated Care Board approved a regional Digital Inclusion Strategy. Progress to date:

- Discussions with Integrated Care Board colleagues about the Trust's participation in a regional device repurposing programme which aims to improve digital inclusion through access to devices.

- Trust colleagues are members of the North East and North Cumbria Integrated Care Board Digital Inclusion Steering Group which has led development of a regional ICS Digital Inclusion Strategy 2024-2026.
- Delivery of projects to support knowledge and awareness among Trust staff of accessibility features available within existing Trust IT systems are ongoing, with plans to explore support for service users.

2.5 CNTW as an Anchor Institution

Anchor institutions are organisations which operate in a specific place and will not move their operations elsewhere due to the nature of their work, and whose sustainability is linked to the wellbeing of their local populations. Through strategic management of their resources and operations, anchor institutions can help tackle the wider social, economic and environmental determinants of wellbeing. Progress to date:

- Data analysis is underway which aims to (as far as possible) quantify the proportion of Trust procurement contracts awarded to local suppliers and establish the proportion of staff living local to Trust sites, with a view to developing approaches to increasing local spend.

Future plans include identifying approaches to improve inclusive recruitment, and exploring support for community groups through the sharing of Trust estates and facilities.

Progress against the key objectives and data metrics will be reflected fully in the annual report.

Jane Welch

Health Equity Lead

Appendix 1
CNTW Patient and Carer Race Equality Framework Plan

This plan is available on our Trust website here: PCREF plan - Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Our plan for improving our services for people from marginalised ethnic, faith and cultural backgrounds

In November 2023 NHS England published the Patient and Carer Race Equality Framework (PCREF). The Framework says how the NHS should improve mental health services for people from marginalised ethnic, faith and cultural backgrounds. NHS England agreed to do this after the Independent Review of the Mental Health Act in 2018. The review made suggestions for improving the Mental Health Act, the law which says when you can be taken to a mental health hospital and treated against your wishes.

We have worked with local communities to agree our priorities for improving our services for people from marginalised ethnic, faith and cultural backgrounds.

Our priorities

1. **Piloting the use of Advance Choice Documents**

- The number of Black people detained under the Mental Health Act in our Trust has increased each year since 2021/22.
- People with a Mixed ethnicity who are an inpatient in one of our hospitals are much more likely to be detained within 1-3 months of leaving hospital, compared to the average.
- People from marginalised ethnic backgrounds are given a Community Treatment Order more often than White patients in our Trust.

We want to reduce the number of patients from marginalised ethnic backgrounds who are detained under the Mental Health Act in our Trust.

We will work with patients admitted to our hospitals under the Mental Health Act to create a document with information about what works to keep them well. There is evidence that working with patients to make a record of their needs (including cultural or faith needs) and how they would like to be cared for can help people stay well and reduce the need for them to be admitted to hospital under the Mental Health Act.

Watch Dr. Lade Smith, a Consultant Psychiatrist from South London and Maudsley NHS Foundation Trust, talk about how Advance Choice Documents can benefit Black people: ACDs 1: Why ACDs may benefit black service users on Vimeo

2. **Working with partners to develop Culturally Appropriate Advocacy services for our local area**

People admitted to our hospitals are usually very unwell. It can sometimes be difficult for patients to communicate their needs to our staff. An Independent Mental Health Advocate is someone who doesn't work for the NHS. It is the advocate's job to help patients communicate their needs and be involved in decisions about their care. In some parts of the country, people from marginalised ethnic, faith and cultural backgrounds get support from an advocate who recognises and understands their cultural and faith needs. This is called Culturally Appropriate Advocacy. We plan to talk to other public services about developing Culturally Appropriate Advocacy support for our local area.

Watch this video to hear more about how Culturally Appropriate Advocacy can benefit people from marginalised ethnic backgrounds.

3. Understanding and reducing restraint of people from marginalised ethnic backgrounds

Restrictive interventions are actions that limit someone's movement or freedom, for example, moving someone into a room on their own for a short time to stop them harming other people. Compared to White patients, we care for small numbers of patients from marginalised ethnic backgrounds in our Trust. While this can make it difficult to draw conclusions from our data, we do see some differences between ethnic groups in the use of different types of restraint. For example, even though the rate has decreased quickly, we know that over several years Black patients have been more likely to be mechanically restrained.

We already have a programme of work to reduce the use of restraint in the care we provide to all our patients. We will focus on ethnicity to gain a better understanding of the complex reasons behind the use of restraint among patients from different ethnic backgrounds and reduce any unfair differences.

4. Supporting people from marginalised ethnic backgrounds to get help early

Our data suggests that people from marginalised ethnic backgrounds are struggling to get support for their mental health at an early stage:

- Compared to White patients, a bigger percentage of adults from marginalised ethnic backgrounds (except Mixed ethnicity patients) who are admitted to one of our hospitals have never accessed mental health support from our Trust before.
- The rate of referrals into our services is much lower for children and young people from Black, Asian and Other ethnic backgrounds.
- Compared to White people, a bigger percentage of people from some marginalised ethnic backgrounds are referred to our services by the police and from A&E.

We will work with community groups, our community mental health teams and partners that deliver mental health support in the community to encourage people

from marginalised ethnic, faith and cultural backgrounds to get help for their mental health at an early stage, before they reach crisis point.

5. Tackling barriers to accessing community mental health support

Our data shows that when people from marginalised ethnic backgrounds do try to access mental health support from our community teams, they may find it difficult to attend their appointment:

- The percentage of missed appointments offered to adults from a marginalised ethnic background is higher than the percentage of missed appointments offered to White patients. For example, in 2023-24 9.6% of appointments offered to White patients were missed, compared to 15.8% of appointments offered to Mixed ethnicity patients and Black patients, 12.4% of appointments offered to Asian patients, and 12.2% of appointments offered to patients with an Other ethnicity.
- Among children and young people, the percentage of missed appointments offered to Black and Asian children is higher than the percentage of missed appointments offered to White children.

We will work with our patients, carers and communities to develop a project which aims to better understand the reasons people from marginalised ethnic backgrounds feel unable to come to their appointment and remove these barriers to accessing care.

6. Working in partnership with our communities, patients and carers to improve our services for people from a marginalised background

We want to work in partnership with people from marginalised ethnic, faith and cultural backgrounds to improve our services and over the longer-term, to reduce the health inequalities they experience. We will work with our communities, patients and carers to design a system for people from marginalised backgrounds to give and receive feedback and participate in improving and developing Trust services. While the Trust already has systems in place for gathering patient feedback and supporting patients and carers to get involved in our work, we will work with communities, patients and carers from marginalised backgrounds to create or adapt approaches which are culturally sensitive, and which focus on understanding and meeting the needs of marginalised communities.

7. Develop a plan to improve the quality and completeness of our ethnicity and religion data

We record the ethnicity and religion of our patients on our patient record system, however, there are some gaps in the recording of this data. In 2024/25 85% of our patients had an ethnicity recorded on our patient record system, and 25.7% of patients had a religion recorded. There are also a number of patients whose ethnicity or religion is recorded as Not Known (the patient was not asked) or Not Stated (the

patient was asked but chose not to answer). We will develop a long-term plan to improve the quality and completeness of the information we record about the identity of our patients, focusing on ethnicity, faith and culture in the first stage of this work.

8. Upskilling our workforce

We have a dedicated programme of work which aims to promote equality, diversity and inclusion in our workforce. As part of this we will develop our long-term approach to improving the skill and confidence of our staff in challenging racist language and behaviour and delivering culturally competent care.

9. Supporting the wellbeing of our staff from marginalised ethnic, faith and cultural backgrounds

We will work with our Cultural Diversity Staff Network to better understand the experiences and needs of our staff from marginalised backgrounds and review our staff wellbeing support to make sure it is culturally appropriate.

Delivering our plan

We have a Patient and Carer Race Equality Framework (PCREF) Steering Group which will make sure we deliver against our priorities. The group is chaired by our Director of Community Services and brings together staff from across the Trust who will drive forward the delivery of this work, and members of our local communities who have been involved in shaping our priorities. We have a detailed action plan which we will use to monitor our progress against each priority area. We will continue to meet with a wider group of community leaders and with patients and carers from marginalised backgrounds to review our progress and offer them an opportunity to shape this work as it develops.

7. GOVERNANCE AND REGULATORY

Darren Best, Chair

7.1 AUDIT COMMITTEE ASSURANCE REPORT

Robin Earl, Audit Committee Chair

REFERENCES

Only PDFs are attached

7.1 Audit Board Assurance report - Nov 25.pdf

Report to the Board of Directors
Wednesday 5 November 2025

Audit Committee Quarterly Assurance Report
August 2025 – October 2025

1. Purpose

This report seeks to provide the Board with assurance of ongoing oversight of key areas of focus and risk undertaken by the Audit Committee. This includes an overview of the areas of focus, discussion and assurance and the risk management for the Trust.

2. Audit Committee overview

The Committee is a statutory committee of the Board of Directors for the Trust and is a standing committee for the NTWS Ltd Board of Directors. It provides assurance to the Board that effective internal control arrangements are in place for the Trust and its subsidiary company. The Committee also provides a form of independent scrutiny upon the executive arm of the Board. The committee independently monitors, reviews and reports to the Board on the process of governance, and where appropriate, facilitates and supports, through its independence, the attainment of effective processes.

There has been one substantive meeting of the Committee during the period August 2025 – October 2025 held on 15 October. The Committee also held two extra-ordinary meetings held on 11 September and 13 October.

3. Board Assurance Framework risks within Committee remit

The Committee has delegated responsibility for review of the adequacy and effectiveness of the overall management of principal risks through oversight of the Board Assurance Framework (BAF) and compliance with and effectiveness of the Risk Management Policy and processes. As such, the Audit Committee reviews the BAF in its entirety, following meetings of all other Board Committees.

At the meeting held 15 October, the Committee reviewed the Board Assurance Framework and updates from other Board committees following review in the context of their substantive meetings. In terms of the risk management process, all BAF risks were reviewed within timescale and there were no recommendations escalated from Board committees to amend risk scoring.

The Committee noted the following escalations from Board committees held during October:

- Following a strategy session held regarding the potential impact of changes arising from the forthcoming Mental Health Bill review, a BAF-level risk will be developed by Mental Health Legislation Committee members during October for consideration. The Audit Committee agree with the recommendation to develop a BAF level risk.
- Whilst there were no significant issues to raise in relation to the BAF risks associated with the Quality and Performance Committee, a query was raised in relation to the scoring of the risk relating to compliance with statutory and regulatory requirements. The query was made in the context of the number of actions complete to address the CQC regulatory breaches. There was no formal recommendation to amend the risk score at this time, but a review of the assurances provided will be undertaken. The Audit Committee agreed with the need to review assurances.
- At the Resource and Business Assurance Committee, it was agreed that the controls, assurances and outstanding actions relating to risk 2545 – risk of achieving financial

sustainability – be strengthened. Assurance was provided at the meeting in relation to actions being taken but it was recognised that these are not currently reflected in sufficient detail in the BAF risk. The Audit Committee agreed with this recommendation.

- At the Resource and Business Assurance Committee, it was agreed that whilst risk 2547 – relating to digital vulnerabilities and loss of, and/or public disclosure of, information and loss of access to critical systems – has sufficient assurance was provided in relation to mitigating the risk of such incidents occurring, further detail on controls and actions to mitigate and reduce the impact on quality, safety, care and treatment would be beneficial. This risk will also transfer to the new Digital Committee from December. The Audit Committee agreed with the action to review the risk controls and actions.
- Following the transfer of Digital services to NTW Solutions Limited, all digital risks sitting at directorate level (corporate risk register) and operational level have been transferred to a separate risk register (previously held on the finance and digital risk register). Work is required to review all digital risks as to whether they sit with NTW Solutions Limited or the Trust depending on the nature of the risk (i.e., quality and service impact, or contractual delivery impact).

Following the implementation of the new WebRisk training package and the decision to move the training to a mandatory requirement for Band 7 staff and above where risk management is a core part of their work, training compliance figures as of 30 September 2025 have increased to 84% from 74% which is marginally below training compliance of 85%. Since the meeting, training compliance has exceeded the 85% target.

4. Issues relating to statutory and regulatory compliance and governance oversight

CQC Well led inspection high-level feedback

The Committee noted the CQC initial high-level feedback following the well led inspection undertaken in September/October. It was recognised that the feedback was high-level at this stage, and the final full report was forthcoming. Discussions with the CQC continue to gain further clarity on some of the findings in the letter which will be shared at the open Board meeting in October. It was noted that there was reference to governance and the importance of ensuring a clear line of sight between operations and the Board. This includes being as robust as possible in terms of governance processes and this will be a continual focus for all Committees and the Board as part of planning, agenda setting and reporting.

Declaration of interest and standards for business conduct

The Committee received the annual report on declarations of interest which included compliance with the requirements for declarations in line with the policy. Of the 1,830 staff required to provide declarations, only 346 are compliant within the last 12 months. Medical staff compliance has improved following the introduction of the new process to declare interests via job planning.

The committee agreed that although significant measures are put in place via the Corporate Affairs Team and Local Counter Fraud service to raise awareness of the importance of the declaration process and requirements of the policy, further work is required in terms of leadership support and ensuring accountability. Actions to take to further increase compliance was provided in the report but the Committee agreed that an additional action for all non-compliance to be escalated to Director-level also be included.

The importance of the declaration of interest/standards of business conduct policy and processes was highlighted further in the Trusts counter fraud annual return. The annual return was fully compliant with all NHS requirements with the exception of the requirement that *"the organisation has a managing conflicts of interest policy and registers that includes reference to gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act*

2010. Staff awareness of the requirements of the policy is tested sufficiently regularly to demonstrate effectiveness of the process" which was rated as amber. This is due to non-compliance with the requirements of the declaration of interest policy as outlined above.

5. Internal audit and internal control issues and areas of focus

Internal Audit Programme Report

The 2024/25 plan is complete; for 2025/26, three audits are in planning, six in fieldwork, three reported, and sixteen yet to start. There were no plan changes requested during the period. Internal Audit advised that the limited assurance report (Oxevision) will be referenced in the head of internal audit opinion.

Overdue recommendations remain a concern and a request has been made the Executive colleagues to ensure recommendations are actioned and reviewed in a timely way.

The report noted four actions from NHS England/ICB Financial Controls Review audit monitored internally by the Trust which had been excluded from the audit figures. A request will be made to the Resource and Business Assurance Committee Chair to obtain an update on these to ensure internal oversight and assurance.

Local Counter Fraud

The Committee received the Local Counter Fraud Annual Report which included detail on the new "failure to prevent fraud" offence. Under the legislation, an organisation will be criminally liable where a fraud offence is committed by an employee, agent or other associated person, with the intention of deriving a benefit for the organisation or a related body and, the organisation did not have reasonable fraud prevention procedures in place.

The Trust must ensure preventive measures are in place, and investigations could fall outside NHS Counter Fraud's remit, instead being handled by police or other authorities. A fraud risk assessment is being developed with Trust colleagues to evaluate compliance.

Oxevision – Limited Assurance Report

An update was provided on the immediate actions required to address the recommendations outlined in the report. This included provision of patient information and engagement, signage, clear and standardised procedures and training. All actions are on track to be complete by the end of November.

External audit

The following reports were received from the External Audit Team with no issues of concern to note:

- Group Engagement letter and general terms and conditions of business
- NTW Solutions Engagement letter
- Charity engagement letter

People Committee assurance update

All Board committee Chairs attend the Audit Committee on a cyclical basis to provide an assurance update on their approach to managing risks and internal control through their respective Committees. An update was provided in relation to the People Committee.

The Committee Chair provided a detailed overview of the focus of the Committee during the period and the link to the Board Assurance Framework strategic risks, and key areas of focus for the Board. It was recognised that further work is required to gain assurance and increase the pace of the development of the Trust Workforce Plan and its alignment to the development of the medium-term resource plan and delivery of the Trust Model of Care and Support programme.

As of July, from the 2024/25 Internal Audit plan, eight final reports have been issued since the last committee in June 2025 and issues two final reports in relation to Cyber Assessment (CAF) Aligned Data Security and Protection Toolkit (DSPT) and the Company Data Security and Protection Toolkit (DSPT). All core and NTW Solutions Limited audits have been completed to final report.

Extra-ordinary meetings

11 September 2025

The following three items were discussed and reviewed at the 11 September extra-ordinary meeting and were subsequently presented to the September closed Board for approval. There were no issues of concern to note:

- Risk Management Policy review
- Fit and Proper Persons Test update
- Draft Charity Annual Accounts 2024/25

13 October 2025

The Committee reviewed the draft NHS England Provider Capability Board Self-Assessment prior to consideration at the October Board development session. The Committee reviewed the self-assessment in its entirety following review in draft form at all other Board committee meetings held in October.

All Provider Trusts have been asked to complete the self-assessment against the six domains outlined in the NHS England Insightful Board guidance:

- Strategy, leadership and planning
- Quality of care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

The self-assessment was reviewed in the context of identifying any gaps associated with the business of the Quality and Performance Committee in relation to the stated domains. Due to tight timeframes issued by NHS England for completion of the assessment, gaps remained in relation to a number of domains at the time of reporting. For the purpose of this Committee, these related primarily to Domain 2 – quality of care and Domain 4 – access and delivery of services. These gaps were recognised by the Committee and were populated prior to submission to the Board development sessions held on 15 October.

Summary and recommendation

The Board is asked to note the content of the report and seek further assurance on any issues where appropriate.

Robin Earl
Chair of Audit Committee
November 2025

7.2 2024 / 25 ANNUAL ? SAFETY, SECURITY AND RESILIENCE REPORT (INCLUDING EPRR CORE STANDARDS ASSESSMENT)

Ramona Duguid, Chief Operating Officer

REFERENCES

Only PDFs are attached

7.2 Safety Security and Resilience Annual Report - 24-25 Board.pdf

Meeting	**Board of Directors - Public**		**Agenda item: 7.2**
Date of meeting	Wednesday 5 November 2025		
Report title	2024 / 25 Annual – Safety, Security and Resilience Report (Including EPRR Core Standards Assessment)		
Report Lead	Ramona Duguid, Chief Operating Officer		
Prepared by	Craig Newby – Head of EPRR and Health and Safety Alan Lynam – Safety, Security and Resilience Manager		
Purpose	**For decision**	**For assurance**	**For awareness**
			x
Report previously considered by	N/A		
Executive summary	This report provides assurance on the systems and practices overseen by the Trust's Safety, Security and Resilience Team, demonstrating compliance with key legislative and NHS contractual requirements, including the Civil Contingencies Act 2004, NHS England EPRR Core Standards, and the Health and Safety at Work Act 1974. It highlights the Trust's commitment to maintaining a safe and secure environment for patients, staff, and visitors. Key achievements include meeting EPRR standards, managing over 300 drug dog searches, 122 RIDDOR-reportable incidents, 2000+ body-worn camera-linked incidents, and 400+ CCTV requests. The team also supported over 100 health and safety inspections, managed 3500 lone worker devices, and updated 161 policies and PGNs. Despite structural changes and ongoing challenges, the team continues to drive improvements. The report also addresses the high volume of violence and aggression incidents and outlines progress made in response to an active HSE Improvement Notice. Overall, it evidences the Trust's proactive approach to safety, security, and resilience.		
Detail of corporate/ strategic risks	**Strategic Ambition 1** Quality care, every day - We want to deliver expert, compassionate, person-led care in every team, every day. **Strategic Ambition 4** Sustainable for the long term, innovating every day - We will be a sustainable, high performing organisation, use our resources well and be digitally enabled.		
Recommendation	To note		
Supporting information / appendices	Appendix 1 Emergency Preparedness, Resilience and Response (EPRR) assurance 2024-2025 STATEMENT OF COMPLIANCE		

Board of Directors Public Meeting
Wednesday 5 November 2025

2024 / 25 Annual – Safety, Security and Resilience Report (Including EPRR Core Standards Assessment)

1. Executive Summary

The purpose of this report is to provide assurance around the systems of work in place overseen by the Trust's Safety, Security and Resilience Team, this report also provides assurance around the organisations compliance with several legislative and NHS contractual expectations e.g. Civil Contingency Act 2004, NHS England Emergency Preparedness, Resilience and Response Core Standards, Health and Safety at Work Act 1974 and associated legislative framework.

Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust is committed to the delivery of an environment for those who use or work in the Trust that is safe and secure to ensure the highest possible standards of care can be delivered to patients. Safety, Security and aspects of Emergency Preparedness, Resilience and Response (EPRR) affect everyone who works for or uses the NHS. The safety and security of staff, patients, carers and assets continue to be a priority of the organisation.

The Safety, Security and Resilience team are integral in the delivery of the above, covering a wide variety of responsibilities and working closely with internal and external colleagues to achieve a number of goals this year:

1. Continuing to meet the requirements of the NHS England EPRR Core Standards including participation in a number of internal and external exercises.
2. Maintaining a responsive and effective drug dog search team completing over 300 searches this year.
3. Complying with RIDDOR legislation in the timely investigation and reporting of 122 incidents meeting the criteria for reporting to HSE.
4. Providing overall management of the Body Worn Camera (BWC) system linking over 2000 incidents containing BWC footage.
5. Downloading and managing over 400 requests for CCTV.
6. Undertaking over 500 Display Screen Assessments.
7. Ensuring over 70 Clinical Environmental Risk Assessments and associated action plans are completed and managed respectively.
8. Maintaining strong links with Staffside colleagues and supporting over 100 health and safety inspections annually.
9. Managing the effective use, maintenance and training requirements of around 3500 lone worker devices.
10. Reviewed, updated and shared 161 Policies and PGNs

Changes in structure and personnel, over the previous twelve months, have brought many challenges, but importantly also provide a platform to review current practice and where necessary drive forward efficiency and improvements.

The report highlights the high level of violence and aggression incidents during the previous year and the impact a small number of patients have on the number of incidents.

The Trust still has an active Improvement Notice, issued by Health and Safety Executive around the management of violence and aggression. A significant amount of work has been undertaken since the initial notice was issued; however, work is required to provide further clarity prior to the notice being closed down.

This report seeks to provide assurance and evidence of the Trust's commitment to safety, security and resilience.

2. Background

The portfolio of the Safety, Security and Resilience team covers the following corporate responsibilities.

Health and Safety

- Workplace Safety
- Clinical Environmental Risk Assessment
- Work with clinical teams to find safety solutions to reduce harm
- Safe Work Equipment
- Control of Substances Hazardous to Health (COSHH)
- Display Screen Equipment Guidance
- Health and Safety Inspections in partnership with staff-side
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
- Maintaining and updating policies to ensure they comply with national guidance and legislation
- Development, Management and performance of the Trust's Incident Reporting System (Safeguard)

Security Management

- Overseeing the Security Strategy of the Trust
- Monitoring Security Contracts
- Monitoring the Secure Transport Contracts
- Setting standards of CCTV and ensuring compliance / supporting clinical services with CCTV Evidence
- Management of the Lone Working System within the Trust
- Management of Body Worn Cameras within in-patient services.

Emergency Preparedness, Resilience and Response

- Planning, reviewing and implementing Emergency Planning arrangements
- Reviewing and updating guidance in respect of the Adverse Weather Plan (both Heat and Cold)
- Working in partnership with our ICS Resilience Team / Local Health Resilience Partnership
- Working in partnership with NHS England regional and national EPRR Teams
-

3. Health, Safety and Security

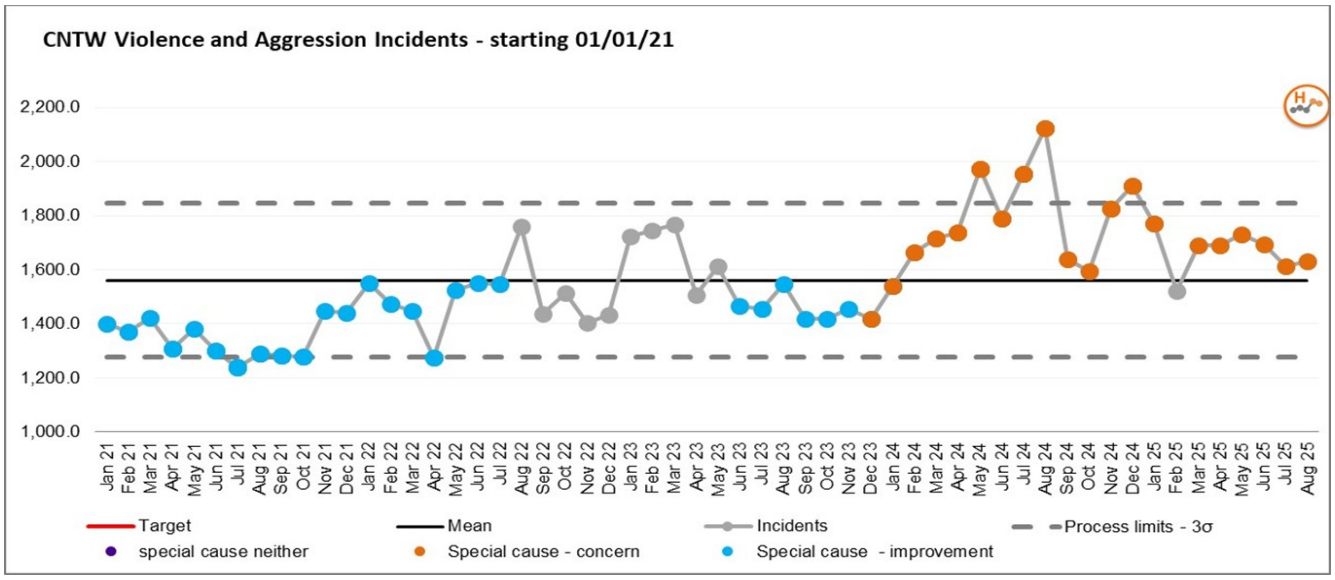
3.1 Violence and Aggression / Health & Safety Executive Improvement Notice

The Trust received notification of a planned inspection on 25th October 2023. The purpose of this inspection was to focus on three key areas, these being Aggression and Violence, Manual handling and Musculo skeletal issues and stress.

The inspection was a direct result of concerns raised within Autism services in the North Locality, where concerns were raised regarding the levels of aggression and violence and staff safety. The inspection took place on the 20th February 2024 where the Trust received the improvement notice in relation to the exposure to staff of violence and aggression.

Following a comprehensive review and response to the HSE, further meetings have taken place to provide assurance that all areas of concern have been addressed. Despite a significant amount of work and progress, to address key issues, the HSE have required further evidence around the harm grading and involvement of the Health and Safety team in the investigation of violence and aggression incidents. Recent changes to the proforma's, used for RIDDOR reporting, have including additional information around remedial actions to prevent re-occurrence and support to staff. Further work is underway to provide the HSE with evidence around the use of NHS England Learning from Patient Safety Events (LFPSE) guidance for grading all incidents and the use of ward-based risk assessments / patient care plans to identify potential risks of violence and aggression.

Violence and aggression incidents remain high across the organisation. The Statistical Process Chart (SPC) shown below shows a steady increase in overall violence and aggression incidents since November 2023 (this includes both physical and non-physical incidents).



Since November 2023, 36,247 incidents of violence and aggression were reported with almost 25% of these incidents being liked to 10 patients.

Physical assaults on staff follow a similar pattern; although over the past seven months the number of incidents have levelled out and follow a trend closer to the monthly average of approximately 450 incidents.

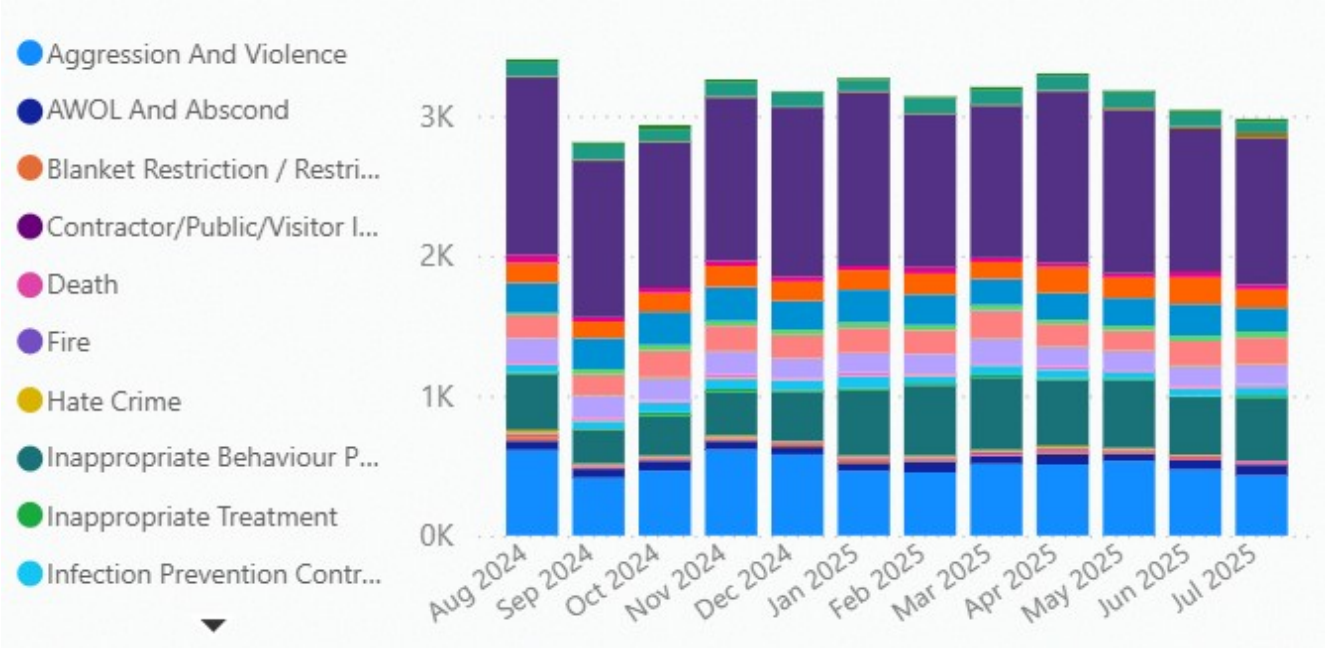
There are plans to merge the Reducing Restrictive Intervention Group and the Violence Reduction Group in late 2025, which will help to align initiatives and provide a better understanding of driving factors.

3.2 Incident Reporting

The Trust's incident reporting system is the foundation of activity that drives improvement and learning across the organisation, and the team have overseen the Trust's Local Risk Management Software – Ulysses (Safeguard system) over the past 12 months. The system is used to record, report and manage a range of incidents covering

- Serious incidents / patient safety incidents in line with the requirements of the Learn from Patient Safety Events (LFPSE) and the Patient Safety Incident Response Framework
- Staff incidents including those falling under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) activity
- An extensive range of other types of incidents e.g. infrastructure, staffing, security, etc

During the period 1st August 2024 – 31st July 2025 37,686 patient safety incidents were reported. The table below shows the breadth of incident type reported with a majority of incidents being self-harm related.



Further information around patient safety incidents is provided on a frequent basis to several different groups.

- Each Care Group have a weekly Safety meeting which reviews ELRs / AARs and RIDDORs.
- PSLIP discuss thematic reports and PSIIs.
- The Learning Improvement Webinar also shares learning in relation to incidents and quality priorities.

The Safety, Security and Resilience Team have recently transferred responsibility for the day-to-day management of the Safeguard incident system to the Patient Safety team. This transition has provided the opportunity for both teams to work collaboratively and ensure an open culture of incident reporting remains the foundation of a healthy safety culture. Further work is planned in 25-26 to ensure incident based dashboards are fit for purpose and continue to provide a range of services up to date comprehensive analysis of incident activity across the organisation.

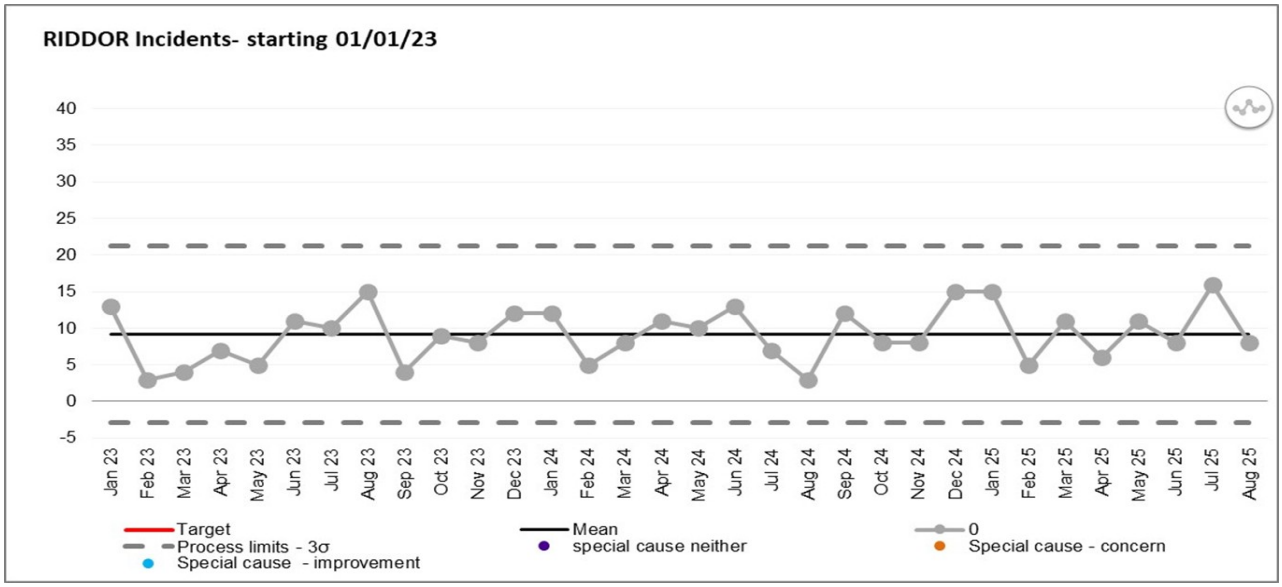
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

There were 122 RIDDOR incidents reported during period 1st September 2024 - 31st August 2025. This showed a 20% increase in the total number of RIDDOR incidents compared to same period in 2023 – 2024. Violence related RIDDOR incidents increased by 34% over the same period. A majority of the incidents reported were categorised as resulting in an over 7-day absence from work as a result of an injury. Ninety-nine (99) of these absences have

resulted from exposure to violence and aggression and twenty-three involved accidents at work. All RIDDOR incidents are investigated by the reporting ward / department and the Health and Safety team as part of their continuous monitoring and support arrangements.

	Aggression & Violence	Accident (involving staff, visitors etc.)	Total
Sept 2024	10	2	12
Oct 2024	7	1	8
Nov 2024	6	2	8
Dec 2024	12	3	15
Jan 2025	13	2	15
Feb 2025	4	1	5
Mar 2025	9	2	11
Apr 2025	4	2	6
May 2025	10	1	11
Jun 2025	8	0	8
Jul 2025	10	6	16
Aug 2025	6	1	7
Total	99	23	122

The SPC chart below provides an overview of RIDDOR incident numbers since January 2023.



3.3 Lone Working

Health care workers have long been identified as a high-risk group when considering lone working. Issues identified in high profile incidents emphasise the scale of the risk faced by mental health care staff on a daily basis.

Lone workers face environmental risks and are increasingly exposed to incidents with regards to assaults, aggression, abuse and harassment, which can result in lone workers feeling isolated or unsupported.

Activity for the team

The Lone working team currently manage 3494 lone worker devices across the organisation, including a small stock of 48 devices to issue to staff members who require these at short notice.

Activity in the last 12 months has included the processing of 997 applications for devices, 699 returns of devices, and 456 changes forms have been completed. The Team has also reviewed 53 emergency contact forms with the Team managers to ensure emergency contacts are up to date.

Carried out extensive testing of lone working devices in Mitford ground and first floor plant rooms to confirm signal strength in various areas providing assurance for estates staff. The test sites and results were further used for marking up on estates drawings.

Roll out of Pulse devices in six areas, providing support to staff working in isolated clinical areas.

All training is now on-line enabling the lone working team to dispatch a device at short notice when a staff member is identified as being at risk of a specific threat.

Lone Working Device Audit

The lone working device system audit in June and July 2025 achieved reasonable assurance.

Significant work has been undertaken in line with the audit including a review of the generic lone working SM-PGN-02 to clarify areas around dynamic risk assessments in favour of formal documented risk assessments for individual staff the aim was to simplify the wording for easier understanding. The next stage of this work is to combine this PGN and SM-PGN-09 The Reliance Protect Lone Working Device System into a Lone Working Policy to strengthen the process. This will be completed in early November 2025 and follow the required policy consultation process.

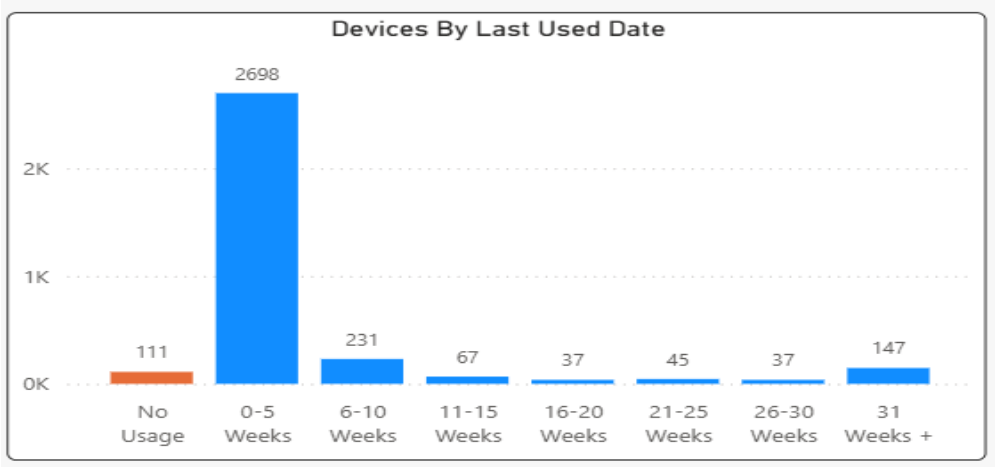
Further work will be undertaken by the lone working team to provide additional dashboard training to managers, this will ensure managers are fully aware of how to use the Lone Working Dashboard on Teams, to support their ability in monitoring of staff usage rates. This will be co-ordinated by Community Care Group Operational Managers and dates have been set for October 2025.

In order to strengthen the review process of the escalation contacts, the team have created a new process to review these on a 2 x yearly process and will further strengthen this by providing the care groups with quarterly reports to ensure this is being completed and followed up in areas where contact have not been reviewed.

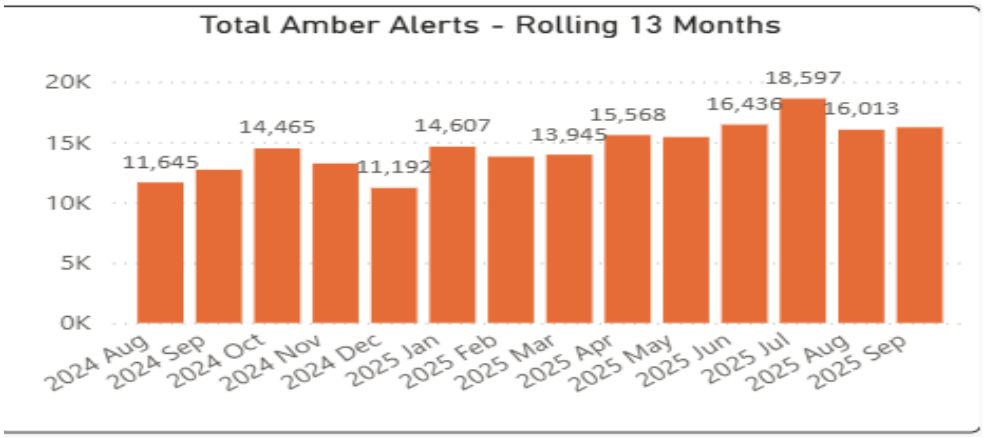
Lone worker device usage

The lone working team and the operational support officers for the Care Groups continue to review and monitor lone working device usage, the chart below highlights most devices are used regularly (in line with PGN guidance) and identifies where additional support may be required by Care Group representatives. Work began in early 2024 to formalise an HR procedure around misuse or non-use of a lone working device by staff. We can report that by

July 2025, there have been a number of fact finds conducted by HR due to non-compliance with policy.



The lone working device usage continues to improve, and the dashboard chart below shows an improved picture around compliance of staff leaving Amber alert messages prior to appointments being attended.



The lone working team continue to monitor and process Red Alerts activated in emergencies. During the last 12 months we have received 7 genuine red alerts where staff have utilised the red alert button during an incident, these have been handled swiftly by the Alarm Receiving Centre (ARC), and all appropriate support has been provided to staff involved.

System Outages

Only one outage of the lone working device system reported on 21st October 2024 affecting a limited number of devices with potential connectivity problems.

A CAS alert was issued highlighting users to potential connectivity issues

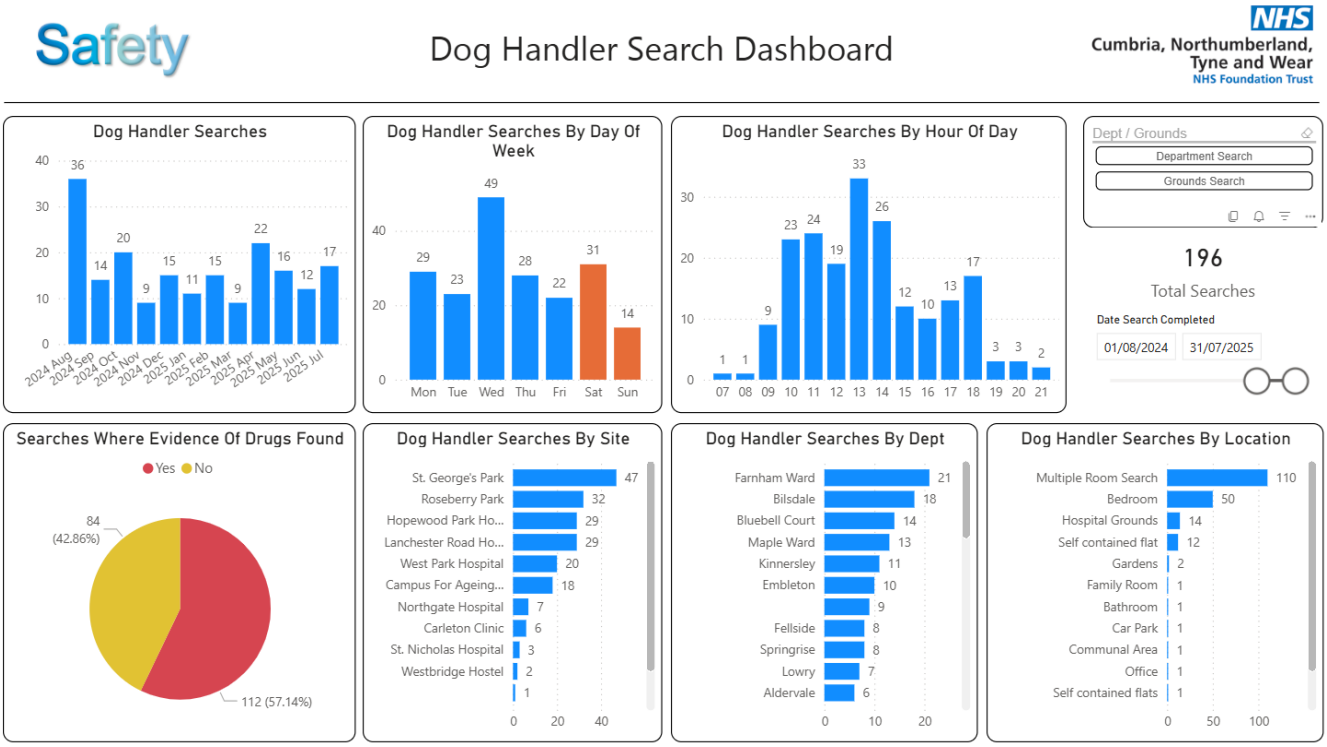
Reliance quickly identified users with the affected devices and immediately sent an update to each device. The incident was managed safely and effectively with no issues noted.

3.4 Tackling Illicit Drug Use / Narcotics Search Dogs

The use of illicit drugs continues to be a problem in some inpatient settings. A number of serious incidents have occurred relating directly to consumption of illicit substances both on the ward and following an episode of leave. The Trust isn't an outlier in this and continues to support a Service Level Agreement to provide a service in partnership with Tees, Esk and Wear Valley NHS Foundation Trust. We have 2 Search Dog Handlers and Search dogs

working across the whole North-East and North Cumbria ICS and working closely with respective Police Forces that cover the geographical locations, to identify trends and report activity, sharing intelligence of vehicles that come onto Hospital sites and known sellers of illicit substances. The data shows that our Dog Handlers have conducted 196 searches across the services in the last 12 months with a 57% retrieval rate of illicit substances or paraphernalia. There have been 1639 searches conducted by our dog handlers since November 2020.

Further work is required to review the SLA with TEWV to ensure a more realistic target ensuring the welfare of both search dog handlers and their dogs.



3.5 Clinical Environmental Safety Group

The Clinical Environmental Safety Group is informed from the work carried out by the Safety, Security and Resilience Team undertaking Clinical Environmental Risk Assessments (CERA) across in-patient services and 136 facilities. It is also informed through its terms of reference by incident, complaints and claims activity, Regulation 28 prevention of future death reports and risks that present across the organisation and any national alerting / learning available.

The group is currently overseeing a number of workplans in relation to improvements in the in-patient environment including but not limited to the following:-

- Implementation of ligature reduction en-suite doors
- Environmental improvements to Seclusion facilities, Resin on walls and floors
- Implementation of digitally enabled metal detectors
- Implementation of Oxe-health and relationship to other safety systems
- Standardisation of Staff attack and nurse call systems, from Blick to SAS
- Implementation of CCTV on all in-patient wards
- Review of door access systems for patients
- Review of ligature reduction bedroom doors and alarm mechanisms

It is acknowledged that a number of these schemes and assessments will take a number of years and is strategically built into the capital planning considerations of the organisation.

Work has progressed this year to develop a community based CERA, to compliment the assessments carried out in inpatient areas. The template draws on the same template but adding in information which grades rooms via a tiered approach, similar to those identified in the CQC ligature risk assessment template. A programme of assessments is currently being planned.

The CERA process for inpatient areas is currently on schedule. More recently the three wards at Bamburgh Clinic have been assessed following their move from CAV. The CERA process has also been reviewed, following a number of concerns highlighted by CQC. As a result, six inpatient areas have piloted the CQC ligature risk assessment template and a plan is in place to adopt this approach as well as using heat map plans to help staff identify higher risk areas using the tiered room approach.

The SPACE (Simulation , Performance , Assessment of Clinical Environments) continues to support the Trust in providing the ability to review all the latest technology available to reduce harm to patients and see how the systems holistically integrate and work together to support engagement and observation, whist supporting and promoting recovery for patients.

This environment continues to develop and is being installed with the latest technology to help the Trust learn from incidents and understand when they are reported, how they happened and whether they can be prevented in future.

Visits were arranged in May 2025 for service users and carer representatives to visit the SPACE this resulted in positive feedback received and the groups visiting were impressed with the pro-active approach being taken.

3.6 Body Worn Video and CCTV

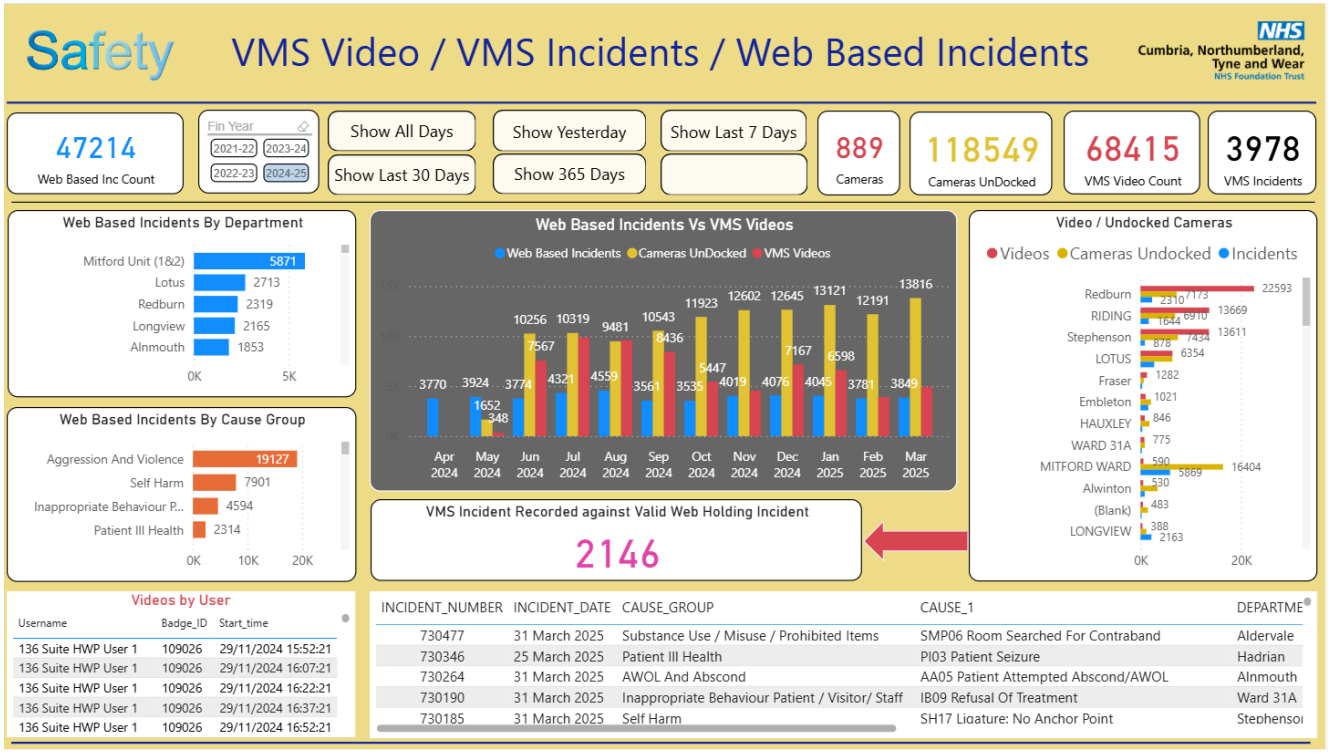
The Safety Team supports the safe operation, management and use of body worn video within the Trust and continues to see improvements in use of this system.

April 23 – March 24: 3 incidents containing footage
April 24 – March 25: 2123 incidents containing footage
April 25 - present = 1564 incidents containing footage
This year we are already ahead of what we were last year when it comes to the number of incidents containing body camera footage.

The number of lost cameras has declined significantly since the introduction of the VT100s.
April 24 – March 25:
An average of 26 x VT50s missing per month (smallest camera)
An average of 1 x VB100 missing per month
Only 2 x VB400s missing throughout the whole period

Since taking over the management of CCTV footage, requests have gradually increased from 459 in (23/24) to 466 Requests (24/25) this is anticipated to rise again substantially following the introduction/increase of cameras to CCTV systems across the trust with Bamburgh and St Georges Park being key areas of focus. Support from our estates partners is essential to maintain with ongoing aim for all cameras trust wide to be managed by the Safety Teams main in the office at SNH. LIO/OxeHealth footage requests have also been introduced and

used as evidence over the past 2 years this also may be an area where the need of the expertise in the Team increase



The Trust's new Practice Guidance Note has drawn on wider experiences of Police in both local and national guidance and is in principle aligned to the Mental Health Units (Use of Force) Act 2018. As it is implemented it will be an expected standard of use for staff to wear and use cameras in defined incidents such as Police intervention etc. The guidance also includes the requirements for staff to respond to disclosure requests by patients or their representatives for any recordings made, subject to any redaction requirements.
Further discussion is required at the Trust Ethics Committee to consider whether BWC's should be used during incidents of immediate life support.

3.7 Display Screen Assessments

Many CNTW and NTWS staff are classed as DSE habitual users and are required by law to have an assessment of their workstation.
The Safety Team continue to provide expert advice and guidance as well as producing detailed reports, allocating eyecare vouchers to staff who require them.
Workstation assessments average around 500 per year along with 450 eyecare vouchers.

3.8 Staffside H&S Inspections

Health and Safety auditing is as an ongoing process involving an examination of the Trust's activities against a set of specific and attainable standards. It is a tool used to identify the strengths and weaknesses within a working environment and covers elements such as policy, staff attitudes, training, personal protection, and emergency procedures.

Staff side safety representatives have the right under Regulation 5 (1) of the Safety Representatives and Safety Committee Regulations 1977, to carry out inspections and in partnership with the Safety Team continue to carry out these to ensure staff, patients and visitors are working in a safe environment.

During the last twelve months 112 inspections have taken place. A recent Internal Audit report highlighted 'Reasonable' assurance primarily with concerns related to the follow up of actions following an inspection. Work is ongoing to identify a robust mechanism for recording and following actions.

4. Emergency Planning, Resilience and Response (EPRR)

EPRR is supported across the Trust by the Safety, Security and Resilience Team, it is not a dedicated function of the team, and work is prioritised in line with all other operational pressures and activities the team deals with on a daily basis, both locally and nationally.

It is important to recognise from a resource perspective that this additional function was as a direct result of previous efficiencies and is kept under constant review.

There are 3 members of staff who support the EPRR agenda within the team, The Head of EPRR and Health and Safety, the Safety Security and Resilience Manager and the EPRR Support Officer.

4.1 EPPR Core standards

The EPRR Team have worked through the proposed standards for 25-26, identifying compliance levels and adding in relevant evidence where required. The current position as of 29th September 2025 shows 'partial compliance' with a slightly improved position from the previous year (see table below).

Year	Total Standards Applicable	Fully Compliant	Partially Compliant	Non-Compliant
24-25	58	45	13	0
25-26	58	46	12	0

This position is likely to change positively prior to submission in late October 2025 following further evidence gathering.

Any gaps in evidence or assurance will be built into the EPRR workplan, which is currently being formulated. This will support the EPRR team in building on the current position as we strive to fully comply with all core standards. The EPRR Workplan is a required document identifying key EPRR workstreams and progress on achievements.

Appendix 1 shows last years agreed compliance rates externally scrutinised by ICB EPRR.

4.2 Review of EPRR Policy and PGN's

The suite of EPRR policy documents have been reviewed recently, including the following:

- **EPRR Policy** has been rewritten, effectively streamlining the document, moving to a more realistic three stage model (bronze, silver and gold) of incident management and building on the internal stakeholder list.
- **EPRR PGN-01 Incident Response Plan** – Minor changes to align the document with PGN-02 Business Continuity Plan.
- **EPRR PGN-02 Business Continuity Plan** is a new document aligning the Trust with the NHS England Business Continuity Management Toolkit and ISO 22301 principles. This also highlights the requirement to undertake Business Impact Assessments, which have recently been undertaken by nominated leads working in critical services

across the Trust. BIA's help the Trust to identify weak points in the business continuity plans; particularly for critical activities with a low tolerance for disruption.

- **EPRR PGN-03 OPEL Framework** is another new document building on the original OPEL framework and associated action cards.
- **EPRR PGN-04 – Adverse Weather Plans** – Originally two separate documents, this PGN will encompass both the Adverse Weather and Health Winter Plan and Heat Health Plan. This will be subject to six monthly reviews in line with national expectations.

4.3 Business Continuity Plans

The EPRR team has worked with the operational services around review of the Business Continuity Plans and the current position has increased to 81.5% compliance. As part of this review we have requested that teams conduct an annual tabletop exercise on an annual basis to further strengthen the effectiveness of the continuity arrangements, so far we have received evidence of 10.19% compliance with this request (16 out of 157 active BCPs) with this expected to increase during the 12 month period teams have been given to comply with this request).

4.4 Industrial Action

The Team supported in the planning and preparation of the latest period of IA which took place between 7am on 25th July to 7am on the 30th July. Due to the Plans put in place during the previous periods of industrial action, the Trust were suitably prepared and this period resulted in no impact to our Services and patient safety was not compromised.

There is also the ongoing GP's Collective Action for which there are regular meetings and an Issue Log maintained.

4.5 Portfolios

The EPRR team has developed Strategic and Tactical Commander Portfolios for our on-call staff, and for the EPRR Specialist (Head of EPRR and Health & Safety). This is in line with the Core standards and the requirement for such as directed by NHS England. Awareness sessions have been held with all appropriate staff who are expected to maintain and complete training within this ask. A Teams channel has been set up to allow for any pertinent information to be stored and accessible as needed. This includes not only the Portfolio templates but any other information that may be necessary for staff to complete their on-call activities along with a Training Compendium which has been developed allowing for the registration and completion of supporting NHSE training.

As internal training is developed, staff will be alerted of its availability allowing for them to undertake as required. All of this activity will be supported by the EPRR team with regular spot-checks undertaken to ensure that any issues are addressed and resolved and that elements of the training and completion are successfully on-going.

4.6 Testing and Exercising

The following exercises took place during the previous twelve months:

- **External**
  Ex. Gunpowder – November 2024
  Ex. Arcadia 2 - December 2024
  Ex. Cerberus – January 2025
  Ex. Carmen – September 2025

- **Internal**
  Ex. Sycamore – June 2025

Exercise Sycamore

The EPRR team planned and coordinated a multi-agency tabletop exercise at Sycamore unit in June 2025, this was a 5-hour exercise that was focused on a major incident resulting in the evacuation of a secure ward. The exercise consisted of 30 participants ranging from local health resilience partners – representatives from TEWV, NEAS, NTW Solutions Estates and Facilities, CNTW Communications team, Northumbria Fire Service, Northumbria Police, Northumberland County Council, Secure Transport provider and the Ministry of Justice.

Exercise Sycamore was developed to test the Trust's internal processes for responding to an escalating and multi-faceted major incident.

Aims:

- To test the Trust's emergency responses relating to multiple casualty and evacuation on a low/medium secure ward.
- To develop staff competencies and practice in carrying out roles in response to a Major Incident.
- To review multi-agency working and communication arrangements.

Objectives:

- Notification & Detection – Evaluate the ability of the Trust to appropriately detect escalate a fire requiring evacuation of a secure area including the management of a patient in seclusion and several individuals who might pose a threat to the public (and the associated notification to relevant stakeholders).
- Identification of the resultant demand on staff by the need for them to accompany patients requiring treatment in an Acute setting, or themselves requiring conveyance to an Acute hospital for treatment.
- Triage and Treatment – Use of triage protocols and management of patients.
- Command & Control – Information sharing and decision making using JESIP principles.
- Recovery & Debrief – Rapid and adequate deployment of resources for the response, including staff and facilities.

Outputs: The main outputs from the exercise were as follows:

- Identify areas for improvement in collaborative working arrangements
- Identify gaps within the Business Continuity Plans, Policies and PGNS, and associated action cards
- Identify gaps in key staff knowledge and understanding
- Identify any training needs.

- The feedback from the exercise was positive and there was some good practice identified following this such as positive engagement between clinical teams, internal support i.e. Estates, Loggists and multi-agency partners to enable all Players to see the Incident and its progression through the various stages rather than just view their parts in a narrower impact

Other exercises are currently in the planning phases. These include Ex. Bamburgh which will be a counter terrorism exercise and will take place in November 2025 and will involve external partners as will Ex. Ferndene which will be taking place in December 2025.

A Cyber Security Simulation Exercise is also in the planning stages. This will be a national exercise within which the Trust will be expected to take a key part.

A further internal exercises is being planned to test Lockdown training.

4.7 Other EPRR Activity

The team is involved in ensuring that critical business functions can be maintained during other impacts to the Trust.

Recent examples of this have included civil unrest including Far-Right marches taking place in Newcastle, evacuation of local communities due to the threat of discovered unexploded devices, and evacuation of CNTW teams due to fire as was necessitated recently due to an arson attack and destruction of Vermont House. If it is possible to plan for these incidents as forward warning has been received, CNTW ensures that relevant staff are aware and are given support to plan for any disruption. IMGs are set up for any incidents for which it is considered the impact may be considerable, communications are cascaded throughout the Trust and liaison is maintained with the wider ICB and other partners.

5. Recommendations

The Trust's Safety, Security and Resilience Team have worked tirelessly this year to help provide robust governance structures across the organisation.

This annual report is presented to provide assurance across a broad spectrum of safety / resilience work, which includes compliance with external requirements such as RIDDOR and EPRR Core Standards.

Ramona Duguid
Chief Operating Officer

Russell Patton
Deputy Chief Operating Officer

Craig Newby
Head of EPRR and Health and Safety

Alan Lynam
Safety, Security and Resilience Manager

Emergency Preparedness, Resilience and Response (EPRR) assurance 2024-2025
STATEMENT OF COMPLIANCE

Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Partial (from the four options in the table below) against the core standards.

Organisational ratin	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Ramona Duiguid

Signed by the organisation's Accountable Emergency Officer

30/10/2024	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report	Date signed

7.3 BOARD ASSURANCE FRAMEWORK / RISK MANAGEMENT REPORT

Debbie Henderson, Director of Communications and Corporate Affairs

REFERENCES

Only PDFs are attached

7.3 Board Assurance Framework risk management report.pdf

Meeting	**Board of Directors Public meeting**		**Agenda item: 7.3**
Date of meeting	Wednesday 5 November 2025		
Report title	Board Assurance Framework (BAF)/risk management report		
Report Lead	Sarah Glacken, Executive Director of Nursing and Therapies		
Written by	Debbie Henderson, Director of Communications and Corporate Affairs		
Purpose	**For decision**	**For assurance**	**For information/ awareness**
		x	
Report previously considered by	• Quality and Performance Committee • Resource and Business Assurance Committee • Audit Committee		
Executive summary	The Board Assurance Framework has been subject to review by all Board Committees during October 2025. The People Committee did not meet during the period. All Committees were satisfied that the BAF continued to reflect appropriately the risks to the achievement of the Trust Strategic Ambitions. All Committees were satisfied that the risks were being managed appropriately and received assurance that risks were subject to ongoing active review. The Audit Committee reviewed the BAF in its entirety at its meeting held 15 October to gain assurance on the robustness of the risk management process. The Committee was satisfied that appropriate controls were in place reflecting the Trusts approach to risk management and that internal audit planning continued to reflect the key risks and challenges facing the organisation. Key items noted at the Audit Committee following review by Board committees were as follows: - A BAF risk relating to the potential impact of the forthcoming changes to the Mental Health Legislation Bill to be developed and circulated to members of the Mental Health Legislation Committee before end of October. - Resource and Business Assurance Committee recommended that a review of the controls, assurances and outstanding actions relating to risk 2545 – risk of achieving financial sustainability – be strengthened. Assurance was provided at the meeting in relation to actions being taken but it was recognised that these are not currently reflected in sufficient detail in the BAF risk. - Resource and Business Assurance Committee noted that although risks relating to digital vulnerabilities and loss of, and/or public disclosure of, information and loss of access to critical systems		

	were robust, further detail on controls and actions to mitigate and reduce the impact on quality, safety, care and treatment would be beneficial. - A key theme from committees held during the period related to the need for 'grip and pace' and in the context of risk management, and the ability to identify any potential further issues which could lead to breaches or regulatory action in future.
Recommendation	The Trust Board are asked to note the Board Assurance Framework/risk management update and note the issues raised in the context of the planned Board development session on risk management and risk appetite in November.
Supporting information	Full Board Assurance Framework is available to Board members on request.

Board Assurance Framework (BAF)/Corporate Risk Register Report
Wednesday 5 November 2025

1. Key definitions

Board Assurance Framework – contains a record of the risks to achieving our Strategic Ambitions. This is held by the Board of Directors and its committees. Risk Owners are the Executive Directors.

Corporate Risk Register – contains a record of the most significant (those risks scoring 16+) operational risks across the Trust. This is held by the Executive Management Group. Risk owners are the Executive Directors.

Trust wide risk register – contains a record of operational risks currently being managed across the Trust. This includes risks scoring below 16 held at ward/service level, Clinical Business Unit/Speciality level, directorate/group level. This is held at BDG-Risk.

2. Executive Summary

Understanding, monitoring, and mitigating risks are fundamental tasks in a successful Organisation. They are also seen as a basic aspect of good governance. In the Trust it is the role of the Board of Directors, delegated to the statutory Audit Committee to oversee the risk management system and obtain assurances that there is an effective system of internal control across the Trust. In addition to the responsibilities of the Audit Committee, each Board committee has responsibility for reviewing and monitoring progress against the BAF risks pertinent to their remit.

The purpose of this report is to provide an update on the position of the Board Assurance Framework and the Corporate Risk Register. A copy of the full CRR can be accessed on request.

3. Key issues, significant risks and mitigations

As a part of the refinement of the Trust's Risk Registers, systems and processes the Risk Management Lead has reviewed with each of the lead Executive Directors/Director, the Board Assurance Framework (BAF) Risk Register, and risks have been reviewed by the respective Board Committees.

The report provides an update on the development of the BAF strategic risks, detail of corporate risks which align to these where appropriate, and detail of corporate risks not currently aligned to BAF risks, but which remain a significant area of concern from an operational perspective. The report also provides any updates on developments associated with the organisations risk management processes during the period.

A brief, at a glance summary of the Board Assurance Framework and movement since the previous report is below.

Board Assurance Framework – summary (August 2025 – October 2025)			
Risk description	**Risk reviewed within timescale**	**Has the risk score changed**	**Changes to assurance, controls and actions**
Due to increased demand the Trust is unable to meet regulatory standards relating to access, responsiveness, and performance resulting in a risk to quality and safety of services	Yes	No Remains as 4 X 4 = 16	- New controls/assurances added: • Internal Audit Report – Mental Health Act – Compliance Audit -Receipt and Scrutiny of MHA Section Papers. - Two actions have been completed and closed: • Sexual Safety - clinical audit – all actions complete. • Mental Health Act - Section 136 Place of Safety - Limited level of assurance – process for Northumbria and Cumbria Police areas agreed. Guidance issued and implemented for Crisis Northumbria and Cumbria.
Risk of not meeting regulatory and statutory requirements of Care Quality Commission (CQC) registration and quality standards.	Yes	No Remains as 4 X 5 = 20 Score increased to 20 in July 2025	Context of the risk has been amended to reflect recent CQC activity. - Four new controls have been added: • Clinical audit – Compliance with Fasting Times for ECT – minor areas of concern • MM-23-038.01 The Safe Prescribing of RT - minor areas of concern • Clinical audit – Cardiac Monitoring in Newcastle Old Age Teams – good level of assurance given. • Clinical audit – Smokefree and E-cigarette Trust Wide Audit - minor areas of concern. - One action has been closed: • NA – Use of Melatonin – all actions have been completed. - 2 new actions have been added: • MM – Safe Prescribing of RT - minor areas of concern requiring action. • Clinical audit – smokefree and E-cigarette Trust Wide Audit - minor areas of concern requiring action.
Risk of failing to maintain a positive patient safety learning culture resulting in avoidable harm, poor systems, process and policy, and escalation of serious issues of concern.	Yes	No Remains as 4 X 4 = 16 Score increased to 16 in July 2025.	- One new control added: • Clinical audit – Smokefree and E-cigarette Trust Wide Audit - minor areas of concern. - Four actions have been closed: • Outcome measures to be developed over time rather than a single document – Audit one audit report gave assurance that PSIRF was well embedded within the Trust. • Clinical audit – Sexual Safety with Limited assurance – all actions complete.

Board Assurance Framework – summary (August 2025 – October 2025)			
Risk description	**Risk reviewed within timescale**	**Has the risk score changed**	**Changes to assurance, controls and actions**
			• Gaps in the organisations approach to learning from incidents identified in CQC assessment reports in 2025 – New governance structures established for learning with escalation from CBUs to Group and PSLIP. • NA – Use of Melatonin – all actions have been completed. - One new action added: • Clinical audit – Smokefree and E-cigarette Trust Wide Audit - minor areas of concern requiring action.
Failure to deliver our transformation plans around the model of care which affects the quality and sustainability of services.	Yes	No Remains as 3 X 4 = 12	- One action has been closed: • GP shared Care arrangements formally escalated to NENC ICB. Internal EPRR approach for potential GP industrial action to be considered – ongoing discussions within place teams with primary care continue to be monitored with place directors. Risks in relation to ADHD monitoring and review captured on the corporate risk register. New model agreed and implemented in south locality following identified risk for this patient cohort. - One new action added: • Outputs from NENC ICB configuration and role of place commissioning teams will require review in the context of delivering the transformational programme at place.
Failure to deliver a sustainable financial position and longer-term financial plan, will impact on Trust's sustainability and ability to deliver high quality care.	Yes	No Remains as 4 X 4 = 16	Context amended to reflect changes to the 2025/26 plan. - One action has completed: • Internal Audit – Outstanding Debt Resulting From Salary Sacrifice Schemes – audit recommendations have been actioned.
Risk that restrictions in capital expenditure imposed regionally / nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments and infrastructure.	Yes	No Remains as 3 X 4 = 12	- One control has been removed: • Secure funding and authority to implement changes to Estate through the CEDAR programme: OBC approval (including inherent improvement in revenue position): Bridging Loan Secured: Business Case Addendum. - One new control has been added: • Engage across the ICB to secure

Board Assurance Framework – summary (August 2025 – October 2025)			
Risk description	**Risk reviewed within timescale**	**Has the risk score changed**	**Changes to assurance, controls and actions**
			CDEL limit and pursue all initiatives for capital funding through clinical areas, estates areas and IT schemes. Approval of any business case and associated funding must provide the required resources to adequately fund any development.
Risk that the Trust's information and systems is at higher risk of being compromised leading to unknown vulnerabilities. This could lead to loss of, and/or public disclosure of, information and loss of access to critical systems.	Yes	No Remains as 3 X 4 = 12	No changes since April 2025.
Failure to develop a sustainable workforce model to recruit/retain/ and support the development of the right people with the right skills to deliver safe and effective services, our strategic objectives, and contractual obligations.	Yes	No Remains as 4 X 4 = 16	- One new control/assurance has been added: • Establishment of Strategic Workforce Group as part of Governance Structure. - Three new actions have been added: • Organisational Change plan – Inpatients. • Implement actions following letter received regarding Graduation guarantee for Newly Qualified Nurses. • Review of process for CPD monies to ensure monies are distributed in line with the Model of Care.
Risk of poor staff motivation, engagement, and job satisfaction if issues affecting staff experience are not addressed including health and wellbeing support, inclusion and the ability to speak up.	Yes	No Remains as 3 X 4 = 12	- One new control/assurance has been added: • Internal audit report – Local Induction (Onboarding) Follow Up - final report - Good level of assurance received.

4. Board Committee updates following October meeting reviews

All Committees continue to review the risks aligned to their respective terms of reference and delegated authority. Aligned to the new Board Committee assurance reporting to the Board,

Committee Chairs reflect on agenda items in the context of the Trust strategic ambitions and associated BAF risks. Included in the discussion for each agenda substantive item is a reflection on the level of assurance provided, the level of control and mitigations in place, actions being taken to manage issues, and any gaps in assurance and actions still to be taken.

The Committees also continue to distinguish between outstanding actions and mitigations which are within the Trust control, those which sit outside of the Trusts direct control but may require a level of influence and collaborative working, and those issues which need to be accepted and cannot be controlled nor influenced (i.e., changes to national policy/legislation).

The BAF risks remain as the last item on agendas for all Committees so that the Committee can look at the key risks holistically to ensure the Committee remains focused on the relevant issues. It is also used to identify potential gaps in Committee oversight.

Each Committee has also reviewed the Corporate Risk Register risks. These are the highest-level operational risks facing the Trust and are managed by Executive Directors through the Executive Management Group on a bi-monthly basis. This gives Board Committees a 'line of sight' to issues which may require strategic intervention at a future date.

4.1 Mental Health Legislation Committee – held 8 October 2025

At its meeting held 11 April 2025, the Mental Health Legislation Committee reviewed the need for a Board Assurance Framework risk relating to the impact of the changes to the Mental Health Bill. At that time, the Committee felt that risks associated with this were being managed at the most appropriate level in the organisation. This, alongside the unknowns in relation to the planning for the Bill, led the Committee to agree not to hold a BAF-level risk but to undertake regular reviews of this on an ongoing basis.

In October, a strategy session was held, facilitated by DAC Beachcroft, attended by the Chair of the Mental Health Legislation Committee, the Executive Lead and members of the Mental Health Legislation Team. At that session, an update was provided on progress on the plans for the implementation of the Bill. It is understood that the Bill is at the third reading and will receive general assent and come into force in the future. Although the date remains unknown, to ensure the Board are sighted on the potential risks and impact of the Bill, it was agreed that a BAF-level risk be developed during October for consideration in the context of the Trust Board session on risk appetite and risk management scheduled to take place on 26 November.

4.2 Quality and Performance Committee – held 8 October 2025

Whilst there were no significant issues to raise in relation to the BAF risks associated with the Quality and Performance Committee at the October meeting, a query was raised in relation to the scoring of the risk relating to compliance with statutory and regulatory requirements. The query was made in the context of a number of actions undertaken to address the regulatory breaches issued following CQC service-level inspections during 2024/25. There was no formal recommendation to amend the risk score at this time, but a review of the assurances provided will be undertaken.

4.3 Resource and Business Assurance Committee – held 10 October 2025

At the meeting held 10 October, it was agreed that the controls, assurances and outstanding actions relating to risk 2545 – risk of achieving financial sustainability – be strengthened. Assurance was provided at the meeting in relation to actions being taken but it was recognised that these are not currently reflected in sufficient detail in the BAF risk.

In relation to 2547 – risks relating to digital vulnerabilities and loss of, and/or public disclosure of, information and loss of access to critical systems – although sufficient assurance was provided in relation to mitigating the risk of such incidents occurring, further detail on controls and actions to mitigate and reduce the impact on quality, safety, care and treatment would be beneficial.

It was recognised that whilst the risk would be transferred to the Digital Committee when established, an update on this would be useful at the November meeting of the Resource and Business Assurance Committee in the context of a wider update on the Digital service transfer to NTW Solutions Limited.

4.4 People Committee

No meeting of the Committee was held however, the BAF risks associated with the Committee have been updated and reflected in this report. The focus remains on the development of a People Plan.

4.5 Audit Committee – 15 October

In line with the Trust Risk Management Policy, approved by the Board of Directors, the Audit Committee has delegated responsibility within its terms of reference to oversee the risk management system and gain assurances that there is an effective system of internal control across the Trust. As such, the Audit Committee reviews the BAF in its entirety which includes relevant updates from each of the Committees as appropriate.

A key theme from Committee meetings during the period related to the need for ‘grip and pace’ and in the context of risk management, the ability to identify any potential further issues which could lead to a breach in the future. It is recommendation that this be a key issue as part of the Board risk appetite/risk management discussion in November.

The Committee also noted Webrisk training compliance continues to increase and has now exceeded the training compliance target of 85% for the first time since introduction of the mandatory training in 2024. Monitoring of training compliance is undertaken at the Trust Wide Business Delivery Group to ensure sustained performance.

5. Recommendation

The Board is asked to:

- Note the content of the report in the context of Board discussions.
- Gain assurance that the BAF risks are being managed effectively by the respective Committees and Executive leads.

Debbie Henderson, Director of Communications and Corporate Affairs
24 October 2025

8. ANY OTHER BUSINESS / ITEMS FOR INFORMATION

Darren Best, Chair

8.1 CHAIR'S UPDATE

Darren Best, Chair

REFERENCES

Only PDFs are attached

8.1 Chairs report November FINAL.pdf

Meeting	**Board of Directors - Public**		**Agenda item: 8.1**
Date of meeting	Wednesday 5 November 2025		
Report title	Chairs Report		
Report Lead	Darren Best, Chair		
Prepared by	Kirsty Allan, Deputy Trust Secretary / Corporate Governance Manager		
Purpose	**For decision**	**For assurance**	**For awareness**
			x
Report previously considered by	N/A		
Executive summary	The Chair's report is a standing agenda item, for the purposes of transparency and accountability which provides the Board updates on strategic activity undertaken since the last meeting and draws the Board's attention to any other issues of significant interest. These include: - Annual Members / Annual General Meeting - CQC Well-Led - Council of Governors Elections - NHS Capability Assessment – October 2025 - Appointment of Associate Non-Executive Director - Internal and External engagement and activity - Local and Regional Network meetings		
Detail of corporate/ strategic risks	N/A		
Recommendation	To note		
Supporting information / appendices	N/A		

Meeting of the Board of Directors
Chair's Report
Wednesday 5th November 2025

1.1 Annual Members / Annual General meeting

I would like to extend my thanks to all who contributed to the success of this year's Annual Members / Annual General Meeting. It was a pleasure to welcome members, colleagues, governors, partners, service user and carers to reflect on our progress and look ahead to the future. Your contributions and insights are vital as we continue to shape the future of mental health and disability services across our region.

The meeting provided a valuable opportunity to share out Annual Report and Accounts for 2024/25, highlighting the Trust's continued commitment to delivery safe, compassionate and effective care. It was particularly encouraged by the engagement around our forward view, which sets out the Trust's strategic ambitions and the evolving needs of our communities.

A standout moment was hearing from the team at Hope Haven, who shared their inspiring work in expanding 24/7 community access to support. This marks a significant and positive shift in our 10-year plan, reinforcing our vision of care that is more accessible, person-centred and rooted in the places people live.

1.2 CQC Well-Led

We recently welcomed the Care Quality Commissioned (CQC) for a well-led review. While we wait for the formal outcome, I want to thank colleagues across the Trust for their openness and professionalism throughout the process. Early insights have highlighted areas where we can and need to improve and where we need to focus our efforts going forwards.

As a Trust, we are committed to listening, learning and acting. We'll be looking closely at the feedback and working together to strengthen the areas that need attention. That said, it's just as important to celebrate the good work that's happening every day across CNTW. The feedback also reflected the dedication, compassion and professionalism of our teams and we mustn't lose sight of that. It's a reminder that while there's always room to grow, we have some strong foundations to build on.

1.3 Governor Elections update

The Trusts latest round of Governor elections commenced on 15 September 2025, with the nomination period closing on 13 October 2025. I am pleased to report a strong engagement across our constituencies, with several seats contested – a positive reflection of the growing interest in shaping the future of our services.

Key milestones:

- Notice of Poll Published: 3 November 2025
- Close of Elections: 27 November 2025
- Formal Declaration of Results: 28 November 2025

It is encouraging to see so many individuals stepping forward to represent their communities and contribute to the Trust's governance. I would like to extend my thanks to all nominees for their commitment and enthusiasm. I would also like to express my gratitude to those Governors who have stepped down during this cycle, your contributions have been deeply valued. You have helped shape our Trust with integrity, compassion and dedication and

helped strengthen the Trust's accountability and connection with service users, carers and the wider public.

Governors play a vital role in holding the Trust to account, amplifying the voices of service users and carers and ensuring our services reflect the needs of the communities we serve. I look forward to welcoming our newly elected Governors and continuing this important journey together. Further updates will be shared following the declaration of results, including induction plans for newly elected Governors.

1.4 NHS Capability Assessment – October 2025

This month the Trust undertook the NHS Capability Assessment as part of the National Oversight Framework led by NHS England. The assessment provides a structured opportunity to reflect on our performance across six key domains: strategic alignment, leadership, quality of care, workforce and culture, access and delivery and financial sustainability. It has been reviewed by our Board Committees and submitted in-line with national timelines. This process supports continuous improvement and ensures we remain aligned with system-wide priorities and expectations and our commitment to transparency, learning and delivering high-quality mental health and disability services across our communities.

Following submission of the Trust's capability assessment, NHS England's Regional Oversight team will review our self-assessment and supporting evidence. This process may involve moderation of ratings to ensure consistency across Trust's and alignment with national benchmarks. The outcomes will inform our Segment rating under NHS Oversight Framework and guide any future support or improvement actions. We welcome this opportunity for constructive dialogue and remain committed to continuous learning and service excellence across our communities.

As many will be aware, CNTW is currently placed in Segment 4 of the NHS Oversight Framework which reflects the need for intensive support. While this position recognises the challenges we face, it also brings with it a focused opportunity for improvement. We are working closely with NHS England and our system partners to address the areas identified, as we are fully committed to delivering the highest standards of care and governance. The recent NHS capability assessment has helped us reflect on our progress and sharpen our priorities. We are eager to demonstrate sustained improvement and to move to a more stable position within the system, with the continued supports of our staff, service users, carers and communities.

1.5 Appointment of Associate Non-Executive Director

I am delighted to confirm the appointment of a new Associate Non-Executive Director (ANED) to the Board of Directors, commencing in December 2025.

The Trust has appointed Richard Lee who brings a strong background in digital, transformation and innovation as well as having a good knowledge of CNTW services. Richard's appointment supports our ambition to enhance the breadth and diversity of the Board and will enhance our strategic leadership and capacity and capability. As a ANED Richard will join the Board in a non-voting capacity, providing valuable insight and expertise while contributing to Board discussions and assurance. This appointment reflects our ongoing commitment to Board diversity, innovation and future-focussed leadership.

1.6 Internal and External engagement and activity

In addition to our schedule of planned Board and Governor meetings, I continue to have regular planned meetings with our Interim Lead Governor and meet weekly with James Duncan our Chief Executive Officer. I have also met with numerous individuals, including Executive Officers, Senior Managers and members of staff; the primary aim of which is to inform discussions with the Board and help shape our thinking and decision making. I am aware that our Non-Executive Directors have also involved themselves in a range of visits and meetings to help shape their thinking and discussions with the Governors and the Board.

During July 2025 – October 2025, I visited and / or met with:

- Service User Carer Reference Group (October)
- Lowry Cultural Celebration Day, Bamburgh Clinic
- Trust Memorial Service
- Trust-wide Strategic Workforce Group
- Annual Members Meeting
- Stuart Corbridge, Chair of North East Ambulance Service (NEAS)
- Bev Reilly, Interim Chair at Tees, Esk and Wear NHS FT (TEWV)
- Fiona Edward's, Regional Director, NHSE
- Observed a range of Board Committee Meetings
- Trust-wide Safety Group
- Executive Management Group
- CQC Well-led assessment interview
- Interview panel for Executive Director of Finance
- Mid-Year appraisals for Non-Executive Directors and Chief Executive

1.7 Local and Regional Network meetings

It is important to continually be connected to the local and national agenda by meeting key individuals for mutual benefit, to sustain strong relationships, and to continue discussions on key issues.

In this period, I have attended / met with:

- **Integrated Care System, (ICS) Foundation Trust (FT) Chairs Meeting** – this is a meeting of all of the Chairs operating in the North East and North Cumbria area. The meeting provides a good opportunity to discuss individual Trust and system wide pressures, concerns and learning.
- **Integrated Care Board (ICB) Chair and Foundation Trust Chairs Forum** – this meeting is attended by all of the FT Trust Chairs and is Chaired by Professor Sir Liam Donaldson (the Chair of the ICB) with the ICB CEO, Sam Allen and other senior ICB personnel. The meeting provides a forum to discuss system and wider NHS related issues, assess how we in the North East and North Cumbria are performing as a system and understand the strategic / wider issues that impact on the individual Trusts and the system collectively.

Darren Best
Chair of the Council of Governors and Board of Directors
November 2025

8.2 CHIEF EXECUTIVE REPORT

James Duncan, Chief Executive

REFERENCES

Only PDFs are attached

8.2 CEO Report FINAL.pdf

Meeting	**Board of Directors - Public**		**Agenda item: 8.2**
Date of meeting	Wednesday 5 November 2025		
Report title	Chief Executive Officer Report		
Report Lead	James Duncan, Chair		
Prepared by	Debbie Henderson, Director of Communications and Corporate Affairs / Company Secretary		
Purpose	**For decision**	**For assurance**	**For awareness**
			x
Report previously considered by	N/A		
Executive summary	The Chief Executive's report is a standing agenda item which provides an overview of key developments across the Trust and nationally. These include: Trust updates - Care Quality Commission Well Led inspection - Freedom to Speak Up (FTSU) Self-Assessment Tool - Lived Experience Academy hosts event on involvement in research - Changes to the way people contact our crisis services is changing - Planned industrial action by resident doctors – November National updates - Medium term planning framework - Request for action on racism including antisemitism - 10-year NHS Workforce Plan - New Workforce Management Solution for the NHS		
Detail of corporate/ strategic risks	N/A		
Recommendation	To note		
Supporting information / appendices	N/A		

Board of Directors
Chief Executive's Report
Wednesday 5 November 2025

1. Trust updates

1.1 Care Quality Commission Well Led inspection

At the end of September/early October, we had a Well Led Review from the Care Quality Commission. While we have not received a full report from this, we did receive some initial high-level feedback telling us about where we need to go further, and where they found positive practice (appendix A). Areas of positive practice was found in relation to the strength and cohesion of our leadership teams, the strong sense of values demonstrated across the Trust, knowledge and awareness of our purpose and vision as an organisation, and recognition on our approach to learning and innovation.

The most important thing is that they recognised the Trust's ambition to provide high quality, person-led care to the communities we serve and that we all want to do the right thing for those who need us.

Although organisational culture was seen to be generally positive, the CQC have noted that there are some areas where this isn't as good as it could be. We know that this has been an issue in some of our own internal work including recent surveys and intelligence linked to bullying, freedom to speak up processes and the outcome of our 2024 staff survey. We will of course, continue to focus on this as part of our key priorities for the coming year and beyond linked to our strategic ambition to be a great place to work.

The CQC have raised some issues around the way our Trust's governance works. Governance describes the systems we have in place to make sure we focus on the right things, and how we make decisions. They also raised some issues about whether the way we use information supports our ability to maintain a focus on our key areas of challenge. Over the coming weeks, we will continue to meet with our CQC colleagues to understand their concerns further. We want to seek clarity on these areas so that we can make sure that we respond in a way that adds value to our existing structures and processes.

What is most important is that there are no concerns raised in this or other reports that we have received about the quality of care that we provide and that is testimony to everyone that works across the organisation. I would like to thank all of our staff for their efforts during the past several weeks and for any contribution that you made, large or small, to the inspection process in terms of time, dedication, and honesty.

We will share the final report once we receive it and, in the meantime, we will progress with our ongoing discussions and start working on the things we need to improve.

1.2 Freedom to Speak Up (FTSU) Self-Assessment Tool

The National Guardian's Office produced an improvement tool to assist organisations to identify strengths and gaps across individuals, leadership teams and organisations in terms of FTSU.

The initial self-assessment was discussed at Trust Board in November 2023. It was recommended that this review is undertaken every two years. Therefore, the self-assessment has again been completed with support from the Non-Executive Director with

responsibility for FTSU and current FTSU Guardians and highlights areas of good practice and gaps that need further consideration (Appendix B).

Six actions have been developed for the period October 2025 – March 2026, including increasing capacity of Guardians and learning from concerns raised. Actions will be monitored through the People Committee.

1.3 Lived Experience Academy hosts event on involvement in research

On 17 October, the Lived Experience Academy hosted an event talking about co-production, lived experience and involvement in research. Taking place in the centre of Newcastle, the event featured a day of discussion and ideas focussing on the future of lived experience involvement in health and social research.

The Lived Experience Academy is made up of Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW), Durham University, Gateshead Council, Northumbria University and community organisation ReCoCo (Newcastle Recovery College). The project is funded by the National Institute for Health and Care Research (NIHR)'s Programme Development Grant and aims to redefine the role of lived experience in health research.

Lived experience is the knowledge and understanding someone gets when they have personally lived through something. The first-hand perspective provides unique insight and can enhance the quality and relevance of research.

Throughout the project, people with lived experience have been equal partners, co-designing and co-delivering all elements including today's event. Rather than a one-way process, both people with lived experience and established researchers have been learning from each other in the most effective way to embed lived experience into research.

The findings from the project will form part of a larger funding bid to make the Lived Experience Academy a UK-wide project.

1.4 Changes to the way people contact our crisis services is changing

Last year, the NHS 111 'mental health' option was launched across the country. This means that wherever you are, you can get help in a mental health crisis by calling 111. Anyone calling 111 from the North East or North Cumbria and selecting the 'mental health' option is put through to our wonderful team of call handlers based at Hopewood Park in Sunderland.

Because this service is now up-and-running, from 1 October the local 0800 numbers which people used to use to call for crisis support was switched off. Instead, if you or someone you know is experiencing a mental health crisis, you call NHS 111 and select the 'mental health' option. NHS 111 is free and available 24/7, every day, just like the old 0800 numbers.

Our crisis teams and services have not changed. People will still receive the same expert help from our trained mental health teams.

1.5 Planned industrial action by resident doctors – November

The British Medical Association resident doctors committee have announced that doctors are expected to take part in industrial action from 7am 14 November. This follows a series of

negotiations between the British Medical Association (BMA) and the government, which have yet to reach a resolution.

The Trust will work closely with clinical leaders to ensure patient safety remains our top priority. The Trust have contingency plans in place to maintain safe staffing levels, including the redeployment of senior clinicians and prioritisation of critical services. Staff are encouraged to support colleagues and patients during this period and to stay informed through internal updates and briefings.

2. National updates

2.1 Medium term planning framework

On 24 October, NHS England published the Medium-Term Planning Framework – delivering change together 2026/27 to 2028/29. The document signals the end of the short-termism, providing local leadership teams and Boards with the opportunity to break the cycle of 'just about managing' by creating the environment and headroom to fix the fundamental problems we all face, while in parallel improving care in the immediate term.

It seeks to close the gap between the national centre and service. The document has been coproduced with leaders from primary care, acute, mental health, ambulance and community services demonstrating a collective desire to genuinely embrace the change the public told us they wanted, and drive improvement in every part of the country. But most importantly, it seeks to create the platform for NHS Boards and leaders to truly listen to their communities and drive the change they want and need.

The document sets out how we are moving to a new operating model, resetting the financial framework and creating much greater opportunity for local autonomy through the new neighbourhood health approach, a new foundation trust model and the creation of integrated health organisations. It also sets out the early progress being made on reforming our approach to quality, workforce and neighbourhood health, while setting the scene for embracing a crucial new principle that services should be delivered digitally as the default wherever possible.

We will be discussing the framework both internally and as a system over the coming weeks.

2.2 Request for action on racism including antisemitism

Last week, Sir James Mackey, Chief Executive of NHS England, wrote to all NHS Trusts to reaffirm our shared commitment to creating inclusive, respectful and professional environments across the NHS.

His message was clear; there is no place in our services or workplaces for hatred, antisemitism, Islamophobia, racism, or any form of discrimination. Every person - regardless of background, faith or identity - should feel safe, valued and supported.

As part of this commitment, NHS England is taking important steps, including adopting the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism, updating uniform guidance, and strengthening mandatory training on Equality, Diversity and Human Rights to include more content on antisemitism and Islamophobia. This will be rolled out to all staff soon.

With this in mind, we reminded our staff of our 'Give Respect, Get Respect' campaign. Here at CNTW, respect is one of our core values. It means recognising, accepting and more importantly, valuing each other, whatever our background, culture, or beliefs. It means standing up for what's right and making sure our services and workplaces are places where everyone feels they belong. And it means recognising that it's our differences that make us stronger together.

There is no place here for harassment, discrimination, or bullying. We continue to encourage anyone who has experienced or witnessed any of these things to raise concerns and get support. I understand that speaking up can sometimes feel difficult, but it's only by raising issues that we can get a chance to put them right. We are committed to making CNTW a great place to work for all of us.

2.3 10-year NHS Workforce Plan

The Department of Health and Social Care has launched a call for evidence to inform its 10-Year NHS Workforce Plan. The government is seeking evidence and views primarily from healthcare organisations and those with expertise in workforce planning to inform the development of the 10 Year Workforce Plan.

As part of the 10 Year Health Plan for England: fit for the future, we conducted the biggest ever public and staff engagement exercise on the future of the NHS. In the 10 Year Health Plan we set out how we will reinvent our healthcare model from hospital to community, analogue to digital, and sickness to prevention.

The 10 Year Workforce Plan will build on the 10 Year Health Plan to set out how we will deliver a new workforce model with staff who are aligned with the future direction of reform and have real hope for the future.

Rather than a formal consultation on specific proposals, this call for evidence is an opportunity to provide views on the government's plans for the next decade and to share examples and case studies that will support delivery.

The Trust is developing its own People Strategy and Workforce Plan and will consider the 10-year workforce plan in this context.

2.4 New Workforce Management Solution for the NHS

The NHS Business Services Authority (NHSBSA) has awarded a £1.2 billion contract to Infosys to deliver a new and enhanced workforce management solution for the NHS.
The solution will support NHS organisations and their employees by providing a complete employment lifecycle platform, generating significant benefits for the NHS over the 15-year contract duration. It will support everything from recruitment and onboarding to career development, workforce management, payroll and retirement.
This aligns with the NHS 10-Year Health Plan's focus on the government's 3 shifts, one of which is the shift from analogue to digital and is expected to be implemented by 2030.

James Duncan
Chief Executive
November 2025

Care Quality Commission
Citygate
Gallowgate
Newcastle-Upon-Tyne
NE1 4PA

Mr James Duncan
Chief Executive
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

By Email

3rd October 2025

Care Quality Commission
Health and Social Care Act 2008
RE: Well-led Review Headline Feedback

Trust name: Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
Provider ID: RX4
Our reference: LAP-

Dear Mr James Duncan,

Following our feedback discussions with your team on, 2nd October 2025 please find below confirmation of the high-level feedback shared during this meeting. This letter does not replace the draft reports we will send to you but simply confirms the feedback we provided during our meeting. We encourage you to share these findings at your next public board meeting and with your communications team.

A draft assessment report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the reports.

The feedback we provide below reflects our early findings at the end of the on-site aspect of our well-led review.

Our feedback was:

Our trust-level assessment was the first for this trust undertaken using the new single assessment framework. The framework required the team to consider the well-led key question in the context of the well-led eight quality statements. We are simplifying ratings for NHS trusts by publishing a single trust-level rating, rather than multiple levels of complex, aggregated trust-level ratings.

We have completed a range of assessments of some of the trust's frontline services. This has included visits to wards for older people with mental health problems, community mental health teams for adults of working age, child and adolescent mental health wards and wards for people with a learning disability and/or autism.

Vision Strategy and Culture

- The trust's vision and strategy are clear, with high awareness across services and staff groups. The trust's drive to move to a community and preventative model of care aligns with the NHS ten-year plan.
- The trust's ambitions to provide high quality, person led care to the communities it serves have not been lost and the trust want to do the right thing for the communities it serves.
- The trust is aware of the risks to the achievement of its strategy and there is a need to move forward with further grip and pace particularly in being a great place to work and clearly articulate in the BAF clear and timely plans to address risks.
- There has been rapid progress in several areas, but it is not clear how these initiatives are coordinated and prioritised to ensure they collectively support the trust's core objectives. There is a risk that running too many projects simultaneously could dilute focus and resources from essential business.
- Staff we have spoken with and those who have offered us feedback have talked of pockets of culture in some services which are not in line with the trust's values. This is corroborated within the staff survey. The leadership development programme is a positive step forward to addressing these concerns.

Capable, Compassionate and Inclusive Leaders

- We have seen visible executive and senior leaders who role model trust values and behaviours.

- Senior Leaders are capable and compassionate towards patients, staff and the communities they serve. The leaders we have spoken to are passionate about the delivery of safe and high-quality care and show absolute commitment to do the right thing.

Workforce equality, diversity and inclusion

- Workforce issues are a key area of risk for the trust. Leaders were open about improvements needed to the trust's approach to workforce equality, diversity and inclusion and to make improvements to wres and wdes outcomes. The trust has strong staff networks in place who can help lead the trust forward in these important improvements.

Freedom to speak up

- The freedom to speak up process in place is not one which staff feel secure in using. Staff have reported that it does not feel safe and confidential to use.
- The instances of freedom to speak up use appear relatively low for the size of the trust.
- The capacity of the team in comparison to other organisations is low.

Governance, management and sustainability

- We appreciate that the non-executive team is undergoing a period of change. This should enable the trust to strengthen and understand the skills of the team, refine lines of accountability and put into place systems which enable nonexecutive directors to challenge quality, performance and push for decisive actions.
- The trust's governance structure for service-to-board oversight appears overly complex, with a noticeable separation between day-to-day operational management and board-level oversight. This may create a disconnect, rather than the integrated approach expected from a unitary board model. As a result, there may be a lack of clear line of sight and accountability from frontline services up to the board, potentially hindering effective decision-making and assurance and risking gaps and duplication in processes which distract leaders from management responsibilities.
- Over the last 12 months CQC and other external bodies have raised several concerns about the safety and quality of services including concerns about staff safety, restrictive practices, ligature and environmental risks, safeguarding reporting, training, supervision and appraisal. The trust's audit and governance processes failed to ensure leaders were alerted to early warning signs to enable proactive action.
- There has been a positive picture in the reduction of restraint, strengthened by the trust's new ambition to reach zero prone and mechanical restraint. There is a strong service user voice through this work, and a number of key

initiatives have been put into place to make significant improvement. There remains more to do.

- The trust has not acted with the required pace in some areas of concern raised in the 2018 inspections such as; supervision and appraisal rates, restrictive practice and making improvements to disciplinary and grievance processes.
- Safeguarding processes continue to be an area of risk for the trust; there appears to be an over reliance on internal reporting. This is in part due to the complex environment and significant number of partners the trust needs to work with. There would be a benefit of working with partners to create clear and concise reporting processes which meet the needs of patients, staff and all stakeholders.
- We can see that the trust has worked on duty of candour and complaints responses and can see improvements. However, in some cases there is a remaining culture where the organisation hesitates to acknowledge errors promptly and with the required clarity.
- The trust has developed its strategy in the management of physical health concerns, and we can see how this has been in response to incidents of concern. However, there is more to do in ensuring the required resources are given to the physical and public health teams to strengthen the trust's approach and ensure parity of esteem particularly in understanding and making real impact on health inequalities.
- The trust's PCREF implementation plan is moving forward but needs to be further prioritised.
- The underlying financial position is unclear currently and going into the next year.

Partnerships and Communities

- The trust's strategies for community led working are clear and a focus in both inpatient and community care groups.
- Care groups work in close partnership to ensure seamless transition through services for service users.
- We have seen high quality partnership working particularly on estates and ICT/digital projects.
- The trust would benefit from continuing to work closely with trusts facing similar complexities.

Environmental Sustainability

- The revised strategy has a clear and manageable structure and forward plan. Including examples of positive practice internally and alongside partners.

Learning, improvement and innovation

- We have seen a real focus on research and innovative practices; the research team are focussed and passionate about making real changes to improve care and treatment. The trust has been at the forefront of guiding national responses to new and emerging concerns and have provided robust responses to national concerns, for example the work post Nottinghamshire and closed cultures dashboards following the Shanley review.
- The patient safety and learning processes are well embedded and we have seen positive impact particularly in how the trust manage thematic reviews and learning from patient safety events through systems approaches.

Next steps:

We will undertake several post-assessment processes as below:

- **Evidence requests:** We may make requests for further information to support our assessment. There will be a small number of requests in line with areas discussed in interviews. We welcome any additional evidence the trust wishes to provide to support our assessment.
- **Feedback from partners:** We continue to review the data shared with us by the trust and the feedback we have received from trust partners and stakeholders.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to NHS England via their designated email address of england.cqcreportsne@nhs.net.

Could I take this opportunity to thank you once again for the arrangements that your team made to help organise the assessment, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please do not hesitate to contact us.

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Yours sincerely,

Victoria Marsden
Deputy Director of Operations

Gemma Berry
Operations Manager

CC:
NHS England
Arun Chopra, Chief Inspector of Mental Health, Care Quality Commission

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool

Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
I have led a review of our speaking-up arrangements at least every two years	Yes
I am assured that our guardian(s) was recruited through fair and open competition	Yes
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	Yes (though currently under review)
I am regularly briefed by our guardian(s)	Yes
I provide effective support to our guardian(s)	Yes

Enter summarised commentary to support your score.

The Executive Director of Workforce and OD is the senior lead responsible for FTSU and has been involved in all stages of its inception and development. Initially the arrangements were not formally reviewed but incrementally reviewed as issues/developments arose locally/nationally. The arrangements were formally reviewed in 2022 and again in 2024 when new Guardians were appointed.

At the end of 2022 the original FTSU Guardian stood down and two others appointed through expressions of interest. One was a three year tenure, the other a two year tenure. It was intended that moving forward all Guardians would be recruited for two years to allow a more experienced Guardian to support new Guardians. Unfortunately, due to unavoidable circumstances both Guardians stood down within a short time of each other therefore the new Guardians were recruited with staggered tenures. .

The Executive Director of Workforce is briefed by the Guardian every month and is available for additional support as required. In addition, the Deputy Director of Workforce and OD and Group Heads of Workforce and OD meet monthly with the Guardians.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. N/A

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
I am confident that the board displays behaviours that help, rather than hinder, speaking up	Yes
I effectively monitor progress in board-level engagement with the speaking-up agenda	Yes
I challenge the board to develop and improve its speaking-up arrangements	Yes
I am confident that our guardian(s) is recruited through an open selection process	Yes
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	Yes
I am involved in overseeing investigations that relate to the board	N/A
I provide effective support to our guardian(s)	Yes

Enter summarised evidence to support your score.

The NED lead for FTSU meets with the Guardians every two months and receives updates on issues/complaints that have been reported. Emergent themes are reviewed as well as the Guardians views on how concerns or complaints have been acted upon and whether the support they receive is adequate to fulfil their role.

The NED lead for FTSU also chairs the Trust's People Committee. This a formal committee of the Board. The FTSUGs attend alternate meetings as a standing agenda item, where they can report back on their work over that period. The NED lead for FTSU has good access to, and regular contact with, the Executive Director of Workforce and OD where any specific issues can be raised. The process, relationships and reporting to date are deemed to have worked well from the NED lead perspective.

Whilst there have been no investigations that relate to the Board, the NED lead would provide oversight of any concerns raised.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. N/A

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	5
We regularly and clearly articulate our vision for speaking up	5
We can evidence how we demonstrate that we welcome speaking up	5
We can evidence how we have communicated that we will not accept detriment	4
We are confident that we have clear processes for identifying and addressing detriment	3
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	4
We regularly discuss speaking-up matters in detail	5

Enter summarised evidence to support your score.

Raising Concerns/Whistleblowing cases are discussed bi-annually through our formal management meetings, as well as the People Committee and Board of Director Meetings. Cases and themes are now discussed monthly at operational meetings.

FTSU Guardians attend the People Committee bi-annually and the Audit Committee annually (as necessary). They have also attended Trust Board.

Speaking up is specifically articulated in our Trust strategy which was ratified by Trust Board in April 2023.

There are posters throughout all wards and departments to identify the FTSU Guardians and their contact details.

There is communication about the role and speaking up in the Trust Bulletin which highlights that there will be no detriment to staff for speaking up. This has been further articulated by other means such as the Exec Q&A sessions and Manager's Meetings..

The staff survey results are one indicator used to understand the feedback from staff that leaders role-model behaviours that encourage people to speak up.

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)

1. Review processes for identifying and addressing detriment.

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	Yes
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	Yes
We support our guardian(s) to make effective links with our staff networks	Yes
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	Yes

Enter summarised evidence to support your score.

Speaking up culture is discussed in leadership programmes, management skills programmes and Trust induction.

Disciplinary and Resolution policies and processes have been reviewed in 2025 and written in a trauma informed way and in line with a Just and Restorative Culture approach. Linked to PSIRF approach.

FTSU Guardians are linked into staff networks and work closely with trade unions colleagues as necessary.

FTSU intelligence is discussed at regular meetings with Executive Director of Workforce and OD and Non-Executive Director with responsibility for speaking up. Data is discussed monthly at operational meetings and bi-annually at the People Committee with the FTSU Guardians in attendance.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. N/A

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	4
We have reviewed the ringfenced time our Guardian has in light of any significant events	4
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	5
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	5
Enter summarised evidence to support your score. Ring-fenced time for FTSU Guardians was discussed between Executive Directors prior to advertising the role and in discussions with feedback from the previous FTSU Guardians. Over the period of FTSU ring-fenced time has been increased. On appointment of the new Guardians 37.5 hours was agreed but due to standing down of Guardians this is currently being reviewed with the remaining Guardians.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1. Review ring-fenced time for Guardians.	

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	5
We can evidence that our staff know how to find the speaking-up policy	5

Enter summarised evidence to support your score.

The Trust's Speaking Up policy entirely reflects the National Guardian's Office speaking up policy. This has been communicated in the Trust Bulletin and on the intranet.

Staff survey results indicate that staff know how to find the speaking up policy, however, more can always be done to raise the awareness of the policy.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. N/A

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	5
We have an annual plan to raise the profile of Freedom to Speak Up	4
We tell positive stories about speaking up and the changes it can bring	3
We measure the effectiveness of our communications strategy for Freedom to Speak Up	3

Enter summarised evidence to support your score.

The appointment of the FSTU Guardians was communicated in the Trust Bulletin and there are regular slots identified throughout the year to publicise the Guardians and the work that they do.

The Trust intranet site has a section for Freedom to Speak Up which includes details of the policy, how to speak up and who the FTSU Guardians and Champions are.

We currently do not communicate positive stories about Speaking Up to the Trust as a whole, though it forms part of the FTSU Champions' training.

We do not routinely measure the effectiveness of the communications strategy for FTSU, however, the National NHS Staff Survey is a good indicator of whether staff know how to raise concerns.

We have introduced Learning and Improvement Webinars and consideration to be given to how FTSU can be included, particularly positive stories or learning.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Further consider how learning can be shared in terms of positive speaking up stories.

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	2
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	5
Our HR and OD teams measure the impact of speaking-up training	3

Enter summarised evidence to support your score.

Training is available for staff via the Academy. There are no current plans to mandate the training for staff.

FTSU face to face training has been delivered by the Freedom to Speak up Guardians – further review is planned.

All FTSU Champions undertake training.

Freedom to Speak up features in corporate induction as well as the Trust Leadership and Management Skills programmes.

The impact of speaking up training is not measured, however feedback from staff and results of the staff survey linked to speaking up are considered at both a Trust and a local level.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Review the training offer for staff.

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	4
All managers and senior leaders have received training on Freedom to Speak Up	2
We have enabled managers to respond to speaking-up matters in a timely way	3
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	2

Enter summarised evidence to support your score.

The FTSU policy has been ratified and communicated via the Trust Bulletin and intranet. FTSU training was encouraged as part of the launch of the new policy.

The majority of concerns are low level and are dealt with by managers on a day to day basis: speaking up is seen as part of normal practice. More significant concerns are co-ordinated via the Employee Relations team or via the FTSU Guardians.

Recent evidence suggests that not all managers embrace FTSU as much as they could though there are some excellent examples of really responsive and supportive managers. There is a plan in place to further communicate the value of speaking up via the Bulletin and Manager's meeting. This will also be reinforced via the Leadership Programme and Management Skills Programme.

There is evidence that some staff are still afraid to speak up, and we are continuing to work on culture change with respect to this.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Review the training offer for staff.
2. Further communicate the value of FTSU to managers and reiterate the Trust position in terms of the value of speaking up

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	4
We use triangulated data to inform our overall cultural and safety improvement programmes	4

Enter summarised evidence to support your score.

The FTSU Guardians are supported to identify potential areas of concern and follow up on them. This can be demonstrated via meetings/e-mails from the Guardian to local line managers, CBU/Group level or with Executive Directors and in the bi-annual reports through the People Committee and Trust Board.

Data is triangulated with other metrics such as incidents, disciplinaries, grievances, absences, turnover and patient safety / Patient Advice and Liaison Service data to understand overall culture and safety in specific areas.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Consider how learning can be shared in terms of positive speaking up stories.

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	3
We use this information to add to our Freedom to Speak Up improvement plan	3
We share the good practice we have generated both internally and externally to enable others to learn	4

Enter summarised evidence to support your score.

FTSU Guardians network nationally and regionally and discuss best practice and lessons to be learned cross-organisationally.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. N/A

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	5
Our guardian(s) has been trained and registered with the National Guardian Office	5

Enter summarised evidence to support your score.

The Trust FTSU Guardians were appointed through a Trustwide expressions of interest. They were interviewed by a panel consisting of the Chief Executive Officer, Executive Director of Workforce and OD and the Non-Executive Director with FTSU responsibilities.

Guardians have been trained and registered with the NGO.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. N/A

Statements about the way we support our guardian(s)	**Score 1–5 or yes/no**
Our guardian(s) has performance and development objectives in place	2
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	5
Our guardian(s) has access to a confidential source of emotional support or supervision	5
There is an effective plan in place to cover the guardian's absence	5
Our guardian(s) provides data quarterly to the National Guardian's Office	5

Enter summarised evidence to support your score.

There are no formal performance and development objectives in place currently, however, there are identified objectives for the current Guardians eg development of FTSU Champions.

The Guardians receive support from the Executive Director of Workforce and OD on a monthly basis.

There is additional support from the Non-Executive Director with responsibility for FTSU.

Guardians have access to emotional support / supervision and also peer support from each other.

Regional and National FTSU networks provide peer guidance and support to each other.

Guardians provide the necessary data quarterly to the NGO.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Consideration to be given to setting specific performance and development objectives for FTSU Guardians.

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	3
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	4
We are assured that confidentiality is maintained effectively	4
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	3
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	3

Enter summarised evidence to support your score.

We are assured that local low level concerns are progressed in a timely manner within teams or directorates. Cases raised via the FTSU Guardians or via other routes can experience delays depending on the complexity of the issues raised. Timescales are monitored by the FTSU Guardians who would escalate delays to the Executive Director of Workforce and OD as appropriate.

As referenced above, further work to be undertaken with managers to further communicate the value of speaking up via the Bulletin and Manager's meeting. This will also be reinforced via the Leadership Programme and Management Skills Programme.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. Further communicate the value of Freedom to Speak Up and reiterate the Trust position in terms of the value of speaking up.

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	3
We know who isn't speaking up and why	3
We are confident that our Freedom to Speak Up champions are clear on their role	5
We have evaluated the impact of actions taken to reduce barriers?	3

Enter summarised evidence to support your score.

The Trust had four current FTSU Guardians who have been in post for several months. One Guardian has recently stood down from their role and arrangements are in place to increase capacity. The Guardians have completed the National Guardians office training and we are confident they understand their role.

The majority of concerns are low level and are dealt with by managers on a day to day basis: speaking up is seen as part of normal practice.

There is evidence that some staff are still afraid to speak up, and we are continuing to work on culture change with respect to this.

A speaking up survey has been recently conducted and results will be shared at September's Executive Management Group. This will help determine next steps. A form is now sent out to all staff who have raised concerns for feedback on the process and any learning.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. Explore reasons why there are barriers to raising concerns with the FTSU Guardians and agree what actions need to be undertaken. The results of the recent speaking up survey will support this work.

Statements about detriment	**Score 1–5 or yes/no**
We have carried out work to understand what detriment for speaking up looks and feels like	2
We monitor whether workers feel they have suffered detriment after they have spoken up	2
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	3
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	2
Enter summarised evidence to support your score. Currently the FTSU Guardians determine what they consider to be detriment, undertake monitoring, and report that in the quarterly data. There is still some work to be done by the board to explore their role in this process. A speaking up survey has been recently conducted and results will be shared at September's Executive Management Group. A form is now sent out to all staff who have raised concerns for feedback on the process and any learning.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	

1. Review speaking up survey and agree any actions with FTSU Guardians.

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	2
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	3
We routinely evaluate the Freedom to Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	3
Our improvement plan is up to date and on track	2

Enter summarised evidence to support your score.

There have been three external audits of the FTSU process in the past seven years. We learned from each and improved our processes.

The current FTSU Guardians have identified areas for improvement and these are currently being progressed, eg, FTSU Champions, recording of cases, post-speaking up survey.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Review the approach to improve the speaking up culture with current Guardians and leadership team.

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	4
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	2
Our speaking-up arrangements have been evaluated within the last two years	5

Enter summarised evidence to support your score.

We have introduced new Guardians as part of the evaluation of speaking-up arrangements. We have determined that their appointments will be time-limited, in order to keep a fresh pair of eyes on our arrangements.

Post-speaking up survey will support the measurement of improvements in how safe and confident staff are to speak up. The annual staff survey is also a measure.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Review the approach to improve the speaking up culture with current Guardians and leadership team.

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	4
We have we evaluated the content of our guardian report against the suggestions in the guide	3

Our guardian(s) provides us with a report in person at least twice a year	5
We receive a variety of assurance that relates to speaking up	5
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	3

Enter summarised evidence to support your score.

Raising Concerns/Whistleblowing reports have been reviewed. In addition to the bi-annual report which is discussed at Executive Management Group, People Committee and Trust Board, a more detailed monthly report is discussed operationally on a monthly basis and this is triangulated with other metrics as required.

FTSU Guardians attend the People Committee bi-annually and the Audit Committee annually (if required).

Learning and improvement from cases to be shared as part of the Learning and Improvement Webinars as necessary.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. N/A

Summarise your high-level development actions for the next 6 – 12 months

Development areas to address in the next 6–12 months	Target date	Action owner
1. Review ring-fenced time for Guardians	October 2025	Exec Director of WoD
2. Further consider how learning can be shared in terms of positive speaking up stories	December 2025	Exec Director of WoD
3. Review the training offer for staff	March 2026	Exec Director of WoD
4. Raise the profile of FTSU Guardians, communicate the Trust position in terms of the value of speaking up	October 2025	Exec Director of WoD
5. Consideration to be given to setting specific formal performance objectives for FTSUG	December 2025	Exec Director of WoD
6. Explore reasons why there are barriers to raising concerns, address issues of detriment and review approach to speaking up	March 2026	Exec Director of WoD / FTSUGs / leadership team

8.3 QUESTIONS FROM GOVERNORS AND THE PUBLIC

Darren Best, Chair

Date of next meeting
Wednesday 28 January 2026, St Nicholas Hospital Board Room and via MS Teams