NHS

Cumbria, Northumberland, Tyne and Wear

NHS Foundation Trust

BOARD OF DIRECTORS MEETING HELD IN PUBLIC

BOARD OF DIRECTORS MEETING HELD IN PUBLIC

28 January 2026

10:00 GMT Europe/London

Trust Board Room and via Teams

AGENDA

1. STANDING AGENDA ITEMS

Darren Best, Chair

REFERENCES

Only PDFs are attached

0.0 Board Agenda Public 28 Jan 26 CONFIRMED.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 28 January 2026 Time: 10:00am – 1pm	
	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 meeting held 5 November 2025 – **for approval**	Darren Best, Chair	Enc
1.4	Action Log and Matters Arising from previous meeting	Darren Best, Chair	Enc
1.5	Integrated Performance Report (Quarter 3)	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	CQC Action Plan update and final assessment reports - Children and Adolescent Mental Health Services (CAMHS)	Sarah Glacken, Executive Director of Nursing and Therapies	Enc
2.4	Learning from Deaths Assurance Report	Rajesh Nadkarni, Deputy Chief Executive and Medical Director	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	Raising Concerns and Whistleblowing Bi-annual Report	Lynne Shaw, Executive Director of People and Organisational Development	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 3)	Lis Dunning, Executive Director of Finance	Enc
5.3	Annual Plan Delivery Update 2025/26	James Duncan, Chief Executive	Enc
6. Strategic Ambition 5 – working for, and with our communities			
6.1	Digital, Data and Technology Committee Report	Thomas Webb, Committee Chair	Enc
6.2	Charitable Funds Committee Report	Vikas Kumar, Committee Chair	Enc
7. Governance and Regulatory			
7.1	Audit Committee Assurance Report	Vikas Kumar, Committee Member	Enc
7.2	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 29 April 2026, 10.00am – 12.30pm, 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 5 NOVEMBER 2025 - FOR APPROVAL

Darren Best, Chair

REFERENCES

Only PDFs are attached

1.3 AUTHORISED PUBLIC BOARD Minutes 5th November 2025.pdf

Minutes of the PUBLIC meeting of the Board of Directors
Wednesday 5th November 2025, 10am – 12.30pm
Trust Boardroom, St Nicholas Hospital

Present:
Darren Best, Chair
Brendan Hill, Non-Executive Director/Vice-Chair
Louise Nelson, Non-Executive Director / Senior Independent Director
Rachel Bourne, Non-Executive Director
Robin Earl, Non-Executive Director
Vikas Kumar, Non-Executive Director
Emma Moir, Non-Executive Director
Thomas Webb, Non-Executive Director

James Duncan, Chief Executive
Rajesh Nadkarni, Deputy Chief Executive / Executive Medical Director
Ramona Duguid, Chief Operating Officer
Sarah Glacken, Executive Director of Nursing and Therapies
Chris Cressey, Interim Executive Director of Finance
Lynne Shaw, Executive Director of Workforce and Organisational Development
Debbie Henderson, Director of Communications and Corporate Affairs / Trust Secretary

In attendance:
Sarah Craig, Executive Assistant (Minutes)

1. STANDING AGENDA ITEMS

1.1 Welcome and apologies for absence.
There were no apologies for Absence
A round of Introductions was made.

There was no public in attendance.

1.2 Confirmation of quoracy and declarations of Interest
There were no new conflicts of interest declared for the meeting. The meeting was confirmed as quorate.

1.3 Minutes of the meeting held on 25th July 2025 – For Approval
The Board accepted the minutes from the Meeting held on 25th July 2025 subject to some minor amendments.

1.4 Action log and Matters arising from previous meeting
The Board reviewed and discussed the Action Log. There we no updates scheduled for this meeting.

There were no matters arising.

1.5 Integrated Performance Report (Quarter 2)
Ramona Duguid referred to the integrated performance report which the Board discussed in detail, focusing on the shift to a quarterly review of key performance indicators for better trajectory analysis, rather than monthly. The board was briefed on the new approach and its alignment with the Quality and Performance Committee's monthly reviews.

Highlights included positive performance in urgent care pathways, no out-of-area placements for two months, and a reduction in MRE restraints, supporting a zero-tolerance approach.

Challenges were noted around occupancy, length of stay, and sickness rates Recovery plans for these areas were scheduled for review in upcoming committee meetings, particularly within the Quality Performance Committee and People Committee.

The report also addressed improvements in clinically ready-for-discharge data, especially in the rehab pathway, attributing changes to better data reporting quality and targeted clinical reviews.

Brendan inquired whether increased measurement has identified issues within rehabilitation pathways or if alternative factors are leading to delays. Ramona confirmed that the delays are primarily attributable to external influences such as social care, housing, and onward transitions to suitable placements. The Board engaged in a discussion regarding the Trust's provision of rehabilitation in a hospital setting rather than in the community and considered how the Trust addresses challenges contributing to the exceptionally high number of Clinically Ready for Discharge cases. Ramona also referenced various ICB forums and regional meetings, highlighting the necessity for a formalised escalation process within those forums. The importance of defining our role as a system partner to develop community capacity and resources was emphasised, as well as the need for thorough planning as part of our medium-term strategy discussions. It was noted that TEWV is recognised nationally for its best-in-class length of stay, attributed to effective utilisation of the independent sector.

Darren Best shared insights with the Board following a recent service visit to Lotus Ward. He encouraged the Board to consider whether lessons from that ward could inform our approach to managing Clinically Ready for Discharge patients and the associated responsibilities. Darren also emphasised the importance of understanding CNTW's plans and processes to improve the trajectory of Clinically Ready for Discharge cases, ensuring alignment with both the Local Authority and the ICB. Concerns were highlighted regarding waiting times for children and young people, particularly within neurodevelopmental pathways and central localities. Plans are in place for targeted updates and a renewed focus in these areas.

The Board engaged in a comprehensive discussion on the impact of addressing length-of-stay metrics. The measure used is of the length of stay at discharge so as the Trust progresses the discharge of patients with a long length of stay, this measure will deteriorate in the short term. Ramona briefed the Board on targeted initiatives related to length of stay, outlining both short- and long-term operational implications. Quality and Performance Committee will apply this dual-lens approach in their review of length of stay activities, with further details to be examined at the committee meeting.

The significance of complaints data and its integration into assurance frameworks was emphasised, along with recommendations to enhance thematic reporting and improve Board oversight.

Robin Earl queried potential consequences if we don't meet the ICB targets regarding sickness levels. James provided the board context on the ICB position and the work on going to address sickness levels in the Trust but reassured the Board there was no financial penalties that would be imposed on the Trust.

Rachel Bourne inquired whether the Trust had implemented any new measures contributing to the reduction in self-harm cases. She also noted that progress on Safety and Risk plans remains below target and requested assurance from the Board regarding the timeline for achieving 100% completion. Rajesh explained that the reduction in self-harm cases is attributable to updated reporting methods, as well as improved performance. He further reassured the Board that these matters will be discussed in detail at the forthcoming Quality and Performance Committee meeting. The Board sought further assurance on the quality of Safety and Risk Management Plans through the Quality and Performance Committee including clarification on the monitoring processes the Trust intends to implement.

The format and content of the report were commended, particularly the inclusion of a table on slide eight. It was suggested that a similar approach be adopted for reporting on mental health legislation. The Board acknowledged the importance of clearly framing reports to facilitate strategic discussions and invited feedback on both the dashboard and narrative components.

It was agreed that committee chairs should confirm assurance prior to closing actions, and that any regulatory breaches or performance issues will be tracked through the integrated performance report and regular committee updates.

ACTIONS:

- **Ramona Duguid will provide further details on the plans to reduce and manage Clinically Ready for Discharge patients which will be considered through the Quality and Performance Committee**

2. **Strategic Ambition 1 – Quality Care, Everyday**

2.1 Quality and Performance Committee Quarterly Assurance Report

Louise Nelson introduced the Quality and Performance Committee quarterly assurance report and reviewed highlights from the past 2 meetings that were held in September and October.

The Committee met twice during the reporting period, with ICB representation. Oversight responsibilities included performance, quality, safety strategies, and patient experience.

Louise advised The Committee reviewed and managed risks including access and responsiveness challenges, CQC regulatory compliance, patient safety culture, and transformation plan delivery. Risk scores ranged from 12 to 20.

Issues were discussed regarding barriers faced by patients clinically ready for discharge, waiting times in community services (notably gender services), and ongoing monitoring of adult pathways and neurodevelopmental services.

The Committee noted significant progress in addressing CQC breaches across multiple services. Actions included implementation of new governance structures, mandatory training, ligature risk assessments, and privacy and dignity audits.

Serious incident investigations and quality reports were reviewed. The Committee acknowledged improvements, particularly reductions in self-harm incidents, and discussed ongoing evaluation of the impact of learning from investigations.

The urgent development of medium-term resource and workforce plans aligned with the Model of Care and Support was emphasised, aiming to ensure sustainable service transformation.

Louise summarised the report by informing the Board that The Committee will maintain oversight of recovery plans for waiting times, reduction of restrictive practices, ongoing CQC action plans, and improvements to reporting and escalation processes related to staffing and financial recovery.

The Board inquired about the timeframe for the enhancement of the Lived Experience report, with Sarah Glacken confirming that the updated report will be presented to the Quality and Performance Committee in January. The Board also discussed the use of the term "safer staffing" in relation to staff reductions, with James Duncan and Sarah Glacken providing insights into ongoing regional and national discussions on this issue.

The Board discussed ligature risks following the CQC regulation breach, requesting clarification on the breach's current status, as well as the necessary actions the Trust must undertake to resolve the issue. Ramona Duguid informed the Board that the Trust has completed a pilot program across six ward areas —including Older Peoples, Children and Young People, and Adult Acute—to assess the tool recommended in the national guidance by the CQC. This pilot was concluded during the summer. Feedback from participants has been collected, and, as a result, the Trust has agreed to extend the rollout to the Female Pathway and Children's and Young People's Pathways, given that these two pathways present the highest challenges in terms of ligature risk. The second area identified by the CQC as a gap within the Trust was related to training, specifically whether staff received adequate preparation to conduct risk assessments effectively. Work is ongoing. Sarah Glacken assured the Board that a paper is currently being prepared to go back to the CQC to address their concerns and update them on the

work being completed. A conversation between James Duncan and Jenny Wilkes (Interim Mental Health Director for the CQC) is also being scheduled for clarity on expectations to be explored.

2.2 Mental Health Legislation Committee Quarterly Assurance Report
Emma Moir presented the committee report, noting that the committee convened once during the reporting period to review assurance systems and compliance processes regarding mental health legislation in both inpatient and community contexts. While no current BAF risk exists, a new risk will be established following a strategy session, specifically addressing the anticipated impact of the forthcoming mental health bill on quality of care, workforce considerations, and service delivery. Although progress on the bill continues, a definitive implementation timetable has yet to be confirmed. Emma underscored the importance of revisiting and updating the committee's reporting approach to enable more targeted data analysis, enhanced benchmarking, and clearer assignment of improvement responsibilities, complete with explicit timelines. She advocated for concise, strategic summaries in place of excessive detail, highlighting that over 50 metrics are currently reviewed and proposing a focused synopsis of priority discussion areas.

The committee agreed to draft a risk associated with the mental health bill, to be circulated internally and subsequently discussed at the November Board Development Day.

The Board also addressed the collaborative relationship between the Mental Health Legislation Steering Group and the committee. The Board emphasized the value of improved data quality, analytical insight, and sustained coordination between the two bodies. Jonathan Richardson was announced as the incoming chair of the steering group.

Sarah Glacken and Louise Nelson recommended that the steering group sharpen its focus and transition from repetitive statistical reporting to developing actionable plans and measurable outcomes, discouraging purely congratulatory updates.

The committee anticipates an expanded remit in light of significant legislative changes ahead, and Emma affirmed her commitment to advancing future reporting practices to further support effective and insightful committee operations.

2.3 Care Quality Commission Final Assessment Report (Older Peoples Wards and CQC Action Plan Update)
Sarah Glacken advised the board have received updates on recent CQC assessments, including the well-led assessment and the assessment of children and young people's mental health services. High-level feedback has been received, but draft reports are still pending. Additional information and focus groups have been provided to the CQC, indicating that the draft report may take longer to arrive.

It was noted that The CQC have published results for the assessment of older people's services, with the trust rated as "requires improvement," a downgrade from the previous "good" rating. Breaches of regulation identified by the CQC are included in the improvement plan, which was reviewed in the meeting.

The improvement plan outlines thematic analysis of breaches, completed actions, outstanding actions, and deadlines.

The Board raised concerns regarding gaps identified in care records and inquired about the reporting process to ensure the Trust is informed of these deficiencies. Sarah clarified that the report is submitted to the Quality Improvement Group, where assurances are provided concerning the actions that remain outstanding. It was discussed amongst the Board for the opportunities to be featured as part of the assurance report to the Quality and Performance Committee.

The Board discussed the importance of clear accountability and assurance before closing actions, especially those related to mental health act compliance

2.4 Safeguarding Adults and Children's Annual Report 2024-2025
Sarah Glacken presented the safeguarding annual report, noting it should be taken as read and highlighting that it demonstrates the trust's safeguarding activities and statutory responsibilities over the past year.

Sarah Glacken mentioned concerns raised by the CQC and safeguarding chairs about the trust's ability to be present at all partnership boards and subcommittees, given the challenge of working with seven local authorities. Ongoing work with the ICB is addressing representation, with a commitment to attend statutory meetings and use the ICB for health responses at other meetings.

Rachel Bourne inquired about incorporating a health inequalities perspective into safeguarding, with particular reference to protected characteristics and connections to PCREF. Rajesh confirmed that this would be addressed in the report for next year.

Brendan Hill introduced the concept of "professional curiosity" during safeguarding training, inquiring about its internal promotion. Rajesh and other members affirmed that it constitutes a fundamental aspect of their training, supported by case studies and analytical exercises designed to foster critical inquiry. The board noted the challenge of sustaining professional curiosity while managing competing priorities and underscored its significance within safeguarding practice. The Board also requested Rajesh to continue working with the ICB and safeguarding chairs to clarify trust representation at partnership boards and subcommittees, ensuring statutory responsibilities are met.

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

There were no reports for this period

4. STRATEGIC AMBITION 3 – A GREAT PLACE TO WORK

4.1 People Committee Quarterly Assurance Report
Brendan Hill summarised the People Committee report, highlighting ongoing reviews of risks related to staffing and sickness, with improvements noted in key areas.

Recruitment challenges in Cumbria were discussed, with a focus on targeted interventions in hotspot areas for better results.

There was clarification on terminology: the trust will have both a people strategy and a workforce plan by year-end, with resource planning as a separate but related effort.

The committee addressed support for Freedom to Speak Up Guardians, noting variability in managerial support across the organisation and ongoing efforts to strengthen the champion network.
The committee discussed the new health, wellbeing, and attendance policy, co-created with the Disabled Staff Network, and the importance of early resolution in grievance cases.
Progress on grievance resolution was reported, with early-stage resolutions increasing and ongoing efforts to support managers and reduce formal grievances.

Vikas Kumar raised concerns about the integration of workforce race equality, disability standards, and Freedom to Speak Up, emphasising the need for lived experience representation and decision-making power in relevant groups. Lynne Shaw provided the Board with assurance that co-creation with staff networks and ongoing participation in policy development.

The Board requested that The People Committee are to monitor the implementation and impact of the new health, wellbeing, and attendance policy, ensuring co-creation with staff networks.

Robin Earl inquired about the procedures surrounding grievances, specifically asking how managers are supported throughout the process and whether there are any sanctions for managers who do not prioritise resolving grievance matters. Lynne Shaw provided assurances that managers are fully supported by workforce leads and are encouraged to proceed down a resolutions process rather than a grievance. Lynne also noted that there is dedicated training for managers with timescales for complex grievance still to be worked through.

4.2 Resident Doctors 10 Point Plan
Rajesh Nadkarni presented the implementation of the 10-point plan for resident doctors, noting that all organisations received a letter from Sir Jim Mackey and the Health Secretary. The plan focuses on improving resident doctors' working lives, including challenges like providing hot food 24/7 on mental health sites.

Rajesh advised the timescales are between 6-12 weeks with the paper articulating the work implemented so far, with the first being the establishment of a working group for Resident Doctors. Amongst the 10 actions 7 of the actions are relevant to the organisation.

The board was asked to approve governance for monitoring progress through the People Committee, appoint an executive lead (Rajesh volunteered), and select a resident doctor representative via an expression of interest. Once elected the representative will join the People Committee.

Thomas Webb raised concerns that the plan may achieve its stated goals without adequately addressing the core issues. He emphasised the importance of wider dialogue and ensuring the plan responds effectively to the specific needs of resident doctors within the organisation, rather than focusing solely on the NHS England conversation. Rajesh confirmed strong relationships with resident doctors, ongoing satisfaction surveys, and that the plan is part of wider efforts beyond the 10 points

The Board suggested that the appointed resident doctor representative could help further develop the plan and ensure it meets real needs.

APPROVED:
The Board approved the governance process through the People committee

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

5.1 Resource and Business Assurance Committee Quarterly Report
Emma Moir summarized the committee's assurance that systems and processes are in place for resource management, strategy, and operational plans.
The committee focused on three key risks: financial stability (short and medium term), capital restrictions, and digital vulnerabilities.

Financial stability was highlighted as the primary concern, with requests for additional assurance on financial and workforce trajectories and medium-term sustainability. Emma noted that the agenda was adjusted to ensure clear focus on financial stability, workforce trajectory, and medium-term planning.

It was noted that Controls and outstanding actions for risk 2545 were to be strengthened with Debbie Henderson taking forward.

The committee commended the estates program and requested future reports include metrics on project completion, spend, and risks.

The committee recommended reviewing the likelihood of cyber-attack risk and requested more detail on controls and mitigation, noting a new digital committee will be established.

Provider collaborative arrangements were delegated to the committee, with a specific agenda item planned for the next meeting.

Emma Moir and Louise Nelson emphasised the need for clearer metrics, actions, timelines, and ownership in future reports.

Chris and Emma agreed to follow up on financial stability and resource transfer at the next RABAC meeting.

5.2 Finance Quarterly Report (Quarter 2)
Chris Cressey presented the finance report, noting the trust is ahead of plan due to a land sale, but behind plan when excluding it.

The financial trajectory for the rest of the year is being consolidated, with a single set of projections to be monitored and reported at the RABAC Committee

There is a £4 million financial recovery required, with pressures from clinically ready for discharge (£2.8 million) and antipsychotic drugs budget (£1.4 million).

Chris noted discussions with the ICB are ongoing to seek support for these pressures.

Chris advised The Trust is launching a severance scheme, but significant reductions from this are expected only from next year.

The Board extensively discussed the concerning financial position with the Board challenging if lessons could be learned from not acting sooner on cost pressures. Chris explained the balance between sustainable measures and urgent action, noting operational teams are now seeing reductions in agency and bank staffing.

Chris emphasized that the urgency stems from recent changes in national NHS financial support, and the trust is committed to ensuring that the upcoming year does not begin under crisis conditions.

5.3 Annual Plan Delivery 2025-2026 Mid-Year Review Report (Including quality priorities)
James Duncan referenced the report, noting that there may be a need to reassess or deprioritise certain aspects of the plan for the remainder of the year. Any adjustments will be communicated at the January board meeting.

The Board emphasised the importance of incorporating more metric-driven updates (e.g., reduction in sexual safety incidents) rather than relying solely on narrative to more effectively monitor progress and outcomes. The linkage between committee work plans and annual plan priorities was highlighted, with a focus on establishing clear measurement and reporting of results.

6. STRATEGIC AMBITION 5 – WORKING FOR AND WITH OUR COMMUNITIES

6.1 Charitable Funds Committee Report
Vikas Kumar introduced the Charitable Funds quarterly assurance report and reviewed highlights from the draft charity accounts noting a modest resource investment. He mentioned efforts to connect with schools to promote mental health awareness among children and young people building long term relationships with the Trust. The Charity received a £160k legacy grant, commemorated by a plaque at St Nicholas Grounds built from Craft Shack at Northgate Hospital. Vikas also shared positive news about the Charity's participation in the Great North Run.

6.2 Health Inequalities Quarterly Report
Lynne Shaw presented an update on health inequalities work across the Trust outlining the Trusts current position and future plans in addressing health inequalities, with a particular focus on racial disparities in-line with the National Patient and Carer Race Equality Framework (PCREF). The report identified six strategic priorities, which are referred within the main body of the report and highlighted the Trust's commitment to co-producing solutions in partnership with local communities.

It was noted that a 2-year plan has been developed collaboratively with community stakeholders, as detailed within Appendix A of the report. The high-level plan outlines the trust's approach to tackling health inequalities in a way that is informed by lived experience and shaped by those most affected. The Trust has held three engagement sessions with community groups to date, which have been positively received and have laid strong foundations for ongoing relationship-building.

The Board acknowledged that while the Trust is not yet in a position to define specific metrics for measuring progress, with is ongoing to improve data quality and analytical capability. A PCREF steering group has been established and will continue to oversee data analysis and the development of meaningful indicators. In addition, a health inequality steering group will provide overarching governance for all related workstreams, including the development of detailed work and action plans. Digital inclusion will form a key component of this work.

The Board welcomed the report and noted positive progress made in engaging with communities and establishing governance structures to support the delivery of the Trust health inequalities agenda.

7. GOVERNANCE AND REGULATORY

7.1 Audit Committee Assurance Report

Robin Earl reported that the committee convened three times during the quarter, addressing matters such as draft charity accounts and the NHS provider capability assessment.

The committee identified the need to address digital risks, particularly following the transition of digital services to NTW Solutions.

It was noted that compliance with the declaration of interests policy remained below acceptable thresholds; escalation procedures were proposed to address instances of non-compliance. Ongoing monitoring of internal audit recommendations continues, with particular attention to those requiring extended completion timelines.

The local counter fraud team highlighted the introduction of a new criminal offence, "failure to prevent fraud," necessitating an impact assessment and related actions to ensure organisational compliance. Robin advised that the committee received limited assurance on the internal audit report regarding Oxe Vision. Ramona updated the committee on steps taken to address identified weaknesses, with full implementation anticipated by the end of November.

Robin also conveyed concerns about potential liability under new fraud legislation and assured that the committee remains vigilant in monitoring these matters.

The committee will continue to address these issues and provide further updates as necessary.

7.2 2024-2025 Annual – Safety, Security and Resilience Report (including EPRR Core Standards Assessment)

Emma Moir referred to the list of activities highlighted within the annual report and invited reflection on the impact these activities have had across the organisation.

Ramona Duguid confirmed EPRR standards have been incorporated into the Trust compliance framework with a continued emphasis on the ‘check and challenge’ approach. The Trust continues to perform well against core standards, which are used as the basis for ongoing measurement and assurance.

In response to a query regarding the Trusts overall position, Ramona referred to points 1-10 within the report, noting that the majority of EPRR activities are focused on planning and exercising to identify potential weaknesses and assess organisational resilience. The Trust has demonstrated strong performance in recent testing and exercises, with two significant incidents – the Residents Doctors Strike and a major IT outage within the past four weeks. Providing real-time tests of the Trusts resilience systems. These incidents will be reflected in the next annual EPRR report.

With specific reference to the IT outage, it was note4d that the Trust was able to rapidly initiate its emergency response protocols. A formal debriefs followed the unplanned outage, which affected access to electronic healthcare records (RiO). Key learning points have been identified by the Trust-wide Safety Group. The incident highlighted the importance of anticipating digital vulnerability and embedding resilience into critical systems.

All incidents will be reported to the Executive Management Group and Trust-wide Safety Group with onward reporting to Board. The Quality and Performance Committee will also receive updated and the findings will inform the ongoing digital infrastructure review, which forms part of the wider work plan and governance cycle.

ACTION:

- **It was agreed that formal updates should be provided to the Audit Committee in and added to the reporting cycle.**

7.3 Board Assurance Framework / Risk Management Report

The BAF was discussed with members reflecting positively on its current position and governance ownership.

Debbie Henderson referred to the Executive Summary of the BAF report and noted the BAF had been updated to reflect current strategic risks and that its integration within the Board papers provided assurance on the Trust's approach to risk management.

A dedicated Board session on risk is scheduled for 26 November to further strengthen oversight and will allow a deeper exploration of risk appetite, escalation and mitigation strategies.

Board members expressed confidence that the BAF is in a good position, with clear alignment to strategic objectives and improved visibility of key risks. James Duncan reminded the Board that the BAF is owned by the Board itself, not by Committees. He emphasised that while committees play a vital role in reviewing risks, identifying areas outside of risk appetite, and considering de-escalation strategies with ultimate accountability rests with the Board.

It was acknowledged that some risks may remain outside the Trusts direct control, and that timing for mitigation may vary, however the BAF provides a structured framework to sharpen controls, monitor progress and ensure that risk management remains dynamic and responsive.

The Board noted the importance of continued scrutiny and welcomed the up coming session as an opportunity to further embed risk ownership and strengthen assurance processes.

8. Any Other Business / Items for Information only

8.1 Chairs Update

The Chair referred to the ongoing Council of Governors elections, noting that the results will be formally declared on 28th November. The Board acknowledges that this will result in new governors joining the Council and others stepping down and expressed thanks to those who have contributed to the work of the Council during their term.

The chair also referenced the National 10-year plan framework for NHS Governance, which outlines that newly established Foundation Trusts will not be required to have a Council of Governors. However existing Foundation Trusts will remain the choice to continue with governor arrangements. The Chair confirmed that for CNTW, the Council of Governors remains a vital part of the Trusts governance structure and that for as long as they are in post, the council will continue to operate.

The Board welcomed this reaffirmation of the Council's role in providing public accountability, stakeholder engagement and assurance and noted the importance of maintaining strong links between the Board and Council of Governors.

The Chair formally welcomed Richard Lee, Associate Non-Executive Director who will be joining the Board of Directors from December. It was noted that Richard will attend all Board meetings with the exception of those involving legally privileged matters. The Chair confirmed that while committee membership is yet top be finalised, Richard will sit on the Digital Committee, which is due to be established next month. This appointment reflects the Directors background and expertise in digital transformation and governance, and the Board acknowledged the value this will bring to the Trusts strategic ambitions.

8.2 Chief Executive Report
James Duncan referred to the report, which included reference to the recent correspondence received from the CQC following inspection activity. The letter was noted as constructive with recognition of the Trusts ongoing commitment to quality and safety. The Board acknowledged the importance of the feedback and the continued focus on regulatory compliance and service improvement.

James also noted that this meeting marked the final attendance of Chris Cressey as Interim Executive Director of Finance. Lis Dunning has been appointed to the role and will formally take up the position in the coming months. James extended sincere thanks to Chris for his leadership and contribution during a particularly challenging period, acknowledging the significant impact of their work across the organisation.

8.3 Any Other Business
There was no further business discussed.

Date and time of next meeting:

Wednesday 28th January 2026, St Nicholas Hospital Board Room and 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 January 2026 DH.pdf

Board of Directors Meeting held in public

Action Log as at 28 January 2026

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.
Completed Actions					
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	Complete – agenda item for January 2026 meeting.
05.11.25 (1.5)	Integrated Performance Report	Further details on the plans to reduce and manage Clinically Ready for Discharge patients which will be considered through the Quality and Performance Committee.	Ramona Duguid	December 2025	Complete – regular updates provided to Quality and Performance Committee
05.11.25 (7.2)	EPPR Annual Report	It was agreed that formal updates should be provided to the Audit Committee in and added to the reporting cycle.	Ramona Duguid	December 2025	Complete – included on annual cycle of business for Audit Committee

1.5 INTEGRATED PERFORMANCE QUARTERLY REPORT (QUARTER 3)

Ramona Duguid, Chief Operating Officer

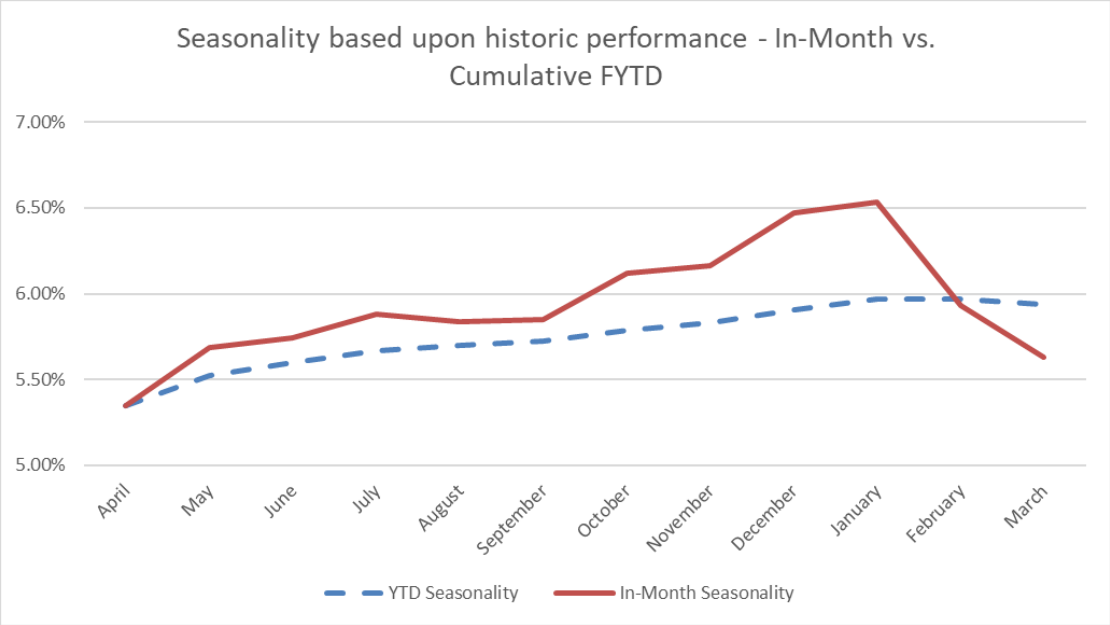
REFERENCES

Only PDFs are attached

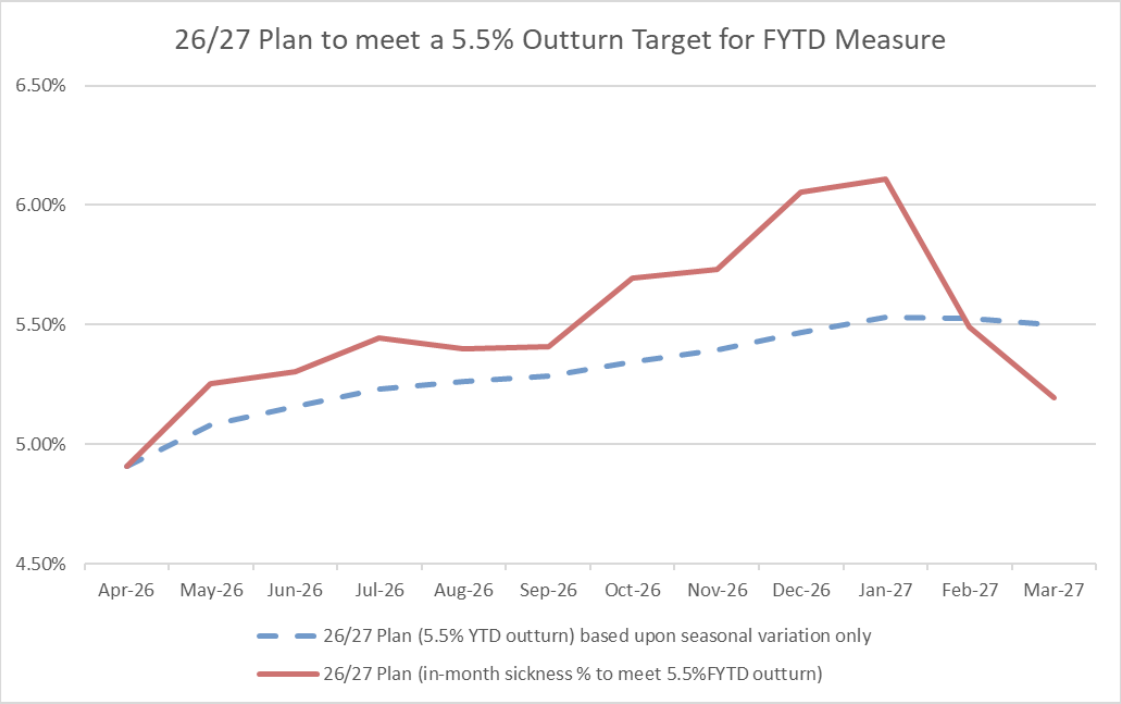
1.5-Trust-Board-IPR-Q3-Final-RD.pdf

Meeting	**Trust Board of Directors**		**Agenda item: 1.5**
Date of meeting	28-01-2026		
Report title	Quarter Three 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 Three 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 which was first published in September 2025, and was refreshed for the first time in December 2025. The Trust remains 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. As per the Board action log, the Board of Directors requested a sickness trajectory for 2026/27 that takes into account the seasonal variation in sickness performance and measures sickness performance year to date. This approach will provide a clearer indication of ongoing delivery against the full-year target of 5.5% for 2026/27, which has been agreed as part of the workforce planning targets. Once the trajectory is agreed, further work will progress to develop short-term and long-term sickness trajectories.		

- Sickness data has been analysed back to 2017/18 (excluding x3 years impacted by Covid-19) to understand the seasonality in sickness absence and specifically the Cumulative YTD measure.
- The chart below shows how our in-month sickness position typically impacts our cumulative FYTD sickness position.



Using the 26/27 out-turn target of 5.5% for sickness over the 12-month period, the position has been extrapolated back to April 2026, to include seasonal variation as per the above. It is clear for the need to manage in-month sickness to meet the 5.5% FYTD target. The blue in the chart below is the proposed year to date trajectory being proposed.



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 Q3 Performance Report and to take assurance that appropriate actions are in place to address areas of underperformance. • Approve the sickness trajectory for 2026/27.
Supporting information / appendices	Appendix 1 – Quarter Three 2025-26 – Integrated Performance Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Trust Board of Directors

Integrated Performance Report

Patients | Quality | People | Person Led Care | Sustainability

Quarter Three – 2025-26 Report

(Reporting Data to Dec-25)

With YOU in mind

Trust Board of Directors Q3 25-26 - Key messages

Reporting Period: Dec-2025

What's going well?

Multiple safety measures continue to show low levels of restraint usage in Quarter 3 of 2025/26. MRE restraint usage reduced to zero in December 2025, and prone restraints have remained at consistently low levels since the beginning of 2025. Assaults on patients are now showing consistent improvement throughout Quarters 2 and 3, with December recording the lowest level since April 2023. The number of incidents of self-harm is also showing consistent improvement. The Trust is maintaining an above-target position for the percentage of patients who report they "feel safe."

Our urgent and crisis care services continue to perform well. The percentage of Crisis Urgent Referrals seen within 24 hours is 83.5%, which is in the top quartile nationally. Crisis Very Urgent Referrals seen within 4 hours is at 70.7%, which is also top quartile, above target, and a statistically significant improvement over the past year. Psychiatric Liaison measures continue to demonstrate consistently strong performance.

Following the significant improvement in Quarter 2, Early Intervention in Psychosis wait times have remained well above the target of 60%, with performance at 83.7% in December 2025.

Of the "All Staff Priority" training courses, 10 courses are above target, 1 course is only 0.1% below target, and 1 course does not have a target set. Of the 11 Clinical Priority training courses, 7 are showing consistent improvement in Quarter 3, with the remaining 4 maintaining previous performance levels.

What's of concern?

The NHS Oversight Framework measures were refreshed for the first time in December 2025, and the Trust remains in Segment 4 for overall performance. While performance improved in the Effectiveness and Experience segment driven by an improvement in Length of Stay >60 days for inpatients aged 18–65, this was offset by lower performance in the Access to Services segment. However, the Access to Services segment contains only one measure which is to increase the number of CYPS accessing services.

Sickness absence rates continue to be a concern in both the National Oversight Framework and internal measures. The 2025/26 trajectory aimed to reduce sickness absence by 1% by year-end, which will not be achieved at current levels. A new trajectory is being proposed to the Trust Board of Directors, measuring a year-to-date position against a seasonally adjusted year-to-date trajectory, with a full-year sickness absence target of 5.5% for 2026/27. The Strategic Workforce Group is leading actions to deliver a reduction in sickness absence, including targeted support, interventions for teams with higher absence rates, and the procurement of an Absence Management System.

Trust Board of Directors Q3 25-26 - Key messages

Reporting Period: Dec-2025

What's of concern? - continued

Clinically Ready for Discharge (CRFD) rates have deteriorated in Quarter 3 compared to Quarter 2. The full Hospital to Home model was implemented in November 2025 and includes a CRFD pathway which will focus on patients who are ready for discharge, working across the system. This includes increasing the focus on patients' pathways and their status, and therefore, initially more patients will be clinically ready for discharge than previously. Once the work of the Hospital to Home model continues to embed across the Trust and the wider system in future quarters, this number will come.

Community waits within 4 weeks for CYPS, Adults, and Older Adults are off target, with no change in the trend over Quarter 3. The Monthly Access Oversight Group with CBUs continues to focus on waiting time performance, including the standardisation of processes and data recording practices. There are also several new national metrics that will provide future benchmarking for waiting times and will be more meaningful to monitor within the Integrated Performance Report, such as the average length of waits and longer waits, including those over 104 weeks.

The position of significant long waits for access to Autism and Attention-Deficit/Hyperactivity Disorder assessments remains an ongoing and significant concern for the organisation. In January 2026 the Trust, along with partners in Tees Esk and Wear Valley NHS Foundation Trust have provided the North East and North Cumbria Integrated Care Board with a formal proposal to move forward with the significant backlog of adults waiting assessment. The Board will be updated on the response to this proposal in February 2026.

What's worth watching?

Whilst Clinical Staff Priority Training metrics have improved over the last 24 months since the introduction of training prioritisation, close monitoring is continuing as compliance rates are close to or on track for 6 of the 11 measures and off target for 5 measures.

The steady improvement in appraisal rates in Quarter 2 has now slowed, caused by cancellations due to clinical capacity and balancing capacity between improving training compliance and appraisals. Further improvement is required to meet the 85% target by the end of the year.

Our patient experience measures are showing a, short-term downward trend in November and December 2025, and will require monitoring into Quarter 4.

Psychiatric Liaison Team Emergency Department Referrals seen within 1 hour has dipped to 78.1%, slightly below the 80% target for the first time in 9 months.

NHS Oversight Framework CNTW Q2 25/26 domain Scoring

Reporting Period: Dec-2025

Segments	Segment Domain (Change vs. Q1)	Measure	Data Period	Actual	Actual (Previous Quarter)	Peer Median/ Mean	NOF Score Domain	NOF Score	Updated in Q2 25/26?
Access to services	4 (-1) ↓	Annual change in the number of children and young people accessing NHS-funded MH services	Sep-25	**1.33% decrease**	3.06% increase	0.04% decrease	3	**3.3**	Yes
Effectiveness and experience	3 (+1) ↑	CQC community mental health survey satisfaction rate	Q2 25/26	**2**	2	-	2	**2**	Yes
		Percentage of inpatients aged 18-65 with over 60 day length of stay	Sep-25	**26.07%**	29.80%	21.77%	2	**2.98**	Yes
Patient safety	2 (==)	NHS Staff survey - raising concerns sub-score	2024	**6.7**	-	6.69	3	**2.9**	No
		Percentage of patients in mental health crisis to receive face-to-face contact within 24 hours	Sep-25	**75.78%**	72.00%	55.54%	1	**1.73**	Yes
People and workforce	4 (==)	Sickness absence rate	Jun-25	**6.65%**	6.53%	5.16%	4	**3.87**	Yes
		NHS staff survey engagement theme sub-score	Dec-24	**6.97**	-	7.09	3	**3.15**	No
Finance and productivity	2 (==)	Planned surplus/deficit	Apr-25	**0.39%**	-	0.00%	1	**1**	No
		Variance year-to-date to financial plan	Sep-25	**0.68**	2.67	0.19	1	**1**	Yes
		Relative difference in costs	Mar-25	**112.32%**	112.00%	100.82%	3	**3.27**	Yes
Overall Segment	**4 of 4**					**Average NOF Score:**		**2.69**	

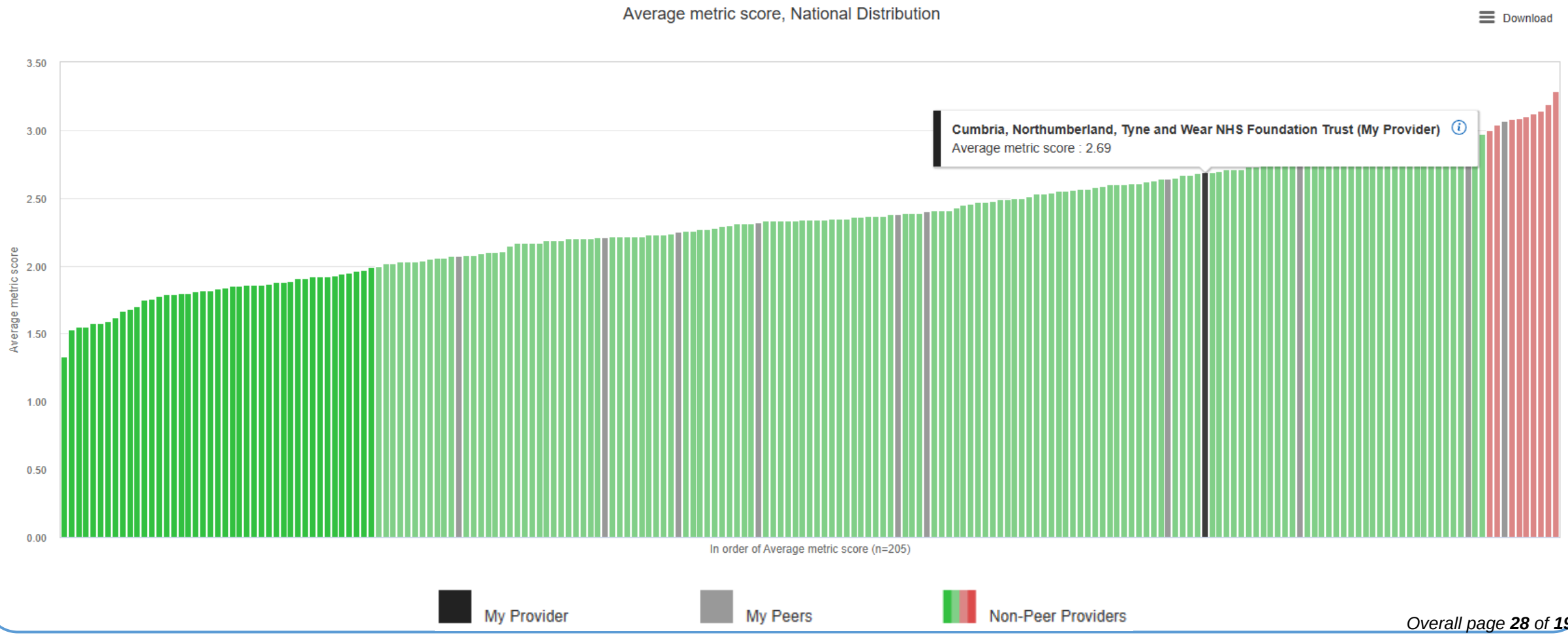
NHS Oversight Framework – Q2 25-26 national distribution

Reporting Period: Dec-2025

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Select chart type: Variation

Select level: Provider | Scope: National | Highlight system providers | Include independent provider data? | Chart View / Table View



Headline SPC performance measure summary

Reporting Period: Dec-2025

Target assurance

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

Core Trust Integrated Outcome Measures - Summary Overview

Reporting Period: Dec-2025

	Ref	Indicator Name	Variation	Assurance	Performance	Target	Target Type	Risk Rating	Summary Narrative	Exec
Commitments	C01	How was your experience? (FFT)	Concern	Achieve at Random	84.0%	90%	CNTW Std	High (Action)	Deteriorated in the month	SG
	C02	How was the care we provided?	Normal Variation	Achieve at Random	86.8%	90%	CNTW Std	Med (Monitoring)	Deteriorated in the month	SG
	C03	Did you feel safe?	Normal Variation	Consistently Achieve	92.4%	90%	CNTW Std	Low (On Track)	Reported consistently above target	SG
People	P01	Sickness in Month	Concern	Consistently Off Target	7.1%	5%	NHSE Std	High (Action)	Deteriorated in the month, remains above target (excludes NTWS)	LS
	P04	Appraisal rate	Improvement	Consistently Off Target	80.6%	85%	CNTW Std	High (Action)	Performance improved in the month (excludes NTWS)	LS
	P05	% Clinical Supervision completed	SPC n/a	SPC n/a	83.6%	80%	CNTW Std	Low (On Track)	Performance remains consistently above the target	LS
Quality Care	Q01	MRE Restraints	Normal Variation	SPC not applicable	0	n/a	n/a	Med (Monitoring)	No reported MRE incidents reported for the 1st time in 24 months	SG
	Q02	Prone Restraints	Normal Variation	SPC not applicable	15	n/a	n/a	Med (Monitoring)	Position deteriorated in the month, remains within control limits	SG
	Q03	Long term segregation and prolonged seclusion	Normal Variation	SPC not applicable	14	n/a	n/a	Med (Monitoring)	Position improved in the month	SG
	Q04	Assaults on Patients	Improvement	SPC not applicable	103	n/a	n/a	Med (Monitoring)	Position improved in the month (126 reported November 2025)	RN
	Q05	Assaults on staff	Normal Variation	SPC not applicable	439	n/a	n/a	Med (Monitoring)	Significant deterioration in the month (357 reported Nov 2025)	RN
	Q06	% of patients with a Safety & Risk Management Plan	Improvement	Consistently Off Target	93.0%	100%	CNTW Std	Med (Monitoring)	Position improved, continual improvement since April 24	RN
	Q07	Reducing incidents of self-harm	Improvement	SPC not applicable	963	n/a	n/a	Med (Monitoring)	Position deteriorated in the month (931 reported November 2025)	RN
	Q08	Rights at Point of Detention	Normal Variation	Consistently Off Target	92.5%	100%	CNTW Std	High (Action)	5.1% deterioration from November 2025	RN
	Q09	Record of Capacity/ CTT at point of detention	Improvement	Consistently Off Target	84.6%	100%	CNTW Std	High (Action)	Remains consistently off target, position deteriorated in the month	RN
Person Led Care	A01	Active Inappropriate Out of Area Placements	Normal Variation	Achieve at Random	2	0	NHSE LTP	Med (Monitoring)	There were two active Out of Area Placements at the end of Dec	RD
	A02	Bed Occupancy including leave (open beds on RiO)	Normal Variation	Consistently Off Target	92.5%	85%	NHSE Std	High (Action)	Improved in the month, remains above target	RD
	A03	% of Adult Inpatients Discharged With LoS > 60 days	Normal Variation	Consistently Off Target	25.6%	20%	CNTW Std	High (Action)	Reported above target	RD
	A04	% OP inpatients discharged with LOS > 90 days	Normal Variation	Achieve at Random	48.7%	40%	CNTW Std	Med (Monitoring)	Reported above target	RD
	A05	Adult & Older Adult Wards - ALoS Rolling 3 months	Concern	Achieve at Random	71.1	59.8	CNTW Std	High (Action)	Off target for the past 14 months	RD
	A06	Clinically Ready for Discharge (formerly DTOC)	Concern	Consistently Off Target	18.2%	7.5%	NHSE Std	High (Action)	Remains off track	RD
	A07	Crisis % Very urgent seen within 4 hours (WAA&OP)	Normal Variation	Achieve at Random	70.7%	65%	CNTW Traj	Med (Monitoring)	53 out of 75, position improved in the month	RD
	A08	Crisis % Urgent seen within 24 hours (WAA&OP)	Normal Variation	Achieve at Random	83.5%	85%	CNTW Std	Med (Monitoring)	375 out of 449, reported 1.5% below target	RD
	A09	% PLT ED Referrals seen within 1 hour	Normal Variation	Achieve at Random	78.1%	80%	CNTW Std	Med (Monitoring)	Reported below target for first time in 9 months	RD
	A10	% PLT Ward Referrals seen within 24 hours	Normal Variation	Consistently Achieve	92.5%	85%	CNTW Std	Low (On Track)	Reported consistently above the internal target	RD
	A11	% Waiting 4 wks or less to treatment (WAAOP)	Normal Variation	Consistently Off Target	20.7%	75%	CNTW Traj	High (Action)	79.3% (2,155 of 2,717) have been waiting longer than 4 weeks	RD
	A12	% Waiting 4 wks or less to receive help (CYPS)	Concern	Consistently Off Target	5.5%	55%	CNTW Traj	High (Action)	94.5% (9,025 of 9,547 have been waiting longer than 4 weeks	RD
	A13	EIP – starting treatment in 14 days	Normal Variation	Consistently Achieve	83.7%	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	-£2.7m	n/a	Low (No Target)	£0.6m deficit YTD, £1.9m ahead of plan as land sale received early	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	Improvement	Achieve at Random	8,316	8,478.1	CNTW Traj	Low (On Track)	The Trust was 162 WTE under established at month 9	CC
	S04	Capital spend compared to plan (£)	SPC not applicable	SPC not applicable	£1.1m	£0.6m	n/a	Low (No Target)	Capital programme behind plan at month 9. Forecasting to deliver	CC
	S05	Cash balance compared to plan (£)	SPC not applicable	SPC not applicable	£17.2m	£26.0m	n/a	Low (No Target)	The Trust cash balance is lower than plan at month 9	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	Normal Variation	Consistently Achieve	91.9%	90%	CNTW Std	8,091	8,803	Low (On Track)
TA02	Corporate Induction	Concern	Consistently Achieve	95.8%	95%	CNTW Std	8,437	8,803	Med (Monitoring)
TA03	Local Induction	Improvement	Achieve at Random	94.9%	95%	CNTW Std	8,353	8,802	Low (On Track)
TA04	Safeguarding Adults Level 1	Improvement	Consistently Achieve	95.9%	85%	CNTW Std	1,494	1,558	Low (On Track)
TA05	Safeguarding Children Level 1	Normal Variation	Consistently Achieve	95.1%	85%	CNTW Std	1,481	1,558	Low (On Track)
TA06	Fire	Normal Variation	Consistently Achieve	89.8%	85%	CNTW Std	7,901	8,803	Low (On Track)
TA07	Equality & Diversity Introduction	Improvement	Consistently Achieve	95.8%	85%	CNTW Std	8,432	8,803	Low (On Track)
TA08	Health & Safety	Improvement	Consistently Achieve	95.6%	85%	CNTW Std	8,415	8,803	Low (On Track)
TA09	Infection Prevention & Control (IPC)	Concern	Consistently Achieve	93.0%	85%	CNTW Std	8,183	8,803	Med (Monitoring)
TA10	Moving & Handling Awareness Training	Improvement	Consistently Achieve	94.5%	85%	CNTW Std	8,316	8,803	Low (On Track)
TA11	Web Risk Register	Improvement	Consistently Off Target	90.6%	85%	CNTW Std	716	790	Med (Monitoring)
TA12	Oliver McGowan Mandatory Training	SPC not applicable	SPC not applicable	75.6%	n/a	n/a	1,321	1,748	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	Normal Variation	Achieve at Random	83.7%	85%	CNTW Std	3,446	4,119	Med (Monitoring)
TC02	Biopsychosocial at Risk Assess. & Safety Planning	Improvement	Consistently Achieve	92.4%	85%	CNTW Std	3,806	4,119	Low (On Track)
TC03	Resuscitation L2 Adult Basic Life Support	Improvement	Consistently Off Target	82.9%	85%	CNTW Std	1,561	1,883	Med (Monitoring)
TC04	Resuscitation L3 Adult Immediate Life Support	Normal Variation	Consistently Off Target	76.2%	85%	CNTW Std	2,594	3,406	High (Action)
TC05	Resuscitation L3 Paediatric Immed Life Support	Improvement	Consistently Off Target	77.5%	85%	CNTW Std	31	40	High (Action)
TC06	Resuscitation L2 Paediatric Basic Life Support	Improvement	Consistently Off Target	81.2%	85%	CNTW Std	501	617	Med (Monitoring)
TC07	PMVA Basic	Improvement	Consistently Off Target	84.1%	85%	CNTW Std	2,041	2,428	Med (Monitoring)
TC09	Engagement & Observation	Improvement	Achieve at Random	88.7%	85%	CNTW Std	2,907	3,276	Low (On Track)
TC10	Dysphagia Awareness	Improvement	Achieve at Random	91.4%	85%	CNTW Std	2,215	2,424	Low (On Track)
TC11	Autism Core Capabilities: Tier 1 & 2	SPC not applicable	SPC not applicable	69.2%	80%	CNTW Traj	4,476	6,470	High (Action)
TC12	Learning Disability Tier 1	SPC not applicable	SPC not applicable	60.9%	70%	CNTW Traj	3,938	6,470	High (Action)

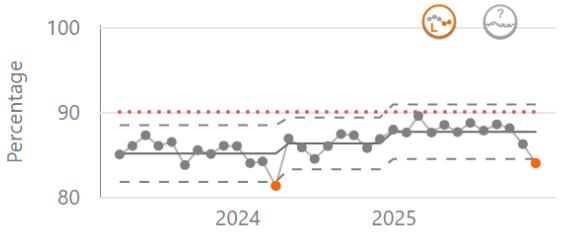
Commitments to our Carers and Patients

Reporting Period: Dec-2025

How was your experience? (FFT)

High (Action)

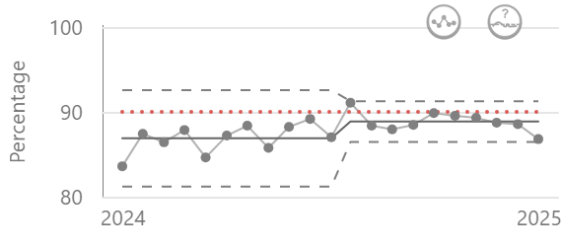
Ref: C01 December: 84.0% CNTW Std: 90%



How was the care we provided?

Med (Monitoring)

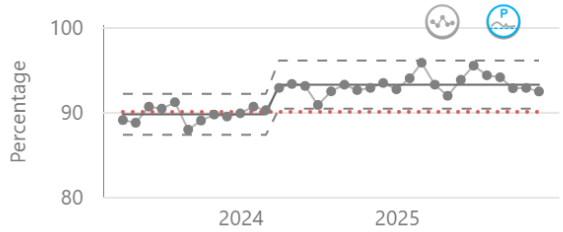
Ref: C02 December: 86.8% CNTW Std: 90%



Did you feel safe?

Low (On Track)

Ref: C03 December: 92.4% CNTW Std: 90%



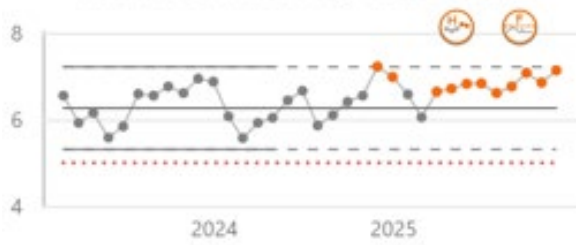
Great Place to Work

Reporting Period: Dec-2025

Sickness in Month

High (Action)

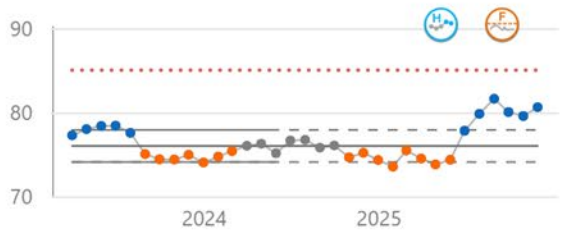
Ref: P01 December: 7.1% NHSE Std: 5%



Appraisal rate

High (Action)

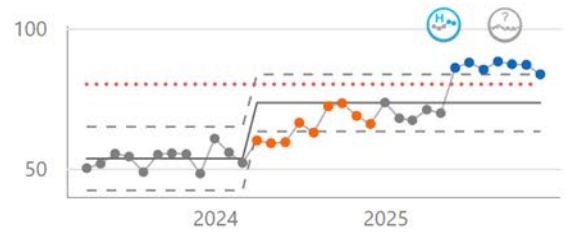
Ref: P04 December: 80.6% CNTW Std: 85%



% Clinical Supervision completed

Low (On Track)

Ref: P05 December: 83.6% CNTW Std: 80%



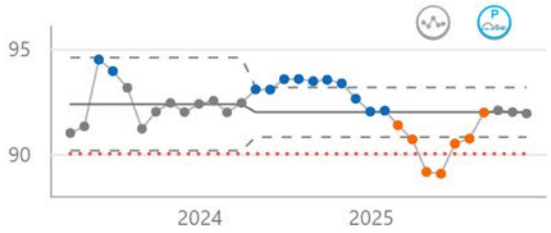
Great Place to Work – All Staff Priority Training Compliance %

Reporting Period: Dec-2025

Information Governance

Low (On Track)

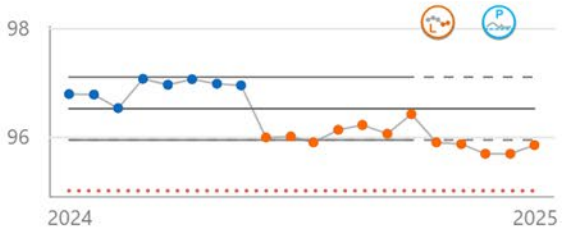
Ref: TA01 December: 91.9% CNTW Std: 90%



Corporate Induction

Med (Monitoring)

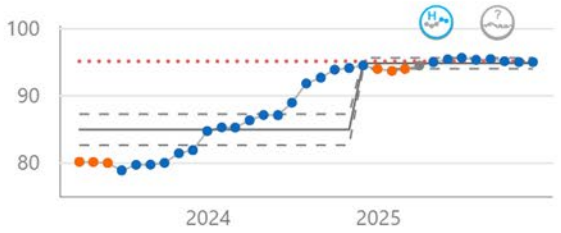
Ref: TA02 December: 95.8% CNTW Std: 95%



Local Induction

Low (On Track)

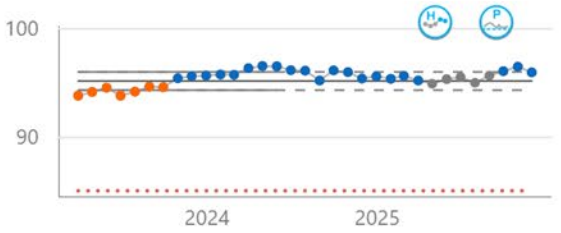
Ref: TA03 December: 94.9% CNTW Std: 95%



Safeguarding Adults Level 1

Low (On Track)

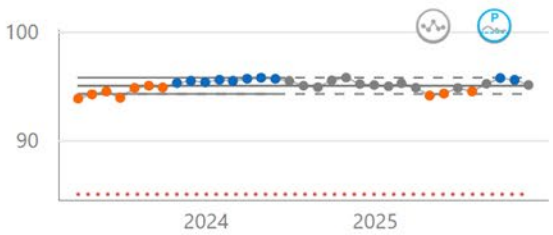
Ref: TA04 December: 95.9% CNTW Std: 85%



Safeguarding Children Level 1

Low (On Track)

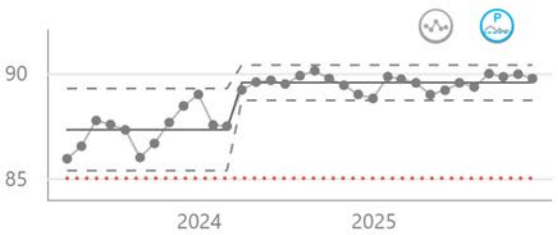
Ref: TA05 December: 95.1% CNTW Std: 85%



Fire

Low (On Track)

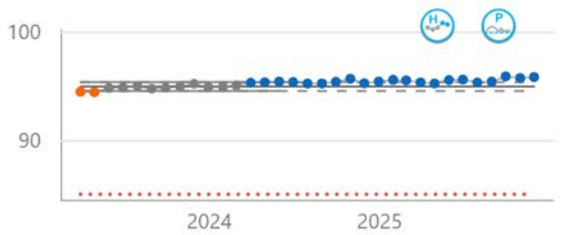
Ref: TA06 December: 89.8% CNTW Std: 85%



Equality & Diversity Introduction

Low (On Track)

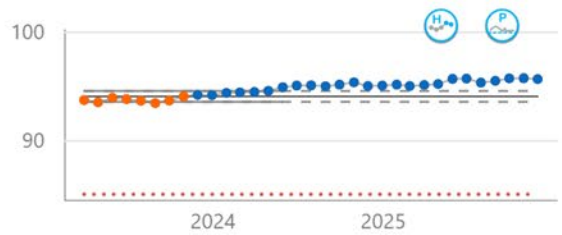
Ref: TA07 December: 95.8% CNTW Std: 85%



Health & Safety

Low (On Track)

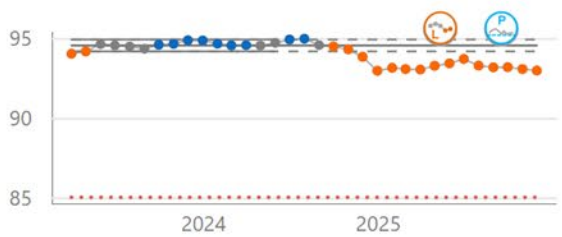
Ref: TA08 December: 95.6% CNTW Std: 85%



Infection Prevention & Control (IPC)

Med (Monitoring)

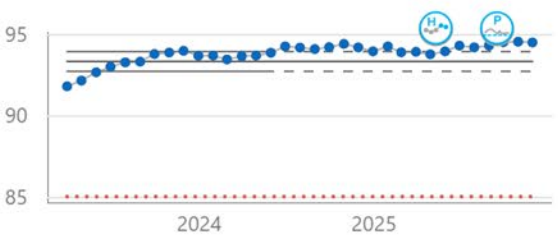
Ref: TA09 December: 93.0% CNTW Std: 85%



Moving & Handling Awareness Training

Low (On Track)

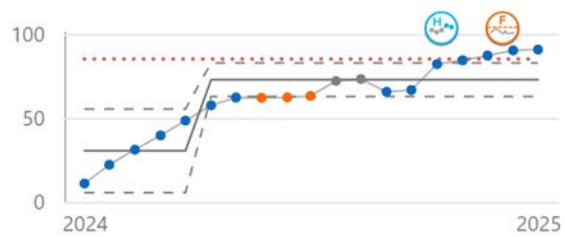
Ref: TA10 December: 94.5% CNTW Std: 85%



Web Risk Register

Med (Monitoring)

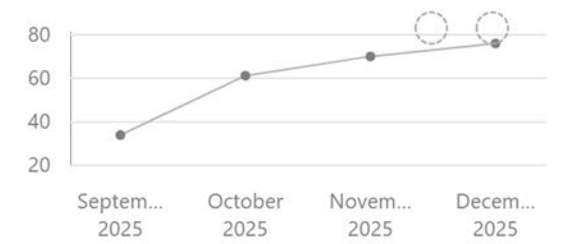
Ref: TA11 December: 90.6% CNTW Std: 85%



Oliver McGowan Mandatory Training

Low (No Target)

Ref: TA12 December: 75.6% Plan: n/a



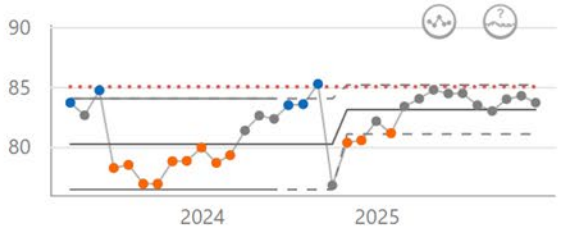
Great Place to Work – Clinical Staff Priority Training Compliance %

Reporting Period: Dec-2025

Clinical Risk and Suicide Prevention

Med (Monitoring)

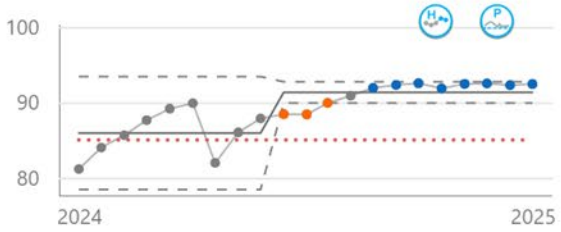
Ref: TC01 December: 83.7% CNTW Std: 85%



Biopsychosocial at Risk Assess. & Safety Planning

Low (On Track)

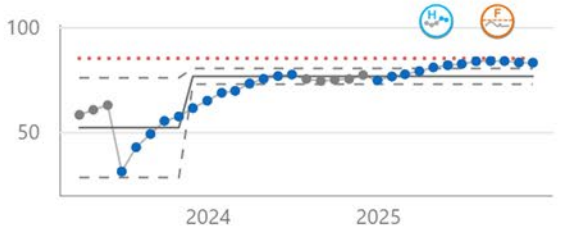
Ref: TC02 December: 92.4% CNTW Std: 85%



Resuscitation L2 Adult Basic Life Support

Med (Monitoring)

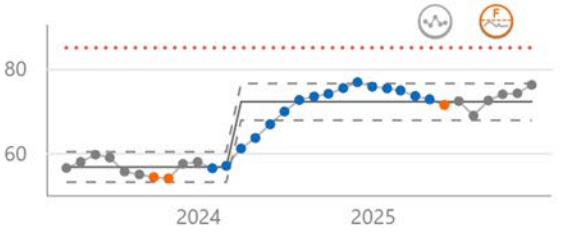
Ref: TC03 December: 82.9% CNTW Std: 85%



Resuscitation L3 Adult Immediate Life Support

High (Action)

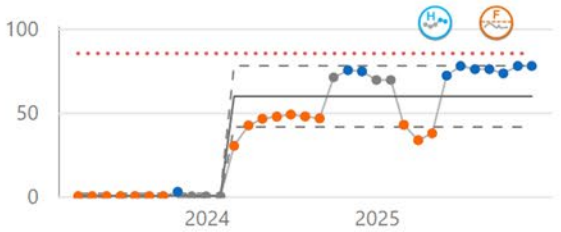
Ref: TC04 December: 76.2% CNTW Std: 85%



Resuscitation L3 Paediatric Immed Life Support

High (Action)

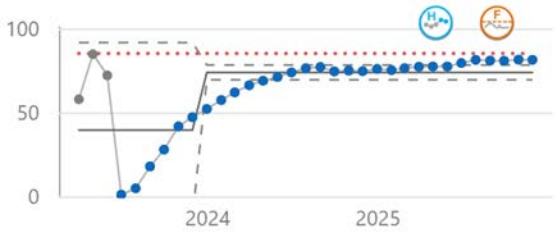
Ref: TC05 December: 77.5% CNTW Std: 85%



Resuscitation L2 Paediatric Basic Life Support

Med (Monitoring)

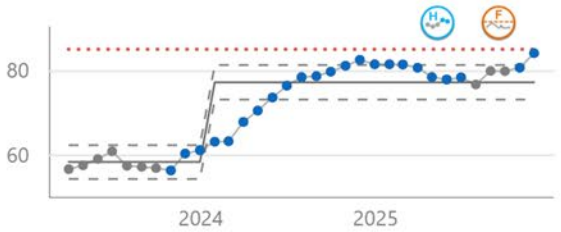
Ref: TC06 December: 81.2% CNTW Std: 85%



PMVA Basic

Med (Monitoring)

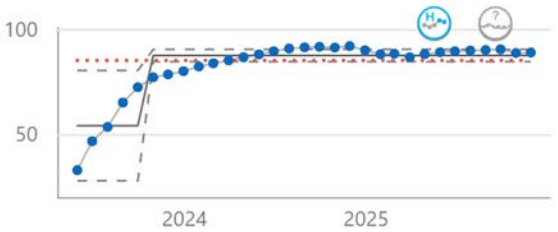
Ref: TC07 December: 84.1% CNTW Std: 85%



Engagement & Observation

Low (On Track)

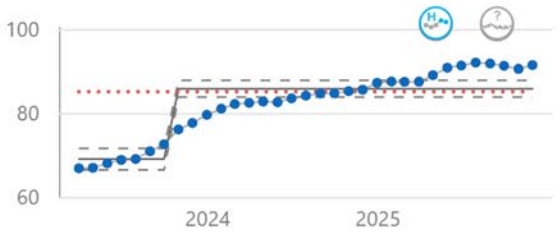
Ref: TC09 December: 88.7% CNTW Std: 85%



Dysphagia Awareness

Low (On Track)

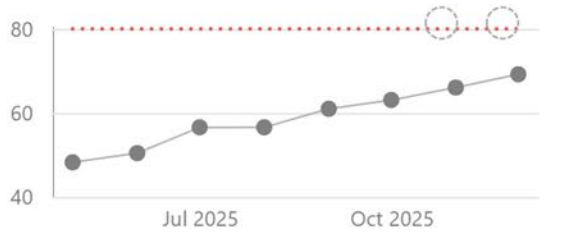
Ref: TC10 December: 91.4% CNTW Std: 85%



Autism Core Capabilities: Tier 1 & 2

High (Action)

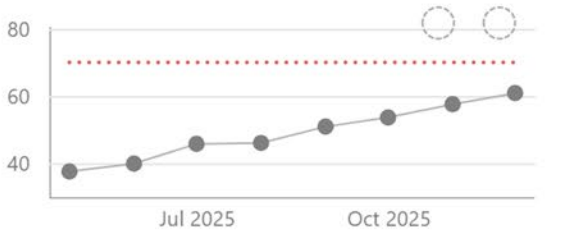
Ref: TC11 December: 69.2% CNTW Traj: 80%



Learning Disability Tier 1

High (Action)

Ref: TC12 December: 60.9% CNTW Traj: 70%



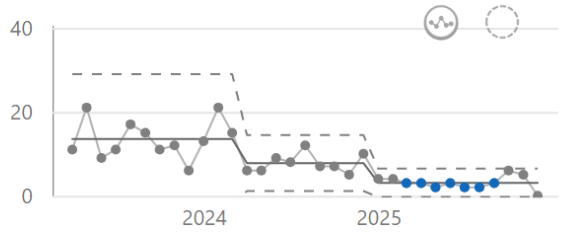
Quality Care, Every Day

Reporting Period: Dec-2025

MRE Restraints

Med (Monitoring)

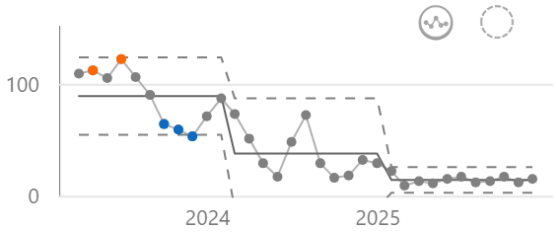
Ref: Q01 December: 0 Plan: n/a



Prone Restraints

Med (Monitoring)

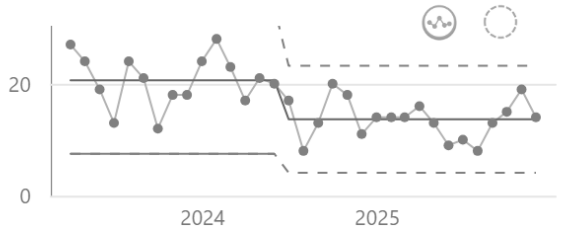
Ref: Q02 December: 15 Plan: n/a



Long term segregation and prolonged seclusion

Med (Monitoring)

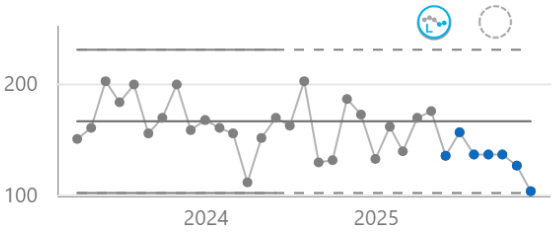
Ref: Q03 December: 14 Plan: n/a



Assaults on Patients

Med (Monitoring)

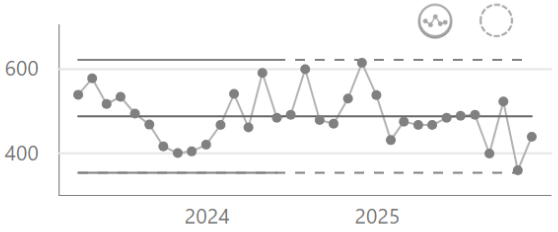
Ref: Q04 December: 103 Plan: n/a



Assaults on staff

Med (Monitoring)

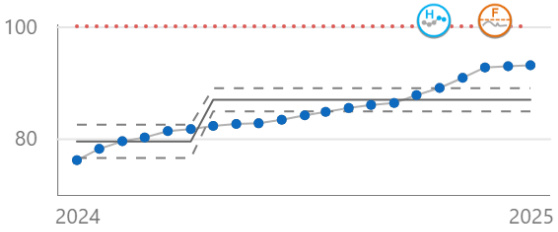
Ref: Q05 December: 437 Plan: n/a



% of patients with a Safety & Risk Management Plan

Med (Monitoring)

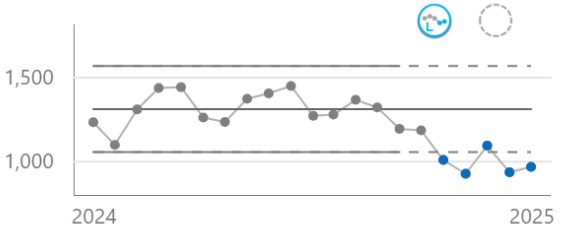
Ref: Q06 December: 93.0% CNTW Std: 100%



Reducing incidents of self-harm

Med (Monitoring)

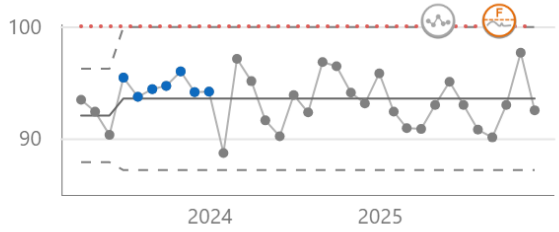
Ref: Q07 December: 963 Plan: n/a



Rights at Point of Detention

High (Action)

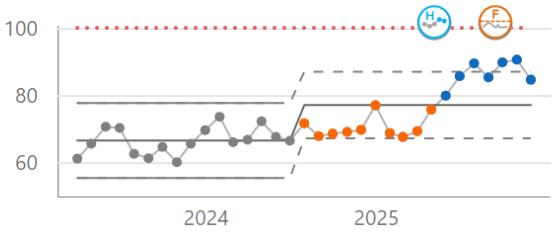
Ref: Q08 December: 92.5% CNTW Std: 100%



Record of Capacity/ CTT at point of detention

High (Action)

Ref: Q09 December: 84.6% CNTW Std: 100%



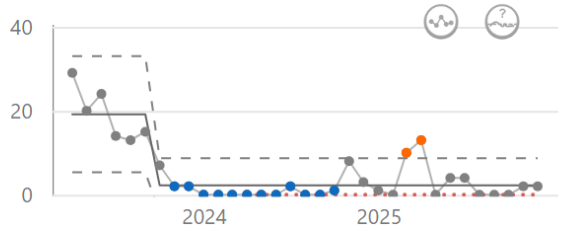
Person-led Care, when and where needed

Reporting Period: Dec-2025

Active Inappropriate Out of Area Placements

Med (Monitoring)

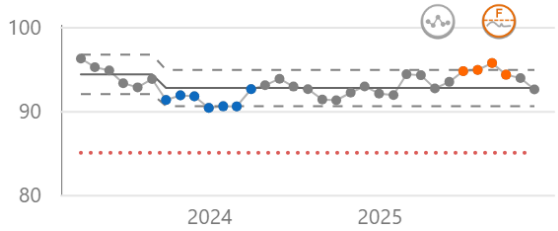
Ref: A01 December: 2 NHSE LTP: 0



Bed Occupancy including leave (open beds on RiO)

High (Action)

Ref: A02 December: 92.5% NHSE Std: 85%



% of Adult Inpatients Discharged With LoS > 60 days

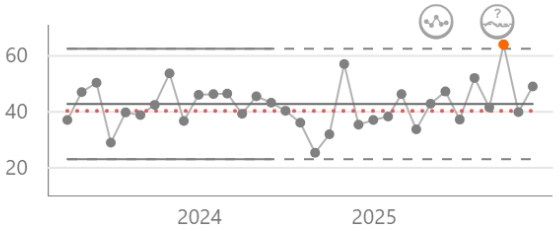
High (Action)

Ref: A03 December: 25.6% CNTW Std: 20%

% OP inpatients discharged with LOS > 90 days

Med (Monitoring)

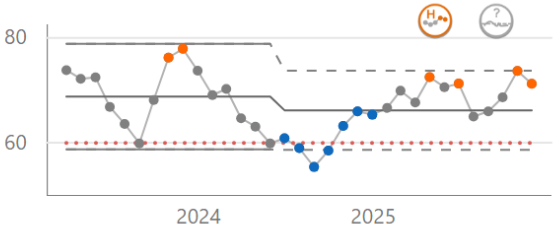
Ref: A04 December: 48.7% CNTW Std: 40%



Adult & Older Adult Wards - ALoS Rolling 3 months

High (Action)

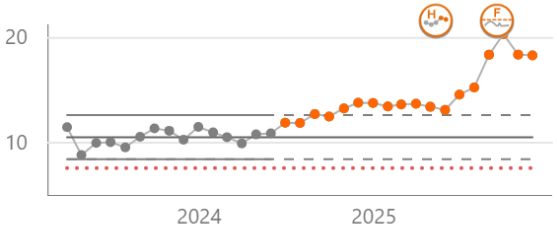
Ref: A05 December: 71.1 CNTW Std: 59.8



Clinically Ready for Discharge (formerly DTOC)

High (Action)

Ref: A06 December: 18.2% NHSE Std: 7.5%



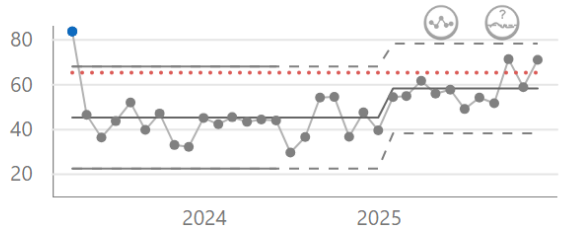
Person-led Care, when and where needed

Reporting Period: Dec-2025

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

Med (Monitoring)

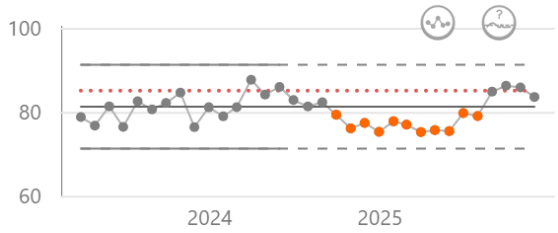
Ref: A07 December: 70.7% CNTW Traj: 65%



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

Med (Monitoring)

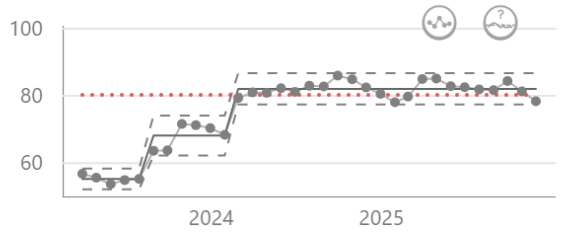
Ref: A08 December: 83.5% CNTW Std: 85%



% PLT ED Referrals seen within 1 hour

Med (Monitoring)

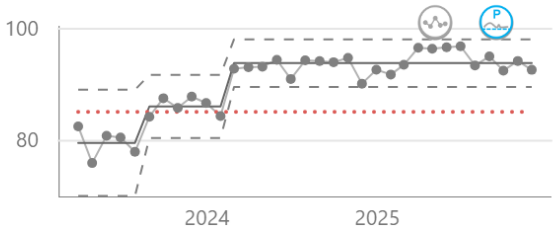
Ref: A09 December: 78.1% CNTW Std: 80%



% PLT Ward Referrals seen within 24 hours

Low (On Track)

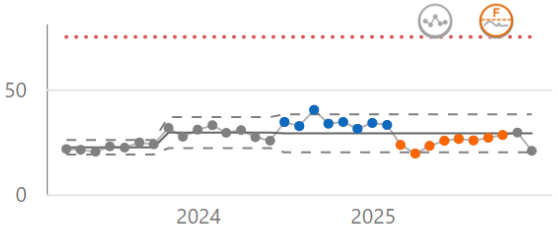
Ref: A10 December: 92.5% CNTW Std: 85%



% Waiting 4 wks or less to treatment (WAAOP)

High (Action)

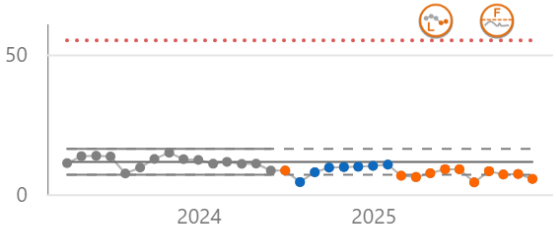
Ref: A11 December: 20.7% CNTW Traj: 75%



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

High (Action)

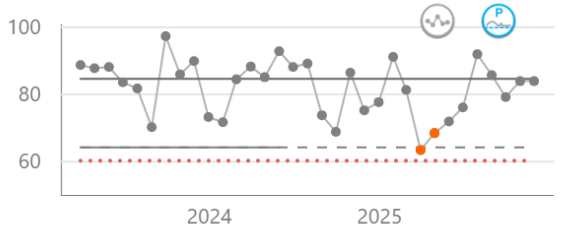
Ref: A12 December: 5.5% CNTW Traj: 55%



EIP – starting treatment in 14 days

Low (On Track)

Ref: A13 December: 83.7% CNTW Std: 60%



Sustainable for the Long Term

Reporting Period: Dec-2025

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

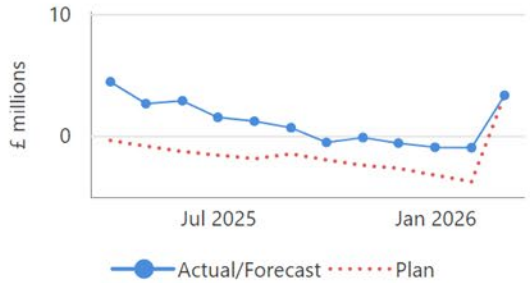
Low (No Target)

Ref: S01 December: -£0.6m Plan: -£2.7m

Income & Expenditure Forecast

Low (No Target)

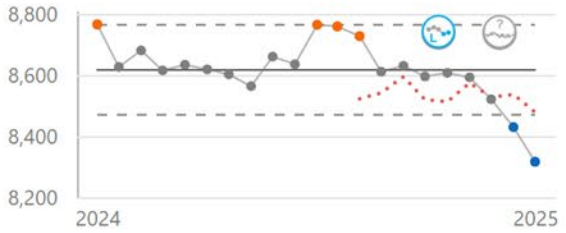
Ref: S02 March: £3.3m Plan: £3.3m



All staff WTEs

Low (On Track)

Ref: S03 December: 8,316 CNTW Traj: 8,478.1



Capital spend compared to plan (£)

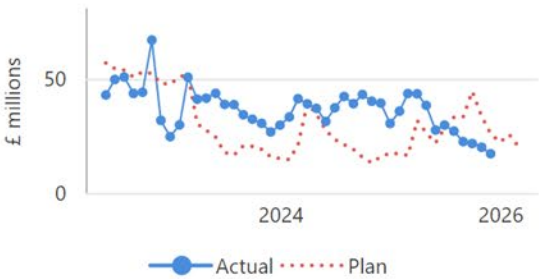
Low (No Target)

Ref: S04 December: £1.1m Plan: £0.6m

Cash balance compared to plan (£)

Low (No Target)

Ref: S05 December: £17.2m Plan: £26.0m



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

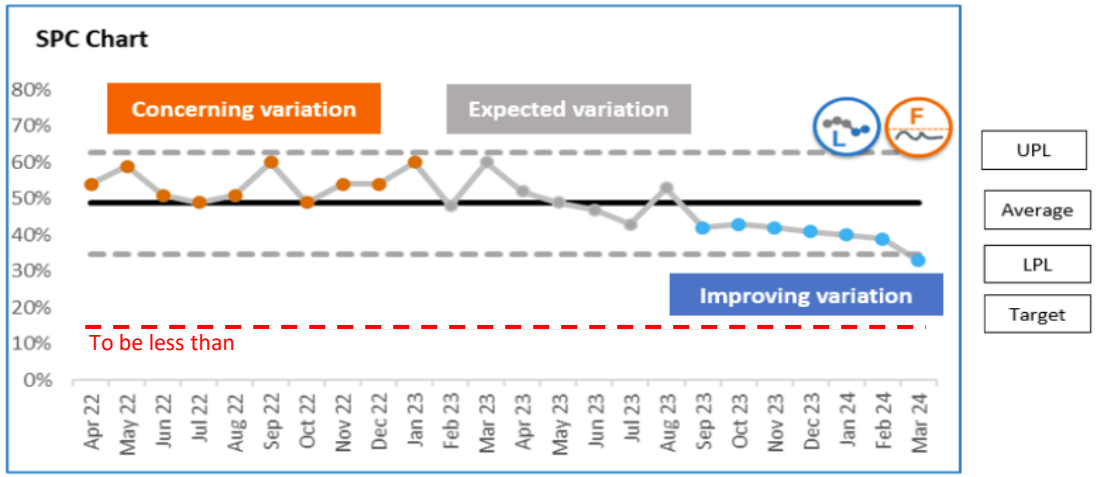
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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 Q&P Assurance report to Board - Jan 26.pdf

Report to the Board of Directors
Wednesday 28 January 2026

Quality and Performance Committee Quarterly Assurance Report
November 2025 – January 2026

1. Purpose

This report provides an assurance summary to the Board of Directors relating to the business of the Quality and Performance Committee at its meeting held on 3 December 2025. This report assumes full assurance to the Committee where this is noted and focuses primarily on gaps in assurance, where the committee may require continued or increased focus, or if any issues require Board awareness or escalation.

The agenda for Quality and Performance Committee is structured around the Trust's agreed quality aims and priorities for 2025/26 and the four principles of the Patient Safety Incident Response Framework.

2. Quality and Performance Committee overview

The Committee receives assurance on the implementation and delivery of key performance, quality and safety strategies, programmes of work and systems. It also has oversight of patient and carer experience. 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 has been one meeting of the Committee during the period November 2025 – January 2026 held on 3 December 2025.

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

4.1 Integrated Performance Report (IPR)

The Integrated Performance Report provides a summary of all performance metrics for the period. This is supported with bespoke reports and discussions at the committee on key areas of focus and is continually reviewed on an ongoing basis with areas of concern or deterioration in performance informing the ongoing committee agenda planning.

There continues to be concern around patients clinically ready for discharge, but the Board and committee are fully sighted on this issue as a key area of focus. Crisis performance also continues to be a key area of concern.

The committee noted a deterioration in performance associated with assaults on staff. This relates to a small number of patients and there are no significant concerns around the level of harm. It was agreed that this will be scheduled as an item of quality focus at a future meeting.

The committee recognised that there has been a lot of improvement in many performance areas given the challenging context within which the Trust and the wider NHS are operating.

4.2 Qualiy Focus – Self-harm and suicide

As well as assurance, the update provided a deeper understanding of specific areas relating to governance processes, quality priorities related to this as a Trust quality aim for 2025/26, data and metrics, learning from ligature incidents and measuring the impact of interventions to reduce self-harm and suicide.

NICHE consultancy has been commissioned by NHS England to undertake an assurance review of the risk assessment practice in place. This report is expected to be presented to the February Committee.

4.3 Nasogastric (NG) feeding and restraint

A detailed update was provided which again provided a deeper understanding of the issues and the committee acknowledged the reduction in cases attributed to both natural fluctuations in low patient volume and positive contributions from community engagement, early intervention and the application of new eating disorder toolkit. Comparative datasets from across Humber, and North Yorkshire were shared. A significant level of assurance was received from the update provided.

4.4 Length of stay

A detailed overview of both national and internal factors affecting length of stay was provided, referencing the NHS oversight framework and specifically addressing patients who remain in hospital for over 60 days.

An update was provided on the recovery actions, including the implementation of the "10 High Impact Actions" (previously known as the 100 Day Challenge), provision of monthly updates, introduction of a 40-day review process, deployment of dedicated community consultant resources, temporary closure of Rose Lodge, ongoing review of admission and discharge policies, and the development of an in-reach and treatment team for learning disabilities.

Despite the significant progress made and actions in place to reduce length of stay, the committee noted the ongoing concerns that continued increases patients may make it impossible to meet set standards. The relationship between clinical readiness for discharge and local authority capacity continues to be a factor within these challenges. Discussions are taking place with directors of adult

social care to address community capacity issues that contribute to prolonged hospital stays. Challenges were also noted associated with provider collaborative commissioning arrangements, with current funding models prioritising location rather than individual patient needs. This is particularly concerning in terms of the implications both financially and from a patient experience perspective.

Length of stay will continue to be a priority area of focus for the committee and future updates will include further detail on the outcome and actions from meetings with partner organisations.

4.5 Learning from incidents

The new report consolidates data from the quarterly Quality and Safety Report, independent reviews, and safeguarding case reviews, and information from themes from the Patient Safety Incident Response Framework (PSIRF). The report provides oversight of incident learning, identification of recurring themes, and detail on actions taken in response. It was recognised that future reports would require further iteration in terms of outcomes and impact of actions taken.

4.6 Care Quality Commission action plan and report

The committee received a detailed up on compliance with regulatory activity and progress to address the regulatory breaches issued by the CQC during recent inspections. Future reports will include clear action completion dates and identification of responsible officers for outstanding actions. It was noted that most actions are scheduled for completion by the end of December, with the remaining actions scheduled for completion by end of March 2026, subject to planned service moves.

The committee were asked to approve the closure of five long-standing actions inherited from Cumbria Partnership NHS Foundation Trust following the transfer of services in October 2019. Following receipt of satisfactory levels of assurance and evidence, the committee approved closure of the actions.

A Rapid Quality Review meeting with the North East and North Cumbria Integrated Care Board (NENC ICB) would be taking place in January focusing on children and young people's services. An update will be provided to the committee as part of the regular CQC reporting process.

The draft well led inspection report is yet to be received following inspection in September/October 2025.

4.7 Quality and safety report (Integrated Quality Report)

The new Integrated Quality report is still under development in terms of the inclusion of some metrics. The report utilises Statistical Process Control (SPC) charts and the report detailed how it will evolve over time. It was agreed that the report will include in-depth reviews of progress against the Trust quality aims and priorities including impact and outcomes, particularly for measures which relate to process rather than core metrics i.e., effectiveness and experience measures.

It is expected that the report will enable the committee to enable the triangulation of information, including insights concerning organisational culture.

The Committee welcomed the report and its ongoing development as valuable but the need to ensure a balance between detail and ability to focus on key issues would be important.

4.8 Community services waiting times report

There has been steady progress in reducing the number of patients waiting in adult and older adult pathways, though challenges remain in meeting four-week wait targets. Work on the CYPS pathway continues to be developed.

The commissioning policy for the adult neurodevelopmental pathway is forthcoming following the joint work with the NENC ICB and consideration needs to be given to the impact of the new policy on, existing waiting lists and the pace of change given ongoing high referral rates.

An update will be provided to a future meeting on the outcomes and recommendations from a recent peer review relating to gender services.

4.9 Learning from deaths report

The North East continues to experience the highest rate of drug and alcohol-related deaths in England, particularly among males. Forty percent of unnatural deaths were attributed to drugs or alcohol, while self-harm or suicide accounted for one in four such deaths. The committee received a high level of assurance in terms of the North East Quality Observatory's review. Having said that, further analysis of deaths related to addiction and those occurring among older adults will be undertaken.

The committee noted that, notwithstanding the level of regional statistics, patients who have received care and treatment from CNTW services have a lower likelihood of death by suicide. The team will undertake a review of this in terms of positive learning.

In terms of demographics, the limited representation of non-white groups in the local population poses challenges for comparative analysis and there continues to be ongoing efforts to examine ethnic pathways through healthcare services.

An update on progress against the five-point improvement plan for drug and alcohol care pathways, previously discussed at the Board of Directors in 2025, was also provided.

The report will also be presented for discussion at the January Board of Directors meeting.

4.10 Service user and carer experience report

The report, based on the 'Your Voice' survey responses from patients and carers was discussed with a slight decrease in completed surveys, but responses provided assurance of continuing positive experience results in general, particularly in relation to involvement in care and feeling safe.

A new methodology for reporting patient and carer experience is under development to bring together experience from surveys, activity, Board and Governor walkrounds, as well as seeking to improve the voice of the patient and carer at Board level. This will enable improved triangulation of feedback to look at themes, outcomes and impact. The new approach to reporting is expected to be received by the committee in Q4 2025/26.

4.11 Non – Executive Director and Governor Programme of Leadership Walk arounds

The committee received the bi-annual report which provided a strong level assurance in terms of the themes identified on walk arounds being sighted within the Trust's governance framework and risk management processes. The schedule for visits for 2026/27 has been developed to align to the Trust's strategic ambitions but it was suggested that this could be further developed to align to the Trust's quality aims and priorities and other areas of intelligence including CQC actions and work around safety and culture. For example, Non-Executive Director members of the committee are developing a schedule of visits with a specific focus on safer staffing and hot spots.

5. Other issues and assurance received by the Committee

5.1 Infection prevention and control quarterly assurance report

Full assurance was provided in terms of audit activity and activity to manage vaccination programme and outbreaks within the Trust.

5.2 Patient safety Incident Investigation reports

In line with the national Patient Safety Incident Response Framework (PSIRF), the Committee receives and reviews all Patient Safety Incident Investigations (PSIIs). Three reports were received. 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. This includes further development of how PSIIs are presented.

5.3 Internal Audit reports

Due to time constraints it was agreed to discuss the progress against the recommendations of the report at the February meeting. The report has also been discussed at the Audit Committee. Immediate actions have been taken to address areas within the Trust's control.

5.6 Committee governance

In line with the five objectives agreed by the Chair and Chief Executive for the second half of the year, the outcomes from the ConsultOne independent review of governance and recent high-level feedback following the CQC inspection, work is taking place to review the governance arrangements for all Board Committees. Meetings with the Director of Communications and Corporate Affairs, Committee Chairs and Executive Leads have been arranged to take place in January to undertake a review of cycles of business and reporting requirements to ensure committees have a strong process in place underpinned by the provision of robust assurance and enabling key areas of focus to be identified.

6. 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 agreement by the committee to close of overdue outstanding legacy actions inherited from CPFT due to sufficient assurance in place.
- Note the continuing focus on addressing the actions to close the regulatory breaches issued to the Trust by the CQC and 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 committee governance and reporting including ensuring the link between finance, workforce, Model of Care and Support and quality and safety.

Louise Nelson
Chair of Quality and Performance Committee
January 2026

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 - Jan 26 - FINAL.pdf

Report to the Board of Directors
Wednesday 28 January 2026

Mental Health Legislation Committee Quarterly Assurance Report
November 2025 – January 2026

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 3 December 2025.

3. Board Assurance Framework (BAF) risks within Committee remit

At the April 2025 meeting of the committee, a discussion took place regarding the need for a BAF 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 agreeing not to hold a BAF-level risk but to undertake regular reviews of this on an ongoing basis.

Following a strategy session held in October attended by the Chair of the Mental Health Legislation Committee, the Executive Lead and members of the Mental Health Legislation Team, an update was provided on progress on the plans for the implementation of the Bill, 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 for consideration.

The draft proposed BAF risk was presented to the December meeting of the committee and is included in the January BAF/risk report to Board following review at the Audit Committee in January. The Executive Lead for MHLC has agreed to review the risk descriptor for submission to the February meeting of the Committee. In the meantime, the committee agreed that the controls, assurances and actions were reflective of the current risk and Audit Committee are asked to note and agree it's inclusion on the BAF.

It was also acknowledged that the Board has recently held a development session on 26 November to review the Trust risk appetite. However, the committee felt it was important to continue to monitor risks, including BAF-level risks during the period of amending the Trusts appetite scheduled for completion and full implementation by April 2026.

4. Mental Health Legislation Committee focus

4.1 Mental Health Legislation activity and monitoring – improving committee performance reporting

There has been improvement since the previous meeting in the use of prototype data and insights in activity reporting. The committee was reassured that the data/insights approach can also be used by other committees and groups for triangulation purposes using Power Business Intelligence and to avoid duplication of effort. The new style report will be used to inform future areas of focus for the committee to enable more meaningful, action focused discussion, agenda planning and timing allocations for detailed discussions where needed.

The prototype report focusses on core metrics using statistical process control methodology and aims to provide trend analysis and breakdowns by clinical business units, with the goal of aligning with Board level reporting. Additional data including workforce training and key activity insights will enable the committee to identify areas needing assurance or further focus. The importance of including risk and mitigation commentary will also help in that regard. A further iteration of the report is planned for March.

4.2 Giving of rights for patients (GoR) on Community Treatment Orders (CTO)

CTO giving of rights compliance and revisiting of rights has improved. As of 2 December 2025, overall compliance was reported as 66.7% (compared to 60% compliance in December 2024. As of December 2025, overall compliance with revisiting of rights was reported as 88.8% (compared to 78.5% in December 2024). The target is 100% and further work is required to achieve and maintain this standard.

An in-depth discussion on this item was deferred to the March meeting which will include a focus on data and insights, outcome and impact. Similar in-depth discussions are planned in relation to Second Opinion Appointed Doctor requests, and Part A and Part B Compliance, both of which are key areas of focus for the committee.

In line with Mental Health Act (MHA) Code of Practice when a patient is first detained the Responsible Clinician should meet with the patient, to carry out an assessment of capacity and a discussion in relation to treatment for their mental disorder. This would be recorded on Record of Capacity **Part A form**. This form should be completed by the RC within 7 days of the patient's detention.

Prior to the expiry of 3 months from the date of detention, the Responsible Clinician must have authorisation via a certificate issued by a Second Opinion Appointed Doctor, or the patients consent if they have capacity, to continue treatment. To determine if the patient has capacity to consent or lacks capacity or refuses treatment, the Responsible Clinician must meet with the patient to carry out assessment of capacity and discuss treatment for their mental disorder. This would be recorded on Record of Capacity **Part B form**. The Part B form should be completed prior to the 3-month expiry date. The committee will review the assurance in terms of compliance in this regard.

4.3 CQC Mental Health Reviewer Visits Report

CQC Mental Health Act reviewer visits are qualitative, focussing on patient and staff experience rather than quantitative data.

Only one CQC Mental Health Reviewed Visit was held at Mitford during the quarter. This is due to the increase in CQC inspection activity within the Trust during that time. The service continued to experience challenges with staffing, and the content of care records was to a good standard.

Mental Health Reviewer visit outcomes, themes and actions are monitored at the Quality and Performance Committee from an assurance perspective, including assurance around target dates and ownership. These are triangulated at the Quality and Performance Committee with findings from other CQC inspection activity to identify common themes and ensure actions address both compliance and regulatory requirements.

4.4 Workforce and training reporting

There has been a slight reduction in compliance at 83% as of 1 December 2025, against the 85% standard for Mental Health Act, Mental Capacity Act, and Deprivation of Liberty training. Targeted work in areas with low compliance is taking place and is monitored through the Trust wide strategic workforce group and Trust wide performance group. The training is mandatory for all registered clinicians with critical compliance required for Approved Clinicians and Responsible Clinicians and reassurance was given that robust systems in place to ensure regulatory requirements are met.

The committee agreed that levels of assurance provided to the committee will improve over the coming months as part of the development of the new data and insight reporting in 2026 which will incorporate workforce training and ensure clear presentation of targets, current performance, risks and actions.

5. Other issues and assurance received by the Committee

5.1 Committee governance

In line with the five objectives agreed by the Chair and Chief Executive for the second half of the year, the outcomes from the ConsultOne independent review of governance and recent high-level feedback following the CQC inspection, work is taking place to review the governance arrangements for Board Committees. Meetings with the Director of Communications and Corporate Affairs, Committee Chairs and Executive Leads have been arranged to take place in January to undertake a review of cycles of business and reporting requirements to ensure committees have a strong process in place underpinned by the provision of robust assurance and enabling key areas of focus to be identified.

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
- **Note** the proposal of the new BAF risk associated with the committee relating to the implementation of the new Mental Health Legislation Bill. Forma approval from the Board is requested as part of the BAF/Risk Report.

Emma Moir
Chair of Mental Health Legislation Committee
January 2026

2.3 CQC ACTION PLAN UPDATE AND FINAL ASSESSMENT REPORTS

Sarah Glacken, Executive Director of Nursing and Therapies

- Children and Adolescent Mental Health Services (CAMHS)

REFERENCES

Only PDFs are attached

2.3 CAMHS inspection findings and Core Service Improvement Plan Update V6.0_.pdf

Meeting	Trust Board of Directors		**Agenda item: 2.3**
Date of meeting	Wednesday 28 January 2026		
Report title	To receive the Child and Adolescent Mental Health Ward Assessment Report and 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 CQC conducted 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. At the time of writing this report the draft assessment report has not been received. On 16 January the CQC published the results from their assessment of child and adolescent mental health wards that took place in August. During December 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). The Trust has received 5 breaches of regulation following this assessment as follows: • Staff did not always assess risks to people's health and safety or mitigate them where identified. Environmental safety was not always managed effectively or consistently. For example, comprehensive ligature risk assessments had not been carried out. • The use of prone (face down) restraint and mechanical restraint was high and mechanical restraint was not carried out in line with national guidance. • Staff had not received all the relevant training to enable them to support the young people they were caring for appropriately. For example, autism training compliance was low. • Young people were not always involved in their care and treatment; particularly on Lotus ward where young people were excluded from multi-disciplinary meetings, which were meetings about their care and treatment. • Governance systems and audits were not always effective in identifying or addressing areas for improvement. On 9 December a three-day assessment of crisis teams and health-based places of safety across all localities commenced. This assessment follows the publication of the Section 48 review into Nottinghamshire Healthcare NHS Trust where CQC made a commitment to review the standard of care in community mental health services and crisis teams across the country. This set of assessments will form part of this programme. The Trust received initial high level		

	inspection feedback by way of a letter on 15 December and awaits receipt of the formal report findings. The Trust continues to progress with actions received from this assessment and previous assessments through a Core Service Improvement Plan. **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 2: Environmental risk / concerns Regulation: 12 Safety care and treatment			
Three buildings were not accessible to people with mobility needs and this was not risk assessed or mitigated.		NTW Solutions to complete an audit of mobility needs across all community premises. Order raised for access audits, awaiting firm dates from external service provider. Still aiming for completion by 28/02/2026.	**28/02/2026**
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 (CERA) template for community areas in place. A programme of assessments using the new framework has commenced across community services.	To date, there have been 8 new CERA assessments undertaken within community service properties, with a further 12 planned to take place before the end of January 2026. This will leave 34 properties to assess thereafter. The intention is to have all assessments completed by the end of May 2026.	**Complete – process in place**
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	Trustwide Safety Group received an update on 20/01/2026 and supported the proposal for the roll out of ligature risk management training and assessments for older people's wards.	**31/03/2026**

Breach of regulation	What have we done about it?	What still needs to be done?	Timescale for completion
	instance which are the highest risk pathways. Ligature assessments and heat maps have now been completed for all female adult acute wards and CAMHS wards. A bespoke ligature management e-learning package has been 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.	Handrail leading towards garden area has been replaced.	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 is on track to be completed by 31/03/2026.	**31/03/2026**
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.		**Complete**
Theme 4: Assessment process and waiting times management			

Breach of regulation	What have we done about it?	What still needs to be done?	Timescale for completion
Regulation: 17 Good governance			
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. All community teams are expected to be using this live tool by end of December 2025 followed by a period of business change / embedding of new process.	**31/01/2026 – all actions achieved – full closure extended by 4 weeks to include the embedding in process and will be taken to Q&P in February to agree closure.**
Theme 5: Mental Health Act compliance **Regulation: 17 Good governance (breach)**			
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. On review of data for revisiting rights for those on a CTO, compliance has fallen from 91% in November to 87% in January. Despite this assurance processes have been strengthened to manage compliance more effectively. Oversight of compliance continues through the monthly Community Care		**Complete – process in place**

Breach of regulation	What have we done about it?	What still needs to be done?	Timescale for completion
	Group Quality meeting, Mental Health Legislation Steering Group and through Trustwide Safety Group.		
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. Mental Health Legislation Steering Group members have developed a robust process to monitor SOAD referral compliance, including an escalation process to ensure timescales are met. On review of the data between 01/11/2025 and 31/12/2025 there has been a marked improvement in this reporting period with 54 applications submitted 28 days or more, whereas in the previous report there were 25. Compliance continues to be monitored by senior leaders.		**Complete – process in place**
Theme 7: Safety and quality metrics Regulation: 17 Good governance			
Training levels, supervision and appraisal levels were low. Learning disability and autism training was not mandatory and there were low levels of compliance. Compliance levels were less than 41% in teams.	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.		**Complete – to seek approval from Q&P Committee in February to close breach.**

Breach of regulation	What have we done about it?	What still needs to be done?	Timescale for completion
	Mandatory training, supervision and appraisal levels have improved since this inspection and the Community Care Group have a robust process in place to provide oversight and assurance of training, supervision and appraisal figures through their monthly Quality Operational Management Group meetings.		
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. A feasibility paper to facilitate drug and alcohol awareness training was taken to Trustwide Safety Group in October where the paper was agreed in principle. Task and Finish Group established to review addiction screening tool which is a national tool and facilitation of brief interventions by community staff.	Proposal agreed for the roll out of drug and alcohol training and adopting screening tool at Trustwide Safety Group on 20/01/2026.	**Complete – to seek approval from Q&P Committee in February to close breach.**
Staff in older person's wards were not provided with the training and supervision required for their role.	Teams consistently underperforming against training, appraisal and clinical supervision standards have been identified with clear actions to improve compliance. Improvements have been noted since the inspection. The Inpatient Care Group have a robust process in place to monitor compliance and identify hot spots through their monthly Quality Operational Management Group.		**Complete – to seek approval from Q&P Committee in February to close breach.**

Breach of regulation	What have we done about it?	What still needs to be done?	Timescale for completion
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. Procurement of electronic process (MyKit Check) to standardise practice. Roll out has commenced. In the interim monthly Infection Prevention Control checks (includes fridge and room temperatures) have been reinforced with teams and are carried out at each community site.		**Complete**
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 and the teams are now achieving the standard.		**Complete**

2.4 LEARNING FROM DEATHS ASSURANCE REPORT

Rajesh Nadkarni, Deputy Chief Executive and Medical Director

REFERENCES

Only PDFs are attached

2.4 Learning from Deaths Report - Jan 2026.pdf

Meeting	**Board of Directors - Public**		**Agenda item: 2.4**
Date of meeting	Wednesday 28 January 2026		
Report title	Learning from Deaths Assurance Report Summary of Deaths 2023/24 - 2024/25		
Report Lead	Dr Rajesh Nadkarni, Medical Director / Deputy Chief Executive		
Prepared by	Dr Damian Robinson, Deputy Medical Director, Safer Care		
Purpose	**For decision**	**For assurance**	**For awareness**
		✓	
Report previously considered by	• Trust wide Safety Group • Quality and Performance Committee		
Executive summary	It is a requirement for NHS Boards to ensure that robust systems are in place for investigating and learning from deaths. It is expected that Board members have the capability and capacity to understand these issues and receive regular reports. Deaths and mortality information is reported through our governance systems to Quality and Performance Committee. This report covers the years 2023 / 2024 / 2025 and has been undertaken by the North East Quality Observatory Service (NEQOS) on behalf of CNTW. Foundation Trust. **<u>Summary of Findings</u>** • Death from drugs and alcohol continues to be a significant concern in the North East. • Death from self harm and suicide remains high although suicide amongst service users appears lower than nationally. • Death rates amongst males are notable for all types of deaths. Most deaths are in White British ethnic groups though there are gaps in the data. • Premature deaths highlight high morbidity and risk factors in adults with SMI. **<u>Agreed Actions</u>** The report has been considered by Trust wide Safety Group, and the following areas were identified, and report are the agreed actions. • To focus on the system wide public health initiatives to manage suicide deaths in Newcastle, Sunderland and Cumbria. • To review the progress and impact of our addictions five-point plan.		

	• Report to be communicated to all our older people's services to identify if any specific further actions need to be considered in respect of this report. • Review our multiagency arrangements with public health for suicide prevention. • The report to be considered by the Physical Health Steering Group in relation to our objectives and outcomes to manage premature deaths in adults with severe mental illness. Learning from the report and the ongoing recommendations will be fed into Trust and system initiatives following discussion at Patient Safety Learning Improvement Panel. Regular updates around assurance of about learning from deaths will be provided through the quality / safety report to Quality and Performance Committee.
Detail of corporate/ strategic risks	Not applicable.
Recommendation	The Board to be cited on the findings of the learning from deaths report to discuss, amend if required and approve the actions taken by the Trust.
Supporting information / appendices	**Appendix 1.** CNTW Learning from Deaths Summary of Deaths 2023/24 – 2024/25

North East Quality Observatory Service

CNTW Learning from Deaths

Summary of Deaths 2023/24 – 2024/25

November 2025

Undertaken by:
North East Quality Observatory Service (NEQOS)

On behalf of:
CNTW FT

BetterKnowledgeBetterCareBetterOutcomes

Contents

1. Purpose

1.1 The purpose of this report is to provide a summary update to the board in relation to death activity experienced by the Trust across all its services for the financial years 2023/24 to 2024/25.

1.2 The previous report containing an analysis of deaths related to the four calendar years 2020 to 2023, therefore the data presented in this version are not directly comparable with previous reports.

2. Background and context

2.1 Classification of deaths.

Deaths are usually considered in terms of the broad underlying cause – natural or unnatural - and the expectation of death – expected or unexpected. The reporting, scrutiny and investigation of deaths is dependent on this classification.

A **natural death** occurs due to natural processes, typically from an internal medical condition or aging, without external intervention. This includes deaths from illnesses such as heart disease, cancer, infections, and age-related organ failure. Natural death is often the result of the body gradually declining due to disease or age, rather than an immediate or sudden external factor.

Many natural deaths are expected due to clear physical deterioration. In such cases a **Medical Certificate of Cause of Death** (MCCD) can be issued by the attending doctor although there is now additional scrutiny from the local Medical Examiner. CNTW has had a formal relationship with a **Medical Examiner** in North Cumbria since April 2023 for natural cause deaths occurring while a CNTW in-patient. The process for interacting with the Medical Examiner is the subject of Practice Guidance Note IP-PGN-13.

However, a number of deaths occur suddenly and/or unexpectedly. In the first instance these are referred to the local **Coroner's office** for initial investigation. In the majority of cases this, together with a postmortem, reveals an underlying natural cause and a MCCD is issued. All deaths of service users subject to restrictions under the Mental Health Act are also referred to the Coroner whether they appear to be natural or not.

An **unnatural death** is caused by external factors rather than natural internal processes. Unnatural deaths include those resulting from accidents (like car crashes), violence (homicides), suicide, drug overdoses, or other interventions. This type of death usually involves an unexpected or preventable factor that disrupts normal bodily functions.

All unnatural deaths are referred to the Coroner's office and may be the subject of a Coroner's Inquest sometimes in front of a jury. The inquest determines who the deceased person was and how, when and where the person died. The conclusion may be expressed as a short form (natural causes, accident, misadventure, alcohol or drug related, unlawful or lawful killing, industrial disease, road traffic collision, suicide or

open) or as a longer narrative conclusion which describes the events leading to death. Where an inquest is held this may not take place until several months (or in rare cases years) after the death has occurred. This was a particular issue during the pandemic.

In 2018 the level of proof required to issue a conclusion of suicide changed which increased the number of suicide conclusions recorded. However, it is not unusual for a death which initially appears to be due to suicide is granted an alternative conclusion such as accident, misadventure of drug/alcohol related.

2.2 Identification and reporting of deaths.

Reports of a death of a service user are made by staff when they become aware of the death. Where service users are undergoing active regular treatment, their death is usually noted within a short timescale; for service users where contact is less frequent a death may not be reported until some time after the event. From time to time the Medical Examiner or Coroner's office will inform CNTW of the death of a possible service user.

The **Spine** is a component of the NHS IT infrastructure which enables exchange of information between local and national systems. One use of the Spine is to notify organisations of the death of a service user in order that appointments and communications can be halted. The Trust uses the Spine to identify the death of service users not otherwise recorded on the SafeGuard (Incident reporting) system.

A significant failing of the current system is that in most cases the underlying cause of death of a service user is not known to CNTW. This hampers efforts to understand the impact of mental ill health on physical health outcomes. A project is now underway to attempt to link data on SafeGuard with data held by the ICS.

In addition to data held within CNTW, additional data used is available from the Office of National Statistics (ONS) and the Office for Health Improvement and Disparities (OHID) https://fingertips.phe.org.uk/ . The national **Mental Health Data Set** (MHDS) holds anonymised data for deaths of persons with current and recent contact with mental health services and can be used for epidemiological level analyses.

SafeGuard is the Trust's local risk management system which holds data on all incidents including deaths, complaints and risks. All staff have access to enable reporting of incidents with levels of access dependent on their role in the organisation. There are electronic links between SafeGuard and the Trust patient administration system RiO.

Whenever a death is reported it is coded within SafeGuard to best describe the event at the time of report; however, as outlined above, this may change as more information comes to light as part of internal or external investigations.

The SafeGuard system contains a considerable amount of data which can be analysed and used for multiple purposes. For example, the data is valuable for understanding health inequalities. However, a recent review has indicated that there are some data

quality issues which are currently being managed. Therefore, some of the data presented in this report is subject to minor revision and should be read in that context.

The analysis in this report includes all deaths recorded in the SafeGuard system over a two-year period between 1st April 2023 to 31st March 2025.

2.3 Learning from Deaths guidance

The Learning from Deaths guidance was borne out of national reports produced and shared based on poor experiences of families and carers, where their death had not had a level of investigation which would reasonably have been expected.

The main report which focused national attention was commissioned by NHS England and written by Mazars following a review in Southern Health NHS Foundation Trust, triggered by the preventable death of Connor Sparrowhawk in July 2013. It is also important to note, that whilst not referenced in the Mazars report the serious incident processes followed in CNTW were used as baseline of best practice nationally. The Learning from Deaths guidance was published in 2017 and although it has not been updated in line with the introduction of PSIRF it remains relevant and complementary.

The guidance requires that mortality governance should be a key priority for Trust Boards. The responsibilities of Boards as outlined in the guidance include that:

- Boards must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care
- Executives and non-executive directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge.
- Mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board in order that the executives remain aware and non-executives can provide appropriate challenge
- Providers should engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death and operate according to the following key principles below

Quarterly Safety and Quality report presented at the Trust Quality and performance meeting includes data on the number of incidents, the level and number of relevant investigations (mortality reviews, after action reviews, serious incident investigations and, since PSIRF, patient safety investigations), and reporting into the local LeDeR process. This paper complements this routine data by providing a summary of learning from reviews including deaths. The Trusts new Integrated Quality Report (IQR) also tracks death reporting month to month.

2.4 Learning from Patient Safety Events (LPSE)

The Learn from Patient Safety Events (LFPSE) service is a national NHS system for the recording and analysis of patient safety events that occur in healthcare. The service

introduces a range of innovations to support the NHS to improve learning from the over 2.5 million patient safety events recorded each year, to help make care safer.

LFPSE is now in use across the NHS, and organisations have switched to recording patient safety events onto the new LFPSE service rather than the National Reporting and Learning System (NRLS), which was decommissioned on 30 June 2024. The data held within the two systems is, unfortunately, not comparable. This means that it will take several years to be able to identify trends and enable comparisons across services. LFPSE has been designed to be compatible with the new Patient Safety Incident Response Framework (PSIRF)

CNTW was one of the first NHS mental health and learning disability providers to connect its Local Risk Management System (SafeGuard, also called Ulysses after the supplier) to the LFPSE in September 2022.

3. Methodology

3.1 In relation to the analysis of SafeGuard data NEQOS have taken the following approach:

- This analysis was conducted on a snapshot of data taken on 13th November 2025 from the live system subject to change as a result of internal or external investigations. This data was reviewed by the Clinical Risk and Investigations Team before sending to NEQOS for analysis.
- Service Type and Revised Outcome were grouped by the Clinical Risk and Investigations Team. For Service Type NEQOS aggregated to broader categories to aid presentation and interpretation, this aggregation was approved by the Clinical Risk and Investigations Team.
- For drug and alcohol use the original Outcome column has been used to disaggregate if it was drug, alcohol or both.
- Where a service user has been in contact with more than one team within CNTW, the team assigned in the database is either the team which found out about the death; or team with most input/main care team (more often the latter). However when an incident is reviewed all teams involved are included in this process.
- Due to low numbers, ethnicity data is presented as White British, All other ethnic groups combined, and unknown.
- Residence has been based on the District column. This field contains a mix of current CCGs, defunct CCGs and some PCTs. We have matched these to localities e.g. (NHS Newcastle West CCG and NHS Newcastle North and East CCG to Newcastle). Any non-CNTW localities have been presented as Out of area.
- Data has been presented as counts of deaths by various categories. Presenting rates was considered but discounted due to the district field issues outlined above, the difficulty in identifying an appropriate denominator for Cumbria and the fact that rates vary significantly depending on varying levels of service in different localities e.g. some areas do not have addictions services or older adult services.
- Disclosure control has been applied by combining categories together where counts are under 5, for example by widening age bands or categorising services as 'Other'.

3.2 Data from the Office for Health Improvement and Disparities (OHID) is provided to give a population view of mortality in relation to specific causes. In all cases this data relates to the North East population (with Cumberland, and Westmorland and Furness included for the local authority charts) as a whole and not just those known to CNTW.

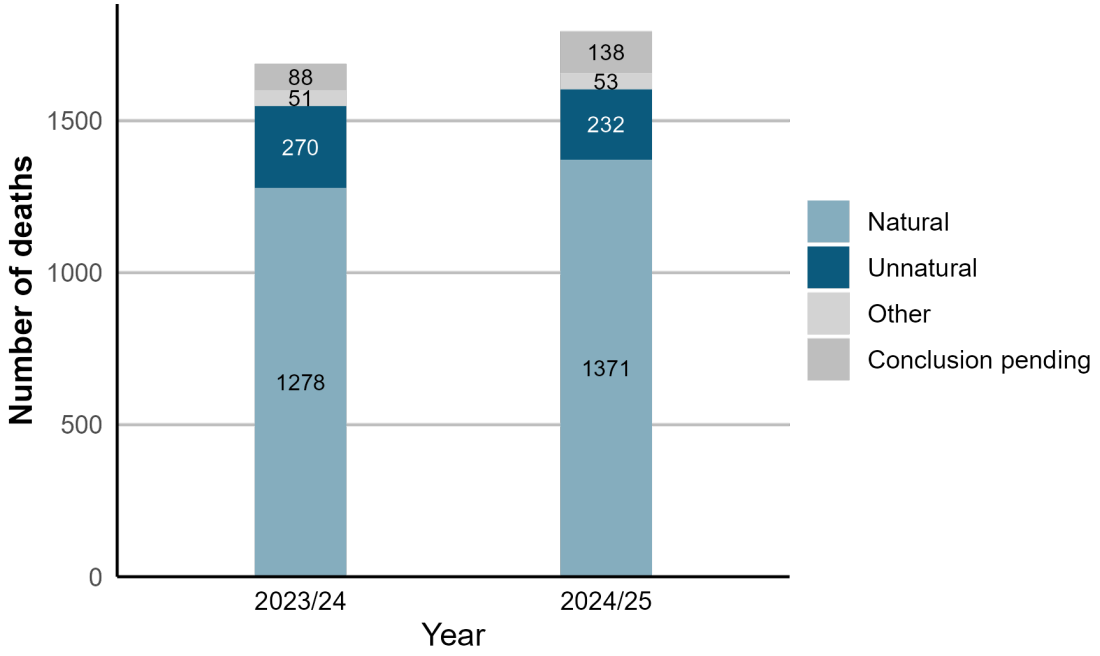
4. All Cause Deaths recorded in SafeGuard

4.1 The total number of deaths recorded in SafeGuard from 2023/24 to 2024/25 was 3,481. The previous report to the Board (December 2024) showed that from 2020 to 2023 there were approximately 1,660 deaths per annum. In 2023/24 there were 1,687 deaths; in 2024/25 there were 1,794 deaths.

4.2 Figure 4.1 shows the number of recorded deaths which were categorised as natural, unnatural, other (including no information required by coroner); or where the conclusion is pending. Although the total number of deaths has increased in 2024/25 the number of natural deaths has increased by a similar number. The number of deaths recorded as unnatural has decreased, although this number may be revised as more conclusions are updated following Coroner proceedings.

4.3 In 2023/24 there were 270 deaths recorded in SafeGuard where the cause appeared to be unnatural and an additional 88 where the conclusion is pending. In 2024/25 there were 232 unnatural deaths and 138 with conclusion pending.

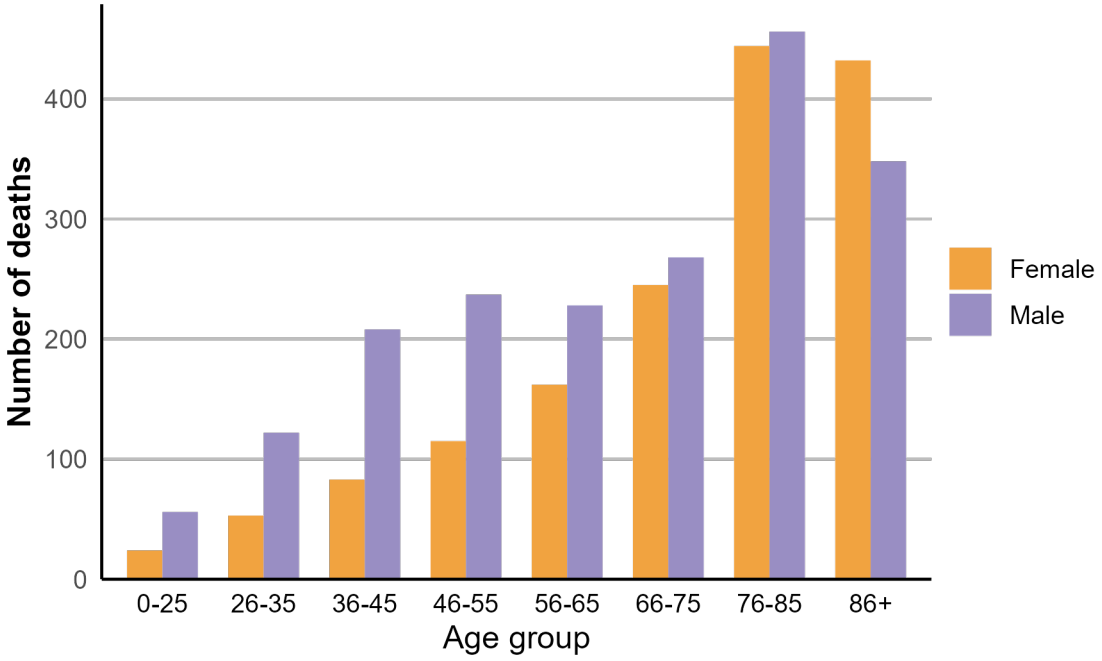
Figure 4.1 All cause deaths recorded in SafeGuard



Source: SafeGuard

4.4 Across 2023/24 and 2024/25 higher numbers of males than females died of all causes across all age groups up to 86+, with the difference greatest in the youngest age groups (Figure 4.2).

Figure 4.2 All cause deaths by outcome recorded in SafeGuard – by age and sex (2023/24 and 2024/25 combined)



Source: SafeGuard

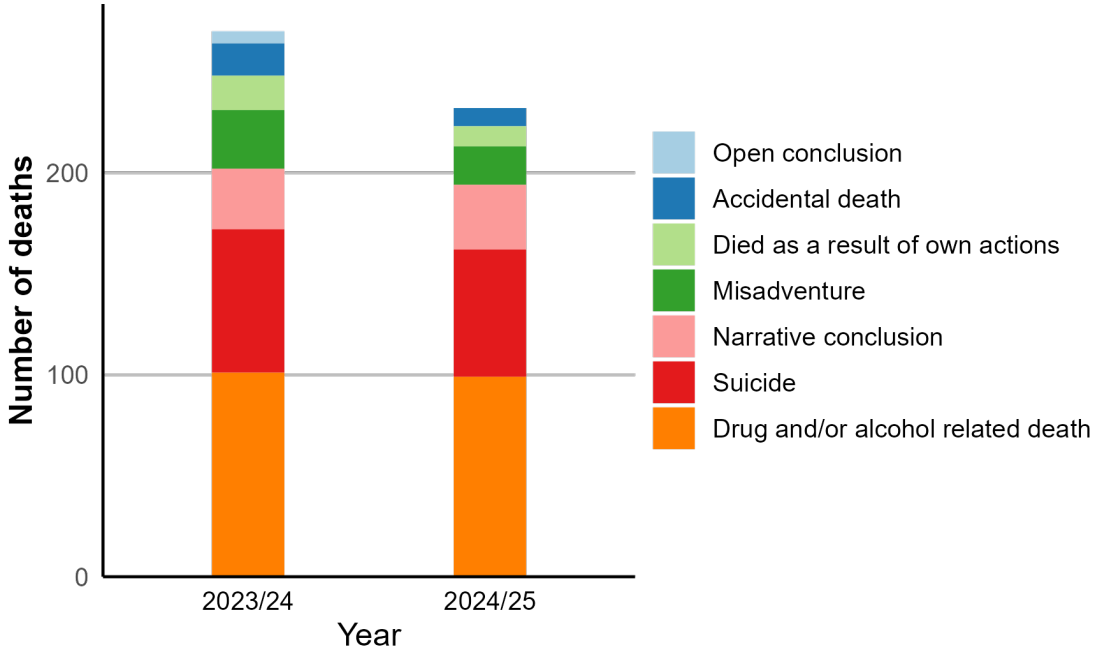
4.5 Further breakdowns of all cause deaths are shown in Appendix section 1, including ethnicity, geography and service type.

4.6 Over 85% of all cause deaths were in the White British ethnic group, and this is consistent across all breakdowns used in this report. Less than 3% are in other ethnic groups combined, with around 10% unknown.

5. Unnatural Deaths recorded in SafeGuard

5.1 Figure 5.1 shows the breakdown of unnatural deaths recorded in SafeGuard by outcome. The most frequent outcomes were Drug and/or alcohol related death (40% of all unnatural deaths over the two-year period) and Suicide (27%).

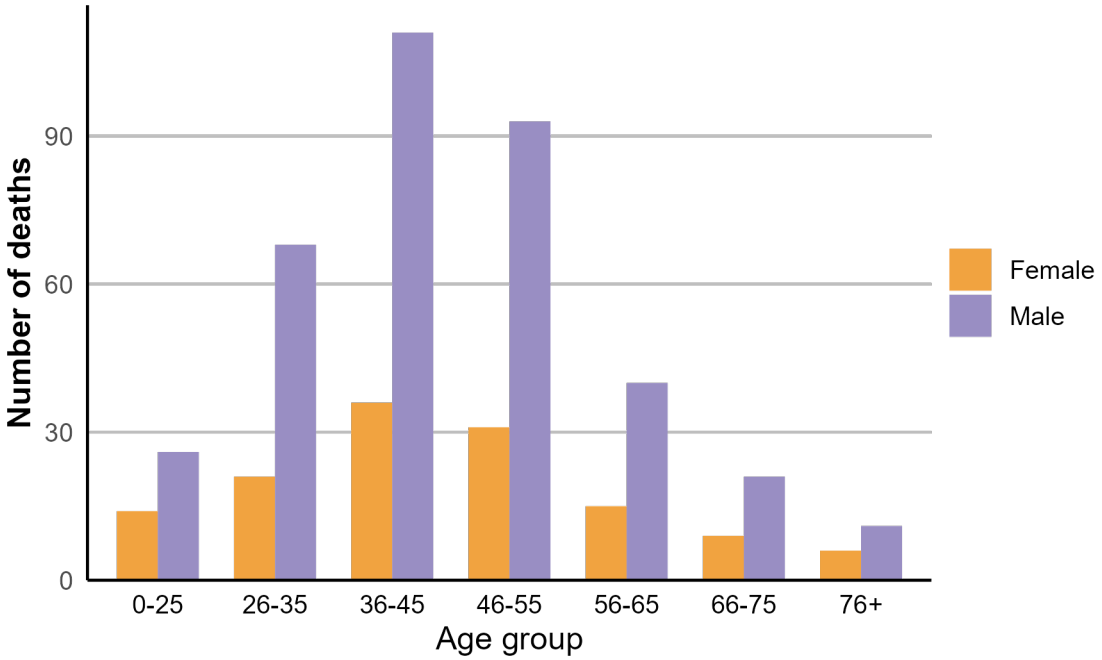
Figure 5.1 Unnatural deaths by outcome recorded in SafeGuard



Source: SafeGuard

5.2 Figure 5.2 shows unnatural deaths by age and sex across the two-year period, with higher counts for males than females in all age groups. Note that 76-85 and 86+ age groups have been combined due to small number suppression.

Figure 5.2 Unnatural deaths recorded in SafeGuard – by age and sex (2023/24 and 2024/25 combined)



Source: SafeGuard

5.3 Further breakdowns of unnatural deaths are shown in Appendix section 2, including ethnicity and geography.

5.4 3.8% of unnatural deaths were all other ethnic groups combined.

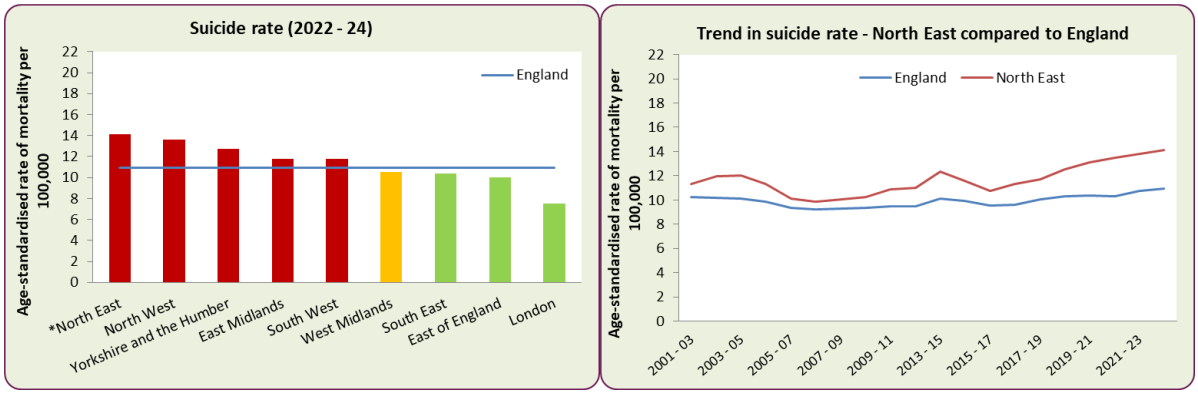
5.5 The most frequent localities of residence for unnatural deaths were Newcastle, Cumbria and Northumberland. Unnatural deaths recorded in Northumberland approximately halved between 2023/24 and 2024/25. Unnatural deaths in Gateshead reduced by around 40% in 2024/25 while other localities showed similar levels across the two financial years.

5.6 The most frequent service types for unnatural deaths were Addictions, CMHT – Adult, Crisis Response & Home Treatment and Psychiatric Liaison.

6. Deaths associated with self-harm

6.1 Data from OHID shows that the North East has the highest rate of suicide in England. The trend is increasing and the gap between the North East and England has been widening since 2015-17. To note that this data provides a population view and is not limited to those known to CNTW services.

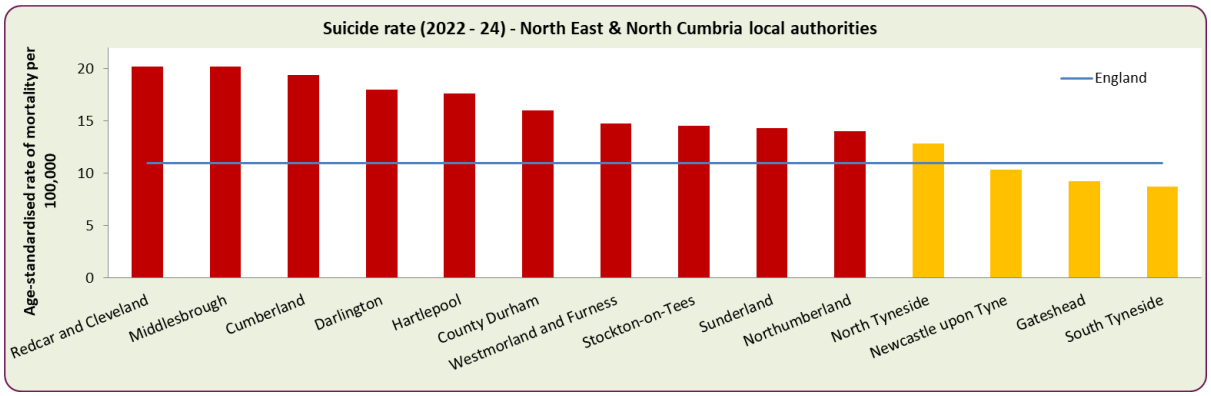
Figures 6.1 and 6.2 Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population – by region



Source: Office for Health Improvement and Disparities, Public Health Profiles, 2025, https://fingertips.phe.org.uk/ © Crown Copyright 2025

6.2 There is wide intra-regional variation across local authority areas in North East and North Cumbria, with Cumberland and Westmorland and Furness higher than those in Tyne and Wear.

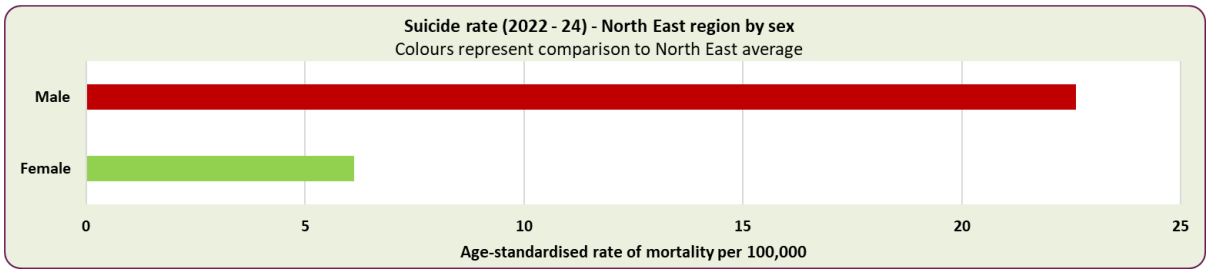
Figure 6.3 Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population – by local authority



Source: Office for Health Improvement and Disparities, Public Health Profiles, 2025, https://fingertips.phe.org.uk/ © Crown Copyright 2025

6.3 Suicide rates are significantly higher among men than women in the North East.

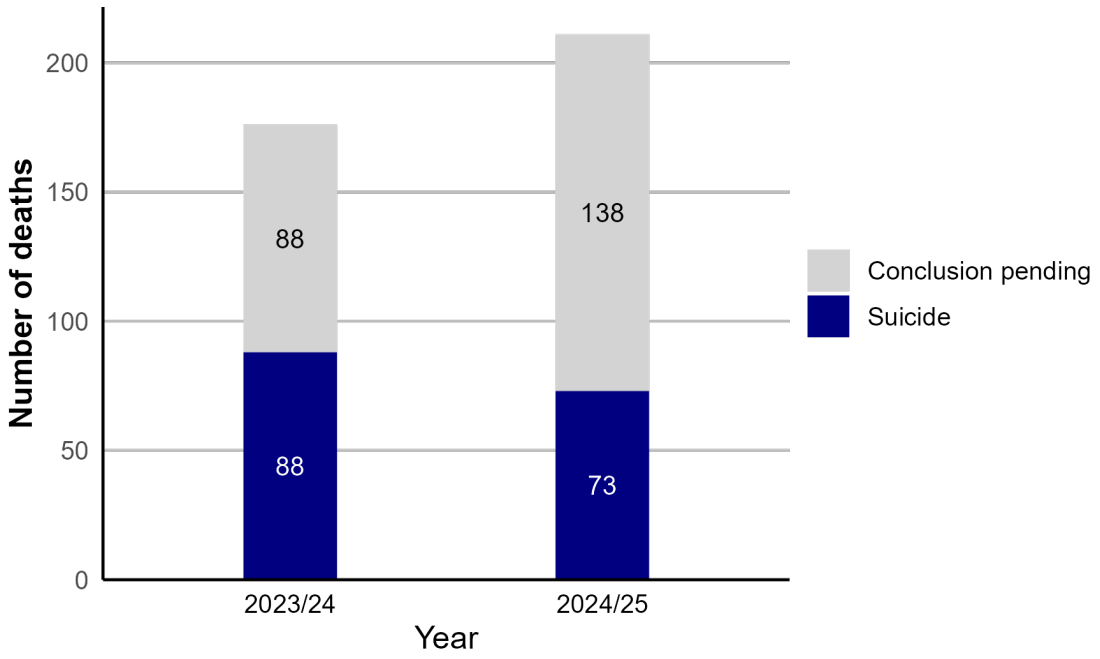
Figure 6.4 Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population – North East, by sex



Source: Office for Health Improvement and Disparities, Public Health Profiles, 2025, https://fingertips.phe.org.uk/ © Crown Copyright 2025

6.4 From 2023/24 – 2024/25 there were 161 deaths recorded in SafeGuard as suicide (134) or died as a result of own actions (27). Combined, this comprises 32% of all unnatural deaths.

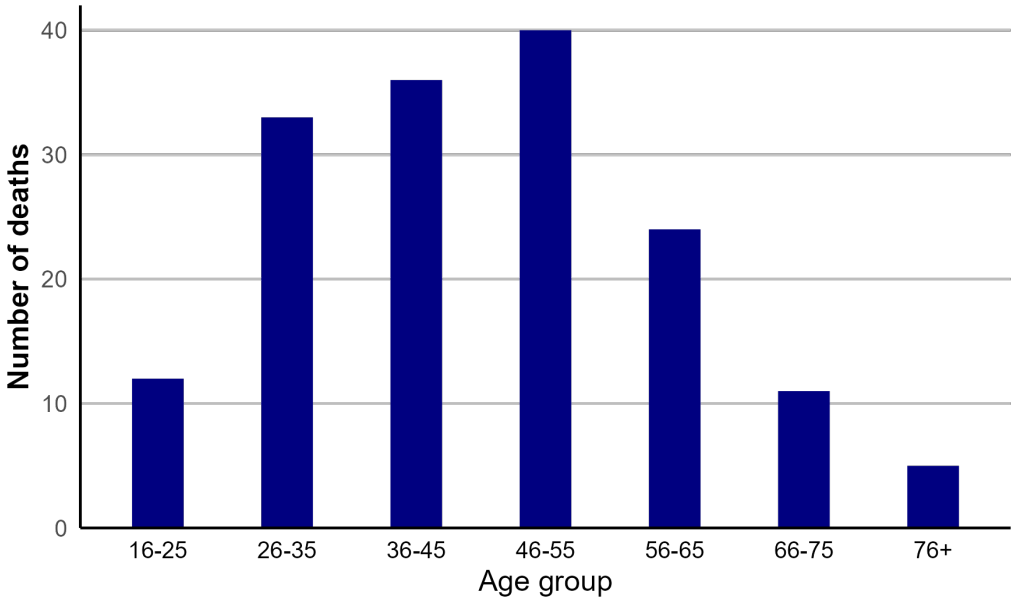
Figure 6.5 Number of deaths recorded in SafeGuard as suicide or died as a result of own actions including those with conclusion pending



Source: SafeGuard

6.5 Only 16% of deaths recorded as suicide or died as a result of own actions from 2023/24-2024/25 were female (n=26), with male deaths higher than female in all age categories. A sex breakdown is not included in Figure 6.6 due to these low numbers for females.

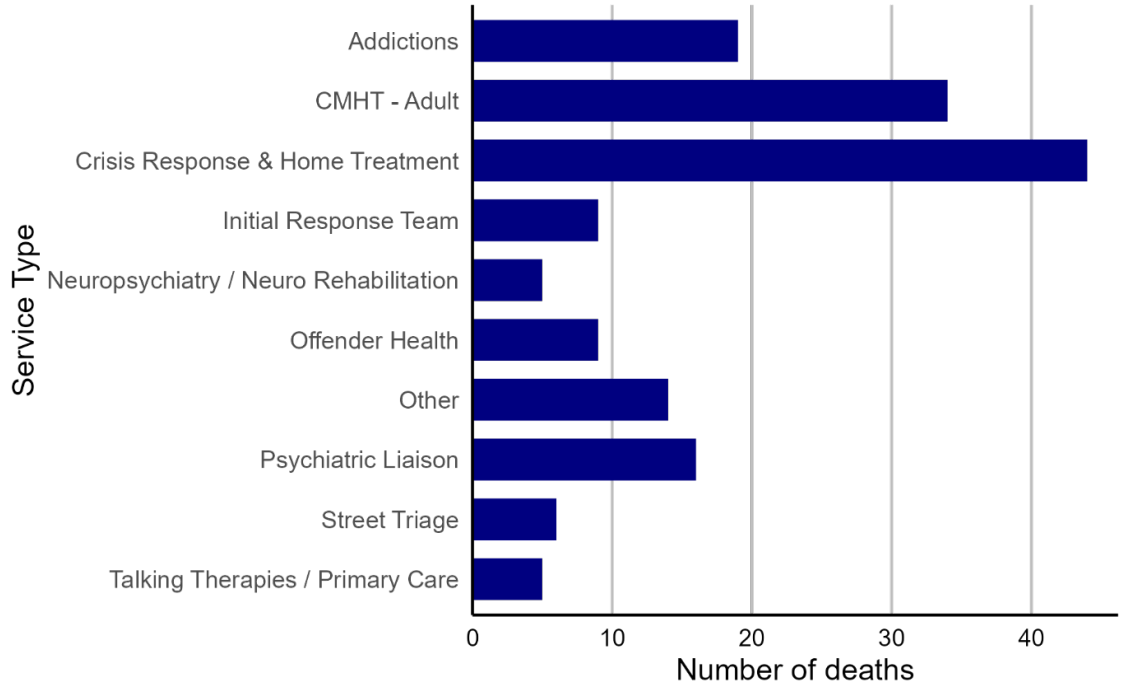
Figure 6.6 Number of deaths recorded in SafeGuard as suicide or died as a result of own actions – by age (2023/24 and 2024/25 combined)



Source: SafeGuard

6.6 The most frequent service type for deaths by suicide or as a result of own actions were Crisis Response & Home Treatment, CMHT – Adult and Addictions.

Figure 6.7 Number of deaths recorded in SafeGuard as suicide or died as a result of own actions – by service type (2023/24 and 2024/25 combined)



Source: SafeGuard

6.7 Further breakdowns of deaths from suicide or as a result of own actions are shown in Appendix section 3, including ethnicity and geography.

6.8 The most frequent localities of residence for deaths by suicide or as a result of own actions were Northumberland, Sunderland, Cumbria and Newcastle.

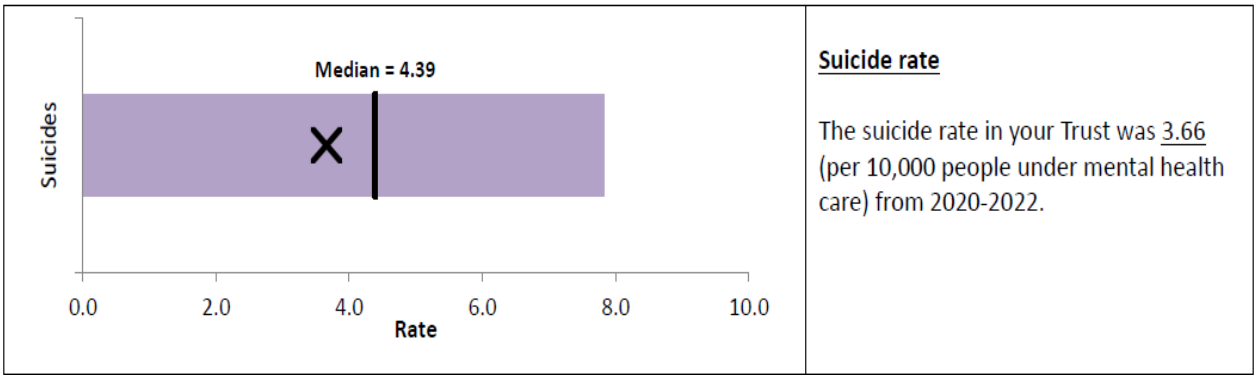
6.9 National Confidential Inquiry into Suicide and Safety in Mental Health

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) is hosted within Manchester University and has been collating information on deaths resulting from suicides for over 20 years. This includes deaths occurring in persons in current or recent receipt of mental health services. They produce annual reports and research papers informing interventions designed to reduce the risk of future self-harm and suicide. It is important to note that deaths included in their database are those where there has been a coroner conclusion of suicide or undetermined cause of death. This leads to a delay between the date of death and the inclusion in the relevant annual report; the most recent annual report published in 2025 includes deaths occurring up to 2022.

NCISH produces a Safety Scorecard each year which benchmarks each NHS Mental health in England trust against their rate of suicide per 10,000 people under care. Because of the small numbers involved they use a three-year rolling average, and the data is delayed by several years due to the process outlined above. The most recent scorecard available currently covers period 2020- 2022.

For each of the most recent time periods for which a scorecard is available, CNTW had a lower suicide rate than the national median rate.

Figure 6.9 NCISH Scorecard CNTW

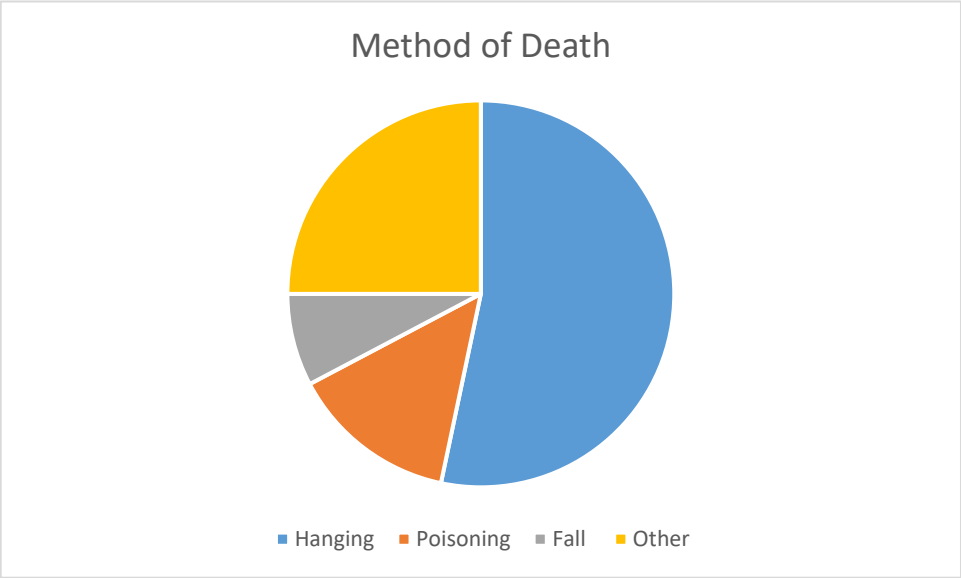


Source: NCISH

6.10 Method of death

The most common method of self-harm leading to death was hanging followed by poisoning, and falling from a height.

***Figure* 6.10 Method of death from self-harm or suicide, 2023/24 - 2024/25**



Source: SafeGuard

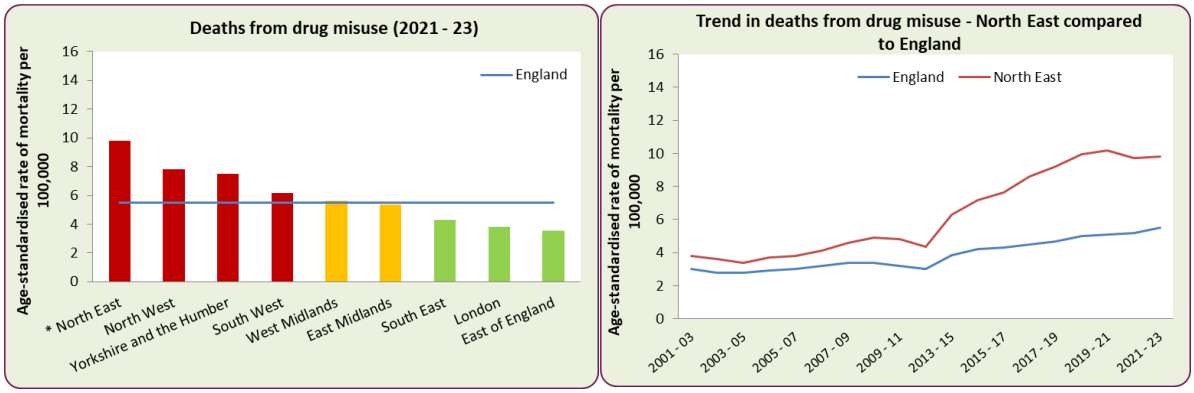
6.11 The ICB has established a regional surveillance process to identify suspected suicides in near real time which should enable a timelier response to apparent clusters and changes in local epidemiology. A monthly dashboard summarising events over the NENC area is available monthly. CNTW is closely aligned to this process.

6.12 The Trust has identified reducing self-harm as one of its quality priorities. A self-harm steering group has been established with identified aims of reducing hanging/asphyxiation in in-patient areas and self-harm repetition in the community. A new biopsychosocial risk assessment framework has been adopted in 2024 to replace FACE.

7. Deaths associated with alcohol and drug use

7.1 The North East has the highest rate of deaths from drug misuse in England. The trend is increasing and the gap between the North East and England widened from 2012-14 to 2019-21. The rate has dropped slightly since the 2019-21 peak. To note that this data provides a population view and is not limited to those known to CNTW services.

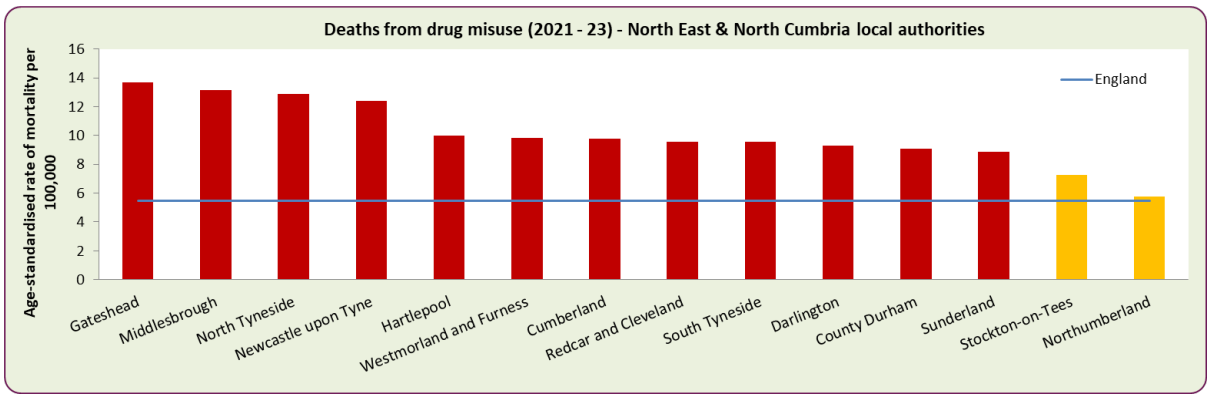
Figures 7.1 and 7.2 Age-standardised mortality rate from drug misuse per 100,000 population – by region



Source: Office for Health Improvement and Disparities, Public Health Profiles, 2025, https://fingertips.phe.org.uk/ © Crown Copyright 2025

7.2 All NENC local authorities except Stockton-on-Tees and Northumberland had rates which were significantly higher than the national average in 2021-23.

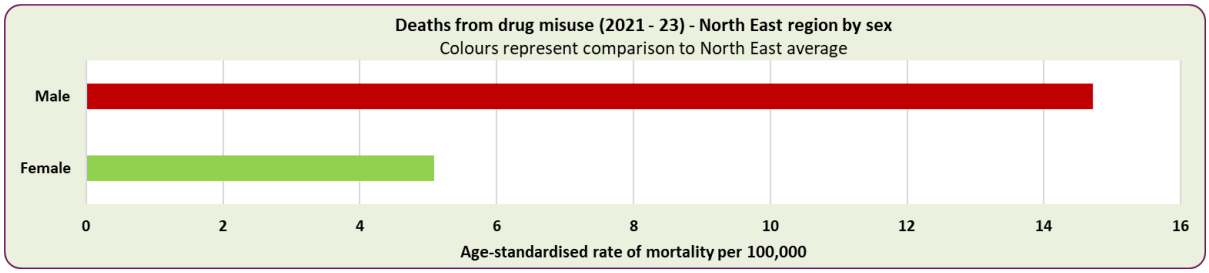
Figure 7.3 Age-standardised mortality rate from drug misuse per 100,000 population – by local authority



Source: Office for Health Improvement and Disparities, Public Health Profiles, 2025, https://fingertips.phe.org.uk/ © Crown Copyright 2025

7.3 Rates of deaths for drug misuse in the North East are significantly higher in males than females (Figure 7.4).

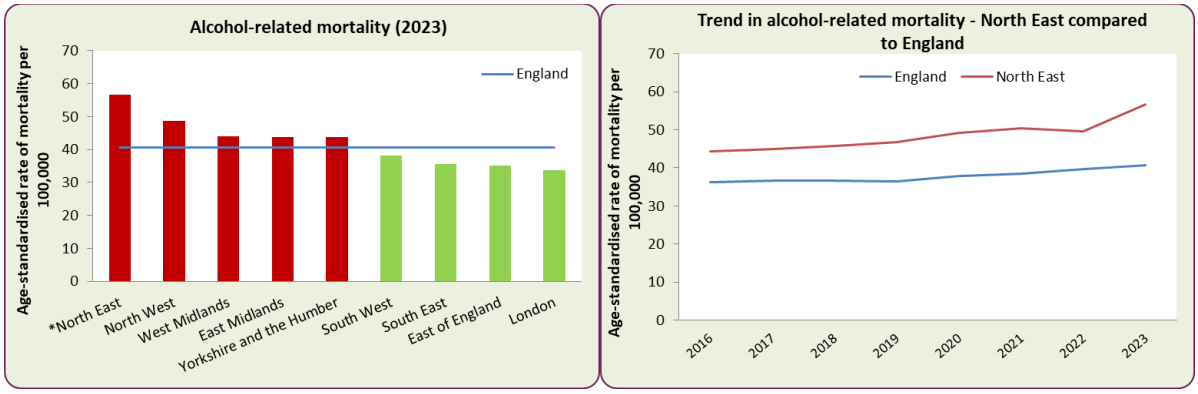
Figure 7.4 Age-standardised mortality rate from drug misuse per 100,000 population – North East, by sex



Source: Office for Health Improvement and Disparities, Public Health Profiles, 2025, https://fingertips.phe.org.uk/ © Crown Copyright 2025

7.4 Figures 7.5 and 7.6 show that the North East has the highest rate of alcohol-related mortality in England. The trend is increasing, and a sharp increase took place in 2023. To note that this data provides a population view and is not limited to those known to CNTW services.

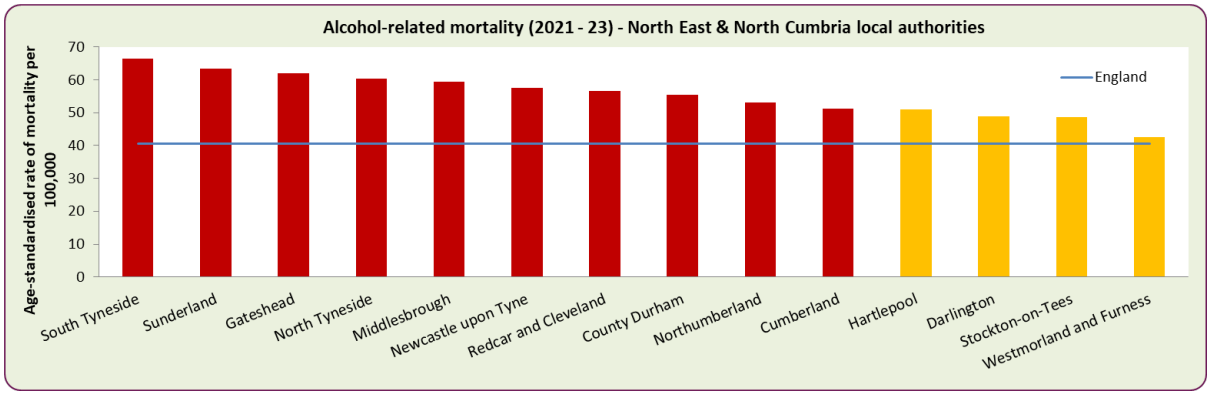
Figures 7.5 and 7.6 Age-standardised alcohol-related mortality rate per 100,000 population – by region



Source: Office for Health Improvement and Disparities, Public Health Profiles, 2025, https://fingertips.phe.org.uk/ © Crown Copyright 2025

7.5 Most NENC local authorities had rates which were significantly higher than the national average in 2021-23.

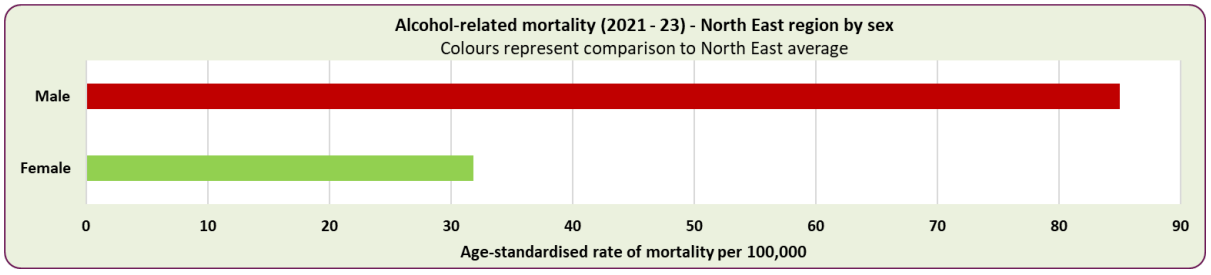
Figure 7.7 Age-standardised alcohol-related mortality rate per 100,000 population – by local authority



Source: Office for Health Improvement and Disparities, Public Health Profiles, 2025, https://fingertips.phe.org.uk/ © Crown Copyright 2025

7.6 Rates for alcohol-related mortality in the North East are significantly higher in males than females.

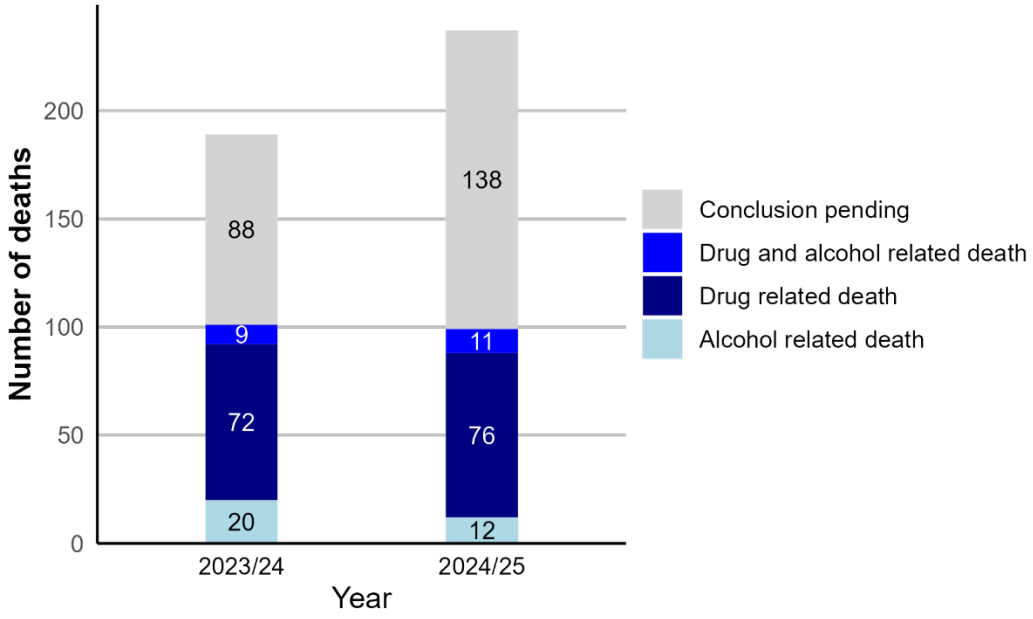
Figure 7.7 Age-standardised alcohol-related mortality rate per 100,000 population – North East, by sex



Source: Office for Health Improvement and Disparities, Public Health Profiles, 2025, https://fingertips.phe.org.uk/ © Crown Copyright 2025

7.7 Figure 7.8 shows that from 2023/24 – 2024/25 there were 200 deaths recorded in SafeGuard as drug and/or alcohol related (40% of all unnatural deaths).

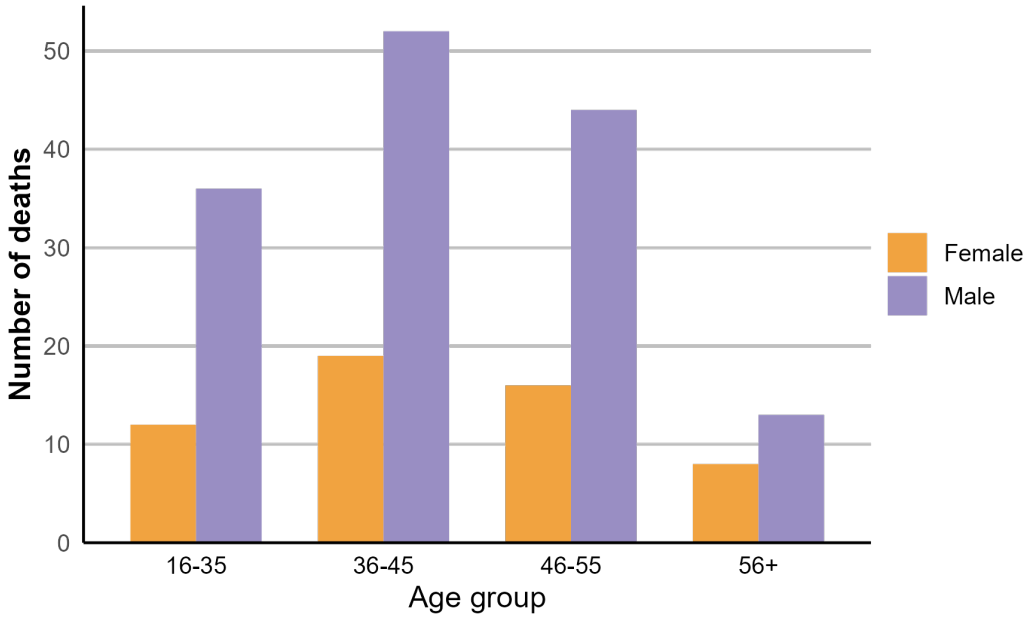
Figure 7.8 Number of deaths recorded in SafeGuard as drug and/or alcohol related death



Source: SafeGuard

7.8 Age bands were aggregated in figure 7.9 due to low numbers. Male deaths were higher than female in all age bands, particularly for age 55 and under.

Figure 7.9 Number of deaths recorded in SafeGuard as drug and/or alcohol related death – by age and sex (2023/24 and 2024/25 combined)



Source: SafeGuard

7.9 Further breakdowns of drug and/or alcohol related deaths are shown in Appendix section 4, including residence and service type. Ethnic group breakdowns have been suppressed due to low numbers.

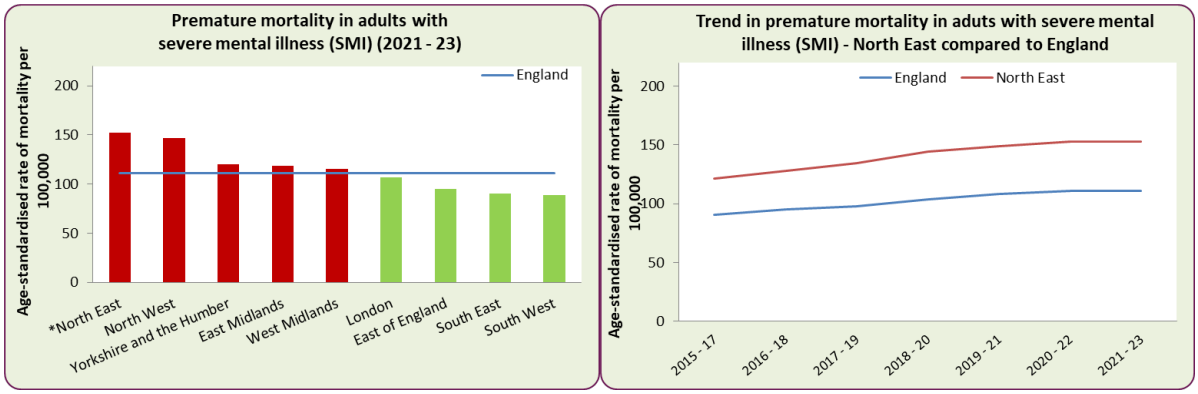
7.10 The most frequent localities of residence for drug and/or alcohol related deaths were Newcastle, Northumberland and Cumbria.

7.11 The most frequent service type for drug and/or alcohol related deaths was Addictions, followed by CMHT-Adults, Psychiatric Liaison and Crisis Response & Home Treatment.

8. Deaths due to natural causes

8.1 Data from OHID shows that the North East has the highest rate of premature mortality in adults with severe mental illness in England. The trend is increasing and the gap between the North East and England has been widening since 2015-17. To note that this source data is not limited to those known to CNTW services.

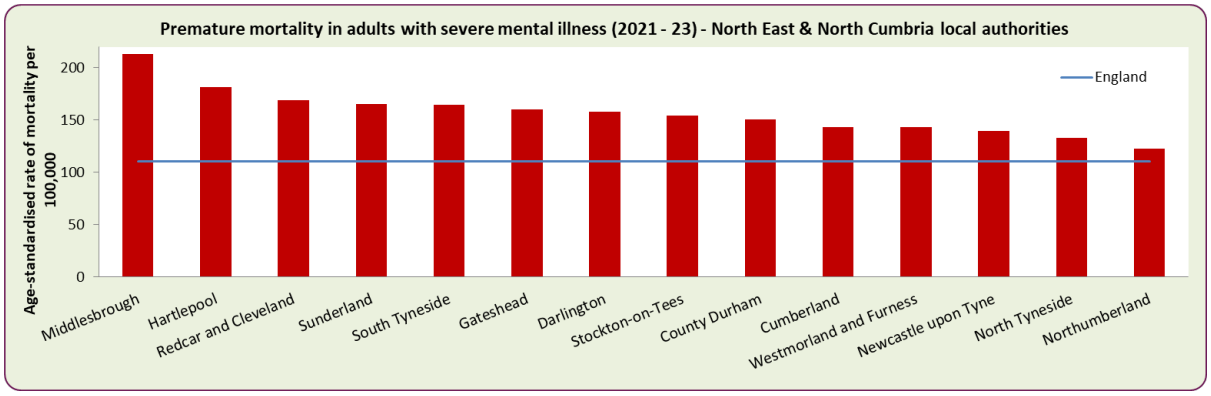
Figures 8.1 and 8.2 Age-standardised premature mortality rate in adults with severe mental illness per 100,000 population – by region



Source: Office for Health Improvement and Disparities, Public Health Profiles, 2025, https://fingertips.phe.org.uk/ © Crown Copyright 2025

8.2 All NENC local authorities had rates which were significantly higher than the national average in 2021-23.

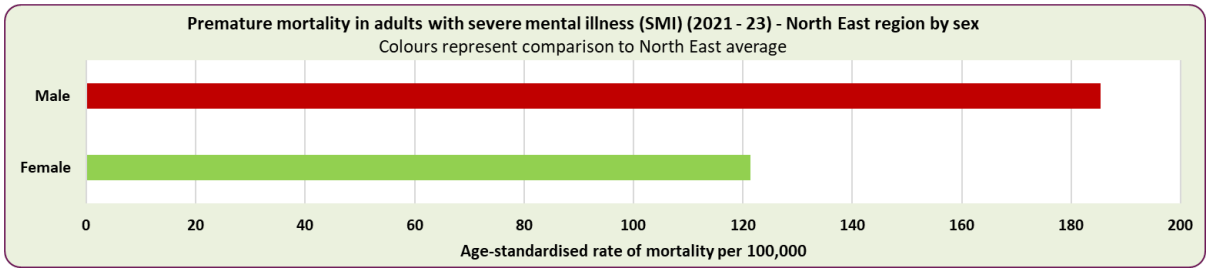
Figures 8.3 Age-standardised premature mortality rate in adults with severe mental illness per 100,000 population – by local authority



Source: Office for Health Improvement and Disparities, Public Health Profiles, 2025, https://fingertips.phe.org.uk/ © Crown Copyright 2025

8.3 Rates for premature mortality in adults with severe mental illness in the North East are significantly higher in males than females (Figure 8.4).

Figures 8.4 Age-standardised premature mortality rate in adults with severe mental illness per 100,000 population – North East, by sex

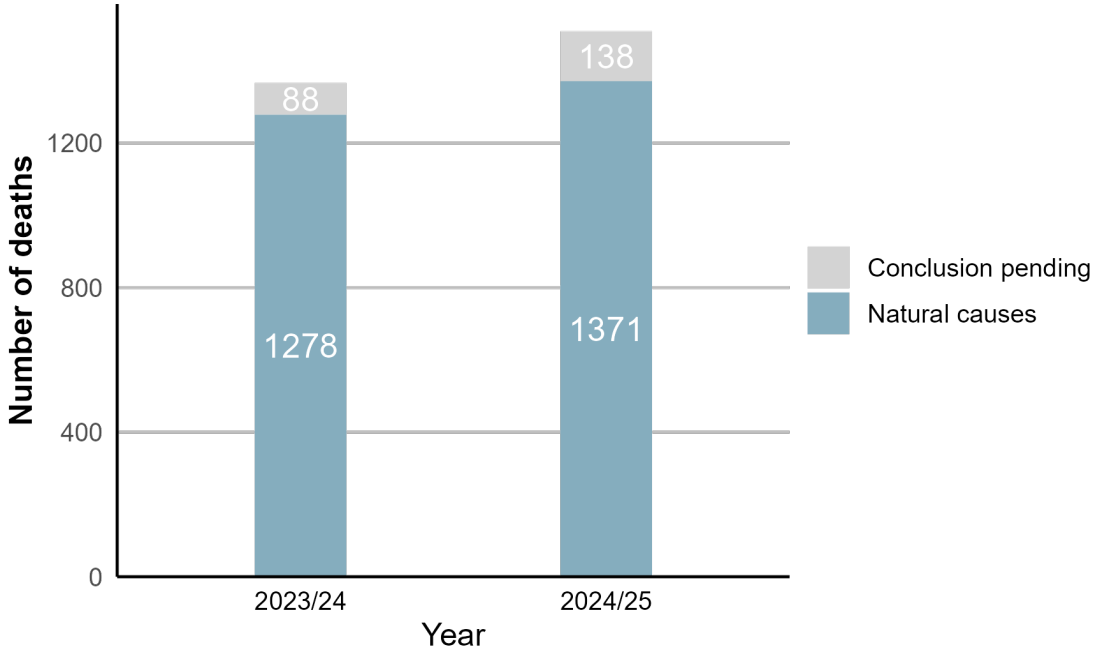


Source: Office for Health Improvement and Disparities, Public Health Profiles, 2025, https://fingertips.phe.org.uk/ © Crown Copyright 2025

8.4 The previous report to the Board (December 2024) reported an average of 1,136 deaths recorded as natural causes per year from 2020-2023. The lowest was 1,025 in 2023. These figures may have been affected by the pandemic.

8.5 From 2023/24 – 2024/25 there were 2,649 deaths recorded in SafeGuard as natural causes. This represents 76% of the total all cause deaths.

Figure 8.5 Number of deaths recorded in SafeGuard as natural causes

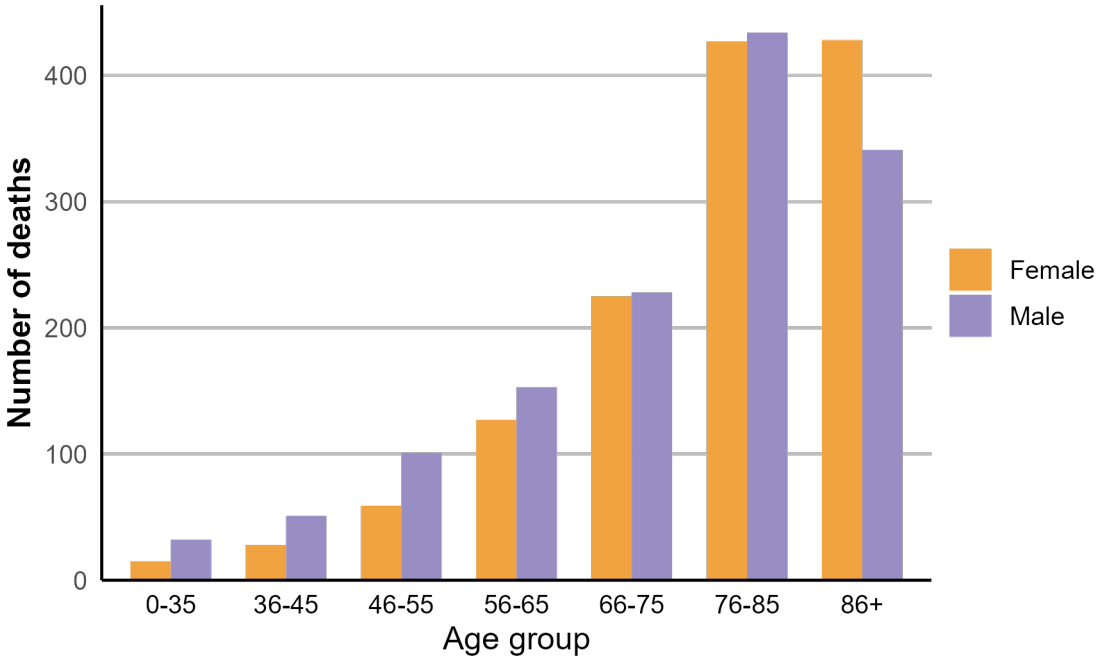


Source: SafeGuard

8.6 Age bands up to 35 years were combined in Figure 8.6 due to low numbers. 37% of deaths due to natural causes were in individuals under the age of 75, meeting the definition of premature mortality.

8.7 Natural deaths were higher for males than females in all ages under 86, particularly in the younger age categories.

Figure 8.6 Number of deaths recorded in SafeGuard as natural causes – by age and sex (2023/24 and 2024/25 combined)



Source: SafeGuard

8.8 Further breakdowns of natural deaths are shown in Appendix section 5, including ethnic group and geography.

8.9 The most frequent localities of residence for natural deaths were Northumberland, Sunderland, Cumbria and Newcastle.

8.10 The majority of natural deaths were recorded for the CMHT – Older Adults and Memory Assessment – Older Adults service types, followed by CMHT – Adults, Neuropsychiatry / Neurorehabilitation and Psychiatric Liaison.

9. Review of Deaths in CNTW

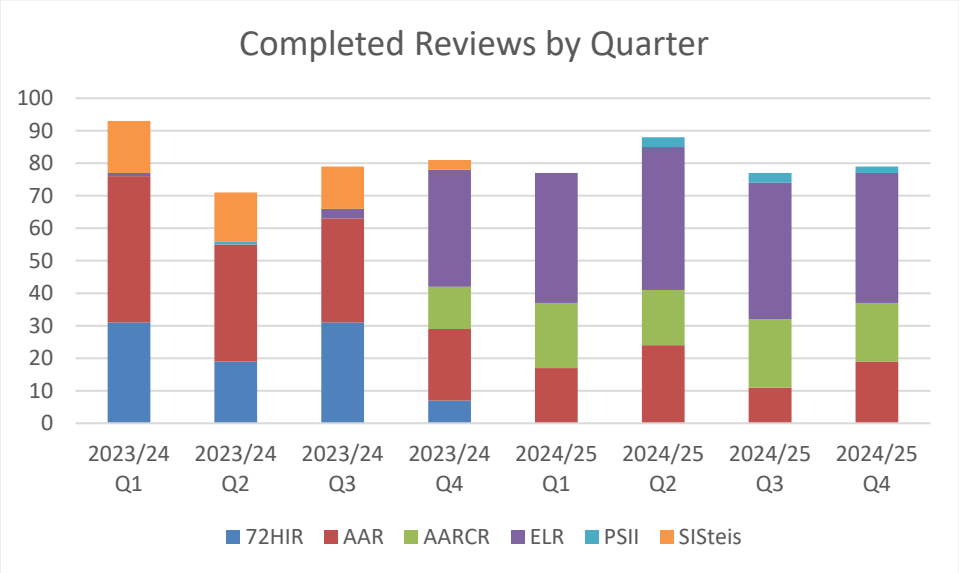
9.1 CNTW has a long-established process for reviewing and investigating unnatural and unexpected deaths which was, until 2024, complaint with the NHS Serious Incident Framework. From January 20th 2024 the Trust has moved to adopt an approach outlined within the NHS Patient Safety Incident Response Framework (PSIRF).

9.2 Over the period covered by this report the review process comprised, Early Learning Reviews, After Action Reviews (AAR), Mortality Reviews and Patient Safety Incident Investigations (PSII). All PSII's, Mortality Reviews, Serious Incident Reviews and a small proportion of AAR's are undertaken by independent investigating offices based within the Safer Care directorate. The remained of the AAR's and ELR's are completed by the

care groups. ALL PSII's are reviewed by the Patient Safety Learning Improvement Panel to identify appropriate actions and learning, and summaries are presented to the weekly Trustwide Safety Group.

9.3 During the period some reviews were completed under the NHS Serious Incident Framework which were Serious Incident Reviews. Under the NHS Patient Safety Incident Response Framework (PSIRF) some of these would be reviewed as a PSII and others by an AAR-CR. (An AAR-CR is and After action review completed by an independent investigating officer based within the Central Clinical Risk and Investigations Department).

Figure 9.1 deaths by review type



9.4 Learning from Deaths - Deaths reviewed under PSIRF as Patient Safety Incident Investigations (PSII's)

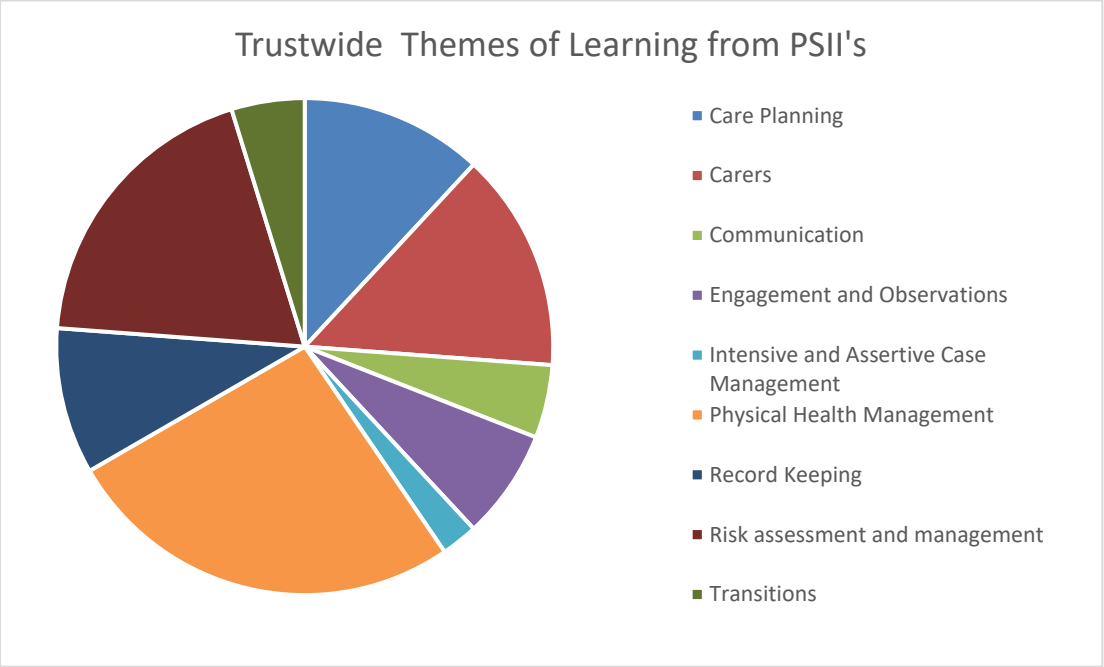
9.5 The NHS Patient Safety Incident Response Framework (PSIRF). Replaced the previous NHS Seriosu Incident Framework (2015). CNTW moved to PSIRF on January 20th, 2024. PSII's replaced Serious Untoward Incident Reviews (SI's) as the highest level of Provider led incident review in the NHS.

9.6 The Criteria for a PSII is stricter than the previous SI criteria. As this report spans a timeframe when both frameworks were used, the following data and narrative speaks only to deaths reviewed as PSII's under PSIRF and SI reviews (pre January 2024) that would meet the current PSII threshold.

Event	Action Required	Lead body for response
Deaths thought to be more likely than not due to problems in care (Incidents meeting the Learning from deaths criteria)	PSII	Organisation in which the event occurred
Deaths of patients detained under the MHA or where the MCA applies. Where there is reason to think the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	PSII	Organisation in which the event occurred
Never Events (2018 NHS Criteria or its replacement)	PSII	Organisation in which the event occurred
Mental health-related homicides	PSII	Decision to be taken after discussion with (RITT) NHSE Regional Independent Investigation Team

During the period covered in this report 11 PSII's were completed and signed off through PSLIP panel. There were a further 3 Serious incidents completed under the previous framework but that would have also met the criteria for a PSII.

Each incident identifies both local and trust wide learning. The trust wide learning covers 9 areas.



Learning has been fed into the following Trust wide workstreams for consideration and action.

- Changing the Front Door and Prevention:

- Community Treatment (all ages):
- Supporting those with SMI and Long Term Complex Needs:
- Urgent and crisis care:
- Inpatients (all relevant bed-based service improvements):
- Biopsychosocial risk assessment working group
- Clinical Record Keeping Standards Group
- Carers and Involvement Group
- Transitions

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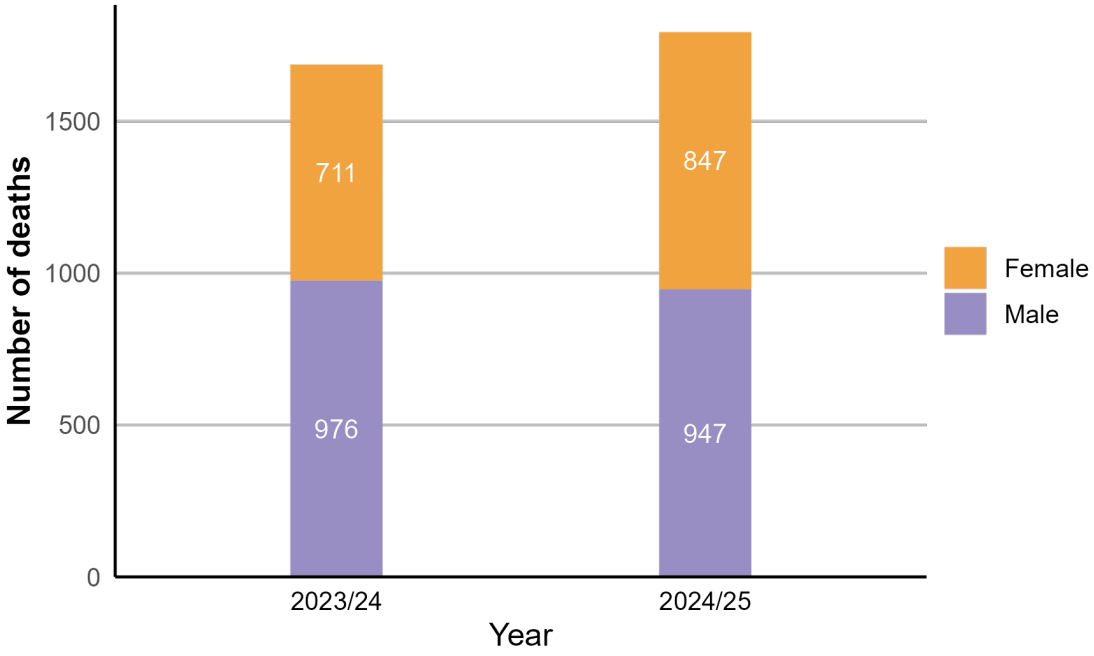
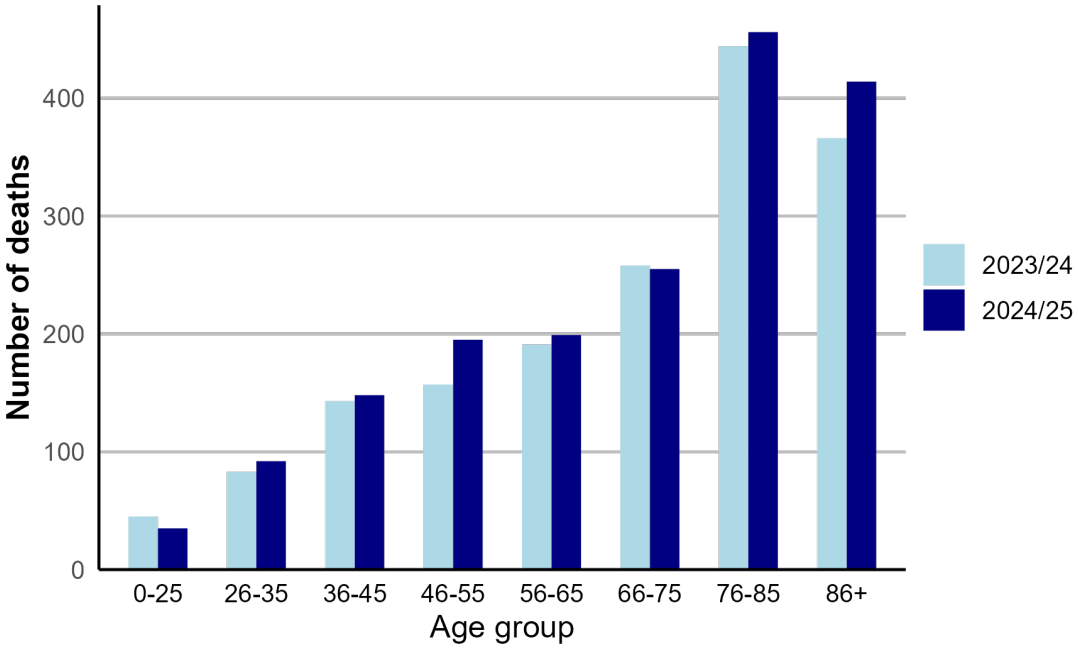
Appendix – Deaths recorded in SafeGuard: demographic, area of residence and service type breakdowns

• All deaths

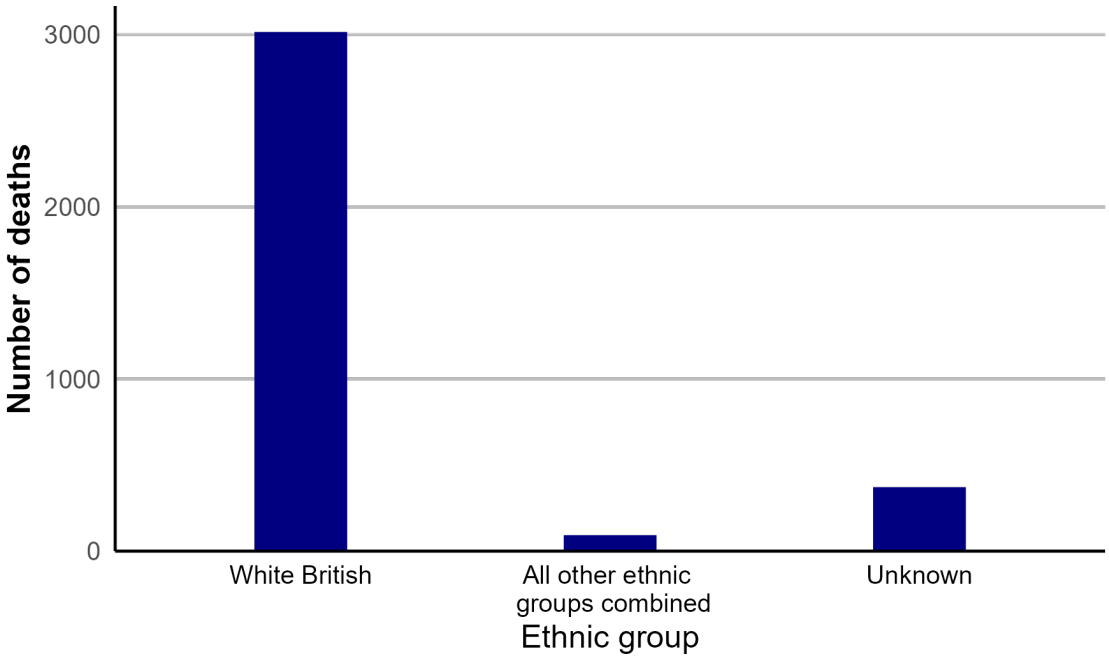
All deaths recorded in SafeGuard by sex



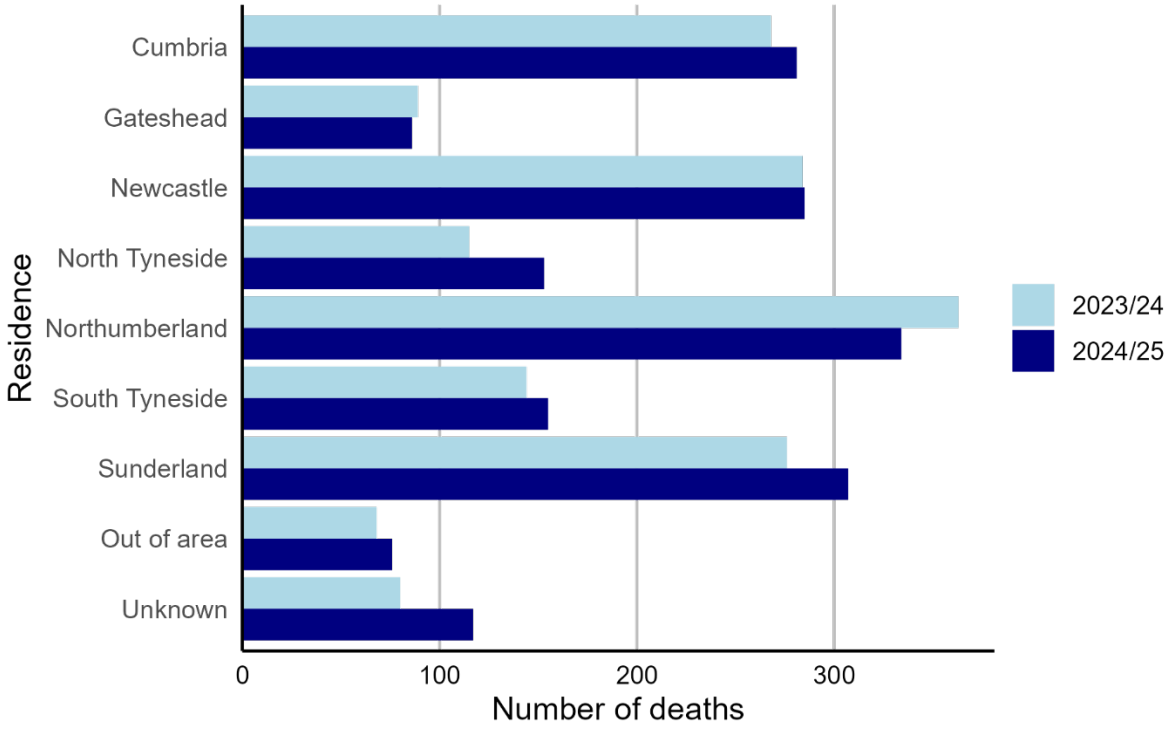
All deaths recorded in SafeGuard by age



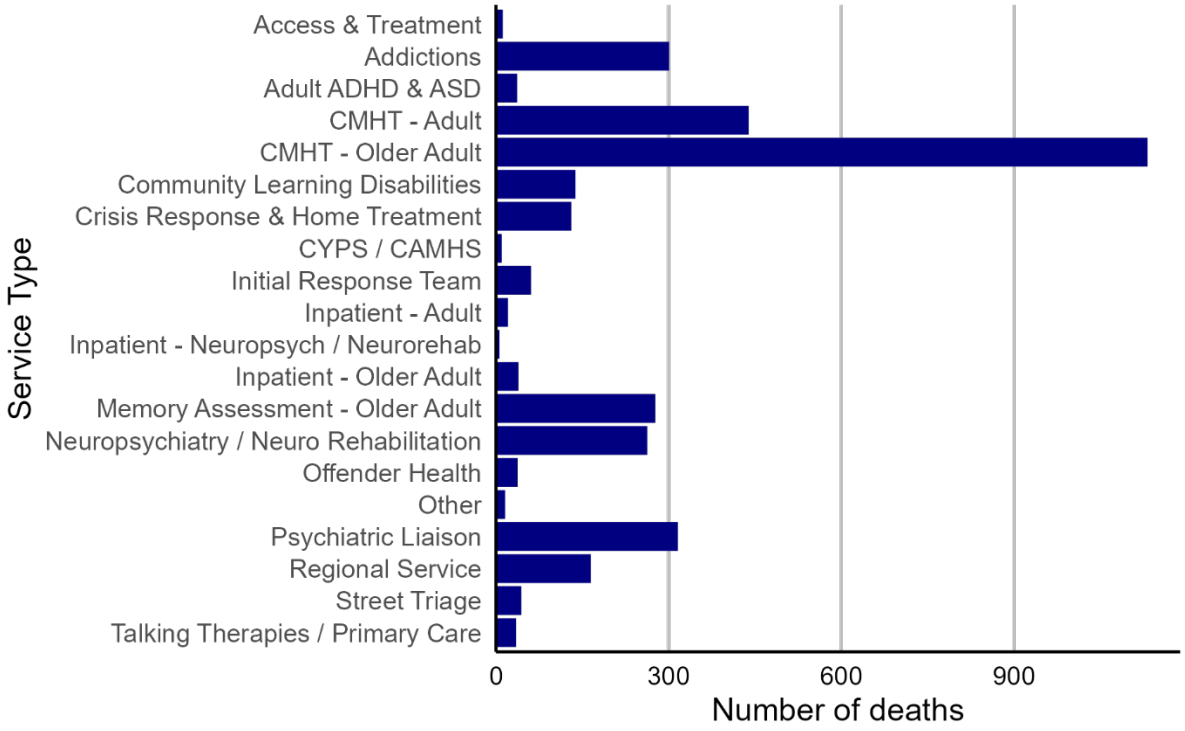
All deaths recorded in SafeGuard by ethnic group



All deaths recorded in SafeGuard by residence

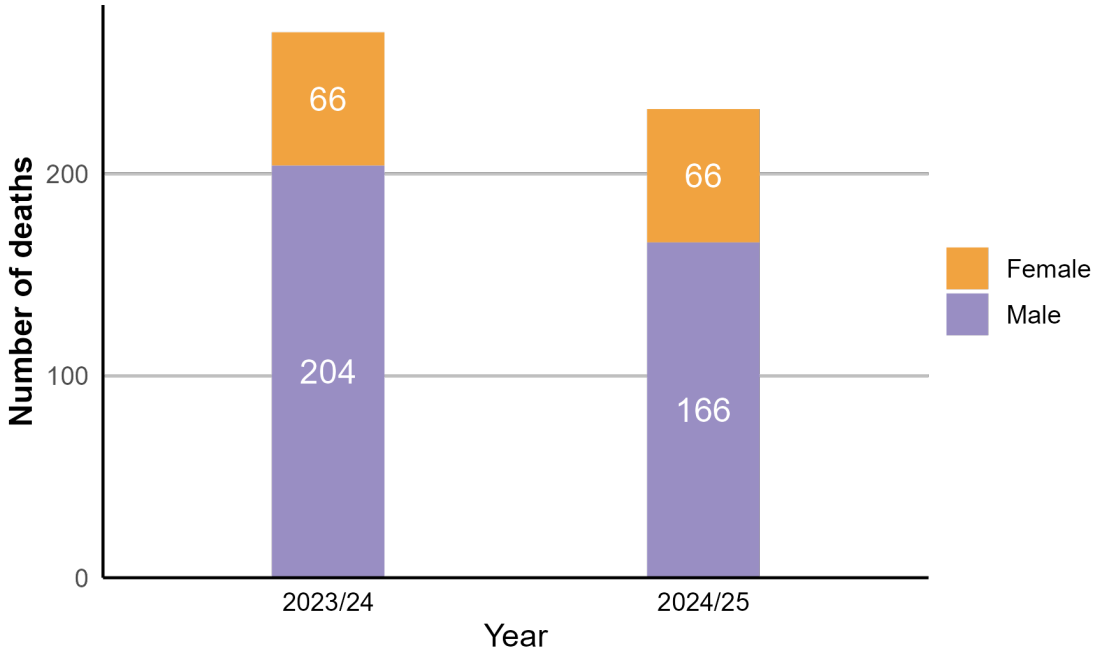


All deaths recorded in SafeGuard by service type

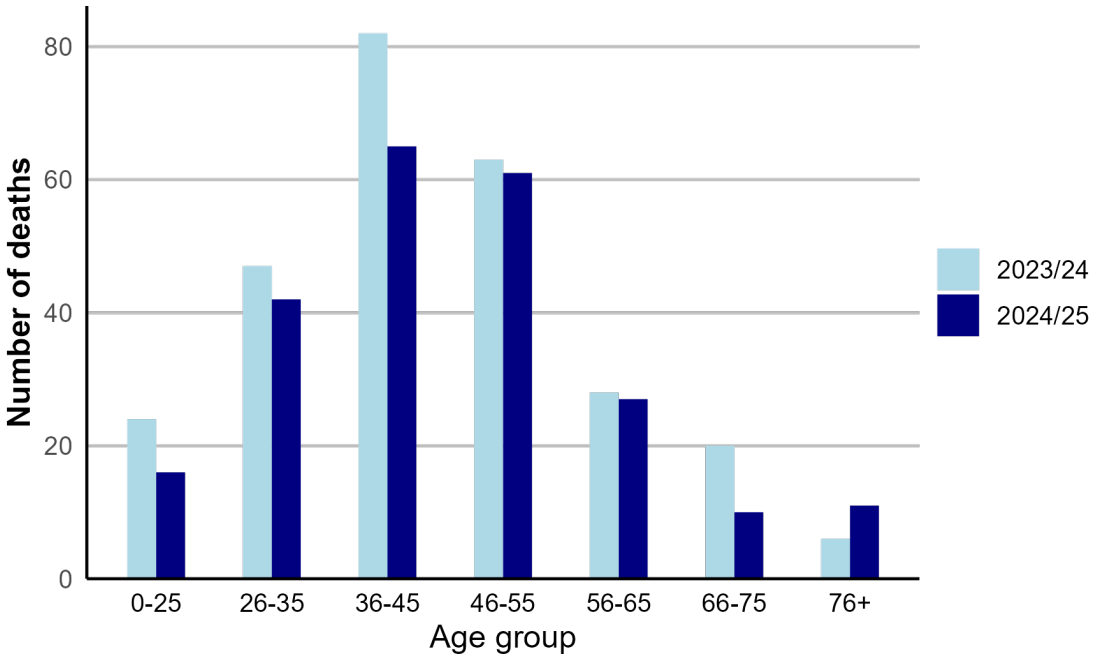


• Unnatural deaths

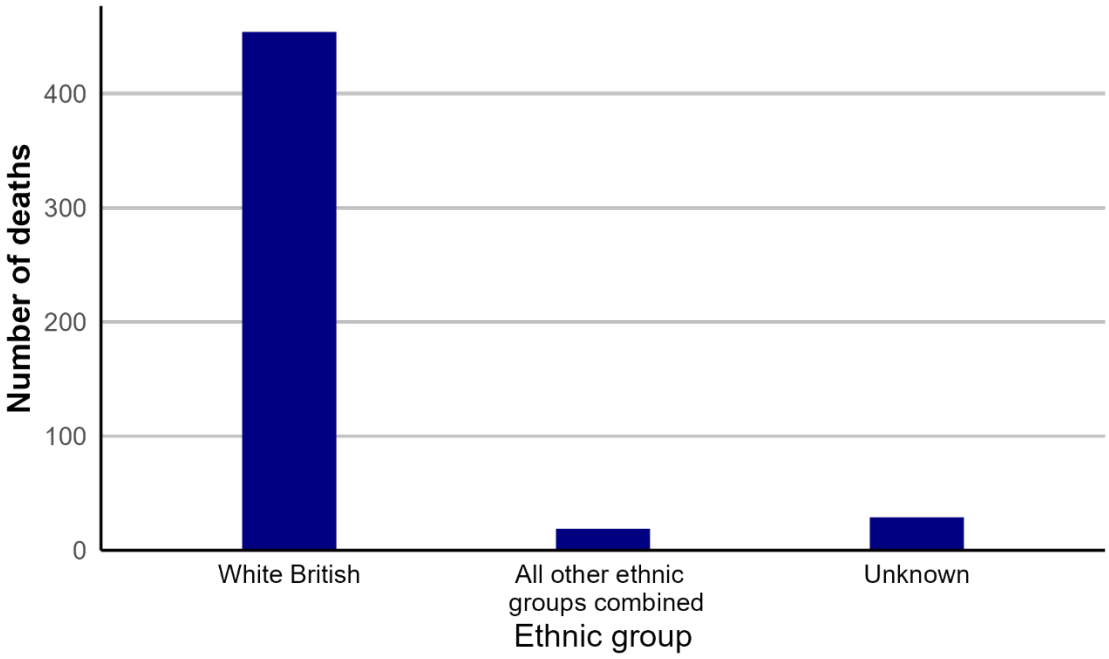
All unnatural deaths recorded in SafeGuard by sex



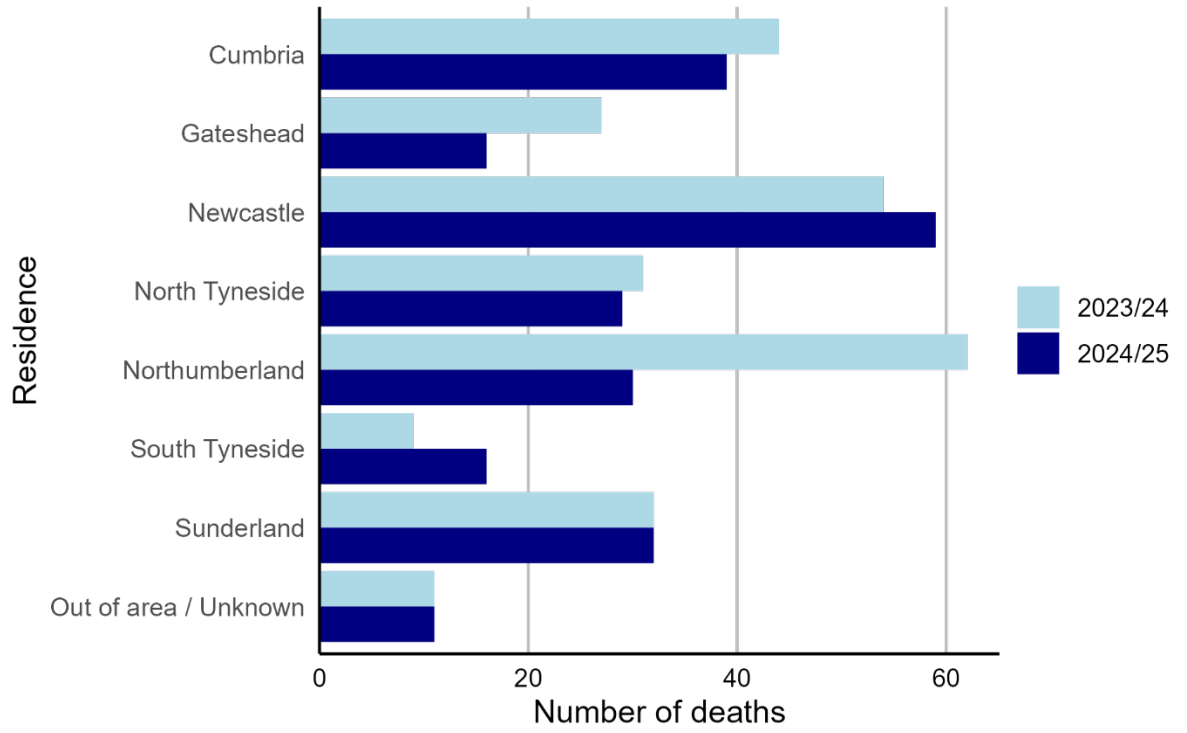
All unnatural deaths recorded in SafeGuard by age



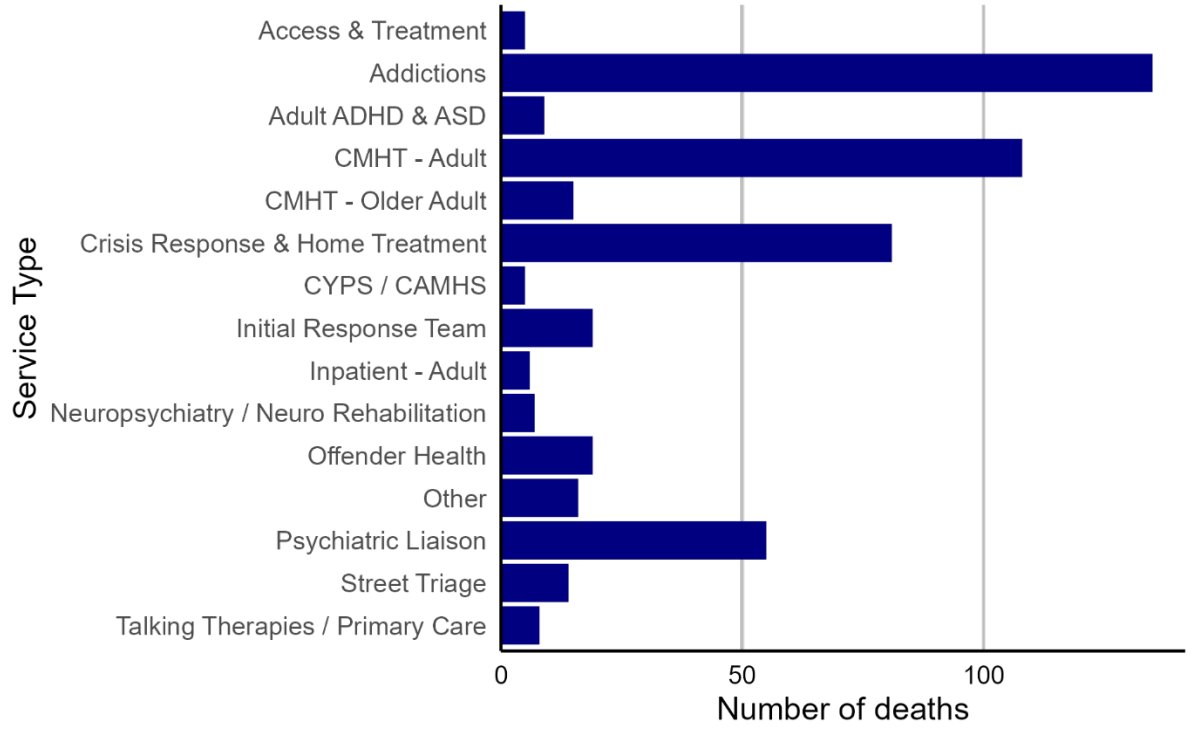
All unnatural deaths recorded in SafeGuard by ethnic group, 2023/23-2024/25



All unnatural deaths recorded in SafeGuard by residence

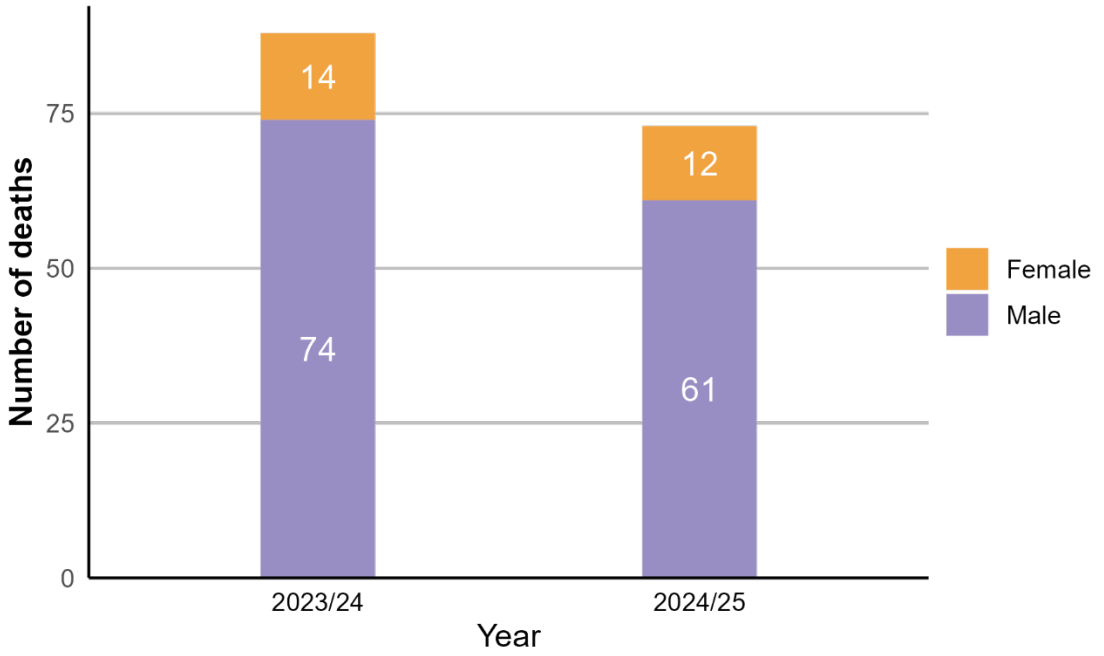


All unnatural deaths recorded in SafeGuard by service type

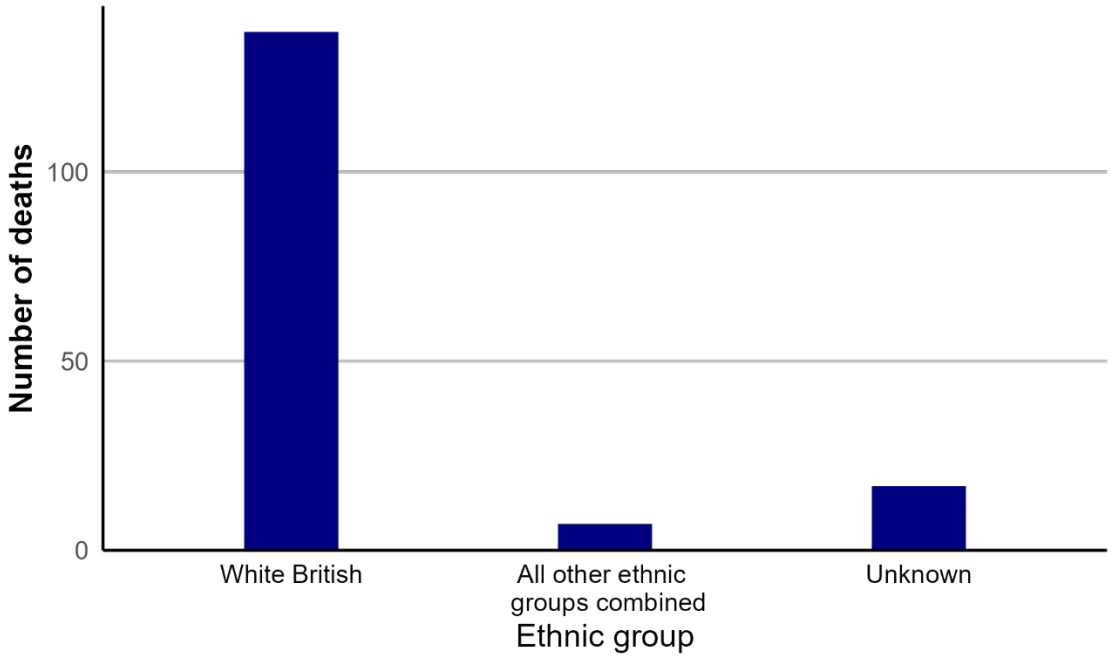


• Self-harm deaths

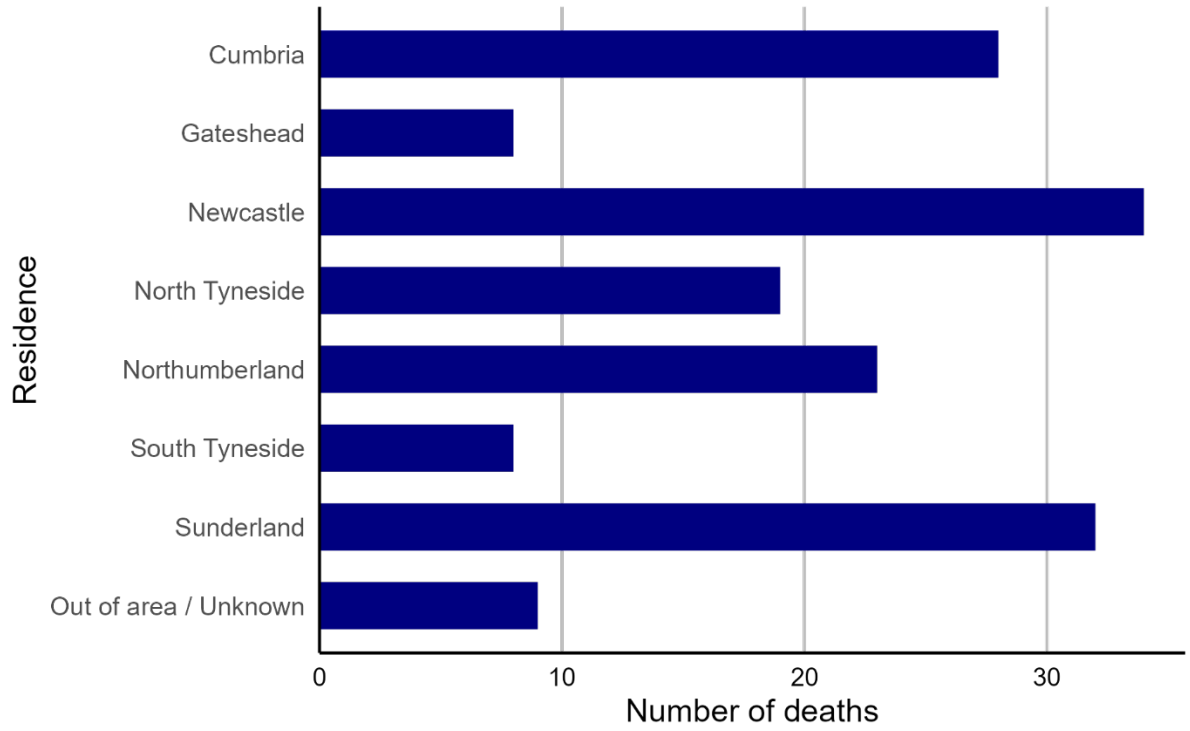
All deaths recorded in SafeGuard as suicide or died as result of own action, by sex



All deaths recorded in SafeGuard as suicide or died as a result of own actions, by ethnic group, 2023/24-2024/25

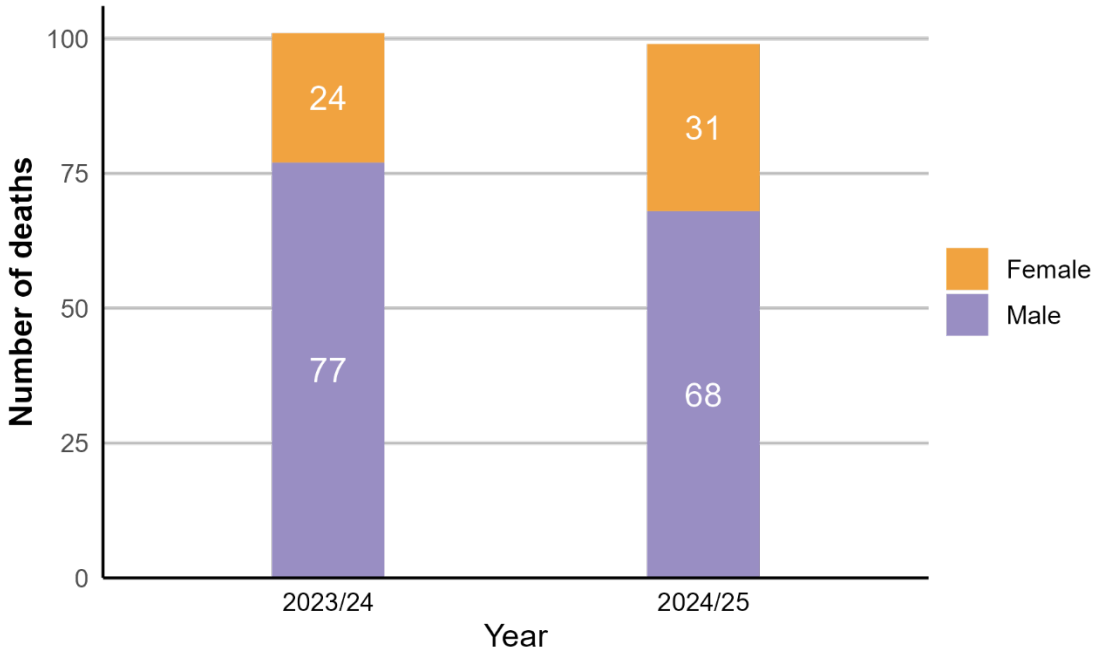


All deaths recorded in SafeGuard as suicide or died as a result of own actions, by residence, 2023/24-2024/25

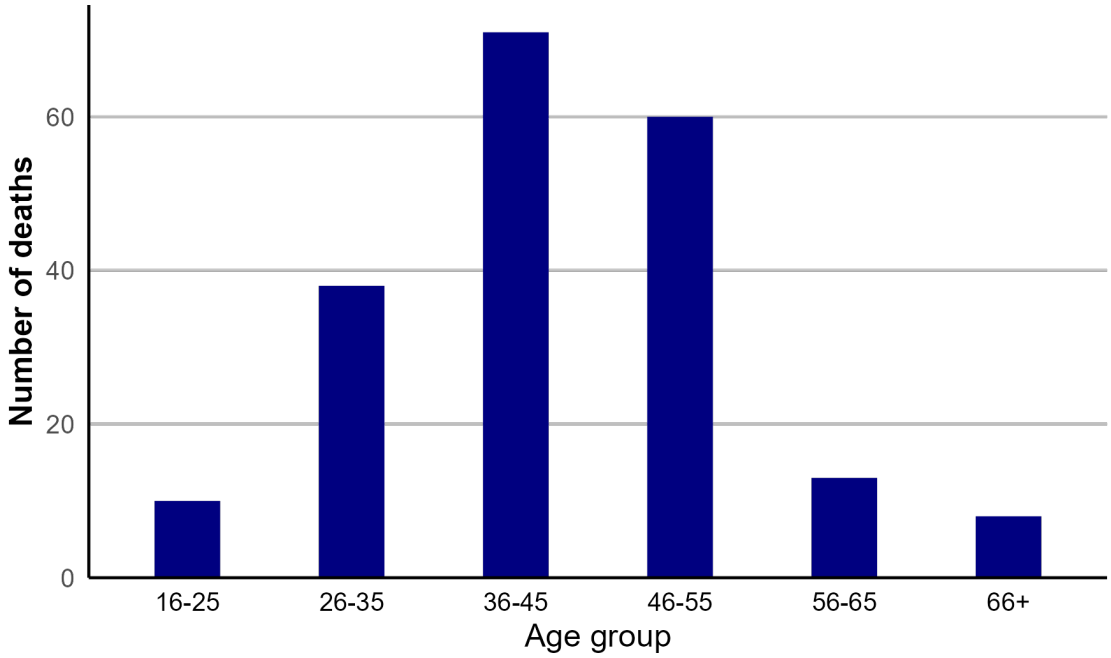


• Drug and / or alcohol deaths

All deaths recorded in SafeGuard as drug and/or alcohol related, by sex

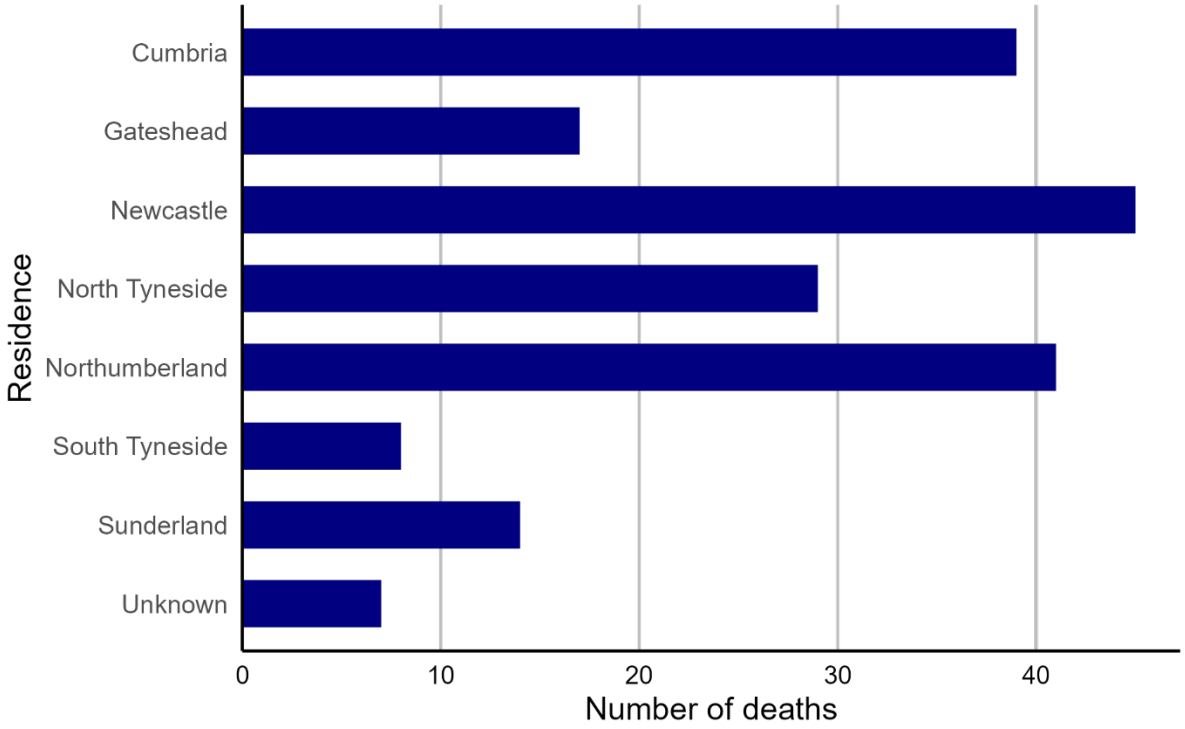


All deaths recorded in Safeguard as drug and/or alcohol related, by age, 2023/24-2024/25

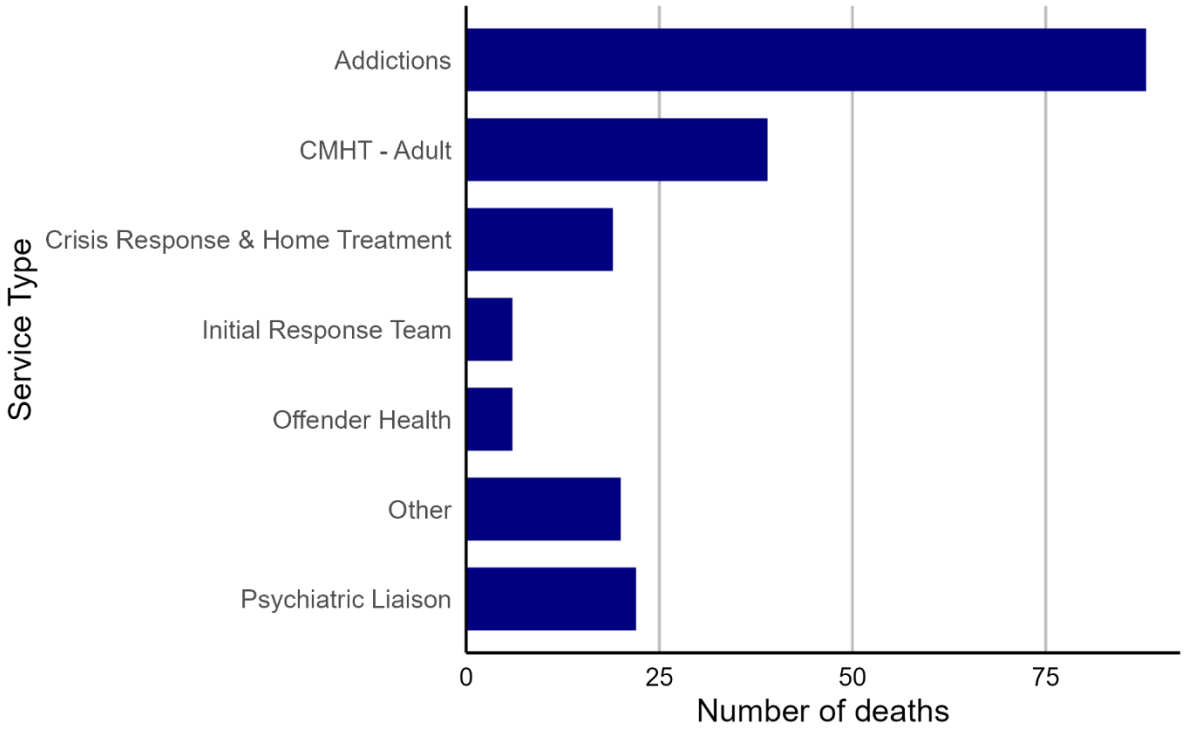


Note – drug-related deaths by ethnic group chart suppressed due to low numbers (<5) in all other ethnic groups combined category.

All deaths recorded in SafeGuard as drug and/or alcohol related, by residence, 2023/24-2024/25

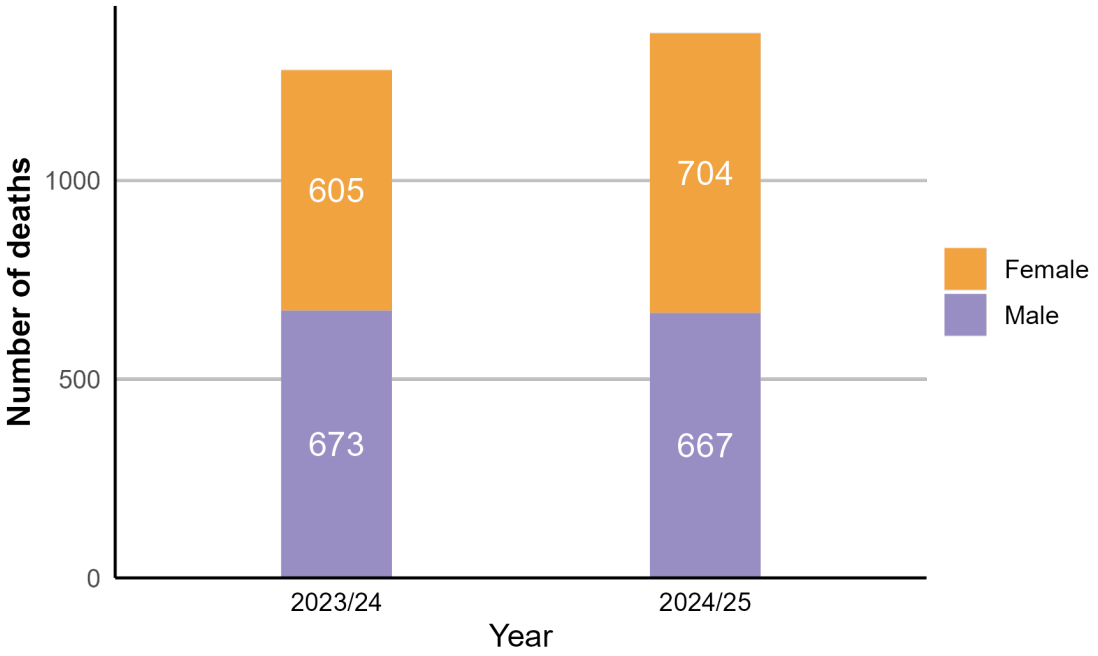


All deaths recorded in SafeGuard as drug and/or alcohol related, by service type, 2023/24 – 2024/25

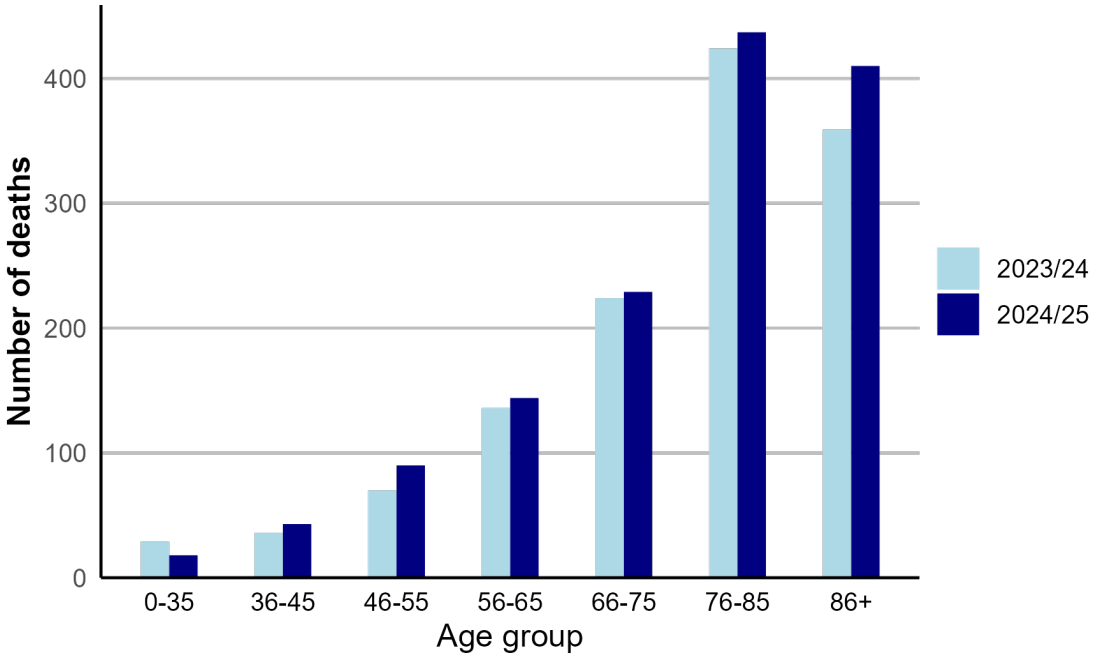


• Natural deaths

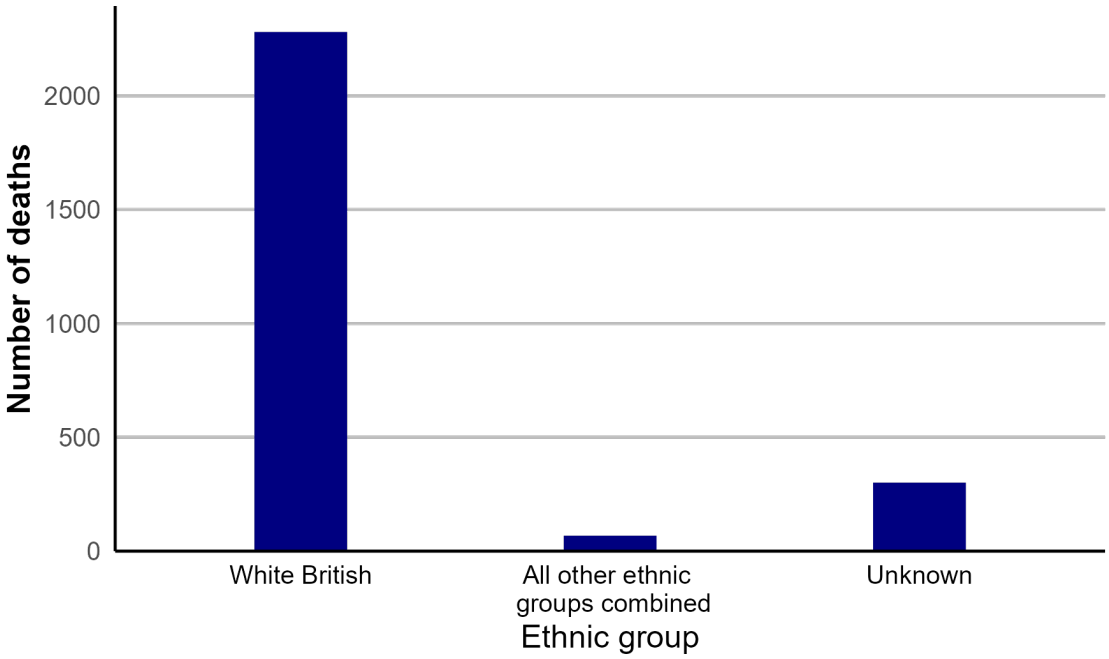
All natural deaths recorded in SafeGuard by sex



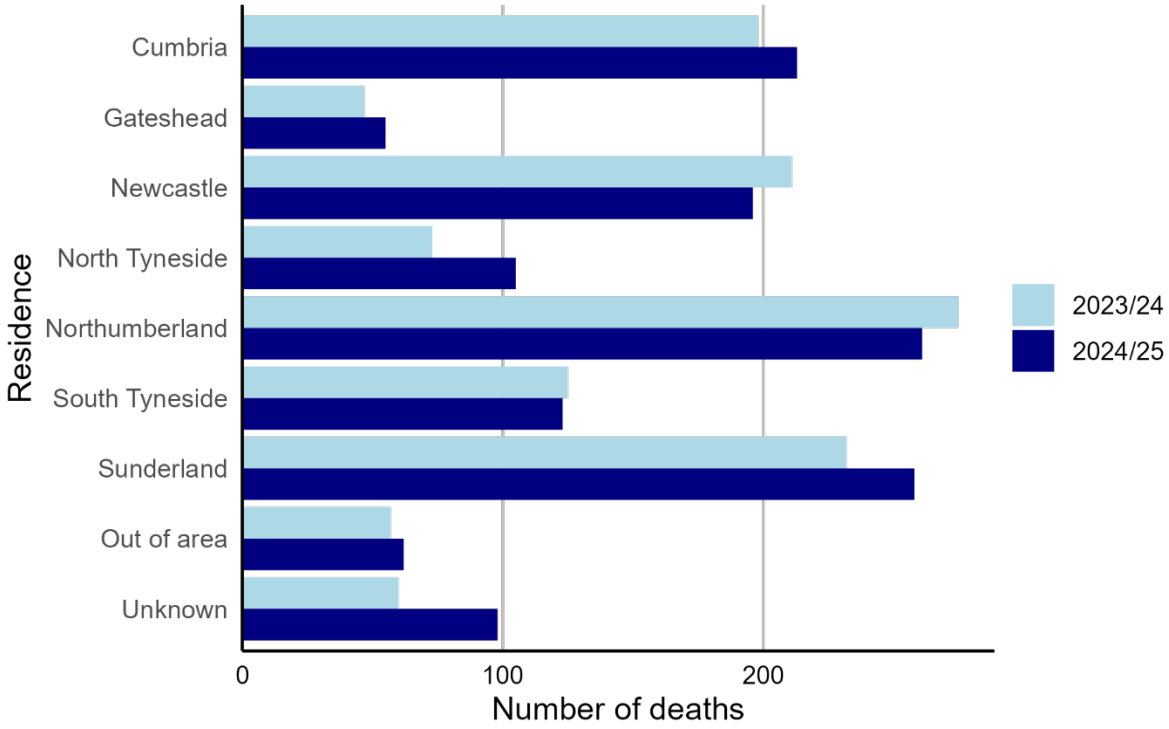
All natural deaths recorded in SafeGuard by age



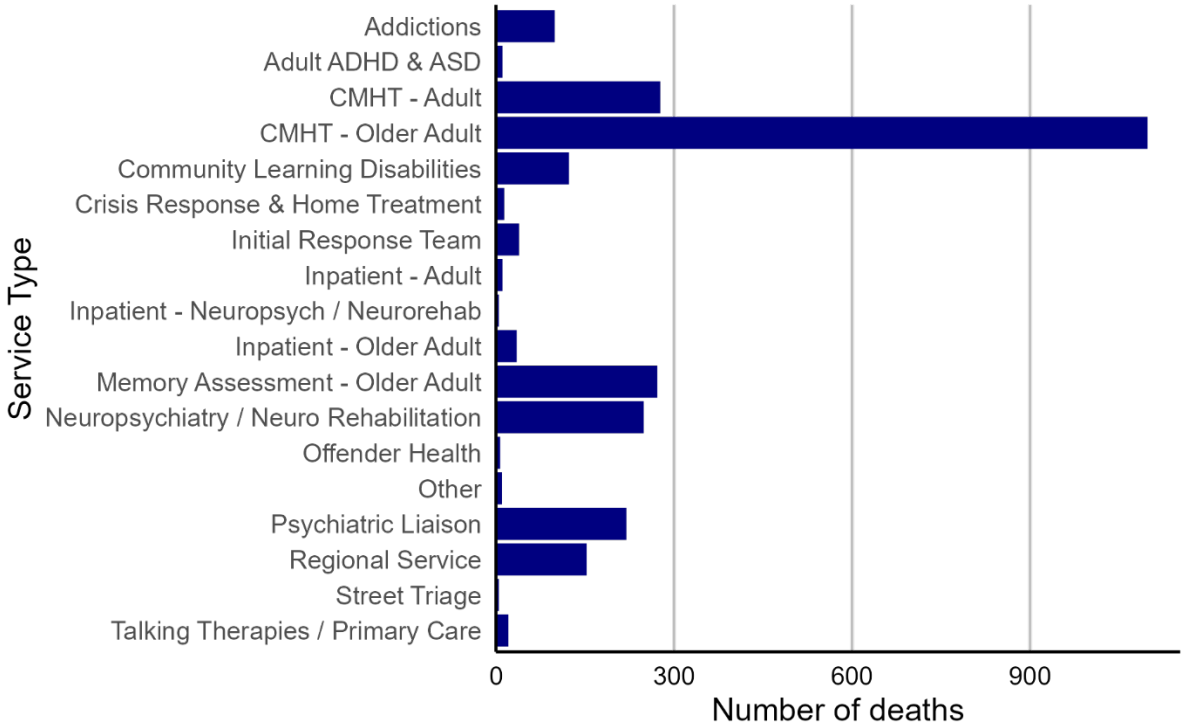
All natural deaths recorded in SafeGuard by ethnic group, 2023/24-2024/25



All natural deaths recorded in SafeGuard by residence



All natural deaths recorded in SafeGuard by service type, 2023/24-2024/25



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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 - Jan 26.pdf

Report to the Board of Directors
Wednesday28 January 2026

People Committee Quarterly Assurance Report
November 2025 – January 2026

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

The Committee provides assurance to the Board with regard to workforce development and delivery of the People strategy, enabling its programmes and plans to be delivered. In accordance with the ambitious purpose of the Committee, it will appropriately appraise the Board on how the Trust is influencing workforce development systemically with partners in line with the Trust's Strategy.

There has been one meeting of the committee during the period held on 3 December 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 254 2	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 254 4	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

It was acknowledged that the Board has recently held a development session on 26 November to review the Trust risk appetite. However, the committee felt it was important to continue to monitor risks, including BAF-level risks during the period of amending the Trusts appetite scheduled for completion and full implementation by April 2026.

4. People Committee focus

4.1 General workforce performance

In terms of workforce performance, there has been an increase in sickness rates above target.(at time of committee 6.68%) A sickness action plan in place and sickness absence is monitored monthly at the Trust-wide performance meeting. Positive improvements were reported in appraisal compliance. Training compliance continues to improve, though challenges remain in

resuscitation and learning disability/autism training due to capacity constraints. Efforts are underway to increase training capacity and improve figures by the end of the financial year.

There has been a decline in turnover rates. Recruitment challenges were discussed, particularly in Cumbria, with a medical position assurance group established to address hotspot areas.

Agency usage has increased, but there is focused work in inpatient services which has led to a reduction in quarter three. In line with national guidance, measures are in place to restrict agency use for bands 2 and 3, with a break-glass process from November and a target for no agency use by January 2026.

Flexible working requests have increased. Work is underway on reviewing the process of ratification and impact on operations.
The committee acknowledged sustained progress in training and workforce metrics, and agreed to keep monitoring key areas such as sickness, agency usage, and flexible working impacts.

The January People Committee workshop will focus on People related actions from CQC reports including Well-led and the development of the Workforce Plan to be submitted to the Board in March 2026.

4.2 Sickness action plan

The committee discussed the Trust-wide sickness absence improvement plan which included actions for both Trust-wide and group-specific implementation. The impact of the loss of the previous absence management system following a service transfer was noted with monitoring of sickness absence currently being undertaken manually. Procurement of a new system is underway. The Trust is learning from other organisations to learn from best practice. A review of the Trust's reasonable adjustments processes will also be undertaken taking into consideration best practice from other organisations.

4.3 Guardian of Safe Working Hours report

The report focuses on support for resident doctors' well-being, training, and contractual responsibilities, was received with particular attention to exception reporting for hours worked beyond contract. Relationships with resident doctors continue to be positive. The upcoming resident doctor strike was discussed with the Trust having plans in place to maintain urgent and elective services, with previous strikes having minimal service impact.

4.4 Raising Concerns report

The report highlighted an increase in reporting in comparison to previous periods with main themes relating to management processes and behaviours. There has been an increase in visibility, awareness and engagement, with improved support from management, and a rise in cases from inpatient and Community North areas, attributed to greater awareness, communication and improvements to speaking up processes. Hotspot areas are being identified and addressed, with leadership and culture issues under review. The committee formally acknowledged and thanked the Freedom to Speak Up champions for their active role.

4.5 Employee Relations report

The committee received an update on performance in relation to employee relations cases. Fact-find investigations are taking an average of 41 days and is considered too long, and the committee recognised the need to balance process speed with safeguarding requirements for

vulnerable patients. An action plan is in place for all cases over 12 months, with themes and learning being incorporated into training and Patient Safety Incident Investigations.

The committee queried the processes in place to enable issues to be resolved without the need for a formal process where appropriate There is ongoing work to improve early resolution, mandatory training for managers, and sexual safety is a quality priority for the Trust in 2025/26. Updates on progress against the Trust quality priorities is undertaken at the Quality and Performance Committee.

4.6 Equality, Diversity and Inclusion Action Plan

The committee received an update on progress against the plan with many actions being reflected in a revised Equality, Diversity, and Human Rights policy, due for ratification in May 2026. The new policy will incorporate reference to anti-racism and ableism. The committee is awaiting the revised Equality and Human Rights Commission's code of guidance, which may require adjustments to priorities and timelines once released.

In terms of the work on the Patient, Carer Race Quality Framework there have been improvements in community engagement, but further progress is required around internal engagement. PCREF updates will be provided directly to the Board moving forward as part of Health Inequality reporting.

4.7 Health and wellbeing update

A detailed update was provided on health and wellbeing initiatives, focusing on assurance and progress for quarters 1 and 2, with a look ahead to quarters 3 and 4. Regular monitoring of key performance indicators is in place as well as data from external providers and regular reviews of operational issues and collaboration opportunities.

Increased staff engagement with EAP services was noted following awareness sessions, and musculoskeletal issues, especially back problems, are being addressed through collaboration with Optima and health and safety teams. Burnout remains a consistent theme, with plans to work with the North East and North Cumbria Integrated Care System (NENC ICS) Wellbeing Hub to share information and support for staff.

Flexible working data is shared with groups to support staff wellbeing, and the special leave policy has been updated, with CNTW influencing regional retention work.

A new Practice Guidance Note and toolkit for managers has been developed linked to the sexual safety charter with a campaign launch planned for the new year.

The Trust has been successful in securing £50,000 from NHS Charities Together for a programme supporting staff through people processes. Ongoing evaluation will be undertaken and progress will be monitored through the Charitable Funds Committee in terms of the resource allocation.

5. Other issues and assurance received by the Committee

5.1 Training Academy Annual Report

The report provided detail on the delivery of statutory and mandatory training, growth of the Digital Academy, and development of AI tools for clinical scenarios and training support.

The apprenticeship and career development team currently supports 300 staff across 35 apprenticeships, with 62 new starters this year.

The Accredited Learning Centre continues to deliver a range of courses, including children and young people's programmes, preceptorship, and a new Level 4 course for admin team leads.

The committee noted the need to align student and apprenticeship supply with future workforce planning, acknowledging ongoing change and the importance of linking CPD spend and workforce planning.

5.2 Job evaluation project

The job evaluation project is a national initiative related to pay and conditions, with a recommendation for Board-level oversight. It was agreed at the December closed meeting of the Board that oversight would be delegated to the People Committee.

5.3 Committee governance

In line with the five objectives agreed by the Chair and Chief Executive for the second half of the year, the outcomes from the ConsultOne independent review of governance and recent high-level feedback following the CQC inspection, work is taking place to review the governance arrangements for Board Committees. Meetings with the Director of Communications and Corporate Affairs, Committee Chairs and Executive Leads have been arranged to take place in January to undertake a review of cycles of business and reporting requirements to ensure committees have a strong process in place underpinned by the provision of robust assurance and enabling key areas of focus to be identified.

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** that the January workshop will focus on the development of the Trust Workforce Plan in advance of submission to the Board of Directors in March 2026.

Brendan Hill
Chair of People Committee
January 2026

4.2 RAISING CONCERNS AND WHISTLEBLOWING BI-ANNUAL REPORT

Lynne Shaw, Executive Director of People and Organisational Development

REFERENCES

Only PDFs are attached

4.2 Raising Concerns bi-annual Report November 2025.pdf

Meeting	**Board of Directors**		**Agenda item: 4.2**
Date of meeting	**Wednesday 28th January 2026**		
Report title	**Raising Concerns/Whistleblowing Report**		
Report Lead	**Lynne Shaw, Executive Director of People & OD**		
Prepared by	**Gemma Pattinson, Deputy Director of People & OD**		
Purpose	**For decision**	**For assurance**	**For awareness**
		X	x
Report previously considered by	People Committee – 3rd December 2025 Audit Committee – 14th January 2026		
Executive summary	This report provides an overview of whistleblowing and concerns raised within Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust for the period 1 April to 30 September 2025. It covers cases reported centrally to the Workforce team, those raised with the Freedom to Speak Up Guardians (FTSUG), and concerns reported to the CQC. Informal concerns managed locally by operational managers are not included. **Key points:** • 72 issues were raised during the period (67 via FTSUG, 4 via CQC, 1 via Workforce), an increase from 65 in the previous period and the highest reporting period to date. • The main themes remain Management Processes and Bullying. Other themes include patient safety, recruitment, behaviour, support, culture, and equality, diversity and inclusion. • Two cases were reported through multiple channels (Workforce & FTSUG, CQC & FTSUG). • The Trust continues to ensure all concerns are reviewed robustly, with formal investigations undertaken where required. • Improvements are ongoing in employee relations processes, including updated Disciplinary and Resolution Policies and a new training package to roll out to managers. • The number of Freedom to Speak Up Guardians has decreased to three, with recruitment underway to increase capacity. • The FTSUGs and champions continue to support staff in resolving issues locally, with ongoing efforts to raise awareness and improve feedback mechanisms. The Trust recognises the risk of poor staff motivation and engagement if staff concerns are not addressed. Regular meetings and a clear process for raising and addressing concerns are in place to mitigate these risks. The Trust remains committed to fostering a culture where staff feel safe to raise concerns, with ongoing work to improve processes, support, and communication.		

Detail of corporate/ strategic risks	**SA3 – Great Place to Work**. 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.
Recommendation	No note
Supporting information / appendices	N/A

Give respect
Get respect

Board of Directors
Wednesday 28th January 2026
Raising Concerns/Whistleblowing Report

1. Executive Summary

The purpose of this paper is to provide a summary of whistleblowing cases/concerns raised over the period from 1 April to 30 September 2025.

The paper aims to give an overview of cases reported centrally to the Workforce team in line with the Trust's Raising Concerns Policy. Concerns raised with the Freedom to Speak Up Guardian (FTSUG) are also included. Additional concerns are raised and dealt with informally at a local level by operational managers and these concerns are not logged centrally.

In Sir Robert Francis' Freedom to Speak Up review it stated that not all concerns raised become subject to formal investigation under Raising Concerns or Grievance Policies. This is an approach welcomed and adopted by the Trust.

Everyone deserves respect and work should be a safe space for everyone, all concerns are taken seriously, and staff can raise concerns via line managers, Workforce, Trade Union representatives and Freedom to Speak Up Guardians. Support is offered via the Regional Wellbeing Hub, staff networks and support groups as well as the Trust Occupational Health service – Optima.

During the period identified, 72 issues have been raised via the FTSUG (67) CQC (4) and Workforce (1). This is an increase compared to the previous period (65). The four CQC concerns related to:

- Yewdale (Inpatient) August 2025 - regarding the support during planned closure (CAS-1024961-W1S3T3)
- Primary Care Mental Health Teams in South Shields (Community) August 2025 - regarding Culture (CAS-1022255-B6W3N9)
- North Cumbria Crisis Team (Community) May 2025 - regarding Patient Safety (CAS-847875-G4Q7N6). This is a case also raised by the Freedom to Speak up Guardians
- Rowanwood (Inpatient) April 2025 - regarding Staffing (CAS-866074-P7H4X7)

The one Workforce concern related to:

- Sycamore (Specialist) August 2025 - regarding bullying behaviours. This is a case also raised by the Freedom to Speak up Guardians.

The trend remains linked to Management Processes and Bullying.

In terms of the report, it should be noted that two cases above were reported twice. The first to Workforce and FTSUG and the second to the CQC and FTSUG.

2. Risks and mitigations associated with the report

The Trust ensures all concerns raised are reviewed robustly and where required undertakes formal investigations.

3. Position Update

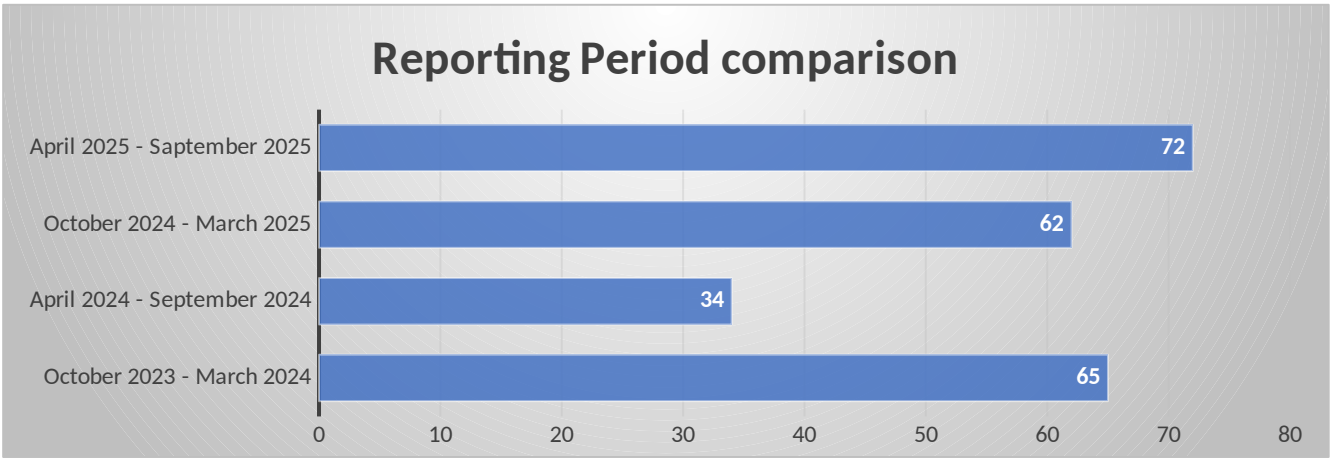
The Trust has had for a number of years a clear, defined process for recording cases that fall under the scope of a policy such as whistleblowing (raising concerns), disciplinary or grievance, however, there are a number of concerns raised which do not meet the Disclosure Act's definition of whistleblowing. In these instances, the Trust has developed a separate recording category called "raising concerns" for reporting purposes.

Concerns which have been raised through the disciplinary and grievance procedures are not included within this report.

Summary of Cases Logged Centrally and with FTSUG for the period 1 April – 30 September 2025

Theme	FTSUG	CQC	Management
Management Process	15	1	
Bullying	9		1
Patient Safety	8	1	
Recruitment	6		
Behaviour	5		
Support	4		
Culture	4	1	
Sponsorship	2		
Wellbeing	2		
Fraud	2		
Assignment of duties	2		
Equality Diversity and Inclusion	2		
Infection Prevention and Control	1		
Accommodation	1		
Unknown	1		
Staff allegation	1		
Staffing	1	1	
Relationships	1		
Grand Total	**67**	**4**	**1**

The graph below shows that in comparison to the previous reporting period the total number of concerns raised has increased and is the highest reporting period to date. The number more than doubled the amount from the same reporting period last year.



The Freedom to Speak Up Guardian follow-up process continues with monthly meetings between the Group Heads of Workforce, Deputy Director of People and OD and Freedom to Speak Up Guardians. These meetings ensure that timely action is taken for concerns raised.

During this reporting period the number of Freedom to Speak up Guardians has decreased to three. There is an ongoing recruitment process to increase capacity.

Areas where concerns have been raised

Area	FTSUG	CQC	Management
Inpatient	21	2	
Community North	13	1	
Specialist	10		1
Corporate	9		
Community South/Central	8	1	
NTWS	4		
Unknown	1		
Trustwide	1		
Grand Total	**67**	**4**	**1**

4. Themes

Management Process
Mirroring the previous reports, many of the concerns raised regarding Management Processes (policies and procedures) are linked to employee relations processes. The main reason for concerns raised is where an employee is not in agreement with a disciplinary process being undertaken, the timeliness of investigations or being placed on alternative duties while an investigation is ongoing. A newly raised concern under the theme management process is consultation for Organisational Change.

Work is ongoing on improving Employee Relations Processes, the updated Disciplinary and Resolution (formerly Grievance) Policies have been ratified and are now in circulation. A training needs analysis was conducted in September 2025 to assess managers' knowledge and confidence in managing employee relations issues to inform the new training rollout.

Work is also ongoing to support improvements in timescales for employee relations processes. This remains a challenge, in the main due to the high number of cases being managed.

Behaviours (including bullying)
Behaviour continues to be a theme with the behaviour of management/supervisor being highlighted; this includes concerns regarding unfair treatment, inappropriate emails to one another. Under this umbrella of behaviour, it can also include the theme of bullying and harassment. Not all cases are escalated, however, and in most instances the Freedom to Speak up Guardians support and coach staff members to address concerns locally.

In the reporting period the Trust continues the rollout of the Leadership programme which focuses on compassionate leadership.

Role of Guardians

The Freedom to Speak Up Guardians have sought to help staff resolve issues themselves without them having to escalate the issue. This is through encouraging conversations to take place with managers in line with the Raising Concerns policy, signposting staff to utilise existing processes and support mechanisms available or providing some confidence and reassurance to staff.

The Guardians continue to work with the FTSUG champions and meet with the champions on a regular basis. Currently there are 74 Champions, 34 of which are new in their role. All champions have been issued with a slide pack which they will be presenting locally in their own teams.

In terms of gathering feedback, there was a FTSUG survey undertaken which aimed to gather the views from staff, including the awareness of speaking up and whether staff are comfortable approaching the Guardians and raising concerns. There was a low response rate at 287 responses over 6 weeks (17/03/25 – 29/04/25).

The Communications team continues to raise the profile of speaking up and raising concerns. A refreshed communications plan is established. There have been no visits carried out by the FTSUGs during the reporting period as focus has been given to working with the champions. However, there has been attendance at the Manager's meeting and the Ward Manager's Forum to raise the profile and there are plans to continue to link into various Trust-wide meetings.

In terms of feedback from individuals when the FTSUG case is closed, this is information gathered by a Teams link sent out to feedback on the FTSUG service. Currently there is a low response rate of 4 - all have been positive.

Our FTSUGs confirm that over the period of the report the themes as described above remain similar to previous reporting periods.

There continues to be regular meetings with the FTSUGs and the Executive Director of People and Organisational Development to discuss themes and escalate any cases that need support to resolve.

Gemma Pattinson
Deputy Director People & OD

Lynne Shaw
Executive Director People & OD

10 November 2025

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 - Jan 2026.pdf

Report to the Board of Directors
Wednesday 28 January 2026

Resource and Business Assurance Committee Quarterly Assurance Report November 2025 – January 2026

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 have been three meetings of the Committee during the period held on 14 November, 5 December and 12 December 2025.

The agenda has been revised to better align with current Trust objectives and to enable the committee to focus adequate time on key priorities. The content of committee reports continues to be refined with a focus on data insights to inform assurance.

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
NEW RISK There is a risk that the Trust has insufficient cash which would lead to reputational damage and ongoing costs of, and reliance on, borrowing cash from NHSE.	4 (likely) X 4 (significant) 16

Risk management

The Committee continues to use the BAF risks as a reference point for focus and discussion on the highest risks for the organisation. During the period, the controls, assurance and actions relating to BAF risks 2545 and 2546 were strengthened in terms of detail and clarity. Risk 2546 also included reference to the risk relating to the £3m surplus.

The Board held a development session on 26 November to review the Trust risk appetite which will inform the BAF risks associated with the committee moving forward. The BAF in its entirety will be reviewed during January and February with a view to implementing the new risk appetite from April 2026 following Board review in March. This process will include discussions with Executive Leads to review individual BAF risks.

In the meantime, a further outstanding committee action was agreed to develop a new BAF risk regarding cash flow – see section 3 above. It was agreed that it is important to ensure appropriate sightedness at Committee and Board level in terms of risk, during the period of transition to the new risk appetite. The risk was presented and agreed at the 16 December closed Board meeting.

4. Resource and Business Assurance Committee focus

4.1 Themes and main highlights from the meetings

During the period, the committee has focused on the short-term 2025/26 financial performance, specifically how deliverable the remaining financial recovery is, how sustainable the solutions are and the significance if assumptions fail. In parallel, the committee has also focused on the medium-term plan position, including 2026/27, 2027/28 and 2028/29 both in terms of the planning process and delivery confidence, as well as the draft planning Board assurance statement in terms of maturity, consistency with the medium-term plan position, language and grading position.

4.2 Progress against short-term financial plan (including progress against Workforce Reduction Plan

The Trust continues to engage in discussion with the North East and North Cumbria Integrated Care Board (NENC ICB). There has been a particular focus on closing the remaining financial gap which would require service change, mainly due to antipsychotic drug costs and care packages.

The short-term finance report was discussed in detail focusing on progress against the workforce reduction plan and financial delivery for months 7–12. The committee emphasised the importance of being clear about tracking progress against the overall reduction target and discussed the likelihood of achieving the additional workforce reduction target. Detailed actions and progress updates will be provided to every meeting to ensure the Trust is working toward a realistic position in the context of the feasibility and impact of further reductions on service delivery, quality and safety. If further savings are required, alternative areas for cost reduction should be explored alongside additional workforce reductions. The importance of triangulating discussions across all Board committees, particularly Quality and Safety and People Committee was recognised. For the remaining financial gap, options and mitigations to achieve this will be monitored through the committee, which may include but are not limited to further workforce reductions.

Additional financial risks were discussed, including a potential £3m capital overspend due to changes in national rules. Risk registers including the BAF have been updated accordingly. The national rule change is being challenged as unreasonable since contracts and projects were already committed based on previous rules. The team is working on mitigations, such as reviewing which capital projects could be delayed or negotiating for capital slippage and will update the committee with options.

The committee requested clearer detail in future reports of what is already secured as achievable, probable, and aspirational within the contingency plans if ICB funding support is not forthcoming, and explicit reporting of recurrent versus non-recurrent delivery, emphasising the need for transparency and assurance on the Trust's financial position.

The committee will maintain a strong focus in 2026/27 to address the underlying deficit and reference costs for long-term sustainability, while ensuring the quality and safety of services. It was recognised that aligning ongoing oversight of the Trust financial planning in the short and medium-

term with the Workforce Plan and Model of Care and Support would be crucial in terms of reporting and strategic discussions moving forward.

4.3 Medium-term resource plan – plan for development

The committee discussed the draft medium-term resource plan which to date is underpinned by three-year workforce and financial projections from all departments, aligned to the Model of Care and Support and service transformation objectives. The plan covers three years of detailed plans and a five-year narrative and must meet national expectations for inflation and efficiency. Concerns were raised about whether mental health services will receive adequate community growth funding due to how national allocations are structured and updates continue to be provided to the committee as the planning process is progressing.

The committee discussed the draft plan in detail including the underlying financial position and gap, the impact of cost improvement plans and the availability of non-recurrent funding. Achieving the required efficiencies required is unprecedented, and breaking even in 2026/27 will be critical for future investment and sustainability. The discussion also touched upon the funding and investment required to deliver the ambitions aligned to the Trust's Model of Care and Support. Confidence in the plan across the three years increases year-on-year but the robustness in the detail and deliverability of plans will be key.

The medium-term plan also requires submission of a Board assurance statement to provide assurance relating to the development of the plan. The committee suggested some amendments to strengthen the commentary within the statement prior to submission to the closed Board for review and approval at the December meeting. The assurance narrative emphasises the robustness of the process, and Board and committee level challenge and scrutiny, while acknowledging the scale of financial risk and challenge, and the importance of continued Board scrutiny.

The medium-term plan continues to evolve for final submission to NHS England on 12 February 2026. The meeting of the February committee will be opened up the wider Board membership to review the medium-term plan.

4.4 Benchmarking – reference costs and corporate benchmarking

The committee reviewed benchmarking data comparing the Trust's reference costs (the average unit costs for specific healthcare services provided to NHS patients) and benchmarking costs and efficiency to other providers. Several corporate functions have been identified as cost outliers in higher quartiles. Deep dives into high-cost areas have been undertaken to identify potential efficiencies and inform planning. The committee asked that future reports be concise, focusing on key insights and actionable findings. Reference cost results show the Trust is less efficient than the national average. Higher costs are due to high acuity of services, a larger inpatient footprint, and reduced community activity, which raises unit costs.

Further clarity is needed as to which cost variances are genuinely addressable and which are justified by service needs or scope. Decisions on targeting savings or maintaining higher costs for quality will be made as part of the medium-term planning process. This will remain an item on the committee agenda for oversight and assurance.

4.5 Provider Collaborative assurance report

The committee noted an overspend in adult secure services mainly due to out-of-area placements and delayed reopening of beds. Plans are underway to open more beds and bring patients back in-area, which should reduce costs and address the overspend. The committee will keep this issue under regular review, focusing future updates on key risks and progress.

4.6 Estates and capital update

Key projects, including the older people's Newcastle inpatient scheme, are already underway based on the original funding plan. Mitigations associated with the risk of the £3m surplus (see section 3) include reviewing projects for possible delays, negotiating capital allocation swaps with other providers, and possibly deferring schemes. The risk has been formally documented and updates on mitigations will be provided at the next meeting.

The committee has requested a recovery plan to reinstate the backlog allocation across the next two years and prioritise critical patient facing areas, and to note the potential for future risks in 2026/27 and 2027/28.

Improvements have been made to the estates and capital report which now includes a dashboard overview of capital projects, focusing on completing current schemes. Future dashboards will include RAG status on individual projects for clarity.

5. Other issues and assurance received by the Committee

5.1 Update on transfer of Digital Services to NTW Solutions Limited

The committee received an update at the November meeting on the process for transfer of the Digital Solutions to NTW Solutions Limited on 1 October 2025 and assurance was provided that a smooth transfer of the service had been undertaken.

The BAF risk associated with cyber-threat has been transferred to the new Digital Committee and will be reviewed over the coming months in the context of the refresh of the Digital Strategy.

5.2 Committee governance

In line with the five objectives agreed by the Chair and Chief Executive for the second half of the year, the outcomes from the ConsultOne independent review of governance and recent high-level feedback following the CQC inspection, work is taking place to review the governance arrangements for Board Committees. Meetings with the Director of Communications and Corporate Affairs, Committee Chairs and Executive Leads have been arranged to take place in January to undertake a review of cycles of business and reporting requirements to ensure committees have a strong process in place underpinned by the provision of robust assurance and enabling key areas of focus to be identified.

6. 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 BAF 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.
- **Note** the Committees concerns regarding the short-term financial position and note the ongoing oversight of planning delivery.
- Note the review of the Medium-Term Plan prior to submission to NHS England on 12 February.
- **Note** the work to improve the governance of, and reporting to, the committee over the coming months.

Emma Moir
Resource and Business Assurance Committee Chair
January 2026

5.2 FINANCE QUARTERLY REPORT (QUARTER 3)

Lis Dunning, Executive Director of Finance

REFERENCES

Only PDFs are attached

5.2 M9 Finance Report.pdf

Meeting	**Board of Directors**		**Agenda item: 5.2**
Date of meeting	**Wednesday 28th January 2026**		
Report title	**Month 9 Finance Report**		
Report Lead	**Lis Dunning, Executive Director of Finance**		
Prepared by	**Chris Cressey, Deputy Director of Finance & Business Development**		
Purpose	**For decision**	**For assurance**	**For awareness**
		X	
Report previously considered by	Executive Management Meeting (26th January 2026) have received the Month 9 detailed finance report.		

Executive summary

Overall Financial Position

The Trust has reported a £0.6m deficit at Month 9 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 9. See the table below: -

	£m
Planned Deficit	(2.7)
Northgate Land Sale	6.6
Red Shale Provisions	0.7
Expected Surplus	4.6
Reported Deficit	(0.6)
Shortfall	**5.2**

The shortfall plan is from overspends in three areas, staffing over establishment through the first half of the year, Out of Area Treatments (OATs) and pressures on delivering recurrent efficiencies. In addition, there are two key commissioning pressures arising from the impact of GP collective action on the Trust prescribing budget (forecast at £1.7m overspent) and the impact of care packages for inpatients who are clinically ready for discharge (forecast impact of £2.8m).

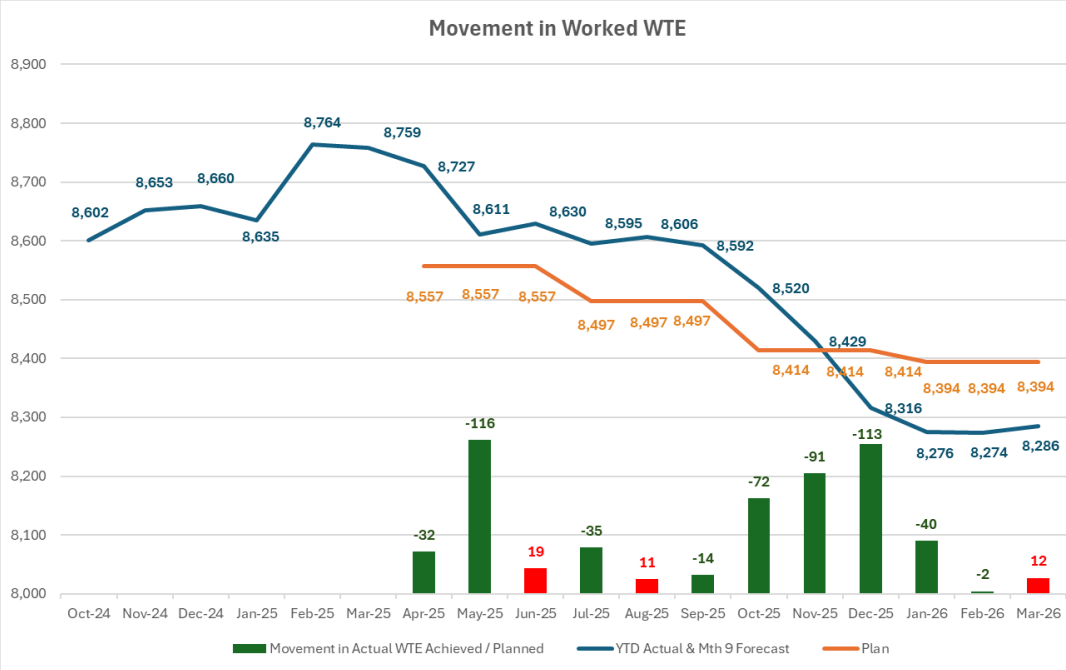
Staffing Over Establishments

The Trust has been over established throughout the first half of year, the staffing over establishment has been reversed through Quarter 3. The table below show the movement in variance from the end of Quarter 2 to the end of Quarter 3.

	Month 9			Month 8	Month 7	Month 6
	Budget	Actual	Variance	Variance	Variance	Variance
	WTE	WTE	WTE	WTE	WTE	WTE
Inpatients	1,673	1,689	16	9	62	106
Community	3,100	3,020	(79)	(42)	(15)	(28)
Specialist	1,917	1,865	(52)	(15)	0	29
Infrastructure	1,821	1,741	(80)	(61)	(55)	(89)
TOTAL	**8,510**	**8,316**	**(194)**	**(108)**	**(8)**	**18**

All clinical groups have reduced the WTE pressure from Month 6 and the infrastructure areas have maintained the position.

The graph below shows the staffing trends against the planned WTE included in the 2025/26 workforce plan. The graph includes the WTE movement month on month through the financial year. The Trust has reduced by over 400 WTE through the financial year to December and is forecasting to reduce by a further 30 WTE by the end of the financial year. The green blocks represent a monthly reduction in WTE from the previous month and a red block shows an increase from the previous month.



The staffing reduction is being managed through the Trust urgent recovery programme presented to Resource, Assurance and Business Committee (RBAC) in November. Detail of the movement at Month 9 is part of the reporting to RABAC on 6th February.

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 £1.3m 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 £8.1m of planned recurrent savings which will not deliver and are being offset by £8.1m 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 £1.7m, a cost shift from the ICB prescribing budget to CNTW.

The Board are already aware of pressures arising from care packages to support inpatients 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. The Executive team implemented an urgent recovery programme in Quarter 2, aimed at delivering staff reductions and non-pay savings in the second half of the year. The programme identifies a range of measures to recover £4.1m in savings. At the end of Quarter 3 the Trust has recovered £3.8m, through staffing reductions and some non-recurrent income and non-pay management.

Through Quarter 3 the Trust has run a Voluntary Severance Scheme (VSS). The one-off cost is included in the 2025/26 position and further mitigations are required to offset these costs to deliver the planned £3.3m surplus.

Capital Expenditure

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

Capital Programme	2025/26
	£'000
CEDAR	450
Newcastle Older Peoples Wards	4,953
Benton House	950
Backlog Maintenance	489
Sustainability	477
Carlisle Civic Centre	363
Omnicell Cabinets*	990
Equipment	100
IM&T	800
Minor Schemes	1,581
Bamburgh 136	100
Clozapine Clinic	394
Tyne Ward	114
PDC – Solar Energy Project	2,032

De-steaming – Prep Works	123
	13,916

The National Oversighting Framework introduced in year restricts organisations in Segment 4 using previous years revenue surpluses within capital. The CNTW plan included £2.9m of previous year surpluses, due to being placed in Segment 4, the Trust is required to reduce the capital programme. CNTW has revised the programme by £1.4m and is working with the ICB to manage the balance of the reduction.

Cash Position

The Trust has a cash balance of £16.6m, at the end December, a decrease from the balance of £20.0m in November. The December balance is £9.4m behind the plan for £26m. The Trust has received the land sale proceeds in Quarter 1 rather than Quarter 4 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 end 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 Trust has increased the price of the Mitford service based on current costs for 2025/26 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). The Trust has agreed with some commissioners to receive payments on account while the dispute on price is settled. This will support the cash position.

Detail of corporate/ strategic risks

The three 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.
- There is a risk that the Trust has insufficient cash balances through 2025/26 through overspends on staffing budgets.

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 reduction in staff numbers delivered through Quarter 3, which must be maintained for 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 financial delivery in Quarter 3 and for the remainder of the financial year supporting the further recovery plan to offset the pressure from VSS, will be taken to RABAC in February.
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 UPDATE 2025/26

James Duncan, Chief Executive

REFERENCES

Only PDFs are attached

5.3 Mid Year Review.pdf

Meeting	**Board of Directors – Public Board**		**Agenda item: 5.3**
Date of meeting	Wednesday 28th January 2026		
Report title	Annual Plan Delivery Update		
Report Lead	James Duncan, Chief Executive		
Prepared by	Ramona Duguid, Chief Operating Officer		
Purpose	**For decision**	**For assurance**	**For awareness**
		X	
Report previously considered by	N/A		
Executive summary	In November 2025 the Board received a progress report on delivery of the objectives set out in the 2025/26 annual plan. The Board noted that the remainder of the year in terms of delivery would be reviewed against the five priority areas set by the Board, which was reported to the Board of Directors in December 2025. Appendix one summarises the position forecasted for the end of Q4 and includes, where possible supporting metrics against delivery. As the Trust develops its medium-term plan, the key deliverables for 26/27 against the strategic ambitions will also be reviewed and presented to the Board of Directors for approval in March 2026.		
Recommendation	The Board of Directors are asked to note the updates against delivery of the 25/26 plan.		
Supporting information / appendices	Appendix 1 – 25/26 Objectives		

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Our five trust strategic ambitions: aims and priorities

2025-26 : Q3 Current Position

With YOU in mind

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

Strategic ambition 1

Quality care, every day

Priority	Latest update/re-prioritisation	Outcomes/metrics
A Strengthen communication with families and carers, ensuring they are actively involved in care decisions and when a patient deteriorates.	**Remaining - delivery planned by end Q4** • Introduction of Martha's Rule. • Strengthening responsiveness to families and carers who raise concerns, which incorporates : o Learning from the pilot cohort "deterioration of patients who have SMI" (identified cohort of 375 patients) o Strengthening Safety Plans (digital record being designed) and ensuring involvement of carers/families **Removed as 2025/26 priority or transferred into BAU** • Triangle of Care - this is now embedded into practices as business as usual	**The number of biopsychosocial risk frameworks that have had carer input – Change: +2.7%** Apr-25: 40.9%; Dec-25: 43.6% **The Number of Service Users who have been involved in developing their Care Plan – Change: -1%** Apr-25: 98.7%; Dev-25: 97.7% **How was your experience? (Trust) - Change: -3.6%** Apr-25: 87.6%; Dec-25: 84.0%; Target: 90% **How was the care we provided? (Trust) - Change: -1.6%** Apr-25: 88.4%; Dec-25: 86.8%; Target: 90% **Did you feel safe? (Trust) - Change: -0.8%** Apr-25: 93.2%; Dec-25: 92.4%; Target: 90%
B Promote care planning that is person-centred, co-produced, and informed by the multidisciplinary team.	Streamlining policies in line with CPA - moved to 2026. **Remaining - delivery planned by end Q4** • Care Plan Improvements o RiO build will be complete by December 2025; o comms and training to be launched in January 2026; **Removed as 2025/26 priority** Monitoring of underperforming metrics continues via Performance meetings (business as usual)	**% service users with Care Plan Reviewed in last 6 months - Change: +14.0%** Apr-25: 59.6%; Dec-25: 73.6% **% service users with Care Plan Complete - Change: +8.5%** Apr-25: 82.3%; Dec-25: 90.8% **% service users with complete risk management and safety plans - Change: +7.6%** Apr-25: 85.4%; Dec-25: 93.0%

Strategic ambition 1

Quality care, every day

Priority	Latest update/re-prioritisation	Outcomes/metrics
C Develop a consistent and evidence-based approach to **risk assessment** and safety planning across all services.	Robust and continuous quality improvement approach to BPS - being introduced via annual audit with first exercise due to complete in Q1 then move to business as usual via clinical audit cycle. **Remaining - delivery planned by end Q4** • Internal metrics around carer engagement; • Thematic review of PSIIs where there are findings relating to risk assessments; • Process around monitoring and reporting of training compliance being agreed and will report update to Trustwide QI Group quarterly. • Updates to Self-Harm & Suicide Prevention policy. **Complete** • Increased access to Risk Champions, gaps identified being addressed, process to monitor & maintain being agreed; • Implementation/updates to BPS Policy. **Removed as 2025/26 priority or transferred into BAU** • Annual update of clinical risk training materials (complete and now business as usual); • Internal metrics around patient access to safety plans (metric around carer engagement prioritised as Q&P request).	**% service users with complete risk management and safety plans - Change: +7.6%** Apr-25: 85.4%; Dec-25: 93.0% **Clinical Risk and Suicide Prevention Training - Change: -0.4%** Apr-25: 84.0%; Dec-25: 83.6%
D Ensure safe and co-ordinated **Transitions** between services	**Remaining - delivery planned by end Q4** • Review of policies is underway and will be complete by end of Q4; • Hospital to Home - care groups have been working well to implement, to be business as usual by end of Q4. **Moved to Q1 26/27** • Comply with NG181 and Commissioner guidance for adult community mental health rehabilitation services published June 2025 in terms of rehabilitation transitions; • Align CYPS and adult Learning Disability service models to offer lifespan approach - moved to Q1. **Removed as 2025/26 priority or transferred into BAU** • PGN standards embedded in practice (duplicated within implementation of PGN/policy process)	Audit of Transitions in place for 17 year olds – twice yearly. Delivery will be in Q4, outcomes/metrics to follow

Strategic ambition 1

Quality care, every day

Priority	Current position / Revised plan	Outcomes/metrics
E Improve the early recognition and response to **deteriorating patients** (bed-based services).	**Removed as 2025/26 priority** • Optimising pathways between CNTW and acute Trusts - (as relates to Strategy) • Reviewing usability of the Physical and Public Health policy - (BAU of Steering Group) All other objectives are expected to be complete by the end of Q4.	**Incident rates related to choking - Change: -2** Apr-25: 22; Dec-25: 20 **BLS Training Compliance - Change: +4.1%** Apr-25: 78.8%; Dec-25: 82.9% **ILS Training Compliance - Change: +2.6%** Apr-25: 73.5%; Dec-25: 76.1%
F Continue to improve **sexual safety** by reducing incidents and strengthening prevention and response.	All actions within objectives confirmed as complete or expected to be by end of Q4.	In the initial phase of raising the profile there could be an increase in reporting of cases after which we would hope to see a reduction based on understanding behaviours. Incidents relating to sexual safety to be reported to Q&P.
G Improve **handovers** of care across inpatient services.	**Remaining - delivery planned by end Q4** • Policy work - underway and will be published in Q4; • Increasing time allocated for Handovers - shift patterns approved, roll-out plan being agreed Q4; • Effective Use of technology (Digital At a Glance boards being implemented in Inpatients by end Q4). **Removed** • Training (duplicated within implementation of PGN/policy process); • Monitoring of expected standards (duplication within Debrief work); • Improving culture of safety and accountability (business as usual within quality framework).	Delivery will be in Q4, outcomes/metrics to follow on reduction in safety incidents as a result of poor handovers of care.

Strategic ambition 1

Quality care, every day

Priority	Current position / Revised plan	Outcomes/metrics
H Improve therapeutic **engagement** and observation across inpatient services.	**Work commenced but expected to roll into Q1** • Full scale policy update. • Develop Best Practice Guidelines. **Removed as 2025/26 priority or BAU** • Training (duplicated within implementation of PGN/policy process)	**How was your experience? (Inpatients) - Change: +6.1%** Apr-25: 85.3%; Dec-25: 91.4% **How was the care we provided? (Inpatients) - Change: +8.4%** Apr-25: 88.2%; Dec-25: 96.6% **Did you feel safe? (Inpatients) - Change: -3.6%** Apr-25: 93.6%; Dec-25: **90.0%** Target 90% **Engagement & Observation Training Compliance - Change: +2.2%** Apr-25: 86.5%; Dec-25: 88.7% **Green Inpatient Bed Days - Change: +5.1%** Apr-25: 76.1%; Dec-25: 81.2%
I Manage and reduce the risk of cardiorespiratory arrest caused by sedative medication.	**Remaining - delivery planned by end Q4** • Review of Trust Safety team data learning from identified incidents; • Creation of 'at risk' criteria; • Relative potencies document (not to include benzodiazepines, SPS online tool available); • Infographic for patients on sedative combination risks, side effects and overdose risk. **Complete** • Literature search; • Safety alert review; • Service evaluation for inpatient sedative medication prescribing. **Removed as 2025/26 priority or BAU** • Q-Risk Scoring on physical health assessment on RiO (Business as usual); • Management of cardiorespiratory risk – action mocved • Review of patient information leaflets to include CV risk • Develop a PGN (will be informed by learning once identified); • Deliver a learning webinar (will be informed by identified learning and PGN).	Completed literature search; completed safety alert review; completed service evaluation for inpatient sedative medication prescribing. Reduction in incidents metrics to follow in Q4

Strategic ambition 1

Quality care, every day

Priority	Current position / Revised plan	Outcomes/metrics
J Manage and reduce the risk of severe clozapine-induced constipation.	**Removed as 2025/26 priority** • Creation of a patient group directive (for timely access to laxative treatment) - complex action which would impact staff capacity of implemented with minor impact to quality of care. • Ensuring clozapine e-learning is completed by clinicians - availability of the package to be added to PGN as training is supplementary. **All other objectives/actions to be delivered by end Q4** • Reviewing incidents for learning (for presentation to Medicines Optimisation Committee in February); • Establish baseline data for compliance with current guidance (via RiO Audit); • Updating PGN in line with best practice, (will be revised by end Q4 and will then follow policy process for publication in Q1); • Patient Information Leaflet/poster being designed with patient involvement group; • Updating guidance for Primary Care and Acute Trusts.	**Number of staff completed Clozapine Training - Change: +16** Apr-25: 6; Dec-25: 22 Reduction in incidents metrics to follow in Q4
K Support **staff wellbeing** through increased access to resources, compassionate leadership, and healthy workplace culture.	**Remaining - delivery planned by end Q4** • Delivery of compassionate leadership programme - commenced but a number of sessions were cancelled (completion date unknown) • Supporting the Trust objective to reduce sickness absence by 1% - work ongoing **Complete** • Re-highlighting current offers of financial wellbeing resources ensuring these are fit for purpose • Increase awareness and understanding of flexible working • Funding bid for NHS Charities Workplace Wellbeing Programme (bid successful) **Removed as 2025/26 priority** • Increase understanding of special leave options (removed as business as usual) • Monitor and respond to staff feedback data (removed as business as usual) • Ongoing commitment to Wellbeing Guardian role (removed as business as usual)	**% Sickness Absence (Monthly) - Change: 0.5%** Apr-25: 6.6%; Dec-25: 7.1% **Staff Survey – In my team we support each other – Change: +1.4%** Apr-25: 74.6%; Jul-25: 76.0% **Staff Survey – My organisation is proactively supporting my health and wellbeing – Change: +1.0%** Apr-25: 53.4% Jul-25: 54.4% **Staff Survey – I feel well informed about important changes taking plance in my organisation – Change: +1.3%** Apr-25: 43.6% Jul-25: 44.9%

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.

Strategic ambition 2

Person led care, when and where it is needed

Priority	Current position / Revised plan	Outcomes/metrics
Redesign and improve the pathway for specialist children and young people's eating disorder service.	**In place/complete** • Quality Improvement Group continues to lead and monitor progress. • Specification Change - Minor adjustment (data recording only, no clinical impact) agreed by CNTW & TEWV; formal sign-off expected late Dec 2025. • Demand data collected for new clinical offer in Nov 2025 to inform pathway design. • December Workshop held - Explored TEWV ARFID model, reviewed demand data, and considered CNTW bolt-on support. **Future Work (Jan-March)** • Jan 2026 workshop to Design pathway for new clinical offer, review other spec elements (age of referral, opening hours, training offer) and explore Physical Health Offer - Progress limited due to complexity; further work required. • Continue to meet with ICB for assurance and share demand data	Too early to provide metrics for this, pathway not implemented
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)	Phase 1 Newcastle and Gateshead teams identifying patients suitable for cohort using a referral form on RIO. Assessments being reviewed December/January aiming for titration and treatment from February 2026. Delay in accommodation – now expected March 2026 means team will need to travel to community bases in first instance. Phase 2 requires additional funding and operational development – task and finish group being established Development of Intensive and Assertive and also rehab patient lists to ensure close monitoring and offer of depot medication. Depot clinics and assertive follow up ensure those prescribed receive depots as required. Patient cohort identified, RIO indicator developed and live ready for operational roll out. Clinical pathways and workforce plan identified. Patient cohort monitored on key metrics with improvement plans in place. Clinically led group working on pathway.	**Intensive and Assertive cohort mean appts: change: -2** Jan-Jun 2025: 23; Jul-Dec 2025: 21 **Intensive and Assertive cohort mean DNAs: Change: -1** Jan-Jun 2025: 6; Jul-Dec 2025: 5 3% increase in the number of antipsychotic injections in 2025

Strategic ambition 2

Person led care, when and where it is needed

Priority	Current position / Revised plan	Outcomes/metrics
Develop, agree and progress the implementation of a new model of care for the Mitford Unit Autism Spectrum Disorder Inpatient Unit.	Business case developed in collaboration with Inpatient Service with a proposal to coordinate Autism and LD services within one Inpatient Unit. Planned for presentation to EMG January 26.	Plan **on schedule**
Reconfiguration of inpatient provision in West Cumbria	Complete	**Complete**
Delivery of partnership hub working across all other areas and embedding of Neighbourhood Health working.	Hope Haven – West Cumbria has gone live and includes full range of services wrapped the patient from different organisations. There is a single care record for all interactions to be recorded and range of live services with the temporary accommodation open and in use to support patients in the community. The Hope Haven building will open its doors in March 2026 Hope Haven pilot of Neighbourhood Mental Health Centre is one of six across England, capital money has now been made available and CNTW aim to bid for another 5 similar centre in North Tyneside, Carlisle, Northumberland, Newcastle and Sunderland.	**434 people** have been opened on the Hope Haven single care record access system since services went live last year.
Collaborate with TEWV, Primary Care, VCSE, and other partners to design a significantly different pathway for ADHD and Autism Spectrum Disorder needs.	A joint approach is underway with the input of the ICB, TEWV, and CNTW, indicating a coordinated, system-wide approach to the development of a draft ADHD and autism commissioning policy. The discussions are focused on proposed transformation objectives, including revised referral pathways and prioritisation for adults, greater use of NHS Trust provision, measures to reduce overall activity and costs, and the consideration of alternative delivery models. These include needs-led triage, changes to diagnostic and prescribing arrangements, and the potential for increased involvement of Independent Providers, alongside future implications for children and young people's services. A paper will be presented to the MHLDA Sub Committee on the 16th January 2026 to outline the provider proposals, assess impacts on access and quality, and progress the work through subsequent meetings and formal governance processes.	**CMH - Number of ADHD/ASD Patients Waiting (full clock stop) – Change: +1,936** Apr-25: 22,788; Dec-25: 24,724 **CYP - Number of ADHD/ASD Patients Waiting (full clock stop) – Change: -37** Apr-25: 9,129; Dec-25: 9,092

Strategic ambition 2

Person led care, when and where it is needed

Priority	Current position / Revised plan	Outcomes/metrics
Improve UEC interface and alternatives for crisis support and intervention.	4 Safe havens' operational – Northumberland , North Tyneside, Newcastle and Gateshead. 3 bids to be submitted to support the development of MHED across the Trust footprint in Jan 2026 4 Short stay Beds in Whitehaven extended to support the wider population of West Cumbria	**Crisis % Very Urgent seen within 4 hours (WAAA&OP) – Change: +9.4%** Apr-25: 61.3%; Dec-25: **70.7%;** Target: 65% **Crisis % Urgent seen within 24 hours (WAA&OP) – Change: +8.3%** Apr-25: 75.2%; Dec-25: **83.5%;** Target: 85%
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 2 Home model development including the management of the deteriorating patient fully launched Development and implementation of new weekly Crisis and CTT Interface Meetings Trustwide, within all localities. A new form was developed on RiO to support the clinical MDTs which are now live.	**% PLT ED Referrals seen within 1 hour – Change:** Apr-25: 84.7%; Dec-25: **78.1%;** Target: 80% **% PLT Ward Referrals seen within 24 hours – Change:** Apr-25: 96.4%; Dec-25: **92.5%;** Target: 85%
Management of frequent attenders to inpatients	The Multiple Admission Forum is held monthly for patients with 3 or more admissions in past 12 month. Team complete a criteria proforma and the forum will ensure that there is a robust plan. The outcome of the work is to reduce in reduce admissions or time spent in hospital.	**Average Admissions of "Frequent Attenders" cohort in comparing previous and most recent 18 months – Change: -2** Jan-23 to Jun-24: 3; Jul-24 to Dec-25: 1
Successfully deliver and sustain the Hope Haven 24/7 Neighbourhood Health Centre as part of the government flagship Neighbourhood Health approach.	Hope Haven model fully operational with a move to the main building in March 2026. 4 further bids for 24/7 Neighbourhood MH centres to be submitted in Jan 2026.	Delivered services and single shared care record system. Temporary accommodation open, main building to open in Mar-26

Strategic ambition 2

Person led care, when and where it is needed

Priority	Current position / Revised plan	Outcomes/metrics
Reduce waiting times for assessment and access to treatment	Work has been undertaken in collaboration with TEWV colleagues to review and improve neurodevelopmental pathways as part of the wider system initiative to reduce waiting times. A series of agreed actions have been identified and will begin implementation in the next quarter, with the aim of delivering measurable improvements in access. The new national performance measure released in November 2025 will focus on having no 104 week waits by Mar-27 (excluding Gender, and Neurodevelopmental waits). This will be presented as the new performance measure in the IPR once the definitions are released. Presented alongside average waiting times, it will provide better focus for improvement, comparing the different pathway performance across the Trust. **Expected impact and by when** Any significant impact of any improvement actions is expected in next financial year due to the size and scale of the impact of the increased demand of Neurodevelopmental CYPS and the need to collaborate, plan and implement new pathways with partners	**No. of CMH referral-spells waiting for full clock stop at end of month - Change: -950** Apr-25: 5785; Oct-25: 4835 **No. of CYP referral-spells waiting for full clock stop at end of month – Change: +625** Apr-25: 13,700; Oct-25: 14,325 **Number of CYP Referral Spells (exc. Autism, Neurodevelopmental or Gender Identify) waiting more than 104 weeks for full clock stop** Apr-25: No data as new national measure; Oct-2025: 1820
Reconfigure Inpatient services to optimise the estate to have the maximum impact on the quality and safety of patient care	As of December 2025, we have successfully completed a number of our planned developments / changes. Yewdale ward has been successfully closed and inpatient care for the residents of North Cumbria is now provided from Carlton Clinic in Carlilse. Rose Lodge, Learning Disability Treatment Unit has temporary closed for 6 months to enable us to look at an innovative approach to the delivery of services via a Learning Disability In reach Team, (LDITT) which promotes collaborative working with colleagues from adult mental health wards. This model is in its infancy, and over the next 5 – 6 months we will be undertake high levels of engagement and potential consultation with a range of internal and external stakeholders to agree the optimum approach for the medium to long term. Within the Trust's Central Locality significant work has been undertaken to ensure the efficient and effective transfer of services from the CAV (Newcastle General) to St Nicholas Hospital. All three of the adult acute wards, with increased bed capacity, have successfully transferred into enhanced facilities. A post project benefits realisation process is taking place and information to date suggests that key stakeholder, notability, service users, cares and staff, have highlighted the positive nature of this move. Older people's services in terms of both wards and day hospital, are due to move in Q4 25/26. This move is continuing to be managed by a formal project methodology. The optimum use of inpatient clinical space will be regularly reviewed to ensure that the infrastructure supports efficient and effective care.	**Active Inappropriate Out of Area Placements – Change: -11** Apr-25: 13; Dec-25: 2 **Number of Inpatient Discharges (all wards) – Change: -50** 2024: 1,738; 2025: 1,688 **% of Adult Inpatients Discharged with LoS >60 days – Change: +1.58%** Apr-25: 25.86%; Dec-25: 27.44%

Strategic ambition 2

Person led care, when and where it is needed

Priority	Current position / Revised plan	Outcomes/metrics
Review of Learning Disability inpatient provision and reconfiguration	All 2025/26 actions complete. Engagement plan on NENC next task to deliver changes to ATUs across NENC in 26/27 The temporary closure of Rose Lodge occurred on 10th November 2025, this coincided with the establishment of the Learning Disability In reach and Transitions Team. (LDITT). We have established a set of key metrics based on the 'baseline' position which will be reviewed during the 6-month pilot phase of this scheme. Correspondence has been sent to key external stakeholders / partners and as a result attendance at health overview and scrutiny committees have occurred. We recognise the significance of clinical ownership of the future learning disability and autism model, therefore the newly established Trustwide LDA clinical senate will be a key driver for change over the coming months. As well as reviewing the clinical model it is essential that the Trust takes advantage of recently announced capital opportunities that will be key enables to the development of a sustainable LDA pathway.	100% of actions complete
Proactive support for patients who require effective discharge from inpatient care	Demands for inpatient beds remain high particularly within the male acute pathway. This is a key factor that contributes towards the Trust's OPEL level 3 position. There are now daily escalation meetings over and above the Locality flow meetings which assist in the decision-making process. The Hospital to Home (H2H) service has been recently developed and introduced with a key focus on providing oversight and support to clinical areas, via the promotion of information to support flow. A key element of the H2H work to date has been on supporting clinical reviews within key pathways e.g., adult rehabilitation, older people's services. These reviews have enabled host clinical teams and the H2H service to identify patients who are CRFD, but more importantly help facilitate discharge where clinically appropriate. To support this work infrastructure in the form of a dedicated dashboard including supportive metrics and SOPs are being developed. In addition to this initiative, we successfully obtained £25,000 via the NEY Mental Health Learning & Improvement Fund to support medical reviews of those patients who are at risk of breaching the 60 day LOS target. Engagement with the wider system, particularly local authorities, has allowed for more targeted discussion and planning for discharge – enabling timely funding approvals and care packages being devised and arranged prior to point of readiness for discharge.	**Active Inappropriate Out of Area Placements – Change: -11** Apr-25: 13; Dec-25: 2 **Number of Inpatient Discharges (all wards) – Change: +6** Apr-25: 180; Dec-25:186 **% of Adult Inpatients Discharged with LoS >60 days – Change: +1.58%** Apr-25: 25.86%; Dec-25: 27.44% **Clinically Ready for Discharge – Change: +4.6%** Apr-25: 13.6% Dec-25: 18.2%

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

Priority	Current position	Outcomes/metrics
Roll out Leadership Programme (3 modules) and Clinical Support Worker Development Programme	Programme was paused due to summer period and during Industrial Action. Dates to complete priority modules have slipped slightly. CSW Development Programme has been paused due to operational challenges and will be evaluated prior to re-commencement decision.	**% Sickness Absence (Monthly) - Change: 0.5%** Apr-25: 6.6%; Dec-25: 7.1% **Staff Turnover Rate – Change: +1.1%** Apr-25: 8.3%; Nov-25: 9.4% **% Clinical Supervision Completed – Change: +12.7%** Apr-25 – 70.9%; Dec-25 – 83.6% **Appraisal Rate – Change: +6.1%** Apr-25: 74.5%; Dec-25: 80.6% **Staff Survey Response Rate – Change: +14.99%** 2024: 42.19%; 2025: 57.18% Note: other staff survey measures will be added from National survey results 2026
Map current and future clinical support workforce requirements in line with organisational change, immigration policy changes.	Workforce plans on track for delivery, aligned to Medium Term Delivery Plan and Model of Care.	
1% sickness absence reduction across all operational and corporate areas	Short term sickness remains a challenge and areas with the highest rates continue to be targeted.	
Ensure that the legal framework is followed in all staff consultations and that appropriate support is put in place for staff as required	All consultations successfully completed during 2025/26. currently scoping for 2026/27.	
Raise awareness across the Trust of the Sexual Safety Legislation and individual and collective responsibilities therein	Work continues to raise awareness and work towards the elements of the Sexual Safety Charter.	

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

Strategic ambition 4

Sustainable for the long term, innovating every day

Priority	Latest update/revised plan
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 £0.2m deficit year to date in month 8, this is £2.2m ahead of plan, 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 ICS 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. **WTE reduction in staffing by 412 - from WTE 8,726 in Apr-25 to 8,314 WTE at Dec-25**
Roll out paperless working in the last two remaining clinical services areas (Therapeutic Observations in Inpatients and Electronic prescriptions in the Community)	• The Access Group's RIO upgrade which includes the necessary development was received for testing by the Trust in Q3, however due to a couple of Priority 1 issues identified, this prevented promotion into our live environment. A revised upgrade is now expected in **Q4 25/26**, and if testing completes successfully, this will move into the live environment providing the development for inpatient therapeutic observations to go paperless in the remaining two areas • All pre-project documentation and governance for the CLEO implementation has been complete, and the initiative has now moved into the project initiation stage. We are forecasting go-live for Adult ADHD in **Q3 26/27**, supporting electronic transfer of prescriptions directly from the Trust to local pharmacies
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 has provided the NENC ICB a proposed realignment of the contractual income to best reflect the most recent costs across services. The CNTW 3 year plan is built from the carried forward underlying deficit is identifying how to be financially sustainable by the end of the planning period. Medium term plans are under development at Care Group Level to provide services within the contracted level of income to provide long term sustainability. Service delivering underlying deficits are being reviewed to develop plans to deliver within financial envelopes. The plan is challenged to delivery financial balance year on year through the planning period. Final plans will be submitted by the national deadline of 12th February
Develop our digital strategy to support the model of care	• Work has begun to review the Digital Strategy to fully align with the 10-year plan and CNTW's Model of Care programme, with clinical and operational engagement shaping the roadmap. An initial draft will go to the newly established Digital, Data & Technology Committee in **Q4 25/26**, ensuring governance and a clear path to delivery.
Ensure CNTW is a leader and an influencer in local and national research networks and partnerships	CNTW continues to develop its position as a leader in local and national networks for research. We have just had the NIHR Applied Research Collaboration (ARC), which CNTW hosts on behalf of NENC, funded for another 5 years from 2026 which is a significant boost in terms of research capacity and capability for the region. In addition we jointly host the mental health Translational Research Centre for Mood disorders funded by the Office of Life Sciences and the joint deputy head of the national Dementia Goals research initiative is a CNTW clinician. Regionally we are key partners in the NIHR Biomedical Research Centre, the Newcastle Health Research Partnership (formerly AHSC), the NIHR Patient Safety Research Centre and the NIHR Clinical Research Facility. The next period will focus in particular on developing partnerships in Cumbria, in particular with the new medical school and the new application for the Mental Health Research Centre.
Green plan	• The Green Plan has been approved through the Trust governance structure.

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

Priority	Latest update
Develop an effective partnership between TEWV and CNTW and support the Provider Collaborative to be successful.	Provider Collaborative governance refresh being undertaken and to be completed in the next few months.
Engage with and support the 10-year plan, transforming how services are commissioned for patients.	Hope Haven progressing well including the opening of the crisis beds and an interim evaluation of its functioning and effectiveness is currently being requested. We continue to engage with acute Trusts and Tees Esk and Wear Valley to progress the development of the Mental Health Emergency Departments.
Support the Neighbourhood Health Models by engaging with partners to develop new and cohesive ways of working.	Review of Senior Leadership / Executive engagement with the new Neighbourhood Health place arrangements being reviewed and to be finalised in the next few months.
Roll out the Patient and Carer Race Equality Framework (PCREF) across all marginalised groups.	Development and implementation of PCREF workstreams underway: Advance Choice Documents working group established. PCREF Communications and Engagement plan in place. Continuing engagement with racialised and culturally minoritised communities.

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

Darren Best, Chair

6.1 DIGITAL, DATA AND TECHNOLOGY COMMITTEE REPORT

Thomas Webb, Committee Chair

REFERENCES

Only PDFs are attached

6.1 DDTaC Board Assurance report - Jan 26.pdf

Report to the Board of Directors
Wednesday 28 January 2026

Digital, Data and Technology Committee Quarterly Assurance Report
November 2025 – January 2026

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. Digital, Data and Technology Committee overview

The committee is a standing committee of the Board of Directors for the Trust and includes representation from NTW Solutions Limited.

The committee assures the effective development and delivery of the Trust's Digital and Data Strategies, ensuring alignment with the Trust's strategic ambitions of With You in Mind, as well as relevant national and regional digital priorities. It oversees the appropriate use of digital and data resources – financial, human and technological – ensuring that investment is of an appropriate level and type (capital and revenue), affordable within the Trust's financial framework, and optimally targeted to maximise benefits across the digital and data portfolio.

There has been one substantive meeting of the committee during the period held 5 December 2025. The committee also held a 'shadow' meeting on 20 November. This meeting was held to discuss the purpose and focus of the committee and included a review of the committee membership, terms of reference and draft cycle of business for the year ahead. It was recognised that as a new Board committee, a regular review of the terms of reference and cycle of business will continue to take place throughout the year.

3. Board Assurance Framework risks within Committee remit

Following a meeting with the Director of Communications and Corporate Affairs, the Risk Management Lead and the Executive Chief Digital Information Officer for NTW Solutions Limited, Directorate-level digital risks have now been transferred to NTW Solutions Limited following the transfer of the Digital Solutions service on 1 October 2025. This included a review of risks to ensure clear alignment between risk owner (CNTW) and risk handler (NTW Solutions) to ensure that there is awareness, and management of risks from the perspective of both organisations.

The Board held a development session on 26 November to review the Trust risk appetite which will inform the BAF risks associate with the committee moving forward. The Board Assurance Framework, in its entirety will be reviewed during January and February with a view to implementing the new risk appetite from April 2026, following Board approval in March. The BAF risks associated with Digital, Data and Technology will also be reviewed from April 2026 taking into consideration the refresh of the Digital Strategy.

In the meantime, the current BAF risk 2547 relating to cyber-threat was discussed and reviewed at the December meeting following transfer of the risk from the Resource and Business Assurance Committee. At the December closed meeting of the Board, an increase to the risk score from 12 (possible 3 x significant 4) to 16 (likely 4 x significant 4) was approved based on the number of cyber-attacks experienced across NHS and other UK government services over the past 12 months and to ensure appropriate sightedness at Board level in that regard.

4. Digital Data and Technology Committee focus

4.1 Cybersecurity posture overview

A cybersecurity posture review is an assessment of an organisation's overall readiness and capacity to identify, prevent, and respond to threats across its entire IT infrastructure. A detailed discussion took place which included an update on technical protections, incidents response processes, supplier assurance, benchmarking, and a proposal to increase the BAF risk score relating to cyber threat (the proposed increase was approved by the Board of Directors at the December closed Board meeting).

The committee received an update on the Trust's multilayered approach to cybersecurity describing how various technical and procedural defences such as firewalls, email filtering, end user training, privileged access management, and immutable backups work together to mitigate cyber risks, particularly ransomware attacks, as well as back-up strategies. The committee also discussed the process for responding to high severity alerts and business continuity plans.

It was agreed that incidents relating to digital business continuity be reviewed by the committee on a regular basis to provide assurance of controls in place.

4.2 User engagement/usability

An update was provided on structure, activities and governance of the Digital Health Team in the context of focussing on user engagement, clinical safety, survey feedback, and the need for clearer reporting lines and assurance mechanisms moving forward. The team described the multiple engagement channels already in place and further work required to ensure continuous improvement and inclusion of service users, carers and disabled staff.

Findings from the baseline and national experience surveys noted improvements in user experience and the Trust's relatively strong performance in this area. The importance of explicitly defining the Digital Health Teams deliverables, aligning operational work with strategic oversight, and ensuring key issues such as diagnosis recording and outcome measures are appropriately governed and escalated was discussed.

A discussion took place regarding the governance arrangements and reporting lines of assurance in terms of critical areas such as clinical record keeping and digital health data, particularly in light of the current low compliance with diagnosis recording and the transition to new clinical outcome indicators. The committee will undertaken a focused assurance-based discussion on this issue over the coming months.

In terms of staff and patient engagement specifically, regular groups exist for engagement including the Electronic Patient Record Development Group and the Clinical Record Keeping Standards Group, but it was acknowledged that clinical engagement in these meetings is challenging and requires further focus and oversight from the committee.

In summary, further assurance is required that digital services provided are aligned to the needs of service users, carers and staff and that there is proactive outreach into services. Reporting and assurance in this regard requires strengthening including how we have an ongoing dialogue with those utilising our systems and services, and that service transformation and optimisation include digital tools from inception.

4.3 Digital national benchmarking – model hospital

The Digital National Benchmarking compares the Trusts digital spend, staffing and device numbers to other mental health trusts, using Model Hospital Data. It was recognised that benchmarking is challenging due to differences in how Trusts categorise costs and roles, making direct comparisons difficult.

The Trust is in the lower quartile for digital costs per £100 million income and has fewer digital staff compared to peers. Device numbers (desktops, laptops, tablets, mobiles) are like other Trusts reflecting the needs of community-based staff. It was noted that low spend and lower staffing levels may indicate underinvestment rather than efficiency, and a further breakdown of the percentage figures will be undertaken to gain additional understanding of the position.

5. Other issues to note

5.1 Committee governance

In line with the five objectives agreed by the Chair and Chief Executive for the second half of the year, the outcomes from the ConsultOne independent review of governance and recent high-level feedback following the CQC inspection, work is taking place to review the governance arrangements for Board Committees. Meetings with the Director of Communications and Corporate Affairs, Committee Chairs and Executive Leads have been arranged to take place in January to undertake a review of cycles of business and reporting requirements to ensure committees have a strong process in place underpinned by the provision of robust assurance and enabling key areas of focus to be identified.

Summary and recommendation

The Board is asked to:

- **Note** the content of the report and seek further assurance on any issues where appropriate.
- **Note** the infancy of the committee having has its inaugural meeting in December and the only development of its business in that regard.

Thomas Webb
Chair of Digital, Data and Technology Committee
January 2026

6.2 CHARITABLE FUNDS COMMITTEE REPORT

Vikas Kumar, Committee Chair

REFERENCES

Only PDFs are attached

6.2 Charitable Funds Committee Trustee Assurance report - Jan 26.pdf

Report to the Board of Directors
Wednesday 28 January 2026

Charitable Funds Committee Quarterly Assurance Report
November 2025 – January 2026

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 meeting of the committee during the period held on 14 January 2025.

4. Charitable Funds Committee focus

4.1 Chair's Charity Network

Following discussion during quarter 3 of the year with the Chair's Charity Network, responses from individual Trust charities across North East and North Cumbria regarding the proposal to create a Memorandum of Understanding was collated which included a review of the appetite of levels of commitment from each Trust. This related to proposals to collaborate through funding contributions/ring-fenced funding to support specific initiatives or building additional capacity, sharing knowledge and experience on how committees operate including sharing of policies and process, creation of a system-wide approach to lobbying and influencing, and proposals for collaborative funding/bids.

The majority of responses agreed that whilst Trust charities would support shared knowledge, learning, experience, support for options around ring-fenced funding and collaborative bids would not be viable at the current time. Individual charities were not in a position financially to support central contribution requests and recognised the importance of focusing on impact locally in line with the purpose of individual charities.

A decision has been made to stand down the Chair's Charity Network. This does not reflect the appetite for collaboration and working together to support local populations, but it was recognised that continuing to focus resource and effort into operational networks would be of more value.

4.2 Fund balances report

There are currently 54 Specific Funds and one General Fund (SHINE – Support, Hope, Inspire, Nurture and Empower). Two new new funds have been opened during the period for the Christmas Carol Service Sponsorship and North Cumbria Perinatal MH Team. Two funds have been closed which had been used to fund part of Akenside Garden.

4.3 Dormant funds

The Committee noted that there are funds which are not regularly utilised. Work has been undertaken during the period to work with fund holders to utilise these funds. There has been a slight increase in expenditure associated with these but focused work to seek opportunities to utilise these funds will continue. The fund balances report will include movement on dormant funds moving forward.

4.4 Charity expenditure activity

There have been 13 withdrawals from specific funds and 5 withdrawals from the SHINE fund during the period. The Marketing and Charity team continue to undertake targeted work in areas of low uptake to raise awareness of the funds available and support opportunities for use of funds and fundraising activity.

4.5 Charity accounts update

Confirmation was received on the successful submission of the Charity Annual Accounts for 2042/25. The committee commended the finance team, marketing and charity team and auditing team for their work throughout the year.

As of end of December, the Charity Accounts is reporting a net increase in funding. This is largely due to the recent legacy donation received. Excluding the legacy donation, fundraising and other donation income has increased in comparison to the same period in the previous year. Investment income is in line with previous years but is variable throughout the year based on market fluctuations. A meeting is being planned with Cazenove to receive an update at the committee in the coming months.

5. Charity strategy and activity

5.1 Approval process for bids via bid review meetings

The Committee continues to hold bespoke regular meetings to review and approve funding bids received. The process has been strengthened to ensure it supports the charity and its impact through timely approvals of applications with bids being approved via email communication for bids below the value of £500.00.

5.2 Delivery of the Charity strategy

An update was provided by the Marketing and Charity team on the charity and fundraising activity delivered during November and December. 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 donations from supermarket champions for Christmas concert, local service-led Christmas fairs and activities, individual skydives, Dunelm Delivering Joy campaign, support for Holly's Hope charity via Northumberland CYPS service for their bleed box campaign, Clifford Chance grant, partnership with a local school delivering mental health

wellbeing sessions with ongoing fundraising support, donation for CYPS from Children's Hospital Pyjamas charity, and a patient at Northgate Hospital who auctioned two items built using kits. The Christmas concert at St. Nicholas Hospital, supported fully by sponsorship, raised over £2000.

The development of community and school partnerships with local schools was highlighted as a particularly positive step in the context of support local communities and the team look to build on this further in other localities subject to capacity.

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.

In the coming months, planned activity includes: the charity website launch, planting of Sycamore sapling (the Tree of Hope), ongoing projects / fundraising via the community link with St. Paul's School, Ryhope, the Voyage of Discovery 2026 and Easter activity.

At the April meeting, an update will be provided on progress against year-one of the charity strategy.

The committee commended the Marketing and Charity Team for their continual dedication and hard work.

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
January 2026

7. GOVERNANCE AND REGULATORY

Darren Best, Chair

7.1 AUDIT COMMITTEE ASSURANCE REPORT

Vikas Kumar, Committee Member

REFERENCES

Only PDFs are attached

7.1 Audit Board Assurance report - Jan 26.pdf

Report to the Board of Directors
Wednesday 28 January 2026

Audit Committee Quarterly Assurance Report
November 2025 – January 2026

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 Limited 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 have been two meetings of the Committee during the period held on 20 November 2025 and 14 January 2026.

3. Board Assurance Framework and risk reporting

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 14 January, 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.

The risk report highlighted the key changes to the Board Assurance Framework during the period. This included:

- An increase in the risk score relating to the cyber threat risk, approved by the Board at the December closed meeting. This is based on the number of cyber-attacks experienced across NHS and other UK government services over the past 12 months.
- The introduction of a new risk related to the Trust's cash position, approved by the Board at the December closed meeting. This is the risk that the Trust has insufficient cash which would lead to reputational damage and ongoing costs of, and reliance on, borrowing cash from NHSE. See below.

A new risk associated with changes to the Mental Health Act was reviewed by the committee, with the expectation that its impact will be long-term and may later move to directorate level subject to continual review by the Mental Health Legislation Committee. A discussion took place in terms of the appropriateness of proposed risk score. It was noted that the risk referred to the Trust's readiness for the impact of the changes to the Act and the score will likely be reviewed as

controls and assurances are further established. The committee supported the recommendation from the Mental Health Legislation Committee to include the risk on the Board Assurance Framework. Formal approval of the Board's acceptance of the risk is requested as part of the BAF/risk report at the January meeting of the Board.

The Resource and Business Assurance Committee continues to focus on short-term financial delivery and medium-term sustainability. These risks have been strengthened in terms of controls, assurance and actions. The focus has been on the short-term 2025/26 financial performance, specifically how deliverable the remaining recovery is, how sustainable the solutions are and what are the downside if assumptions fail. The committee focused in parallel on the medium-term plan position, including 2026/27, 2027/28 and 2028/29 both in terms of the planning process and delivery confidence.

The People Committee continue to review their BAF risks and the January People Committee workshop will focus on the development of the Workforce Plan.

Following a meeting with the Director of Communications and Corporate Affairs, the Risk Management Lead and the Executive Chief Digital Information Officer for NTW Solutions Limited, Directorate-level digital risks have now been transferred to NTW Solutions Limited. In the meantime, the current BAF risk relating to Digital has been reviewed as part of the initial substantive meeting of the new Digital, Data and Technology Committee held 5 December and will be reviewed further in the coming months in the context of the refresh of the Digital Strategy.

All Committees, including Audit, noted the Board development session held on 26 November to review the Trust risk appetite which will inform the BAF risks associated with the committee moving forward. The Board Assurance Framework, in its entirety will be reviewed during January and February 2026 with a view to moving to the new risk appetite from April 2026, subject to Board approval in March 2026.

The committee noted the report as comprehensive and clear in terms of key messages and asks of the committee.

4. Audit Committee focus

4.1 Declarations of interest and standards of business conduct

The committee reflected on the mainstream media coverage about public sector, NHS and government issues and concerns relating to declarations of interest and standards of business conduct. The importance of maintaining vigilance on these issues within the Trust in terms of policies, procedures and compliance with declarations of interest was discussed, noting that this will be a key focus of the committee over the coming year. The committee noted that current compliance levels at CNTW were well below a satisfactory level. Work continues to be undertaken on processes to ensure a strong level of governance and compliance and although significant measures are in place via the Corporate Affairs Team and Local Counter Fraud service to raise awareness, further work is required in terms of leadership support and ensuring accountability. Actions to take to further increase compliance were agreed including escalation of non-compliance to Director-level for oversight and action. See also section 4.6.

4.2 Charity Accounts 2024/25

The charity accounts and annual report for 2024/25 were reviewed and approved by the committee and Board of Directors for submission to the Charity Commission in January. There were no issues of concern following the audit process. The committee formally recorded its appreciation for the finance team, marketing and charity team, fundraisers and volunteers and the Charitable Funds Committee for their contributions during the year.

4.3 NTW Solutions Limited Accounts 2024/25

The committee reviewed the NTW Solutions annual accounts. Auditors presented a clean audit completion report for NTW Solutions indicating that the audit process went smoothly and there were no significant issues identified. There are no statements or internal control recommendations. The Accounts were approved by NTW Solutions Limited Board of Directors in November.

4.4 Raising concerns annual update

An update was provided which included a reported increase in the number of concerns raised, an update on the changes to the Freedom to Speak Up Guardian structures and processes to increase visibility across the organisation. It was recognised that an increase in the number of concerns raised should not be deemed to be a negative issue but a positive in terms of people feeling confidence to speak up. During the previous 12 months, there has been significant work to raise the profile of raising concerns and the role of the guardians including a Trust wide communications review.

In terms of future reporting, it was acknowledged that performance, themes and actions to improve the Trust approach to raising concerns sits within the remit of the People Committee. Audit Committee reports will focus on policy, process and strength of internal control procedures.

4.5 Internal Audit Progress report

The committee received the internal audit progress report and assurance was provided that internal audit progress and outstanding actions are being managed effectively. Assurances and updates were provided relating to two outstanding recommendations which were over 12 months old. One related to the Provider Collaborative audit from 2023/24 with delays due to management changes and instability within the collaborative. New leadership was now in place, as well as strengthened governance arrangements which continue to be reviewed and developed for final implementation by end of March 2026.

Final audit reports were received relating to manual rostering, Mental Health Act Section 136 – place of safety and IAPTus System Security and Governance controls. The manual rostering system audit received limited assurance (both the MHA Section 136 and IAPTus audit received reasonable assurance).

A discussion took place regarding the manual rostering audit, and it was noted that many risks are mitigated as wards have transitioned to the Allocate rostering system, which addresses previous concerns and inconsistencies in manual processes. Concerns were raised about historic non-compliance and cultural resistance to change following the introduction of new systems, focusing on the importance of proper onboarding, training, and management information to ensure full adoption and effective controls. Local Counter Fraud also highlighted that the manual system made it difficult to detect fraud or errors, and the Allocate system is expected to improve auditability and control. Future internal audit planning will include a review of the Allocate system's implementation and effectiveness.

4.6 Local Counter Fraud progress report

All proactive work to identify and manage incidents of fraud remains on track. The committee received an update on ongoing cases and further system improvements planned. Future audit planning will include a focus on systems to prevent overpayments and ensure compliance.

At the October meeting of the committee, a briefing highlighting the corporate offence of 'failure to prevent fraud' (FTPFO) was provided. To support the Trust in its self-assessment process, it

was agreed to allocate contingency resource from the 2025/26 counter fraud work plan, for the joint undertaking of a bespoke risk assessment. The completed risk assessment will be presented to the April meeting of the committee. The implementation of this new statutory corporate offence is particularly important in the context of the work to improve the Trust compliance with the Declaration of Interest/Standards of Business Conduct policies and procedures.

5. Other issues and assurance received

5.1 Audit Committee Handbook updated December 2025

The updated NHS Audit Committee handbook was published in December. The committee undertakes an annual self-assessment against the requirements of the handbook as part of the Trust annual reporting arrangements. The review to be undertaken in quarter 4 will include an assessment of the changes and new additions to the guide. This will include triangulation with other Board committees, for example Quality and Performance Committee and oversight and assurance on clinical audit. A review will also be undertaken to consider training needs for Audit Committee members to identify any gaps.

5.2 Institute of Internal Auditors Risk in Focus 2026

The committee discussed the briefing which provided detail on emerging risks for NHS organisations and the relevance of this to the Board's recent discussions on risk appetite and risk management, noting the need to improve consideration and reporting of emerging risks within the organisation.

5.3 Committee governance

In line with the five objectives agreed by the Chair and Chief Executive for the second half of the year, the outcomes from the ConsultOne independent review of governance and recent high-level feedback following the CQC inspection, work is taking place to review the governance arrangements for Board Committees. Meetings with the Director of Communications and Corporate Affairs, Committee Chairs and Executive Leads have been arranged to take place in January to undertake a review of cycles of business and reporting requirements to ensure committees have a strong process in place underpinned by the provision of robust assurance and enabling key areas of focus to be identified.

Summary and recommendation

The committee continues to operate in line with its terms of reference and ensure alignment of business with the BAF, internal audit planning and external audit/statutory requirements. The Board is asked to:

- **Note** the content of the report and seek further assurance on any issues where appropriate.
- **Note** the assurances provided to the committee relating to risk management, Board Assurance Framework oversight, internal control and audit and external audit.
- **Note** the committee's support for the inclusion of the new BAF risk relating to the changes to the Mental Health Act to receive ongoing oversight and review by the Mental Health Legislation Committee.

Robin Earl
Chair of Audit Committee
January 2026

7.2 BOARD ASSURANCE FRAMEWORK / RISK MANAGEMENT REPORT

Debbie Henderson, Director of Communications and Corporate Affairs

REFERENCES

Only PDFs are attached

7.2 BAF and risk management report - Board Jan 26.pdf

Meeting	**Board of Directors Public meeting**		**Agenda item: 7.2**
Date of meeting	Wednesday 28 January 2026		
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	x	
Report previously considered by	• Quality and Performance Committee • Resource and Business Assurance Committee • Mental Health Legislation Committee • People Committee • Digital, Data and Technology Committee • Audit Committee		
Executive summary	The Board Assurance Framework has been subject to review by all Board Committees during December 2025 and January 2026. 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 14 January 2026 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 has been developed (detailed in section 3.2). - The Committee noted that the risks associated with short-term financial planning and delivery and medium-term financial sustainability have been updated and reviewed by the Resource and Business Assurance Committee. - The Committee received an update on the new BAF risk relating to cash flow in the context of the BAF. - The Committee noted that the directorate-level risks relating to Digital have transferred to NTW Solutions with oversight and ownership of risks remaining with the Trust for alignment on		

	ongoing risk management and mitigation. - The Committee discussed the timeline for implementation of the Trust's new Risk Appetite, review of the BAF risks in that context, and associated changes to Trust policy with a view to full implementation of the new Risk Appetite from April 2026. - The Committee were confident that the BAF continues to align to the internal planning process as reported and agreed through the Committee.
Recommendation	The Trust Board are asked to: - **Approve** the BAF risk relating to the potential impact of the forthcoming changes to the Mental Health Legislation Bill detailed in Appendix 1. - **Note** that the new BAF risk relating to cash flow has now been added to the BAF following approval at the December closed Board meeting. - **Note** the timeline for implementation of the Trust's new Risk Appetite, review of the BAF risks in that context, and associated changes to Trust policy in Section 5 with a view to full implementation of the new Risk Appetite from April 2026.
Supporting information	Full Board Assurance Framework is available to Board members on request.

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.

3.1 Board Assurance Framework – at a glance summary

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**	**Updates made the BAF during the reporting period (detail provided to Audit Committee)**
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	Controls updated. Actions updated.
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	Controls updated. Actions updated.
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.	Actions updated.
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	No changes during the period.
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	Controls updated. Actions updated.
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	Controls updated. Actions updated.
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	**Yes** Score increased to 4 X 4 = 16 From 3 X 4 = 12	Increase in score agreed at December closed Board due to the increase in the number of cyber-attacks experienced across NHS/UK government services over the past 12 months.
Failure to develop a sustainable workforce model to recruit/retain/ and support the development of	Yes	No Remains as 4 X 4 = 16	Actions updated.

Board Assurance Framework – summary (August 2025 – October 2025)			
Risk description	**Risk reviewed within timescale**	**Has the risk score changed**	**Updates made the BAF during the reporting period (detail provided to Audit Committee)**
the right people with the right skills to deliver safe and effective services, our strategic objectives, and contractual obligations.			
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	Actions updated.
NEW RISK There is a risk that the Trust has insufficient cash which would lead to reputational damage and ongoing costs of, and reliance on, borrowing cash from NHSE.	N/A	Risk opened with a score of 4 X 4 = 16	New BAF risk added following review and approval at the December closed Board meeting.

3.2 Proposed new Board Assurance Framework risk

Risk description	Risk Score	Comments
Failure to prepare and adapt services to the requirements and operational impacts of the Mental Health Bill reforms will lead to non-compliance, increased litigation/tribunal risk, poor patient outcomes, workforce pressure, and reputational harm.	Proposed residual risk score of 4 X 4 = 16	The proposed risk has been reviewed and discussed at the December meeting of the Mental Health Legislation Committee and January meeting of the Audit Committee. See section 4 and Appendix 1.

4. Board Committee updates following December and January 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' of emerging issues which may require strategic intervention at a future date.

Meetings are taking place during January with the Director of Communications and Corporate Affairs, Committee Chairs and Executive Leads for committees to review governance processes, cycles of business and where reporting can be further strengthened. These discussions are taking into consideration the outcome of the ConsultOne independent review, the high-level feedback from the CQC well led inspection, and overarching commitment to continually improve the Trust's governance framework.

4.1 Mental Health Legislation Committee – held 3 December 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.

Following a strategy session held in October attended by the Chair of the Mental Health Legislation Committee, the Executive Lead and members of the Mental Health Legislation Team, an update was provided on progress on the plans for the implementation of the Bill, 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 for consideration.

The draft proposed BAF risk was presented to the December meeting of the Mental Health Legislation Committee. The Committee agreed that the controls, assurances and actions were reflective of the current risk and Audit Committee reviewed and supported its inclusion on the Board Assurance Framework subject to Board approval.

4.2 Quality and Performance Committee – held 3 December 2025

Whilst there were no significant issues to raise in relation to the BAF risks associated with the Quality and Performance Committee at the December meeting, issues for escalation and actions from meetings of the Trust wide Business Delivery Group held in October and November relating to the business of the Quality and Performance Committee included:

- A specific focus on fire risks and the work of the fire risk oversight group in relation to a risk around critical shortage of fire safety advisors. A new risk has been added to the Corporate Risk Register.
- Learning from areas piloting the new tiered risk assessment template for ligature risks will be considered prior to full roll-out to ensure this is improving the outcome for patients and agree a sensible review process to manage high volumes. Dedicated time was given to discuss ligature risks at the December Patient Safety Away Day.
- A focus on risks relating to major incident planning, stress testing our major incident plan policy/exercise will be carried out in the coming months. An update will be provided to the Quality and Performance Committee in March 2026.

The committee noted that the discussions held throughout the meeting reflected in the Board Assurance Framework and no gaps were identified.

4.3 People Committee – held 3 December 2025

While the committee did not raise any significant issues in relation to the BAF risks within its remit, it was acknowledged that the key risks remain focused on the development of a Trust Workforce Plan. Workforce plans and workforce actions from recent CQC reports will be the focus of the People Committee dedicated workshops to take place in January 2026.

4.4 Digital, Data and Technology Committee held on 5 December 2025

Following a meeting with the Director of Communications and Corporate Affairs, the Risk Management Lead and the Executive Chief Digital Information Officer for NTW Solutions Limited, Directorate-level digital risks have now been transferred to NTW Solutions Limited.

In the meantime, the current BAF relating to Digital has been reviewed as part of the initial substantive meeting held 5 December following transfer of the risk from the Resource and Business Assurance Committee to Digital Committee. At the December closed Board meeting, approval was given to increase the risk score from 12 (possible 3 x significant 4) to 16 (likely 4 x significant 4) based on the number of cyber-attacks experienced across NHS and other UK government services over the past 12 months and to ensure appropriate sightedness at Board level in that regard.

4.5 Resource and Business Assurance Committee – held 5 December 2025

The Committee focused on the short-term 2025/26 financial performance, specifically how deliverable the remaining recovery plan is, how sustainable the solutions are and what are the downside if assumptions fail. The Committee focused in parallel on the medium-term plan position, including 2026/27, 2027/28 and 2028/29 both in terms of the planning process and delivery confidence.

The Committee reviewed the draft planning assurance statement in terms of maturity, consistency with the medium-term plan position, language and grading position.

In the context of the ongoing focus and concerns relating to the Trust's financial position, the new BAF risk relating to cash flow approved at the December closed Board meeting has been added to the BAF.

4.5 Audit Committee – 14 January 2026

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.

The Committee discussed the risk score relating to the proposed risk associated with the response and impact of the Mental Health Act 2025 and queried whether the risk score was proportionate as

a score of 16. It was recognised that whilst the direct impact of many of the changes will not be felt for some time, a small number of early provisions will be happening soon for example, supervised discharge arrangements for conditionally discharged restricted patients. Until the assurances within the BAF i.e., the 'impact' of the controls in place, can be evidenced, it would be prudent to maintain the proposed risk score and review this over time. A discussion also took place in terms of the risk potentially de-escalating to corporate level as risks move to 'business as usual'. The risk position will continue to be monitored through the Mental Health Legislation Committee.

A similar discussion took place in relation to the cash flow risk, and it was noted that the current risk score is based on the Trust current position and may potentially decrease over time moving into 2026/27 to 2028/29. Again, this will be kept under review through the Resource and Business Assurance Committee.

5. Risk appetite development and timescale

The Audit Committee discussed the recent Board development session held on 26 November to review the Trust Risk Appetite which will inform the BAF risks associate with the committees moving forward. The Board Assurance Framework in its entirety will be reviewed during January and February 2026 in line with the new Risk Appetite.

The proposed Risk Appetite and proposed BAF risks will be discussed at the Board Development session scheduled to take place on 18 March 2026, following discussion with Executive Director leads in February, and submitted to the 28 March closed Board meeting for approval.

Subject to Board approval in March, the new Risk Appetite will be fully implemented from April 2026. This will include a review of the Risk Management Policy and framework. Oversight of the Trust risk management systems and processes will continue to be overseen by the Audit Committee.

6. Internal Audit - BAF and Risk Management

In accordance with the operational internal audit plan for 2025/26, an audit of the BAF and risk management processes will take place in February 2026. This audit underpins the annual Head of Internal Audit Opinion and the Trust's Annual Governance Statement. The Annual Internal Audit Opinion must conclude on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

The BAF and risk management processes will continue to be audited separately. This entailed a review of commonly reported issues in audit work across the sector, and in CQC and Well Led reports. This annual review was structured to build on previous work and to specifically target those areas of reported weakness.

7. Recommendation

The Board is asked to:

- **Approve** the BAF risk relating to the potential impact of the forthcoming changes to the Mental Health Legislation Bill detailed in Appendix 1.

- **Note** that the new BAF risk relating to cash flow has now been added to the BAF following approval at the December closed Board meeting.

- **Note** the timeline for implementation of the Trust's new Risk Appetite, review of the BAF risks in that context, and associated changes to Trust policy in section 5 with a view to full implementation of the new Risk Appetite from April 2026.

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 January 2026 DRAFT FINAL.pdf

Meeting	**Board of Directors - Public**		**Agenda item: 8.1**
Date of meeting	Wednesday 28 January 2026		
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: • Opening Remarks and Reflections for the New Year • Update on NHS Financial Business Rules (effective April 2026) • Council of Governors Election update • Strengthening Governance • 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 28th January 2026

1.1 Opening Remarks and Reflections for the New Year

Despite it now being the end of January, I would like to begin by wishing all of those who use our services, those that care for them, governors, colleagues and partners a happy, healthy and productive 2026.

Earlier this month I wrote a New Year message to CNTW, the full message is included in our weekly Bulletin. I must be honest and say, it wasn't the most joyous message; I wanted to acknowledge the tough year 2025 had been for CNTW and be open and honest by saying I think 2026 will be even tougher. Within that message however, I made three commitments to our staff, I think it is right that I make them publicly and extend the same commitments more widely to the people who use our services, those that care for them and those that we work with across all of our communities.

The first is that the Board of Directors will be honest and transparent. Those words are from our 'With you in mind' strategy. On that basis people may think that is simply to be expected and therefore 'so what?'. The 'so what' is I'm talking about being really honest and really transparent.

We may need to provide information that will be tough to hear and indeed, tough to deliver. What we say will be genuine, based on the best information available and steeped in the realities of how things really are.

I'd like people to know you can rely on me and the Board to tell you the truth, even if it's uncomfortable.

The second is that we will be balanced. As I've said, 2025 was a difficult year for CNTW for many reasons. Despite this, our staff have continued to deliver and deliver really well. I've said it before, but I'll say it again, they do amazing things every single day.

Undoubtedly, some things will change, some things will go wrong, and our challenges will likely grow rather than subside. However, I am entirely confident that our people will continue to deliver brilliant and innovative care. It's important that we strike a balance between operating in our realities but never forgetting why we are here. We need to move forward, together, with confidence and determination to succeed.

The third is that we will listen to you. That's not to say we'll do everything that people would like. It means we will listen to you as people with knowledge and experience of how things feel and how they really are. You have insight into what works and what doesn't, and we will use what you're telling us to improve. I have in no way lost sight of our strategic ambitions to deliver quality care every day, to be person led and / or our commitments to our service users and staff.

Two specific challenges we face are:

A financial position that reflects a system under strain. The Trust reported a modest deficit in the last financial year, driven by sustained demand pressures, increased acuity and the rising cost of delivering safe and effective services. While the organisation continues to demonstrate strong financial stewardship, the margin for flexibility has significantly narrowed

and this will require some difficult decisions, discipline and collective focus as we progress through 2026.

We continue to respond to a number of CQC inspection reports and findings. The overall judgement of those reports is disappointing i.e. Requires Improvement. That said, we genuinely welcome the insight and narrative that the CQC has provided to help us further focus and improve; we will improve and address the issues the CQC have raised. We also appreciate and recognise that looking beyond the 'headline' the CQC has reported on some fantastic work being conducted by our staff in the various services they have inspected. We await further reports from the CQC following their inspection activities. In the spirit of what I say above regarding honesty and transparency, as we move forwards, early indications suggest that the Trust will likely move from an overall rating of 'Outstanding' to 'Requires Improvement'. I know this will be a blow to the organisation and particularly to those who give their best every single day, however it is also an opportunity, one that we must approach with honesty, optimism, determination and unity. I will provide a further update in my next report.

CNTW has faced significant challenges before, and each time has risen to those challenges. I have every confidence that with commitment of our staff, the support of our partners and governors and the leadership of our Board we will do so again. Our work remains aligned with national NHS priorities including the focus on collaborative system working and laying the foundations for wider reform. Engagement with our Council of Governors continues to play a vital role in shaping our direction and our Trust strategy 'With you in mind' remains central to our improvement journey.

Thank you for your continued dedication and resilience. I look forward to working with you all to ensure we maintain are focus on quality, safety and compassionate care as we navigate the opportunities and challenges of the year ahead.

1.2 Update on NHS Financial Business Rules (effective April 2026)

NHS England has confirmed that the new financial business rules for Integrated Care Boards (ICB) and NHS Trusts will come into effect from 1 April 2026. The updated framework strengthens organisational accountability by requiring all providers and ICBs to deliver an individual breakeven revenue position, moving away from the previous emphasis on system-level balance. The rules also set out clearer expectations for how surpluses and deficits will be managed in future years, alongside restating statutory duties relating to revenue, capital, cash and value for money. These changes form part of the wider NHS operating model and the 10-Year Health Plan and all organisations are expected to reflect the new requirements in their medium-term financial and operational plans for 2026/27 to 2028/29.

For CNTW, the emphasis on organisational financial discipline reinforces the importance of robust planning, productivity improvement and continued focus on delivering high-quality mental health, learning disability and autism services within available resources. That said, the Board has a central role in ensuring these new requirements are properly scrutinised, embedded and actively monitored across all of its work. As Chair, this includes maintaining clear oversight of the Trust's financial position, ensuring that all board and committee discussions apply appropriate challenge, and seeking assurance that the executive team has credible and deliverable plans aligned to the 2026 framework. It also involves working closely with our Council of Governors, so they are well-briefed, engaged and able to hold the Non-Executive Directors to account for the performance of the Board. Continued transparency, constructive challenge and alignment with the ICB will be essential as CNTW prepares for the implementation of the new financial rules.

1.3 Council of Governors Election update

The Trust has now completed a successful round of Governor elections, with our newly elected and re-elected Governors formally taking up their roles in December 2025. I want to extend a warm welcome to all those joining the Council of Governors and thank them for their commitment to supporting the work of CNTW. It is equally important to recognise and thank those Governors who have chosen to stand down or were not re-elected. Their contribution, challenge and dedication over recent years have been invaluable and the Board is grateful for the time and energy they have given to the Trust.

Governors remain instrumental in the effective running of CNTW. Their role in holding Non-Executive Directors to account for the performance of the Board, representing the views of our service users, carers and communities and providing constructive challenge is central to strong governance. I look forward to working closely with the refreshed Council as we continue to strengthen our oversight, transparency and engagement across the organisation.

1.4 Strengthening Governance

We continue to strengthen governance arrangements across the Trust to ensure our decision-making, oversight and assurance processes remain robust and fit for purpose. That said, this work is not simply about tightening controls, it is about improving clarity, accountability and the quality of information that comes to the Board. Over recent months we have taken steps to streamline reporting, sharpen escalation routes and ensure that risks, performance issues and financial pressures are surfaced earlier and addressed more consistently.

As Chair, I am placing particularly emphasis on ensuring that Board and committee discussions are grounded in high-quality assurance, that actions are followed through and that our governance culture supports openness, constructive challenge and timely decision-making. I am also continuing to work closely with our Council of Governors, so they remain well-informed and able to carry out their statutory duties effectively. This collective focus will help ensure CNTW maintains strong, transparent and accountable governance as we move into 2026.

1.5 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 November 2025 – January 2026, I visited and / or met with:

- Bamburgh Unit
- Houghton Day Unit
- Trust-wide Strategic Business Delivery Group
- Bev Reilly, Interim Chair at Tees, Esk and Wear NHS FT (TEWV)
- Observed a range of Board Committee Meetings
- Trust-wide Peformance Meeting
- Governors Induction
- Medical Staff Committee
- Chair of NTW Solutions
- Mid-Year appraisals for Non-Executive Directors
- My Mid-Year appraisal

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.
- **Regional NHSE Team** – During January 2026 the Regional NHSE team are meeting with all Trust Chairs and Chief Executives to discuss the robustness of plans for 2026/27. Our meeting took place on 14th January 2026, we await formal feedback from the meeting, however there was nothing raised during the meeting that required us to change course on the plans that we continue to develop.

Darren Best
Chair of the Council of Governors and Board of Directors
January 2026

8.2 CHIEF EXECUTIVE REPORT

James Duncan, Chief Executive

REFERENCES

Only PDFs are attached

8.2 CEO Report Jan Open Board 26 DRAFT.pdf

Meeting	**Board of Directors - Public**		**Agenda item: 8.2**
Date of meeting	Wednesday 28 January 2026		
Report title	Chief Executive Officer Report		
Report Lead	James Duncan, Chair		
Prepared by	James Duncan, Chair		
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 for information and awareness only. These include: Trust updates on: - The 2025 staff survey - Changes to Agency Rules for NHS Organisations / Reduction of Agency Workers - Showcasing an Involvement Bank in Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust - Supporting National Ambitions for Life Sciences Research and the 150-day target on set-up of clinical trials - Smokefree policy relaunch National updates on: - The Home Office consultation - A Fairer Pathway to Settlement - Mental Health Act 2025 - Consultation on expanding access to naloxone: supply and emergency use - NHS England's response to the ADHD Taskforce final report		
Detail of corporate/ strategic risks	N/A		
Recommendation	To note		
Supporting information / appendices	N/A		

Chief Executive's Report
Wednesday 28 January 2026

1. Trust updates

1.1 Thank you

I feel that it's important to start this report, at the beginning of a new year, to say a heartfelt thank you. Thank you to our incredible workforce, our partners, and thank you to our service users and carers.

2025 has seen a lot of challenges, both internally for the Trust and the wider NHS, but externally for local communities across the region and across the country.

We, and the whole of the NHS, are going through a period of significant change. This feels hard, and sometimes difficult to understand. The coming year will also be challenging but what gives me confidence is you - our people. Across our organisation, I continue to see a remarkable response to the challenges we face. We have the strength and ambition to lead in creating services for those who need us, both locally and nationally. Your shared commitment and values shine through. In 2026, we will continue delivering on our strategy, With You in Mind, and take the next steps in implementing our Model of Care and Support. To achieve this, and manage the financial pressures facing the NHS, we will be bold and decisive. This will mean a lot of change happening across the organisation.

We will keep everyone informed about the changes ahead and involve people in shaping and implementing our plans. Please get involved where you can, share your ideas and work with us. Together, we can make CNTW the best it can be and deliver the highest quality care with the resources we have.

1.2 Changes to Agency Rules for NHS Organisations / Reduction of Agency Workers

Background

The updated 2025 Agency Rules took effect on 1 November 2025 and restrict the use of agency workers in Band 2 and 3 roles. This national decision to restrict the use of agency workers at this level follows a period of analysis, consultation and cross-system collaboration. The policy mandates that:

- No new agency bookings for Band 2 and 3 roles are permitted after this date unless through a formal "break glass" process
- Trusts and Integrated Care Boards (ICBs) must put in place plans to completely stop the routine use of agency workers in these bands by the end of January 2025, ensuring resilience through strengthened NHS staff banks
- Regional teams will monitor and intervene in systems at risk, providing tailored support, peer learning networks and escalation of persistent non-compliance.

The mandate covers all workers engaged in Band 2 and 3 roles.

Trust Position

In order to support these changes a number of operational meetings have been held with key leaders within the Operational/Support services. We have also confirmed those service areas that are perceived to be most at risk of non-compliance, namely, North Cumbria and Inpatient Children's services. A number of immediate actions were put in place and continue, including:

- All Band 2 and 3 agency requests are escalated to the Chief Operating Officer or Executive Director of Nursing and Therapies.
- Posts going through recruitment at this level have been prioritised.
- Those agency workers who work the highest number of shifts have been approached to encourage them to transition into Bank posts within the Trust, in line with the procurement guidelines.
- Current Bank staff have been offered substantive posts and are being fast-tracked through the process, ensuring NHS Employment Standards are met.

Impact to Date

The implementation of this "Rule" is aligned with the work currently ongoing within the bed-based services to reduce spend with the more effective management of "head count". The bed-based services have adopted a methodology which highlights baseline numbers for each ward on a twice weekly basis, with the request for any additional Bank staff triggering a process that requires Director sign off. These additional requests tend to be linked to:

- Short notice staff sickness
- Ward admissions with high levels of acuity
- Transport of patients to Acute Trusts following incidents/accidents.

It is imperative therefore that over the coming weeks we develop robust approaches to the medium/long term mitigations, particularly for the Carleton Clinic site in Cumbria.

Risks

The full implementation of this "Rule" will no doubt cause a level of anxiety within the services as it is perceived that timely access to staff will be adversely impacted in terms of risk and safety as well as patient experience.

We are currently capturing and reviewing information from our Trust systems in terms of the number of incidents, delays/cancellations of key interventions, patient feedback – Your Voice and we will undertake regular triangulation of this data.

1.3 Staff Survey 2025

The NHS Staff Survey 2025 launched on 16 September 2025 and closed on 28 November 2025. The final response rate was 57.88% which was a significant increase from the 2024 response rate of 42%. The Bank staff response rate was 25.75% compared with 22.6% the previous year. Management Reports are due to be published on 30 January 2026 and the results will be embargoed until mid-March (exact date not yet given). Plans are in place to discuss at Trust Leadership Forum, Ward Managers' Forum and other key meetings and the results will be discussed at local level at the earliest opportunity.

1.4 Showcasing an Involvement Bank in Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

On 20 January 2026 an NHS England Lunch and Learn session was hosted by the Trust's Lived Experience Service to showcase how people with lived experience play a vital role in shaping and strengthening the organisation.

The session talked about the Involvement Bank, its role, how it works, and the opportunities it offers for meaningful involvement.

Attendees also heard directly from people with lived experience, who shared how it feels to be involved in service design and delivery, as equal partners. They talked about activities they have supported and the impact this has had on their own development and wellbeing, whilst also contributing to improved service provision, culture, and outcomes.

1.5 Supporting National Ambitions for Life Sciences Research and the 150-day target on set-up of clinical trials

On 17 November 2025 a letter was sent to Trust Boards from Professor Lucy Chappell (Chief Scientific Advisor, NHS England /National Institute for Health and Care Research (NIHR) Chief Executive) and Professor Meghana Pandit (Medical Director, NHS England) updating expectations for set up and approval times for clinical research in the NHS with the aim of ensuring the UK is a global leader in clinical research. A new target of 150 days will be implemented by March 2026. This is a headline action in the NHS 10 year plan, reinforced in the Life Sciences Sector plan and a requirement in the Medium-Term Planning Framework – delivering change together 2026/27 to 2028/29.

There are new expectations on NHS Trusts as a result of this:

- Monitoring performance against the 150 day target with a particular focus on commercial trials.
- Embedding monitoring into routine governance (including Board level review).
- Driving improvement.

The existing governance process around clinical research is monitored through the Trusts Research Governance Oversight Committee which reports to the Quality and Performance Committee of the Board. The committee currently reviews set up times, but we will update this with the new metrics and expectations, and we will provide assurance on our performance to the Quality and Performance Committee. We have also implemented a monthly operational group to monitor and address any set up delays as they occur.

CNTW currently has six research studies in set up which will meet the criteria for monitoring (annually we expect around 10 relevant studies, while the aspiration is to increase further the number of commercial research studies) although the majority of these should be set up before 1 April meaning they may not be subject to the new metrics. There is currently some uncertainty around recording the data for the metrics, in particular, where there are delays outside of Trust control. The expectation from the Research and Development team is that once the new processes are up and running, it is unlikely that there will be studies which breach this target where the issue is within our control.

1.6 Supporting our patients to be smokefree: Tobacco Dependence Treatment across CNTW

Smoking remains one of the leading causes of preventable ill health and premature death for people who use mental health services, contributing significantly to long-standing health inequalities. We know that supporting people to address tobacco dependence is therefore a vital part of delivering high-quality, holistic mental health care and is a core component of our physical and public health strategy.

On 5 January, the Trust strengthened its commitment to smokefree care with the relaunch of our smokefree policy. The policy reinforces our Trust-wide commitment to safer, healthier environments for patients, staff and visitors. It aligns policy with practice by ensuring consistent access to support, clear expectations, and a compassionate approach across all settings.

On Monday 5th January, we held a lunchtime webinar 'Embedding Tobacco Dependence Treatment across CNTW in 2026'. Mary Yates, a renowned speaker and smokefree advocate, attended the session and is a registered Learning Disability and Mental Health Nurse who supported our smokefree relaunch by visiting some of our sites and giving support and advice to staff.

Our Tobacco Dependence Treatment Service provides dedicated support to patients to manage nicotine withdrawal and reduce or stop smoking in a safe, compassionate and evidence-based way. Tobacco dependence is treated as a clinical condition, not a lifestyle choice.

All inpatient wards now have access to dedicated tobacco dependence support.

- All patients who smoke and are admitted to the Trust will be offered support from the Tobacco Dependence Treatment Team.
- A member of the team will attend the ward to complete a comprehensive assessment of the patient's smoking history and nicotine dependence.
- Patients will be informed of the range of support available, including nicotine replacement therapy and vape options, where appropriate.
- Ongoing behavioural support will be offered to patients who choose to engage, to help them manage withdrawal and maintain a smokefree status during their admission.
- The team will support quit attempts and ensure appropriate referral to local authority stop smoking services to enable continued support following discharge.

Enhanced Tobacco Dependence support is also available within our Newcastle and North Tyneside community treatment teams. All other community patients can continue to be referred for community support. Information on community support for tobacco dependence.

Everyone has a role to play in embedding tobacco dependence treatment into routine care. By working together, we can reduce health inequalities, improve outcomes, and support people using our services to live longer, healthier lives.

2. National updates

2.1 Home Office consultation - A Fairer Pathway to Settlement

The Home Office has launched a 12-week consultation on proposals to reform the UK's immigration settlement rules. These changes aim to replace automatic settlement after a fixed period with an earned settlement model, where permanent residence is achieved through meaningful contribution to UK society and the economy. Key changes are:

- Qualifying period: Increase from 5 to 10 years.
- Earned settlement: Time may be reduced for positive contributions (e.g., earnings, volunteering) or extended for negative indicators.
- Special groups: Tailored pathways for dependants of British citizens, British Nationals (Overseas), vulnerable groups, and HM Armed Forces.
- Access to benefits: Considering restricting benefits until British citizenship.

It is anticipated that if these proposals are agreed, there will be significant impact on our unregistered workforce. Ongoing communication and support is already in place for those affected by previous immigration changes and will continue over the coming months.

The consultation closes on Thursday 12 February 2026.

2.3 Mental Health Act 2025

On 18 December, the Mental Health Act 2025 received Royal Assent, the most significant change to mental health legislation in more than 40 years. Although the 2025 Act amends rather than replaces the 1983 Act, the scale of change it introduces is significant.

Although the direct impact of the changes will not be felt immediately, there are big changes to come. The Act will help ensure that people with severe mental illness receive better, more personalised treatment. It aims to address longstanding disparities, including the experiences of people with a learning disability and autistic people, and the unacceptable racial inequalities that see black people detained at more than three times the rate of white people. The Act helps to ensure that crisis care is safer, more effective and centred on people's needs, giving detained patients genuine input into their treatment and timely care plans.

Having said that, a small number of early provisions will be happening now. For example, supervised discharge arrangements for conditionally discharged restricted patients, will come into force in February.

As a Trust, we are working through, and are preparing for these changes so that the Trust is in the best position possible to react swiftly, proportionately and safely in terms of its policies, processes and procedures. This will be monitored through assurance reporting to our Mental Health Legislation Committee.

2.3 Consultation on expanding access to naloxone: supply and emergency use

Naloxone is a life-saving drug that reverses the effects of an opioid overdose and can help to prevent overdose deaths. Anyone can administer naloxone in an emergency but currently, it can only legally be supplied to an individual for future use by a list of professionals and services named in the Human Medicines Regulations 2012.

The Department of Health and Social Care is seeking views in this consultation on proposals to further expand access to naloxone across the UK. Specifically, they are proposing to make further legislative changes to:

- Allow hostels, day centres and outreach services for people experiencing homelessness to supply naloxone without a prescription.
- Create publicly accessible emergency naloxone boxes, similar to defibrillator cabinets.
- Clarify rules for workplaces at risk of opioid contamination (accidental exposure)

The consultation document provides the public and people with experience or expertise in substance use disorders with further information about the proposed changes. The consultation closes on 9 March 2026.

2.4 NHS England's response to the ADHD Taskforce final report

An independent taskforce established to tackle challenges in attention deficit hyperactivity disorder (ADHD) care has today (6 November 2025) published its final report. The report assessed services across health, education, employment, and the criminal justice system.

The independent report recognises that cross-sector services across the country are under significant pressure due to the growing number of people seeking assessment and support which has resulted in long waits for diagnosis and treatment.

Through the Medium-term planning framework, NHS England has set clear expectations for local integrated care boards (ICBs) and Trusts to improve access, experience, and outcomes for ADHD services over the next three years, focusing on improving quality and productivity. The report makes a series of recommendations to transform ADHD services across England, many of which require cross-government collaboration. This includes calls for ADHD to be recognised and treated as a common condition, supported by new diagnosis models to help reduce waiting lists and that professionals across healthcare including GPs should receive more training on recognising symptoms and having an appropriate role in treatment.

Other recommendations include greater use of digital tools and data to enable services to work more efficiently with patients.

James Duncan
Chief Executive
January 2026

8.3 QUESTIONS FROM GOVERNORS AND THE PUBLIC

Darren Best, Chair

Date of next meeting
Wednesday 29 April 2026, 10.00am ? 12.30pm, St Nicholas Hospital Board Room and via MS Teams