Well-Led assessment report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Assessment Plan ID : AP3542

Inspection visit date(s): 30 September to 2 October 2025

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Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Overall findings

Overall

Rating Requires improvement 

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) provide specialist mental health, learning disability, and neuro-rehabilitation services across the North of England. It is one of the largest trusts of its type in England. CNTW operates from over 70 sites across:

- Cumbria
- Northumberland
- Newcastle
- North Tyneside
- Gateshead
- South Tyneside
- Sunderland

We assessed all 8 of the quality statements in the well-led key question used when assessing an NHS trust using our current framework.

We identified positive findings within 4 of the 8 quality statements and areas for improvement within 4 of the 8 quality statements. We used our professional judgement to moderate the rating for this assessment due to the breach of regulation we identified during our assessment within these 4 quality statements. We took into account the quality of the services we assessed prior to our trust level assessment and NHS England's oversight of the trust to ensure our rating was fair and proportionate. We also took into account the changes the trust was already making to ensure improvements to the care it provides and the trust's innovative approach to service delivery.

The trust provides 12 services within our assessment service groups (ASG's). The well-led review followed assessments of these frontline services. The initial assessment of the trust's services was triggered by information received about risk in some of the trust's frontline services and the age of the trust's ratings.

The ASGs we assessed included:

- Wards for people with a learning disability and/or autism
- Community mental health services for adults of working age
- Wards for older people with mental health problems
- Child and adolescent mental health wards

We undertook these assessments to ensure we had a thorough understanding of a range of services provided by the trust ahead of our well-led review.

During the assessment we undertook a visit to the trust's headquarters from 30 September to 2 October 2025. We carried out interviews with more than 20 members of the trust's executive leadership team, including the chief executive, trust chair, executive medical director, and deputy chief executive, chief operating officer, executive director of nursing and therapies, and interim executive director of finance. We also held interviews with non-executive directors.

During the assessment we also:

- undertook group interviews with the directors of all three care groups, directors of research and innovation, estates and sustainability and of public health.
- ran focus groups with; trade union leads, staff network leads, governors, freedom to speak up guardians, nurses, doctors, allied health professionals and healthcare support workers.
- spoke with trust leads for allied health professionals, equality diversity and inclusion, use of force and reducing restrictive practice leads, patient safety and safeguarding.
- received feedback via our give feedback on care process from more than 90 members of staff.
- observed a range of trust meetings and committees which included; quality and performance committee, people committee, mental health legislation committee, patient safety learning and improvement panel, service user and carer reference group, and mortality review panel.
- wrote to stakeholders including; local authorities, NHS England, the police, Healthwatch and the Integrated Care Board (ICB) to seek feedback about the trust.

During the trust's well led assessment, we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Overall findings

The trust did not have effective systems to consistently assess, monitor, and drive improvement in the quality and safety of the services provided. **Regulation 17, 1, 2 (a) (b) Good Governance**.

Key Question Summary

Shared direction and culture

We scored this quality statement as 2, the evidence showed some shortfalls and the trust were in breach of Regulation 17 (Good Governance). Risks to staff welfare and patient safety arising from poor culture and workforce instability were not fully mitigated. The trust did not consistently embed its values and foster an open, inclusive culture, with persistent barriers to speaking up, ongoing bullying and discrimination concerns, and workforce challenges, with an increasing impact on people from ethnic minority groups and disabled staff.

Leaders ensured a clear, shared vision and strategy across the organisation, and staff understood how their roles contributed to achieving these goals. The vision, values, and strategy were developed collaboratively with staff, service users, and external partners through a structured planning process. The vision and values were well-articulated and widely known.

The trust actively considered the demographics of the local population and tried to address health inequalities. The trust's priorities included tackling health inequalities, promoting digital inclusion, and reducing morbidity and mortality through improved physical health outcomes. The patient and carer race equality framework (PCREF) was in development with consultation underway.

While strategic clarity existed, the culture within some areas of the trust did not always reflect trust values in day-to-day practice. There were pockets of poor culture, and staff feedback indicated that the values were not consistently embedded across all teams. The 2024 staff survey results indicated a decline in staff satisfaction.

Leaders had assessed and documented risks to the delivery of the strategy, and mitigating actions were in place. Whilst the trust's ambitious transformation programme would support achievement of its strategic goals, it was not consistently supported by a clear line of sight between operational risks and the Board Assurance Framework, limiting assurance that strategic risks were being effectively reduced.

Capable compassionate and inclusive leaders

Overall findings

We scored the trust as 3. The evidence showed a good standard.

Leaders had the experience, capacity, capability and integrity to ensure the organisational vision could be delivered. Executives were visible, approachable, and committed to the trust's values. Regular structured visits to frontline services by executives, non-executive directors, and governors had improved leadership visibility and allowed leaders to triangulate governance information with real staff experience.

Stakeholder feedback described the board and senior leaders as experienced, values-driven, and committed to partnership. The trust was recognised as an active and constructive member of the integrated care system.

The board was stable and experienced, with a development plan in place.

The trust had robust policies for disciplinary and grievance processes, and had made key changes to improve them, but cases often took a long time to resolve.

Freedom to speak up

We scored this quality statement as 2, the evidence showed some shortfalls. The trust were in breach of Regulation 17 (Good Governance). Not all leaders demonstrated an open culture where staff felt safe and empowered to raise concerns, with some staff fearing detriment or lacking confidence that their feedback would lead to change. Staff feedback highlighted ongoing negative experiences, including reports of retaliation, performative feedback mechanisms, and whistleblowers feeling isolated or pressured to leave.

Freedom to speak up reports showed that bullying, management processes, and safety were common themes which staff raised concerns about, but reporting rates across the trust remained low in comparison to other trusts of a similar size.

Senior leaders were seen as supportive and role-modelled good speaking up behaviours, but engagement from middle management was inconsistent, and the trust acknowledged that more work was needed to ensure staff could safely raise concerns. To support leaders, the trust had launched a leadership academy programme. This was a central part of the trust's approach to developing leadership capability, supporting cultural change, and ensuring the development of compassionate, skilled leaders. It offered structured programmes, supported by executive leaders.

Workforce equality diversity and inclusion

We scored this quality statement as 2, the evidence showed some shortfalls. The trust were in breach of regulation 17 (Good Governance). Despite executive engagement and some positive initiatives, barriers to engagement and progression persisted for some people with protected characteristics, and ongoing work was needed to address bullying, discrimination, and to embed a more inclusive culture. Sustained focus on board and workforce diversity, as well as on tackling inequalities, is essential for the trust to achieve its ambition of being a 'great place to work'.

The trust had made progress in representation of people from ethnic minority groups, particularly at board level, and had developed ten-point action plans for both race and disability equality, including anti-racism initiatives, improved reporting, and targeted support. Staff networks played a key role in shaping policy and supporting staff.

The 2024 NHS Staff Survey and the trust's annual workforce race/disability equality standard report(s) highlighted persistent inequalities for staff from ethnic minority groups and those with disabilities or long-term conditions.

Staff from ethnic minority groups reported higher rates of discrimination, bullying, and harassment, and felt less positive about career progression compared to white colleagues, with these gaps often wider than national averages. Disabled staff also reported more negative experiences than non-disabled staff, including higher rates of bullying and lower satisfaction with workplace support and reasonable adjustments.

Governance and assurance

We scored this quality statement as 2, the evidence showed some shortfalls. The trust were in breach of Regulation 17 (Good Governance). The trust's governance systems did not always ensure effective and timely action was taken to address risks in services including areas of low compliance highlighted through internal governance systems. Early warning signs of deteriorating quality and safety were sometimes missed prior to external reviews. This included in staff safety, reducing restrictive interventions, managing the assessment of environmental ligature risks and training and supervision compliance. These cross-cutting risks were not always included in corporate risk registers to ensure clear oversight, action and mitigation.

There were established clear governance structures, defined roles, and systems of accountability from ward to board level. However, inspections and reviews found that these systems had not always

operated effectively, with some early warning signs of deteriorating quality missed and a lack of consistent assurance that governance drives high-quality, sustainable care. Committee oversight lacked clarity and focus in some areas, with complex papers and assurance reports that did not always identify clear actions, ownership and timescales.

The trust had undertaken significant organisational change, including leadership restructuring, new strategies, and external audits, to strengthen governance and risk management. Despite these improvements, board and committee papers were lengthy and complex, sometimes obscuring key issues and making effective scrutiny challenging. Assurance reports did not always have clearly identified actions, ownership, or timescales for improvement, and there was a need for more outcome-focused oversight and escalation of significant risks.

Risk management was structured and proactive, with a tiered system of risk registers and regular reviews. However, some key patient safety risks such as high use of restraint, delays in discharge, and mandatory training gaps were not always reflected on the corporate risk register, raising concerns about the visibility and management of cross-cutting risks.

Workforce challenges persisted, including high vacancy and sickness rates in some areas, increasing reliance on temporary staff, and inconsistent supervision and training compliance at team level.

Board, committee and governor meetings did not always demonstrate a culture of challenge. There was room for more robust scrutiny, clearer linkage of risks to patient experience, and more consistent action on assurance gaps.

The Trust's approach to financial management was robust, but the sustainability of ambitious cost improvement plans was unclear at the time of the inspection.

The trust did not always ensure they worked with partners to ensure safeguarding concerns were accurately reported. The Trust's safeguarding processes were complex due to working with eight local authorities. During inspections, it was found that local authorities were not always aware of incidents involving harm to patients, and there was confusion among staff about what types of incidents should be reported and when.

The Trust had not undertaken audits in relation to safeguarding children, and the 2024 safeguarding audit was primarily process-based rather than practice-based, highlighting the need for more robust assurance on the quality of safeguarding practice. Safeguarding supervision was well-embedded, and learning from reviews was disseminated through meetings and training.

Estates, pharmacy, infection prevention, and digital governance were well-developed, with clear oversight and evidence of innovation and improvement. The trust's subsidiary, NTW Solutions, supported operational resilience.

There was effective management of information governance, and digital transformation is a strategic priority.

Partnerships and communities

We scored the trust as 3. The evidence showed a good standard.

There was strong strategic engagement with local authorities, police, and other agencies, and the trust participated in statutory reviews and multi-agency audits.

The trust demonstrated strong partnership working across health, social care, voluntary, and community sectors, with a clear commitment to collaborative service delivery and quality improvement. Stakeholders consistently recognised the trust's openness, adaptability, and willingness to co-produce solutions. There were examples of innovative joint projects and effective multi-agency governance.

However

The trust had clear and embedded processes for the management of complaints, but the trust did not always clarify whether complaints had been upheld in line with good practice.

Learning, improvement and innovation

We scored the trust as 3. The evidence showed a good standard, our concerns relating to learning from incidents are outlined in the governance and assurance section of this report.

The trust's focus on continuous learning, innovation, and quality improvement across the organisation and local system was a key strength in their delivery of services. The trust's transformation agenda was led by senior leaders and specialists, with a particular emphasis on co-designing new models of care that integrate social care and health services.

A robust quality improvement (QI) ethos underpinned the trust's work, with leaders trained in QI methodologies and a programme board overseeing transformation. Staff, service users, and carers were actively involved in shaping services through workshops, reference groups, and the involvement

hub, ensuring that transformation was meaningful and co-produced.

Research and innovation were central to the trust's approach, with strong partnerships across academic, clinical, and community sectors. The trust is recognised nationally for its research activity, leadership in co-production, and the development of accredited services.

However

The learning culture at CNTW is present but the governance processes were variably embedded. There were structures for learning, but they were not applied consistently, leading to missed opportunities, uneven implementation of guidance, and limited evidence that learning always translated into sustained improvement across the Trust.

While the Trust had established frameworks for learning from incidents and deaths, we had concerns about missed opportunities for improvement. Incidents were not always correctly categorised according to trust policy, reducing opportunities for learning and oversight. Learning from incidents and reviews was not always triangulated across services and the trust did not always ensure refreshed national guidance was implemented. There was inconsistent tracking of actions from mortality reviews and incident reviews did not always contain concrete actions for improvement. There was incomplete application of duty of candour processes and reporting to LeDeR (Learning from Lives and Deaths – People with a Learning Disability and Autistic People which is a national service improvement programme commissioned by NHS England to reduce health inequalities and prevent premature deaths among people with learning disabilities and autistic people) was not always consistent. This concern was addressed in the report section relating to governance.

Ongoing challenges included ensuring the patient voice was heard consistently at board level.

The trust had made some progress in work to reduce restrictive interventions, particularly in the use of restraint. However, this required further progression and has been a key feature at the trust for several years.

Environmental sustainability

We scored the trust as 3. The evidence showed a good standard.

The trust had set a strategic ambition to become a sustainable organisation, underpinned by its green plan (2025–2028). The plan provided a comprehensive framework for environmental sustainability,

including detailed strategies for estates decarbonisation, capital planning, heat decarbonisation, and renewable energy initiatives. Governance was robust, with the green plan management group overseeing nine thematic workstreams.

The trust had embedded sustainability into its digital infrastructure and workforce development, supporting staff engagement through apprenticeships, specialist training, and the promotion of greener NHS resources.

The trust had achieved a 14% reduction in carbon emissions over five years, though current levels remained above the required trajectory, and the trust recognised the need for accelerated reductions. The trust benchmarked its progress against a 2019 baseline, aiming for a 47% reduction in carbon emissions by 2032 and net zero by 2040.

Peoples Experience

The trust monitored people's experiences through several channels, including the 'Your Voice' survey, launched trust-wide in April 2024. This survey collected feedback from service users and carers on care, safety, information, medication, treatment, and waiting times, it was distributed after discharge and available online. Results were themed for quality improvement and shared quarterly with the quality and performance committee.

In the past year, 6,239 surveys were completed (10–12% response rate per quarter), with carers providing about 20% of feedback. Positive experiences remained high (85–87% satisfaction), while negative responses were 6–8%. The survey included the NHS Friends and Family Test, with trust scores just below the national average.

Involvement in care was the highest scoring area (89–91% of people felt involved), especially in inpatient services. Some community service users felt unheard. Positive comments praised staff for their care and support, while negative feedback focused on long waits for specialist services and crisis support.

Overall, most feedback was positive, especially regarding involvement and staff attitudes, but concerns remained about waiting times, crisis services, and communication.

During our assessment service group inspections, we visited four services, spoke with 76 people using services and

60 carers.

Feedback was mixed for learning disability and autism wards: some carers felt safety and care had improved, especially at Rose Lodge. While others raised concerns about safety, staff shortages, and inconsistent support. Medicines management and clinical leadership were praised, but there were concerns about psychotherapy access, healthy living support, and dignity.

In community mental health services for adults, most patients reported respectful, supportive care and valued employment and recovery support, though some experienced long waits for therapy and inconsistent staff contact. Carers generally felt involved but highlighted issues with staff changes, neurodiversity training, and crisis support.

Feedback from older people's wards was overwhelmingly positive, with patients and carers describing compassionate, knowledgeable staff. Patients felt involved in their care, and end-of-life support was highly valued.

On child and adolescent mental health wards, young people mostly described staff as kind and helpful, and said that they felt safe, though some carers were concerned about agency staff and communication. Young people valued activities and peer support. Carers praised education staff and the family ambassador but raised concerns about food provision and inconsistent communication.

In the 12 months prior to the inspection, the CQC had also carried out Mental Health Act review visits to 10 of the trust's inpatient wards.

Patients across all sites generally reported feeling safe, respected, and supported. Staff were described as caring, approachable, knowledgeable, and proactive. We heard positive feedback about therapeutic activities, autonomy, and involvement in care.

Carers were mostly satisfied with communication and involvement in care planning. Family involvement was reported positively, especially in units like the mother and baby unit and ward for older people. There were some concerns about inconsistent updates and accessibility of meetings. We found that IMHA (Independent Mental Health Advocacy) services were present and valued, but advocacy referrals and access to MDT (multi-disciplinary team) meetings were noted as an area for improvement.

Reviews found that wards were generally clean and therapeutic, but our concerns included patients describing poor catering, lack of air conditioning, hot water issues, insufficient communal seating and

some units had locked garden doors or inaccessible bathrooms.

During visits we found that patients were regularly reminded of their rights under the Mental Health Act and that noticeboards and advocacy information were widely available, though some wards had outdated or missing materials.

The annual Community Mental Health Survey, conducted by CQC, assesses the experiences of people aged 16+ using NHS community mental health services in England. The 2024 survey, conducted between April and May and published in April 2025, had a 19% response rate for CNTW (down slightly from 20% in 2023).

CNTW's 2024 benchmark report compared results with other trusts and its own 2023 data. Compared to other trusts, one question was rated 'much better than expected', five 'better than expected', four 'somewhat better than expected', and one 'somewhat worse than expected'. Compared to last year, one question was 'significantly better', with none significantly worse.

Key strengths included enough time for patients to discuss needs ('somewhat better than expected'), more frequent care planning reviews ('better than expected'), and positive discussions about medication, especially side effects ('much better than expected'). Crisis support and carer involvement also improved. Respect, dignity, and compassion were rated 'somewhat better than expected', and overall experience was positive. The only area needing improvement was support with financial advice or benefits.

The trust's service user and carer reference group is a user-led forum ensuring meaningful involvement in designing and evaluating CNTW services. Meetings are held regularly, featuring Q&A panels with senior leaders and inclusive sessions led by service users and carers, supported by the involvement team.

We observed a meeting, attended by around 200 people (including executives, staff, service users, and carers), it included presentations on trust priorities and group discussions on topics like service redesign, digital developments, equality frameworks, and workforce wellbeing. Service users shared involvement work, and members described valued opportunities to participate in training, interviews, and service development.

The group's chair attended the executive management group, ensuring service user and carer perspectives influence trust decisions.

Shared direction and culture

Score: 2. Evidence shows some shortfalls in the standard of care

The Trust had a clear, shared vision and strategy focused on transparency, equity, human rights, diversity, inclusion, and meeting the needs of its local communities.

The Trust's transformation programme was ambitious and had achieved some key milestones. However, some fundamental patient safety issues had not been addressed promptly, suggesting that the focus on innovation and transformation may have overshadowed essential quality and safety priorities.

Despite this strategic clarity, the culture within some areas of the trust was poor. Staff concerns indicated that the values set out in the strategy were not always reflected in day-to-day practice.

In assessing this quality statement, we considered feedback from leaders, staff, people using services and local system partners, as well as reviewing trust processes and survey results.

The trust's strategy, vision, and values launched in May 2023 as "with you in mind". They were developed through engagement with staff, service users, carers, and partners. The vision centred on compassionate, lifelong care, and the values emphasised respect, honesty, and sustainability.

The trust's vision was "to work together, with compassion and care, to keep you well over the whole of your life".

With values which are:

- caring and compassionate: treating others as we'd want those we love to be treated.
- respectful: everyone is of equal value, entitled to dignity and equal rights.
- honest and transparent: fair, open, and helping people make informed decisions.
- protecting rights and the planet: committed to future generations and sustainability.

The trust strategy set out 5 ambitions:

- quality care, every day: deliver expert, compassionate, person-led care in every team, every

day.

- person-led care, when and where it is needed: support changing needs over people's whole lives, working with partners and communities.
- a great place to work: ensure the workforce has the right values, skills, diversity, and experience.
- sustainable for the long term, innovating every day: be a sustainable, high-performing, digitally enabled organisation.
- working with and for our communities: build trusted, long-term partnerships to help people and communities thrive.

The strategy was described as a "living document," designed to evolve in response to ongoing feedback.

The trust told us that when their strategy was launched in 2023, they made the decision not to have enabling strategies but to have a single trust strategy underpinned by annual priorities to enable delivery. Where there was a need for a wider strategy (such as for physical health) they had been developed but each strategic ambition had a delivery plan or similar associated with it, these were noted as:

- workforce
- estates
- green plan
- digital
- risk management
- quality priorities
- physical health
- together strategy

The trust also told us that following publication of the NHS long term plan and forthcoming long-term workforce plan they agreed to develop a people strategy which was currently moving through

engagement processes.

The trust's ability to measure success against its strategic objectives were outlined in their board assurance framework (BAF). The highest rated risks were noted as CQC compliance, access and performance, patient safety culture, workforce sustainability, and financial sustainability. Moderate risks included transformation/model of care, staff motivation and wellbeing, estates infrastructure, and digital/cyber threats.

Risks were reviewed regularly, with most reviewed between June and September 2025. Each risk was assigned for oversight and management to an executive board member and to the responsibility of a sub-committee of the board.

Key to delivery of their strategic ambitions was the trust's ability to deliver their revised model of care and support. There was a programme of five key elements of change overseen by a single transformation board, the 'model of care programme board'.

- **Understanding and prevention:** Developing neighbourhood health models, including Hope Haven, one of six national 24/7 mental health centres.
- **Community treatment:** Expanding community-based care to support people outside hospitals.
- **Long-term complex needs:** Providing sustained, assertive care for severe mental illness, moving away from episodic support.
- **Urgent and crisis care:** Improving crisis response, safety planning, and access, aiming to reduce self-harm, suicide, and readmissions, with tailored support for autism and complex needs.
- **Inpatient care:** Focusing on person-centred, therapeutic treatment, early discharge planning, and reducing restrictive practices, with ongoing ward redevelopment and partnership work.

The programme board met regularly, with sub-groups managing workstreams such as:

- Front door and prevention: Shifting to personalised, keyworker-led care, digital tools, and community hubs.
- Community treatment: Workforce planning, improved access, expanded therapies, and better transitions.

- Severe mental illness and complex needs: Intensive support for those with complex needs.
- Urgent care and crisis: Hospital-to-home models and enhanced crisis triage.
- Inpatient care: Redeveloping wards, enhancing rehabilitation, and new clinical models.

Whilst the transformation programme would enable the trust to achieve its strategic ambitions, there appeared to be a lack of clarity between operational and strategic risk management. While the Trust had a comprehensive risk management framework, there remained a gap between strategic risk oversight through the Board Assurance Framework (BAF) and operational risk management via the Corporate Risk Register (CRR). The BAF provided clear visibility of the Trust's principal risks, which remained above the stated risk appetite, and demonstrated appropriate governance, review, and assurance processes. However, the persistence of these risks over time suggested that while risks were identified and monitored, there was less evidence that mitigating actions were consistently translating into measurable risk reduction at operational level. The CRR contained a large volume of risks, which may dilute focus on the specific operational drivers underpinning BAF risks. This weakened the thread between frontline controls, care-group delivery, and strategic assurance, creating a position where risks are known, accepted, and reviewed, but not always demonstrably reduced. Strengthening the alignment between BAF risks and the specific, outcome-focused actions within the CRR would provide greater assurance that risk management activity was leading to tangible improvements in safety and quality.

The trust commissioned an external review of strategic embeddedness in 2024. The review found that there was a high awareness of the strategy with positive cultural alignment. However, the review suggested that the strategy lacked measurable deliverables and clear links to annual planning with pockets of poor culture in some localities (particularly in west Cumbria). The review made recommendations for the trust to develop supporting strategies (clinical, digital, workforce) and to articulate how it meets strategic milestones to enhance oversight of strategic delivery.

The trusts medicines optimisation strategy was supported by an action orientated plan. This was reviewed through medicines governance channels and was aligned to the trust's strategic aims.

Culture

Executive leaders demonstrated their commitment to compassionate and inclusive leadership. They were positive about the trust's culture and aware of the work required to make improvements. However, data and staff narrative highlighted the need for leadership to focus on rebuilding engagement, recognition, inclusion, and staff voice at all levels.

The NHS Staff Survey provides insights into staff engagement, morale, and workplace experience. In 2024 CNTW had 3,354 completed questionnaires with a response rate of 42%, which was lower than

the national rate of 54%.

The 2024 survey provided evidence that staff engagement and morale had both declined since 2020 and are now just below the national average for similar trusts. The trust score was significantly lower when compared to 2023 results for the following elements of the survey:

- we are compassionate and inclusive

- we are recognised and rewarded
- we each have a voice that counts
- we are a team
- staff engagement

Key sub-themes such as; motivation, involvement and advocacy all show a downward trend. Fewer staff reported looking forward to work, feeling enthusiastic, or feeling able to make improvements in their area. Morale was lower, with more staff thinking about leaving, feeling work pressure, and experiencing stressors.

Scores for "We are compassionate and inclusive" and related sub-themes (compassionate culture, leadership, diversity, inclusion) have declined since 2022. The trust was previously above average for compassionate leadership but is now slightly below the national average.

Significant reductions were seen in:

- recognition and reward
- having a voice that counts
- teamwork

Staff felt less recognised, less able to influence decisions, and less positive about teamworking than in previous years.

One area with notable improvement was in appraisals (within "we are always learning"), which had steadily increased since 2021. The trust's score for "we are learning" was slightly higher than the national average.

Fewer staff felt able to raise concerns or advocate for the trust as a place to work or for care. The "raising concerns" score had reduced, and fewer staff would recommend CNTW as a place to work or receive care.

Between October 2024 and October 2025, CQC had received 120 concerns from staff. 96 of these were received following a letter we sent to staff asking them to share their feedback to support our assessment. The feedback we received was mainly negative. Staff reported unsafe staffing levels,

heavy reliance on agency staff, and frequent redeployment without consultation, they told us this led to increased risks, burnout, and compromised safe care. Some staff highlighted unsafe physical environments, especially at the Campus for Ageing and Vitality, with staff feeling unsafe, particularly after dark. Concerns were raised about inadequate training, lack of supervision, and unqualified staff performing tasks beyond their competence. There was a perceived disconnect between senior leadership and frontline staff, with decisions made top-down and staff feeling unsupported and unheard. Reports described bullying, intimidation, and a culture of fear, resulting in low morale, high sickness rates, and distress over not meeting care standards. Allied health professionals felt devalued and underrepresented.

We also received some positive feedback which included that despite systemic issues, some staff reported strong support from immediate managers and teams, good local leadership, and a commitment to patient care at the ground level. Staff gave examples of innovative practice, compassionate team leadership, and positive patient and carer feedback in some areas.

Staff we spoke with during focus groups gave feedback about the approach of leaders. They described their immediate managers and team leaders as approachable, compassionate, and supportive, especially regarding induction, training, and wellbeing. Staff in some teams felt valued and appreciated, with managers who fostered open communication and encouraged speaking up about safety. Some staff and staff networks reported that executive leaders, including the chief executive and board members, were visible, approachable, and receptive to feedback, particularly through direct visits, open channels of communication, and engagement with staff networks.

However, staff also described a disconnect, staff felt there was a significant gap between senior leadership and those delivering care. Decisions were often perceived as top-down, with limited consultation or understanding of frontline realities. Some described a "them and us" culture, especially since the pandemic, with senior leaders being less visible and more remote.

Staff frequently reported that the quality of leadership and support varied greatly depending on the team or service. While some managers were described as compassionate and effective, others were seen as unsupportive, dismissive, or even fostering favouritism and a lack of accountability. Some staff described a culture of fear around disciplinary processes, with "fact finds" seen as interrogative and punitive rather than supportive or focused on learning.

Staff highlighted inconsistent or delayed communication from leaders, especially regarding changes, policies, or incidents. Some felt information was not cascaded effectively, particularly through middle

management.

Leaders were seen as constrained by financial challenges, which impacted staffing, training, and career progression. Some staff felt leaders were open about these pressures, while others felt decisions were made without sufficient transparency or frontline input.

Despite challenges, there were examples of positive, inclusive leadership and supportive cultures in certain teams and services. The chief executive officer (CEO) acknowledged that poor culture could develop over time and was committed to open conversations to manage staff experiences with sensitivity. To make cultural improvements the trust had invested in a leadership development academy. The leadership programme was being delivered to all staff at band 7 and above, it was led directly by executives, with 150 people having completed it and a goal to reach all eligible staff by March 2026. The aim was to embed leadership skills and support a compassionate, values-driven culture. People we spoke with told us about the positive impact of the academy and leadership development on staff morale, succession planning, and the ability to respond to challenges.

Stakeholder feedback described CNTW as a trust with a strong, values-led culture, committed to partnership, inclusion, and continuous improvement. Leadership was described as accessible and effective, and the organisation was praised for its openness, innovation, and collaborative approach.

Capable, compassionate and inclusive leaders

Score: 3. Evidence shows a good standard of care

The trust have inclusive leaders who understand the context in which they deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.

In assessing this Quality Statement, we considered feedback from leaders, staff, people using the services and local system partners, as well as reviewing trust processes and survey results.

The chief executive officer (CEO) had worked at the organisation for more than 20 years and had been in post as CEO since 2022. Our discussions and observations demonstrated a leader with deep commitment to values-driven transformation, who continued to lead the trust through significant

challenges and change. A considerable amount of work had gone into strengthening governance and risk management across the trust with a focus on clarifying where responsibility was held. While progress has been made, the CEO acknowledged that the journey was ongoing.

The trust chair had been in post since October 2023. They brought thirty years of experience in the police, including a decade in senior executive roles and as a previous non-executive director they brought operational and strategic insight to the board. The chair was passionate about setting and strengthening the culture of the organisation, believing that accountability and performance must be visible to those served by the trust. A strong advocate for staff engagement, the chair paid close attention to staff survey response rates.

The executive leadership team worked in a triumvirate model with an executive medical director, executive director of nursing and therapies and a chief operating officer. This leadership structure was modelled through each care group. All 3 leaders described collective and collaborative leadership, with a relentless focus on quality and safety, and a deep commitment to staff development and engagement. All 3 leaders valued the importance of working together as a triumvirate, ensuring that decisions were made with input from multiple perspectives and that oversight of quality, safety, and people was robust and shared. They highlighted the value of expert staff, the need for clear governance structures, and the importance of adapting to change whether in response to inspections, system pressures, or evolving workforce needs. The team demonstrated a passion for their teams and a commitment to fostering a culture where clinical voices were heard, risks were managed proactively, and continuous improvement was at the forefront of organisational priorities.

We observed the trust's board meetings and attended several governance and committee meetings. We observed leaders acting with integrity, credibility and kindness. The trust actively supported diverse communication needs and ensured meetings were accessible.

Leaders undertook regular visits to frontline services. These visits improved leadership visibility and ensured leaders were able to triangulate the information received through the trust's governance systems, particularly in relation to staff experience. Between March 2024 and July 2025, more than 80 structured visits were undertaken by the chief executive, non-executive directors, governors, and executive directors, covering a broad spectrum of services including inpatient wards, community teams, specialist units, and digital services. The programme reflected a consistent pattern of engagement, with visits occurring monthly across different localities and care groups.

Governors and non executive directors completed reports shared with the board following visits.

Topic Areas

Service visit reports highlighted strong staff morale, teamwork, and commitment to high-quality care across teams, with positive service user experiences and recognition for innovation in areas like digital services. However, significant challenges remained, including workforce shortages (especially in specialist areas), high sickness rates, reliance on temporary staff, increased demand and long waiting lists, and delays in discharge due to limited community placements. Environmental concerns, facility upgrades, and systemic issues such as integration with social care and operational pressures were also noted, with some teams reporting a lack of autonomy and high administrative burdens.

For the chief pharmacist and medicines optimisation service there were clear lines of accountability, through the trust's governance structure. Visibility of leadership was described as integral with several strategies in place to ensure all staff including those at remote sites were regularly able to meet with the pharmacy leadership team.

Staff network representatives described the attitude and approach of senior leaders as supportive and engaged, particularly at the executive level. Leaders were recognised for embracing staff networks, providing administrative support, and responding promptly to urgent issues, such as requests for statements or safe spaces following incidents. However, concerns were raised about the consistency of this support, with some staff noting that positive engagement from executives did not always filter down to middle management, resulting in varied experiences across teams.

Staff-side (union) representatives described positive working relationships with leaders; highlighting open communication, regular partnership meetings, and successful collaboration on issues such as Disclosure and Barring Service charges, parking, and mileage. However, they also raised concerns about staffing shortages, high agency use, and the risk of losing international staff due to visa issues. Outsourcing of services and inconsistent communication were ongoing frustrations. Health and safety processes were praised but challenges remained in services with high levels of violence towards staff and in ensuring consistent application of policies such as sickness and bereavement leave.

There was a mixed view of the support received from executives from freedom to speak up guardians (FSUG). They told us about good support from the chair and executive director of workforce who were described as approachable and understanding. But shared a perception that many managers, especially at middle management level, did not value or fully understand the importance of the FSUG role. They told us that issues that reached higher levels of management were often resolved quickly, but many concerns get "stuck" at middle management level and are not escalated or addressed promptly.

Topic Areas

The trust had processes to identify and address behaviours that were inconsistent with the values of the NHS. Between 1 July 2024 and 1 July 2025, there had been 107 disciplinary cases and 8 grievances raised within the trust. The processes were undertaken thoroughly but were not always completed in a timely manner. Staff we spoke with did not feel comfortable with the processes.

Of the disciplinary cases, 57 cases had been completed, 49 were ongoing and the oldest ongoing case was from August 2024. Eighty-two cases had been brought against staff who identified as white, 23 had been brought against staff who were not white and 2 did not have their ethnicities stated.

Of the grievance cases, 2 had been completed, 8 were ongoing and the oldest open date was September 2024. All staff who brought grievances identified as white other than 1 staff member. Only 1 of these cases were noted to be related to bullying and/or harassment. This is a low figure for a staff team of this size and may indicate a concern about cultures and freedom to speak up.

The most frequent disciplinary cases at the trust involved inappropriate behaviour towards colleagues, breaches of observation protocols, criminal convictions, inappropriate behaviour towards patients, neglect of duty, improper access to patient records, unprofessional conduct, boundary breaches, inappropriate use of physical intervention, and alcohol or substance misuse. Grievances most often related to pay and departmental processes, bullying and harassment, colleague behaviour, and discrimination or lack of support. The services most commonly involved were adult community mental health, autism wards, adult acute wards, children and young people's inpatient and community services at Ferndene, inpatient rehabilitation, and access and treatment teams.

The trust disciplinary policy (August 2024) set out clear standards of conduct for all employees and provided a framework for addressing concerns about behaviour. The policy emphasised early, informal resolution of issues wherever possible, with formal procedures reserved for persistent or serious breaches.

The process included informal management, fact-finding investigations, and where necessary, formal hearings. Disciplinary sanctions ranged from written warnings to dismissal, with the right of appeal at each stage.

We reviewed 7 examples of disciplinary cases, and all had been completed in line with the trust's process although 3 of these cases took considerable time to be resolved (between 3 and 6 months). The trust's target for disciplinary cases was 56 days to hearing. Of the 57 completed cases in the data provided by the trust the quickest resolution was 3 days with the longest 322 days, 32 cases took

longer than 56 days to resolve.

We reviewed 3 examples of grievance cases, 1 had been withdrawn, and the remaining 2 cases had been undertaken in line with trust policy however the cases took considerable time to be resolved (between 10 and 20 months).

The trust policy did not set out clear time limits for resolution of grievances but described they should be handled without delay.

The trust had a resolution policy which replaced the grievance policy and was introduced in February 2025. The policy applied to all trust employees and prioritised early, informal resolution of concerns. Grievance and disciplinary cases were overseen by a triage decision making group. The group met weekly and was made up of the care group nurse director and head of workforce and organisational development, as well as a senior member of the workforce and employee relations team. Where possible concerns were resolved quickly and informally as a method of reducing the stress and costs associated with long term cases.

Since the policy was updated in February 2025, the triage group had heard 18 resolution requests in replacement of formal grievance processes. In these cases, 8 were resolved at the early resolution stage, 4 were ongoing in early resolution and 6 had proceeded to the early resolution stage. Between 1 April and 30 September 2025 the triage group had reviewed 135 disciplinary cases and 50% of these had received an informal outcome.

At the time of the inspection, the trust had ten ongoing employment tribunal cases involving claims of discrimination, harassment, unfair dismissal, victimisation, and whistleblowing. The cases covered a range of staff roles and included allegations related to race, sexual orientation, religion, disability, and sex discrimination.

Stakeholder feedback demonstrated that partners viewed the board and senior leaders as experienced, capable, and values-driven, with a strong commitment to openness, integrity, and collaborative working. Leaders were described as accessible, inclusive, and forward-thinking, setting a positive culture. Partners shared examples of positive partnership working, highlighting proactive, co-operative relationships with individual leaders and joint achievements in areas such as integrated crisis support, the Hope Haven project, and joint scoping of mental health priorities.

There was evidence that leaders were visible both within services and across the wider local system, regularly engaging at strategic and operational levels through multi-agency meetings, management

forums, and partnership boards. The trust was recognised as an active and constructive member of the integrated care system participating in system-level groups and provider collaboratives, and contributing to joint quality forums, strategic planning, and operational pilots.

The board were a stable and experienced team. The trust's board comprised of the chair and chief executive and five executive directors including the chief operating officer, executive medical director (deputy chief executive) interim executive director of finance, executive director of nursing, therapies and quality assurance and executive director of workforce and organisational development. There was also a director of communications and corporate affairs.

The trust had a group of non-executive directors who chaired the sub committees of the board including quality and performance, mental health act legislation, people, resource business and assurance, audit, renumeration and charitable funds. At the time of the inspection there were some ongoing changes in the non-executive director team with several relatively new team members being recently recruited.

There was a board development plan in place.

In 2024 the trust commissioned reviews of board, committee and executive effectiveness. These reviews were undertaken 12 months after the trust launched their strategy and following a period of organisational restructure. The reviews found that in board and committee effectiveness there was positive progress with improved diversity, enhanced focus on governance and positive board development activities. There were recommendations to improve report quality to board to focus on assurance, strengthen levels of challenge and accountability and streamline committees which were noted as having busy agendas and duplicate reporting.

Reviews discussed a commitment to cross sector working and to reach strategic objectives by executives. It recommended improvements in portfolios with some overlap of job roles and unclear accountability.

The trust had a fit and proper persons policy and process in place which outlined a framework for inclusion in the checks, this framework included 22 senior leaders and 4 directors from NTW solutions. An audit of the trust's process was given substantial assurance for 24-25. In June 2025 the trust submitted the annual fit and proper persons test report to the board. The report provided full assurance that the Board of Directors and those with "Director" in their title met the requirements for 2024/25. The report showed that four directors had outstanding DBS checks, however this was being

acted upon at the time of our assessment.

All files we reviewed showed the trust had mainly completed appropriate checks of directors' suitability for their roles. All directors had received an annual appraisal within the previous year other than one individual who was leaving the trust at the time of the assessment. Of the six files we reviewed we noted that one director did not have references located on their file.

The trust also undertook social media screening checks annually for board members and this was noted on fit and proper persons checks.

Freedom to speak up

Score: 2. Evidence shows some shortfalls in the standard of care

The evidence that we reviewed did not always demonstrate an open culture in which staff felt able to raise concerns, report incidents and suggest improvements. There was fear of detriment, staff were not always confident that their feedback, suggestions and concerns would be welcomed and lead to improvements in the trust.

In assessing this Quality Statement, we considered feedback from leaders and staff as well as reviewing trust processes and survey results.

Executive leaders role-modelled good speaking up behaviours, they listened to staff feedback and concerns, they demonstrated candour and empathy when things went wrong.

Two freedom to speak up reports were submitted to the board in the last 12 months; in December 2024 and July 2025. In the period from April to September 2024, a total of 39 concerns were raised, with the majority (36) reported via the freedom to speak up guardian, 2 via CQC, and 1 directly to workforce. This represented a decrease from the previous period. The most common themes were management processes and behaviour, including issues such as lack of support and bullying.

From October 2024 to March 2025, the number of concerns increased to 65 (59 via freedom to speak up) and 6 via CQC, which is consistent with the same period in the previous year. Bullying emerged as the most frequently cited issue, followed by concerns about management processes and safety.

Concerns were raised across a range of areas, with community and inpatient services accounting for

the highest numbers.

Data from staff surveys provided further insight into the trust's speak up culture. The bullying survey conducted in August to September 2024 found that 36% of respondents had experienced bullying in the previous 6 months, but only 22% had reported the incident. Barriers to reporting included fear of repercussions, lack of trust in confidentiality, and a belief that nothing would change. The July 2024 quarterly pulse survey indicated that while most staff feel empowered to speak up, a significant minority remained hesitant due to similar concerns. The survey noted that 24% of respondents were unaware of external avenues for raising concerns.

There were 3 freedom to speak up guardians, and the trust stated in the July 2025 board paper that the speaking up process had been strengthened with monthly meetings between workforce and freedom to speak up guardians. These meetings were to ensure that timely action was taken for concerns raised. There were 37 freedom to speak up champions.

National data showed that between April 2024 and March 2025, staff raised 64 concerns with their freedom to speak up guardians. When comparing CNTW to 7 other NHS trusts in the North East and Yorkshire of a similar size (each with more than 10,000 employees), the number of concerns raised at CNTW is low. For context, 1 of these trusts had 271 cases reported, while another had just 60.

Staff we spoke with did not always feel safe to raise concerns and challenge unsafe practice. Speak up guardians described a role that had struggled to maintain momentum over recent years, with limited proactive engagement and underutilisation of the champions across the trust. While some progress had been made in establishing policies and procedures, they described that the service remained reactive, and champions' involvement as minimal beyond basic visibility measures such as email signatures. Training sessions were planned to reinvigorate the network, and there was a clear aspiration to involve managers as champions to strengthen cultural buy-in.

They told us that support from senior leaders was acknowledged as positive. However, engagement from middle management was less responsive.

We spoke with a range of staff in focus groups and several staff shared their feedback through our online experience form. We heard that awareness of freedom to speak up varied. Some staff did not know the process existed, while others had used it but did not receive feedback or see outcomes. Staff described barriers to speaking up which included fear of retaliation, lack of confidentiality, and concerns about career impact (especially for staff on visas or from minority backgrounds). Some staff

reported that concerns were referred back to managers and not addressed or that speak up concerns sometimes became investigations, or fact finds for people processes which made them reluctant to use the process.

Some positive examples were shared and staff told us that where the process worked well it was due to supportive local managers or networks. There was recognition that recent efforts had increased promotion and awareness.

The pharmacy team were supported to speak up and had embedded a freedom to speak up champion at each of their four department bases. Staff were encouraged to report incidents, and we could see from incident data that there was a positive culture of incident reporting.

Between October 2024 and October 2025, CQC had received 120 concerns from staff. 96 of these cases were received following a letter we sent to staff asking them to share their feedback to support our assessment. The feedback we received about the freedom to speak up process was mainly negative.

Staff reported barriers to speaking up citing fear of retaliation, lack of confidentiality, and previous negative experiences with the process. Some reported that concerns were ignored, dismissed, covered up or lead to negative consequences for the complainant. There were reports that staff were told what to say to CQC inspectors, that feedback mechanisms were performative, and that whistleblowers were isolated or pressured to leave.

Workforce equality, diversity and inclusion

Score: 2. Evidence shows some shortfalls in the standard of care

The trust was proactive in its approach to workforce equality, diversity and inclusion, with clear accountability, and a willingness to learn and improve with clear plans in place to increase staff experiences and truly embed equality, diversity and become an inclusive workplace. However, whilst we saw improvements in board and workforce diversity metrics showed that some staff continued to experience disadvantages while working at the trust. Improvement to these metrics is key to meeting the trust's strategic objective to be a 'great place to work'.

As part of the NHS Staff Survey, the workforce race equality standard (WRES) highlights potential differences between the experiences of white staff and staff from ethnic minority groups. Much like the

Topic Areas

WRES, the workforce disability equality standard (WDES) allows NHS trusts to compare the experiences of staff with a disability, a long-term condition and other types of illnesses, with those of non-disabled staff.

At the trust, people from ethnic minority groups made up 13% of the workforce (up from 11% in 2024), higher than the regional population average of 7%. Fifty-two% of medical staff were from a minority ethnic group background. Board representation was relatively strong, with 14% of board members identifying as from a minority ethnic group, compared to 13% of the overall workforce. Board representation for disabled staff was 7%, compared to 10% of the overall workforce.

In the workforce race equality standard, most indicators got worse for minority ethnic staff between 2023 and 2024, especially around bullying, harassment, and discrimination. Disabled staff also reported worse experiences in 2024 than in 2023, particularly regarding bullying, harassment, and feeling valued. Some improvements were seen in representation, but overall, the experience gap had widened.

The results of the 2024 NHS Staff Survey were worse for staff from all other ethnic groups at the trust when compared to white staff for all four metrics, indicating these staff experienced more instances of discrimination, harassment, bullying or abuse, and a lesser sense of equal opportunities within the trust. Key aspects were reported as:

- White applicants were currently 2.24 times more likely to be appointed from shortlisting than minority ethnic applicants, and this gap had widened.
- Staff from minority ethnic groups were 1.69 times more likely to enter formal disciplinary processes than White staff, which represented a slight improvement.
- Bullying and harassment remained significant issues, with 48% of minority ethnic staff reporting such experiences from patients or the public (a gap that had doubled) and 24% reporting it from other staff, though this gap had narrowed.
- In terms of career progression, 56% of staff from minority ethnic groups believed there were equal opportunities, and this gap was closing. However, 18% of staff from minority ethnic groups reported experiencing discrimination from managers or colleagues, with this gap increasing.

Almost 10% of staff at the trust declared a disability, an increase from 9%, though the NHS staff survey indicated that 37% of staff live with a long-term condition.

- In recruitment, non-disabled staff were 1.4 times more likely to be appointed from shortlisting, a trend that remained unchanged.
- Bullying and harassment were ongoing concerns, with 29% of disabled staff reporting these experiences from patients or the public, and 22% from colleagues; an area where the gap had increased.
- 58% of Disabled staff believed there were equal opportunities, but this gap had widened.
- The proportion of disabled staff who felt adequate reasonable adjustments were made had slightly decreased to 80%.

The trust's annual WRES and WDES report was presented to the board in September 2025, acknowledging that the trust had made progress in representation and reporting but continued to face significant challenges in recruitment, progression, and workplace experience for staff from minority ethnic groups and disabled staff.

The trust had ten-point plans in place to address the issues. For race equality, the trust was adopting the NHS race and health observatory's seven anti-racism principles, using the UNESCO anti-racism toolkit, developing a visible race equality statement, and ensuring all policies were anti-racist. Efforts were also being made to improve reporting and support for staff experiencing racism, to launch a talent management framework to address progression gaps, collect better data on training access and exit interviews, and hold dedicated WRES meetings to monitor progress.

In terms of disability equality, the trust was auditing and embedding anti-ableist practices using national frameworks, developing a disability equality statement and anti-ableist policies, and improving reporting and support for staff experiencing ableism. Additional measures included reviewing and enhancing reasonable adjustment processes, working towards Level 3 Disability Confident accreditation, running campaigns to raise awareness and promote respect, and monitoring and reporting on capability processes through dedicated WDES meetings.

Staff networks had been built to promote equality, diversity and inclusion. The trust had 4 staff networks. Each staff network had an executive sponsor. These were

- cultural diversity staff network

- disabled staff network
- LGBT+ staff network
- armed forces and veterans staff network

We spoke with staff network representatives. The veteran's network, had grown rapidly with about 100 members, including veterans, reservists, cadets, and family members. The network was well-supported by leadership, had strong community links, and had influenced trust policy, such as flexible working for reservists. Members felt the trust was a good place to work, with leaders actively promoting the network's activities.

Feedback from the disabled staff network was mixed. Experiences for disabled staff varied significantly depending on team and manager, with some reporting compassion and support, while others faced challenges, particularly around reasonable adjustments. The network fostered understanding of disabilities and had developed toolkits but recognised that implementation of adjustments remained inconsistent. Executive support was described as strong, but admin support was lacking to ensure the network could fulfil all of its key roles and achieve its aims.

The LGBTQ+ network was impacted by national changes, causing anxiety among staff, especially those who are transgender or non-binary. The trust was preparing to respond proactively, but there were concerns about the visibility and responsiveness of senior leaders to these issues. The network was involved in national initiatives and collaborates with other NHS providers.

The cultural diversity network reported increased anxiety among staff due to immigration laws and societal events, with some staff limiting their movements and expressing concerns about residency and career progression. There was a perception that allegations against staff from minority ethnic groups were handled differently, and a lack of representation in senior roles was noted. However, the executive team was described as responsive and supportive, particularly in crisis situations.

Across all networks, there was an appreciation for executive engagement, but concerns remained about the consistency of support at other levels, the effectiveness of the freedom to speak up process, and the need for greater intersectionality and team working. Networks valued opportunities to influence policy and culture, but highlighted ongoing barriers such as financial constraints, lack of admin support, and the need for more compassionate leadership and improved progression opportunities.

The trust employed a highly experienced equality, diversity, and inclusion (EDI) lead. The EDI lead described how the networks had added a significant strength to the trust's focus describing a trust historically focused on compliance with equality legislation to one which sought to foster positive change. They described networks as playing a crucial role in shaping policy, sense-checking progress, and ensuring that initiatives were coproduced, for example via the development of a reasonable adjustments toolkit, the creation of a wellness attendance policy that prioritises wellbeing and a trauma-informed approach.

The trust had made measurable progress in representation of staff from minority ethnic groups, increasing from 7% in 2015 to 13% in 2025, and had seen some staff progress into leadership roles through coaching and inclusive mentoring. The trust's EDI action plan was mapped to national and local objectives, and regularly reviewed by a dedicated steering group, ensuring accountability and continuous improvement.

The pharmacy departments workforce strategy was comprehensive and supported ongoing staff development and leadership. Staff within the pharmacy department were supported with monthly 1 to 1s which were described as supportive and wellbeing focussed meetings. Flexible working arrangements were described in the pharmacy workforce strategy and secondments, shadowing and training and development were also integral to the workforce plan. Several staff were currently undertaking advanced leadership qualifications and royal pharmaceutical society credentialling.

Governance, management and sustainability

Score: 2. Evidence shows some shortfalls in the standard of care

The trust had clear responsibilities, roles, systems of accountability and governance structures. Our findings from other key questions and inspections of assessment service groups evidenced that these governance and assurance systems were not always operating effectively across the trust. Governance systems in place did not always ensure high quality service delivery and some early warning signs of deteriorating quality had been missed. The trust's internal operational audit plan would benefit from clearer alignment to its risk profile. There were ongoing issues with safeguarding processes which meant that the trust did not always work effectively with partners to safeguard people and safeguarding audits were not entirely effective to manage and mitigate risks. There was ongoing work to do in relation to the reduction of restrictive practice.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

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The trust's governance framework operated across three levels: the board of directors led strategic direction and assurance through committees; the executive management group oversaw trust-wide operational governance and strategic objectives, supported by various forums and care group and clinical business unit meetings managed day-to-day safety, quality, and efficiency, with regular reviews and learning groups to ensure compliance and continuous improvement.

The trust was placed in segment 4 of the NHS Oversight Framework ratings for non-acute trusts in September 2025. This meant it was identified as facing performance challenges and was likely to receive additional support from NHS England. The reasons for this were related to:

- The percentage change in number of under 18s supported through NHS funded mental health with at least one contact in a rolling 12-month period
- The percentage of adult discharges with a length of stay above 60 days
- The trust's sickness absence rate
- The NHS Staff Survey engagement score
- Higher Reference Costs

The trust were aware of some issues with governance processes and structures and were taking action to make improvements. In 2023/2024, the trust had made several organisational changes, which included:

- changes to the executive team structure and responsbilities,
- the appointment of a new chair and non-executive directors.
- implementation of a new strategy

To assess the success of these changes the trust had commissioned an independent audit provider to review board and committee effectiveness. The trust had progressed several recommendations from these reviews; bringing in for example a new non-executive director with legal experience to chair the mental health legislation committee and adding a digital committee to the board structure to enhance oversight.

The trust had also developed a performance management framework which was in line with the NHS oversight framework, and which had been developed with stakeholder engagement. The framework aimed to consolidate existing mechanisms, such as care group well-led reviews and board assurance

reporting, into a single, formal structure with clearly defined roles and responsibilities for staff, teams, executives, and committees.

Performance reporting and escalation processes were standardised, with metrics and key performance indicators directly linked to the trust's strategic ambitions and national NHS requirements. The framework promoted a culture of continuous improvement and accountability, ensuring that deteriorating performance is identified early and addressed through clear action plans.

The trust's board assurance framework (BAF) was structured in line with national NHS guidance. Risks were clearly described, scored for likelihood and impact, and assigned to strategic objectives. Controls, mitigations, assurance mechanisms, and gaps were documented for each risk.

Across the sub committees of the board, the BAF was consistently embedded into trust governance processes. It was discussed at every committee meeting and formal BAF & risk register reviews occurred at least quarterly in all committees. Assurance levels were recorded in minutes, and triangulation across committees was noted.

Further refinement of board and committee governance processes would support the trust to meet its strategic aims and strengthen oversight of risks and deterioration in services.

The most recent independent audit(s) April 2025 into risk management and board assurance confirmed substantial assurance.

Board committee papers were difficult to digest; the September 2025 people committee papers were 267 pages long while the April 2025 quality and performance committee papers contained more than 30 individual reports for review. The volume of material made it difficult for members to read, digest, and critically review all relevant information ahead of meetings, potentially undermining scrutiny and decision-making. Important issues or risks may be obscured by the quantity of content, leading to missed opportunities for challenge or assurance. Best practice recommends concise, well-structured papers with clear executive summaries and focused recommendations to support effective assurance, challenge, and strategic leadership.

Each committee chair provided a quarterly report to the trust's public board and assurance reports to the private board. These assurance reports lacked clarity on actions required to reduce risk or make improvements.

In September 2025, the quality and performance committee reviewed reports on key areas like ligature assessments, staffing, and discharge processes. While most items received full assurance, several—such as ligature risk, community waiting times, and staffing in Cumbria—were only partially assured due to ongoing risks. Actions for these areas often lacked clear ownership, timescales, or

concrete improvement plans, with some issues simply added to risk registers rather than actively addressed. Committee discussions focused on compliance rather than patient experience, and escalation to the board was routine, not always highlighting significant risks. Overall, there was limited challenge or debate, and committees did not consistently demonstrate ownership or pursue solutions for identified risks.

The trust demonstrated effective governance of the Mental Health Act and Mental Capacity Act, with strong oversight to ensure people's rights and safety. The mental health legislation committee, supported by a dedicated team, prioritised compliance, regular audits, and continuous improvement, though challenges remained with data accuracy and the rollout of the Patient and Carer Race Equality Framework (PCREF). The team was proactive in addressing documentation, training, and SOAD referral delays, and maintained robust links with local authorities. Recent audits received good assurance ratings, and the board showed strong awareness of key risks and a commitment to ongoing improvement.

Committees' discussions and findings were mapped directly to the board assurance framework (BAF) and relevant risk registers, ensuring oversight of key concerns such as regulatory compliance, workforce sustainability, patient safety culture, and information governance.

While the board was well-informed, there appeared to be a gap between their knowledge of risks and the depth of scrutiny regarding how these risks impact patient safety service quality. Non-executive directors sometimes offered limited challenge, which suggested an opportunity for more robust debate and assurance.

We attended a council of governors meeting and held a focus group with trust governors. The governor's meeting was well-organised, with hybrid attendance (20 online, 18 in-person). Governors engaged actively, asking questions about committee structures, digital priorities, risk management, and regulatory breaches. There was constructive challenge, particularly around the purpose of new committees, regulatory risks, and service changes. Governors sought clarification on key risks (e.g., ligature points, learning disability training, MH legislation compliance) and requested further information or agenda items. The meeting covered a wide range of topics, including quality and performance, people and workforce, finance, audit, and annual planning. Governors were encouraged to visit new facilities and participate in service improvement activities. We noted there was limited amount of time for questions at the end of the meeting.

In the focus group governors described the trust's culture as open, transparent, and increasingly

responsive, with people feeling able to raise concerns and leadership demonstrating a willingness to listen and act. The onboarding process for new governors was praised for its clarity and support. Governors felt empowered to question non-executive directors, challenge board decisions, and engage with executives. Service visits were valued as opportunities to see frontline care and influence improvements. Governors reported that views of members and the public were sought and increasingly reflected in board discussions. Senior leadership had responded to feedback, though some felt there was room to further amplify diverse voices, especially from service users and minority ethnic groups. Governors saw themselves as guardians of patient and public interests, passionate about protecting and improving services. They highlighted their role in promoting lived experience, and challenging decisions to ensure the best outcomes. Some governors noted the need for continued improvement in how staff concerns were raised and addressed, and in ensuring all voices were heard, including those of minority groups and staff governors.

The trust had a process for gathering, analysing and escalating performance data in an accessible format to the board consistently and regularly. The trust's integrated performance report was aligned to its five strategic priorities. Statistical process control charts were used to highlight concerning, expected and improving variations. The report focussed on a range of 33 outcome measures each linked to the trust's strategic objectives to commitments to patients, people metrics, quality care, person led care and sustainability. The report was reviewed in committees and at executive management group. An executive summary was provided outlining areas for improvement and those which had improved or met target. Recovery plans had been provided for discussion for each of these key areas for improvement.

It was positive that the trust had included oversight of prone and mechanical restraint to the integrated performance plan in order to achieve their ambition of zero use of these methods this year. This was following concerns being raised about it's use. The trust had continued to work towards reducing restrictive practices, particularly the use of physical interventions, however there remained work to do.

Between July 2024 and July 2025, the trust had recorded 9,944 incidents of restraint, this included 286 episodes of prone restraint and 61 episodes of mechanical restraint. Prone restraint is a type of physical restraint where a person is held face down (chest down) on a surface, regardless of whether they placed themselves in that position or were moved there. It includes situations where the person's face is down or turned to the side. Mechanical restraint is a form of restrictive intervention that involves the use of a device such as handcuffs to prevent, restrict, or subdue movement of a person's body or part of the body, primarily for the purpose of behavioural control There had been 204 uses of

seclusion and 6 uses of long term segregation.

Analysis of restraint incidents across all service types revealed significant variation between services. In learning disability services, Mitford Unit recorded the highest overall number of restraint incidents (1,636), as well as the highest numbers of both prone restraints (91) and mechanical restraints (10). In child and adolescent mental health services, Redburn had the highest total number of restraints (1,002), while Riding ward reported the highest number of prone restraints (91). In acute adult mental health and psychiatric intensive care units, Shoredrift had the most restraint incidents (287), with Beckfield PICU having the highest amount of prone restraints (12). In wards for older people with mental health problems, Woodhorn reported the highest total number of restraints (527). The highest use of restrictive interventions both overall and for specific types such as prone and mechanical restraint was concentrated in learning disability services and child and adolescent mental health services.

During our service level inspections, we raised concerns with the trust about their use of restraint and restrictive practice. We took enforcement action against the trust in 2024 when we found that they had undertaken high levels of mechanical and prone restraint with patients using learning disability and autism services. We also found that the trust were using high levels of prone restraint and some mechanical restraint in child and adolescent mental health wards. The trust had made positive progress on this and had produced an ambition for zero prone and mechanical restraint across all trust services (unless mechanical restraint is ministry of justice approved). Whilst this was positive it was of concern that this was highlighted externally rather than via the trust's own governance processes. We also told the trust that we were concerned about their decision to deviate from best practice with the continued use of mechanical restraint.

The trust's annual positive and safe (use of force) report was finalised in May 2025. CNTW's approach to restrictive practice aligned with the national restraint reduction network standards and the mental health units (use of force) Act, focusing on systemic change, robust risk assessment, and trauma-informed care. The report outlined key strategies which included cultural change, honest and transparent reporting of data, biopsychosocial formulation to improve risk assessment and expansion of meaningful activities. The report showed some improvements and the trust were aware there was more to do.

- prone restraint had reduced by 64.5% (from 1,050 to 373 incidents).
- mechanical restraint reduced by 49.4% (from 160 to 81 incidents), and by over 80% compared

to three years ago.

- seclusion reduced by 22.3% (from 1,021 to 793 incidents).

It was difficult to understand why these areas had been chosen for focus in the executive summary of the performance report rather than highlighting all areas with cause for concern. For example, there remained several clinical priority staff training courses which were not meeting trust target. These included areas important to the provision of safe care including; adult immediate life support (69%), autism core capabilities (57%) and learning disability tier one (46%).

The trust used a structured, tiered risk management system, with risks identified, assessed (using a 5x5 matrix), and escalated from ward to board via electronic risk registers. Risks above certain thresholds were moved to higher-level registers, with the most serious added to the corporate risk register. As of August 2025, there were 13 corporate risks, mainly from community care, including; waiting times, staffing, and environmental risks. Despite substantial assurance from an external audit, some long-standing risks (e.g., CCTV, waiting lists, cyber security) remained unresolved, and some actions were overdue, particularly in inpatient care.

It was difficult to track across the trust's governance systems how key risks to patient safety were included on the corporate risk register.

These included but were not limited to:

- high use of restraint and restrictive practice
- ligature risk assessment quality and ligature incidents
- mandatory training, supervision and appraisal
- out of area placements. Between August 2024 and August 2025, the trust had 110 out of area placements. Thirty-three of these were deemed appropriate and 77 were deemed inappropriate. Numbers had decreased overall from 2023 but there had been fluctuations from late 2024.
- high levels of bed occupancy. Several acute adult wards consistently showed occupancy rates above 100% (Alnmouth, Embleton, Fellside, Longview, Lowry, Shoredrift, Springrise, Warkworth). Several forensic wards (Berwick, Linhope, Tweed, Tyne) reported occupancy at or near 100%. Rehabilitation wards also frequently exceed 100% occupancy.

Most older people's wards operated close to or above 100% occupancy, with occasional dips below this level. The Royal College of Psychiatrists and NHS guidance recommend a maximum occupancy of 85% for mental health inpatient beds to ensure safety, flexibility, and quality of care. Occupancy rates above this threshold are associated with increased risks.

- lengths of stay. Many wards, especially forensic and rehabilitation wards had average lengths of stay far above national averages. The longest reported stay was 6,199 days (Tweed). Acute ward admissions generally ranged from 30 to 90 days, rehabilitation and forensic wards often exceeded 300 days, with some outliers over 1,000 days.
- patients clinically ready for discharge. The trust reported 420 patients who were clinically ready for discharge who were delayed. The majority of delayed discharges were from wards for older people with mental health problems and Beckfield psychiatric intensive care unit.

We could see the trust were acting on these matters with clear improvement plans, workstreams and incident management groups but there lacked a central place to measure, assess and mitigate these risks.

Medicines optimisation was embedded within the trust. The medicines optimisation committee was supported by a varied staff group which ensured that medicines priorities were scrutinised and communicated at every level.

The trust had an internal audit plan. The internal audit plan was developed each year through a risk-based approach, aligning with the trust's strategic objectives and key risks, and was approved by the audit committee.

The 25-26 operational audit plan included; risk management and the assurance framework, emergency preparedness and resilience, performance management and quality assurance. It also included; data security, system security, finance and payroll, rostering, job plans, clinical record keeping, patient document tracking, patient involvement, section 136 (place of safety), learning from patient safety, MCA, waiting list management, staff safety, board assurance framework. This was broadly aligned with some of the trust's major operational risks, especially in areas of risk management, safety, compliance, and workforce. However, there are some gaps particularly around estates and environmental risks, safeguarding, workforce EDI, waiting times in high-risk pathways, and

service transformation. Addressing these gaps would strengthen assurance and ensure the audit plan is fully responsive to the Trust's current risk profile.

Clinical audits were monitored by the clinical audit and effectiveness team. Audits were conducted across a wide range of topics, including covert medication, restrictive practices such as seclusion and rapid tranquilisation, and adherence to NICE guidelines. In the past twelve months, the trust completed a substantial number of audits, many of which were trust-wide or linked to national priorities.

Each audit was conducted according to trust policy which sets out clear expectations for planning, data collection, reporting, and monitoring. Where audits identified areas for improvement, action plans were developed which were monitored to completion, with progress reported to relevant committees and any outstanding actions escalated as necessary. Re-audits were routinely scheduled to confirm that improvements had been sustained.

The trust engaged in national audits. Examples from the past year included the national audit of inpatient falls and prescribing observatory for mental health (POMH-UK) audits, such as those focusing on rapid tranquilisation and the use of medicines with anticholinergic properties. The results of these audits were used to drive improvements in clinical practice. For instance, findings from the National Audit of Inpatient Falls led to changes in falls prevention protocols and enhanced staff training, while the POMH-UK rapid tranquilisation audit prompted updates to guidelines and improved monitoring of physical health following interventions.

The trust had clear plans to tackle health inequalities and employed a health equity lead. They described their role as bringing together staff, carers, patients, and communities to take a structured, evidence-led approach to reducing inequalities at both clinical and population levels.

In 2024/25, the board agreed five key priorities to tackle health inequalities:

- developing the PCREF framework
- implementing Core20Plus5 for children and young people,
- strengthening CNTW's role as an anchor institution to address wider social determinants, promoting digital inclusion and accessibility,
- reducing morbidity and mortality through improved physical health outcomes (including Core20Plus5 for adults).

Dedicated subgroups, including the PCREF steering group, EDI steering group and the health equity data and evidence group, supported delivery of priority actions through data-driven insights and co-production with patients and carers.

The trust produced its first an annual health inequalities report (June 2025) which showed that in 2024/25, detentions under the Mental Health Act at the trust fell to 86 per 100,000, with the highest rates among younger adults and those over 76, and more males than females detained. Detentions were most common in deprived areas, though ethnicity data was limited. Use of restrictive interventions (seclusion, restraint, chemical) increased, especially among children and young people, with females and those of mixed ethnicity most affected. Recovery rates for talking therapies remained stable overall, but Black patients saw a notable drop, and recovery was lower in deprived areas. Access to mental health services for children and young people improved, particularly in the most deprived areas, though most users were white.

The trust had physical and public health leads to lead the public and physical health agenda. They had developed the trust's public and physical health strategies and strengthened pathways for health improvement, working closely with stakeholders, local authorities, and service users. Despite progress, they faced ongoing challenges related to capacity, embedding the new strategy across diverse care groups, and addressing complex issues such as obesity, smoking, and diagnostic overshadowing.

The patient and carer race equality framework (PCREF) was launched in November 2023 by NHS England. The PCREF is an NHS England-mandated framework designed to embed anti-racism and race equity across mental health services. It focuses on three core domains: leadership and governance, ensuring accountability and co-production with racialised communities, data, requiring trusts to collect, analyse and act on ethnicity data to address disparities; and patient and carer feedback mechanisms, creating accessible systems for culturally sensitive engagement and service improvement.

Trusts are expected to have fully implemented PCREF by March 2025, aligning with NHS England's Advancing Mental Health Equalities programme and demonstrating measurable progress in reducing racial and cultural inequalities.

The trust had a plan in place which was not yet implemented. The plan prioritised piloting advance choice documents, developing culturally appropriate advocacy, understanding and reducing restraint, supporting early access to help, tackling barriers to community mental health support, and working in partnership with communities to reduce health inequalities. It also focused on improving the quality of

ethnicity and religion data, upskilling the workforce in cultural competence, and supporting the wellbeing of staff from marginalised backgrounds. Delivery will be overseen by a dedicated steering group, with ongoing engagement from community leaders, patients, and carers to ensure progress and accountability.

Safeguarding was overseen by a dedicated safeguarding and public protection team (SAPP) who acted as the executive lead for safeguarding. The team included a mental capacity lead, SAPP practitioners, and specialist roles such as a clinical police liaison nurse. This team provided clinical leadership, triage, supervision, and strategic oversight for safeguarding concerns and public protection activity. The trust had a named doctor for safeguarding children, and a named nurse for children and adults in post with the executive lead for safeguarding transitioning at the time of the inspection from the executive medical director to the executive director of nursing and therapies. The trust had an executive lead for Prevent.

The trust had in date safeguarding adults and children's policies. Both policies were aligned with national and intercollegiate guidance, including the Care Act 2014, Mental Capacity Act, Working Together to Safeguard Children (2023), and NHS/CQC requirements.

Between July 2024 and July 2025, a total of 5,079 safeguarding incidents were reported to local authorities. In addition to these, safeguarding concerns were also managed through the safeguarding and public protection team. The trust maintained a separate record of safeguarding concerns managed internally by SAPP, including those that did not meet the threshold for local authority referral.

The trust had complex safeguarding processes, because they worked with eight local authorities. service level agreements were in place to manage referral and information sharing with local authorities. These agreements set out expectations for response times, escalation, and joint working. During our assessments of services, we found that local authorities were not always aware of incidents involving harm to patients and there was confusion amongst staff about what types of incidents should be reported and when. Particularly in wards for people with a learning disability and/or autism, and child and adolescent mental health wards.

The trust had undertaken one safeguarding audit in 2024. The audit of 64 adult cases showed good performance in timely reporting, documentation, and triage, with most referrals initiated by frontline staff and improvements in person-centred safeguarding. However, the audit identified areas needing attention, including faster recording of local authority outcomes, better consent documentation,

increased advocacy for those lacking capacity, and updates to safeguarding policies. The audit was process-focused rather than being related to quality of practice and no audits of safeguarding children were undertaken.

The trust delivered safeguarding supervision, with 1,537 safeguarding supervisions delivered across all localities (adults and children), supporting reflective practice and case discussion.

The trust had a safeguarding training plan in place it included four levels of training, from induction to specialist safeguarding leadership. There was integration with local authority training and multi-agency learning.

The trust had achieved good compliance rates in safeguarding training over 95% of staff had completed safeguarding level 1 training for both children and adults. Safeguarding training also demonstrated strong performance at level 2, with 95% of staff trained in safeguarding adults and 92% in safeguarding children. However, compliance rates were lower at Level 3, with 81% for safeguarding adults and 82% for safeguarding children. This indicated that while the majority of staff had completed essential safeguarding training, there remained a need to further improve uptake at the advanced level. Training was aligned with national intercollegiate competencies and incorporated learning from local and national reviews.

The trust produced its safeguarding and public protection annual report for the period April 2023 to March 2024, which was presented to the quality and performance committee in October 2024. The annual safeguarding report showed that in 2023/24, the trust participated in 17 statutory reviews (10 safeguarding adults reviews, 4 domestic homicide reviews, and 3 child safeguarding practice reviews). Learning from these reviews was disseminated through meetings, bulletins, and bespoke training, with themes including domestic abuse, exploitation, application of the Mental Capacity Act, and self-neglect. The trust noted that the Home Office have developed an intercollegiate framework on training for Prevent. Work had commenced to review those currently identified to complete Prevent training to ensure it aligns to the Home Office document and would be completed in 2024/25.

The trust's strategic workplan for safeguarding in 2024/25 included training (in domestic abuse), policy review, quality improvement projects in multi-agency public protection arrangements (MAPPA) ongoing work with Prevent panels and professional curiosity, audits, partnership and representation and learning from reviews.

The trust worked in partnership to safeguard people as key partners in multi-agency strategic

approaches. However, there were some gaps in processes which had meant that safeguarding concerns at service level had not always been shared with partners in a detailed and timely manner.

The trust had an established Duty of Candour process and a clear policy in place. Between 1 July 2024 and 1 July 2025 the trust told us that 36 incidents met the statutory duty of candour. We reviewed 6 of these duty of candour responses. Responses demonstrated some compliance with trust policy and the statutory requirements outlined in Regulation 20. Each reviewed letter included key elements mandated by the policy; an apology, an explanation of the incident, and details of investigations or learning actions. Responses also reflected the principles of openness and transparency with offers of further engagement and support for families.

However, some gaps remained in the quality of the trust's processes.

The trust's Duty of Candour policy distinguished between the professional and statutory duties of candour. The professional duty applied to all healthcare staff as part of their ethical and regulatory responsibilities, requiring openness and honesty with patients, families, and colleagues whenever something goes wrong, regardless of the level of harm. In contrast, the statutory duty of candour is a legal requirement placed on the organisation by CQC and is triggered specifically by notifiable safety incidents that result in moderate or severe harm, or death. The statutory duty mandates a defined process, including prompt disclosure, a written apology, ongoing communication, and thorough documentation.

In 3 cases we reviewed we found that the trust had taken the decision not to apply the statutory duty of candour. In all 3 cases, the patient had been deemed to have died by suicide. The trust told us that the reason for not applying statutory duty of candour was because "the treatment or care provided went as intended, and as expected, therefore it does not meet these criteria and does not qualify as a notifiable safety incident, even if harm occurred". The trust explained that in these cases, professional duty of candour was applied but were unable to provide evidence of how this had been applied from case recordings and formal letters to families involved. We could see that condolences were offered and explanations of incident review processes were given, but open apologies and transparency on where things may have gone wrong were not always shared.

Of the 36 cases, not all staff had followed the requirements of the trust's own policy for storing the correct documentation on patient files. We saw that 19 of the 36 cases did not have duty of candour confirmed and uploaded to the trust's electronic system.

The trust were aware of some limitations to its current processes and had commissioned an external audit in January 2024 to review processes with a follow up audit in April 2025. A comparison of the two audits showed that despite some progress, some weaknesses remained. While improvements were made in updating guidance, triaging moderate harm incidents, and assigning responsibility for actions, the follow-up audit continued to identify gaps in comprehensive staff training, inconsistent documentation of duty of candour actions (such as apologies and support), and incomplete monitoring and reporting to governance committees. As a result, both audits issued a "limited assurance" rating, highlighting that action was still required to achieve full compliance and to ensure that patients and families are properly supported following notifiable incidents.

There were processes to manage the financial resources and sustainability of the trust. The trust had signalled a need to deliver £30m cost improvements in 2025-26 and had requested but not transacted deficit support funding this year.

The trust was facing a significant financial challenge for 2025/26. Across the North-East and North Cumbria ICB, the wider system was also under pressure. The trust had an interim Director of Finance since the previous substantive postholder left in April 2025. The interim director of finance was clear on the trust's financial position and knew what action was needed going forward. They worked well with the rest of the executive team and there was a clear alignment with the operational care group structure; the action plan was clear, and evidence based. Assurance was given that the finance team was challenged but coping well and capacity was not a risk.

Financial planning was ongoing and closely linked to workforce, activity, and quality metrics. The Trust was building summaries for each clinical business unit and care group to identify areas where financial resources were insufficient. Priorities for 2025/26 were being set in alignment with the trust's strategy and overall plan, with quarterly reporting and approval processes through the executive management group and board. The planning process included phasing of cost savings and workforce impacts. The Trust was committed to supporting staff through changes and mitigating negative impacts on morale and service delivery.

The financial position year to date is ahead of plan (£1.5m surplus to date) despite a £7m stated risk in relation to the £30m cost improvement plan. This risk was covered by a £7m mitigation plan and the year-to-date position had been supported non-recurrently by the sale of land at the Northgate Hospital site, which improved the quarter 1 position by c£4m.

The £30m cost improvement plan was the highest target in the trust's history and the realism of the

delivery of such a high figure was questionable in the short to medium term. Quality impact assessments were in place for these schemes and delivery progress was reported to the relevant committees. The programme was weighted more towards the second half of the financial year.

The trust had a turnover of £650m and began 2025-26 with £44m cash. Overall, the trust had a relatively weak balance sheet compared with most NHS providers (negative income and expenditure reserve due to previous years asset impairments) leading to a net asset figure of £52m. This is not dissimilar to other providers due to the revaluation/impairment issues.

These measures, together with non-recurrent sources of income and cost reduction, appeared to be supporting the financial position. However, it remained uncertain whether the trust can sustainably reduce its costs in line with plan and timescale. The trust planned to make significant savings whilst continuing to grow and develop new services and initiatives.

The trust employed 8557 whole time equivalent staff. Staff both during and prior to our assessments of frontline services told us the trust did not always ensure services were safely staffed.

The most recent trust safer staffing report published in May 2025 showed that staffing fill rates for combined day/night shifts and registered/unregistered nurses were consistently higher than 100% for the reporting period (April 2023 to March 2025), and frequently over the upper limit of 120%. However, the staffing fill rates were notably lower (under 90%) for registered nurses, and notably higher (over 125%) for unregistered nurses. This suggested there were pressures on registered nurse numbers for both day and night shifts across inpatient wards, and that unregistered nurses were being used to compensate for these lower staffing rates.

The trust had ongoing difficulties maintaining adequate numbers of registered nurses, especially during day shifts. This shortage affected multiple services, including rehabilitation, learning disability, adult acute, child and adolescent mental health, forensic psychiatry, older people's services, and psychiatric intensive care units.

Between August 2024 and July 2025, a total of 262 incident reports relating to low staffing were submitted across the trust's services. The community care group accounted for the majority of notifications. In the inpatient care group, Hadrian (14), Ruskin (12), and Yewdale (10) were most affected. The specialist care group saw fewer incidents overall, with Riding and Stephenson each reporting 4 notifications.

The trust were aware of their staffing challenges, in August 2025:

- The inpatient care group had 147 vacant posts. 107 of these posts were 'additional clinical services' and 46 were registered nurses. The care group had a turnover rate of 8% with particularly high turnover rates for administrative and clerical staff (27%) and allied health professionals (19%). There was a sickness rate of 9%.
- The community care group had 13 vacant posts, however they had 28 vacant posts for registered nurses and 11 vacant administrative posts but were over established in other posts giving an overall more positive view. The care group had a turnover rate of 8% and a sickness rate of 7%. Turnover rates were particularly high for additional clinical services (11%) and administrative staff (12%).
- The specialist care group had 42 vacancies, there were actually 53 vacancies for additional clinical services and 23 for registered nurses. Over establishment to other posts gave a more positive overall rate. The service had a 6% turnover rate with administrative and clerical staff having the highest rate of turnover and a 7% sickness rate.

The quarterly workforce performance report was reviewed by the people committee in September 2025. It described key risks as sickness, appraisals and staff whole time equivalents against plan. The trust was taking a proactive approach to workforce management by closely monitoring sickness and appraisal rates, with targeted improvement plans and recovery strategies being developed for teams with higher absence or lower appraisal completion. Monthly reviews of staffing levels were being conducted to support financial performance, ensuring that any variances were addressed and future workforce needs were forecasted. In addition, a detailed analysis of staff turnover was underway to identify teams with consistently high turnover, incorporating sickness, appraisal, and survey data for a comprehensive understanding. To control costs, a monthly ceiling on agency spending had been introduced, supported by dashboards that tracked compliance and workforce developments. From June 2025, enhanced reporting on temporary staffing was introduced to enable better oversight of mandatory training and staffing levels.

It was concerning that the workforce report offered positive assurance for mandatory training and clinical supervision rates. Staff were not always given the appropriate level of managerial and clinical supervision and appraisal. It was likely that this was because overall rates showed positive improvement, however at service and team level there was a poor picture.

Recent training compliance data highlighted several areas of concern within the trust. Among clinical staff priority training some compliance levels were low; resuscitation level 3 paediatric immediate life

support was 72% with level 2 at 78% and learning disability tier 1 was particularly low at 40%. The trust were aware of the low levels of learning disability training and had a trajectory in place since this was raised with them as a concern during our service level inspections over the last 12 months. Mandatory Training on learning disability and autism became a legal requirement for NHS trusts and all CQC-registered health and social care providers in 2022.

Data provided by the trust showed that out of 184 teams, 62 of these had clinical supervision compliance rates of below 75%. There were 62 teams out of 184 with managerial supervision and appraisal rates below 75% as of August 2025.

To alleviate staffing issues, the trust used bank and agency staff. The trust used bank staff more than agency staff, mainly to cover for unregistered nursing shifts. In the most recently published safer staffing report action plan, the trust stated that there was a 'robust authorisation for temporary staffing, so that bank staff are considered before agency'. The trust advised that bank staff and overtime was reducing reliance on agency staff. However, data showed this not to be the case as both bank staff and agency staff levels were increasing. The most recently published board papers (July 2025) showed that 'at the end of Month 3 the trust had spent £2.2m on agency staff against a plan £1.5m', indicating that the intention to reduce the reliance on agency staff was not successful.

The proportion of the trust's financial year-to-date total staff spend on temporary (agency and bank staff combined) was 5.9% in April 2025 although has decreased from 7% for the same period in 2024.

Between July 2024 and August 2025 the trust had used agency staff on 1636 occasions and bank staff on 3838 occasions.

The trust recognised these challenges and was implementing further workforce transformation and training initiatives, but ongoing pressures meant that reducing temporary staffing remained a key focus for the coming year, particularly in line with the financial plan.

The trust maintained safe working hours for resident doctors through active monitoring, exception reporting, and a culture of improvement. Exception reports (mainly about hours and rest) were addressed with time off or payment, and handover issues had decreased due to better processes. Agency locum use was minimal, with internal doctors covering most shifts, and workforce planning had improved. Doctors' forums provided a platform for feedback and improvements, while most doctors reported good support, protected teaching time, and flexibility for research. Supervision quality varied, and some concerns remained about clinician roles, patient safety, and operational

issues. While workload and burnout were concerns, morale was generally positive, and most doctors felt supported.

The trusts medicines optimisation committee was well established with clear terms of reference and meetings were quorate. Medicines governance dashboards had been developed to facilitate oversight and continual improvement.

Medicines reconciliation data was reviewed monthly and reported through the trust's medicines optimisation committee for oversight and scrutiny. The department had identified issues with the data for medicines reconciliation, and actions had been taken to review and analyse the gaps in reporting. This had shown that medicines reconciliation had occurred however the IT system had not pulled the data accurately. Work was underway to find solutions to this problem.

A comprehensive programme of internal and external clinical pharmacy auditing was in place. Each audit was accompanied by an associated action plan which detailed areas for improvements and timelines and a responsible person.

The pharmacy antimicrobial stewardship lead worked collaboratively with the wider trust and external partners to promote good antimicrobial prescribing and assurance. The oversight of antimicrobial prescribing and use was embedded into the medicine's optimisation governance process.

Risks relating to pharmacy services were identified on both the pharmacy risk register but also where applicable local risk registers such as the medical directorate to ensure the risks were owned in the correct location. Risks were reviewed regularly and dated actions and updates were recorded.

The medicines safety officer role was well embedded into the trust's governance processes. Incidents related to medicines were reviewed by the locality leads with regular oversight and clear escalation processes in place to the medicine's safety team. Three monthly reports were produced and shared with the area teams to highlight risks and share learning and good practice. In addition, reports were shared through the trust wide service group so that learning could be whole trust.

The trust had processes to prevent and control infections. The infection prevention and control (IPC) board assurance framework was reviewed through the quality and performance committee and escalated to the board with oversight from the executive director of nursing and therapies and a dedicated IPC team. Regional collaboration, microbiology expertise, and pharmacy-led antimicrobial stewardship supported operational delivery. Outbreaks, including around 100 COVID-19 cases, were managed effectively, and other incidents like diarrhoea and vomiting were quickly contained. Compliance with

national guidance was ensured through regular audits and targeted interventions. Cleaning standards were high, and vaccination campaigns were enhanced after a decline, using innovative strategies to boost staff and patient uptake.

NTW Solutions provided a comprehensive range of non-clinical and support services for CNTW, covering estates, facilities, clinical, digital, and business functions. Service delivery was monitored through formal contractual arrangements, service level agreements, and regular reporting to the trust's governance committees.

CNTW's estates function was led by an executive director in NTW Solutions. The estates portfolio was broad, covering general maintenance, capital development, medical devices, and sustainability, all managed by a specialist service team.

A central pillar of the trust's capital development was the Cedar programme, representing an investment of £89 million. The Cedar programme was part of the national "40 new hospitals" initiative and had been delivered with a strong emphasis on patient and staff engagement, clinical collaboration, and environmental sustainability. The programme had been subject to external scrutiny, completing its gateway 4 review with a green level of assurance, and had been monitored by the new hospitals programme for operational readiness and national oversight. The phased delivery of Cedar had seen the successful completion and occupation of the Sycamore unit in October 2023 and Ferndene in March 2025, with the final phase at Bamburgh, St Nicholas Hospital, reaching construction completion in June 2025. Patient occupation of Bamburgh was started in August 2025, with the closure and decommissioning of Hadrian ongoing.

The estates strategy, refreshed in January 2023, articulated the need for the Cedar programme and its benefits, as well as the importance of addressing backlog maintenance at sites like Monkwearmouth. The focus had been on delivering major projects, many of which were now nearing completion. The director of finance had led a mid-point review of the estates strategy, looking ahead to a ten-year plan that considered future partnership estates, the optimal use of void space, and opportunities for shared use with other organisations. The vision was to create shared care hubs that triage patients to the right service at the front door.

The estates function was supported by governance structures including regular reporting to the board and the resource and business assurance committee. The trust participated in national benchmarking through estates returns information collection and premises assurance model and had focused on correlating estates data with new model hospital metrics.

There were business continuity plans in place for when unexpected events occurred and created a risk to the delivery of the service. The trust had an emergency preparedness resilience and response (EPPR) policy. The trust advised that it undertakes an annual review of compliance with EPRR standards with the ICB, which is scheduled for November 2025 and work had commenced in preparation for this review. The trust also advised that work to develop a dedicated business continuity plan had been progressed across the trust to support the implementation of business impact assessments in line with NHS England's business continuity management toolkit. At the time of the assessment the trust were not managing any services in business continuity.

The trust maintained data integrity and confidentiality through a strong governance framework, regular audits, and compliance with national standards. In the 2024–25 self-assessment, the trust met or exceeded all required data security outcomes, with external validation confirming low risk and high confidence in its controls. Information security was overseen by a well-defined governance structure, including the Caldicott Guardian and a dedicated team. Information governance breaches were closely monitored; 587 incidents were reported between March and August 2025, mostly due to errors, but none required escalation to the information commissioner. Staff compliance with mandatory information governance training was high at 91%. Information risks were actively managed, with technical controls and ongoing improvements in place. Over the past five years, the trust transformed its digital services, achieving Global Digital Exemplar status and implementing advanced systems like RiO electronic patient records and EPMA across 50 wards. Cyber security was treated as a key risk, with board oversight and ongoing recruitment for specialist expertise. The trust piloted AI tools and invested in digital inclusion, with plans to further strengthen digital governance through a dedicated committee.

Partnerships and communities

Score: 3. Evidence shows a good standard of care

The trust understands their duty to collaborate and work in partnership, so their services work seamlessly for people. They share information and learning with partners and collaborate for improvement. Whilst good complaints processes were in place outcomes were not always clear and transparent.

The trust had a process to respond to complaints from people using services and had received 1,099

complaints in the reporting period, with 255 managed informally and 845 as formal complaints. Seven cases were referred to the Parliamentary and Health Service Ombudsman.

The complaints process aligned with NHS regulations and best practice, ensuring service users, carers and stakeholders have access to a clear and fair process.

Each complaint was triaged as either standard or complex, with defined investigation timescales of 18 or 38 working days respectively, and all complaints were acknowledged within 3 working days. The trust paid attention to issues of consent and capacity, especially for third-party complaints, and had a clear escalation process for persistent or unreasonable complaints.

Learning from complaints was embedded with action plans developed and monitored to ensure improvements were made and embedded in practice.

Performance data showed that almost all complaints were acknowledged within 3 days, and the trust's average monthly compliance with response times was 94%.

We reviewed 10 complaints. Both formal and informal complaints were investigated thoroughly, with timely communication and, where appropriate, apologies or explanations provided. In some cases, complaints were resolved quickly and locally, while others required more detailed investigation and escalation.

One area we identified for improvement was the need for complaint responses to explicitly state whether each issue has been "upheld" or "not upheld." This clarity is important for transparency; it helps complainants understand the outcome and is recommended by national guidance.

The trust demonstrated a wide range of partnership working, both internally (across care groups, staff networks, and governance structures) and externally (with ICBs, local authorities, third sector, academic partners, and service users/carers).

The trust was committed to building trusted, long-term partnerships that worked collaboratively to improve the health and wellbeing of people and communities. As a key part of the north east and north cumbria integrated care system, the trust recognised that achieving its ambitions required working closely with a wide range of partners. The regional plan, "better health and wellbeing for all," set out a shared vision for high-quality, equitable health and social care, with a focus on reducing inequalities, improving life expectancy, and giving children the best start in life.

Topic Areas

The trust's strategy was rooted in community engagement and partnership, aiming to provide evidence-based care for people with complex needs while ensuring support was accessible close to home.

Stakeholder feedback told us that they recognised CNTW's commitment to a shared vision and collaborative working. Local authorities and partners highlighted that meeting the needs of people and communities was at the forefront of joint work, with regular joint scoping sessions and shared priorities (e.g., Section 117 Aftercare, mental health outreach, and autism strategy development).

Community and voluntary sector partners described CNTW as aware that they cannot meet needs alone, valuing the expertise of community partners and integrating them into service delivery.

Feedback from NHS partners noted strong working relationships, regular interface meetings, and joint quality forums that enabled shared learning, risk management, and collaborative planning for complex cases.

Voluntary sector partners described partnership working as "exemplary," citing innovative joint projects like Hope Haven and integrated crisis support services. CNTW's willingness to invest in and reconfigure services to support system-wide solutions is highlighted as forward-thinking.

Local authorities valued CNTW's openness to co-production, adaptability, and recognition of local priorities. There was praise for the trust's willingness to work with third sector and voluntary partners, and for engaging in multi-agency governance structures.

Stakeholders also noted that CNTW is receptive to ideas for joint service development and improvement, and that information sharing is valued and effective.

Some partners noted that there had been occasions where CNTW could have engaged stakeholders earlier in the process of service changes, to better manage risk and operational impact. There were also suggestions to further improve escalation and communication processes between organisations, particularly in crisis situations.

Stakeholders appreciated the trust's focus on continuous learning and innovation, including sharing training opportunities and developing integrated approaches to care. Joint forums and pilot projects were seen as valuable for system-wide improvement.

We saw examples of specific projects which highlighted good practice in partnership working which

included but were not limited too; the Hope Haven project, the model of care programme board, provision of support to veterans, work with acute partners on urgent and crisis care pathways, and with local authorities on discharge planning and the development of community-based alternatives to admission.

Learning, improvement and innovation

Score: 3. Evidence shows a good standard of care

The trust focussed on continuous learning, innovation and improvement across the organisation and the local system. They encouraged creative ways of delivering equality of experience, outcome and quality of life for people. They actively contribute to safe, effective practice and research. There was variable evidence of a learning and safety culture. The Trust had embedded a governance framework for patient safety and incident management but there were inconsistencies in its application which meant that learning from incidents was not consistently applied in line with national and trust policy.

The trust had developed a mature and collaborative approach to research, innovation, and quality improvement, led by a director of research, innovation and clinical effectiveness and a deputy medical director for research. The trust's research leadership was closely linked with both clinical and academic partners.

Oversight of research and innovation was provided by the research and innovation strategy committee, ensuring that strategic direction was maintained and that new opportunities were identified and developed. A key focus for the trust was the use of evidence to influence clinical practice. The trust had re-established its learning and improvement webinars, which have become a valuable platform for sharing key messages with staff on topics ranging from risk assessment and suicide prevention to learning from high-profile cases and national reports.

The trust was the host for the applied research collaboration for the north east and north cumbria, a programme focused on applying research to improve population health, with a particular emphasis on inequalities and prevention. The trust was actively engaged in a range of regional and national partnerships, including the Newcastle health research partnership, the regional research delivery network, the Newcastle biomedical research centre, and the commercial research delivery centre. These collaborations enabled the trust to develop, deliver, and implement research that made a

difference. The recently established suicide and self-harm research collaboration, led by the trust, was an example of how the trust was supporting decision-makers with evidence to improve processes, systems, and treatment in areas of greatest need.

The trust prioritised the development of research careers, particularly for nurses, midwives, and allied health professionals. CNTW worked closely with the National Institute for Health and Care research academy, and staff had secured fellowships and awards that supported their research activity and career progression. The trust led a regional consortium for a health and care professional internship programme, building on its successful non-medical research internship programme, which has supported around 60 professionals over the past 6 years.

Research was compliant with clinical trials regulations, supported by a quality management system. The trust was one of the few mental health organisations in England to sponsor clinical trials of investigational medicinal products, with oversight provided by the research governance oversight committee reporting to the quality committee.

There was a strategic partnership between the trust and university, which enabled the trust to influence research priorities and ensure mental health was represented in regional and national initiatives. The medical director had a background in mood disorder research and led the care pathway enhancement clinic (CAPE), which was at the forefront of translating research into clinical practice. The CAPE clinic is a national exemplar, focusing on unmet needs in primary care, particularly for patients with treatment-resistant depression who are often missed by secondary care services. The clinic worked closely with GPs and community teams to identify suitable participants, and its approach was being rolled out across 15 sites in the UK.

The trust's research delivery network funded around 20 staff, and there was a strong emphasis on engaging clinicians and staff from across the organisation.

Leaders acknowledged the challenges of sustainability, particularly for innovative clinics like CAPE, and the difficulty of bridging gaps between primary and secondary care. There was a recognised need to make research more accessible and relevant to frontline staff, and to provide quicker, locally generated evidence to support decision-making and the evaluation of new models of care. The trust was committed to embedding research more fully into clinical practice, with ongoing work in areas such as Lewy body dementia and autism and was keen to support the academic development of its workforce.

The trust had developed a broad portfolio of accredited services across its inpatient, community, and

specialist mental health provision. As of September 2025, the trust had over 30 services and teams that had achieved formal accreditation status from a range of nationally recognised professional bodies. These accreditations were awarded following rigorous external review processes, peer assessments, and ongoing compliance with best practice standards. The majority of accreditations were provided by the Royal College of Psychiatrists' quality networks, which set benchmarks for excellence in mental health care. Accredited services spanned a wide range of clinical areas, including memory protection clinics, perinatal mental health teams, eating disorder wards, rehabilitation and long-stay wards, crisis resolution and home treatment teams, psychiatric liaison services, forensic inpatient units, and electroconvulsive therapy suites.

The trust innovation group worked in partnership with NHS England, leading on quality improvement training, coaching, and large-scale change management. The team supported both trust-wide strategies and individual service improvements, offering training and coaching to staff and promoting co-production with service users and carers.

The trust used a structured quality improvement (QI) record system to capture, monitor, and communicate the progress and impact of its quality improvement projects. This system provided a clear framework for teams to define the problem they are addressing, set measurable goals, track data, and summarise the benefits and learning from their work.

The trust had developed what is believed to be the only university-accredited course for training people with lived experience in co-production in research, in partnership with the university. A recent programme development grant will support the further development of the lived experience academy, co-led by a person with lived experience, ensuring that service users are at the heart of research and innovation.

The service user and carer reference group was regularly involved in discussions and projects that shaped the future of services. During the meeting we observed, groups discussed how the service user reference group could contribute to the redesign of learning disability and autism services, digital transformation, and the patient and carer race equality framework. There was also a focus on how families could be more involved in seeking second opinions and on workforce wellbeing. Service users from Northgate secure services shared their involvement in developing an animation to support involvement work, and their ongoing efforts to improve food quality at Northgate through taster sessions and direct feedback to catering. The group also reviewed the trust's service user strategy in collaboration with peers from another trust.

The reference group was also linked to the involvement hub, where members were invited to participate in a range of activities, such as delivering training and sitting on interview panels. Members described this involvement as meaningful and not tokenistic, with one individual sharing their experience of being on a psychiatrist interview panel.

The trust would benefit from ensuring board and committees had improved access to patient voice. The trust had paused the use of 'patient stories' at board as they found these had become tokenistic and were seeking new ways to improve hearing from users of their services.

Internal incident reporting was well established, with 76,000 incidents reported in 2024/25. All reported incidents underwent initial review by managers to confirm actions taken and determine if further escalation was required. Subject matter experts provided additional oversight for specific categories such as safeguarding, medicines, infection prevention, tissue viability, and security. Moderate and severe harm incidents, as well as all deaths, were reviewed by the clinical risk team to assess duty of candour compliance and determine the appropriate level of review.

From 1 August 2024 to 31 July 2025, there were 37,562 events recorded by staff at the trust in learning from patient safety incidents system (LFPSE). The majority (50%) were in adult mental health, followed by child and adolescent psychiatry (16%), learning and disability (9%), older peoples services (9%), and forensic services (4%). No harm was recorded for most incidents (67%), 167 were fatal, 107 resulted in severe physical harm, and 135 resulted in severe psychological harm.

No never events were reported.

We were not assured that staff always correctly categorised incidents within this system, this reduces the opportunity for escalation and learning. We completed a key word analysis for incidents involving incidents of aggression and restrictive practice because this had been a focus during our service inspections. From the total 37,562 events recorded by staff at the trust LFPSE, there were 26,606 that included one or more of these search words or terms. 15,353 (58%) of these incidents reported neither physical harm nor psychological harm as result, although the level of concern for 656 of these was reported as 'very concerned'. This suggested some mismatch between level of harm and level of concern.

The trust had not made enough improvement in this area, and it impacted on early identification of signs of deteriorating quality in services. When we conducted an inspection of wards for people with a learning disability and / or autism in 2024, we told the trust that we were concerned about the way in

which staff recorded and reported incidents and how they reported them to safeguarding. In the year prior to that inspection, 491 injuries were reported for 29 service users across Mitford Unit, Mitford Bungalows, and Rose Lodge, with most incidents classified as low or minor harm and nearly half involving self-harm. Safeguarding referrals were much lower than the number of incidents, and there was no clear record of how many injuries resulted from restraint or other causes. There had been similar concerns raised about the reporting of incidents at the child and adolescent mental health units in 2025.

The trust had guidance in place which was mainly aligned with NHS England's patient safety framework guidance and guidance on harm grading.

The trust's "Incident Policy Incorporating the Patient Safety Incident Response Framework (PSIRF) Practice Guidance Note Incident Reporting and Immediate Management – V08" gives detailed examples of levels of harm which should be recorded for certain incident types. These examples illustrated how harm levels escalate with the severity, duration, and consequences of treatment required. For example when an incident involves a service user potentially overdosing with medication in the community, the trust policy describes low harm categorisation as involving short-term A&E treatment with antidote and discharge, moderate harm requires inpatient admission and several days of monitoring, and severe harm involves life-saving intervention, ambulance attendance, and prolonged hospital care.

A detailed review of incidents reported as 'no harm' by trust staff in the LFPSE system revealed several cases that, according to the trust's policy, should be reclassified due to the nature and severity of the events. There were multiple overdose incidents, some requiring ambulance intervention. Ligature attempts were also reported, and significant self-harm was documented along with physical assaults and aggression with possible injury. These examples demonstrated that the original 'no harm' categorisation did not always accurately reflect the actual risk and impact of these incidents and was not always in line with trust policy.

The policy deviated from national guidance because the categories for psychological harm had not been included in the policy. These deviations could lead to under-reporting of harm severity, particularly in cases involving psychological impact. The trust confirmed that psychological harm is included in their web based incident reporting system but was not currently outlined in the policy. The trust are reviewing the policy with a view to supporting staff and making the required policy changes by the end of June 2026.

Learning was reinforced through structured processes, although during our assessment of services it was not always clear how learning was disseminated to front line services and changes made because of incidents. It was also unclear how learning from external reviews such as CQC inspections was shared across all services. For example, we raised a concern with the trust about the quality of ligature

risk assessment following the death of a patient in June 2023. At our assessment of wards for older people with mental health problems in 2025 we found similar concerns about the quality of ligature risk assessments and how the trust had not applied refreshed national guidance. We were concerned that the trust was not taking learning from serious incidents and using national guidance to improve the quality and safety of care.

The patient safety learning and improvement panel was a well-established forum that oversaw key areas such as falls, medicines, addictions, complaints, and workforce issues. Using the NHS patient safety and learning framework, the trust set quality aims for 2024–2025 focused on fostering a positive and safe culture, improving physical healthcare, reducing self-harm, and enhancing care for people with severe mental illness. Priorities included consistent risk assessment, safer transitions, early recognition of deterioration, and supporting staff wellbeing. The panel's thematic reviews have led to tangible safety improvements, such as introducing Life Vac devices to address choking risks and relaunching the physical health strategy in response to identified gaps.

The trust had a process for reviewing incidents in line with the NHS patient safety and learning framework. The trust conducted early learning reviews (ELRs) within three days of patient safety incidents, followed by after action reviews (AARs) or patient safety incident investigations (PSIIs) for more serious cases. In the past year, they completed 172 ELRs, 124 AARs, 17 PSIIs, 50 mortality reviews, and 145 responses to HM Coroner. We asked the trust to provide data on whether the timescales outlined in their policies were met, but they were unable to provide this information.

Action plans from reviews were tracked and approved by senior leaders, with thematic reviews informing quality priorities. In 2025, 457 learning points were identified, mainly around care processes and risk management.

The trust responded to two prevention of future death reports and participated in three independent reviews, which highlighted ongoing weaknesses in risk management, care planning, safeguarding, and communication.

We reviewed a selection of ELRs, AARs and PSIIs. The cases included incidents involving medication errors, self-harm, complex care transitions, and being absent without leave from services. Reports provided detailed chronologies, multi-perspective analysis, and open reflection on both clinical and system-level issues. Most reviews included clear, specific, and actionable recommendations, with a focus on learning rather than blame. Reviews demonstrated sensitivity to the impact on patients, families, and staff, and documented the support offered. Immediate action was taken to manage

incidents which presented ongoing risks.

Some ELRs identified risks (such as medication and waiting list issues) but the reports did not evidence concrete improvement actions, representing missed opportunities for learning. Not all reviews fully explored or documented system-level issues, particularly in cases involving inter-agency working (e.g., with acute trusts or police). Some reports were lengthy, making it difficult to quickly extract key learning points. The inclusion of executive summaries and clearer action plans would enhance practice and drive improvement.

Between July 2024 and July 2025, the trust had received 2 prevention of future death reports (Regulation 28) from HM Coroner. Regulation 28 of the Coroners (investigations) Regulations 2013 relates to "Prevention of Future Deaths" (PFD) reports. After an inquest, if a coroner believes that action should be taken to prevent future deaths, they have a statutory duty to issue a Regulation 28 report. This report is sent to any person, organisation, or authority that the coroner believes has the power to take such action. The trust had responded to both reports clearly articulating the actions taken in response to the concerns raised in both cases with clear actions undertaken to reduce reoccurrence.

In the 12 months prior to the assessment, the trust were involved in 3 published independent reviews into incidents occurring involving patients in the trust's care in 2019, 2020 and 2022. All 3 reports identified weaknesses in clinical risk management, care planning, safeguarding, medicines management, and inter-agency communication. Common findings included inconsistent or inadequate risk assessments, delays and gaps in care coordination, insufficient staff training, and poor information sharing both within teams and with external agencies. Staffing shortages and environmental pressures were noted to have compromised patient and staff safety.

The Trust collected data on all reported deaths (this applied to all deaths of patients open to trust services including all patients who died within 12 months of discharge). Between July 2024 and July 2025, there had been 1810 deaths of patients using or recently discharged from the trust's services. 1418 patients were noted to have died from natural causes or via an accident, with 801 of these deaths being noted as expected.

These incidents occurred in:

- Community care group (1361)

This included the deaths of 7 young people accessing child and adolescent mental health services, 12 people using community forensic services, 74 people with a learning disability and/or autism, 175 people in community mental health teams for working age adults, 131 people using crisis services, 763 people using older peoples community mental health services and 85 people using substance misuse services.

Of these community deaths 65 related to people using community mental health teams for working age adults, and the North Cumbria East community team had the highest amount of deaths (12).

61 deaths related to people using adult crisis services, with the highest amount of deaths occurring for patients of the crisis resolution and home treatment Cumbria (18).

30 deaths related to people who were using psychiatric liaison services, with the highest amount of deaths occurring in the North Cumbria (west) team (8).

Suicide rates in Cumbria are significantly higher than the national average. According to the Office for National Statistics (ONS), Cumberland (North Cumbria) recorded a suicide rate of 19.4 per 100,000 population in 2023, compared to the England average of 10.9 per 100,000.

The trust's approach to self-harm and suicide prevention had evolved through an iterative process. Beginning with the inpatient zero suicide plan in 2019 and the publication of the trust's suicide prevention strategy in 2021. The trust had strengthened its framework through enhanced staff training co-produced with people with lived experience, the implementation of a biopsychosocial risk assessment and safety planning model in April 2024, and active participation in national developments.

The trust's suicide prevention strategy (2021) outlined three priorities;

- safety planning
- support after suicides (for patients, families and staff)
- self-harm reduction using evidence-based approaches

The trust had introduced a family liaison officer, expanding support after self-harm incidents, and used trauma-informed approaches to reduce self-harm in inpatient settings. Oversight was provided by medical leadership and a self-harm steering group, with quality metrics aligned to national standards.

In response to high suicide rates in Cumbria, the trust used a multi-agency approach that addressed rural risk factors and promoted safety planning tailored to local needs. Enhanced training, co-produced with people with lived experience, covered rural and neurodiversity considerations and was supported by digital resources for staff. Risk champions and extended training for social workers further strengthened system-wide capability. The Trust also collaborated with academic partners to refine interventions and inform evidence-based practice.

- Inpatient care group (48)

Of these incidents 35 were noted as 'natural causes' and 13 were unexpected. Of these incidents, 3 died while receiving inpatient treatment, 3 patients died whilst on leave from the ward, 2 people died within one month of being an inpatient and 4 people died within 3 months of being an inpatient, 1 person died within 72 hours of being an inpatient.

- Specialist care group (411)

This included deaths of patients using neuro-rehabilitation services, acquired brain injury services, and criminal liaison and diversion services. 157 of these deaths related to patients using recovery (substance misuse services).

Thirty-one people died whilst on a waiting list (27 people died of natural causes), 4 of these people were open to services at the time of their death and were thought to have died by self harm.

Of reported deaths, 74 deaths occurred involving people with a learning disability. The learning from lives and deaths of people with a learning disability and autistic people (LeDeR) is a national NHS England programme designed to improve health and social care for people with learning disabilities and autistic people by reviewing their deaths and identifying lessons for service improvement. The trust provided data that confirmed that 6 of these incidents were not referred as they were not within the criteria for inclusion or had not been seen by the trust's clinical teams.

During the inspection the trust found that 7 deaths in this cohort had not been referred to LeDeR when they should have been. This had since been completed retrospectively. As a result of this error the trust confirmed that the systems for referral to LeDeR and assurance processes had been strengthened, and the trust carried out a retrospective review of deaths to ensure no other referrals had been missed.

The trust had an established mortality review process as part of its learning from death's policy (2025). Mortality reviews are a structured process used by NHS mental health trusts to examine the deaths of

patients who were receiving care and who died due to a physical health cause, with the aim of identifying learning opportunities and improving service quality.

The trust's mortality review policy and process was in line with national guidance. The policy provided a comprehensive framework for managing deaths using the structured judgement framework which incorporated the reg flags outlined by the Royal College of Psychiatry.

The mortality review panel provided an annual analysis report to the patient safety learning and improvement panel identifying recommendations and areas for improvement. We saw evidence of cases heard at the mortality review panel which were referred to the group with recommendations for further review.

While the policy and our observation of a meeting demonstrated strong oversight and a consistent approach from experienced professionals, our review of mortality review meeting minutes identified areas for improvement. The recordings of these meetings did not consistently capture actionable items, key learning points, and mechanisms to track actions from previous meetings. The trust policy stated 'keep a secure written record of all meetings and communications with the relevant person' and this was not always the case in the minutes we reviewed. Strengthening documentation in these areas would enhance accountability and ensure that learning was effectively embedded and monitored over time.

Environmental sustainability - sustainable development

Score: 3. Evidence shows a good standard of care

Leaders were aware of the trust's impact on environmental sustainability. They were able to provide examples of where the trust had made changes to reduce the trust's carbon footprint.

The trust had a clear strategic ambition to become a sustainable, high-performing organisation. The updated green plan (2025–2028) set out a comprehensive framework for environmental sustainability, including a detailed estates decarbonisation strategy. This encompassed capital planning, heat decarbonisation, and renewable energy initiatives.

Governance arrangements were well established. The green plan management group, chaired by the director of estates, oversaw delivery across nine thematic workstreams: transport, buildings, medicines, food, waste, digital, workforce, supply chain, and care models.

Topic Areas

The trust had embedded sustainability into its digital infrastructure, adopting a cloud-first strategy, extending device lifecycles.

The trust had taken a pragmatic and inclusive approach to workforce engagement. Staff were actively involved through sub-workspaces and delivery groups, with strengthened leadership engagement across estates and clinical teams.

The trust had made demonstrable progress in optimising its estate to support sustainability goals. Key achievements included:

- completion of the Cedar project, delivered with green assurance
- strategic land repurposing
- development of shared care hubs and utilisation of void space

Fleet management was advanced, with 90% of vehicles now electric or hybrid, supported by tracking software and tax incentives. Catering services had been aligned with low-carbon objectives, including food waste reduction, water removal technologies, and sustainable procurement practices.

Carbon emissions had reduced by 1,699 tCO_2e (14%) over five years. However, current levels remained above the required trajectory, and the trust acknowledged the need for accelerated reductions. Supply chain emissions were now tracked using carbon factors per £ spent, reflecting a more sophisticated approach to indirect emissions.

The trust had secured over £6M in sustainability-linked funding, including public sector decarbonisation scheme grants, with a 12% internal match. Capital projects included:

- de-steaming and decentralisation of heating systems
- thermal upgrades at Bamburgh site
- solar panel installations and biodiversity initiatives

Challenges remained, particularly around conservation area constraints, legacy infrastructure, and project timing. The trust remained on track to achieve a 47% carbon reduction by 2032, in line with its net zero roadmap.

Regulation 17: Good governance

Regulated activities

- Assessment or medical treatment for persons detained under the Mental Health Act 1983

How the regulation was not being met

During the trust's well led assessment, we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

The trust did not have effective systems to consistently assess, monitor, and drive improvement in the quality and safety of the services provided. **Regulation 17, 1, 2 (a) (b) Good Governance**