Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

BOARD OF DIRECTORS PUBLIC MEETING

5 July 2023

13:30 GMT+1 Europe/London

Trust Board Room and via Teams

AGENDA

1. AGENDA

Ken Jarrold, Chairman

REFERENCES

Only PDFs are attached

BoD Agenda Public July 2023 FINAL.pdf

Board of Directors PUBLIC Board Meeting Agenda

Board of Directors PUBLIC Board meeting **Venue: Trust Board Room, St Nicholas Hospital and via MS Teams**	**Date: Wednesday 5th July 2023** **Time: 1:30pm– 3:30pm**

	Item	Lead	
1.1	Welcome and Apologies for Absence	Ken Jarrold, Chairman	Verbal
2	Service User / Carer / Staff Story	Guest Speaker	Verbal
3	Declarations of Interest	Ken Jarrold, Chairman	Verbal
4	Minutes of the meeting held 7th June 2023	Ken Jarrold, Chairman	Enc
5	Action Log and Matters Arising from previous meeting	Ken Jarrold, Chairman	Enc
6	Chairman's Update	Ken Jarrold, Chairman	Verbal
7	Chief Executive Report	James Duncan, Chief Executive	Enc
Quality, Safety and patient issues			
8	Integrated Performance Report (Month 2)	Ramona Duguid, Chief Operating Officer	Enc
9	Seasonal Influenza and COVID-19 Vaccination Plan 2023/24	Sarah Rushbrooke, Executive Director Nursing, Therapies and Quality Assurance	Enc
10	COVID National Inquiry Report	Sarah Rushbrooke, Executive Director Nursing, Therapies and Quality Assurance	Enc

Workforce issues			
11	**No reports scheduled for July**		
Regulatory / compliance issues			
12	**CQC Must Do Report**	**Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance**	**Enc**
13	**Governance Framework Review**	**Debbie Henderson, Director of Communications and Corporate Affairs**	**Enc**
14	**Annual Plan 2023 / 24 - For Approval**	**Kevin Scollay, Executive Director of Finance**	**Enc**
Strategy, planning and partnerships			
15	**Integrated Care System/Integrated Care Board update**	**James Duncan, Chief Executive**	**verbal**
16	**Finance Report**	**Kevin Scollay, Executive Director of Finance**	**Enc**
Key item			
17	**International Recruitment**	**Anne-Marie Lamb, International Partnership Matron**	**Verbal**
Committee updates			
18	**Quality and Performance Committee**	**Darren Best, Chair**	**Verbal**
19	**Audit Committee**	**David Arthur, Chair**	**Verbal**
20	**Resource and Business Assurance Committee** *No meeting has been held during the period*	**Paula Breen, Chair**	**N/A**

21	**Mental Health Legislation Committee** *No meeting has been held during the period*	**Michael Robinson, Chair**	**N/A**
22	**Provider Collaborative Committee**	**Michael Robinson, Chair**	**Verbal**
23	**People Committee** *No meeting has been held during the period*	**Brendan Hill, Chair**	**N/A**
24	**Charitable Funds Committee** *No meeting has been held during the period*	**Louise Nelson, Chair**	**N/A**
25	**Council of Governors' Issues**	**Ken Jarrold, Chairman**	**Verbal**
26	**Questions from the Public**	**Ken Jarrold, Chairman**	**Verbal**
27	**Any other business**	**Ken Jarrold, Chairman**	**Verbal**

Date and Time of Next Meeting:

Wednesday 2nd August 2023
1:30pm – 3:30pm
Trust Board Room, St Nicholas Hospital and via Microsoft Teams

1.1 WELCOME AND APOLOGIES FOR ABSENCE

Ken Jarrold, Chairman

2. SERVICE USER / CARER / STAFF STORY

Guest Speaker

3. DECLARATION OF INTEREST

Ken Jarrold, Chairman

4. MINUTES OF THE MEETING HELD 7TH JUNE 2023

Ken Jarrold, Chairman

REFERENCES

Only PDFs are attached

4. Public Minutes 7 June 2023 FINAL DRAFT DH.pdf

Minutes of the Board of Directors meeting held in Public
on 7 June 2023 1.30pm – 3.30pm
Trust Board Room, St Nicholas Hospital and via MS Teams

Present:
Ken Jarrold, Chairman
Darren Best, Vice Chair/Non-Executive Director
David Arthur, Senior Independent Director/Non-Executive Director
Brendan Hill, Non-Executive Director
Louise Nelson, Non-Executive Director
Michael Robinson, Non-Executive Director

James Duncan, Chief Executive
Ramona Duguid, Chief Operating Officer
Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality
Kevin Scollay, Executive Director of Finance
Lynne Shaw, Executive Director of Workforce and Organisational Development

In attendance:
Kirsty Allan, Corporate Governance Manager (minute taker)
Jack Wilson, Corporate Engagement Assistant

1. **Welcome and apologies for absence**

Ken Jarrold welcomed everyone to the meeting and apologies for absence were received from Paula Breen Non-Executive Director, Rajesh Nadkarni, Deputy Chief Executive/Medical Director and Debbie Henderson, Director of Communications and Corporate Affairs

2. **Declarations of interest**

None to note.

3. **Service User/Carer Story/ Staff Journey**

Ken Jarrold extended a warm welcome and thanks to Kevin Hawkes who shared his personal journey.

4. **Minutes of the meeting held 3rd May 2023**

The minutes of the meeting held on 3 May 2023 were considered.

Approved:
- **The minutes of the meetings held 3 May 2023 were approved as an accurate record.**

5. **Action log and matters arising not included on the agenda**

There were no outstanding actions to note.

6. **Chairman's update**

Ken Jarrold reflected on the current challenges within the NHS generally and referred to the lack of sustainable national approach, particularly in relation to capital and workforce the key pillars that underpin so much that we do.

Resolved:
- **The Board received the Chair's update.**

7. Chief Executive's Report

James Duncan referred to the report which included an update on the National Inquiry into COVID19.

James discussed the Junior Doctors strike action commencing on 14 June 2023 and highlighted the level of planning and response across the organisation. He thanked colleagues across and outside the organisation who had ensured that the impact on our service users was kept to a minimum.

James commented on the Trust's Ambassador status for the Better Health at Work Award and referred to the Staff awards nominations with the ceremony due to take place on Friday 29 September 2023.

Regarding national updates, James referred to the primary care recovery plan and the importance of this to us as an organisation and in terms of enabling the North East and Cumbria system to provide the best possible care to the people we serve.

James referred to the reports relating to inequalities on treatment services and the impact this has on long-term care.

James discussed partnership working and referred to a recent meeting at Newcastle Health Innovation Partnership across Newcastle Universities and Newcastle Hospitals, focusing on its developing strategy and purpose, with an intention to focus the aims of the partnership around tackling inequalities.

James reported on his recent visit to Sycamore, the new build at Northgate as part of the Trust's CEDAR Programme and urged Board members and Governors to arrange a visit.

Resolved:

- **The Board received the Chief Executive's update.**

Quality, Clinical and Patient Issues

8. Monthly Integrated Performance Report (Month 1)

Ramona Duguid presented the report and the link to the Trust's newly developed strategic ambitions and the ongoing development of the long-term plan.

Darren Best referred to staffing fill rates showing red 120% and queried where that sits against the current financial challenges. Sarah Rushbrooke advised the was driven by the national agenda and the report is currently being reviewed to be more purposeful and reflect the work on agreeing staffing levels and resources across our wards. Brendan Hill suggested it would be good for assurance purposes to see the risks imbedded into the performance metrics.

Ken Jarrold warmly welcomed the new format of the report and thanked everyone involved for their hard work.

Resolved:

- **The Board received the monthly Integrated Performance Report.**

Workforce issues

There were no issues to report for June.

Regulatory / Compliance Issues

9. CQC Report

Sarah Rushbrooke presented the report and asked the Board for approval to close three action plans relating to staffing levels outlined in the report based on the level of evidence and assurance

provided. Board members were asked to note the Quarter 2 updates on all 54 CQC Must Do action plans. Sarah advised that each action plan is discussed in detail at the CQC Steering Group in terms of progress of actions. The report is also considered at the Quality and Performance Committee.

Louise Nelson raised concerns around the use of restraint and queried whether the increase in autism training was having an impact on this. Sarah Rushbrooke referred to the drive on autism training throughout the whole pathway and suggested providing a more detailed report to a future meeting.

Michael Robinson referred to care planning and queried if the Trust will be reopening the closed Must Do actions relating to this. Sarah agreed to clarify this and provide an update to the Board.

Russell Stronach commented on his previous experiences of autism training and queried whether we should be reframing this as neurodevelopmental disorder training.

Resolved

- **The Board received the CQC report**

Action:

- **Report on the impact of Autism Training on the levels of restraint to be provided to a future meeting**
- **Clarify the status of Must Do action relating to care planning**

Strategy, planning and partnerships.

10. Integrated Care System / Integrated Care Board update

James Duncan noted that the NENC ICB Mental Health, Learning Disability and Autism sub-Committee of the ICB was now established, and it was agreed to report progress to the Board through the Chief Executive's update.

As Senior Responsible Officer for Estates and Capital for the ICS Provider Collaborative, James provided an update on the challenging discussions around resources. James is leading on the development of the ICS wide estate strategy in September/October, and this will be shared with the Board in due course.

Resolved:

- **The Board noted the Integrated Care System / Integrated Care Board update**

Key Item for Discussion

11. Family Therapies update

Kevin Hawkes Consultant Family Therapist, Centre for Specialist Psychological Therapies provided a presentation on family therapy and interventions and building family orientated services across the Trust.

Kevin provided an update on the strategic aims to provide an appropriately trained and supported workforce, and ensuring equitable access to evidenced based family interventions and therapies for all service users who need it.

Ken Jarrold thanked Kevin for his expertise and dedication to such an important issue and its impact on current and future services.

Board sub-committee minutes and Governor issues for information

12. Quality and Performance Committee
No meetings have been held during the period.

13. Audit Committee
No meetings have been held during the period.

14. Resource and Business Assurance Committee
No meetings have been held during the period.

15. Mental Health Legislation Committee
No meetings have been held during the period.

16. Provider Collaborative Committee
No meetings have been held during the period.

17. People Committee

No meetings have been held during the period.

18. Charitable Funds Committee
Louise Nelson advised the Committee met on the 9 May 2023 and are progressing with the development and delivery of the charity strategy. As part of the communications plan, Louise asked that Board colleagues and Governors raise awareness of the Charity when on service visits.

19. Council of Governors issues
Ken Jarrold referred to the Governors survey on the effectiveness of the Council.

Ken advised the Board of three additional appointments to the Council. Michelle Garner has been appointed to represent Cumbria University, Julia Clifford, has been appointed to represent the community and voluntary sector, and Cllr Lara Ellis will be replaced by Miriam Mafemba to represent Newcastle City Council.

20. Any Other Business
There were no issues to note.

21. Questions from the public
There were no questions from the public.

Date and time of next meeting
Wednesday, 5 July 2023, 1:30pm at Trust Boardroom, St Nicholas Hospital and online via Microsoft Teams.

5. ACTION LOG AND MATTERS ARISING FROM PREVIOUS MEETING

Ken Jarrold, Chairman

REFERENCES

Only PDFs are attached

5. BoD Action Log PUBLIC at 5 July 2023.pdf

Board of Directors Meeting held in public

Action Log as at 5 July 2023

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

Item No.	Item	Action	By Whom	By When	Update/Comments
Actions outstanding					
07.06.23	CQC Report	Clarify the status of Must Do action relating to care planning	Sarah Rushbrooke	July 2023	Verbal update to be provided under matters arising 5.7.23
07.06.23 (9)	CQC Report	Report on the impact of Autism Training on the levels of restraint to be provided to a future meeting	Sarah Rushbrooke	August 2023	On track
Completed Actions					
05.04.23 (9)	Staff survey results 2022	Staff survey results containing 5-year comparable data to the circulated.	Lynne Shaw	May 2023	Complete – circulated via email 26 April

6. CHAIRMAN'S UPDATE

Ken Jarrold, Chairman

7. CHIEF EXECUTIVE REPORT

James Duncan, Chief Executive

REFERENCES

Only PDFs are attached

7. CEO Report to Board of Directors July 2023 v2.pdf

Report to the Board of Directors
Wednesday 5th July 2023

Title of report	**Chief Executive's Report**
Report author(s)	**Jane Welch, Policy Advisor to the Chief Executive**
Executive Lead (if different from above)	**James Duncan, Chief Executive**

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day.	x
2. Person-led care, when and where it is needed – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals	x
3. A great place to work – We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers.	x
4. Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled.	x
5. Working with and for our communities – We will create trusted, long-term partnerships that work together to help people and communities.	x

Board Sub-committee meetings where this item has been considered	
Quality and Performance	
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered	
Executive Team	
Executive Management Group	
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability		Reputational	
Workforce		Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness		Service user, carer and stakeholder involvement	

Board Assurance Framework/Corporate Risk Register risks this paper relates to

Meeting of the Board of Directors

Chief Executive's Report
Wednesday 5th July 2023

Trust updates

Healthcare Financial Management Association (HFMA) and Healthcare People Management Association (HPMA) Awards 2023

The Trust has been successful in a number of recent awards submissions. At the Healthcare Financial Management Association Northern Branch Awards ceremony held on Friday 23 June 2023 at the Grand Hotel in Gosforth, NTW Solutions finance staff were winners in two categories:

- David Palmer – Lifetime Achievement Award
- NTWS Accounts Payable (AP) and Accounts Receivable (AR) Team – Small Team of the Year

It was a fantastic achievement for the team and very much deserved.

In addition, two teams have been shortlisted for the Healthcare People Management Association National Awards:

- CNTW Academy has been shortlisted in the Education, Learning and Development Initiative category for the 5 year apprenticeship programme
- Audit One have been shortlisted in the Excellence in OD category for their Organisational Development Programme

This year has seen the greatest number of submissions in the award history therefore being shortlisted is, in itself, an achievement. The winners will be announced at the awards ceremony in Leeds in September. Congratulations and well done to all involved.

Industrial Action

The British Medical Association (BMA) and Hospital Consultants and Specialists Association (HCSA) held a further round of Junior Doctors industrial action which commenced on 14 June 2023 for 72 hours. There were no specific operational issues encountered during this third period of action.

A further announcement has been made for an additional round of action which will take place from 7.00 am on Thursday 13 July to 7.00 am on Tuesday 18 July 2023 which will be the longest period of industrial action in NHS history. Internal preparation is underway and it is anticipated that there will be more operational challenges over this period due to the length of the action which also takes place over a weekend.

The BMA have also announced the outcome of their ballot of Senior Doctors, which has resulted in a vote to strike, with 61% of those balloted supporting industrial action. The BMA have announced industrial action for the 20th and 21st July. The Trust are preparing for the impact that this will have on services.

The Royal College of Nursing ballot closed on 23 June 2023. The response did not meet the threshold for industrial action.

Trust launches first Volunteer Involvement Strategy

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) has launched its first ever Volunteer Involvement Strategy. Many volunteers, patients, and staff have all been engaged in creating the strategy which was launched at a celebration event on Friday 9 June. The dedicated Voluntary Services team within CNTW work to ensure that volunteers are recruited into roles, screened, trained, and supported safely and effectively, including in relation to their wellbeing and personal development. Many of the volunteering opportunities currently available at CNTW involve supporting social activities with patients such as walking and talking, accompanying them to exercise therapy, playing board games, watching films, gardening, accessing local community groups, and seeking feedback from patients and carers.

Partnership Day

For a number of years the Trust has held Partnership Days to bring together Executive Directors, Operational Directors and Branch/Regional Trade Union Representatives to discuss key issues and develop/review the partnership compact which was put in place following the first session in September 2012.

On Thursday 22 June 2023 a further Partnership Day took place. It was well attended, and the scene was set around the national and regional landscape in terms of the political, social and financial context. The rest of the day centred around the Trust position and a number of discussions took place around the new strategy, governance review, emerging clinical model and current financial challenges.

It was a positive day and there was a general reflection of the significant improvements made in the past 10 years and that openness, honesty and true collaboration have been key features of the journey to where we are now in terms of good working relationships and true partnership working.

The Partnership Compact will be reviewed in light of the new strategy, to reflect the current challenges and how we will work collaboratively through the months and years ahead.

Regional updates

Healthwatch Northumberland report on autistic young people and mental health services

Healthwatch Northumberland published a report highlighting the experiences of children and young people with autism and their families when accessing mental health services. The report is based on feedback from 90 people across the county who have children with diagnosed or suspected autism, or autistic behaviours. Some responses were related to the experiences of children with ADHD, learning difficulties or mental health issues and their families. The report covers key aspects of autism and mental health care pathways, including autism referral and assessment and post-diagnosis support, and contains specific feedback linked to different settings including schools, school nursing, Northumbria Healthcare's Primary Mental Health Work service, and CNTW children and young people's services and crisis teams. The report highlights 9 key themes which featured strongly in service user feedback:

1. Staffing – staff provide high-quality responsive care but are struggling due to workforce pressures and heavy workloads
2. Being listened to - Many parents felt they or their children were not being listened to or taken seriously
3. Early intervention – support should be proactive rather than reactive and a variety of services should play a role in supporting early intervention and diagnosis
4. Lack of post-diagnostic support– relating both to practical information and support following a diagnosis and mental health-specific support
5. Lack of parent and family support – including information and support about the diagnostic process and for parents who think their child may have additional needs
6. Support should be more consistent – including timescales and frequency of support, where this is delivered and by who
7. Being holistic – communication and integrated working between services should be improved
8. Staff training – autism training should be delivered to mental health and other staff delivering diagnostic services
9. Valuing autistic people - services and support should accept and value autistic and other neurodivergent children, young people and adults rather than try to change them or make them conform to neurotypical standards

The report makes a series of service-specific recommendations for addressing these themes.

North of England Integrated Care Systems unable to achieve financial balance

The HSJ reports that more than half of Integrated Care Systems (ICSs) in the North of England have failed to agree a balanced financial plan, with fifteen out of a total of 42 Integrated Care Systems planning deficits. North East and North Cumbria, Lancashire and South Cumbria, Cheshire and Merseyside, and North Yorkshire and Humber ICSs have all set deficit plans for 2023-24.

In her Chief Executive's report to the North East and North Cumbria Integrated Care Board (NENC ICB) meeting on 30th May, NENC ICB Chief Executive Sam Allen highlighted that the region's deficit plan was unavoidable due to challenges faced across the system, and that the ICB's priority is to develop a medium-term financial recovery plan for the next three years, seizing the opportunities presented through public sector reform, greater collaboration between NHS providers, and engaging with communities to improve the effectiveness and efficiency of health services.

Sam also set out some of the unique challenges facing our region which have contributed to the deficit position, highlighting the 'quadruple whammy' facing our region – greater health and care need, made worse by the pandemic which hit our region harder than others, more complex geography which increases the cost of service delivery, and reduced funding. It also highlights that funding allocations are not designed in a way which targets support at those who need it most, and that equity must be factored into decision-making about funding to reduce reliance on public services and support greater public sector reform and economic growth. She stressed that the lack of support to address underlying structural deficits is a risk to our region's healthcare system and may necessitate difficult decisions if that support is not granted.

National updates

Government announces investigation into mental health inpatient safety

Health Secretary Steve Barclay has announced a national investigation into the safety of mental health inpatient services. The Department of Health and Social Care (DHSC) has asked the Healthcare Safety Investigation Branch (HSIB) to deliver the investigation, which will start in October when HSIB acquires new powers under the Health and Care Act 2022. A new Health Services Safety Investigations Body will lead the investigation which will look at the following themes:

- How providers learn from deaths in their care and use that learning to improve services, including post-discharge services
- How young people are cared for in mental health in-patient services and how that care can be improved
- How out-of-area placements are handled
- How to develop a safe staffing model for all mental health in-patient services
- How providers use data across these themes

The Health Secretary told the House of Commons that the new Health Services Safety Investigations Body would have 'teeth', work quickly (its predecessor's investigations were typically concluded within a year) and will have the power fine people who refuse to give evidence to the investigation.

Rapid review of mental health inpatient services publishes findings

The Government has published the findings and recommendations of a rapid review into the current use of data linked to mental health inpatient pathways. The review, led by Dr Geraldine Strathdee, was commissioned by ministers in response to concerns that the data and information required to support early identification of risks to patient safety in mental health inpatient settings was not available and was undermining efforts to improve care and keep patients safe. The review looked at the use of quantitative data and qualitative evidence from patients and families, and how this is collected, processed and used to identify and mitigate risks to patient safety. The findings of the review are grouped into 5 key themes:

1. Measuring what matters
    - The review found a large amount of data on activity and process measures is collected, and some on acuity and performance. More systematic metrics on environment and workforce are needed and there are significant gaps in therapeutic care, outcomes and culture.
2. Patient, carer and staff voice
    - There are barriers to getting real-time honest feedback from people most connected to wards through to senior leadership and Board level
    - Patients, carers and staff do not always feel they are listened to and there are fears about raising concerns about safety and care on wards
3. Freeing up time to care
    - It is common for frontline clinical staff to spend half their shift entering data, and roughly half of analysts' time is reported to be spent flowing data to national and local datasets rather than supporting quality improvement and operational delivery
    - There is a risk that the data burden on staff increases the risk to patient safety by reducing contact time with patients
4. Getting the most out of what we have
    - There is a need to move towards understanding root causes and themes and the use of benchmarking to inform quality improvement approaches, and to triangulate data to map risks to patient safety
5. Data on its own is not enough

- Data can help leaders to prioritise and ask the right questions, but it is not a substitute for time spent on wards
- Leaders need to act on information from all sources, including soft intelligence, rather than relying on a dashboard or dataset

The review makes 12 recommendations for addressing these findings, including:

- NHS England should develop a programme to ensure providers, commissioners and national bodies are 'measuring what matters', building on the themes outlined in the review's safety issues framework
- Every provider and commissioner of NHS-funded care should have access to digital platforms that allow the collection of core patient information and associated data infrastructure to allow timely reporting of information to different decision makers
- Actions to improve provider boards' capacity to identify, prevent and respond to risks to patient safety:
    - Every provider board should urgently review its membership and skillset and ensure that the board has an expert by experience and carer representatives
    - Every provider board should ensure that its membership has the skills to understand and interpret data about mental health inpatient pathways and ensure that a responsive quality improvement methodology is embedded across their organisations, including through data literacy training for Board members
    - Every provider board should urgently review its approach to board reports and board assessment frameworks to ensure that they highlight the key risks in all of their mental health inpatient wards
- Trust and provider leaders, including board members, should prioritise spending time on wards regularly, including regular unannounced and 'out-of-hours' visits
- All providers of NHS-funded care should review the information they provide about their inpatient services to patients and carers annually
- Providers should review their processes for allowing ward visitors access to mental health inpatient wards with a view to increasing the amount of time families, carers, friends and advocates can spend on wards

The review suggests that its recommendations should be implemented within 12 months. The Government will consider the findings of the report and respond in due course.

Equality, Diversity and Inclusion Improvement Plan

NHS England published the NHS Equality, Diversity and Inclusion Improvement Plan, making clear that the NHS, as England's largest employer, must lead the way in creating equitable and inclusive workplaces. The key principle guiding this work is that EDI is everyone's business - leaders set the tone and culture of their NHS organisation but we all

have a role to play, and progressing the EDI agenda requires a change in cultures and behaviours as well as systems and processes. The plan sets out six high-impact actions to address direct and indirect discrimination and prejudice, actions that NHS organisations and ICBs must complete, and success metrics.

The high impact action areas are:

1. Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
2. Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
3. Develop and implement an improvement plan to eliminate pay gaps.
4. Develop and implement an improvement plan to address health inequalities within the workforce.
5. Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.
6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

NHS England will evaluate progress against the high-impact actions in years 2 and 5 of the plan, to understand the plan's contribution to transforming culture to one which promotes a sense of belonging to the NHS across the workforce.

Government's 2023 mandate to NHS England

Government published its 2023 mandate which sets out the objectives NHS England is expected to achieve. The mandate includes three key objectives:

1. Cut NHS waiting lists and recover performance
2. Support the workforce through training, retention and modernising the way staff work
3. Deliver recovery through the use of data and technology

Other key programmes of work highlighted in the mandate include:

- Improving access to mental health support, including increasing the number of adults and older adults accessing talking therapies and improving the quality of care
- Shifting to community-based care
- Improving access to and quality of care for people with a learning disability and autistic people
- Preventing ill health and tackling inequalities, through the delivery of the 5 strategic priorities for system action on health inequalities and the CORE20PLUS5
- Supporting the delivery of the Long Term Plan through the development and delivery of the major conditions strategy

Government response to the Hewitt Review recommendations

The Government published its response to the recommendations made by Parliament's Health and Social Care Committee inquiry on 'Integrated Care Systems: autonomy and accountability' and Patricia Hewitt's independent review of integrated care systems (ICSs). Key points from the Government's response include:

- Performance targets - The Government accepts the Review's recommendation for a smaller number of national priorities, as seen in the 2023/24 planning guidance and the NHS mandate.
- Leadership development - A senior advisory group across health and care has been brought together to advise and help to plan a 3 year roadmap of leadership and management support and development in response to the Messenger Review.
- CQC assessments – the Department of Health and Social Care (DHSC) supports the vision set out in the Hewitt Review in relation to CQC assessments of ICS performance. The CQC will also assess systems as a whole including how well system partners are working together.
- Finance - DHSC commits to building on existing work to reduce the prevalence of in-year funding, acknowledges the importance of multi-year funding, and agrees ringfenced funding should be limited but that it is an important means of securing funding for a priority area e.g. via the Mental Health Investment Standard
- High Accountability and Responsibility Partnerships - DHSC supports the intent of Hewitt's recommendation to grant more autonomy to mature ICSs but does not commit to implementing this recommendation given that ICSs have only recently been placed on a statutory footing.
- ICB running costs - DHSC rejects the Review's recommendation to reconsider the 10% cut to ICB's running cost allowance for 2025-26.
- Prevention spending and national mission for health improvement – the Government rejects the recommendation that ICS NHS spending on prevention should be increased by 1% annually. Government has established a Health Mission Working Group to deliver the Levelling Up health mission.
- Capital - Government recognises the need to further review the existing capital system, particularly for primary care, private finance, and the management of the NHS estate.
- Digital – Government supports the intent behind Hewitt's recommendations linked to interoperability, data standards, and investment in the digital capabilities of system partners including social care.

Institute for Public Policy Research health and care workforce assembly report

The Institute for Public Policy Research (IPPR) published the final report of the health and care workforce assembly which it convened during 2021/22, bringing together a diverse range of members from across the health and social care workforce. The report highlights a sustained mismatch between health and care workforce supply and demand which, without transformational productivity gains, results in greater workload and pressure on each individual health and care worker. Issues linked to pay and working conditions have also undermined recruitment and retention, compounding the pressure on the remaining workforce and negatively impacting the desirability of a career in health and care.

The report highlights that the number of managers has declined annually and the growth of the infrastructure and support workforce has grown more slowly than any other, despite these roles being vital to the identification, adoption, and management of change and the modernisation of services. The authors highlight the undermanagement of the health and care sector as a constraint on its ability to innovate and change, suggesting that the NHS is one of the most undermanaged health systems in the world, and that any other comparable business would struggle to maintain effectiveness and productivity with the same management deficit which is equivalent to 10,000 missing managers.

Institute for Government report on NHS productivity

The Institute for Government published a report exploring why NHS productivity has not increased in line with increases in funding and staffing. It highlights that most of the additional funding allocated to the NHS to support the pandemic response has been used to increase staffing - between December 2019 and December 2022 the number of WTE junior doctors increased by 16.4% and the number of WTE nurses and health visitors increased by 10.9%. Despite this, the number of people being treated in hospitals is only marginally higher than it was before the pandemic, and on some important metrics it is lower. The report highlights three sets of issues contributing to the NHS productivity problem, which pre-date the pandemic and have become more apparent in the context of the extra strain on the system in recent years. The three sets of issues are:

1. A lack of capital investment, which has made it harder to treat patients and caused inefficiencies.
    - The slow flow of patients through hospitals is the most immediate cause of the productivity problem, and this is linked to:
        - Low bed capacity relative to other developed countries
        - Delayed discharges
        - Lower outpatient activity relative to staffing, linked to diagnostic testing capacity/equipment.

2. High staff churn, more inexperienced staff and low staff morale

3. Problems with hospital management and incentives from the centre
    - The NHS is chronically undermanaged. Management levels have fallen from an already low base, and managers lack the analytical capacity to identify blockages and solve them.
    - Managers have insufficient ability and freedom to make decisions – recruiting more managers without changing the way NHS management operates is unlikely to deliver change.

The NHS in England at 75: priorities for the future

Ahead of the NHS's 75th anniversary, NHS England commissioned this report from the NHS Assembly (which is hosted by NHSE but independent) looking back at where the service has come from, where it is today, and how it needs to change to meet future needs. The report draws on the feedback of thousands of people including NHS patients, staff and partners as well as the expertise of the NHS Assembly. It was authored by Clare Gerada and Chris Ham, the co-chairs of the Assembly, with support from Eugine Yafele, Claire Fuller and Rob Webster. The report sets out the need for three big shifts to ensure the NHS responds to the continuing increase in chronic ill-health and frailty, the need for people to have greater involvement in their own health and wellbeing, and opportunities linked to technology, data, and modernising care. The three big shifts are:

- Preventing ill-health
    - Shifting funding to evidence-based prevention and management, tackling the root causes of poor health and the wider determinants of health
    - Working more effectively in partnership to reach those most at risk
- Personalisation and participation
    - Ensuring people have control over their own care planning
    - Improving accountability to give greater priority to patient experience, particularly those from marginalised groups
- Coordinated care, closer to home
    - Strengthening primary care and community services, and delivering improved community care to those with complex needs and frailty through sustained transformation and investment across the NHS, social care and public health

Strengthening the conditions for locally-led innovation and renewing the mutual relationship of support and engagement between the NHS and the public will be key to the delivery of these shifts.

8. INTEGRATED PERFORMANCE REPORT MONTH 2

Ramona Duguid, Chief Operating Officer

REFERENCES

Only PDFs are attached

8. Board Cover Sheet - IPR Report..pdf

8. Month 2 23-24 - Intergrated Performance Report FINAL.pdf

Report to the Board of Directors
Wednesday 5th July 2023

Title of report	**CNTW Integrated Performance Report – May 2023** ***(Replaces the Commissioning & Quality Assurance Report)***
Report author(s)	**Tommy Davies, Head of Performance and Operational Delivery**
Executive Lead (if different from above)	**Ramona Duguid, Chief Operating Officer**

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day.	x
2. Person-led care, when and where it is needed – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals	x
3. A great place to work – We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers.	x
4. Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled.	x
5. Working with and for our communities – We will create trusted, long-term partnerships that work together to help people and communities.	x

Board Sub-committee meetings where this item has been considered	
Quality and Performance	x
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered	
Executive Team	
Executive Management Group	x
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability		Reputational	
Workforce		Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness		Service user, carer and stakeholder involvement	

Board Assurance Framework/Corporate Risk Register risks this paper relates to

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Integrated Performance Report

Patients | Quality | People | Person Led Care | Sustainability

2023-24 Month 2 (May 2023)

With YOU in mind

Integrated Performance Report - Headline Commentary

Headline Challenges

- **Sickness** – Off target but has been reducing in the last five months.
- **Information Governance** – requires 95% compliance by June 30th – currently at 91.2%
- **Clinical Supervision** – significantly off target for the last 24 months.
- **Serious Incidents** – Despite the low numbers and steady trend, the incidents are of serious magnitude and therefore in exception with actions in the report.
- **Staff fill rates on wards** – Highest reported month in 24 months.
- **Out of Area Placements** and the supporting measures of:
  - **Clinically Ready for Discharge** – off standard but significantly reduced this month.
  - **Bed Occupancy** - Not meeting the Standard.
- **Psychiatric Liaison Referrals in 1 hour** – Deteriorating trend and lower than peers.
- **Crisis Urgent Referrals seen within 24 hours** – Significantly deteriorating trend in last three months.
- **CYPS Neuro waiting 18 weeks for Treatment** – The demand has more than trebled in four years, significantly outstripping capacity.
- **All CYPS Waiting 18 weeks for Treatment and All Adults and Older Adults Waiting 18 weeks Treatment** - Performance has deteriorated significantly over 24 months but remained fairly static in the last 6 months.
- **Live within our means** – Month 2 is overspent largely due to Inpatient pressure.

Key focus areas of concern

- **Staff fill rates**
- **Information Governance**
- **Clinical Supervision**
- **Out of Areas Placements**
- **Crisis Urgent Referrals**
- **18 weeks for Treatment:**
  - **All CYPS**
  - **CYPS Neurodevelopmental**
  - **All Adults and Older Adults**
- **Live within our means**

Positive Assurance / Improvement

- **72 Hour follow ups** meeting the 80% standard.
- **CYPS urgent eating disorders** is consistently meeting the 95% standard.
- **EIP (Early Intervention Psychosis)** starting Treatment in 14 days consistently meets standard.
- **Appraisal Rate** has seen as significant improvement but has plateaued in the last few months.

Mitigations/actions

- **Staffing Fill Rates**
  There is a comprehensive programme of work to reduce the use of agency and high levels of unregistered staff. High figure for May-23, data quality of this measure is being reviewed.
- **Information Governance –** specific and persistent targeting of non-compliant staff to complete the training.
- **Clinical Supervision –** Promoted through locality workforce meeting. Requires further locality focus.
- **Out of Areas Placements -**
  The Inpatient Improvement Programme will deliver change throughout 2023/24 including four detailed improvement areas to improve quality and patient flow.
- **Crisis Urgent Referrals –**
  Temporary staff used to address staffing challenge. Monitoring of patients on dashboard
- **Patients waiting in the Community over 18 weeks for treatment.**
  There is ongoing improvement actions as part of a weekly oversight group to improve waiting times across the Trust, with localities producing a comprehensive actions summary and data pack to drive change and mitigate risks.
- **Live within our means**
  BDG monthly finance focus sessions with locality input to agree actions to impact on the Trust financial position.

Core Trust Integrated Outcome Measures - Summary Overview

Reporting Period: May 2023

	Ref	Indicator Name	Variation	Assurance	Performance	Standard	Plan	Risk Rating	Summary Narrative	Exec
Commitments	C01	How was your experience?	Normal Variation	Achieve at Random	85.9%	85.0%	Provisional	Low (On Track)	Above standard this month, reflects new methodology	SR
	C02	Did we listen to you?	Normal Variation	Achieve at Random	85.6%	85.0%	Provisional	Low (On Track)	Above standard this month, reflects new methodology	SR
	C03	Were staff kind and caring?	Normal Variation	Consistently Achieve	93.5%	85.0%	Provisional	Low (On Track)	Consistently above standard, reflects new methodology	SR
	C04	Did you feel safe?	Normal Variation	Achieve at Random	88.6%	85.0%	Provisional	Low (On Track)	Consistently above standard, reflects new methodology	SR
	C05	Were you given helpful information?	Normal Variation	Achieve at Random	84.6%	85.0%	Provisional	Med (Monitoring)	Remains below standard this month, reflects new methodology	SR
People	P01	Turnover	Concern	Achieve at Random	11.0%	10.0%	National	High (Action)	Increase across all localities except North Cumbria	LS
	P02	Sickness in Month	Normal Variation	Consistently Fail	6.0%	5.0%	National	High (Action)	Sickness has reduced but still above required standard	LS
	P03	Training Compliance - All standards	Improvement	Consistently Fail	83.3%	85.0%	Internal	Med (Monitoring)	Maintained improvement; close to standard	LS
	P04	Appraisal rate	Improvement	Consistently Fail	78.4%	85.0%	Internal	High (Action)	Improvement over the last year but static over last few months	LS
	P05	% Clinical Supervision completed	Normal Variation	Consistently Fail	51.6%	80.0%	Internal	High (Action)	Slight improvement but remains below 80% standard	LS
	P06	People Pulse Health & Wellbeing satisfaction	SPC N/A	No Standard	65.7%	No Std	No Plan	Low (No Standard)	Risen from 60% in Jan 2023 to 65.7% in April 2023	LS
Quality Care	Q01	Restrictive intervention incidents	Normal Variation	No Standard	19	No Std	No Plan	Low (No Standard)	No significant change in 2 years	SR
	Q02	Serious Incidents	Normal Variation	No Standard	21	No Std	No Plan	High (Action)	Despite low numbers action is required due to the magnitude	RN
	Q03	Harm Incidents	Normal Variation	No Standard	2,061	No Std	No Plan	Low (No Standard)	Remains within expected range	RN
	Q04	Safeguarding and Public Protection (SAPP)	Concern	No Standard	1,557	No Std	No Plan	Med (Monitoring)	Numbers have increased due to improved training and recording	RN
	Q05	Long term segregation and prolonged seclusion	Improvement	No Standard	23	No Std	No Plan	Low (No Standard)	Slight but consistent reduction, below the average for 8 months	SR
	Q06	Aggression and Violence	Normal Variation	No Standard	1,611	No Std	No Plan	Med (Monitoring)	Steep rises and falls in numbers due to current inpatient profile	RN
	Q07	Number of Complaints	Normal Variation	No Standard	65	No Std	No Plan	Low (No Standard)	Average around 60 a month, have been above average last 5 months	RN
	Q08	Care Plans compliance	Improvement	Consistently Fail	94.2%	95.0%	Internal	Med (Monitoring)	Steady increase over last 2 years; close to standard	SR
	Q09	Risk Assessments compliance	Concern	Achieve at Random	94.4%	95.0%	Internal	Med (Monitoring)	Below the standard of 95% for the eleventh successive month	SR
	Q10	CPA Completed review	Concern	Consistently Fail	77.8%	95.0%	Internal	High (Action)	This continues to deteriorate and is below 95% standard	SR
	Q11	Staffing fill rates	Concern	Achieve at Random	136.1%	120.0%	National	High (Action)	Significant increase; highest in two years	SR
Person Led Care	A01	Out of Area Placement bed days	Normal Variation	Achieve at Random	375	217	LTP	High (Action)	Remains above set trajectory but reduction since last month	RD
	A02	Bed Occupancy including leave (open beds on RiO)	Concern	Consistently Fail	95.2%	85.0%	National	High (Action)	Remains higher than expected bed usage	RD
	A03	% Adult inpatients discharged with LOS > 60 days	Normal Variation	No Standard	20.4%	No Std	LTP	Low (No Standard)	Reduction in the month consistent with expected range	RD
	A04	% OP inpatients discharged with LOS > 90 days	Normal Variation	No Standard	46.7%	No Std	LTP	Low (No Standard)	Remains consistent with previous months	RD
	A05	Clinically Ready for Discharge (formerly DTOC)	Normal Variation	Consistently Fail	8.8%	7.5%	National	High (Action)	2.5% decrease since previous month but remains above standard	RD
	A06	Crisis % Very urgent seen within 4 hours (WAA&OP)	Normal Variation	No Standard	46.2%	No Std	No Plan	Low (No Standard)	Fluctuates due to low numbers, new standards required	RD
	A07	Crisis % Urgent seen within 24 hours (WAA&OP)	Concern	No Standard	76.7%	No Std	No Plan	Med (Monitoring)	Continued deterioration in performance over last 3 months	RD
	A08	% PLT ED Referrals seen within 1 hour	Concern	No Standard	55.4%	No Std	LTP	Med (Monitoring)	Continued deterioration over last year and is lower than peers	RD
	A09	% PLT Ward Referrals seen within 24 hours	Normal Variation	No Standard	75.8%	No Std	LTP	Low (No Standard)	Fluctuates but remains between 71% and 84%	RD
	A10	72 hour Follow-Up	Normal Variation	Consistently Achieve	92.0%	80.0%	LTP	Low (On Track)	Consistently exceeds 80% standard	RD
	A11	18 weeks wait to Treatment Adults & Older Adults	Concern	No Standard	73.0%	No Std	No Plan	Med (Monitoring)	Remained steady over last 14 months	RD
	A12	18 weeks waits to Treatment - All CYPS	Concern	No Standard	47.3%	No Std	No Plan	Med (Monitoring)	Deterioration over last 2 years, slight improvement in recent months	RD
	A13	<18 wk waits to Treatment CYPS Neurodevelopmental	Concern	No Standard	44.0%	No Std	No Plan	Med (Monitoring)	56% (2673 of 4771) have been waiting 18 weeks or more	RD
	A14	CYPS Eating Disorders (urgent referrals)	Improvement	Achieve at Random	100.0%	95.0%	LTP	Low (On Track)	Consistently meets the standard of 95%	RD
	A15	CYPS Eating Disorders (routine referrals)	Normal Variation	Achieve at Random	88.2%	95.0%	LTP	Med (Monitoring)	Shows gradual improvement towards, but not meeting standard	RD
	A16	EIP – starting treatment in 14 days	Normal Variation	Consistently Achieve	87.5%	60.0%	LTP	Low (On Track)	Consistently above the standard	RD
	A17	Talking Therapies % Moving to Recovery (IAPT)	Normal Variation	Achieve at Random	52.2%	50.0%	LTP	Low (On Track)	Met the standard for the last 3 months	RD
Sustainable	S01	Live within our means (I&E Surplus/Deficit £)	SPC N/A	SPC N/A	2.9M	2.9M	No Plan	High (Action)	23/24 forecast under significant pressure.	KS
	S02	Capital spend compared to plan (£)	SPC N/A	SPC N/A	0.5M	1.2M	No Plan	Low (On Track)	Capital programme overcommitted	KS
	S03	Cash balance compared to plan (£)	SPC N/A	SPC N/A	41.5M	27.4M	No Plan	Low (On Track)	Cash balance on plan due to additional monies	KS

Commitments to our Carers & Patients - Headline Commentary

Reporting Period: May 2023

Headline Challenges

- Performance standards remain provisionally set at 85% for the 5 questions identified from Points of You survey.
- These standards are non-specific to Triangle of Care principles and carer performance measure which require development
- Did we listen to you? - improvement has been seen over previous months
- Were you given helpful information? - marginal decline this month but within limits
- Service users under 18 are least happy across most areas

Key focus areas of concern

- Were you given helpful information

Positive Assurance / Improvement

Consistently around 85% achieved, will still require future monitoring:

1. Did you feel safe
2. How was your experience
3. Were staff kind and caring
4. Did we listen to you

Mitigations/actions

- Review of data structure within Points of You survey dashboard which highlighted date differences which have been corrected to ensure accurate reporting.
- Improve staff knowledge on the intranet page 'health literacy' to support staff to produce accessible information.
- Linking into ICS health literacy workstreams
- Inform Childrens and Young persons services that their service users feel less listened to
- Offer guidance with CYPS to help explore the feedback provided
- Monitoring within the Involvement and Experience Groups.
- Evaluate appropriate and agreed standards in relation to the principles of the Triangle of Care
- Introduction of Locality Heads process to consider outcomes and apply improvement actions
- New Carer Promise rolled-out and Carer Card rolled out to staff
- Introduction of carer specific roles
- Introduction of new set of co-produced carer resource distributed to clinical services

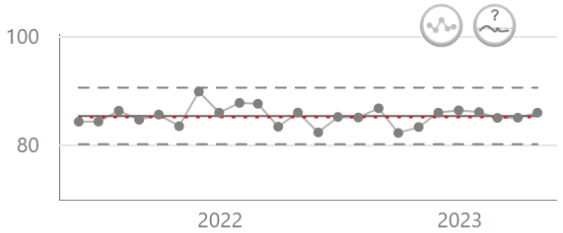
Commitments to our Carers & Patients

Reporting Period: May 2023

How was your experience?

Low (On Track)

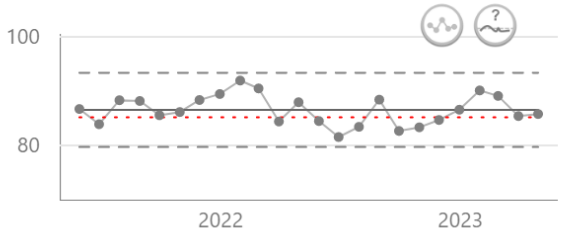
Ref - C01 Performance - 85.9% Standard - 85.0%



Did we listen to you?

Low (On Track)

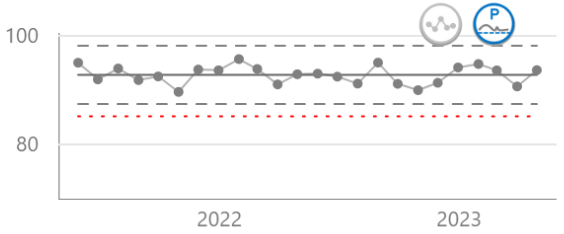
Ref - C02 Performance - 85.6% Standard - 85.0%



Were staff kind and caring?

Low (On Track)

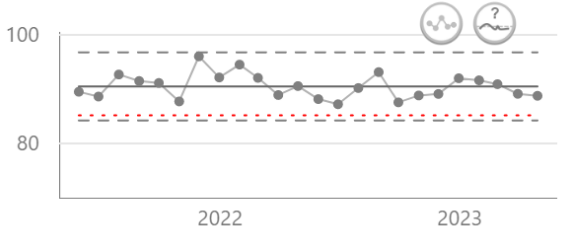
Ref - C03 Performance - 93.5% Standard - 85.0%



Did you feel safe?

Low (On Track)

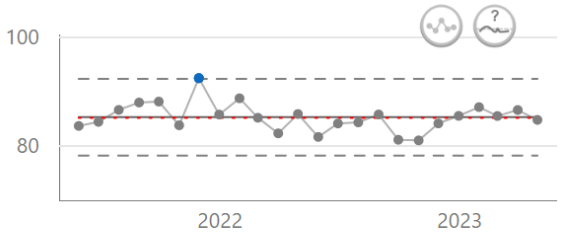
Ref - C04 Performance - 88.6% Standard - 85.0%



Were you given helpful information?

Med (Monitoring)

Ref - C05 Performance - 84.6% Standard - 85.0%



Great Place to Work - Headline Commentary

Reporting Period: May 2023

Headline Challenges

- **Sickness** whilst going in the right direction and reducing remains above the target of 5%
- **Information Governance** – requires 95% compliance by June 30th – currently at 91.2%
- **Clinical Supervision** – significantly off target for the last 24 months.
- **Training** - Capacity within groups linked to clinical demand to provide time for training, clinical supervision and appraisals.

Key focus areas of concern

- **Information Governance**
- **Clinical Supervision**

Positive Assurance / Improvement

- Improvement seen within all areas with the exception of clinical supervision which remains stable
- People Pulse Health and Wellbeing satisfaction score has risen

Mitigations/actions

- **Information Governance** – specific and persistent targeting of non-compliant staff to complete the training.
- **Clinical Supervision** – Promoted through locality workforce meeting. Requires further locality focus.
- **Sickness** –
    - Heads of workforce have reviewed all long term sickness cases over 190 days. In process of reviewing frequent short term absence
    - Ongoing support is being provided by the Wellness Support Team for review point meetings
- **Training** -
    - Groups are reviewing training and ensuring priority given to those areas with low compliance.
    - Bank workers are being reminded on the importance of taking up training,
    - Review and agree statutory and mandatory training to be included in future IPR report

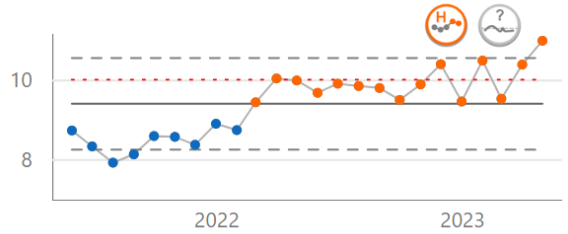
Great Place to Work

Reporting Period: May 2023

Turnover

High (Action)

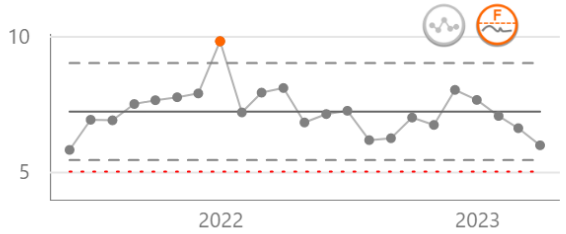
Ref - P01 Performance - 11.0% Standard - 10.0%



Sickness in Month

High (Action)

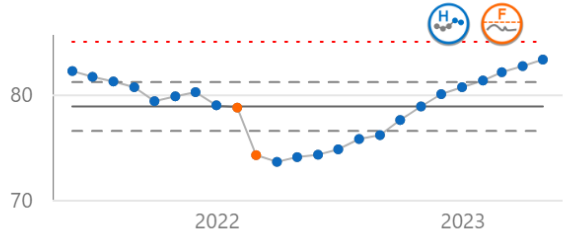
Ref - P02 Performance - 6.0% Standard - 5.0%



Training Compliance - All standards

Med (Monitoring)

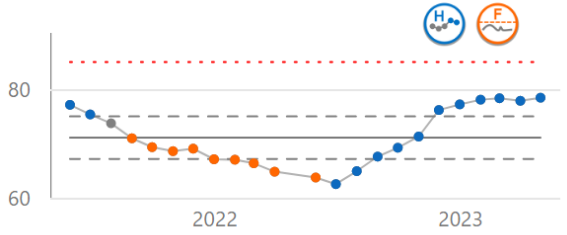
Ref - P03 Performance - 83.3% Standard - 85.0%



Appraisal rate

High (Action)

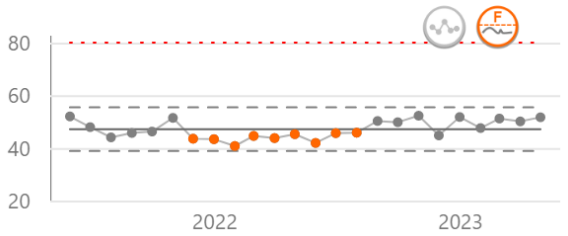
Ref - P04 Performance - 78.4% Standard - 85.0%



% Clinical Supervision completed

High (Action)

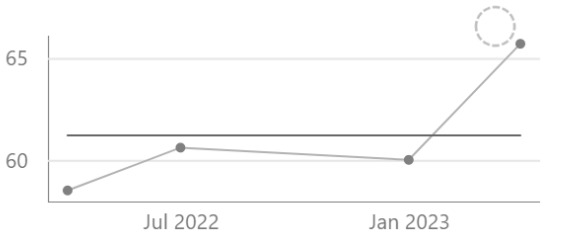
Ref - P05 Performance - 51.6% Standard - 80.0%



People Pulse Health & Wellbeing satisfaction

Low (No Standard)

Ref - P06 Performance - 65.7% Standard - No Std



Quality Care, Everyday - Headline Commentary

Reporting Period: May 2023

Headline Challenges

Staffing fill rates on wards– has increased to 136% in part due to agency usage.

Serious Incidents – Despite the low numbers and steady trend, the incidents are of serious magnitude and therefore in exception with actions in the report.

Safeguarding and Public Protection Incidents– this has continued to increase due to greater awareness and training resulting in more incidents being reported.

CPA Completed review-This has continually declined over two years.

Care Plans compliance – this is improving but remains just below standard.

Risk Assessments compliance – reported below standard for 11 months.

Key focus areas of concern

Serious Incidents

Staff Fill Rates on wards.

CPA Completed Review

Risk Assessments compliance

Positive Assurance / Improvement

Care Plans compliance have consistently improved from around in 2022 and are very close to standard.

Patients in Long Term Segregation and prolonged seclusion has improved.

Mitigations/actions

Serious Incidents- Each serious incident is subject to an investigation which identifies areas of learning and recommendations. This forms an action plan and is subject to The Trust and ICB governance processes to ensure that learning is embedded.

Staffing Fill Rates- There is a comprehensive programme of work to reduce the use of agency and high levels of unregistered staff. High figure for May-23, data quality of this measure is being reviewed.

CPA completed review - There are some data quality improvements to be introduced for this measure which will eventually be superseded with a more effective measure.

Risk Assessments compliance – Overall performing well, any outstanding risk assessments will be allocated to practitioners and localities ensuring they part of the supervision checklist.

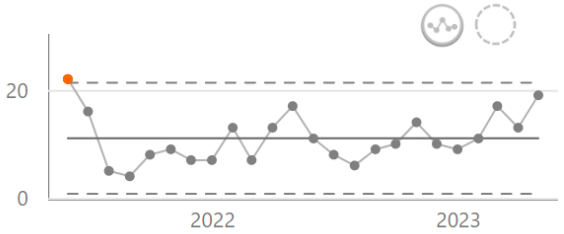
Quality Care, Everyday

Reporting Period: May 2023

Restrictive intervention incidents

Low (No Standard)

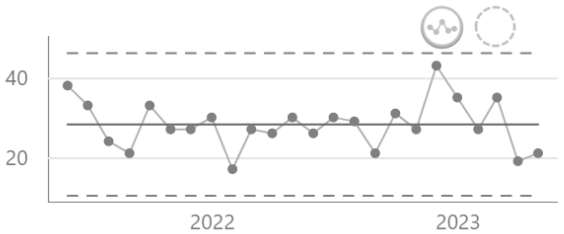
Ref - Q01 Performance - 19 Standard - No Std



Serious Incidents

High (Action)

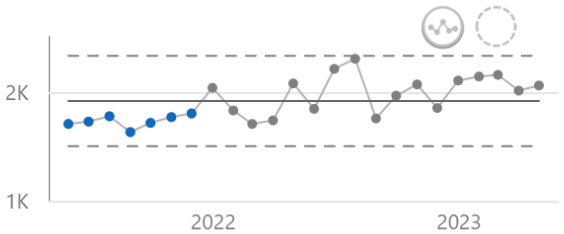
Ref - Q02 Performance - 21 Standard - No Std



Harm Incidents

Low (No Standard)

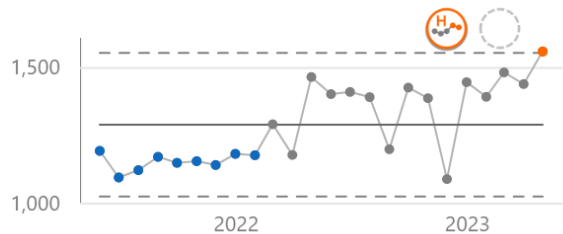
Ref - Q03 Performance - 2,061 Standard - No Std



Safeguarding and Public Protection (SAPP)

Med (Monitoring)

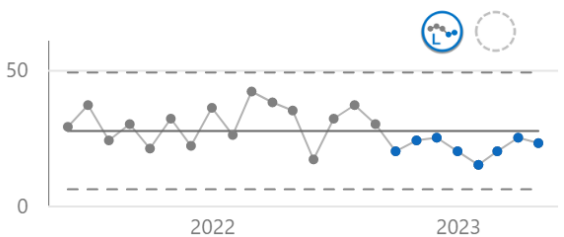
Ref - Q04 Performance - 1,557 Standard - No Std



Long term segregation and prolonged seclusion

Low (No Standard)

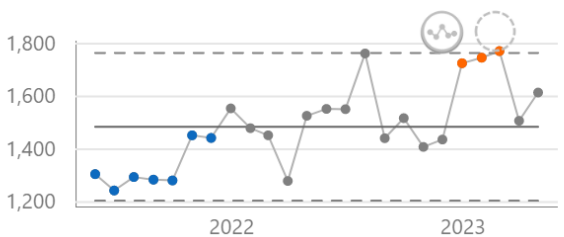
Ref - Q05 Performance - 23 Standard - No Std



Aggression and Violence

Med (Monitoring)

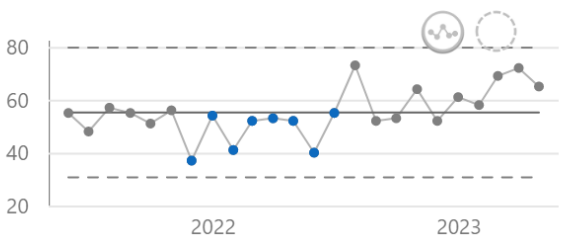
Ref - Q06 Performance - 1,611 Standard - No Std



Number of Complaints

Low (No Standard)

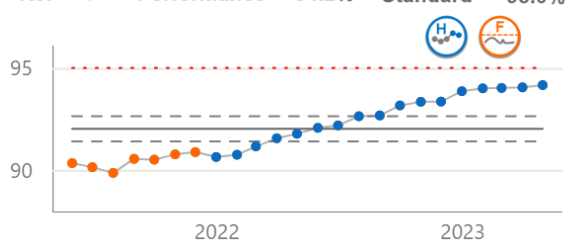
Ref - Q07 Performance - 65 Standard - No Std



Care Plans compliance

Med (Monitoring)

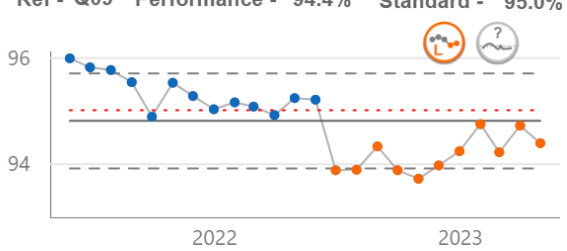
Ref - Q08 Performance - 94.2% Standard - 95.0%



Risk Assessments compliance

Med (Monitoring)

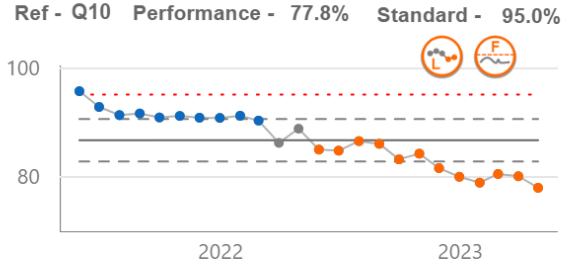
Ref - Q09 Performance - 94.4% Standard - 95.0%



CPA Completed review

High (Action)

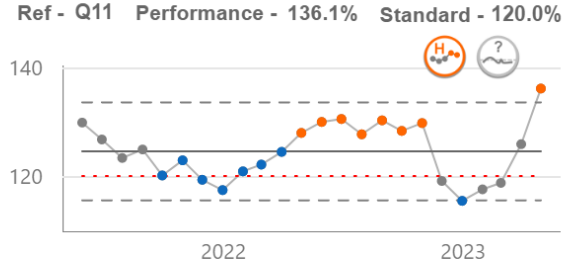
Ref - Q10 Performance - 77.8% Standard - 95.0%



Staffing fill rates

High (Action)

Ref - Q11 Performance - 136.1% Standard - 120.0%



Person Led Care, when and where it's needed - Headline Commentary

Headline Challenges

Out of Areas Placements

CYPS Neurodevelopmental Waits
- The demand for access to neurodevelopment diagnostic services has increased far faster than the available capacity to supply NHS assessments and treatment for ASD/ADHD

Clinically Ready for Discharge – off standard but significantly reduced this month.

Bed Occupancy – Not meeting the standard

Crisis Urgent referrals seen within 24 hours
- Compliance is deteriorating. Performance varies across localities.

1hr Psychiatric liaison
- The Trust benchmarks low on this measure. Performance varies greatly across localities.

All **CYPS Waits for Treatment** and All **Adults and Older Adults Waits for Treatment**
- Performance has deteriorated significantly over 24 months but remains fairly static in the last 6 months.

CYPS Eating Disorder Routine
- despite showing improvement this is still below standard with demand continuing to outstretch capacity.

Key focus areas of concern

Of most concern:
- **Out of Areas Placements**
- **CYPS Neurodevelopmental Waits**

Of concern:
- **Clinically Ready for Discharge**
- **Bed Occupancy**
- **CYPS Eating Disorder Routine**

Positive Assurance / Improvement

- **72 Hour follow up** remains consistently above standard.
- **CYPS urgent eating disorders** is consistently meeting the target.
- **CYPS Eating Disorder Routine** is making a gradual improvement in trend despite not triggering the SPC or meeting standard.
- **EIP (Early Intervention Psychosis) starting Treatment in 14 days** is consistently above standard.

Mitigations/actions

Out of Areas Placements - Work is ongoing with Local Authorities to ensure effective discharge processes are in place. Inpatient Improvement Programme will deliver change throughout 2023/24 including four detailed improvement areas to improve quality and patient flow.

CYPS Neuro waiting 18 weeks for Treatment – The demand has more than trebled in four years, significantly outstripping capacity.

Clinically Ready for Discharge - Weekly meetings across the localities to case manage patients discharges

Bed Occupancy- All patients are encouraged to set a planned discharge date via MDT meetings

CYPS Eating Disorder Routine referrals – A programme of 3 workshops are in place to look at possible system wide improvements, following wide recommendations will be considered by the ICB

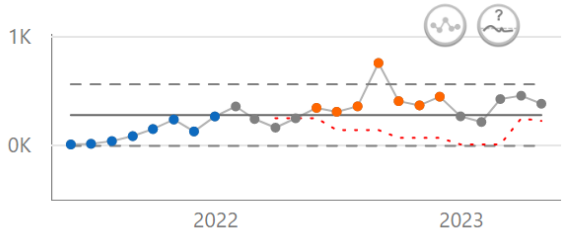
Person Led Care, when and where it's needed

Reporting Period: May 2023

Out of Area Placement bed days

High (Action)

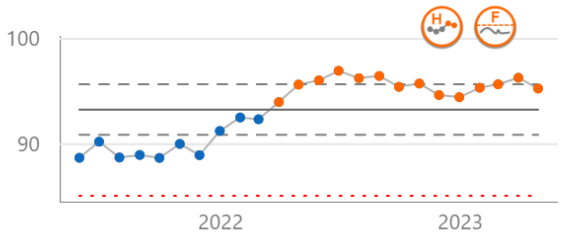
Ref - A01 Performance - 375 Standard - 217



Bed Occupancy including leave (open beds on RiO)

High (Action)

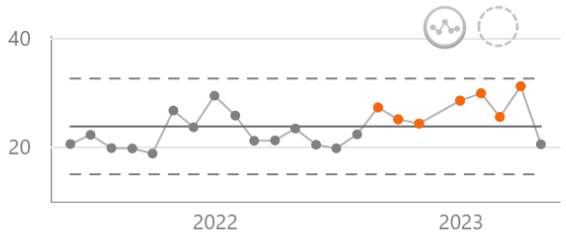
Ref - A02 Performance - 95.2% Standard - 85.0%



% Adult inpatients discharged with LOS > 60 days

Low (No Standard)

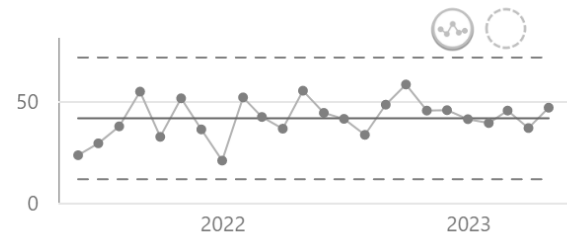
Ref - A03 Performance - 20.4% Standard - No Std



% OP inpatients discharged with LOS > 90 days

Low (No Standard)

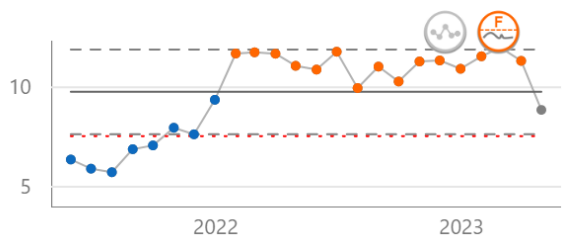
Ref - A04 Performance - 46.7% Standard - No ...



Clinically Ready for Discharge (formerly DTOC)

High (Action)

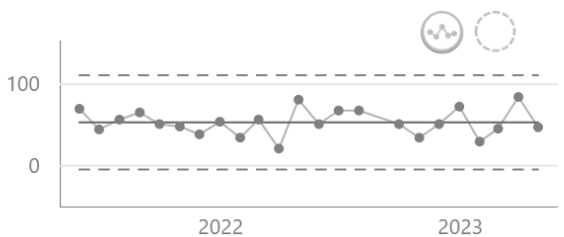
Ref - A05 Performance - 8.8% Standard - 7.5%



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

Low (No Standard)

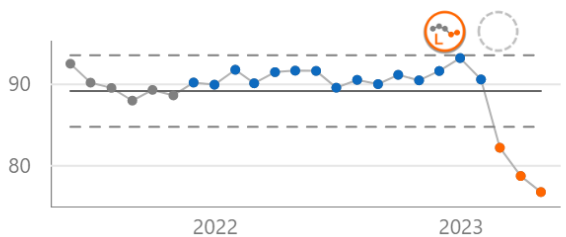
Ref - A06 Performance - 46.2% Standard - No ...



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

Med (Monitoring)

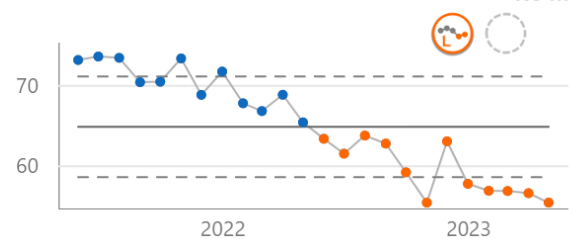
Ref - A07 Performance - 76.7% Standard - No ...



% PLT ED Referrals seen within 1 hour

Med (Monitoring)

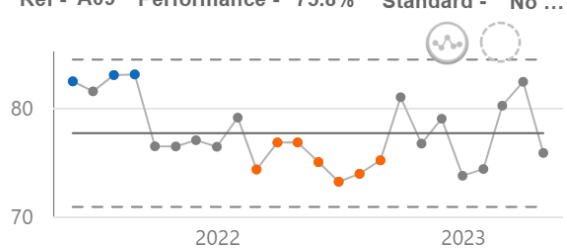
Ref - A08 Performance - 55.4% Standard - No ...



% PLT Ward Referrals seen within 24 hours

Low (No Standard)

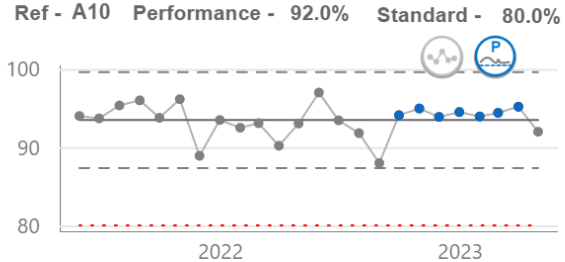
Ref - A09 Performance - 75.8% Standard - No ...



72 hour Follow-Up

Low (On Track)

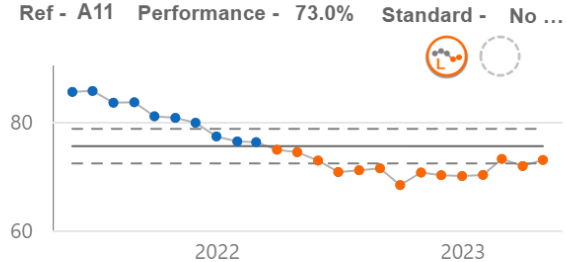
Ref - A10 Performance - 92.0% Standard - 80.0%



18 weeks wait to Treatment Adults & Older Adults

Med (Monitoring)

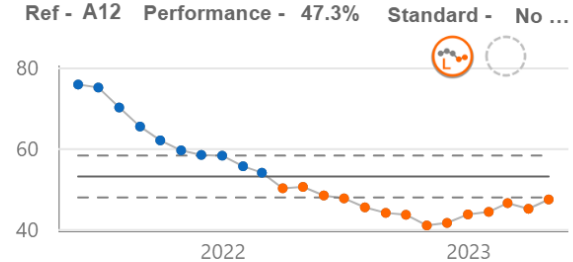
Ref - A11 Performance - 73.0% Standard - No ...



18 weeks waits to Treatment - All CYPS

Med (Monitoring)

Ref - A12 Performance - 47.3% Standard - No ...



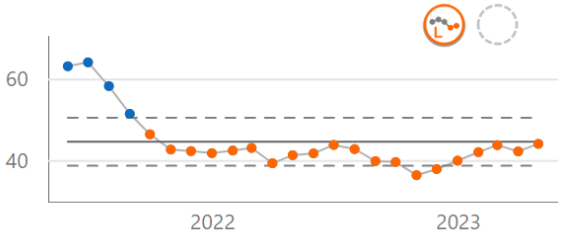
Person Led Care, when and where it's needed

Reporting Period: May 2023

<18 wk waits to Treatment CYPS Neurodevelopmental

Med (Monitoring)

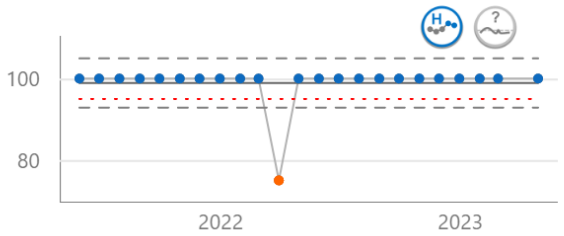
Ref - A13 Performance - 44.0% Standard - No ...



CYPS Eating Disorders (urgent referrals)

Low (On Track)

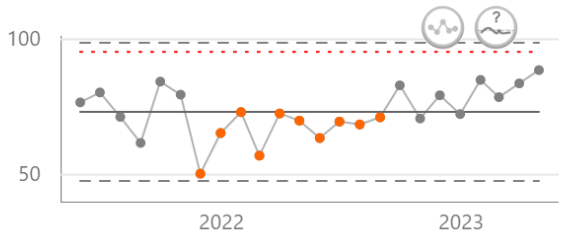
Ref - A02 Performance - 100.0% Standard - 95.0%



CYPS Eating Disorders (routine referrals)

Med (Monitoring)

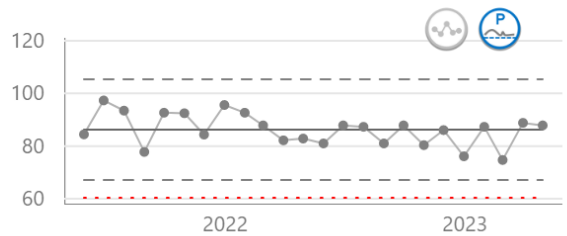
Ref - A15 Performance - 88.2% Standard - 95.0%



EIP – starting treatment in 14 days

Low (On Track)

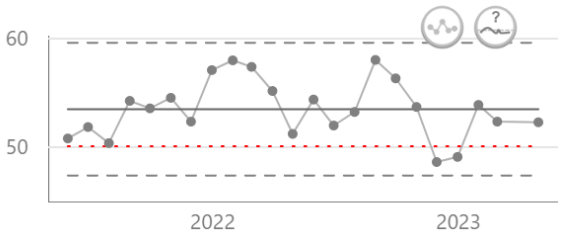
Ref - A16 Performance - 87.5% Standard - 60.0%



Talking Therapies % Moving to Recovery (IAPT)

Low (On Track)

Ref - A17 Performance - 52.2% Standard - 50.0%



Sustainable for the Long Term - Headline Commentary

Reporting Period: May 2023

Headline Challenges

- Trend of increased staffing levels across the Trust beyond the level affordable with agreed resource envelopes across services & departments.
- Pressure on several inpatient wards to deliver services within revised baseline staffing establishments. Three of the four clinical groups showing inpatient pressures.
- Within Corporate Services a vacancy freeze has been agreed and implemented.

Key focus areas of concern

- **Month 2 overspend.**
- **Capital programme over committed.**
- **Cost Improvement Plan (CIP) Delivery.**
- **Cash balances in future.**
- **Underlying financial position.**

Positive Assurance / Improvement

- Current Trust cash balances.
- Commitment of Senior management to improve financial performance.

Mitigations/actions

- BDG monthly finance focus sessions to agree actions to impact on the Trust financial position.
- Groups / Departments highlighted areas under review to impact on financial performance. BDG discussions to clarify where they improve financial forecast.
- Daily staffing reviews taking place across inpatient areas.
- Pursing capital funding to support cash balances.

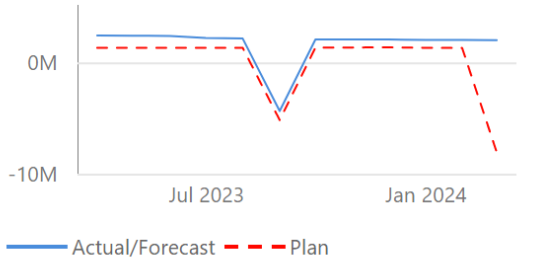
Sustainable for the Long Term

Reporting Period: May 2023

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

High (Action)

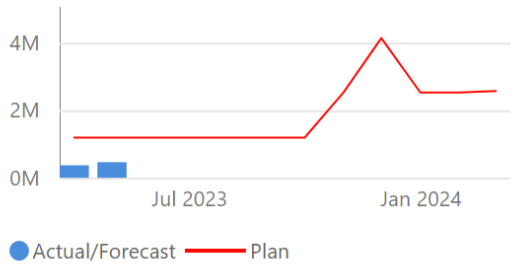
Ref - S01 Actual/Forecast - 2.4M Plan - 1.32M



Capital spend compared to plan (£)

Low (On Track)

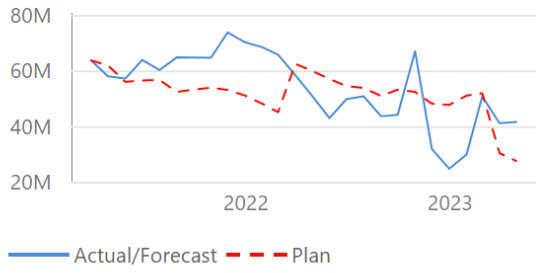
Ref - S02 Actual/Forecast - 0.5M Plan - 1.19M



Cash balance compared to plan (£)

Low (On Track)

Ref - S03 Actual/Forecast - 41.5M Plan - 27.4M



Were you given helpful information?

Were you given information that was helpful?

Risk Rating - Med (Monitoring)

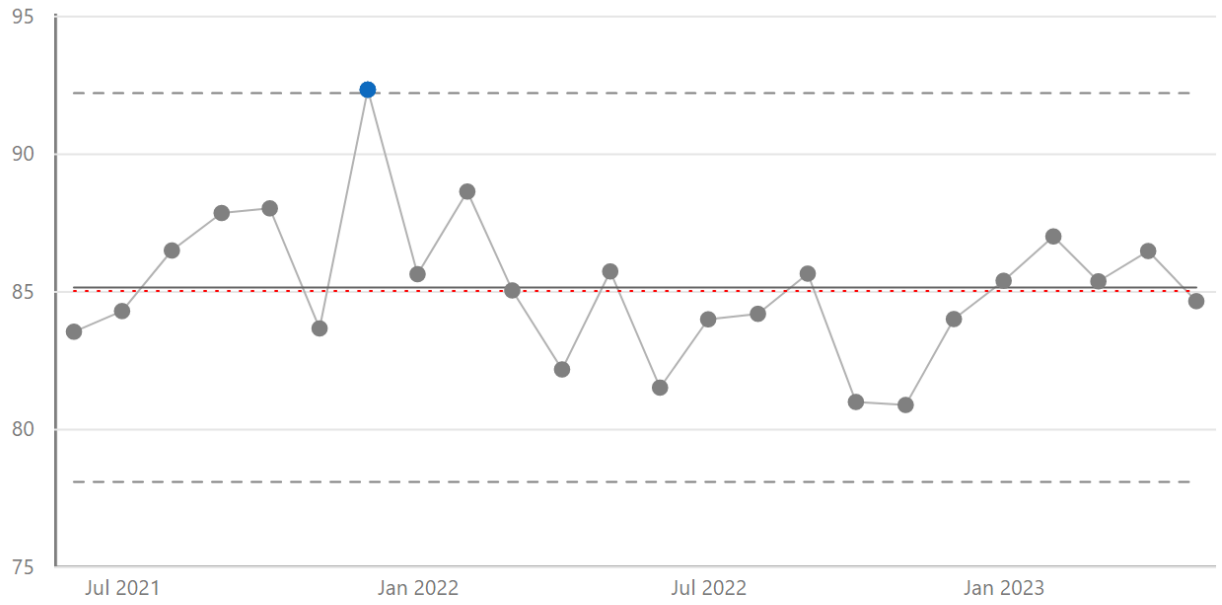
Performance - 84.6%

Standard - 85.0%

Achieve at Random
The standard for this indicator is within the upper and lower control limits

Normal Variation
The variation for this indicator is within the control limits

DQ - Investigation
There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance

No Locality breakdown currently available

Feedback

What the chart tells us?
Performance is consistently between 78% and 92%, averaging 85%. The standard of 85% falls within the expected performance range indicating that it continues to be likely to be achieved some months but not others.

Root cause of the performance issue
84.6% of service users and carers answering the question said 'yes' during May. With 10% answering 'no'. Themes associated with people saying no include information not being made available and it being out of date or inappropriate when it was offered.

Improvement Actions
Improve staff knowledge of the intranet page 'health literacy' which has guidance and training that supports staff to produce accessible information as well as be curious about the communication needs of service users and carers.
Link in to ICS health literacy workstreams to stay up to date with current approaches and be part of research and development in this area.

Expected impact and by when?
6-12 months

Turnover

Turnover FTE 12 month rolling

Risk Rating - High (Action)

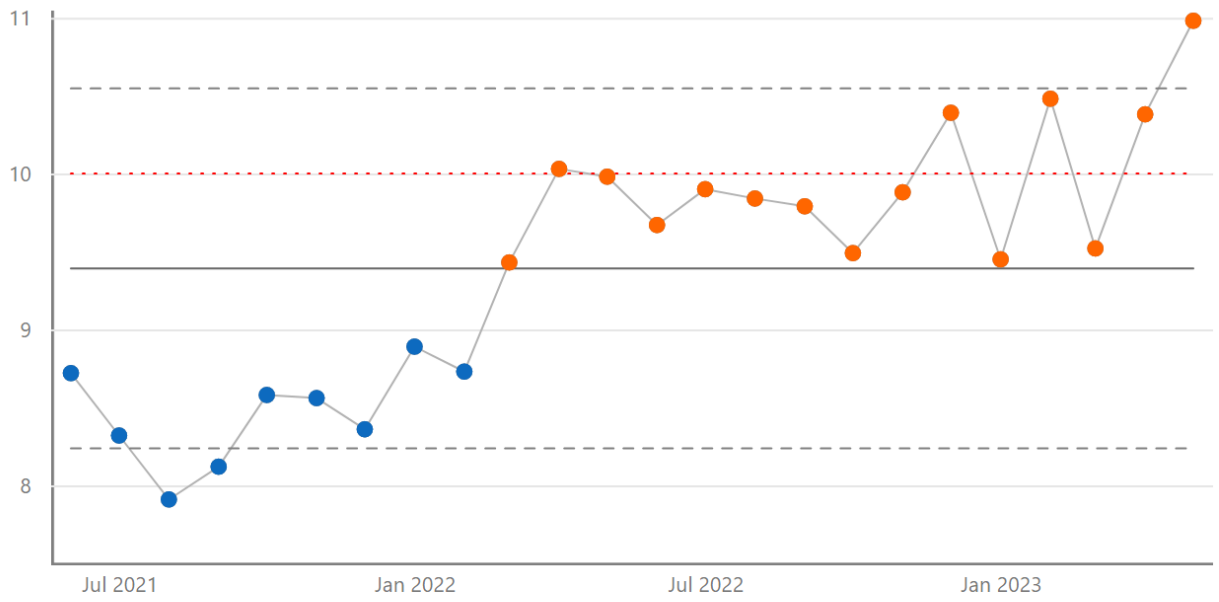
Performance - 11.0%

Standard - 10.0%

Achieve at Random
The standard for this indicator is within the upper and lower control limits

Concern
There is concern because this indicator is increasing

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	9.9%	10.0%	Normal Variation	Achieve at Random
North Cumbria Locality Care Group	11.9%	10.0%	Concern	Achieve at Random
North Locality Care Group	8.8%	10.0%	Normal Variation	Consistently Achieve
South Locality Care Group	9.4%	10.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us?
The chart indicates that there has been a discernible increase in the turnover rate since March 2022, and the expected range of 8.2% to 10.5% is increasing. Turnover in May was 10.98% which falls above that range.

Root cause of the performance issue
- Recruitment
- Retention

Improvement Actions
- Central and North emailing staff on Leavers report, inviting them to complete exit questionnaire/interview
- New Starter process pilot in North Cumbria (flow chart for Managers)

Expected impact and by when?
- Fill vacancies – 6-8 weeks
- Increased response rate to exit questionnaire – ongoing
- New Starter process review – 6 months

Sickness in Month

Percentage of in month sickness absence

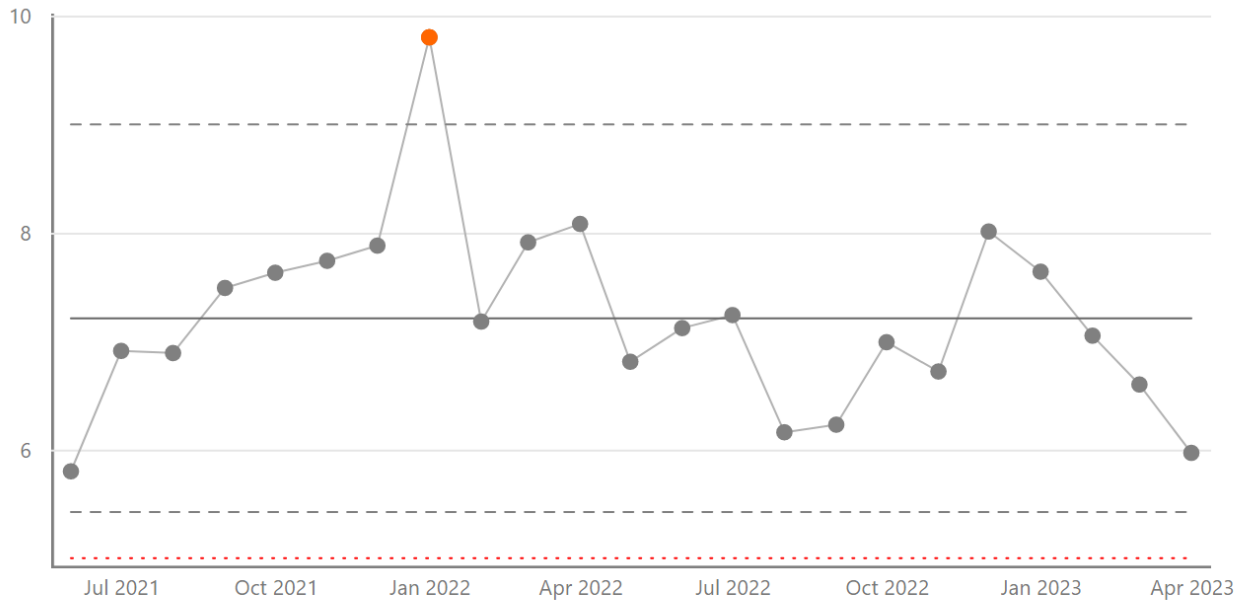
Risk Rating - High (Action)

Performance - 6.0%
Standard - 5.0%

Consistently Fail
The standard for this indicator is outside the control limits

Normal Variation
The variation for this indicator is within the control limits

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	6.4%	5.0%	Normal Variation	Consistently Fail
North Cumbria Locality Care Group	6.6%	5.0%	Normal Variation	Consistently Fail
North Locality Care Group	6.4%	5.0%	Normal Variation	Consistently Fail
South Locality Care Group	6.3%	5.0%	Normal Variation	Consistently Fail

Feedback

What the chart tells us?
The chart shows consistent performance since February 2022, with an expected range between 5.4% and 9.0% and an average of 7.2%. There is no indication that the 5% standard will be met in the near future.

Root cause of the performance issue
- High mental health related absences
- Recovery from covid pandemic
- Covid related absence
- High Musculoskeletal issues

Improvement Actions
- Mental health absence review in all localities
- Workforce support for managers and staff
- Wellness Support Team – support Short Term Sickness Review Point 1 meetings and improved early intervention
- Increased support staff psychological centre
- Improved access to Musculoskeletal services
- Reminder for Occupational Health appointments

Expected impact and by when?
- Short term frequent sickness cases are being reviewed
- More staff being seen by staff psychological centre
- Workforce support – reduced number of days absent, robust support - ongoing
- More Review Point meetings taken place and support mechanisms identified at an early point
- Reduction in DNA for OH appointment

Training Compliance - All standards

Training compliance - All standards

Risk Rating - **Med (Monitoring)**

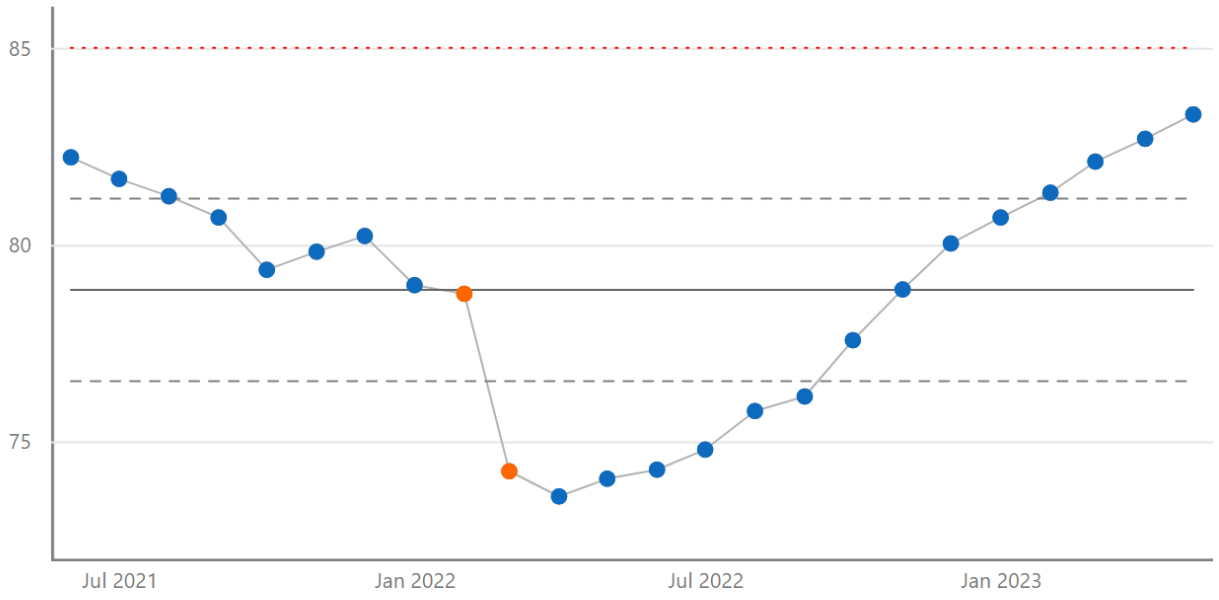
Performance - 83.3%

Standard - 85.0%

Consistently Fail
The standard for this indicator is outside the control limits

Improvement
This indicator is increasing which shows improvement

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	84.4%	85.0%	Improvement	Consistently Fail
North Cumbria Locality Care Group	80.7%	85.0%	Improvement	Consistently Fail
North Locality Care Group	84.3%	85.0%	Improvement	Consistently Fail
South Locality Care Group	86.4%	85.0%	Improvement	Achieve at Random

Feedback

What the chart tells us?
Training Compliance has risen every month since April 2022. In May2023 compliance stood at 83.3%, below the standard of 85%.

Root cause of the performance issue
- Capacity to release for training
- Late cancellations due to clinical activity

Improvement Actions
- Promotion of available methods to access training
- Train the trainer in LD & Autism CBU for core LD training
- Improve IG training rates
- Arranging bespoke training e.g., MHA MCA DoLS

Expected impact and by when?
- LD training improved completion rate – 1-2 months
- IG training – sharing figures with CMs and through CMT/QS&O meetings – ongoing
- MHA MCA DoLs improved completion rate – 1-2 months

Appraisal rate

Appraisal rate

Risk Rating - **High (Action)**

Performance - 78.4%

Standard - 85.0%

Consistently Fail

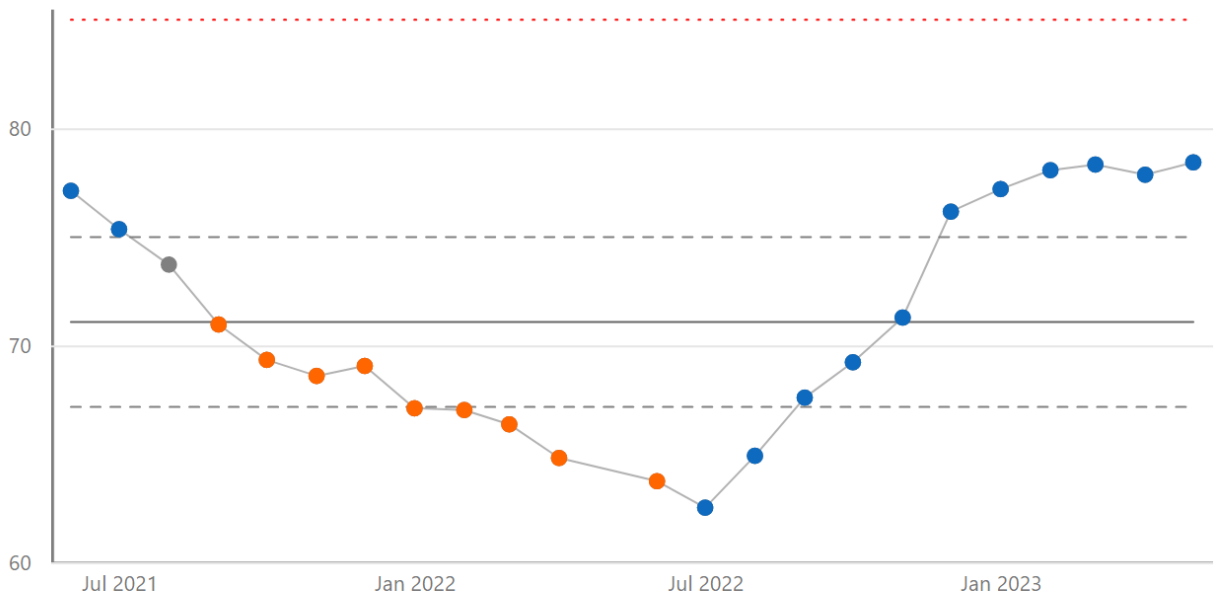
The standard for this indicator is outside the control limits

Improvement

This indicator is increasing which shows improvement

DQ - No Concern

There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	78.6%	85.0%	Improvement	Consistently Fail
North Cumbria Locality Care Group	78.0%	85.0%	Improvement	Consistently Fail
North Locality Care Group	73.9%	85.0%	Improvement	Consistently Fail
South Locality Care Group	84.1%	85.0%	Improvement	Consistently Fail

Feedback

What the chart tells us?
Appraisal Rate increased slightly to 78.4% in May 2023 and remains below the standard of 85%. There has been a general upward trend since July 2022.

Root cause of the performance issue
- Capacity to prepare and undertake appraisal
- Backlog during pandemic
- Late cancellations due to clinical activity

Improvement Actions
- Promoted through locality Workforce Meeting

Expected impact and by when?
- Improved appraisal rates – ongoing

% Clinical Supervision completed

Clinical Supervision

Risk Rating - High (Action)

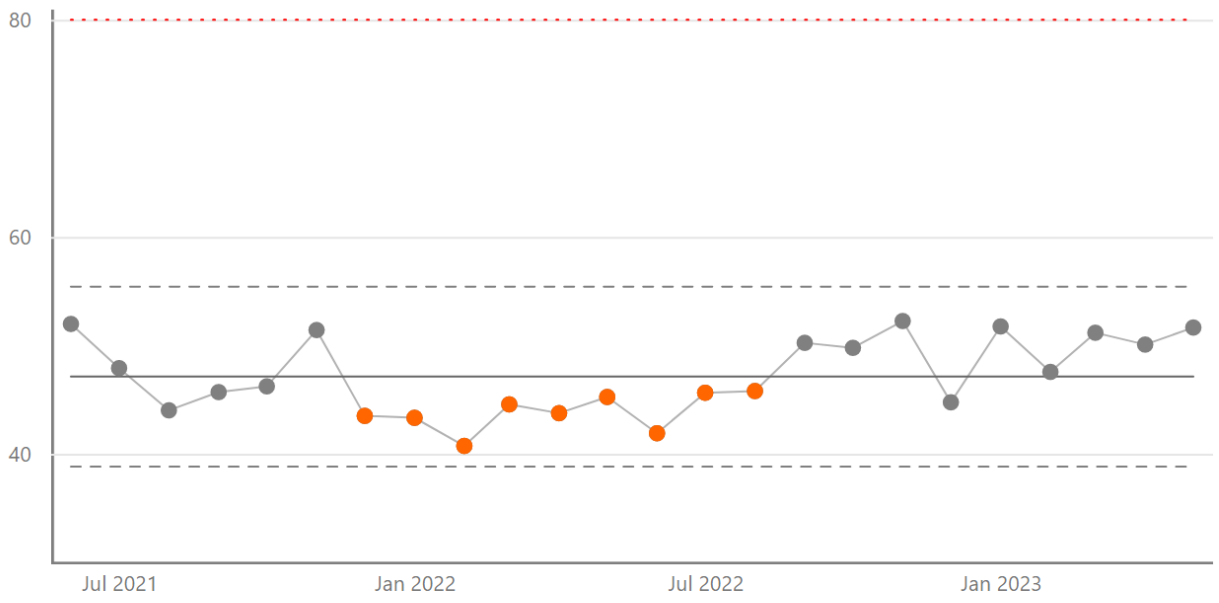
Performance - 51.6%

Standard - 80.0%

Consistently Fail
The standard for this indicator is outside the control limits

Normal Variation
The variation for this indicator is within the control limits

DQ - Investigation
There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	49.7%	80.0%	Normal Variation	Consistently Fail
North Cumbria Locality Care Group	46.0%	80.0%	Normal Variation	Consistently Fail
North Locality Care Group	50.4%	80.0%	Normal Variation	Consistently Fail
South Locality Care Group	61.8%	80.0%	Normal Variation	Consistently Fail

Feedback

What the chart tells us?
Clinical Supervision was 51.6% in May 2023, above the average 47% over the two year period but below the 80% standard.

Root cause of the performance issue
- Capacity to release to undertake supervision
- Late cancellations due to clinical activity
- Electronic system is not being updated by staff to reflect supervision has been completed

Improvement Actions
- Promoted through locality Workforce Meeting

Expected impact and by when?
- Improved completion rate – ongoing

Serious Incidents

Number of Serious Incidents

Risk Rating - High (Action)

Performance - 21

Standard - No Std

No Standard

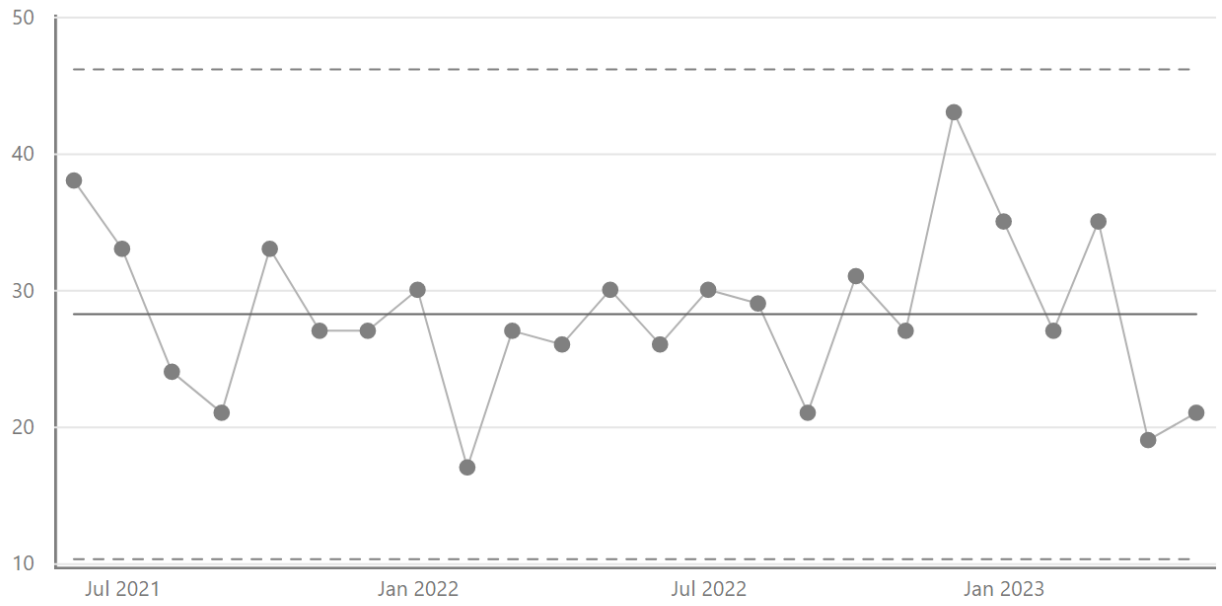
Assurance cannot be given for this indicator as there is no standard set

Normal Variation

The variation for this indicator is within the control limits

DQ - No Concern

There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	6	No Std	Normal Variation	No Standard
North Cumbria Locality Care Group	5	No Std	Normal Variation	No Standard
North Locality Care Group	6	No Std	Normal Variation	No Standard
South Locality Care Group	4	No Std	Normal Variation	No Standard

Feedback

Root cause of the performance issue
There is no significant variation in the trend for the last two years. This measure is being included in this report due to the significance and magnitude of these incidents.

Improvement Actions
Each serious incident is subject to an investigation which identifies areas of learning and recommendations. This forms an action plan and is subject to The Trust and ICB governance processes to ensure that learning is embedded.
A theme identified in recent serious incident investigations has been in relation to observation and engagement levels and the implementation of this on the wards. An action identified was to ensure that all clinical staff working on an inpatient unit undertake the Trust Mandatory engagement and observation training and competency to ensure that staff are aware of the expectations and requirements.

Expected impact and by when?
It is expected that by July 2023 all staff will have undertaken this training and be proficient in this competency.

Safeguarding and Public Protection (SAPP)

Safeguarding and Public Protection (SAPP)

Risk Rating - Med (Monitoring)

Performance - 1,557

Standard - No Std

No Standard

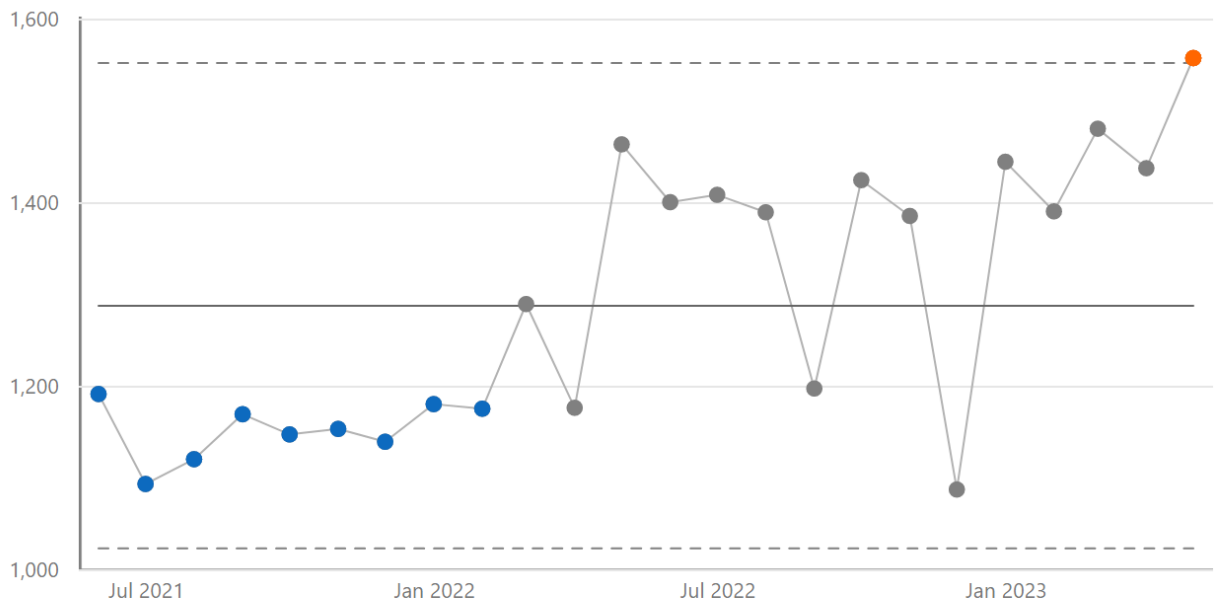
Assurance cannot be given for this indicator as there is no standard set

Concern

There is concern because this indicator is increasing

DQ - No Concern

There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	478	No Std	Normal Variation	No Standard
North Cumbria Locality Care Group	184	No Std	Concern	No Standard
North Locality Care Group	482	No Std	Concern	No Standard
South Locality Care Group	398	No Std	Normal Variation	No Standard

Feedback

What the chart tells us?
Performance in May 2023 was 1,557 which is higher than the expected range of 1,022 to 1,551 suggesting that there may be a cause for this increase rather just the than normal monthly variation.

Root cause of the performance issue
In May reported safeguarding activity breached the upper control (1552). however increased safeguarding reporting is in line with national trends and linked to greater awareness because of the rollout of level 3 training.
In addition, the expected impact of focussed work of the SAPP team has increased reporting in some localities.

Improvement Actions
SAPP team have oversight of all reported safeguarding incidents and continue to provide support advice and supervision where required across all clinical localities.

Expected impact and by when?
Not anticipated that safeguarding activity will decrease current activity levels are accepted as eth new norm.

Aggression and Violence

Aggression and Violence

Risk Rating - Med (Monitoring)

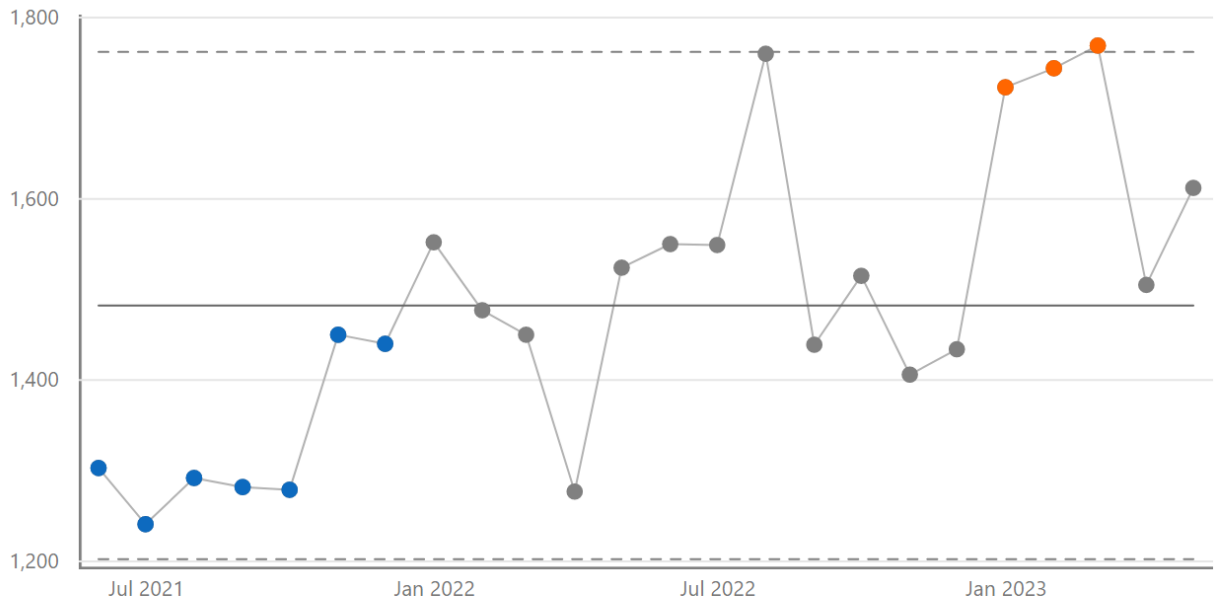
Performance - 1,611

Standard - No Std

No Standard
Assurance cannot be given for this indicator as there is no standard set

Normal Variation
The variation for this indicator is within the control limits

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	218	No Std	Normal Variation	No Standard
North Cumbria Locality Care Group	600	No Std	Concern	No Standard
North Locality Care Group	465	No Std	Normal Variation	No Standard
South Locality Care Group	324	No Std	Normal Variation	No Standard

Feedback

What the chart tells us?
There were 1,611 incidents of aggression and violence in May 2023 which is within the expected range of 1,201 and 1,761. This suggests the number is within normal expected monthly variation rather than there being any underlying cause for the change.

Root Cause of the Performance Issue
- Aggression and violence incidents for month 2 have continued to rise in comparison to previous periods and in direct comparison to May last year, however the 4% increase in aggression and violence incidents is only 1% higher than the increase on all incidents for the same period.
- Aggression and violence incidents link to the patient profile of the Trust each month, and changes in activity can be seen from moment of admission to discharge. A small number of patients can account for a significant number of incidents of aggression and violence incidents. The top 3 patients are all in the same service and account for all the rise in May in comparison to the previous year.

Improvement Actions
- Clinical and operational teams in in-patient services have plans in place to minimise harm from aggression and violence incidents, down to individual patient care planning.

Expected impact and by when?
- It is expected that aggression and violence incidents will rise and fall in line with incident reporting as it accounts for 30% of incidents, no targets are set. However as development and an important consideration , future reporting will also consider by actual impact and psychological impact for aggression and violence incidents.

Care Plans compliance

Care Plans compliance

Risk Rating - Med (Monitoring)

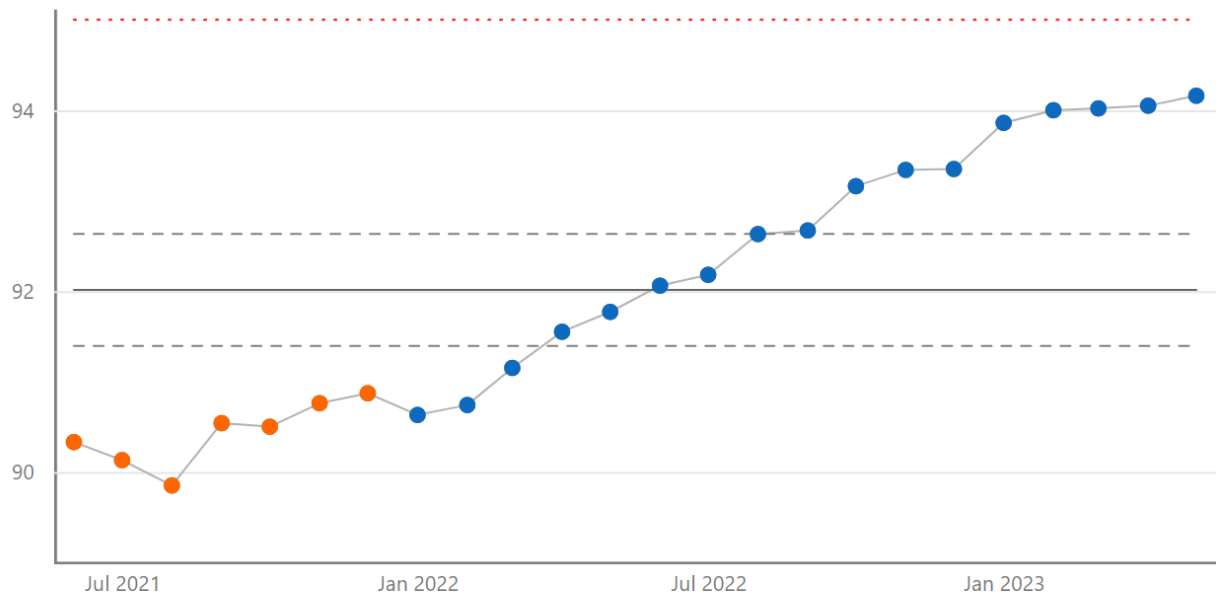
Performance - 94.2%

Standard - 95.0%

Consistently Fail
The standard for this indicator is outside the control limits

Improvement
This indicator is increasing which shows improvement

DQ - Investigation
There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	95.6%	No Std	Improvement	No Standard
North Cumbria Locality Care Group	87.2%	No Std	Improvement	No Standard
North Locality Care Group	96.7%	No Std	Improvement	No Standard
South Locality Care Group	93.4%	No Std	Improvement	No Standard

Feedback

What the chart tells us?
Care plans compliance has risen steadily from 90.6% in January 2022 to 94.2% in May 2023, which remains below the standard of 95%.

Root cause of the performance issue
This metric is improving; however, work is ongoing to identify those pathways and patients which need to be excluded from this metric to provide additional assurance that the denominator is accurate.
The numerator is being review also to potentially include where the care plan has been discussed with a guardian, parent, or poxy contact when it is not appropriate to discuss the care plan with the patient.

Improvement Actions
Metric redefinition process is underway.

Expected impact and by when?
Metric definition to be assessed during Quarter 2.

Risk Assessments compliance

Risk Assessments compliance

Risk Rating - **Med (Monitoring)**

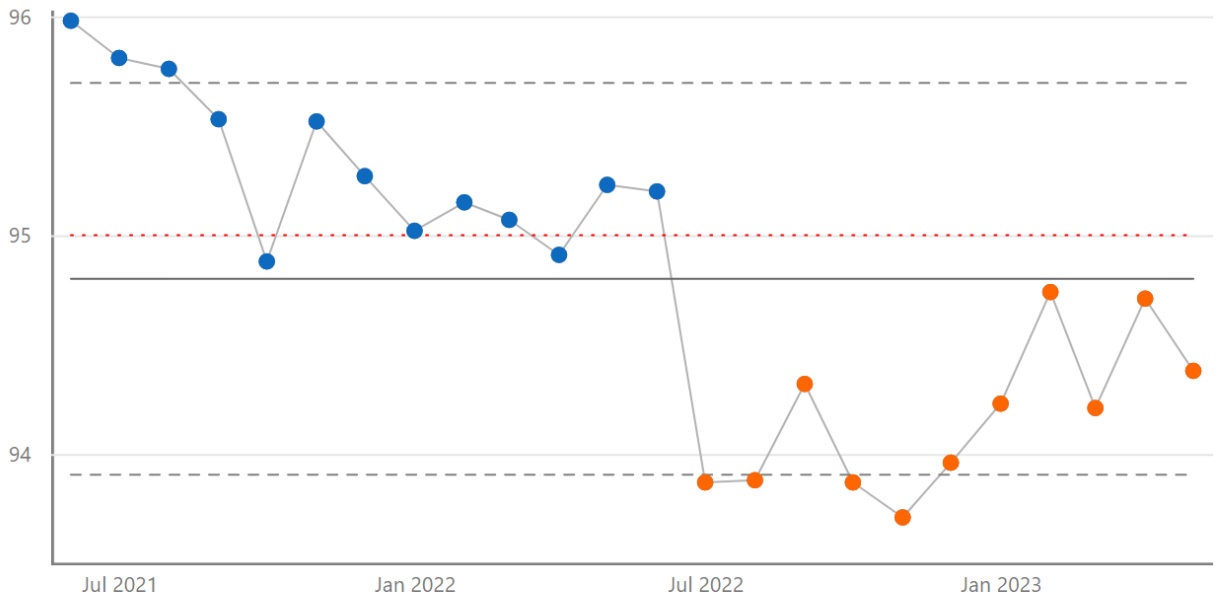
Performance - 94.4%

Standard - 95.0%

Achieve at Random
The standard for this indicator is within the upper and lower control limits

Concern
There is concern because this indicator is decreasing

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	96.0%	No Std	Normal Variation	No Standard
North Cumbria Locality Care Group	87.7%	No Std	Concern	No Standard
North Locality Care Group	97.4%	No Std	Normal Variation	No Standard
South Locality Care Group	95.9%	No Std	Normal Variation	No Standard

Feedback

Root cause of the performance issue
The metric is performing above target.

Improvement Actions
Continued identification of patients requiring a new Narrative or FACE risk assessment, either as part of the CPA process or due to any significant change.
Key part of the management supervision process.

Expected impact and by when?
That the risk assessment metric remains above target.

CPA Completed review

Risk Rating - High (Action)

Number of current Service Users, aged 18 or over, who were on CPA for at least 12, who have had a review in the last 12 months.

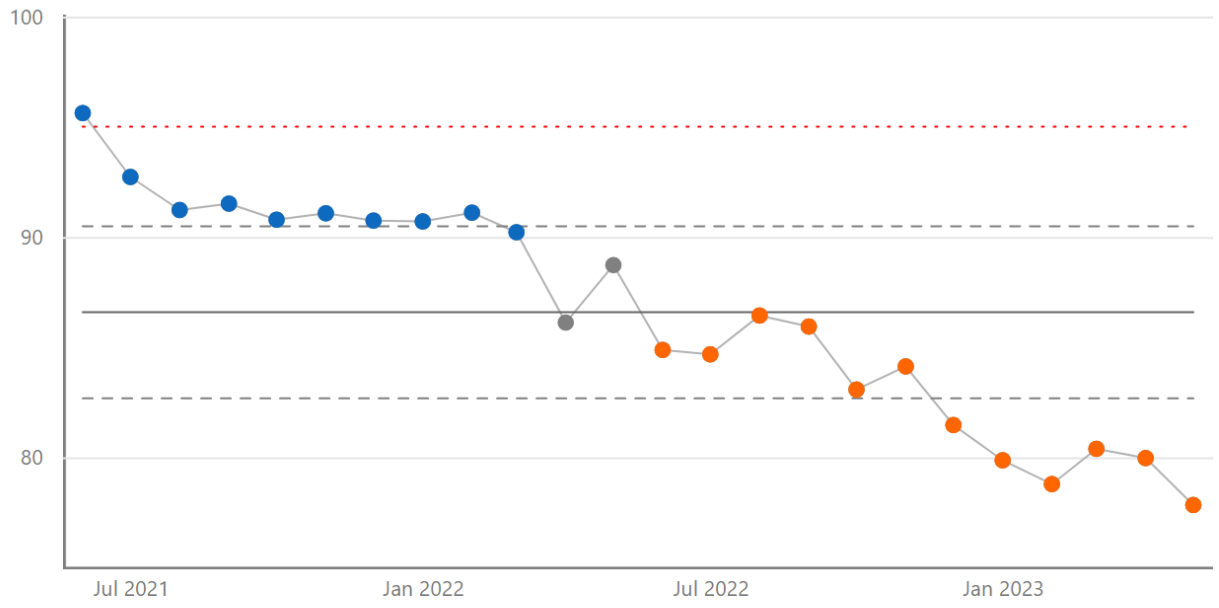
Performance - 77.8%

Standard - 95.0%

Consistently Fail
The standard for this indicator is outside the control limits

Concern
There is concern because this indicator is decreasing

DQ - Investigation
There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	86.4%	No Std	Concern	No Standard
North Cumbria Locality Care Group	47.2%	No Std	Concern	No Standard
North Locality Care Group	92.6%	No Std	Normal Variation	No Standard
South Locality Care Group	81.9%	No Std	Concern	No Standard

Feedback

What the chart tells us?
CPA completed review has fallen steadily over the two year period from 95.6% in June 2021 to 77.8% in May 2023, now below the standard of 95%.

Root cause of the performance issue
The CPA Review Form completion has reduced, however risk assessments for the same group of patients remains high. This indicates the CPA Review Form as part of the review process, which includes updating the care plan, cluster, risk assessment, getting to know you, employment and accommodation etc, is being missed as part of the process.

Improvement Actions
Internal CPA metrics are being reviewed as part of the community transformation process this will provide increased clarity for HCPs regarding the CPA process.

Expected impact and by when?
The review process will be completed by the end of 2023/24, this will inform and provide clarity for the ongoing clinical practice.

Staffing fill rates

Staffing fill rates - All day/night and Reg/Unreg

Risk Rating - **High (Action)**

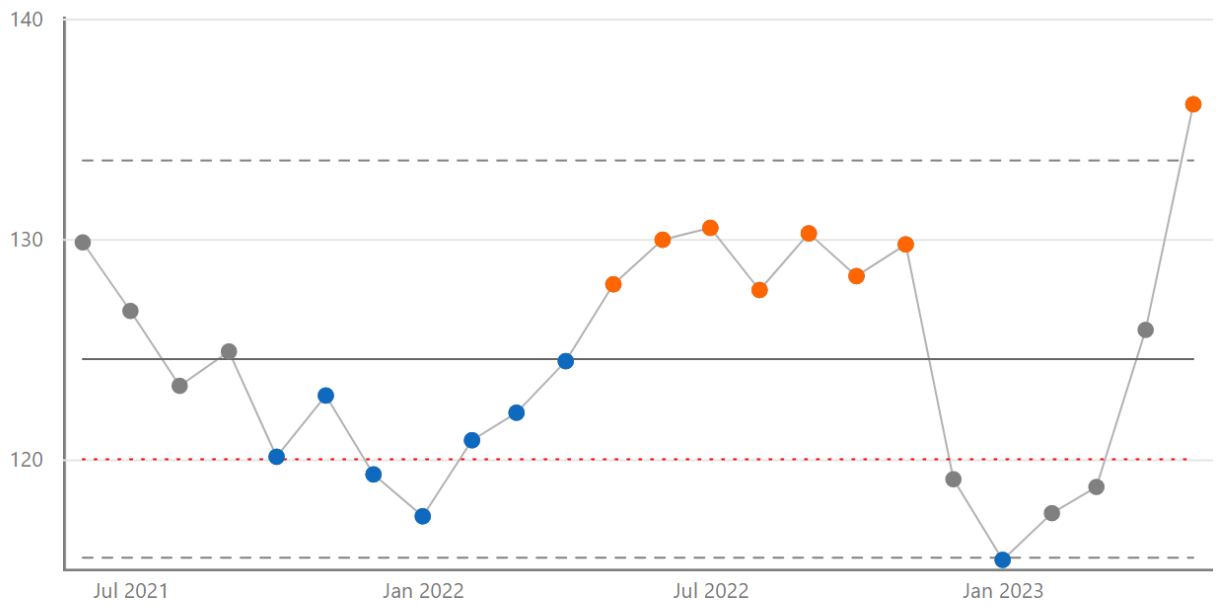
Performance - 136.1%

Standard - 120.0%

Achieve at Random
The standard for this indicator is within the upper and lower control limits

Concern
There is concern because this indicator is increasing

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	142.6%	No Std	Concern	No Standard
North Cumbria Locality Care Group	137.5%	No Std	Concern	No Standard
North Locality Care Group	128.7%	No Std	Normal Variation	No Standard
South Locality Care Group	135.4%	No Std	Concern	No Standard

Feedback

What the chart tells us?
Staffing fill rate was 136% in May 2023, higher than the expected range of 115% to 133% which suggests that there may be a cause over and above normal monthly variation.

Root cause of the performance issue
There are several vacancies across inpatients.

Improvement Actions
Recruitment and retention activities are underway.
Rollout of new shift allocation software across wards.
Reviews of all agency usage.
Preceptorship/newly qualified nurse changes to gain experience on inpatients

Expected impact and by when?
That there is a safe reduction in agency and locum usage during 2023/24, alongside an increase in the number of substantive CNTW staff working on the wards.

Out of Area Placement bed days

Out of Area Placement bed days

Risk Rating - **High (Action)**

Performance - 375

Standard - 217

Achieve at Random

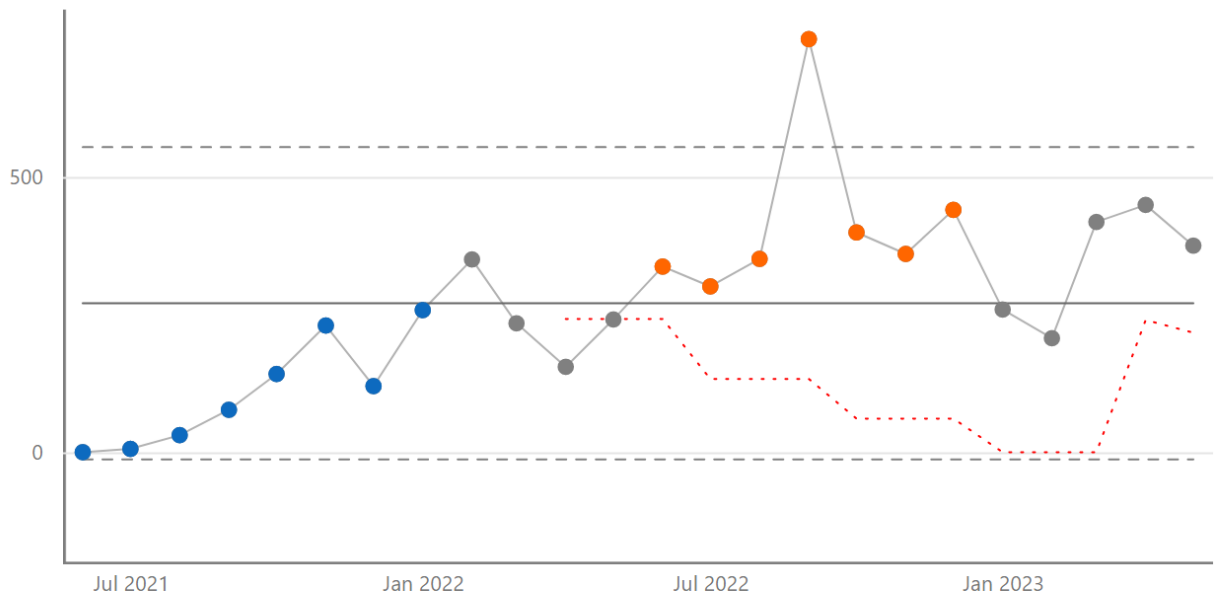
The standard for this indicator is within the upper and lower control limits

Normal Variation

The variation for this indicator is within the control limits

DQ - No Concern

There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance

No Locality breakdown currently available

Feedback

What the chart tells us?
There were 375 Out of Area placement days in May 2023, within the expected range of 0 to 553 days, compared to the trajectory of 217 days for Month 2 2023/4.

Root cause of the performance issue
Patient needing an inpatient admission when there are no appropriate CNTW beds available. The main pressure is within Adult Acute beds.

Improvement Actions
Working with Local Authorities to ensure there are effective discharge process in place to ensure that there are minimal barriers to discharge ensure an efficient flow through wards.
Continuous learning and development, sharing practices between wards to improve the therapeutic milieu impacting the length of stay.
Community transformation and improving services to prevent emergency admissions.

Expected impact and by when?
Reduction in the number of Out of Area beds usage.

Bed Occupancy including leave (open beds on RiO)

Bed Occupancy including leave (open beds on RiO)

Risk Rating - High (Action)

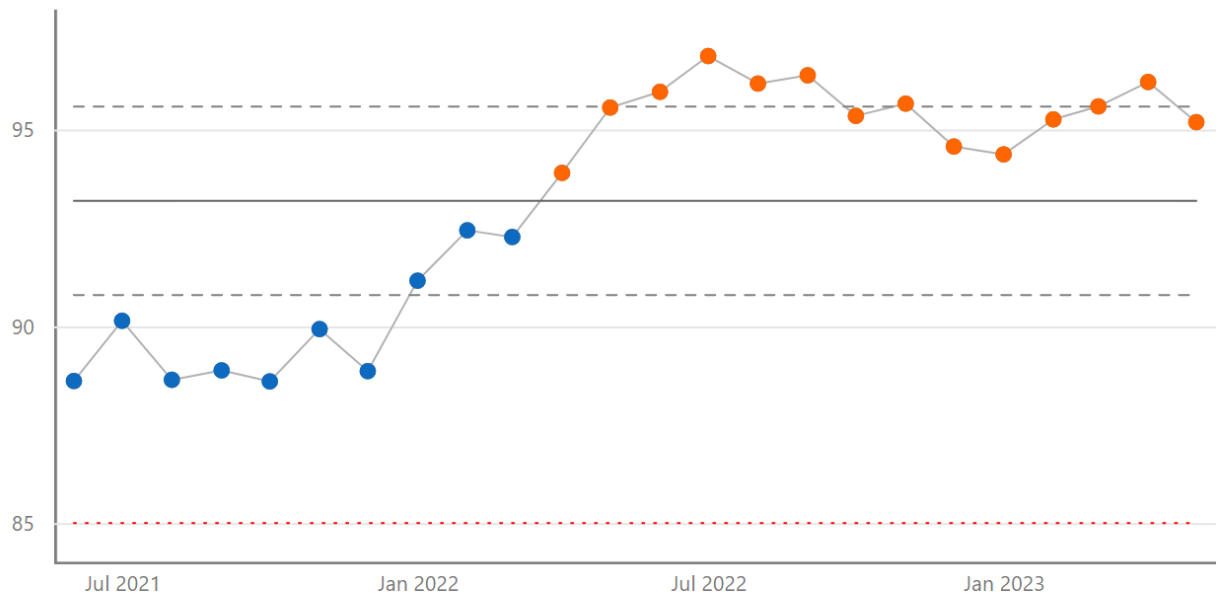
Performance - 95.2%

Standard - 85.0%

Consistently Fail
The standard for this indicator is outside the control limits

Concern
There is concern because this indicator is increasing

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	95.5%	No Std	Concern	No Standard
North Cumbria Locality Care Group	88.8%	No Std	Concern	No Standard
North Locality Care Group	94.2%	No Std	Improvement	No Standard
South Locality Care Group	98.0%	No Std	Concern	No Standard

Feedback

What the chart tells us?
Bed occupancy fell back to 95.1% which is within the expected range of 90.8% to 95.6%, though it is above the optimal level of 85%. There has been a discernible increase since April 2022. This sustained increase may suggest that occupancy is likely to continue at a higher level.

Root cause of the performance issue
More bed days are used than originally planned.

Improvement Actions
All patients are support via an MDT and are encouraged to set a planned discharge day.
New information tools have been shared with bed management.
Discharge flow teams are in place.
Community services transformation to prevent avoidable admissions.

Expected impact and by when?
Reduction in the number of bed days required by 31/02/2024.

Clinically Ready for Discharge (formerly DTOC)

Risk Rating - **High (Action)**

Percentage of patients clinically Ready for Discharge (formerly DTOCs) at the end of the month (Q&P Metric 298: Current Delayed Transfers of Care days (Incl Social Care)

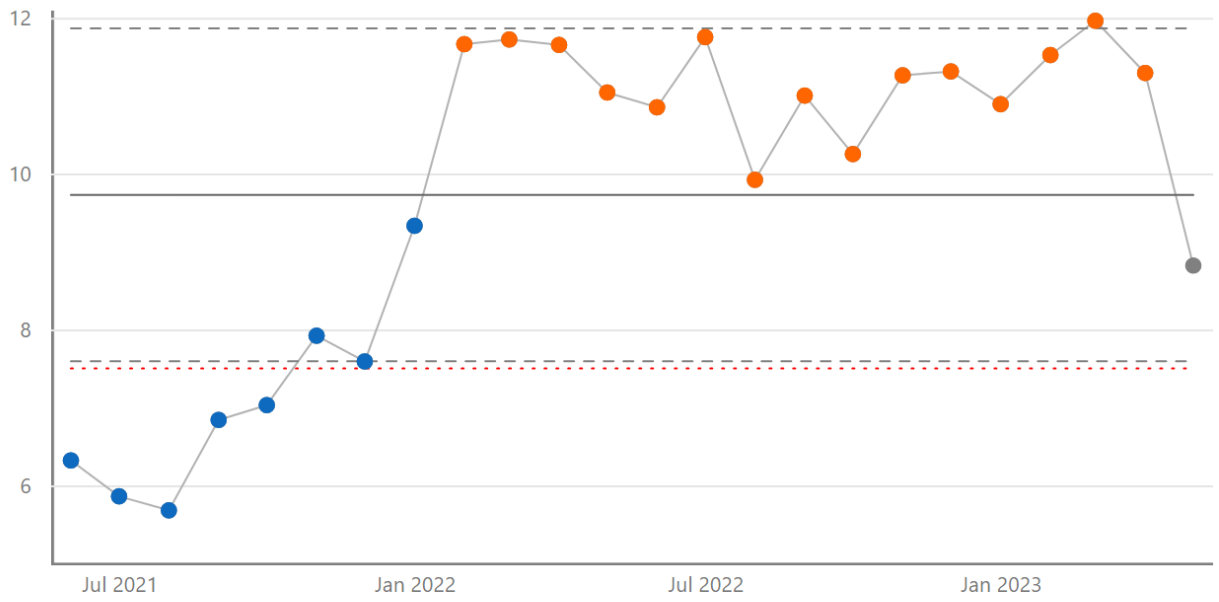
Performance - 8.8%

Standard - 7.5%

Consistently Fail
The standard for this indicator is outside the control limits

Normal Variation
The variation for this indicator is within the control limits

DQ - No Concern
There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	6.3%	No Std	Concern	No Standard
North Cumbria Locality Care Group	15.9%	No Std	Normal Variation	No Standard
North Locality Care Group	8.0%	No Std	Normal Variation	No Standard
South Locality Care Group	9.3%	No Std	Concern	No Standard

Feedback

What the chart tells us?
Performance was within the expected range of 7.5% to 11.8% in May 2023 and fell from an extended period of high numbers down to 8.8%.

Root cause of the performance issue
The availability of onward discharge destinations for patients that are clinically ready for discharge; delays caused by health (such as care agreements) or social care (such as housing)

Improvement Actions
- As reported last month – process remains similar
- Discharge plan for each patient is place supporting their timely discharge from the point of admission. Steps to recruit/explore opportunity for social works continues as felt this could support timely discharge via better coordination
- Weekly meetings across the localities to case manage patients discharges
- Exploring continuation funding for HomeGroup, though all areas are reporting this is unlikely to be funded via Better Care Fund.

Expected impact and by when?
- Some areas have capital investments at place to support flow such as building new properties (at scale) – however this a long term investment and not likely to impact for 18m+

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

Risk Rating - **Med (Monitoring)**

% of Urgent referrals to crisis service seen within 24 hours (Adults and OA)

Performance - 76.7%

Standard - No Std

No Standard

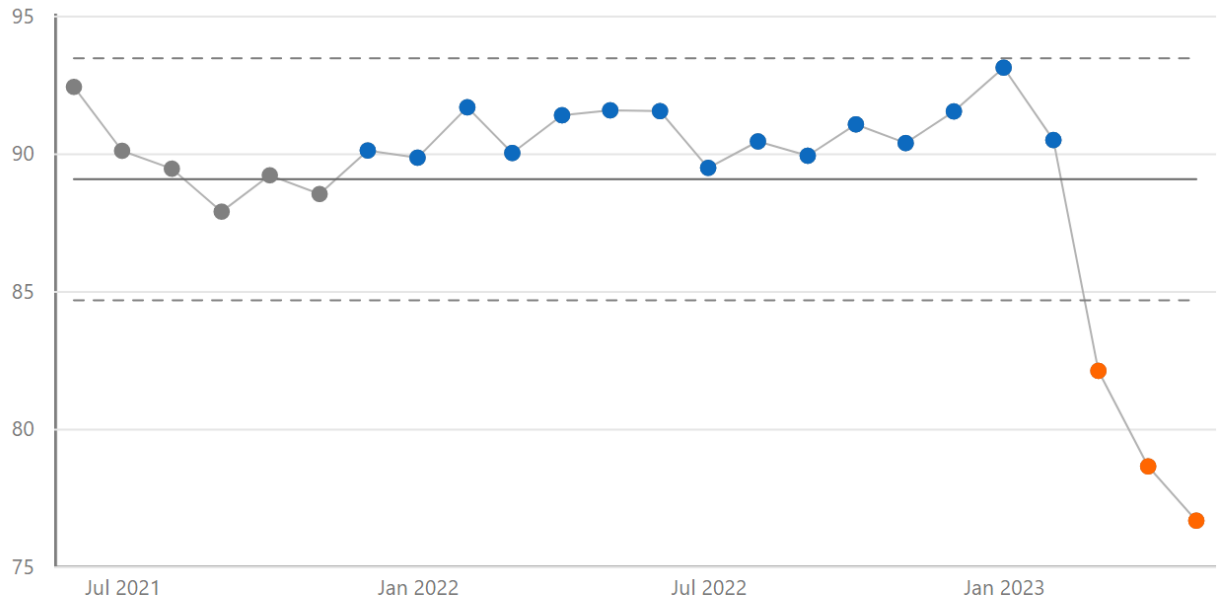
Assurance cannot be given for this indicator as there is no standard set

Concern

There is concern because this indicator is decreasing

DQ - No Concern

There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	77.6%	No Std	Concern	No Standard
North Cumbria Locality Care Group	85.2%	No Std	Concern	No Standard
North Locality Care Group	65.4%	No Std	Concern	No Standard
South Locality Care Group	82.6%	No Std	Normal Variation	No Standard

Feedback

What the chart tells us?
Urgent referrals seen within 24 hours decreased to 76.6% in May 2023. This is below the expected range of 85% to 93% for the third successive month, suggesting a change beyond the normal monthly variation.

Root cause of the performance issue
- Difference in models across the trust mean areas performance has variation
- Staffing (recruitment/retention/sickness) is a challenge
- Some breaches could be result of patient contacts i.e. not able to reach patient/patient DNAs etc

Improvement Actions
- Temp staff use to address staffing challenge
- Monitoring (dashboards) of patients to achieve target

Expected impact and by when?
- Impact would be achieving target in all areas

% PLT ED Referrals seen within 1 hour

Risk Rating - Med (Monitoring)

% Psychiatric Liaison Team Emergency Dept Referrals seen within 1 hour

Performance - 55.4%

Standard - No Std

No Standard

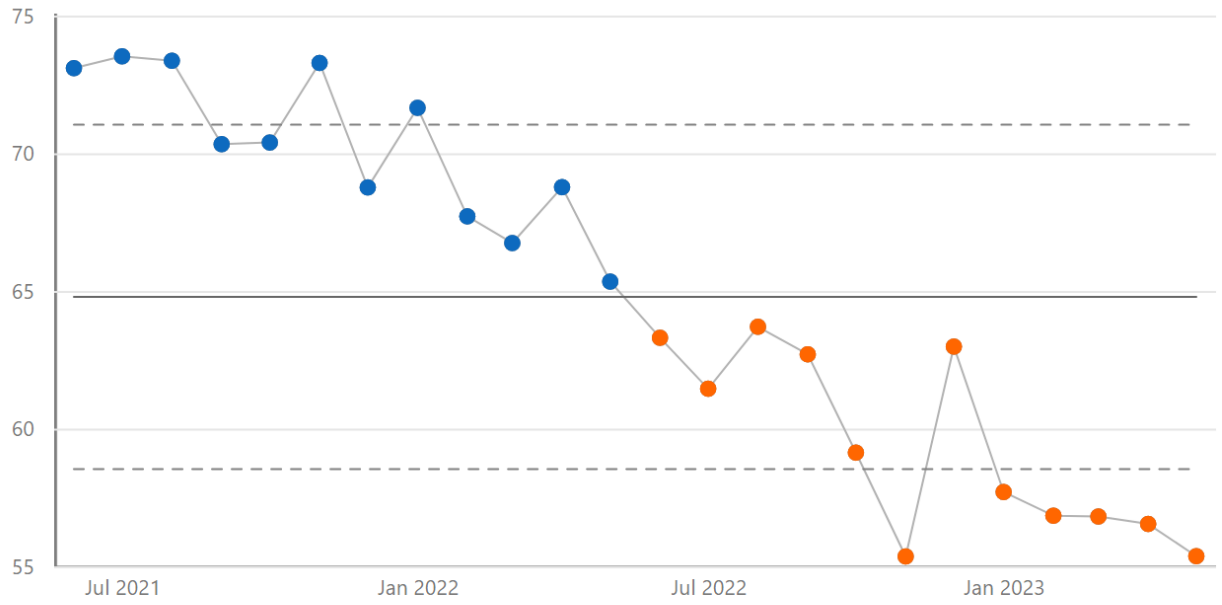
Assurance cannot be given for this indicator as there is no standard set

Concern

There is concern because this indicator is decreasing

DQ - No Concern

There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	45.1%	No Std	Concern	No Standard
North Cumbria Locality Care Group	65.3%	No Std	Concern	No Standard
North Locality Care Group	38.8%	No Std	Concern	No Standard
South Locality Care Group	73.5%	No Std	Normal Variation	No Standard

Feedback

What the chart tells us?
Performance was 55.4% in May 2023 which was below the expected range of 58% and 71%. A sustained period of performance below the average since May 2022 suggests there may be a cause for this decrease.

Root cause of the performance issue
- Difference in models across the trust mean areas performance has variation
- Staffing (recruitment/retention/sickness) is a challenge.
- Issue in some ED's re referrals being made when patients are not medically fit to be seen by PLT
- Increase in police bringing people to ED when not under section/no physical health need

Improvement Actions
- Temp staff use to address staffing challenge.
- Ongoing discussions with ED colleagues and Northumbria police force.

Expected impact and by when?
- Impact would be achieving 1hr target in all areas

18 weeks wait to Treatment Adults & Older Adults

Risk Rating - **Med (Monitoring)**

Percentage of referrals waiting < 18 weeks for treatment (from Q&P Metric 1873,1882)

Performance - 73.0%

Standard - No Std

No Standard

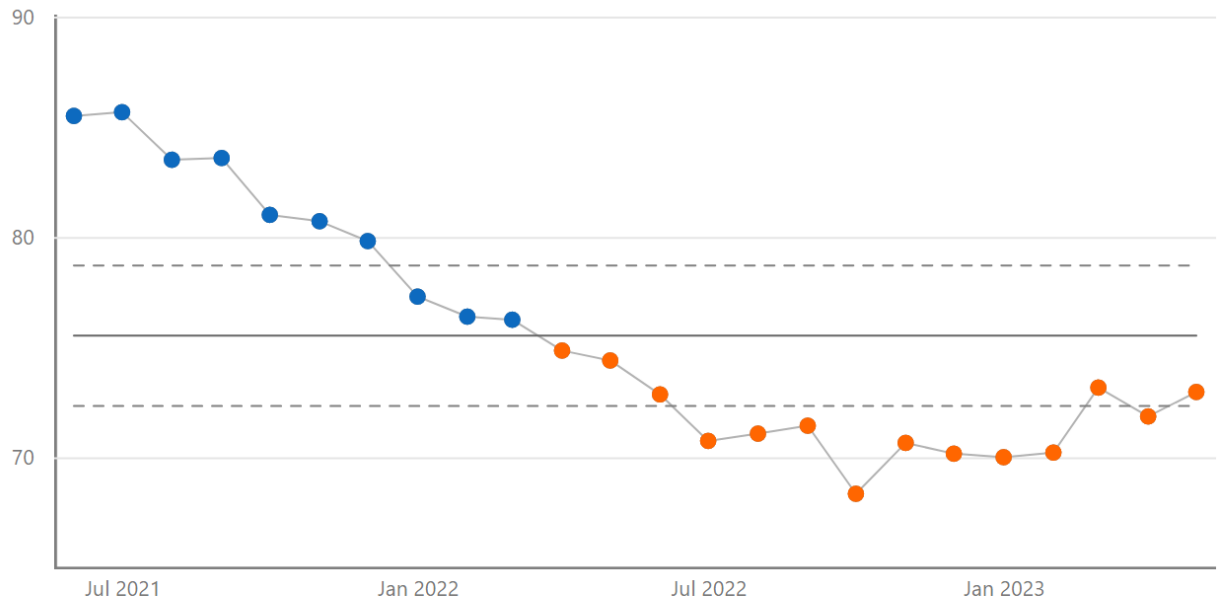
Assurance cannot be given for this indicator as there is no standard set

Concern

There is concern because this indicator is decreasing

DQ - Investigation

There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	81.2%	No Std	Normal Variation	No Standard
North Cumbria Locality Care Group	57.9%	No Std	Concern	No Standard
North Locality Care Group	83.5%	No Std	Concern	No Standard
South Locality Care Group	77.2%	No Std	Normal Variation	No Standard

Feedback

What the chart tells us?
Performance was at 73% in May 2023 and has remained similar since July 2022.

Root cause of the performance issue
- Increased referrals for Memory Assessment
- Staffing pressures resulting in significant floating caseloads (reallocations) in some teams, reducing the capacity for assessment and treatment of new referrals.

Improvement Actions
- Waiting list initiatives with Everyturn in Gateshead, Sunderland and North Cumbria
- Work to streamline admin processes
- Work with acute colleagues to access scans in a timely fashion
- Community transformation and new roles e.g. ARRS, Primary Care Mental Health workers etc
- Embedding new 4ww methodology

•Due to focussed performance work the Community Oversight Group have seen an improvement in numbers waiting overall
•Work is ongoing regarding identified data quality issues which include missing Outcomes and incorrect Referral Received Dates along with retrospective data entry

Expected impact and by when?
- Reduction in the number of people waiting over 4 weeks for treatment by Q4.

18 weeks waits to Treatment - All CYPS

Percentage of CYPS referrals waiting < 18 weeks for treatment (from Q&P Metric 1953)

Risk Rating - **Med (Monitoring)**

Performance - 47.3%

Standard - No Std

No Standard

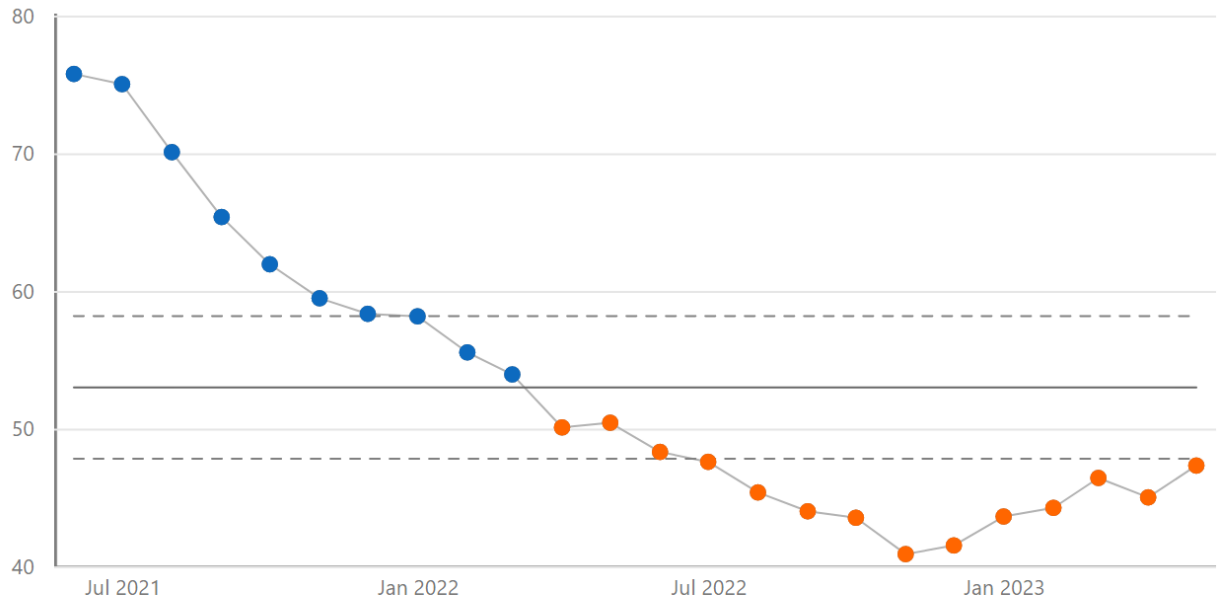
Assurance cannot be given for this indicator as there is no standard set

Concern

There is concern because this indicator is decreasing

DQ - Investigation

There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	40.0%	No Std	Improvement	No Standard
North Cumbria Locality Care Group	52.8%	No Std	Concern	No Standard
North Locality Care Group	91.4%	No Std	Concern	No Standard
South Locality Care Group	38.9%	No Std	Concern	No Standard

Feedback

What the chart tells us?
Performance has 47.3% in May 2023 and has shown a gradual increase from 40.9% in November 2022.

Root cause of the performance issue

- The trajectory for the longest waiters for CAMHS has been increasing, however there is now a reducing trend in some areas. The two main issues have been the increase in complexity of presentations to services, and an increasing trend of referrals, particularly in Neurodevelopmental assessment pathways.

Improvement Actions

- Additional capacity has been commissioned from the independent sector.
- Work is underway in all areas to increase patient flow.
- Dedicated workstreams are evaluating the next steps to reduce the number of children and young people waiting.
- Work with system partners to improve support in the community both pre and post diagnosis for CYP with suspected neurodevelopmental issues.

Expected impact and by when?

- Reduction in the number of people waiting over 4 weeks for help by Q4.

<18 wk waits to Treatment CYPS Neurodevelopmental

Risk Rating - Med (Monitoring)

Percentage of CYPS Neuro referrals waiting < 18 weeks for treatment filtered by team & referral reason from (Q&P Metric 1953)

Performance - 44.0%

Standard - No Std

No Standard

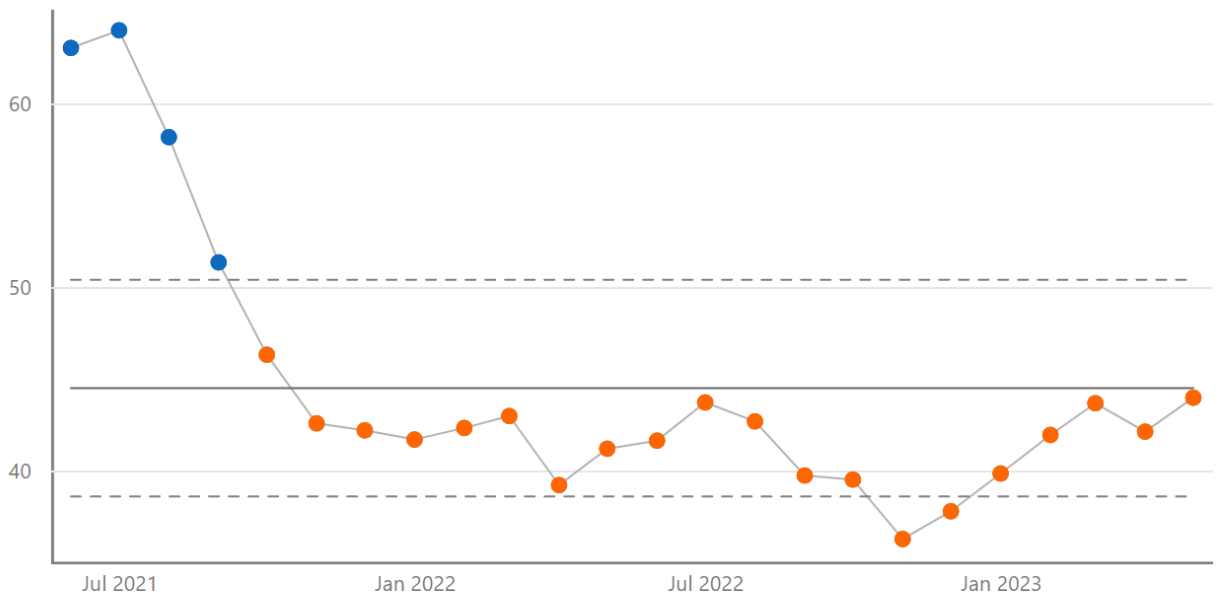
Assurance cannot be given for this indicator as there is no standard set

Concern

There is concern because this indicator is decreasing

DQ - Investigation

There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	35.7%	No Std	Normal Variation	No Standard
North Cumbria Locality Care Group	45.9%	No Std	Concern	No Standard
North Locality Care Group	90.7%	No Std	Concern	No Standard
South Locality Care Group	31.9%	No Std	Concern	No Standard

Feedback

What the chart tells us?
Performance was 44% in May 2023 and has remained similar since November 2021.

Root cause of the performance issue
Long waits for a neurodevelopmental assessment of up to 3 years with over 2000 young people across the CNTW footprint. Demand for this service has increased and has outstripped the capacity for the teams to respond in a timely manner to meet the recommendations in NICE standards

Improvement Actions
- Waiting times recovery workshop took place on 24th May at which areas of focus for the group were identified both short term priorities and medium/longer term priorities. Information has been fed back to oversight group.
- Assessment pathway to stop the Clock for 4 weeks in summer holidays where non-essential work is paused to focus on priority areas to be identified by each locality and clear the decks: screen caseloads, weeks discharge, welcome events.
- Services and service offer workshop to take place on 19th June.
- Referral form/criteria meeting to take place on 22nd June.

Expected impact and by when?

Assessment pathway stop the clock - Aim to increase flow and reduce delay for specific aspects of assessments and formulation. Localities to identify blockages and what they want to achieve to present at the next meeting. Sept 2023

Referral criteria/Referral Form meeting – Aim of this piece of work will be to improve the quality of referrals, which will help to support with flow and complaints.

CYPS Eating Disorders (routine referrals)

Risk Rating - Med (Monitoring)

Percentage of eating disorder CYPS referrals that waited <= 4 weeks routine completed (Q&P Metric 1865)

Performance - 88.2%

Standard - 95.0%

Achieve at Random

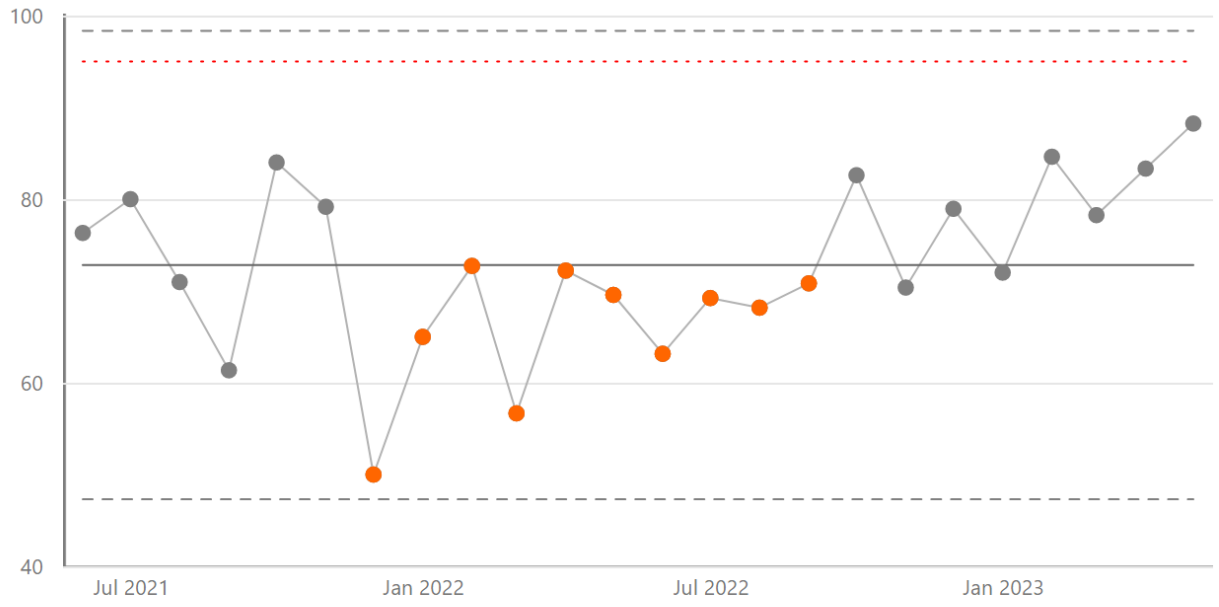
The standard for this indicator is within the upper and lower control limits

Normal Variation

The variation for this indicator is within the control limits

DQ - No Concern

There are currently no concerns with the data quality of this indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	100.0%	No Std		No Standard
North Cumbria Locality Care Group	85.7%	No Std	Normal Variation	No Standard
North Locality Care Group	100.0%	No Std	Improvement	No Standard
South Locality Care Group	100.0%	No Std		No Standard

Feedback

What the chart tells us?
88.2% of routine CYPS Eating Disorder referrals waited < 4 weeks in May 2023 which is within the expected range of 47% and 98%. This range and the average of 72.9% suggests that the standard of 95% will rarely be achieved.

Root cause of the performance issue

- The demand for access to eating disorder services has increased faster than the available capacity to supply NHS assessments and treatment.

Improvement Actions

- A programme of 3 workshops have been plan, the second meeting, on the 7th June 23, took place to look at possible systemwide improvements. Attendees included CNTW, TEWV and Northumbria Healthcare, as all providers are in the same position. Following the 3rd workshop, several recommendations will be considered by the ICB.

Expected impact and by when?

- Reduction in the number of people waiting over 4 weeks for help by Q4.

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

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

Risk Rating - **High (Action)**

Actual/Forecast - 2.9M

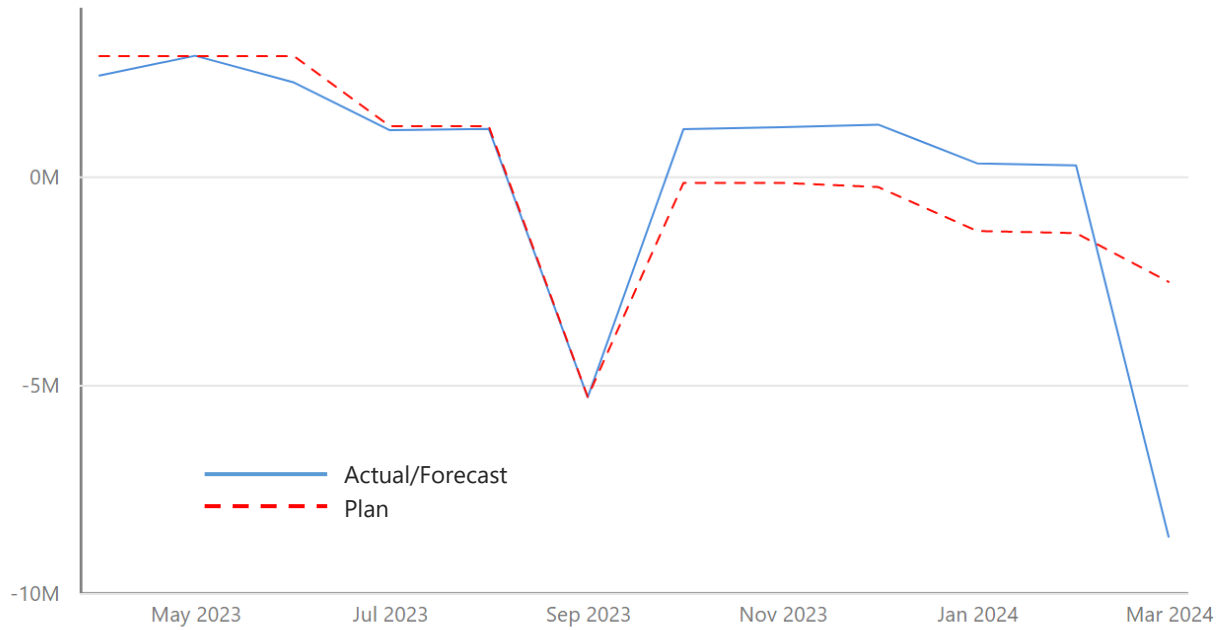
Plan - 2.89M

Not Applicable

Not Applicable

DQ - No Concern

There are currently no concerns with the data quality of this indicator



Locality Name	Off Budget (£1,000)
Central	-667.50
North	-405.53
North Cumbria	30.41
South	-94.56
Corporate	-421.40

Feedback

Root cause of the performance issue

- Budget overspends across clinical groups driven from ward over establishments through April and May. Overspends across Corporate budgets, over established staffing budgets.

Improvement Actions

- Clinical Groups engaged in daily staffing reviews for mental health wards
- Impacts to be managed through monthly Finance focus BDG.

Expected impact and by when?

- Forecast under review with expectations for reductions in costs by the end of the financial year.

9. SEASONAL INFLUENZA AND COVID-19 VACCINATION PLAN 2023/24

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

REFERENCES

Only PDFs are attached

9. CNTW Vaccination Plan 2023 2024.pdf

Report to the Board of Directors
Wednesday 5th July 2023

Title of report	Seasonal Influenza and Covid-19 vaccination Plan 2023/24
Report author(s)	Elizabeth Hanley, Associate Director, Nursing and Quality Kelly Stoker, Head of Infection Prevention and Control
Executive Lead (if different from above)	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality

Strategic ambitions this paper supports (please check the appropriate box)
1. Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day.
2. Person-led care, when and where it is needed – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals
3. A great place to work – We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers.
4. Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled.
5. Working with and for our communities – We will create trusted, long-term partnerships that work together to help people and communities.

Board Sub-committee meetings where this item has been considered		**Management Group meetings item has been considered**
Quality and Performance		Executive Team
Audit		Executive Management Group
Mental Health Legislation		Business Delivery Group
Remuneration Committee		Trust Safety Group
Resource and Business Assurance		Locality Operational Management Group
Charitable Funds Committee		
CEDAR Programme Board		
Other/external (please specify)		

Does the report impact on any of the following areas *(please check the box detail in the body of the report)*		
Equality, diversity and or disability		Reputational
Workforce	x	Environmental
Financial/value for money		Estates and facilities
Commercial		Compliance/Regulatory
Quality, safety, experience and effectiveness	x	Service user, carer and stakeholder involvement

Board Assurance Framework/Corporate Risk Register risks this paper relat

Table of Contents

Seasonal Influenza and Covid-19 vaccination Plan 2023/24

1. Purpose

This plan sets out the Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) strategic approach to the delivery of the seasonal Influenza ('flu) and Covid-19 booster vaccination to both patients and staff (autumn/winter 2023/24). Please note that the plan is not intended to provide clinical guidance on the related vaccines.

The plan incorporates Trust Board Assurance checklist requirements, which needs to be completed by October 2023 and can be found at Appendix 4.

2. Seasonal Influenza ('flu) Vaccination Programme 2023/24

Seasonal Influenza ('flu) vaccination remains a critically important public health intervention and a key priority for 2023 to 2024 to reduce morbidity, mortality and hospitalisation associated with 'flu, at a time when the NHS and social care will be managing winter pressures, whilst continuing to recover from the impact of the coronavirus (Covid-19) pandemic. The delivery of the NHS 'flu vaccination programme over recent seasons has been both ambitious and challenging, as the aim was to offer protection to as many eligible people as possible, exceeding the World Health Organization (WHO) target for those aged 65 years and above for a third season running.

Guidance is expected on how the 'flu programme will be aligned to any seasonal Covid-19 vaccination programme.

The 'flu programme provides direct protection to those at higher risk of 'flu-associated morbidity and mortality, including older people, pregnant women, and those in clinical risk groups and is guided by advice from the Joint Committee on Vaccination and Immunisation (JCVI), an independent departmental expert committee. In addition, based on the JCVI 2021 recommendation, vaccination programme for children using live attenuated influenza vaccine (LAIV) provides individual protection to the children and reduces transmission to the wider population.

The below groups will be eligible for a 'flu vaccine from the 1 September 2023:

- those aged 65 years and over.
- those aged 6 months to under 65 years in clinical risk groups (as defined by the Green Book, chapter 19 (Influenza)).
- pregnant women.
- all children aged 2 or 3 years on 31 August 2023.
- primary school aged children (from Reception to Year 6).
- those in long-stay residential care homes.
- carers in receipt of carer's allowance, or those who are the main carer of an elderly or disabled person.
- close contacts of immunocompromised individuals.

- frontline workers in a social care setting without an employer led occupational health scheme including those working for a registered residential care or nursing home, registered domiciliary care providers, voluntary managed hospice providers and those that are employed by those who receive direct payments (personal budgets) or Personal Health budgets, such as Personal Assistants.

There will be no offer to 50–64-year-olds, unless they belong to a clinically at-risk group. The school-age programme for 7,8-,9-,10- & 11-year-olds is still being considered and an announcement is expected in the near future.

The national 'flu immunisation programme letter 2023/24 is available here

3. Covid-19 Booster vaccination Programme 2023/24

Guidance and advice are awaited from the JCVI as to the eligibility criteria of the Covid-19 autumn booster . It is anticipated to be published before September and will consider the latest epidemiological situation, additional scientific data from trials, real-time surveillance of the effectiveness of the vaccines over time and emerging variants.

The planning of the Trust's Seasonal Influenza and Covid-19 vaccination Programme will include both the 'flu and Covid-19 booster vaccinations. The operational and clinical plans for offering the Covid booster will be based on the 2022/23 planning programme, pending publication of the related guidance. This will include co-ordination of the vaccination programme so that staff members and patients are offered an Influenza and Covid-19 vaccination in the same session.

3.1 Reflections on the Winter Vaccination Programme 2022/23

Covid-19 booster

At the end of the 2022/ 23 season the national total uptake of the Covid-19 booster vaccine amongst eligible Healthcare Workers (HCW) recorded on ESR in Trusts was 54% (742k). This uptake compares to 86% (1.33m) in the same period last season.

Regionally for the 2022/23 season in the Northeast and Yorkshire, uptake was 51%. The Trust total uptake was reported at 56%.

Influenza ('flu) vaccine

The national total uptake of 'flu vaccines was 52% (784k) and compares to 58% (988k) in the same period last season. Regionally, for the 2022/23 season, in the Northeast and Yorkshire, the uptake was 57%. The Trust total uptake was reported at 58%.

These overall figures are lower than in previous years, however the rates across all NHS organisations across the region reported similar vaccination figures. Suggestions that may have resulted in a low rate include:

- Concerns of having vaccines together and the effects of this.
- Comparatively low levels of 'flu this year and in the previous year.

- Prioritisation of the Covid-19 vaccine administration during the pandemic period.

Table 1 below shows the final Winter vaccination 2022/23 staff uptake summary:

Table 1. Winter vaccination 2022/23 staff uptake summary

Group	Total employees	Covid booster %	Covid Booster given by the trust	Flu vaccine %	Flu vaccine given by the trust %
CNTW trust	8482	56.14% (4414)	69.9%(3055)	54.63% (4634)	71.6%(3319)
NTW Solutions	850	57.77% (450)	68.7% (309)	55.76%(474)	65.6%(311)
Total	9817	55.87 (5072	3464(68.3%)	54.11% (5312)	70.1% (3725)

A Lessons Learnt event was held in March 2023 to evaluate the seasonal vaccination campaign and to inform future campaigns. Locality vaccination leads, pharmacy colleagues, representatives from the Health Protection Team and acute Trust colleagues were included in the event. The recommendations for the learning include:

- Planning should be started as early as possible: the 2022-3 seasonal vaccination campaign was the first predominantly booster campaign for Covid and the campaign required specific consideration of the model of delivery to ensure the most efficient model, in terms of staff resource and overall financial cost. The early inclusion of colleagues and teams across the Trust was advocated, supported by a robust communication.
- Early consideration of the barriers to staff uptake of vaccination and how these can be addressed is needed, with the support of local, regional and national colleagues. Communication and support options to assist with decision-making and incentives should be considered.
- The model of delivery of vaccination training and competency sign-off would be strengthened by consolidation into a full day of face-to-face training.
- The early identification of vaccinators and maintenance of a comprehensive list by Locality would build on the previous campaign work.
- The timely identification of vaccination clinic sites, where these are part of the vaccination model, is essential to running a successful campaign.
- More effective engagement with medical staff, including inclusion in operational vaccination campaign meetings, would improve the operation of the campaign.
- Early engagement with Information Governance colleagues to ensure that Data Protection Impact Assessment (DPIA) issues are identified and documented with respect to recording and monitoring the related information should be prioritised.

Additional details about the event can be found at appendices 1, 2 and 3.

3.2 Vaccine Mobilisation Group

For the 2023/24 seasonal vaccination programme, planning forms part of the monthly Infection Prevention Control (IPC) assurance meeting, with specific task and finish groups put in place, which provide feedback into the main assurance meeting.

The purpose of this group is to:

- Produce an effective Influenza / Covid-19 vaccination delivery programme to protect patients, staff, and visitors.
- Ensure that all patients in clinical risk groups are identified and offered Influenza / Covid-19 vaccine.

The group has senior leadership, with a multi-disciplinary team of clinical and non-clinical staff delivering the campaign at a local level. Meeting dates for the group reflect the activity required as the vaccination season approaches, although additional meetings may be required to support the needs of the programme. The group reports into the Infection Prevention and Control Committee. Updates by exception are provided to the Business Delivery Group and the Trustwide Safety Group, via the Director of Infection Prevention and Control.

3.3 Influenza Vaccines 2023/24

The Trust has placed orders with Seqirus for the following vaccines:

Quadrivalent Influenza vaccine (QIVc) will be available to both inpatients and staff (this vaccine can be offered to patients and staff who report allergy to egg products).

Patients who are 65 years old and over will receive the adjuvanted Quadrivalent Influenza vaccine (aQIV), as recommended. This vaccine has a higher immunogenicity and effectiveness than the non-adjuvanted vaccine and is regarded as the best option for this age group.

A small number of vegan based vaccines and Live Attenuated Influenza vaccine (LAIV) which is a nasal spray used for children, young people and adults with a learning disability (when a reasonable adjustment is required), will also be made available. These vaccines will be ordered in small numbers and available through pharmacy.

3.4 Flu Vaccine Delivery

The first vaccine delivery is scheduled to arrive the week commencing the 11 September 2023.

The vaccine will be distributed across the Trust and can be transported to community areas, adhering to the maintenance of the cold chain, in discussion with the pharmacy department. It is anticipated that the seasonal flu vaccination campaign for patients and staff will commence mid-September. This is subject to delivery dates, once confirmed.

3.5 Patient Vaccination

To ensure the health and well-being of our patients, Influenza vaccine is offered throughout the 'flu season to ensure protection against the common circulating influenza strains.

Wards will be asked to review all patients who are in the clinical risk groups and offer Influenza vaccination to both current inpatients and new admissions throughout the 'flu season. It is also an opportunity to ensure that patients are protected against pneumococcal infection where indicated.

Consent will always be obtained prior to vaccination, considering capacity to consent to vaccination and related best interest's decisions. For further information staff are advised to refer to CNTW (C) (05) - Consent to examination or treatment policy

Community teams and day units across the Trust are encouraged to promote influenza and Covid-19 vaccination to patients and carers whom they have contact with and are in the clinical risk groups. Where appropriate, they can support patients to access local vaccination services in primary care. Where patients may not engage with primary care services, vaccination can be offered by clinical teams.

3.6 Influenza Vaccination of Health Care Workers

The Health & Social Act 2008 states that all health organisations should ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be contracted at work and that all staff members are suitably educated in the prevention and control of infection associated with the provision of health and social care (Department of Health, 2008).

The purpose of vaccination of health care workers is:

- To protect clinical risk groups in whom 'flu vaccination may not offer complete protection, thereby reducing the rates of 'flu-like illness, hospitalisation, and mortality.
- To protect the health care worker and their family.
- To ensure business continuity by reducing sickness leave.

National guidance requires that organisations should vaccinate all frontline health and social care staff. However, the intention of our Trust programme is to offer vaccination to all staff, including key partners, employees of commissioned services, regular agency workers and health and care students on placement.

Table 3 below outlines the frontline staff groups. This list is not exhaustive, and each post should be assessed in accordance with ESR and clinical activity.

Table 2: Definitions of frontline staff groups

Staff Group	Description
Doctor	All grades of hospital, community, and public health doctor.
Qualified Nurse	Qualified nursing staff, working on hospital sites and community services. Includes nurse consultants, nurse managers and bank nurses but not student nurses.

Other Professionally Qualified
 	
This comprises:
• Qualified scientific and therapeutic &technical staff
• Qualified allied health professionals
• Other qualified ST&T
	• Qualified allied health professionals (AHPs):
	• Chiropodists/podiatrists
	• Dieticians
	• Occupational therapists
	• Physiotherapists
	• Art/music/drama therapists
	• Speech & language therapists
	• Other qualified health professionals:
	  ○ Pharmacists
	  ○ Psychologists
	  ○ Qualified ambulance staff
	  ○ Ambulance paramedics, technicians, emergency care practitioners.

Support to Clinical Staff This comprises: • Support to doctors and nurses • Support to ST &T • Support to ambulance staff	• Nursing assistants, nursery nurses, health care assistants and support staff in nursing areas. Also includes clerical & administrative staff and maintenance & works staff working specifically in clinical areas, for example medical secretaries and medical records officers. Also includes porters and similar roles provide support to inpatient areas.

3.7 Peer Vaccinators

The 2022/23 vaccinator list was reviewed with support from the Locality Associate Nurse Directors. There were 67 peer vaccinators who supported the 2022/23 campaign. The national protocol defines the roles and tasks that can be undertaken by different staff and the training required for each element and the process.

The current vaccinator list is under review and individuals are being contacted to ask if they would like to support this year's programme.

In recent years, vaccinator training was provided via eLearning packages and competency-based assessment. Vaccinators were required to have completed Intermediate Life Support and Anaphylaxis training. Taking into consideration recommendations from the lessons learnt event, the vaccinator training programme is currently under review, to explore the option to incorporate face to face training.

All vaccinators are still required to meet the competencies of both the 'flu and Covid-19 booster vaccinator competency assessment tools and will be signed off as competent by an experienced vaccinator, if new to the role or who has not vaccinated in the past

12 months. Vaccinators who have vaccinated throughout the previous 12 months can self-assess against the competency assessment tool.

3.8 Legal documents for administration of influenza and Covid vaccination

Vaccinators will be able to administer flu vaccination to staff (CNTW and NTW Solutions) under a Written Instruction document, previously used in 2022/23. The document is currently being revised by Pharmacy for this year's 'flu vaccination programme and the final document will be approved by the Trusts Medicines Optimisation Committee (MOC).

As in 2022/23 for administration of the Covid-19 vaccination a National Protocol is expected to be published to support the Covid-19 vaccination programme. This allows for vaccinations for staff (CNTW and NTW Solutions) and patients to be given by a wide range of registered professionals under the supervision of a registered nurse, doctor, or pharmacist.

3.9 Vaccination Clinics

In planning for the 'flu and Covid-19 vaccination programme 2023/24, it is proposed to use the clinic model for specific days and times during the week, co-ordinated by each Locality Associate Nurse Director. Peer vaccinators will vaccinate staff who are unable to attend a centralised clinic, which is a system that has been used effectively in previous years. The vaccine clinics will offer vaccination with 'flu and Covid-19 in the same appointment.

In recognising the importance of accessibility to vaccination for all frontline healthcare workers in both the NHS and other organisations, CNTW will be offering vaccination to all staff working within, or into CNTW.

The clinic booking system will be reviewed, as the booking system in the 2023/24 campaign was provided by the Trust's Wellbeing Team.

4. Data Collection

All vaccinations will be recorded on the National Immunisation and Vaccination System (NIVS) which is a digital solution used to record the Covid vaccination information for both patients and health and social care workers within hospital hubs. This information is then sent automatically to update individual GP records with the vaccination details. The information team is reviewing how vaccination data interflow for staff who are resident in Scotland and work at CNTW will be recorded, as the Scottish and English systems do not align.

4.1 External reporting

As in previous years, vaccination of front-line health care workers will be reported through the ImmForm website. Uptake data information for healthcare workers will be collected on immunisations given from September 2023 to the end of February 2024 (the final data will be collected in March 2024).

4.2 CQUIN Target 2022/23

Staff Vaccination forms part of the CQUIN scheme 2023/2024:

CQUIN01: Staff 'flu vaccinations are critical in reducing the spread of 'flu during winter months; protecting those in clinical risk groups and reducing the risk of contracting both 'flu and Covid-19 at the same time and the associated outcomes and reducing staff absence and the risk for the overall safe running of NHS services. The proportion of patient-facing NHS staff accessing seasonal 'flu vaccinations has declined significantly since the 2021/22 'flu season and it is important that everything possible is done to reverse this to protect staff and patients.

The CQUIN goal has been set at 75% to 80% uptake of flu vaccinations by frontline staff with patient contact. Data collection will commence 1st September 2023 up to and including 28th February 2024.

4.3 Internal reporting

Internal dashboards will be used and regularly updated with staff and patient vaccination information. Regular reports will be shared with Trust senior managers across all services to assist with identifying areas of poor vaccination uptake in front-line health care workers, which will assist with planning a targeted approach by peer vaccinators. Recording inpatient vaccinations will support in delivery of vaccine and prescribing to eligible patients.

5. Communication

The Communications Team is a key member to the success of the vaccination campaign and the communication plan informs the delivery of information provided Trustwide.

The importance of effective communication throughout the programme is recognised in dispelling myths and in delivering important messages. The dedicated winter vaccination page on the Trust intranet is instrumental in relaying key messages, clinic dates and 'myth busters' information.

The dedicated vaccine e-mail address (vaccinesupport@cntw.nhs.uk) is used as a point of contact for all vaccination queries and is promoted through vaccination training, the staff bulletin and all user e-mails. This is monitored by the Infection Prevention and Control Team.

Following the positive reviews from staff of the "real life" personal stories posters, these will continue into the 2023/24 programme to raise awareness of the importance of vaccination to protect people in clinical risk groups.

Engagement with patients and carers during the vaccination planning remains a key priority to encourage and support informed decision-making about vaccination. Community teams have the responsibility to facilitate patients attending Primary Care for vaccination and, where appropriate, highlighting to carers their eligibility for a free 'flu vaccine. Inpatient staff members are encouraged to use carer/patient meetings as an opportunity to discuss the importance of flu vaccination, especially in clinical risk groups.

6. Reviewing and monitoring

The Trust is committed to continue to increase vaccination uptake rates year on year by:

- Working closely with clinical teams to ensure patients are offered and supported to be vaccinated.
- Supporting carers to ensure they make the right decisions in encouraging their relatives to be vaccinated.
- Providing clinical staff with current information regarding vaccination, including myth busting and common questions through both electronic and paper communications.
- Ensuring that all patients and staff across CNTW have access to vaccination to assist with the promotion of health and wellbeing.
- Continuing to provide information Trustwide relating to the benefits of the flu and Covid-19 vaccinations.
- Undertaking weekly internal reporting of vaccination uptake rates in front line health care workers to address areas within the Trust where there is poor vaccination uptake.
- Working with NHS colleagues to give assurances in our winter preparedness.
- Respond to and share lessons learnt both internally and externally.

7. Conclusion

The Board is asked to agree the Seasonal Influenza and Covid-19 vaccination plan for 2023/24, pending publication of specific information relating to the national Covid-19 vaccination booster campaign.

Appendix 1

Lessons Learnt Event 2022/23
'Time to pause, refocus and reflect'.

Introduction

The importance of health and social care workers being vaccinated with both the Covid-19 and influenza vaccines to protect themselves and their patients over the winter season was reinforced throughout the 2022 booster campaign. All staff members were informed via a range of Trust-wide and targeted communication methods that the viruses can be life-threatening and the benefit of receiving both influenza and Covid-19 vaccines protects against serious illness. These vaccines were available to patients and staff from September and October 2022 respectively.

The Covid-19 booster vaccine and influenza vaccine were offered to all in-patients and staff, including the employees of commissioned services and key partners, regular agency workers, volunteers and health and care students on placement in the Trust during the vaccination programme.

A mixed vaccination model was employed (Roving, Peer and Clinic-based) with the aim of optimising access to the vaccines and a robust data entry system was set up to monitor the delivery of the programme. Details of the booking system was also included in communications to staff and the relevant partners.

The vaccination programme was stood down mid-February 2023, due to the national decisions about the availability of Covid-19 vaccination.

Aim of the Lessons Learnt event.

This event was arranged to pause, refocus and reflect in preparation for the 2023/24 seasonal vaccination programme.

This event was held face-to-face on the 10 March 2023 at St Nicholas House. Localities were asked to provide representation from all disciplines and grades of staff who were involved in the campaign. Northumbria Healthcare NHS Foundation Trust Immunisation Team and the UKHSA Health Protection Team presented.

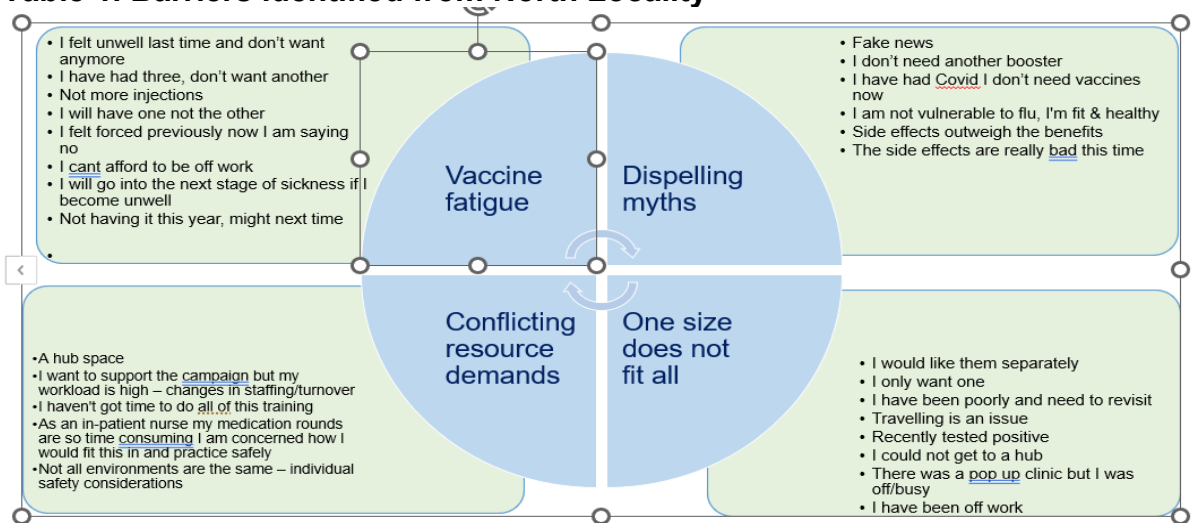
Localities presented their reflections, as well as pharmacy colleagues (all presentations can be found at Appendix 1and the event agenda is included as Appendix 2). An Evaluation form was also requested to be completed by delegates (Appendix 3).

Themes from the workshops that were identified.

Workshop 1 **What are your lessons learnt & do you have any evidence?**
1. Weekly informal Operational meetings provided a forum for the leads to share ideas and provide key updates from SVOC. 2. Strategic planning meetings were very collaborative, open and allowed subject matter experts to guide processes. Pharmacy input felt valued. 3. Having NIVS system in same room as vaccinator was effective. 4. Pharmacy Foundry ordering system worked well : more familiar with products and systems; smoother. 5. Improve on Incentives: pens/lanyards and amazon vouchers were well received by staff. Expand incentives to all staff who received vaccines, i.e., free cup of tea/ coffee. 6. As Associate Nurse Directors were identified leads for their own areas, this facilitated bespoke practice tailored to meet the individual needs of service areas. 7. Clinic environment identified early to prepare and 'trial run' with Vaccinators. 8. The training was complex, which reduced the number of Vaccinators. 9. Vaccine Leads felt in control of venues / facilities to vaccinate. Able to plan to use the Vaccine dashboards as a gauge. Pharmacy colleagues felt that vaccine was distributed to where/when it was needed within CNTW, and Pharmacy staff members were flexible and helpful. 10. Excellent engagement from Pharmacy. Good partnership working enabled stock control to be 'fluid' between localities. 11. Great collaboration with vaccinators: more efficient use of vaccines and less waste than previous campaigns.
Workshop 2 **What would you like to see improved in this season's winter campaign?**
1. Training to be completed in a one-day session / face to face, instead of e-learning (protected time for training). 2. International nurses be involved in the campaign. 3. Booking system to be improved: Clinic lists and numbers were not always accurate/timely as previous system. 4. Vaccination training as part of the Preceptorship pathway. 5. Communication to prescribers needs to be improved. 6. Senior Leadership to be present at clinics / be actively involved in vaccinating. 7. Peer supporters and AHP Involvement involved to support clinical staff to encourage patient uptake. 8. Designated Immunisation team, instead of 'pulling' staff from the wards/ teams. 9. Medical representation for each locality to be more actively involved and attend the Strategic planning meetings. 10. Medical staff to have more awareness and be proactively involved to assist with Consent and Capacity issues. 11. Clarity between Peer Vaccinator and Ward Nurses vaccinating patients and staff. 12. Ordering form(s) and SOP awareness amongst wider teams. Could look to have a dedicated intranet page instead of TEAMS (this would aid version

control).
13. Understand & address the barriers to poor staff uptake

Table 1. Barriers identified from North Locality



Graph 2. What would South Locality like to do differently?

Key identified lessons learnt.

1. Early pre-planning and visible senior leadership is paramount
3. Workforce (upskill and streamline the training)
4. Engagement & Communication
5. Increase resources & Incentives

Recommendations for the 2023-4 Campaign.

- Start planning earlier.
- Include all members who will support and can enable change and development in the early stages of planning.
- Address staff barriers and gain an understanding or why staff uptake is poor; Online staff survey / team conversations.

- New ways of undertaking the vaccine training (discuss with other Trusts how they roll out their training).
- Recruit vaccinators earlier; have a robust list.
- Engagement with medical staff; recruit into the Operational meetings.
- DPIA: complete with IG team in the early stages of planning.
- Agree incentives and include in DPIA.
- Agree clinic venues at the earliest opportunity.
- Agree a communication plan.

All Presentations


COMBINED PRESENTATION.pptx

Appendix 2, Agenda

Winter Vaccine Campaign Lessons Leant Event 2022/23

Date: Friday 10th March 09:30-13:00 Conference Suite, Ground Floor, St Nicholas House, St Nicholas Hospital

This event is to have the opportunity to reflect upon and review the 22/23 Winter Flu & Covid vaccination programme and to inform the planning for the next season 2023/24.

Time	Session	Speakers
Tea, coffee, water and Danish pastries on arrival from 9am.		
09:30	Welcome, Introduction	Kelly Stoker & Liz Hanley
09:45	NE Health Protection, Epidemiology of Infections	Racheal Kain
10:00	Northumbria Healthcare NHS Foundation Trust, Winter Vaccination Team	Danielle Robinson & Kelly Seddon
10:20	Pharmacy ordering for 2023/24 campaign	Anthony Young & Steven Routledge
10:30	Reflections from the North Locality	Victoria Irving & Gayle Wilkinson
10:45	Reflections from the South Locality	Marie Smith & Pam Murray
11:00	Booking system: Getting it right	Pam McIntyre
11:15	**Break**	
11:30	**Workshop 1** *What are your lessons learnt & do you have any evidence ?*	
12 :00	Quiz and reshuffle seats	
12:15	**Workshop 2** *What would you like to see improved in this season's winter campaign?*	
12:45	Closing remarks - Kelly Stoker & Liz Hanley	

Appendix 3, Evaluation form

Winter Vaccine Programme Lessons Learnt Event Evaluation form

- **What locality do you work in?** .....
- **What is your job title?** .....

- **The content of the event was relevant to my role ?** please circle
  Strongly agree Agree Strongly disagree
- **The venue was suitable for this event ?** please circle
  Strongly agree Agree Strongly disagree

What went well at the event? .....
.....
.....
.....
.....

What didn't go so well at the event? .....
.....
.....
.....
.....

What could have been done differently? .....
.....
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.....
.....

What was your role in the Winter vaccination programme? .....
.....
.....

Are you wanting to be involved in this year's winter campaign? Yes / No

Any other comments
.....
.....
.....

.....
.....

Appendix 4

Healthcare worker flu vaccination best practice management checklist

For Public Assurance by Trust Board by November 2023

A: Committed Leadership	Trust Self-Assessment
A1 Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers (both clinical and non-clinical staff who have contact with patients).	
A2 Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers.	
A3 Board receive an evaluation of the influenza programme 2022 to 2023, including data, successes, challenges, and lessons learnt.	
A4 Agree on board champion for the Winter vaccination programme.	
A5 All board members to be offered the flu and covid-19 booster vaccination if eligible and publicise this.	
A6 Vaccination team formed with representatives from all directorates, staff groups and trade union representatives.	
A7 Winter Vaccination Planning team meet regularly from September 2023	
B: Communications Plan	
B1 Rationale for both vaccinations programme and facts to be published-sponsored by senior clinical leaders and trade unions.	
B2 Drop-in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	
B3 Board and senior managers having their vaccinations to be publicised.	
B4 Winter vaccination programme and access to vaccination and induction programmes.	
B5 Programme to be publicised on screensavers, posters and social media.	
B6 Weekly feedback on percentage uptake for directorates, teams and professional groups.	
C: Flexible accessibility	
C1 Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered.	
C2 Schedule for easy access drop-in clinics agree.	
C3 Schedule for 24-hour mobile vaccinations to be agreed.	

D: Incentives	
D1 Board to agree on incentives and how to publicise this.	
D2 Success to be celebrated weekly	

References

- Guidance. National Influenza immunisation programme 2023 to 2024 letter (Updated 8 June 2023) here
- Commissioning for Quality and Innovation (CQUIN): 2023/24 Guidance, NHS England (Updated 17 April 2023) here
- Guidance, Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Updated 13 December 2022) here
- Guidance, Coronavirus (Covid-19) : the Green Book, chapter 14a here
- Guidance, Influenza: the Green Book, chapter 19 here

10. COVID NATIONAL INQUIRY REPORT

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

REFERENCES

Only PDFs are attached

10. Covid 19 National Inquiry.pdf

Report to the Board of Directors
5 July 2023

Title of report	**National Covid-19 Inquiry – Summary Timetable and Actions**
Report author(s)	**Anne Moore, Associate Director National Covid Inquiry**
Executive Lead (if different from above)	**Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance**

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day.	
2. Person-led care, when and where it is needed – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals	✓
3. A great place to work – We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers.	✓
4. Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled.	✓
5. Working with and for our communities – We will create trusted, long-term partnerships that work together to help people and communities.	

Board Sub-committee meetings where this item has been considered	
Quality and Performance	
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered	
Executive Team	
Executive Management Group	
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability	✓	Reputational	✓
Workforce	✓	Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	✓
Quality, safety, experience and effectiveness	✓	Service user, carer and stakeholder involvement	

Board Assurance Framework/Corporate Risk Register risks this paper relates to

National Inquiry Covid 19- Summary Timetable and Actions

1. The National Covid Inquiry is split into different investigations, which will examine different parts of the UK's preparedness for and response to the pandemic and its impact.

2. To date, the Inquiry has opened three investigations:

Module 1	The UK's pandemic preparedness and resilience	The Inquiry will begin hearing evidence for Module 1 in public hearings on **13 June 2023.** • Was the UK properly prepared for a pandemic? • Was the response to it appropriate? • Can we learn lessons for the future?
Modules 2, 2A, 2B and 2C	Core political and administrative decision making in the UK and devolved administrations	Public hearings will begin for Module 2 (decision-making across the UK) in **October 2023.** Module 2A (decision-making in Scotland) **January 2024** Module 2B (decision-making in Wales) in **February 2024** Module 2C (decision-making in Northern Ireland) in **April 2024.**
Module 3	Impact of the pandemic on healthcare systems	It is expected that Module 3 hearings will begin in **Autumn 2024** Core Participant Groups will be pushing the Inquiry to hear evidence, for example: • MIND- re NHS Institutional racism/structural racism • RCN/BMA- funding and Recruitment &Retention workforce impact prior to pandemic • Families of the Bereaved- decisions impacting on access and preventable deaths • CATA-Covid19 Airborne Alliance. View that SARS evidence ignored and protection of HC staff and general public not fully prepared • Pregnancy, Parent and Baby organisations- lack of family centred care from health services during pandemic • Federation of Ethnic Minority Healthcare Organisations- structural racism and failure to protect

3. **In 2023,** the Inquiry will also open three new investigations:

Module 4- therapeutics and anti-viral treatment across the UK.*	Scope will be published on **5th June 2023** for Core Participants to apply	Public Hearings **expected summer of 2024**
Module 5- Government Procurement across the UK.*	Inquiry will open this investigation **24th October 2023**- Scope will follow	Public hearings **scheduled for early 2025**
Module 6- care sector across the UK*	Inquiry will open investigation from **12 December 2023**- Scope will follow	Public hearings **scheduled for spring 2025.**

4. To ensure the Inquiry's recommendations are timely, the Chair has promised to publish regular reports. **Baroness Hallett hopes to publish reports for Module 1 (preparedness and resilience) and Module 2 (core decision making) during 2024.**

5. The Inquiry will announce the next **12 months' investigations in early 2024**. Future investigations will cover:
   - Testing and tracing,
   - Education,
   - Children and young persons,
   - Governmental intervention by way of financial support for business, jobs, and the self-employed,
   - Additional funding of public services and the voluntary/community sector,
   - Benefits and support for vulnerable people.

6. The Inquiry's final modules will specifically investigate impact and inequalities in the context of public services – including key workers – and in the context of businesses.

7. The Inquiry is UK-wide and will examine the responses of both the devolved and UK Government throughout all of its work.

8. **The Inquiry is aiming to complete all Module public hearings by summer 2026.**

<u>Actions Required by CNTW</u>

- The timetable above demonstrates the structured approach being taken by the Inquiry Team. It will be important to note the emerging findings which will play out in the media and the impact negative media may have on staff when they begin to hear evidence. May also require responses from the Trust to NHSE/ICBs as the inquiry gathers momentum.

- Disclosure of Rule 9 – this is a directive to supply information, therefore internal communications must be focused on engaging the workforce with the Inquiry perse, as

well as possible disclosure requests. The Trust should establish a good relationship with the Inquiry Team – this will help if extensions are required on any information requests.

- Managing Rule 9 response - So far, the questions have been very detailed and include requests for documents. It's unlikely that every Trust will get a Rule 9, however they should be prepared. Colleagues should cross reference any request with the Trust questionnaire response December 2022. If questions are woolly, then seek clarity from the inquiry team.

- Advice on how to mitigate the pressures.
  - Continuously review - has the Trust got the right team leading this?
  - Confirm Executive Lead to sign off the response.
  - Confirm Named Senior Lead to co-ordinate responses, wider team to fact check and fresh eyes.
  - Confirm Resource - to collate and respond in timeframe being given.
  - Confirm Legal Advice -internal and external.

- Compassionate Leadership - Reflect on the workforce experience and note the impact negative media may have on staff when they begin to hear evidence being given. Plan to carry the weight and burden of your workforce. Prepare for sickness absence, lines of communication. Well-being Guardian - if not in place, then consider as may need to support. Reinforce the positives in the Trust story.

- Is the Voice of the workforce being heard? Rule 9 responses on behalf of the Trust are likely to be organisational and generic/thematic and not personal stories or experiences. However, it could be about how individual groups of staff were affected, structures, workload, inequalities etc. i.e. ethnic groups or economic disadvantage by staff. What is our evidence base/database saying and is it truly reflective of the workforce as a whole? Have we captured any specific workforce concerns/Freedom to speak up incidents?

- Inquiry Listening exercise - Every Story Matters. This is open to the public, but also NHS Workforce may have contributed to this e.g. re child care, shifts, safe staffing, how it affected individuals. Stories and experiences will be shared outside of formal evidence, but it's an important method to inform each hearing. An Ethical Team has been appointed to review the information submitted.

- There may be opportunity for staff to attend targeted face to face sessions.

- Within any response, Tell the story of the Trust during the pandemic including impact on stopping and starting services, waiting lists, safe staffing levels, patient experience and understand may need to start with the basics.

- The module specifically investigating 'Health' is not due to begin until Autumn 2024, but nonetheless CNTW should continuously monitor emerging trends and cross reference against historical actions and decisions take during public hearings of modules 1 and 2.

- The continuous learning and reflection on lessons learnt throughout the pandemic, has this been used to inform current and any future revisions of Trust Major Incident Plans and Emergency Preparedness.

- To note the Timetable for 3 new modules*. These are likely to impact on the Trust ie Vaccinations, PPE and interface with the Care Sector which may result in Rule 9 requests for information

- Note there are further Investigations planned for 2024/25 which will be cross cutting especially inequalities. This is an area where Mental Health and Disability Trusts may

find greater emphasis on questions relating to the impact on our patient population during the pandemic and also increases in referrals since the pandemic.

Anne Moore
Associate Director – Trust National Covid Inquiry Lead
12 June 2023

11. WORKFORCE ISSUES

Ken Jarrold, Chair

No reports scheduled for July

12. CQC MUST DO REPORT

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

REFERENCES

Only PDFs are attached

12. Summary CQC Must Do Action Plans (end of May position for July Board) FINAL.pdf

Report to the Board of Directors
Wednesday 5th July 2023

Title of report	Update on CQC Must Do Action Plans
Report author(s)	Vicky Wilkie, CQC Compliance Officer
Executive Lead (if different from above)	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day.	x
2. Person-led care, when and where it is needed – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals	x
3. A great place to work – We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers.	x
4. Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled.	x
5. Working with and for our communities – We will create trusted, long-term partnerships that work together to help people and communities.	x

Board Sub-committee meetings where this item has been considered	
Quality and Performance	
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered	
Executive Team	
Executive Management Group	x
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability	x	Reputational	
Workforce		Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness	x	Service user, carer and stakeholder involvement	x

Board Assurance Framework/Corporate Risk Register risks this paper relates to
SA1 Working Together With Service Users And Carers We Will Provide Excellent Care. Supporting People on Their Personal Journey To Wellbeing. Risk 1683 There is a risk that high quality, evidence based safe services will not be provided if

there are difficulties accessing inpatient services in a timely manner due to bed pressures resulting in the inability to sufficiently respond to demands (SA1.4).

SA5 The Trust Will Be The Centre Of Excellence For Mental Health And Disability.
Risk 1688 Due to the compliance standards set from NHSI, CQC and for Legislation there is a risk that we do not meet and maintain standards which could compromise the Trust's statutory duties and regulatory requirements (SA5).

SA4 The Trust's Mental Health And Disability Services Will Be Sustainable And Deliver Real Value To The People Who Us Them.

Risk 1836 A failure to develop flexible robust Community Mental Health Services may well lead to quality and service failures which could impact on the people we serve and cause reputational harm (SA4).

Update on CQC Must Do Action Plans

Board of Directors

Wednesday 5th July 2023

1. Executive Summary

This report provides an update on the 21 remaining areas of improvement (Must Do action plans) which were received following inspections undertaken between 2015 and 2022. This report also includes the action plans from the more recent CQC inspection to three wards on the Campus for Ageing and Vitality hospital site in Newcastle.

- This report seeks approval from the Board that there is sufficient evidence and assurance to close one action plan relating to appraisals. Some action plans remain partially complete as they are linked to other identified breaches of regulation.

- Appendix 1 provides an update on the work that continues to address each of the remaining action plans. The revised timeframes will be kept under review and every effort made to shorten these where possible.

- A summary table in appendix 2 highlights six key themes identified as service shortfalls across a range of methodologies. Five of these feature in our CQC Must Dos and therefore by addressing these they should address the wider findings. It is therefore imperative that we have a particular focus on these areas.

- Quarterly updates on all action plans, including the monitoring of previous actions which have been closed (see appendix 3) will continue to be reported to Trust Leadership Team, Quality and Performance Committee and Board of Directors.

2. Risks and mitigations associated with the report

The Care Quality Commission has raised all the issues within this report as areas of concern and as such are potential risks to the Trust in relation to safe care and treatment of those who use our services and those who work for the organisation. There is a risk of non-compliance with regulatory and legal requirements and potential risk to trust reputation should we fail to achieve completion and implementation of the action plans included within this report.

3. Recommendation

The Trust is required to provide regular updates to the Care Quality Commission on progress against each of these actions and as such it is necessary for the Trust Board to have oversight of progress and be assured that these concerns are being addressed.

Board members are asked to:

- Approve the closure of one action plan listed within appendix 1.
- Note the updates on all 57 CQC Must Do action plans (including impact changes for those closed).

Author:
Vicky Wilkie, CQC Compliance and Governance Manager

Executive Lead:
Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance

19th June 2023

Identified Lead	Source	Must Do	Actions to ensure closures by deadline	Planned timescale for closure	Actions to be taken forward in Q2 23/24	Evidence of impact
(3) Restrictive practices, seclusion and long-term segregation						
David Muir	LDA wards Year: 2019 Org: CPFT	The provider must ensure that all staff complete body maps and carry out and record physical observations following the use of restraint and ensure that there is a rationale recorded for any 'as required' medication being administered following the use of restraint [Linked to rapid tranquilisation task and finish group].	Continued work on the Body map form e.g. conditional logic has been added to the reason for mapping. If falls, accident or assault is selected then it will ask for the incident number which has been made a mandatory field and linked to safeguard. Also, if PMVA is selected the type of restraint will be prompted. PMVA holds have been added which now line up with the incident reporting system. Evidence from Groups that body mapping work/audit findings has been taken to the Quality Standards meetings and assurance obtained about the standard of this.	30 September 2023	Confirm updated audit findings and agree plan from these. Update from Safer Care regarding IR1 form prompting for body mapping when Rapid Tranquilisation intervention has occurred.	Evidence shows limited improvement so the further action is required to make the required improvements.
David Muir	CAMHS wards Year: 2020 Org: CNTW	The Trust must review the use of restraint and mechanical restraint in the Children and Young People's Inpatient Services. The use of mechanical restraint should be used as a last resort in line with Department of Health Positive and Proactive Care. There should be a clear debrief process for the team after an incident and for the person who has been restrained.	All wards are now using an end of day debrief form which will capture the smaller incidents, more significant incidents such as PMVA / MRE / Seclusion / assaults and will be picked up by the staff member allocated on the de-brief rota. Team files with documentation and the rota set up.	30 June 2023	Continue to closely monitor, data to be reviewed on a weekly basis at the locality safety meeting. Ongoing discussions required regarding data being available on the dashboards as current paper system may be a barrier to completion.	MRE use across CAMHS wards has reduced however compliance with staff and patient debriefs needs to improve across all wards (improvements have been noted in some areas). • Ashby No data available for May 2023. • Lennox No data available for May 2023

Identified Lead	Source	Must Do	Actions to ensure closures by deadline	Planned timescale for closure	Actions to be taken forward in Q2 23/24	Evidence of impact
						• Lotus An improvement has been noted in the May 2023 figures. 81% of staff debriefs were completed, 19% were not completed. 57% of patient debriefs were completed, 43% patient debriefs were not completed. • Riding In May 2023, 39% of staff debriefs were completed, 61% were not completed. 30% of patient debriefs were completed, 37% lacked capacity and 32% were not completed. • Redburn In May 2023, 53% of staff debriefs were completed, 47% were not completed. 29% of patient debriefs were completed, 15% were declined, 6% lacked capacity and 49% were not completed.
Dennis Davison	LDA wards Year: 2022	People in seclusion on Lindisfarne ward did not have privacy and	Sycamore to be operational by 31 July 2023.	31 July 2023		This will be achieved on completion of the works.

Identified Lead	Source	Must Do	Actions to ensure closures by deadline	Planned timescale for closure	Actions to be taken forward in Q2 23/24	Evidence of impact
	Org: CNTW	dignity because staff who were not providing direct care entered the seclusion area regularly.	Continue to roll out of training and awareness regarding HOPE's model. Staff are aware that when seclusion room is in use access should be for those managing the patient.			
(4) Appraisal and training						
Ramona Duguid supported by Marc House	Community LD Year: 2016 Org: CPFT	The trust must ensure that all staff have an annual appraisal.	Focus on the teams who are not currently achieving the agreed target.	30 June 2023		86% compliance within LD teams across North Cumbria.
	Community CYPS Year: 2018 Org: CPFT	The trust must ensure that staff complete the mandatory training courses relevant to this service in line with trust policy to meet the trusts training compliance targets.	Focus on the teams who are not currently achieving the agreed target.	30 June 2023		86% combined training compliance within CYPS community teams in North Cumbria. Improvements have been noted since the April update when 9 courses were failing to meet the standard. 6 courses are currently failing: (Fire, Information Governance, MHA/MCA/DOLS, Medicines Management, Clinical Supervision, PMVA Breakaway).
	LDA wards Year: 2019 Org: CPFT	The provider must ensure that staff complete their mandatory and statutory training.	Focus on the teams not currently achieving the agreed target.	30 June 2023		76% combined training compliance within Edenwood ward. 11 courses are currently failing: (Safeguarding Children

Identified Lead	Source	Must Do	Actions to ensure closures by deadline	Planned timescale for closure	Actions to be taken forward in Q2 23/24	Evidence of impact
						level 2 & 3, Safeguarding Adults level 2 & 3, Clinical Risk & Suicide Prevention, Rapid Tranquilisation, Medicines Management, MHA/MCA/DOLS, Clinical Supervision, Seclusion, PMVA Basic).
Russell Patton	LDA wards Year: 2022 Org: CNTW	Staff did not receive training in learning disabilities or autism. [This must do is linked to the must do relating to Cheviot staffing].	Continue to monitor compliance against the Learning Disability and Autism training programme for the specified wards and review progress against proposed trajectories.	30 June 2023		Improvements in training compliance have been noted but all groups have not yet reached the Trust standard. Compliance as at end of Quarter 4: • Autism Core Capabilities training compliance: o North Cumbria Locality – 80% o North Locality – 63% o Central Locality – 77% o South Locality – 77% • Learning Disability Awareness training compliance: o North Cumbria Locality – 77% o North Locality – 62% o Central Locality – 74%

Identified Lead	Source	Must Do	Actions to ensure closures by deadline	Planned timescale for closure	Actions to be taken forward in Q2 23/24	Evidence of impact
						○ South Locality – 84%
Russell Patton	CAV wards Year: 2022 Org: CNTW	The trust must ensure that the wards have suitably qualified and experienced staff to support all admissions including training in specialist autism and learning disabilities.		30 December 2023	Promote Learning Disability and Autism training programme within mainstream Adult Acute wards this quarter and support innovative solutions where required.	
(5) Clinical supervision						
Esther Cohen-Tovee	Community OP Year: 2018 Org: CPFT	The trust must ensure that all staff receive clinical and management supervision and that it is documented. The trust must ensure that supervision figures are shared appropriately with senior managers.	New clinical manager in post who will be reviewing current supervision arrangements to ensure staff aligned with supervisor.	30 June 2023		Improvements have been noted during May/June: 71% for clinical supervision and 82% for management supervision within Memory Services in North Cumbria.
	Trust-wide Year: 2019 Org: CPFT	The trust must ensure it continues its development of staff supervision and the board have clear oversight of both quantity and quality of supervision.		30 December 2023	Actions for Q2: Consultation on revisions to CS Policy if required, revised version to replace current version. Changes to be highlighted to staff. Commence trust-wide audit of adherence to standards and quality of CS. Actions for Q3: Audit closes, analyse results, draft recommendations & review by Clinical Supervision Oversight Group.	All groups did not meet their Quarter 4 trajectories for clinical supervision. Quarter 4 compliance is as follows: North Cumbria Locality - 42% (December), 45% (March) North Locality – 51% (December), 52% (March) Central Locality – 50% (December), 51% (March) South Locality - 42% (December), 59% (March) All groups did not meet their Quarter 4 trajectories

Identified Lead	Source	Must Do	Actions to ensure closures by deadline	Planned timescale for closure	Actions to be taken forward in Q2 23/24	Evidence of impact
					Finalise report & present to Trust Q&P.	for management supervision. Quarter 4 compliance is as follows: North Cumbria Locality – 58% (December), 45% (March) North Locality – 54% (December), 51% (March) Central Locality – 56% (December), 59% (March) South Locality – 75% (December), 71% (March)
	LDA wards Year: 2019 Org: CPFT	The provider must ensure that all staff receive regular supervision.		30 June 2023	Compliance data to be discussed each month in ops huddle and monitored month on month for improvement. Figures will be discussed in HR triage monthly. Clinical nurse manager discusses with ward managers in monthly supervision.	Clinical supervision compliance for Edenwood is at 33%. Management supervision is at 33%.
(9) Environmental issues						
Russell Patton	LDA wards Year: 2022 Org: CNTW	There were issues with the environments on some of the wards. [This must do is linked to the must do relating to seclusion rooms].	Continue to cross reference the available information obtained from PLACE visits, CERAs, MHA Reviewer visits, Peer Review visits to ensure that clinical environments are making a positive contribution towards care delivery.	30 September 2023	Some slippage with works needing to be brought into 23/24 financial envelope for Mitford.	This will be achieved on completion of the works.

Identified Lead	Source	Must Do	Actions to ensure closures by deadline	Planned timescale for closure	Actions to be taken forward in Q2 23/24	Evidence of impact
			A base line assessment of any outstanding issues will be collated and highlighted for capital expenditure as we move into 2023/24.			
Russell Patton	LDA wards Year: 2022 Org: CNTW	There was no nurse call alarm system on Cheviot, Lindisfarne, Tyne or Tweed wards. [This must do is linked to the must do relating to prone restraint].		Complete		Installation of nurse call systems at Rose Lodge, Tyne and Tweed.
				31 July 2023		This will be achieved on completion of the works.
Dennis Davison	LDA wards Year: 2022 Org: CNTW	Three seclusion rooms did not meet the requirements which meant they were not fit for purpose. [This must do is linked to the must do relating to environments].	Sycamore to be operational by 31 July 2023. Tweed: • The viewing screen enables staff to view one or both suites therefore the relevant screen will be viewed and the other switched off to maintain privacy. • Service have explored alternative viewing point for the CCTV monitor. • Relocation of screens to be completed.	31 July 2023		This will be achieved on completion of the works.
David Muir	Adult acute wards Year: 2019 Org: CPFT	The provider must maintain premises in good condition and suitable for the purpose for which they are being used.	In December 2021, work commenced on Hadrian unit which created a 10-bed female ward and 10-bed male while work was being carried out. Hadrian 1 have now moved into the	30 September 2023		Completion of 2nd phase on Hadrian and upgrade of out-door space on Yewdale.

Identified Lead	Source	Must Do	Actions to ensure closures by deadline	Planned timescale for closure	Actions to be taken forward in Q2 23/24	Evidence of impact
			new updated space however works continue on phase 2 areas (functional areas like reception, office, and patient social and therapeutic spaces). Given the extent of these works Rowanwood will remain as a 10 bed acute ward for now. There has been some work completed on Yewdale ward to update the environment. Discussions have happened about the out-door space and quotes received with regard pressure wash, out-door beds being lowered, cladding and different fills.			
Anna English	CAV wards Year: 2022 Org: CNTW	The trust must ensure that the premises are fit for purpose.	Transfer of services from CAV site to St Nicholas Hospital.	30 July 2024	Retro fit windows at Hadrian is now complete. Car parking has been secured to the side of Hadrian Clinic so staff not longer need to walk through the site. Redecoration continues throughout the clinic.	Completion of works and transfer of services to St Nicholas Hospital site.
(10) Risk assessment and record management						
Bill Kay	CAV wards Year: 2022	The trust must ensure that all staff are aware of patients risks and risk	Roll out of Daily Risk handover across Lowry ward.	30 June 2023		

Identified Lead	Source	Must Do	Actions to ensure closures by deadline	Planned timescale for closure	Actions to be taken forward in Q2 23/24	Evidence of impact
	Org: CNTW	management plans on all wards.				
(11) Staffing levels						
David Muir	Adult acute wards Year: 2019 Org: CPFT	The trust must deploy sufficient numbers of qualified, competent, skilled and experienced staff to meet the needs of patients care and treatment.	Continue with recruitment and retention work. Apply new baseline staffing levels for 23/24 Continue the embedding of MHOST to support safer staffing.	30 September 2023		There has been an improvement in vacancy figures. Cohort 4 international nurses to join in September along with new final year students.
Dennis Davison	LDA wards Year: 2022 Org: CNTW	Cheviot ward did not have enough staff on shifts to meet the staffing requirements for enhanced observations. [This must do is linked to the must do relating to LD&A training].	Define patient need linked to care/observation and risk plans. Continued staff recruitment. Staff to be identified for allocation to Alwinton (Cheviot, Lindisfarne equivalent in new MSU).	31 July 2023		
(12) Physical health and Rapid tranquilisation						
David Muir	Adult acute wards Year: 2018 Org: NTW	The trust must ensure that staff monitor the physical health of patients following the administration of rapid tranquilisation.	Continued monitoring via Localities of the Rapid Tranquilisation monitoring form. Ongoing rollout of training across Localities to ensure compliance increases. Discussion with the Academy with regards holding the records of the training compliance. All adult wards now live with the Rapid Tranquilisation NEWS form. This will need continued monitoring to ensure embedded and for any further glitches to worked through	30 September 2023	Continued monitoring via Localities of the Rapid Tranquillisation monitoring form. Ongoing rollout of training across Localities to ensure compliance increases All adult wards now live with the RT NEWS form. This will need continued monitoring to ensure embedded and for any further glitches to worked through by digital / informatics	Further action required to make improvements.
	Adult acute wards Year: 2019 Org: CPFT	The trust must ensure staff monitor patients' physical health including, following rapid tranquilisation, in accordance with national guidance, best practice and trust policy.				
	Adult acute wards Year: 2019 Org: CPFT	The trust must ensure they have effective systems and processes to assess, monitor and improve care and treatment. This includes identifying, individually assessing and reviewing, blanket restrictions, clear oversight of staff supervision				

Identified Lead	Source	Must Do	Actions to ensure closures by deadline	Planned timescale for closure	Actions to be taken forward in Q2 23/24	Evidence of impact
		and ensuring all physical health monitoring is completed as required. [This must do is also linked to blanket restrictions and staff supervision]	by digital/informatics, PEWS to added onto RiO. Complete Rapid Tranquilisation audit and work through returns with feedback to Clinical Effectiveness Committee in April 2023. Rapid Tranquilisation Policy review. Agency access work completed and fed back to Business Delivery Group and accepted. There will be a focus in Quality Standard Groups to operationalise changes. Last audit for the rapid tranquilisation showed little improvement despite the work completed in this area. Task and finish group met to discuss and agreed not in a position to sign off on this. It was suggested the standards within the policy required review and the policy review date could be brought forward to allow this to take place. Raised as a concern at TSG. Policy update has been brought forward. Policy changes have been made over the life cycle of a number of annual audits. Would suggest a		PEWS to added onto RiO. RT Policy review.	
	LDA wards Year: 2019 Org: CPFT	The provider must ensure that all staff review patients' observations following the use of rapid tranquilisation to comply with the provider's rapid tranquilisation policy and National Institute of Health and Care Excellence guidance.				

Identified Lead	Source	Must Do	Actions to ensure closures by deadline	Planned timescale for closure	Actions to be taken forward in Q2 23/24	Evidence of impact
			review of the methodology is required.			

The table below highlights key themes that have been identified as service shortfalls via a range of different inspection methodologies.

Sources of information	**CQC Must do**	**CQC Should do**	**MHA reviewer visits**	**Mock inspections/peer reviews**
Training, appraisal and supervision compliance	X	X	X	X
Staffing	X	X	X	X
Environments	X	X	X	X
Care planning	X	X	X	X
Reading/recording of rights	X	X	X	X
Medicines management		X		X

CLOSED MUST DOS:

Must Do Theme: (1) Personalisation of care plans		**Lead: Chloe Mann, Group Nurse Director**
		Status:
Community LD Year: 2016 Org: CPFT	The trust must ensure that care plans are person-centred, holistic and presented in a way that meets the communication needs of people using services that follows best practice and guidance.	Closed by Board of Directors on 3 August 2022.
Community OP Year: 2018 Org: CPFT	The trust must ensure that all patients have comprehensive and up to date care plans and risk assessments. Care plans and risk assessments must be regularly reviewed, and information must be used to inform each document.	
Community CYPS Year: 2018 Org: CPFT	The trust must ensure that care planning takes place with young people and is recorded in an accessible format that young people can understand. Care plans must be shared with young people and their carers where appropriate.	
Trust-wide	The work around personalisation of care planning to continue due to the repeated concerns and internal intelligence received during Quarter 3 & 4.	
Evidence of Impact:		
• The metric for the number of current service users who have discussed their care plan remains similar to the Quarter 3 position: o North Cumbria Locality – 88% (December), 87% (March) o North Locality – 97% (December), 96% (March) o Central Locality – 93% (December), 95% (March) o South Locality – 93% (December), 93% (March) • Care planning issues were found in 6 of the 8 MHA reviewer visits undertaken during Quarter 4. • Full audit report due for sign off at Clinical Effectiveness Committee in May 2023. • Action plans have been compiled for each locality (one per CBU) signed off at locality Quality Standards in February 2023. These action plans will be monitored monthly through CBU Quality Standards and quarterly through locality Quality Standards.		

Must Do Theme: (2) Blanket restrictions		**Lead: Karen Worton, Group Nurse Director**
		Status:
Adult Acute wards Year: 2018 Org: NTW	The trust must ensure that blanket restrictions are reviewed and ensure that all restrictions are individually risk assessed.	Closed by Board of Directors on 3 November 2021.
Adult Acute wards Year: 2019 Org: CPFT	The trust must ensure that blanket restrictions are all reviewed and individually risk assessed.	
Evidence of Impact:		
1 blanket restriction was identified during a MHA reviewer visit during quarter 4.		

Must Do Theme: (3) Restrictive practices, seclusion and long term segregation		**Lead: Anthony Deery, Deputy Chief Nurse and Locality Group Directors**
		Status:
LDA wards Year: 2022 Org: CNTW	One person had restrictions in place including long term seclusion and no access to their personal belongings which was not based on current risks. There were no plans to end the restrictions.	Action plan closed as patient transferred to a different hospital on 18 August 2022.
LDA wards Year: 2022 Org: CNTW	There was a high use of prone restraint. [This must do is linked to the must do relating to nurse call systems].	Action plan closed by Board of Directors on 7 June 2023.
Evidence of Impact:		
1 issue concerning restrictive practices was identified during a MHA reviewer visit during quarter 4.		

Must Do Theme: (6) Risk registers		**Lead: Lisa Quinn, Executive Director of Finance, Commissioning and Quality Assurance**
		Status:
Trust-wide Year: 2019 Org: CPFT	The trust must ensure it continues to make progress against the trust risk register and board members and members of staff understand the process of escalating risks to the board through the board assurance framework.	Closed by Board of Directors on 5 August 2020.
Crisis MH teams Year: 2019 Org: CPFT	The trust must ensure systems and processes are established and operating effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients.	
Evidence of Impact:		
• Cycle of risk register review through Trust Leadership Team. • Review and update of Risk Management Strategy received by Board in November 2020. • Board Development session in February 2022 to review risks, identify any emerging risks to be added to BAF, review risk appetite categories and scoring. • Development of future Strategy proposed. • Risk Management Strategy to be taken to June 2023 Board meeting.		

Must Do Theme: (7) Documentation of Consent and Capacity		**Lead: Bruce Owen**
		Status:
Community OP Year: 2018	The trust must ensure that consent to treatment and capacity to consent is clearly documented in patient's records.	Closed by Board of Directors on

Org: CPFT		3 August 2022.
Evidence of Impact:		
• Consent to Examination or Treatment ECT internal audit provided good assurance.		

Must Do Theme: (8) Collecting and acting on feedback from service users and carers	**Lead: Allan Fairlamb, Head of Commissioning & Quality Assurance**	
		Status:
Community CYPS Year: 2018 Org: CPFT	The trust must ensure that quality monitoring takes place to measure service performance, outcomes and progress and ensure feedback from young people and their carers is incorporated into this.	Closed by Board of Directors on 5 August 2020.
Evidence of Impact:		
Quarterly report to Board on patient feedback.		

Must Do Theme: (9) Environmental issues	**Lead: Russell Patton, Deputy Chief Operating Officer, Paul McCabe, Director of Estates and Facilities & Locality Group Directors**	
		Status:
Community OP Year: 2018 Org: CPFT	The trust must ensure that all premises and equipment are safe and suitable for patients and staff. Premises must be reviewed in terms of access and reasonable adjustments to meet the needs of service users and staff. Medical equipment must fit for purpose and records kept to ensure it is well maintained.	Closed by Board of Directors on 26 May 2021.
Adult acute wards Year: 2018 Org: NTW	The trust must ensure patients have access to a nurse call system in the event of an emergency.	Closed by Board of Directors on 4 August 2021.
Long stay / rehab wards Year: 2016 Org: CPFT	The trust must ensure that the first floor of the building has clear lines of sight and an alarm call system that can be easily accessed to summon assistance.	Closed by Board of Directors on 4 August 2021.
OP wards Year: 2019 Org: CPFT	The provider must ensure that plans to relocate Oakwood ward are progressed and the use of dormitory style accommodation on Oakwood is either no longer used or a robust assessment and mitigation of risk is put in place.	Closed by Board of Directors on 3 November 2021.
MH crisis teams Year: 2019 Org: CPFT	The trust must ensure that the health-based places of safety promote the privacy and dignity of patients in Carlisle and Whitehaven.	Closed by Board of Directors on 7 June 2023.
Evidence of Impact:		

Completion of works.

Must Do Theme: (10) Risk assessment and record management		**Lead: David Muir, Group Director**
		Status:
Community LD Year: 2016 Org: CPFT	The trust must ensure that staff complete and record patient's risk assessments consistently evidencing contemporaneous care records for patients who use services.	Closed by Board of Directors on 3 August 2022.
Community CYPS Year: 2018 Org: CPFT	The service must ensure that all young people receive a thorough risk assessment which is recorded appropriately in accordance with the trusts policies and procedures to ensure safe care and treatment.	
MH crisis teams Year: 2019 Org: CPFT	The trust must ensure systems and processes are established to maintain the records of each patient accurately, completely and contemporaneously.	
Evidence of Impact:		
• The metric for service users with a risk assessment undertaken/reviewed in the last 12 months remains similar to previous quarters: o North Cumbria Locality – 90% (December), 89% (March) o North Locality – 97% (December), 98% (March) o Central Locality – 95% (December), 97% (March) o South Locality – 97% (December), 97% (March) • The metric for service users with identified risks who have at least a 12 monthly crisis and contingency plan remains similar to previous quarters: o North Cumbria Locality – 83% (December), 84% (March) o North Locality – 94% (December), 96% (March) o Central Locality – 92% (December), 94% (March) o South Locality – 94% (December), 94% (March) • Compliance for clinical risk and suicide prevention training standards at Quarter 4: o North Cumbria Locality – 77% (December), 82% (March) o North Locality – 80% (December), 83% (March) o Central Locality – 79% (December), 84% (March) o South Locality – 83% (December), 86% (March) No concerns have been identified from MHA reviewer visits undertaken this quarter.		

Must Do Theme: (11) Staffing levels		**Themed Lead: Anthony Deery, Deputy Chief Nurse and Locality Group Directors**
Planned timescale for closure: 31 March 2023		**Status:**
Community CYPS Year: 2017 Org: CPFT	The trust must ensure that there are a sufficient number of appropriately skilled staff to enable the service to meet its target times for young people referred to the service.	Closed by Board of Directors on 3 August 2022.

MH crisis teams Year: 2019 Org: CPFT	The trust must ensure there is always a dedicated member of staff to observe patients in the health-based places of safety.	Closed by Board of Directors on 3 August 2022.
LDA wards Year: 2019 Org: CPFT	The provider must ensure that all patients have regular access to therapeutic activities to meet their needs and preferences.	Closed by Board of Directors on 3 August 2022.
Rose Lodge Year: 2022 Org: CNTW	The service must ensure that the ward has enough suitably trained and qualified staff on each shift.	Closed by Board of Directors on 7 June 2023.
Evidence of Impact:		
• Vacancy levels. • Safer staffing reports will show a reduction in exceptional fill rates for qualified staff. • Allocation sheet. • Daily huddle minutes • Activity planner. • Improved mandatory training compliance. • Improved appraisal compliance. • Improved supervision compliance.		

Must Do Theme: (13) Governance	**Lead: Lisa Quinn, Executive Director of Finance and Quality Assurance**	
		Status:
Trust-wide Year: 2019 Org: CPFT	The trust must ensure it reviews and improves its governance systems at a service level to ensure they effectively assess, monitor and improve care and treatment.	Closed by Board of Directors on 5 August 2020.
MH crisis teams Year: 2019 Org: CPFT	The trust must ensure that systems and processes are established and operating effectively to assess monitor and improve the quality and safety of services.	Closed by Board of Directors on 4 November 2020.
MH crisis teams Year: 2019 Org: CPFT	The trust must ensure they take action in response to regulatory requirements and the findings of external bodies.	Closed by Board of Directors on 7 June 2023.
Evidence of Impact:		
• Trust-wide governance structures. • Agreed terms of reference and policies in place. • 2022 Independent Review of Governance findings and action plan. • Outputs from 2023 Trust-wide Governance review led by Debbie Henderson.		

Must Do Theme: (14) Staff engagement	**Lead: Elaine Fletcher, Group Nurse Director**

		Status:
Adult acute wards Year: 2019 Org: CPFT	The trust must ensure staff working on Rowanwood feel supported, valued and respected following serious incidents beyond ward level.	Closed by Board of Directors on 3 August 2022.
Evidence of Impact:		
Staff survey results and local action plans.		

Must Do Theme: (15) Medicines Management		**Lead: Tim Donaldson, Chief Pharmacist/Controlled Drugs Accountable Officer**
		Status:
LDA wards Year: 2019 Org: CPFT	The provider must ensure that all medicines used are labelled and that risk assessments are always in place for the use of sodium valproate in female patients of child bearing age.	Closed by Board of Directors on 4 August 2021.
Evidence of Impact:		
Results of re-audit during Quarter 1 2023/24.		

Must Do Theme: (17) Bed Management		**Lead: Andy Airey, Group Director**
		Status:
Adult acute wards Year: 2019 Org: CPFT	The trust must continue to look at ways of reducing out of area placements and the management of bed availability to ensure this meets the needs of people requiring the service.	Closed by Board of Directors on 3 August 2022.
Evidence of Impact:		
The number of OAP days continues to decline. The figures during Quarter 4 has decreased to 976 OAP days relating to 39 patients. • Sunderland – 217 (December), 207 (March) • South Tyneside – 41 (December), 16 (March) • Newcastle Gateshead – 410 (December), 381 (March) • Northumberland – 281 (December), 155 (March) • North Tyneside – 28 (December), 90 (March) • North Cumbria – 353 (December), 127 (March)		

Must Do Theme: (18) Section 17 Leave		**Lead: Dr Patrick Keown, Group Medical Director**
		Status:
OP wards Year: 2019 Org: CPFT	The provider must ensure that all section 17 leave forms are individually completed for each patient and show consideration of patient need and risks.	Closed by Board of Directors on 4 August 2021.
Evidence of Impact:		
• Compliance with Section 17 leave expiry dates continues to improve. • One issue was raised during a MHA reviewer visit during quarter 4.		

Must Do Theme: (19) Clinical audits		**Lead: Dr Kedar Kale, Group Medical Director**
		Status:
LDA wards Year: 2019 Org: CPFT	The provider must ensure that clinical audits are effective in identifying and addressing areas of improvement within the service.	Closed by Board of Directors on 3 February 2021.
Evidence of Impact:		
• Locality and Trust-wide governance structures. • Locality cycle of meetings. • Locality tracker.		

13. GOVERNANCE FRAMEWORK REVIEW

Debbie Henderson, Director of Communications and Corporate Affairs

REFERENCES

Only PDFs are attached

- 13a. Governance framework review July 2023.pdf
- 13b. Board Governance Structures - June 23.pdf
- 13c. Ops-management Governance Structures - June 23.pdf
- 13d. 5a. EMG ToR draft June 23.pdf
- 13e. 4. BDG ToR draft June 23 V3.pdf
- 13f. OMG ToR draft June 23 V3.pdf
- 13g. Leadership Forum ToR June 23.pdf
- 13h. 2023-06-02 - Scheme Of Reservation And Delegation.pdf

Report to the Board of Directors
Wednesday 5th July 2023

Title of report	**Review of the Trust's Governance Framework 2023**
Report author(s)	**Debbie Henderson, Director of Communications and Corporate Affairs**
Executive Lead (if different from above)	

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day.	x
2. Person-led care, when and where it is needed – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals	x
3. A great place to work – We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers.	x
4. Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled.	x
5. Working with and for our communities – We will create trusted, long-term partnerships that work together to help people and communities.	x

Board Sub-committee meetings where this item has been considered			**Management Group meetings where this item has been considered**	
Quality and Performance			Executive Team	x
Audit			Executive Management Group	
Mental Health Legislation			Business Delivery Group	
Remuneration Committee			Trust Safety Group	
Resource and Business Assurance			Locality Operational Management Group	
Charitable Funds Committee				
CEDAR Programme Board				
Other/external (please specify)				

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability		Reputational	
Workforce		Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness		Service user, carer and stakeholder involvement	

Board Assurance Framework/Corporate Risk Register risks this paper relates to

Report to the Board of Directors
Wednesday 5th July 2023

Review of the Trust's Governance Framework 2023

1. Introduction and context

During the past 24 months, the Trust has been through a period of significant change. There have been significant changes in the leadership of the organisation not only changes to the Executive Team structure and portfolios but also changes in Group leadership within all localities, and corporate services across the organisation.

In May 2022, the Trust undertook significant changes to the management reporting structures including the disbanding of the Corporate Decisions Team and sub-structures, the implementation of the Trust Leadership Team forum and a review of Board sub-committees and their membership.

Governance is a system that provides a **framework** for managing organisations. It identifies who can make decisions, who has the authority to act on behalf of the organisation and who is accountable for how an organisation and how its people behave and perform.

We know that poor governance can lead to inconsistencies in information and reporting, duplication of effort, and gaps in reporting, risk management, and escalation of key issues, leading to a poor culture.

This review looked at the governance arrangements at Board Sub-Committee, Trust-wide management level and Group-level (including corporate services). This includes consideration of the standardisation of governance arrangements, reporting at Board Sub-Committees, Trust-wide meetings (i.e., Trust Leadership Team, Business Delivery Group) and Group-level meetings (i.e., Accountability Frameworks, Group governance meetings etc.), and ensuring levels of accountability and decision-making are appropriate and effective at all levels in the organisation.

2. Approach

The review of the Trust's governance framework was considered in the context of:

- Individual and group discussions with the Director of Communications and Corporate Affairs (50+ people and groups)
- Review of Board, corporate, Group and individual accountability and responsibilities (Scheme of Delegation)
- The refresh of the Trusts overarching strategy
- The outcome of the Trusts recent independent Well Led Review
- Learning from best practice and governance failures detailed in the publication of independent reports from other health and care organisations (including the independent review into the governance arrangements at Tees, Esk and Wear Valley NHS FT).

3. Findings

Key themes following the review were:

- Board and committees work well, but some elements of review required (including a review of the purpose and membership of meetings, particularly in relation to the Provider Collaborative/Lead Provider Committee)
- Senior management level – too many meetings, often leading to duplication of discussions and information required – no time for 'head space' or to 'do the doing'
- Still a sense of command and control and lack of clarity in 'what decisions need to be made where'.
- No space to have real discussions – to answer the 'so what' question
- Gap in a space for 'management' conversations in the governance framework around business cases, tenders and other organisational opportunities
- Unclear of the purpose and value of key senior leadership meetings/forums

4. Outcome of the review

4.1 Board of Directors and Sub-Committees

It was found that the Board generally works well. The Board agenda has a strong balance between a focus on strategic issues, performance and managing organisational risks and issues of concern. The Board works well together and the need to focus on more 'team development' for the Board has already commenced.

It was noted that a review of the Annual Board cycle should be carried out. This includes the information that **must** come to Board, those that **should** come to Board and those that functions **like** to come to Board. It was also noted that timings of meetings should be reviewed to allocate more time to the closed and development meetings given the challenges faced by the organisation, and the need for safe space to discuss issues openly with Board members.

Committees are structured well and focus on issues within their delegated responsibility and terms of reference. There is evidence of more detailed assurance reporting to Committees in comparison to Board, but a review is ongoing on what information is reported, and how, through discussion with the relevant Chairs and Executive Leads.

The Provider Collaborative and Lead Provider Committee (PCLP) requires a review. It is felt that the Committee requires a review of its purpose and function. A review of the PC governance arrangements will inform this review.

The decision to change the membership of Board Committees to be comprised of NED, Execs and Governors only was highlighted as ineffective. Assurance often cannot be provided by the Executive Lead and can only be provided adequately by subject experts. Committee terms of reference including membership, will be reviewed during Quarter 2.

4.2 Council of Governors

The Council of Governors works well and relationships between the Council of Governors and Board of Directors supported by relationships based on mutual respect, openness and transparency.

The Council of Governors has undertaken a review of its effectiveness which was presented to the Governors meeting in June. A detailed discussion took place on areas where the Trust can further support the Governors in their role.

4.3 Trust Leadership Team

It was felt that TLT lacked space to have management or strategic discussions, with little time to focus on the 'so what…' question and actions to be taken. The Trust Leadership Team will be stood down and an Executive Management Group will be established (see below).

4.4 Executive Management Group

The Executive Management Group will be established to make Trust wide and corporate decisions, oversee the Trust's interface with partners across the ICS, oversee the delivery of the Trust's core programmes and ensure it has a collective understanding of the strategic and operational challenges of the organisation. The EMG will discuss and contribute to the opportunities and actions to tackle these challenges in the context of local, regional, and system-wide priorities.

The Executive Management Group will report into the Board of Directors via the Chief Executive's Report as Chair of the Group.

4.5 Leadership Forum

A Trustwide Leadership Forum will be established to take place on a quarterly basis comprised of senior leaders from all localities and corporate services to discuss our strategic direction and plans as an organisation. This will also focus on the leadership and organisational development plan and work on development of organisational culture.

4.6 Transformation Programmes (UIP, CYPs and Community Transformation)

The current programme boards will report to EMG on progress against delivery, but with a focus on items by exception escalated by Executive Leads.

4.7 Business Delivery Group (BDG)

It was acknowledged that the focus of BDG has been primarily focused on the work of the transformation programmes. BDG has been reviewed and re-established to

focus on the coordination, oversight, and monitoring of systems for the effective assessment and management of risk, safety, quality, and performance in relation to the delivery of operational services. This will provide cross-locality consideration of key operational issues affecting quality, workforce, performance, and finance.

4.8 Trust Safety Group

Feedback from the review was that TSG was well established and effective with a clear focus on significant issues, actions and learning at a Trust wide perspective. TSG reports into the Executive Management Group, Quality and Performance Committee and Board of Directors on relevant issues ensuring senior leaders are sighted on key quality and safety issues across the organisation.

4.9 Locality Operational Management Group

Each locality will have an OMG which will provide a means of cascading information and actions from Trust Safety Group and Business Delivery Group, and manage the operational business of the locality, including delivery of performance standards, quality, safety and workforce management.

4.10 Accountability Framework meetings (Well Led Review meetings)

Feedback from all Groups and Director and Associate Director level was that Groups find these sessions incredibly valuable both in terms of visibility of the Executive Team, support from the Executive Team and ensuring that the Executive Team are aware of the issues they're facing. It also provides an opportunity to request support at a Trust wide level as and when needed.

It is proposed that these are reframed as 'Well Led Review meetings'. Chaired by the Chief Operating Officer and to take place within the localities. Meetings should focus on bottom-up discussions and provide an opportunity for the locality to inform Execs of their issues, and how the Execs can support the teams.

Well Led review meetings will report into EMG and Quality and Performance Committee by exception via Group Directors.

4.11 Scheme of Delegation

Following the review and above changes, a review of the Scheme of Delegation has been undertaken and clarity made in terms of delegated authority. Supporting materials will be developed for key leaders and managers across the organisation to ensure clarity in terms of decision making, accountability and authority to ensure decisions are made as close to services as possible.

5. Governance failings in other organisations – lessons learnt

As part of this review, we have reviewed the lessons learnt from governance failings in other organisations. Although the Trust has in place a strong governance framework which has recently been validated through the independent governance review using the CQC Well Led framework, this review has enabled us to implement

changes which will further strengthen the framework in terms of the following key areas:

- Ensuring the Trust continues to listen to families and carers

The Trusts governance framework embeds lived experience within the different tiers of the organisation from locality level to senior level with service user representation on locality meetings, Executive Management Group and Board Sub-Committees.

- Avoiding complicated governance arrangements and ensuring clarity on where decisions are made and where decisions are delegated

The Trust has reviewed the purpose and remit of key operational and management meetings as described in this report and the Trust's Scheme of Delegation.

- Ensuring the framework supports the ability to evidence reporting and escalating key issues of concern, and the ability to escalate issues at the right time

The framework provides a clear line of sight from services to locality, to senior management, to Board/Committees.

- Ensures oversight and ownership of risk management across the organisation and at Board level

The Trust has recently reported a 'good assurance' rating for risk management protocols and procedures. Following the implementation of the new Trust Strategy, With You in Mind, a review of the Trust Board Assurance Framework is underway to ensure the Board and sub-committees through delegated responsibility, are sights on the key areas of risk to the Trust, its workforce, and the people we serve.

- Commitment to openness and transparency with service users and carers

Through the Trust Safety Group, Duty of Candour processes are reviewed and monitored on an ongoing basis. The Group also ensures processes are in place to share learning across and out-with the organisation where appropriate.

- Ensuring that information and reporting consists of both hard and soft intelligence

The Trust has refreshed its approach to Executive, Non-Executive and Governor service visits. Intelligence gathered from such processes is triangulated with hard data and intelligence reporting to ensure a full picture of the experience of our services can be gained. Well led review meetings at locality level provide an opportunity for those working within services to discuss any issues of concern with the Executive Team and seek support when needed.

6. Summary and Recommendations

The review of the governance framework has been a comprehensive and valuable exercise. The report provides details of the actions taken to ensure that we further strengthen our governance arrangements to ensure that Trust is focused on the management of key risks and issues at the most appropriate level in the organisation. It has simplified the framework and will ensure visibility at senior management and Board level on the key issues of concern throughout the organisation, ensure teams in services are supported, and the action is being taken to address such concerns.

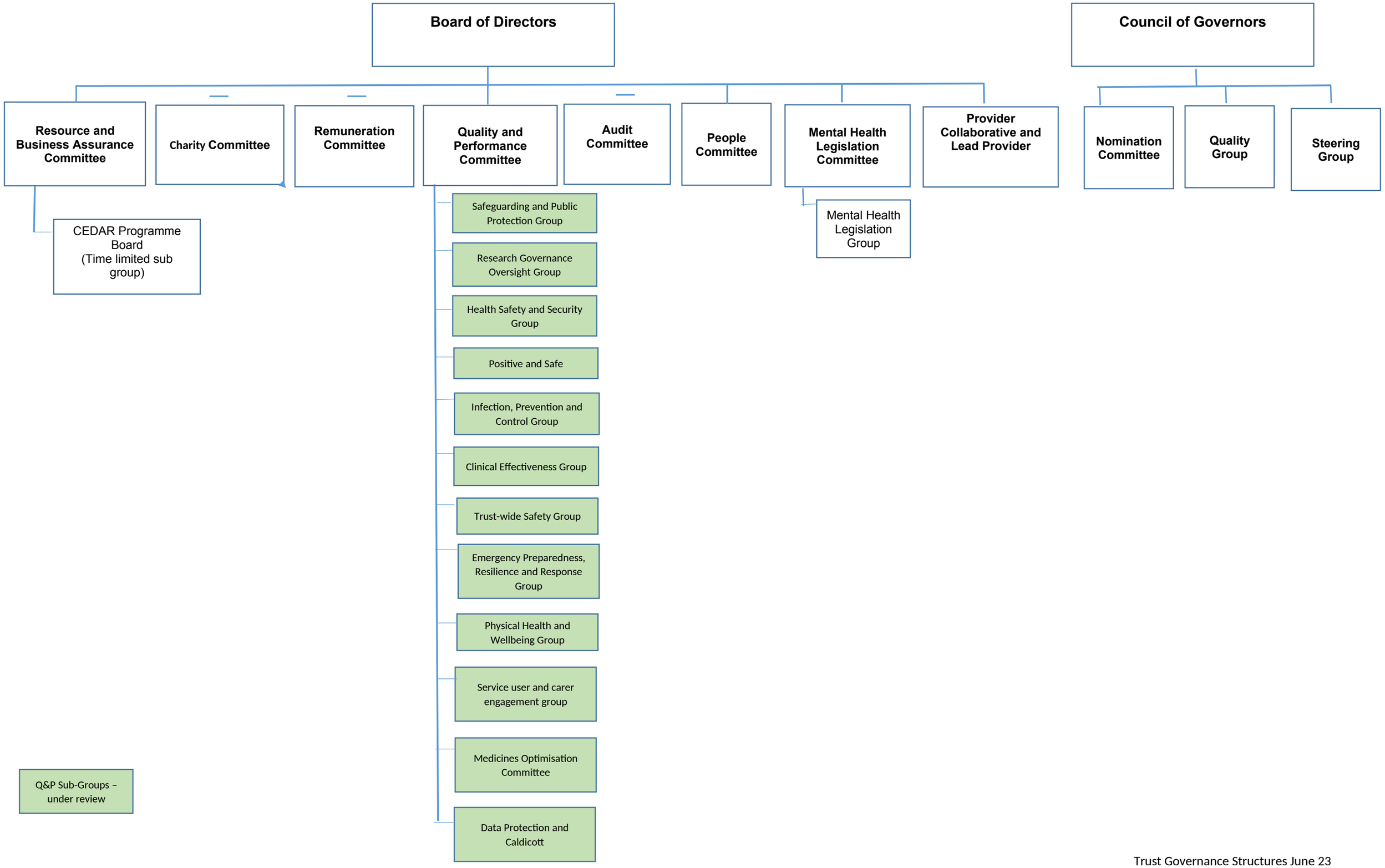
A further review of the new framework will be undertaken in 12 months to assess the effectiveness of the new framework.

The Board is asked to note the content of the report and approve the Scheme of Delegation and Reservation for Trust (Appendix G).

Debbie Henderson
Director of Communications and Corporate Affairs
June 2023

Appendix a – Board structure
Appendix b – Delivery and governance structure
Appendix c – Executive Management Group – Terms of Reference
Appendix d – Business Delivery Group – Terms of Reference
Appendix e – Locality Operational Management Group – Terms of Reference
Appendix f – Leadership Forum Terms of Reference
Appendix g – Scheme of Delegation and Reservation

Board Governance Structure



Delivery and Governance Structure

Board of Directors
(monthly)

Executive Management Group
(monthly)

- Locality Well Led Meetings *(Quarterly in localities)*
- Key Programme Boards
- Trust wide Safety Group (weekly)
- NENC ICB MHLDA Sub-Committee

Leadership Forum
(quarterly)

Trust wide Business Delivery Group
(weekly)

Quality | Finance | People

Operational Delivery Group North Locality
(weekly)

Quality | Finance | People

Service user and carer involvement

Operational Delivery Group South Locality
(weekly)

Quality | Finance | People

Service user and carer involvement

Operational Delivery Group Central Locality
(weekly)

Quality | Finance | People

Service user and carer involvement

Operational Delivery Group North Cumbria Locality
(weekly)

Quality | Finance | People

Service user and carer involvement

Clinical Business Units

Key:

Delegated authority and reporting

Operational/organisational oversight

Executive Management Group

Terms of Reference

Group Name	Executive Management Group (EMG)
Frequency	Monthly
Administration	Executive Assistant – Chief Executive's Office
Reports to	Board of Directors – CEO summary report
Membership	
Chair:	Chief Executive
Deputy Chair:	Deputy Chief Executive/Medical Director
Members:	Chief Executive Deputy Chief Executive/Medical Director Executive Director of Finance Executive Director of Nursing, Therapies and Quality Assurance Executive Director of Workforce and Organisational Development Chief Operating Officer Director of Communications and Corporate Affairs Deputy Director of Nursing Deputy Medical Director *(Deputy Caldicott Lead)* Director of AHP and Psychological Services AHP Lead Psychology Lead Chief Pharmacist Chief Information Officer or Chief Clinical Information Officer Chair of the Service User and Carer Reference Group <u>Locality Director representation:</u> Director representative from each locality (North, South, Central and North Cumbria) (The composition of group representatives for each meeting must include one group director, one group nurse director and one group medical director)
In attendance:	The Chair of EMG may also request individuals to attend on an ad-hoc basis to provide advice and support for specific items.
Quorum	A minimum of 7 members to include: • A minimum of three Executive Directors (including the Chief Executive or Deputy Chief Executive) • One Group Director • One Group Nurse Director • One Group Medical Director • One other member The Chair of EMG may also request individuals to attend on an ad-hoc basis to provide advice and support for specific items.

	Decisions where required will be made by majority vote of all attendees. Where decisions cannot be reached by consensus, the Chief Executive (or their appointed deputy) will make the final decision.

Purpose

The purpose of EMG is to make Trust wide and corporate decisions, oversee the Trust's interface with partners across the ICS, oversee the delivery of the Trust's core programmes and ensure it has a collective understanding of the strategic and operational challenges of the organisations. The EMG will discuss and contribute to the opportunities and actions to tackle these challenges in the context of local, regional, and system-wide priorities.

The Trust operates a devolved model of operational delivery. Responsibility for operational delivery resides with the Locality Operational Management Groups as set out in the Trust Scheme of Delegation, supported by the Trust Business Delivery Group.

The Groups purpose is to:

- Make key decisions, which have corporate and Trust wide implications in line with the scheme of delegation.
- Oversee the Trusts position in terms of influencing the priorities for the North East and North Cumbria Integrated Care System, including Provider Collaborative and the Executive Sub-Committee of the Integrated Care Board for Mental Health Learning Disabilities and Autism.
- Ensure an approach to Involvement is embedded across the organisation in support of the delivery of the Trust's strategic ambitions.
- Oversee the Trusts ongoing position on achievement of strategic and annual objectives, review, and update strategy, and agree the annual plan for approval by the Board.
- Oversee the achievement and delivery of the Trusts key programmes of work.
- Achieve a common understanding of the key areas of priority for the Trust in relation to quality, safety and performance, the actions already being taken, learning from those actions and ability to contribute to discussions on Trust-wide actions which need to be taken to address the challenges.
- Achieve a common understanding of the collective position in relation to other challenges across the organisation and wider system (i.e., finance and workforce), and contribute to actions required to develop strategic, long-term plans in relation to these.
- Achieve a common understanding of the associated risks and mitigations associated with the above.
- Provide a safe space for collective discussion on issues of concern, opportunity, and strategic importance.
- Agreeing and being clear on the key messages that we are sharing across the organisation and ensure collective ownership of Trust wide Communication.
- Provide a space to discuss, share and test the developing culture of the organisation and our devolved model of leadership.

Deliverables

The EMG is responsible for:

- Making decisions according to the authority delegated to the EMG in line with the Trust Scheme of Delegation.
- Have oversight and collective understanding of the delivery of the key programmes of work.

- Sharing intelligence on priorities, discussions, and activity at NENC ICS system-level. Overseeing the interface between the Trust and the ICB.
- Sharing good practice, promoting improvement, and ensuring EMG members are aware of national policy and guidance and local and regional developments.
- Have oversight of major Trust contracts including Provider Collaborative, Lead Provider contracts and NTW Solutions.
- Supporting the Executive Team and Board of Directors in the development and delivery of the Trust's strategic ambitions, supporting strategies and operational plans.
- Have oversight of the key Trust-wide risks associated with the delivery of the Trust's strategy, supporting strategies and operational plans.
- Collectively discuss and contribute to the decisions required to collectively tackle cross cutting and cultural issues within and out-with the organisation.
- Oversight of, and ensure the Trust's influence and involvement at neighbourhood, Local Authority, Integrated Care Partnership (ICP) and Integrated Care System (ICS) level working in the best interests of our service users and carers, and local people more generally.
- Oversee the Trust's approach to learning, research, and innovation.
- Understand and review key areas of regulatory non-compliance.
- Have oversight of the Trusts policies, procedures and internal plans relating to Emergency Preparedness, Resilience and Response (EPRR) and Crisis management.
- Understanding key issues relating to quality, safety, and operational delivery – this is by exceptional only and should only relate to issues which could pose a significant risk to the Trust.
- Understand key messages, communication, involvement, and engagement programmes at regional and system-wide level with aim of influencing system-wide messaging and decisions.
- Have oversight of the development and delivery of the Workforce and Organisational Development enabling strategy.

Decision Making

- Decision making, will be in accordance with the authority delegated to the EMG via the Scheme of Delegation
- Where appropriate, EMG will contribute to recommendations to the Executive Team and Board of Directors in respect of decisions reserved to the Board.

Sub-groups

Business Delivery Group (BDG) – **exception only**
Trust wide Safety Group (TSG) – **exception only**
Trust Key Programme Boards
Service User and Carer Reference Group

The work of the ICB Executive Mental Health, Learning Disability and Autism Committee will also be reported to the Executive Management Group.

Document review date

First draft date – June 2023

Date of next review – June 2024

Business Delivery Group

Terms of Reference

Group Name	Business Delivery Group (BDG)
Frequency	Weekly
Administration	Executive Assistant – Chief Executive's Office
Reports to	Executive Management Group *(by exception only)*

Membership	
Chair:	Chief Operating Officer
Deputy Chair:	Deputy Chief Operating Officer
Members:	Group Triumvirate Directors – North Locality Group Triumvirate Directors – South Locality Group Triumvirate Directors – Central Locality Group Triumvirate Directors – North Cumbria Locality Director of Allied Health Professionals and Psychological Services Director of Safety, Security, Resilience and Trust Innovation Deputy Medical Director for Revalidation and Appraisal Director of Medical Education Chief Pharmacist Director of Informatics Deputy Chief Nurse Deputy Director of Finance Deputy Director of Workforce and Organisational Development Deputy Director for Safer Care Deputy Director of Commissioning and Quality Assurance Associate Director CNTW Academy Associate Director of IG and Mental Health Legislation Head of Performance and Operational Delivery Head of Safety and Security and Resilience
In attendance:	Executive Directors will have open invitation to all meetings. Managing Director or deputy of NTW Solutions will be invited to meetings focusing on finance and estate and workforce. Other representatives will be invited to the meeting at the request of the Chair for specific issues when appropriate.
Quorum	A minimum of 11 members to be present which must include six representatives from Group triumvirate cohort, four corporate leads, and either the Chair or Vice-Chair.

Purpose

The purpose of the meeting is to:

- Co-ordinate, oversee, and monitor systems for the effective assessment and management of risk, safety, quality, and performance in relation to the delivery of operational services.
- Provide a forum for cross-locality considerations on key operational issues affecting quality, workforce, performance, and finance.
- Provide a forum for oversight of operational delivery of key Trust priorities.
- Respond to any urgent operational delivery matters affecting service quality or sustainability.
- Work collaboratively with corporate teams to deliver effective operational services.
- Provide a mechanism to cascade information to operational leadership teams/forums.

Deliverables

Quality and performance

- Provide a forum for cross locality discussion on operational matters affecting the delivery of safe, quality care.
- Ensure effective arrangements are in place for operational delivery of key quality and safety priorities across the Trust.
- Identify changes to policy or practice which require improvement or significant change.
- Share learning across localities and corporate departments on areas of non-compliance.
- Review exceptions on legislative and regulatory compliance visits and associated action plans.
- Ensure changes to policy and practice are considered, clearly communicated, and implemented appropriately.
- Work with the Trust Safety Group on areas of safety and quality improvement to ensure they are embedded operationally across all localities.
- Review and update the highest scoring (>15) risks across all localities.

Workforce

- Embed our strategy, values, and strategic ambitions by ensuring effective staff engagement and communication is in place across operational services.
- Lead and support staff to work safely and promote an open learning culture across all services.
- Monitor and review changes to training priorities across the Trust.
- Review educational and professional development priorities which impact on operational services.
- Oversee the operational delivery of key workforce initiatives and metrics including vacancy position, recruitment initiatives, sickness absence and employee relations.
- Oversee, develop, implement, and report on a range of Workforce and organisational development initiatives across clinical operational services.
- Encourage and facilitate innovation and research.
- Ensure data and information governance reporting across operational services and associated standards are robust and in line with Trust policies and procedures.

Finance and estates

- Co-ordinate and oversee the delivery and assessment of operational financial plans, including efficiency targets and cross locality investments.
- Support the development of key annual business-related tasks including the development of tenders, business cases and contracts *which have cross Trust impact*, prior to consideration for approval at OMG.
- Identify and agree plans to address immediate estate and environment deficiencies impacting on delivery of safe operational services.

Decision Making

- Decisions taken at BDG will be in accordance with the Trust Scheme of Delegation.
- BDG will review locality operational decisions which have cross Trust impact.
- To receive, review and approve all Operational, Clinical, Workforce, Finance and Medicines Optimisation Policies with the Trust, except those that require Board of Directors approval.

Document review date

First draft date – June 2023

Date of next review – June 2024

Locality Operational Management Group

Terms of Reference

Group Name	Locality Operational Management Group (OMG)
Frequency	Weekly
Administration	Group PA
Reports to	Executive Management Group *(by exception for decisions over and above delegated authority as per the Trust's Scheme of Delegation)* Business Delivery Group *(for organisational oversight)* Trust Safety Group
Membership	
Chair:	Group Triumvirate Director
Deputy Chair:	Group Triumvirate Director
Members:	Clinical Business Unit Leadership Teams Associate Director Associate Nurse Director Associate Medical Director Associate Director of AHPs Associate Director of Psychology Lead Pharmacist Head of Workforce Head of Commissioning and Quality Assurance Head of Business Development Operational Support Manager
In attendance:	Other roles will be invited to the meeting from across the locality for specific issues
Quorum	A minimum of 6 members to be present which must include 1 X Group Triumvirate Director and 1 x Representative from each CBU.
Purpose	

The purpose of the meeting is to:

- Provide a means of cascade of information and actions from Trust Safety Group and Business Delivery Group.
- Manage the operational business of the locality, including delivery of performance standards, quality and workforce management.
- Ensure our values and commitments are embedded across the locality.
- Oversee the management and leadership arrangements for all workforce standards in the locality.
- Oversee effective management of risk, safety and quality standards.

- Ensure compliance with law, governance and regulatory standards.
- Ensure lessons learnt, innovation and best practice identified and shared across the Locality.
- Ensure appropriate management controls are in place against key risks or areas of underperformance.
- Oversee the effective use of resources, investments, and delivery of contractual obligations.
- Ensure an approach to service user and carer involvement is embedded across the locality and services in support of the delivery of the Trust's strategic ambitions.

Deliverables

Quality and performance

- Review the locality integrated performance report and implement recovery plans for areas of under performance against key standards.
- Review all legislative and regulatory compliance visits and associated action plans.
- Review all audit and peer review outcomes for the service and ensure appropriate action plans are in place.
- Support the delivery of Trust wide quality initiatives within the locality.
- Ensure changes to policy and practice are clearly communicated and implemented across all CBUs.
- Review and develop service user, carer, and family experience feedback mechanisms to improve services, including action taken on patient complaints.
- Develop and monitor safety and quality improvement plans, including serious incidents and after-action reviews.
- Ensure key quality and safety messages are communicated and discussed across the leadership team.
- Embed learning and improvement on key quality and safety priorities.
- Review and update the locality risk registers for all CBUs.
- Identify service developments and review models of care to ensure the services provide up to date evidence-based treatment.
- Monitor the delivery of contractual requirements and ensure effective engagement is in place with all commissioners.
- Ensure the locality has in place effective arrangements to support the implementation and communication of key Trust strategic programmes of work.

Workforce

- Embed our values and ensure effective staff engagement and communication is in place across the locality.
- Lead and support staff to work safely and promote an open learning culture across all services.
- Help staff to keep healthy, maximising wellbeing and prioritising absence management.
- Educate and equip staff with the necessary knowledge and skills to do their job.
- Develop the leadership capability across the locality.
- Develop effective workforce plans to support recruitment, retention, service development and financial sustainability.
- Encourage and facilitate innovation and research.
- Ensure data and information governance reporting across the locality is robust and in line with Trust policies and procedures.

Finance and estates

- Review the locality financial position and identify areas for increased controls or improvement

in accordance with the locality forecast and financial plan.

- Review, and develop and approve business cases for investment within the delegated authority set out in the Scheme of delegation, to support the delivery of the Trusts strategic ambitions.
- Report and oversee minor works programmes within the locality.
- Ensure key strategic capital developments have robust and appropriate locality delivery plans in place.
- Ensure the estate within the locality is fit for purpose in accordance with Health and Safety Legislation.
- Ensure estate within the locality is up to date in terms of information and guidance.

Decision Making

Decisions taken at OMG will be in accordance with the Trust's Scheme of Delegation for triumvirate directors, clinical business unit leadership teams, clinical services, and departments.

Any decisions requiring escalation will be referred to the Executive Management Group.

Document review date

First draft date – June 2023

Date of next review – June 2024

Trust Leadership Forum

Terms of Reference

Group Name	Trust Leadership Forum (TLF)
Frequency	Quarterly
Administration	Executive Assistant – Chief Executive's Office
Reports to	Board of Directors – via CEO EMG report

Membership	
Chair:	Chief Executive
Deputy Chair:	Deputy Chief Executive/Medical Director
Members:	Executive Directors Group Directors CBU Associate Directors Professional Leads Corporate Deputies / Leads Group / Corporate Heads of Service
In attendance:	Additional attendance as required on an ad-hoc basis depending on topic items.

Purpose

The purpose of the forum is to collectively give and receive important information, discuss and take forward areas of work/initiatives to further develop the organisation and build effective leadership to deliver With You in Mind.

Contribute to the development of a leadership team with:

- The right behaviours, skills, and expertise to draw upon.
- Clarity of purpose and ways of working – being clear on what is important to us and leadership expectations.
- The confidence, information, and skills to champion, engage and empower people, foster innovation, lead large scale improvement and change, develop a (more) collaborative, caring and compassionate culture and influence others to do the same.
- The confidence and ability to lead and partner well within CNTW, and, within and across the North East and North Cumbria Health and Care system.

Deliverables

The Trust Leadership Forum is responsible for:

- Defining and embedding CNTWs leadership approach, aligned to delivery of WYiM

- Building leadership capacity and capability in line with the critical leadership behaviours identified by the Board.
- Ensuring colleagues continuously develop their personal, collective, and collaborative (system) leadership – enabling leaders to use what they know and learn in their everyday work.
- Developing and enabling leaders to create and embed the conditions for people, teams, services, partners to thrive.
- Ensuring leaders are supported and motivated to lead well and Identifying/minimising/ removing obstacles that hinder/prevent effective leadership.

Decision Making

- No formal decision-making responsibility

Document review date

First draft date – June 2023

Date of next review – June 2024

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Appendix 1

Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust ("the Trust") – Scheme of Reservation and Delegation

This Scheme of Reservation and Delegation ("the Scheme") is referred to in the Trust's Standing Financial Instructions (SFIs) and it forms part of the Trust's Corporate Governance Manual. The purpose of the Scheme is to summarise in one document the decision making system that applies at the Trust, including matters which are reserved to the Board of Directors (Part A) and those decisions that have been delegated to certain executives, sub-groups or individuals by the Board of Directors (Part B).

The Board of Directors of the Trust has established a number of direct sub-committees, which provide the Board of Directors with Assurance on specific areas of the Trust's business and operations. Decision making on management issues is delegated to the Executive Directors, who manage this through a number of sub-groups. The governance structure of the Trust, both in terms of assurance and management matters is set out in the diagram at Appendix A to this document. (Page 29)

The Trust's subsidiary company, NTW Solutions Limited has its own Scheme of Reservation and Delegation, under which certain matters are reserved to the Trust as the sole shareholder.

Part A - Decisions reserved to the Board of Directors

HR Decisions	Source of additional advice to support decisions	Source of assurance
Approve the basis for the determination of commencing pay rates, conditions of service, etc. for officers (e.g., AfC terms and conditions and associated regulations)	Director of Finance and the Director of Workforce and OD	Reports and minutes of meetings
Approve pay increases or terms and conditions review for Executive Directors.	Remuneration Committee for Executive pay (for Trust and NTW Solutions) with advice from Chief Executive and/or Director of Workforce and OD	Reports and minutes of meetings
Appoint one of the NEDS to be the Senior Independent Director (in consultation with the Council of Governors) per NHSE's Code of Governance	Director of Communications and Corporate Affairs Governors' Nomination Committee	Reports and minutes of meetings
Finance and commercial decisions	**Source of additional advice to support decisions**	**Source of assurance**
Approve annual financial plans (including high level budgets and the capital programme)	Director of Finance Resource and Business Assurance Committee	Reports and minutes of meetings
Contracts over £6m (total contract value) for supply of goods, works and services to Trust (non-healthcare)	Director of Finance Resource and Business Assurance Committee	Business Cases/reports Minutes of meetings
Approval of new capital schemes (including acquisitions) above £6m.	Director of Finance Resource and Business Assurance Committee	Business Cases/reports Minutes of meetings

	Council of Governors – significant transactions as described in the Trust Constitution require Council of Governor approval (NHSE definition of significant transaction).	
Approval of disposal of a Trust asset with a book or market value above £6m	Director of Finance Resource and Business Assurance Committee	Business cases/reports Minutes of meetings
Approval of Business Cases with revenue implications above £6m per annum	Director of Finance Resource and Business Assurance Committee	Business cases/reports Minutes of meetings
Approval of Tenders for provision of services by the Trust with revenue implications in excess of £6m per annum	Director of Finance Resource and Business Assurance Committee	Business cases/reports Minutes of meetings
Approval of variations to Trust PFI agreements or agreements with NTW Solutions Ltd with revenue implications in excess of £6m per annum, or capital implications in excess of £6m	Director of Finance Resource and Business Assurance Committee	Business cases/reports Minutes of meetings
Writing off losses and/or approving special payments in excess of £50,000	Director of Finance Audit Committee	Reports and minutes of meetings
Clinical and operational decisions	**Source of additional advice to support**	**Source of assurance**

	decisions	
Agree Trust Level Performance Standards To be agreed in conjunction with Groups and Corporate Directors in line with agreed strategic objectives	Chief Operating Officer Quality and Performance Committee Executive Management Group	Reports and minutes of meetings
Strategic or service development decisions	**Source of additional advice to support decisions**	**Source of assurance**
Define the strategic aims and objectives of the Foundation Trust and the strategic framework to deliver these aims and objectives.	Chief Executive Officer and wider Executive Team (wider stakeholder engagement to be considered) Board sub-committees Executive Management Group	Trust Strategy document Reports and minutes of meetings
Identify the key strategic risks, evaluate them, and ensure appropriate arrangements are in place to monitor and arrange this risk including ongoing Board oversight (Board Assurance Framework)	Director of Communications and Corporate Affairs Audit Committee All Board sub-committees	Reports and minutes of meetings
Approve the Annual Plan including new business development proposals.	Director of Finance Resource and Business Assurance Committee Board sub-committees	Annual plan submission document Reports and minutes of meetings

	Executive Management Group	
Approve short term and long-term financing arrangements, loans and working capital facilities.	Director of Finance Resource and Business Assurance Committee	Planning submissions and Business cases Reports and minutes of meetings
Agree temporary or permanent closure of a ward or service where the closure will be for a period in excess of 72 hours. Or where there has been a previous instance in the preceding three-month period of an immediate closure of the ward of less than 72 hours, approved under Part B of this SoD	Chief Operating Officer Director of Finance Quality and Performance Committee	Reports and minutes of meetings Urgent communications
Approve the establishment of legal partnerships, Provider Collaboratives, subsidiaries, joint ventures and other significant transactions (including mergers and acquisitions)	Director of Finance recommendation on investments and significant transactions Resource and Business Assurance Committee (assurance on the application of the Trust's Investment Policy) Provider Collaborative/Lead Provider committee Executive Management Group View of Council of Governors is required to proceed with significant transaction as defined in the Trust Constitution (incl., mergers and/or acquisitions)	Business Cases Reports and minutes of meetings

Regulation and Control Decisions	**Source of additional advice to support decisions.**	**Source of assurance**
Any matter for which the Board has delegated or statutory authority within its statutory powers.	Chief Executive Officer Director of Communications and Corporate Affairs	Trust Constitution and associated statutory and regulatory guidance.
Approve amendments to the Trust's constitution. Jointly agreed by the Board of Directors and Council of Governors. Where amendments are made to the powers or duties of the Council of Governors, this is subject to a vote by the members at the Annual Members Meeting to ratify the change.	Director of Communications and Corporate Affairs Council of Governors	Trust Constitution Reports and minutes of meetings
Approve • Standing Orders and any variation and amendment • Standing Financial Instructions for the regulation of its proceedings and business • Investment Policy • Standards of Business Conduct and Conflicts of Interest Policy • Any other guidance regarded as key to the governance framework.	Director of Communications and Corporate Affairs Director of Finance Audit Committee Council of Governors	Reports and minutes of meetings Published documents
Suspend Standing orders	Chief Executive Director of Communications and Corporate Affairs	Reports and minutes of meetings

	Audit Committee	
Ratify urgent decisions by Chair and Chief Executive	Chairman Chief Executive	Reports and minutes of meetings Urgent communications
Require and receive the declaration of Board of Directors members' interests	Director of Communications and Corporate Affairs	Reports and minutes of meetings Published documents.
Adopt the organisation governance structures i.e., the structure of the Board of Directors and its sub-committees.	Director of Communications and Corporate Affairs	Reports and minutes of meetings Published documents.
Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention.	Chief Executive Director of Communications and Corporate Affairs	Reports and minutes of meetings
Approval of how the Trust's charitable funds held on Trust will be administered	Director of Finance Director of Communications and Corporate Affairs Charitable Funds Committee	Reports and minutes of meetings Terms of Reference for Charitable Funds Committee outlining delegated authority.
Approve the Trust's registration with the CQC.	Executive Director of Nursing, Therapies and Quality Assurance Quality and Performance Committee	Publication of formal documentation Reports and minutes of meetings

Approve mandatory and statutory reports as required, e.g., Medical Revalidation Annual Report, Safer Staffing, etc.	Executive Directors Director of Communications and Corporate Affairs Board sub-committees	Cycle of business Reports and minutes of meetings
Decisions relating to Sub-Committees of the Board	**Source of additional advice to support decisions.**	**Sources of assurance**
Establish and agree terms of reference for all sub-committees of the Board of Directors. These must include: • Audit Committee • Remuneration Committee • Mental Health Legislation Committee Approve any amendments to existing Terms of Reference for the above.	Director of Communications and Corporate Affairs Committee Chairs/Executive Leads for Board sub-committees	Minutes of meetings Approved Terms of Reference
Disestablish any existing sub-committee of the Board of Directors	Director of Communications and Corporate Affairs Committee Chairs/Executive Leads for Board sub-committees	Minutes of meetings
Take decisions on reports received from sub-committees that are established by the Board of Directors, including those that the Trust is required by the regulation to establish and to take appropriate action on.	Committee Chairs/Executive Leads for Board sub-committees Director of Communications and Corporate Affairs	Minutes of meetings

Decisions relating to Audit matters	Source of additional advice to support decisions.	Source of assurance
Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee	External auditors Audit Committee	Reports and minutes of meetings Publication of documentation
Decisions relating to the Annual Report and Accounts	**Source of additional advice to support decisions.**	**Source of additional advice to support decisions.**
Receipt and approval of the Foundation Trust's Annual Report and Annual Accounts, Annual Governance Statement and Quality Accounts	Director of Finance Director of Communications and Corporate Affairs Chief Operating Officer Audit Committee	Reports and minutes of meetings Publication of Annual Report and Accounts, Quality Account, Annual Governance Statement
Receipt and approval of the Annual Report and Annual Accounts for charitable funds held on trust.	Director of Finance Charitable Funds Committee Audit Committee	Reports and minutes of meetings Publication of Annual Report and Accounts
Board Monitoring Arrangements	**Source of additional advice to support decisions.**	Source of additional advice to support decisions.
Continuous appraisal of the affairs of the Foundation Trust by means of the receipt of reports as it sees fit from Board members, committees, and officers of the Foundation Trust. All **statutory** returns required by the Independent Regulator shall be reported, at least in summary, to the Board of	Director of Communications and Corporate Affairs All sub-committees of the Board	Reports and minutes of meetings Cycles of business

Directors. Approval of all legal and regulatory requirements.		Published documentation

Part B – Matter Delegated by the Board of Directors to Executive Directors, Management Groups and members of staff

This Section sets out the corporate decisions making powers that have been delegated by the Trust's Board of Directors to the Trust's Executive Directors, established sub-groups and officers and employees of the Trust to whom the Executive Directors have in turn delegated certain of their decision-making powers.

Many of the day to day decisions that are made by employees of the Trust do not feature in this document. Such decisions should be made within the context of the individual's role, profession and the Trust's Risk Strategy and Risk Management Policy and the Standing Financial Instructions. Where the employee requires support, the matter shall be referred to their line manager or relevant Executive Director.

Decision makers must evidence that they have factored in the Trust's published Risk Appetite from time to time and that any decisions taken that will create a risk that exceeds the relevant threshold is reported and managed in accordance with the Risk Management Policy. In order to support employees to understand the scope of their decision making powers a series of Decision Making Guides are to be produced to support this document.

Finance/Commercial/Estates Decisions

Delegated responsibility / details	Decision making Forum/ Meeting	Individual Decision Maker(s)						Document to evidence decision
		Chief Executive	Executive Director	Triumvirate Director, Corporate Director or Deputy	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
Finance, commercial and estates decisions								
Levels of budget responsibility by reference to roles within the organisation Postholders are delegated responsibility for financial management of resources and act as authorised signatories for commitments to spend Trust monies		Levels are set out in Annex	Levels are set out in Annex	Levels are set out in the Annex	Levels are set out in the Annex	Agreed budgets	Agreed budgets	SoD and SFIs
Authority to vary the Annual Financial Plan in respect of the amount of contribution delivered or budget allocated to a department. Resource allocation– expenditure (revenue)		Authorised to vary resource allocation across Trust	Authorised to vary resource allocation for cost	Authorised to vary resource allocation for cost centre	Authorised to vary resource allocation for	Authorised to vary resource allocation for designated	Authorised to vary resource allocation for designated	Financial performance reports

Delegated responsibility / details	Decision making Forum/ Meeting	Individual Decision Maker(s)						Document to evidence decision
		Chief Executive	Executive Director	Triumvirate Director, Corporate Director or Deputy	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
Variations approved at relevant level of authorisation. Movement of resources across staff and non-staff. Follow Trust Guidance note – Budgetary Control			centre and across their budgets.	and across Locality / CBUs / Corporate Depts	designated CBU	cost centre and across cost centres	cost centre and across cost centres	
Authority to vary the Annual Financial Plan is respect of income levels – income (revenue) contract with commissioners. Variation of the agreed income plan as approved by the board in the Annual Financial Plan. Follow Trust Guidance note – Budgetary Control			Approval of the Director of Finance	Must be consulted with by Director of Finance				Financial performance reports
Authority to vary the Resource allocation in the agreed Annual financial plan – capital – funding arrangements and expenditure. This delegation operates within the agreed resource allocation. To change the overall value of the Trust funded capital programme requires agreement of the Board.	Executive Management Group		Advice provided by Director of Finance					EMG minutes.

Delegated responsibility / details	Decision making Forum/ Meeting	Individual Decision Maker(s)						Document to evidence decision
		Chief Executive	Executive Director	Triumvirate Director, Corporate Director or Deputy	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
Where external funding is made available for specific schemes this can be incorporated into the capital programme through agreement at Executive Management Group.								
Decision regarding banking arrangements, investments, and external loans			Approval through Director of Finance					Written decision and instruction to Bank
Authority to approve a waiver of SFIs to enter a contract. The SFIs set out the limited circumstances where the SFIs may be waived and a contract with a third-party supplier entered into (SFI 8.10)		Chief Executive (jointly with DoF)	Director of Finance (jointly with CEO)					Written decision via SFI waiver document. Record of waivers is maintained by the Head of Procurement (NTWS)
Authority to agree and enter a contract – **to provide Healthcare services** to a commissioner body or customer. Agree and sign a contract to provide / deliver healthcare (SFI – 7.3)	Locality Operational Management Group		Director of Finance approves and signs these contracts up to value stated in the Annex	Triumvirate Director(s) consulted with by Director of Finance		Assoc. Directors of Contracting (Income) may authorise Trust invoices under an		Reports and minutes of LOMG Contract documentation

Delegated responsibility / details	Decision making Forum/ Meeting	Individual Decision Maker(s)						Document to evidence decision
		Chief Executive	Executive Director	Triumvirate Director, Corporate Director or Deputy	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
						existing contract up to the value stated in the Annex		
Authority to agree and enter a **contract with a third party healthcare provider** including in the Trust's capacity as a Lead Provider. Agree and sign a contract with a third party to provide healthcare services to the Trust SFI 8.3	Locality Operational Management Group		Director of Finance approves and signs these contracts up to value stated in the Annex and authorises purchase orders and invoices to that value	Triumvirate Director(s) to be consulted with by Director of Finance		Assoc. Directors of Contracting (Income) can authorise payments to providers under an existing contract up to the value stated in the Annex		Reports and minutes of LOMG Contract documentation
Launch a procurement and agree and enter a contract for Trust to **purchase services and/or goods** or to materially vary a contract for the same Agree and sign a contract with a third-party provider to deliver non-healthcare services and/or goods. SFI section 8 sets out the	All goods and services contracts between OJEU level and £6m to be approved at Executive Management Group before	CEO and DoF to jointly sign contracts > £2m - £6m CEO and DoF can each individually sign and	Executive Directors other than CEO and DOF can sign and authorise contracts up to £500k as set out	Approve and sign contracts at the levels set out in the Annex – and sign contracts at those levels following	Approve and sign contracts at the authority levels set out in the Annex	Approve and sign contracts at the authority levels set out in the Annex	Approve and sign contracts at the authority levels set out in the Annex	Business cases, reports and minutes – EMG. Signed contracts. Records of tender or

Delegated responsibility / details	Decision making Forum/ Meeting	Individual Decision Maker(s)						Document to evidence decision
		Chief Executive	Executive Director	Triumvirate Director, Corporate Director or Deputy	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
requirements and steps at different financial levels which must be followed to put in place a contract. NTWS Head of Procurement must be consulted with for contracts above £25k	sign off by relevant Director or officer	authorise contracts with a value of >£500k - £2m In all instances following approval at Executive Management Group	in the Annex	Executive Management Group approval where required.				procurement process retained by Head of Procurement or delegated officer
Authority to raise an order or multiple orders under an existing contract. Contracts are to be put in place in accordance with the SFIs		Authority levels are as per the Annex	Authorised up to the levels set out in the Annex	Authorised up to the levels set out in the Annex	Authorised up to the levels set out in the Annex	Authorised up to the levels set out in the Annex	Authorised up to the levels set out in the Annex	Requisitions and purchase orders
Authority to agree to enter into a contract for the provision by the Trust of **non-healthcare services** This includes consultancy services such as those provided by Trust Innovation Group, commercial projects, and joint ventures	Executive Management Group. Note that the Board of Directors has reserved powers for partnerships and joint ventures, as	Signature of contract by CEO and/or DoF at the authorisation levels stated in annex	Signature of contract at authorisation levels set out in the Annex	Signature of contract at authorisation levels set out in the Annex	Signature of contract at authorisation levels set out in the Annex	Signature of contract at authorisation levels set out in the Annex	Signature of contract at authorisation levels set out in the Annex	Business cases, reports, and minutes of EMG Signed contracts

Delegated responsibility / details	Decision making Forum/ Meeting	Individual Decision Maker(s)						Document to evidence decision
		Chief Executive	Executive Director	Triumvirate Director, Corporate Director or Deputy	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
	set out in Part A							
Approval of a Business Case with revenue implications with a value >£500k and £6m per annum or a business case relating to an investment as defined in the Trust's Investment Policy. Development of business cases are led by relevant CBU/dept supported by subject experts in line with Business Change process / Policy and/or Investment Policy	Executive Management Group. Note that the Board has reserved powers to approve significant business cases at the value stated in Part A and in relation to investments in other bodies corporate							Business cases, reports and minutes of EMG
Initiation and approval of a tender submission with revenue implications with a value >£500k and £6m per annum Development of tenders are led by relevant CBU / Dept supported by subject experts. Follow the Tender Process Policy for guidance on the production of a tender	Executive Management Group. Note the Trust Board has reserved powers to approve significant Tenders as set out in							Business case to recommend decision to tender. EMG minutes Tender document and submission DDoF Project

Delegated responsibility / details	Decision making Forum/ Meeting	Individual Decision Maker(s)						Document to evidence decision
		Chief Executive	Executive Director	Triumvirate Director, Corporate Director or Deputy	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
	Part A							Log
Disposal or acquisition of a Trust Asset with a book or net value up to £6m Sale, transfer, or acquisition of a Trust asset. NTW Solutions advise the Trust on these matters.	Executive Management Group up to £6m. Note that the Board has reserved powers for disposals or acquisitions above £6m	DoF to sign contract documentation						EMG minutes, reports and business cases
Authority to manage and vary contracts with NTW Solutions with revenue implications up to £6m per annum, or capital implications up to £6m - and authority to approve matters that are reserved to the Trust in NTWS' own Scheme of Reservation and Delegation. The Operated Healthcare Facilities Agreement and the Estates Management Services Agreement are the main agreements between the	Executive Management Group		Director of Finance is the accountable Executive for the contracts with NTWS					Contracts report to EMG Minutes and reports to EMG Contract variation documents

Delegated responsibility / details	Decision making Forum/ Meeting	Individual Decision Maker(s)						Document to evidence decision
		Chief Executive	Executive Director	Triumvirate Director, Corporate Director or Deputy	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
Trust and NTWS. NTWS is also required to seek Trust approval to enter into leases in its own name.								
Approval of variations to Trust PFI with revenue implications up to £6m per annum, or capital implications up to £6m NTW Solutions manages the PFI contracts on behalf of the Trust and will submit papers on these matters to TLT. Note the reservation of powers to the Board of Directors on these matters above this value, as per Section A.	Executive Management Group		Director of Finance is the accountable Executive for the contracts with NTWS					Business cases, reports and minutes of EMG Contract variation documents
Property & Capital works								
Approval of Minor Works (below £5k) and capital works up to £25k in value. Follow Trust approved Minor Works process and Capital works process. This process is managed by NTW Solutions on behalf of the Trust. Follow minor works and capital works processes	Capital Programme meeting		DOF is the accountable Executive Officer for minor works and overall Capital Programme					Reports and minutes from Capital Programme Meeting and Informed Client meeting

Delegated responsibility / details	Decision making Forum/ Meeting	Individual Decision Maker(s)						Document to evidence decision
		Chief Executive	Executive Director	Triumvirate Director, Corporate Director or Deputy	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
The approval of purchases from third parties of utilities, goods, capital works and or services that relate to the Estate/ Property up to £6m. This process is managed by NTW Solutions on behalf of the Trust and as per SFI 8.2.6	Executive Management Group Note that the Board has reserved powers for capital schemes with a value above £6m		Responsibility is delegated by CEO to DoF					Business cases and contract reports to EMG. Procurement and tender documentation Contracts with suppliers
Approval of new capital schemes (including acquisitions) up to £6m. The Trust's capital programme is managed by NTW Solutions on behalf of the Trust	Executive Management Group Note that the Board has reserved powers capital schemes above £6m		DoF is the accountable Executive Officer for the Capital Programme					Business cases and reports to EMG.
Agree a lease. All lease agreements are subject to approval through a business case to	Executive Management Group		DoF or his delegate are authorised					EMG contract reports and minutes

Delegated responsibility / details	Decision making Forum/ Meeting	Individual Decision Maker(s)						Document to evidence decision
		Chief Executive	Executive Director	Triumvirate Director, Corporate Director or Deputy	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
Executive Management Group. Lease matters are managed by NTW Solutions on behalf of the Trust and therefore they must be consulted with and engaged on these matters.			to sign any lease agreements on behalf of the Trust					
Workforce decisions								
Development of systems and processes linked to local pay arrangements outside of Agenda for Change			Director of Workforce and OD					
Appointment of staff outside general terms and conditions (i.e., appointment on higher pay scale on AfC scale)			Director of Workforce & OD					Evidence of rationale for approval and recommended salary point
Appointment onto local pay		CEO	Director of Finance Director of Workforce and OD					Evidence of rationale
Use of agency worker above cap			Director of Finance Director of Workforce and OD					Discussion with Medical Director / Director of WOD
Introduction of any local terms and			Director of					

Delegated responsibility / details	Decision making Forum/ Meeting	Individual Decision Maker(s)						Document to evidence decision
		Chief Executive	Executive Director	Triumvirate Director, Corporate Director or Deputy	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
conditions (i.e., mileage allowances, continuous service etc).			Workforce &OD					
Introduction of additional expenditure unrelated to terms and conditions (i.e., recruitment incentives, introduction of allowances etc).			Director of Workforce and OD)					
Termination of employment through redundancy			Director of Finance Director of Workforce and OD					
Termination of employment for some other substantial reason			Director of Workforce and OD	Would be consulted with by Director of Workforce and OD				Rationale for decision to be shared with Executive Director of Workforce
Clinical and Operational decisions								
Emergency closure to admissions (<1 month)			Consultation with Chief Operating Officer and Director of Finance					Recorded at Locality Operational Management Group and Business Delivery Group

Delegated responsibility / details	Decision making Forum/ Meeting	Individual Decision Maker(s)						Document to evidence decision
		Chief Executive	Executive Director	Triumvirate Director, Corporate Director or Deputy	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
Variation to Group internal targets			Chief Operating Officer	Triumvirate Director				Recorded at Locality Operational Management Group
Close a ward/service due to urgent clinical risk (where closure will be for a maximum period of 72 hours) Where the ward has previously been subject to this type of closure within the preceding 3-month period the matter must be referred to the Board under Part A of this SORD			Chief Operating Officer or with on-call Director if out of hours	Triumvirate Director				
Agree changes to Trust wide Clinical protocols and standards and Trust policies.	Business Delivery Group							BDG minutes and reports Clinical lead sign off and Trust Safety Group where appropriate.
Expansion of current service			Consultation with Director of Finance, Medical Director	Triumvirate Director				

Delegated responsibility / details	Decision making Forum/ Meeting	Individual Decision Maker(s)						Document to evidence decision
		Chief Executive	Executive Director	Triumvirate Director, Corporate Director or Deputy	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
			and Chief Operating Officer					
Provision of services out with agreed pathways (For example where a child is admitted to an acute adult ward - classed as a "never event")				Triumvirate Director				
Change of service provision linked to OPEL framework – emergency planning/contingency Often linked to staff availability or a surge in demand			Chief Operating Officer (as Exec Lead for EPRR)	Triumvirate director following discussion with Chief Operating Officer				Decisions made and documented as per escalation process for emergency planning.
Amending ward/team skill mix to meet service need						Clinical Manager	Ward/team manager decision	Discussion between managers at these levels is documented in meeting notes

Annex – authorisation levels

Delegating Authorisers	Authorisation Limits	
Post	**Revenue £000**	**Capital £000**
Executive Officers		
Chief Executive and Executive Director of Finance jointly	6,000	6,000
Director of Finance – for contracts with third party healthcare providers where Trust is the lead provider	4,000	
Chief Executive and Executive Director of Finance individually	2,000	2,000
Executive Medical Director & Deputy Chief Executive	500	
Chief Nursing Officer	500	
Chief Operating Officer	500	
Executive Director of Workforce and Organisational Development	500	
Chief Executive Directorate		
Director of Communications and Corporate Affairs/Company Secretary	50	
Chief Nursing Officer's Directorate		
Deputy Director – NTW Academy Development	50	
Deputy Director – Positive and Safe	50	
Group Nurse Director – Safer Care	50	
Group Medical Director – Safer Care	50	
Director of Safety, Security, Resilience & Trust Innovation	50	
Chief Operating Officer's Directorate		
Deputy Chief Operating Officer	500	
Group Directors – operational, nursing and medical	500	
Director of AHPs and Psychological Services	50	
Associate Directors – Group CBU Teams	50	
Clinical Nurse Managers	5	
Ward / Team Managers	5	

Delegating Authorisers	Authorisation Limits	
Post	**Revenue £000**	**Capital £000**
Deputy Chief Executive & Medical Directorate		
Chief Pharmacist	100	
Deputy Chief Pharmacists	100	
Director R&D Innovation and Clinical Effectiveness	100	
Director of Medical Education	50	
Finance Directorate		
Deputy Director of Finance and Business Development	100	
Director of Audit One	100	
Director of Digital	100	100
Clinical Director of Informatics	50	
Associate Directors of Contracting	50	
Associate Director of Finance	50	
Workforce and Organisational Development Directorate		
Deputy Director of Workforce and Organisational Development	100	
Board of Directors	No limit	No limit

14. ANNUAL PLAN 2023/24 - FOR APPROVAL

Kevin Scollay, Executive Director of Finance

REFERENCES

Only PDFs are attached

14a. 23-24 - Board - Annual plan and priorities cover sheet.pdf

14b. 2324 Annual Plan - agreed priorities 25.05.23.pptx

Report to the Board of Directors
Wednesday 5th July 2023

Title of report	**23/24 Annual Plan and Priorities**
Report author(s)	**Executive Directors**
Executive Lead (if different from above)	**Kevin Scollay, Executive Director of Finance**

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day.	x
2. Person-led care, when and where it is needed – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals	x
3. A great place to work – We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers.	x
4. Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled.	x
5. Working with and for our communities – We will create trusted, long-term partnerships that work together to help people and communities.	x

Board Sub-committee meetings where this item has been considered	
Quality and Performance	
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered	
Executive Team	x
Executive Management Group	x
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability	x	Reputational	x
Workforce	x	Environmental	x
Financial/value for money	x	Estates and facilities	x
Commercial	x	Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, carer and stakeholder involvement	x

Board Assurance Framework/Corporate Risk Register risks this paper relates to

15. INTEGRATED CARE SYSTEM / INTEGRATED CARE BOARD UPDATE

James Duncan, Chief Executive

verbal update

16. FINANCE REPORT

Kevin Scollay, Executive Director of Finance

REFERENCES

Only PDFs are attached

16. 2324 - Mth 2 Finance Report Board.pdf

Report to the Board of Directors
Wednesday 5th July 2023

Title of report	**Month 2 Finance Report**
Report author(s)	**Kevin Scollay, Executive Director of Finance**
Executive Lead (if different from above)	**As above**

Strategic ambitions this paper supports (please check the appropriate box)	
1. Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day.	
2. Person-led care, when and where it is needed – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals	
3. A great place to work – We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers.	
4. Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled.	x
5. Working with and for our communities – We will create trusted, long-term partnerships that work together to help people and communities.	

Board Sub-committee meetings where this item has been considered	
Quality and Performance	
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered	
Executive Team	x
Executive Management Group	x
Business Delivery Group	x
Trust Safety Group	
Locality Operational Management Group	

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability		Reputational	
Workforce		Environmental	
Financial/value for money	x	Estates and facilities	
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness		Service user, carer and stakeholder involvement	

Board Assurance Framework/Corporate Risk Register risks this paper relates to

Month 2 Finance Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

1. Executive Summary

1.1 At the end of Month 2 the Trust has reported a £5.3m deficit on Income and Expenditure, which is ahead of the plan submitted to NHSE by £0.4m. It should be noted this plan assumes significant savings (£28.1m) and these are heavily phased into Quarters 3 and 4.

1.2 Agency costs stand at c£3.4m YTD, which is £0.6m higher than planned and c£1m above the 3.7% agency ceiling, which is c£2.4m YTD.

1.4 Agency costs should be set in the context of the overall pay costs and WTE usage for the Trust, which are the key drivers of financial performance for the Trust. Total Trust WTEs have fallen by 130 since last month, but remain 111 WTEs above Dec 2022 levels, which is when 23/24 baselines were set.

1.6 The Trust capital programme is £1.5m under plan at Month 2. The Trust continues to forecast delivery against plan for the year. Given the early underspending against this budget, it will receive a more detailed review of the forecast at the end of Quarter 1 to ensure appropriate decision making is taken around use of CDEL resource for the rest of the year.

1.7 The Trust has a cash balance of £41.5m at the end of Month 1 which is ahead of plan. The cash plan for 23/24 did not include the receipt of PDC funding from the New Hospitals Programme.

2. Key Financial Targets

2.1 Table 1 highlights the key financial metrics for Month 2.

Table 1

	Month 2		
Key Financial Targets	**Trust Plan**	**Actual**	**Variance/ Rating**
I&E – Surplus /(Deficit)	(£5.8m)	(£5.3m)	£0.4m
Agency Spend	£2.8m	£3.4m	(£0.6m)
Cash	£27.4m	£41.5m	£14.1m
Capital Spend	£2.3m	£0.8m	£1.5m

3. Financial Performance

Income and Expenditure

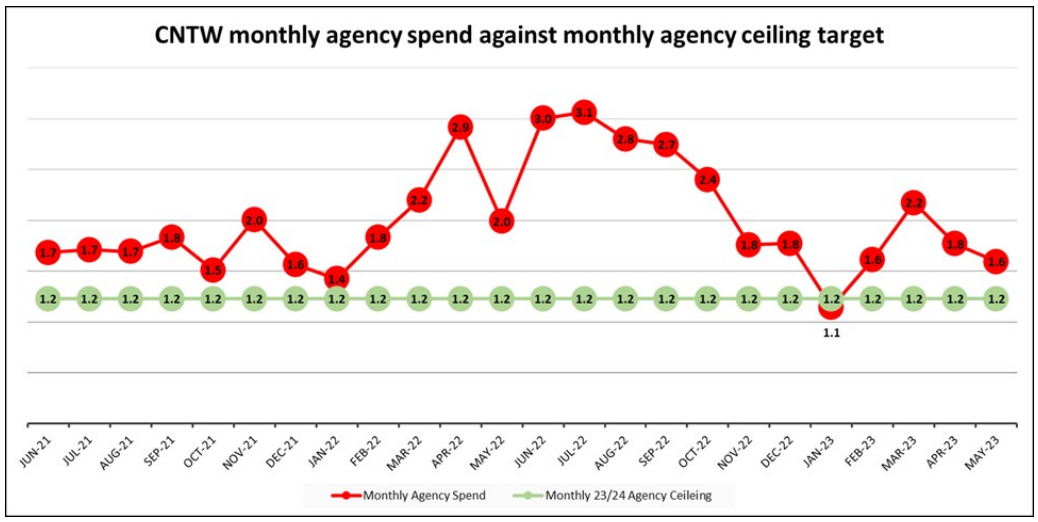
3.1 At the end of Month 2 the Trust has reported a £5.3m deficit on Income and Expenditure, which is ahead of the plan submitted to NHSE by £0.4m. The Trust continues to forecast a breakeven position. Savings plans (£28.1m) are heavily phased into Quarters 3 and 4 which are expected to be delivered through a combination of recurrent and non recurrent measures. Some of these measures

are also non cash releasing in nature and consequently cash levels are expected to fall on delivery of the plan.

3.2 The Trust has a more ambitiously phased internal plan for CIP delivery and is currently managing to this trajectory internally.

3.3 Graph 1 below highlights the agency performance from June 2021. Costs in April have fallen to £1.6m following two months of increased costs. Costs remain above the Trust budget of c£1.4m, the 3.7% agency cap of c£1.2m as well as the prior year ambition to reduce to £1m per month.

Graph 1



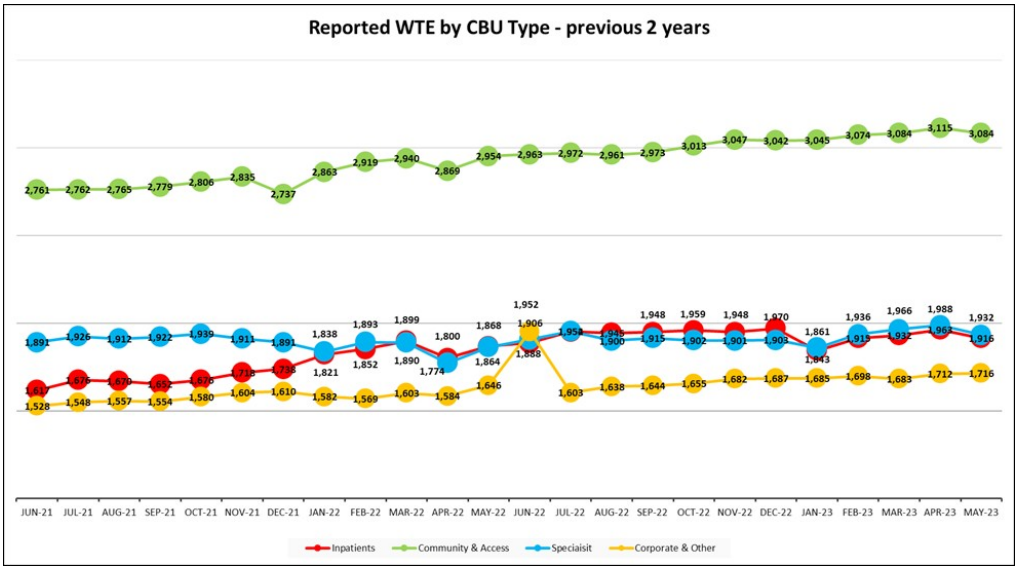
3.4 Agency costs have been a focus for the Trust in managing it's overall financial position for a number of reasons. These inlcude;

- Quality implications of having high numbers of temporary staffing working within our services.
- The premium attached to agency staffing, which increases costs when compared with permanent staffing.
- The temporary nature of agency staffing is 'cost agile' which means it can be reduced quickly without secondary cost implications or lengthy management processes to reduce headcount.

3.5 It is worth noting, however, that the largest driver of overall Trust costs is the total usage of staffing resource – swapping temporary staffing for permanent stafing has a marginal impact on cost, but changing WTE numbers has a much larger impact.

3.6 This can be expressed in cost, but also in overall WTEs. Graph 2 shows the trend in reported WTE over the last two years by CBU type. It shows that all categories have grown consistently over this period, irrespective of changes in agency costs and usage. This growth in WTE has increased overall pressure on staffing costs, and therefore the Trust financial position. Some posts are are funded through MHIS and SDF funding, but aggregate WTE growth is unaffordable.

Graph 2



3.7 In the context of a challenging financial position and significant cost improvement requirement, it is important to understand the general direction of travel on WTEs. Table 3 shows the movement in WTEs (usage) since May 2020. Usage of WTEs has reduced since last month by 130 WTEs – all Groups showed a reduction in May.

Table 3

	May 2020	May 2021	May 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023
North	1,268	1,321	1,415	1,529	1,513	1,529	1,550	1,569	1,506
Central	1,558	1,642	1,671	1,728	1,707	1,754	1,763	1,784	1,753
South	1,860	1,920	2,080	2,114	2,055	2,130	2,134	2,165	2,146
Cumbria	1,286	1,384	1,519	1,480	1,474	1,513	1,535	1,548	1,528
	5,973	6,267	6,685	6,851	6,749	6,925	6,982	7,066	6,933
Corp. & Other	1,569	1,533	1,646	1,687	1,685	1,698	1,668	1,712	1,716
Grand Total	7,542	7,800	8,331	8,537	8,435	8,623	8,650	8,778	8,648

3.8 The Trust will make payments in connection to the NHS pay award in June 2023. The Trust is currently assessing the impact of this on the 2023 financial plan and expects this to create a pressure on the current year forecast. This is due to the cost base reflected in the Cost Uplift Factor (CUF) (which is applied to income acruing from NHS contracts) not being representative of the cost base of the Trust. As Mental Health Trusts have a higher proportion of costs associated with pay than average, costs tend to outstrip allocated funding, resulting in a net pressure. The Trust has also identified a presure with national funding flows assocoiated with Microsoft licences and is currently engaging with the ICB on infleuncing on how these funding flows operate.

4. Cash

Table 4

	Year To Date		
	Plan (£m)	**Actual (£m)**	**Variance/ Rating (£m)**
Cash	27.4	41.5	(14.1)

4.1 Cash balances at the end of May were £14.1m higher than plan.

4.2 The Trust received £15m in PDC funding to support the CEDAR programme in 2023/24, which was not included in the Trust financial planning for 2023/24.

4.3 The 2023/24 financial plan includes non-cash transactions to support delivering financial break-even, this means that cash levels are expected to fall, depsite forecasting a breakeven position.

5. Capital & Asset Sales

Table 5

	Year To Date			Year End		
	Plan (£m)	**Actual (£m)**	**Variance/ Rating (£m)**	**Plan (£m)**	**Forecast (£m)**	**Variance/ Rating (£m)**
Capital Spend	2.3	0.8	(1.5)	20.8	20.8	0.0
Asset Sales	0.0	0.0	(0.0)	6.8	6.8	0.0

5.1 The Trust Capital spend at the end of Month 2 is £0.4m which is £0.8m less than the plan. The Trust is forecasting to deliver the capital programme at the end of the financial year.

5.2 The Trust capital programme includes an assumption of additional PDC funding for the CEDAR programme. This has been part of ongoing discussions with the New Hospitals Programme. The Trust has provided a revised Business Case in line with expectations and timescales outlined by the New Hospitals Programme (NHP). This is currently under consideration by NHP. The Board will receive separate and more detailed updates on this separately from this report.

5.3 The Trust has planned asset sales £6.8m in 2023/24. The sale of land at St Georges Park and Sale of land at Northgate are expected to complete by the end of the July and August respectively.

5.4 Given the early indications of underspending against the capital programme, a more detailed review of the forecast will be conducted at the end of Quarter 1 to ensure appropriate use of capital resources (CDEL) throughout the rest of the financial year.

6. Recommendations

6.1 The Board is asked to note the content of this report.

17. INTERNATIONAL RECRUITMENT UPDATE

Anne-Marie Lamb, International Partnership Matron

verbal update

18. QUALITY AND PERFORMANCE COMMITTEE

Darren Best, Chair

verbal update

19. AUDIT COMMITTEE

David Arthur, Chair

verbal update

20. RESOURCE AND BUSINESS ASSURANCE COMMITTEE

Paula Breen, Chair

No meeting has been held during the period

21. MENTAL HEALTH LEGISLATION COMMITTEE

Michael Robinson, Chair

No meeting has been held during the period

22. PROVIDER COLLABORATIVE COMMITTEE

Michael Robinson, Chair

verbal update

23. PEOPLE COMMITTEE

Brendan Hill, Chair

No meeting has been held during the period

24. CHARITABLE FUNDS COMMITTEE

Louise Nelson, Chair

25. COUNCIL OF GOVERNORS' ISSUES

Ken Jarrold, Chairman

26. QUESTIONS FROM THE PUBLIC

Ken Jarrold, Chairman

27. ANY OTHER BUSINESS

Ken Jarrold, Chairman

28. DATE AND TIME OF NEXT MEETING

Wednesday 2nd August 2023
1:30 - 3:30pm
Trust Board Room, St Nicholas Hospital and Microsoft Teams