Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

# BOARD OF DIRECTORS PUBLIC MEETING

# BOARD OF DIRECTORS PUBLIC MEETING

2 August 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 August 2023 FINAL.pdf

# Board of Directors PUBLIC Board Meeting Agenda

| Board of Directors PUBLIC Board meeting<br>Venue: Trust Board Room, St Nicholas Hospital and via MS Teams | Date: Wednesday 2nd August 2023<br>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 5th July 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 3) | Ramona Duguid, Chief Operating Officer | Enc |
| 9 | Service user and carer experience report – quarter 1 | Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance | Enc |
| 10 | Safer Care Report – Quarter 1 | Rajesh Nadkarni, Deputy Chief Executive and Medical Director | Enc |
| 11 | 5-point Plan Addictions Services | Rajesh Nadkarni, Deputy Chief Executive and Medical Director | Pres |
| 12 | Annual Infection, Prevention and | Sarah Rushbrooke, Executive | Enc |

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|---|---|---|---|
| | **Control Annual Report 2022/23** | **Director Nursing, Therapies and Quality Assurance** | |
| **13** | **Annual Revalidation Report** | **Rajesh Nadkarni, Deputy Chief Executive and Medical Director** | **Enc** |
| **Workforce issues** | | | |
| **14** | **Workforce Race Equality Standard and Workforce Disability Equality Standard** | **Lynne Shaw, Executive Director of Workforce and OD** | **Enc** |
| **15** | **Guardian of safe working hours report – quarter 1** | **Rajesh Nadkarni, Deputy Chief Executive / Medical Director** | **Enc** |
| **Regulatory / compliance issues** | | | |
| **16** | **Board Assurance Framework and Corporate Risk Register Update (Q1)** | **Debbie Henderson, Director of Communications and Corporate Affairs** | **Enc** |
| **17** | **NHSE/I Single Oversight Framework compliance report** | **Ramona Duguid, Chief Operating Officer** | **Enc** |
| **Strategy, planning and partnerships** | | | |
| **18** | **Integrated Care System/Integrated Care Board update** | **James Duncan, Chief Executive** | **verbal** |
| **19** | **Finance Report** | **Kevin Scollay, Executive Director of Finance** | **Enc** |
| **Key item** | | | |
| **20** | **Freedom to Speak Up Guardians** | **Fran Howe and Stephen Hyde** | **Verbal** |
| **Committee updates** | | | |
| **21** | **Quality and Performance Committee** | **Darren Best, Chair** | **Verbal** |
| **22** | **Audit Committee** | **David Arthur, Chair** | **Verbal** |

| | | | |
|---|---|---|---|
| **23** | **Resource and Business Assurance Committee** | **Paula Breen, Chair** | **Verbal** |
| **24** | **Mental Health Legislation Committee** | **Michael Robinson, Chair** | **Verbal** |
| **25** | **Provider Collaborative Committee** | **Michael Robinson, Chair** | **n/a** |
| **26** | **People Committee** | **Brendan Hill, Chair** | **Verbal** |
| **27** | **Charitable Funds Committee** | **Louise Nelson, Chair** | **Verbal** |
| **28** | **Council of Governors' Issues** | **Ken Jarrold, Chairman** | **Verbal** |
| **29** | **Questions from the Public** | **Ken Jarrold, Chairman** | **Verbal** |
| **30** | **Any other business** | **Ken Jarrold, Chairman** | **Verbal** |

**Date and Time of Next Meeting:**

**Wednesday 6th September 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 5TH JULY 2023

Ken Jarrold, Chairman

### REFERENCES

Only PDFs are attached

4. Public Minutes 5 July 2023 FINAL DRAFT ka.pdf

**Minutes of the Board of Directors meeting held in Public**
**on 5 July 2023 1.30pm – 3.30pm**
**Trust Board Room, St Nicholas Hospital and via MS Teams**

**Present:**
Ken Jarrold, Chairman
David Arthur, Senior Independent Director/Non-Executive Director
Darren Best, Vice Chair/Non-Executive Director
Paula Breen, Non-Executive Director

Brendan Hill, Non-Executive Director
Michael Robinson, Non-Executive Director *(online)*

James Duncan, Chief Executive
Ramona Duguid, Chief Operating Officer *(online)*
Rajesh Nadkarni, Deputy Chief Executive and Medical Director *(online)*
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:**
Debbie Henderson, Director of Communications and Corporate Affairs
Kirsty Allan, Corporate Governance Manager (minute taker)
Jack Wilson, Corporate Engagement Assistant
Anthony Deery, Deputy Chief Nurse (Item 3)
Anne-Marie Lamb, International Partnership Matron (Item 17)
Neeraj Berry, Group Medical Director, Central Locality (Item 17)
Dr Erinfolami Adebayo, Consultant Psychiatrist, Inpatient North CBU (Item 17)
Mary Ettah, Nursing Assistant, Inpatients South CBU (Item 17)
Lida Maria Danny, Staff Nurse, St Georges Park (Item 17)

**1. Welcome and apologies for absence**
Ken Jarrold welcomed everyone to the meeting and apologies for absence were received from Louise Nelson Non-Executive Director.

**2. Declarations of interest**
None to note.

**3. Service User/Carer Story/ Staff Journey**
Ken Jarrold welcomed Anthony Deery who played a video, produced by the Trust, reflecting a service users' journey from Lamesley Ward. The journey included supporting the individual out of long-term segregation using the HOPEs model.

**4. Minutes of the meeting held 7th June 2023**
The minutes of the meeting held on 7th June were considered.

**Approved:**
- **The minutes of the meetings held 7th June 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.

***Item 07.06.2023 – CQC Report Must Do Actions***: Sarah Rushbrooke noted that CQC engagement meetings have recommenced to ensure strong relationships with new CQC colleagues. Sarah had discussed with the CQC the Must Do actions relating to care planning. The CQC recognised they

have not provided a comprehensive inspection for Trust services since 2018. While it is accepted that the actions relating to care planning have been completed, it is also recognised that this will remain an ongoing issue for improvement and assurance. Therefore, it was agreed that these actions would be closed, and impact would be reviewed as part of any future inspections.

**6. Chairman's update**

Ken Jarrold noted that the Board meeting was also the 75th birthday of the NHS and referred to the Windrush anniversary on 23rd June. Ken paid tribute, not only to the Windrush generation but to all people from black and ethnic minorities who have sustained the NHS through its 75 years and who continue to make a vital contribution to its work.

Ken commented on the NHS 75th birthday by stating that despite the NHS experiencing its biggest challenges to date, it was important to mark the occasion giving support to the NHS in a time of crisis. Ken referred to a public discussion from the BBC headlining 'can the NHS survive' and explained the NHS can survive if it is appreciated and cared for with appropriate resource, staffing, capital and information technology.

**Resolved:**

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

**7. Chief Executive's Report**

James Duncan followed on from Ken Jarrold's update regarding the NHS 75th birthday stating that when the NHS is in need and struggling, it is important to do everything to support and strengthen the invaluable system which continues to do its very best to care and support people in need.

James referred to the report highlighting the publication of the Volunteers Strategy recognising the great contribution of NHS volunteers throughout the last 75 years. James referred to a recent Partnership Day event held with colleagues from Staff Side and paid tribute to their roles and the importance of partnership working particularly in challenging times.

Along with many regional and national updates highlighted within the report, James referred to the government announcement of a national investigation into the safety of mental health services which will be an important part of the Trust's strategy and priorities.

James referred to the publication of the Government's 2023 mandates setting out three key objectives NHS England is expected to achieve. James also referred to The Institute for Public Policy Research Health and Care Workforce Assembly report as an interesting read which helps to explain the current position of the NHS and suggested that the Board revisit and reflect on the report at a future meeting.

James reflected on his recent visits to services within the organisation and his experiences of working shifts on various wards. James commented on the dedication and commitment of the teams and the open and honest discussions with service users and carers. James noticed a remarkable change to Roselodge in terms of the reduction in restrictive practice and the impact this has had on culture, engagement and the experiences of service users and carers.

Sarah Rushbrooke provided an update on ward visits to gain an understanding of the staffing challenges currently facing the teams. This included observing the new model of Multi-Disciplinary Team working to improve outcomes, the processes relating to discharge planning and the challenges encountered as part of the clinical pathways.

Brendan Hill referred to the Healthwatch Northumberland report and experiences of children and young people with autism and their families when accessing mental health services. The report references nine key themes that need to be taken into consideration and queried if the Trust had agreed to act on the service-specific recommendations outlined in the report. James Duncan confirmed the recommendations are being considered as part of the development of the Trust priorities.

Darren Best referred to information provided to Board regarding Roselodge during the previous two years and requested an update to a future Board meeting on the positive changes which had taken place in the context of potential learning elsewhere.

Lynne Shaw gave a brief overview of the publication of the NHS Workforce Plan. A 15-year costed plan whereby £2.4bn has been committed to fund education and training places over the next five years, alongside existing commitments. The plan outlines three priority areas: Train, Retain and Reform. There will be a drive on retention linked to the seven elements of the People Promise to improve cultural leadership and wellbeing of the workforce with the aim to reduce the number of staff leaving the NHS.

Ken Jarrold thanked Lynne Shaw for the brief overview of the NHS Workforce Plan which the People Committee will review in detail.

**Resolved:**

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

**Action**

- **Discussion on The Institute for Public Policy Research Health and Care Workforce Assembly report at a future meeting**
- **Discussion on the positive changes in relation to Roselodge at a future Board meeting with a focus on potential learning**

**Quality, Clinical and Patient Issues**

**8. Monthly Integrated Performance Report (Month 1)**

Ramona Duguid presented the report and referred to a detailed discussion held at the June meeting of the Quality and Performance Committee with a deep dive session into waiting times. Further actions and outcomes will be taken forward as part of the monthly reporting to the Committee. The ongoing challenge across the children, young people's neurodevelopment pathway was noted. Progress was being made with North East and North Cumbria Integrated Care Board (NENC ICB) colleagues and collective actions agreed to address the pathway challenges.

Progress was noted regarding over 18 week waits within most localities except for North Cumbria, where greater focus was being made to understand the required actions for improvement.

A deep dive has commenced reviewing Care Programme Approach (CPA) metrics to retain further assurance around the reduction in performance. This will be linked to the work which is being undertaken as part of the community transformation programme.

Data quality is currently being reviewed within the urgent care pathway, particularly relating to liaison and crisis services where the report highlights a reduction in performance.

Ramona was pleased to confirm the achievement of the Information Governance training standard for the Trust at the end of June reporting period.

Sarah Rushbrooke referred to work to refresh the service user and carer narrative within the report to ensure alignment with other mechanisms of feedback on lived experience, including 'Points of You' responses.

Lynne Shaw referred to staff turnover advising the Trust's position of 11% and the national turnover target of 10%. During the previous 12 months, the Trust has seen a significant increase in the number of people who have retired and returned, taking advantage of the flexibilities under the pension reforms and Lynne noted that this is included in the turnover figure.

Darren Best expressed thanks to Ramona Duguid and her team for the work that has taken place to develop the new Integrated Performance Report. The document provides greater clarity on elements of performance and areas of focus for the Trust and the Board.

Brendan Hill also commended the new report in enabling the Board to easily identify trends and welcomed the reduction in sickness absence over recent months.

James Duncan welcomed the new report. He also highlighted the reduction in performance in relation to crisis and psychiatric liaison services as an area of particular concern.

David Arthur queried page 37 of the report with the graphs and figure data showing a variance. Kevin Scollay mentioned the in-year and accumulative figures showing a discrepancy and advised the Board that the data will be reviewed and updated accordingly.

**Resolved:**

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

**9. Seasonal Influenza and COVID-19 Vaccination Plan 2023/24**

Sarah Rushbrooke referred to the report and highlighted the comprehensive plan which outlines programme delivery as well as reflecting lessons learnt from previous vaccination programmes. Sarah advised that the vaccination plan will commence imminently.

**Resolved:**

- **The Board received and agreed the Seasonal Influenza and COVID-19 Vaccination Plan 2023/24**

**10. COVID National Inquiry Report**

Sarah Rushbrooke referred to the report which included a summary of the timetable and actions as part of the National COVID-19 Inquiry. Sarah referenced the commencement of hearings and the significant challenges for those service users, families and staff affected during the pandemic. The plan explains the actions required by the Trust with the most significant impact in relation to care homes being the final model, not actioned until 2025. The Inquiry is envisaged to be complete by Summer 2026.

**Resolved:**

- **The Board received and noted the COVID National Inquiry Report**

**11. Workforce issues**

There were no issues to report for June.

**Regulatory / Compliance Issues**

**12. CQC Must Do Report**

Sarah Rushbrooke presented the report and referred to 57 outstanding Must Dos action plans throughout the various inspections over a significant period. Sarah requested the Board's approval to close one action plan relating to appraisals following sufficient evidence and assurance provided.

Sarah noted that many of the action plans relate to environmental issues moving services into new builds with the CQC fully briefed receiving a timetable and assurance of actions. Sarah discussed the need for a more streamlined approach to reporting, ensuring that actions were focussed and that it is clear when an action is closed and moved to oversight through a business-as-usual approach. She agreed to bring back an updated report to the September Board Meeting

**Resolved**

- **The Board received the CQC Must Do Report**

**Approved:**
- **The Board approved the closure of one action relating to appraisals.**
- **The Board agreed for a more streamlined approach to reporting on the fundamental actions through to Board with older actions reported to the Quality and Performance Committee for oversight and assurance purposes.**

**13. Governance Framework Review**

Debbie Henderson referred to the report which outlined the context for the review. Debbie advised that the most significant reasons for undertaking the comprehensive review were to clarify and simplify decision making and to consider the lessons learnt from governance failures in other organisations. The report provided further detail of lessons learnt and where it was felt the Trust would benefit from a strengthening of governance arrangements.

Debbie advised that the actions taken would streamline the governance framework, avoid over-complicated structures, empower people to take decisions at the right level of the organisation, and focuson real issues in terms of reporting with a lot of work undertaken to reflect the Trust's 'see, hear and feel' approach to reporting.

A review of the risk management processes was undertaken to which internal audit gave good assurance with a need to review the Board Assurance Framework in-line with the new Trust Strategy and priorities. This review is underway and is scheduled for completion by September.

Debbie mentioned there is a need to ensure our commitment to the service user, carer and family voice and the review aims to ensure involvement is firmly embedded within locality and corporate structures.

Section 4 of the report details the changes made to the governance framework to address the issues identified from the work undertaken in Section 2. This included having very open and honest conversations with more than 50 people across locality and corporate services. Debbie asked the Board to note the revised terms of reference within the appendices of the report, noting the Operational Management Group will have a separate Terms of Reference for quality standards. Debbie mentioned the revised scheme of delegation is also included with the report for approval by the Board.

Brendan Hill referred to the need to standardise the terminology used in terms of Board Sub-Committee and Sub-Committee.

Ken Jarrold thanked Debbie for all the work that has been undertaken reviewing the governance framework, noting the importance of governance in the functioning of a successful organisation.

**Approved:**
- **The Board approved the revised governance framework and the Scheme of Delegation.**

**14. Annual Plan**

Kevin Scollay referred to the Annual Plan which outlined the key priorities for the Trust for 2023/24 noting the alignment to the new strategic ambitions. The plan also provided detail on the key deliverables, actions and how outcomes will be measured.

**Approved:**
- **The Board approved the Annual Plan update.**

**Strategy, planning and partnerships.**

**15. ICB / ICS update**

James Duncan referred to the first CNTW/ICB oversight meeting scheduled to take place on 28th July. An update will be provided to the August Board meeting.

James also suggested that an update on the work of the ICB Executive Mental Health, Learning Disability and Autism Board be included in the Chief Executive Report going forward.

**Resolved:**

- **The Board noted the ICB / ICS update**

**16. Finance Report**

Kevin Scollay referred to the report highlighting at Month 2 the Trust reported a £5.3m deficit on income and expenditure which is ahead of the plan submitted to NHS England by £0.4m. It was noted the plan assumes significant savings which are phased into Quarters 3 and 4. Progress was noted on agency spend representing an improved position. A reduction in Whole Time Equivalent (WTE) was noted but further work was required to reduce this further.

Kevin highlighted the Capital Programme as £1.5m under plan at Month 2, with the Trust continuing to forecast delivery against plan for the year. A review is planned at end of Quarter 1 to ensure best use of capital resources.

The Trust is currently assessing the impact of the recent NHS Pay award in June on the financial plan which creates an added pressure on the current year forecast. The Trust has also identified a pressure with national funding flows associated with Microsoft licences and is currently engaging with the NENC ICB on influencing on how these funding flows operate.

Ken Jarrold thanked Kevin Scollay for the update and mentioned a separate finance report, in addition to the performance report, was helpful in clearly setting out the main challenges the Trust is currently facing.

**Resolved:**

- **The Board received the Finance update report.**

**Key Item for Discussion**

**17. International Recruitment update**

Ken Jarrold welcomed colleagues to the meeting paying tribute to the importance of International Recruitment for the Trust and the wider NHS.

Anne-Marie Lamb, International Partnership Matron responsible officer for the International Recruitment Team and Relocation support delivered a presentation. This included a trajectory of doctors and nurses who have relocated and joined the Trust since 2020 with the Trust securing 255 international colleagues to date. Anne-Marie explained NHS England will be providing the Trust with £200k to recruit a further 20 nurses in quarter 4. Anne-Marie described the onboarding process to support international recruits. She also noted that the Trust is the first mental health Trust nationally and first Trust in the region to be awarded the NHS Pastoral Care Quality Award.

Dr Erinfolami Adebayo, Consultant Psychiatrist, Mary Ettah, Nursing Assistant and Lida Maria Danny, Staff Nurse provided the Board with their own personal experience and journey on the international recruitment process.

Anne-Marie explained the team supports a range of additional projects throughout the Trust in addition to the recruitment and relocation of international doctors, nurses and allied health professionals.

Ken Jarrold thanked everyone for all they are doing for CNTW and the people we serve which is hugely appreciated.

**Board sub-committee minutes and Governor issues for information**

**18. Quality and Performance Committee**

Darren Best provided an update following the June meeting, which included a discussion on the need for an improved Safer Staffing report. The new report was scheduled to be implemented from September.

The Research and Development Annual report was presented to the Committee with agreement for a quality focus on how research links to other CNTW priorities at a future Committee meeting.

There was a quality focus on waiting times which highlighted the challenges in children and young people's services across all pathways, as well as an increase in 18 week waits. Discussions were taking place with NENC ICB colleagues at system level at the August ICB meeting.

**19. Audit Committee**

David Arthur provided an update following the June meeting in which the Committee reviewed various draft reports in relation to the annual reporting process as well as a review of the internal audit annual report and head of internal audit opinion and operational plans. All reports were reviewed in detail and subsequently approved by the Board at the June extra-ordinary meeting.

**20. Resource and Business Assurance Committee**

No meetings have been held during the period.

**21. Mental Health Legislation Committee**

No meetings have been held during the period.

**22. Provider Collaborative Committee**

Michael Robinson provided an update following the June meeting which included discussions on the future role and purpose of the Committee and underlying governance arrangements associated with Provider Collaborative arrangements. Considering the current NHSE review of the role of the Provider Collaboratives it was agreed to defer the Committee review for 6 months.

Michael referred to a discussion on Adult Secure Services with an update on the current review scheduled for discussion at the September meeting.

There are ongoing discussions on the nature of services to be provided by the perinatal services Provider Collaborative with CNTW considering its interest in acting as Lead Provider.

**23. People Committee**

No meetings have been held during the period.

**24. Charitable Funds Committee**

No meetings have been held during the period.

**25. Council of Governors issues**

Ken Jarrold referred to the Council of Governors Steering Group where a helpful discussion took place regarding feedback following the recent NHS Providers Governor's Conference and the role of the Governor. The Nomination Committee continues to oversee the appointment process for the new Chair.

Ken was pleased to note steps have been taken to rebuild the Council going from one Cumbria Governor representative to four. Julia Clifford has been appointed to represent Community and Voluntary Services, Councillor Martin Harris has been appointed to represent Cumberland Council, and Michelle Garner has been appointed to represent Cumbria University. Ken also noted the appointment of Councillor Jane Shaw for North Tyneside Council and Councillor Ruth Berkley for South Tyneside Council.

There is a Council of Governors meeting on 13th July 2023 where the appointment of the new Chair will be considered.

**26. Any Other Business**

There were no issues to note.

**27. Questions from the public**

There were no questions from the public.

**Date and time of next meeting**

Wednesday, 2 August 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 2 August 2023.pdf

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

**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** | | | | | |
| 05.07.23 (7) | CE Report | The Institute for Public Police Research Health and Care Workforce Assembly report | James Duncan | September 2023 | |
| 05.07.23 (7) | CE Report | Roselodge update on positive changes and potential learning | Ramona Duguid | September 2023 | |
| 05.07.23 (12) | CQC Must Do Report | Updated report to include fundamental actions with older actions reporting to Quality and Performance Committee | Sarah Rushbrooke | September 2023 | |
| **Completed Actions** | | | | | |
| 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 | Complete, update provided at the July meeting |

## 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 August 2023.pdf

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|---|---|
| **Name of meeting** | **Board of Directors** |
| **Date of Meeting** | **2nd August 2023** |
| **Title of report** | **Chief Executive's Report** |
| **Executive Lead** | **James Duncan, Chief Executive** |
| **Report author** | **Jane Welch, Policy Advisor to the Chief Executive** |

| **Purpose of the report** | |
|---|---|
| **To note** | **X** |
| **For assurance** | |
| **For discussion** | |
| **For decision** | |

| **Strategic ambitions this paper supports (please check the appropriate box)** | |
|---|---|
| **1. Quality care, every day** | X |
| **2. Person-led care, when and where it is needed** | X |
| **3. A great place to work** | X |
| **4. Sustainable for the long term, innovating every day** | X |
| **5. Working with and for our communities** | X |

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

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

| **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 and experience | | 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 2nd August 2023**

## Trust updates

### National Preceptorship for Nursing Interim Quality Mark

We are delighted to announce that CNTW have been successful in achieving the National Preceptorship for Nursing Quality Mark. This is valid for two years from 18 July 2023. NHS England published the nationally agreed framework in 2022 to promote good practice in implementing preceptorship for newly registered nurses, and to improve the retention of early career nurses. It is also in line with the Nursing and Midwifery Council Principles of Preceptorship 2020. The CNTW Accredited Preceptorship Programme will be open to Nursing Associates and Allied Health Professionals as well as nurses from October 2023.

### 2023 General Medical Council National Training Survey

As part of their role in overseeing the quality of postgraduate medical training the General Medical Council (GMC) carry out an annual survey of trainees' and trainers' experience. These surveys provide important information about the quality of training across the country, within individual trusts, and across training programmes and locations. Survey data is compiled by the GMC and includes a national ranking of trust performance in this area. This year's results show CNTW's performance in the top 10% nationally for trainees (ranked 19 out of 236 trusts) and the top 5% for trainers nationally (ranked 10 out of 221 trusts). The pattern of performing well across the board and slightly better in the trainer survey has been consistent over the past 3 years.

### Industrial Action

The British Medical Association (BMA) and Hospital Consultants and Specialists Association (HCSA) held a further round of Junior Doctor's industrial action which commenced at 9.00 am on Thursday 13 July until 9.00 am on Tuesday 18 July 2023 – the longest single period of industrial action seen in the NHS. Whilst this round of action was more challenging than the previous dates due to the length of the action and moving into the holiday period, services were covered safely with continued support from senior medical staff, GPs, pharmacists and other clinical colleagues. Fewer Junior Doctors took action than in the previous three periods. Further dates have been released for 11-15 August 2023.

There is currently a further ballot of Junior Doctors underway and this closes on 26 August 2023. If the statutory thresholds are met, further action is likely to take place over the next six month period.

In addition to the Junior doctor's action, Consultant members of the BMA held industrial action from 7.00 am on Thursday 20 July until 7.00 am on Saturday 22 July 2023. Less than one quarter of the Consultant workforce made the decision to strike and whilst this group are a relatively small proportion of the clinical workforce, they provide clinical supervision and leadership within many of the clinical teams therefore small numbers of

activities such as clinics, discharge meetings etc. were postponed. Further dates have been released for 24-25 August 2023.

## Regional updates

### North East and North Cumbria Mental Health, Learning Disabilities and Autism Sub-Committee update

The North East and North Cumbria Integrated Care Board Mental Health, Learning Disabilities and Autism Sub Committee is now established and meets monthly with wide representation from Integrated Care Board representatives, local authority, third sector and health partners. The July meeting focussed on a report prepared by CNTW on patients who are clinically ready for discharge but experiencing delays as well as the Right Care Right Person policy changes. An update was provided on the GP recovery plan and the inpatient transformation programme.

A set of draft programmes of work have been developed by the Integrated Care Board covering the following key areas and the Trust has provided some high-level feedback on content and focus, which will be further discussed in August 2023. It is envisaged that the programmes of work will form a key part of the agenda for this subcommittee:

- Community transformation and access to services
- Suicide prevention
- Mental health ambulance and NHS 111
- Inpatient quality
- Building the right support for learning disabilities

## National updates

### Acute inpatient mental health care for adults and older adults

NHS England published guidance which sets out its vision for adult and older adult acute inpatient mental health services. The guidance describes in detail the key elements of the vision for the inpatient pathway:

Four key principles of effective inpatient care:

1. Personalised care and shared decision making
2. Care that advances health equality
3. Joined up partnership working throughout the patient journey so that people are supported to stay well when they leave hospital.
4. Trauma informed care

Three key stages of effective care across the inpatient pathway:

1. Purposeful admissions - the purpose of admission is clear to patients, families, and staff and admissions happen as close to home as possible.

2. Therapeutic inpatient care - access to assessment and treatment is timely, and care is delivered in a therapeutic environment in a way that is trauma-informed.
3. Proactive discharge planning and effective post-discharge support including a range of community support and supported living options

Key enablers of effective inpatient care

5. A fully multidisciplinary, skilled and supported workforce
6. Continuous improvement of the inpatient pathway, making the best use of data, regularly developing, testing and refining change ideas using quality improvement methodology, and ensuring that service improvements are co-produced with people with experience of inpatient services and their carers.

**NHS Long Term Workforce Plan**

NHS England published the NHS Long Term Workforce Plan on 30th June. The plan includes modelling of NHS workforce demand and supply over a 15-year period which shows that without immediate and focused action, the NHS will face a workforce gap of more than 260,000 – 360,000 staff by 2036/37. The plan sets out the case for change and a long-term strategic direction for the NHS workforce, as well as actions to be taken locally, regionally and nationally in the short-to medium term to address current workforce challenges. These actions are grouped into three priority areas: train, retain, and reform.

Key commitments include increasing medical and nursing training places and apprenticeships, reducing reliance on international recruitment and agency staff, implementing the NHS People Plan, and expanding the community, mental health and primary care workforce to deliver more preventative and proactive care. The Plan is based on an ambitious labour productivity assumption of up to 2%. While the Plan is focused on the NHS workforce and does not address social care workforce issues, it acknowledges the need for increased capacity in social care. NHS England will refresh the plan every two years.

**Public Accounts Committee report on progress in improving NHS mental health services**

Parliament's Public Accounts Committee published a report on progress in improving NHS mental health services. The key conclusions outlined in the report are:

1. Workforce shortages are constraining the improvement and expansion of NHS mental health services, with demand for services outpacing workforce expansion:
    - Between FY16/17 and FY21/22 the NHS mental health workforce expanded by 22%. Referrals increased 44% over the same period.

2. Data and information for NHS mental health services still lags behind that for physical services, including in relation to patient experience and outcomes data, and evidence of cost-effectiveness.
3. New integrated care boards and partnerships could struggle to prioritise mental health services and support, in the face of funding pressures and the need to reduce backlogs for physical health services.
4. There is still no clear definition of the end goal of 'parity of esteem' 12 years after the government first set out its ambitions.
5. The Department and NHS England have still not committed to rolling out waiting times standards to all mental health services.
6. Preventive and public health services for mental health have not had the same priority and focus on improvement as NHS mental health treatment services.

The Committee's report sets outs a series of recommendations to Government for addressing these conclusions. Government has two months to respond.

**Impact of cost-of-living crisis on schoolchildren in the UK**

Two thirds of school nurses and dentists responding to a study carried out by the School and Public Health Nurses Association (SAPHNA) and the British Dental Association (BDA) agreed that the health issues facing children had worsened in the past year. School nurses reported high rates of children presenting with a range of health issues linked to poor nutrition including increased tooth decay or damage, low energy levels, changes in behaviour, lack of growth or weight gain, increased frequency of mental health problems, increased frequency of common colds or fever, and slower cognitive and language development. The study was carried out as part of the No Child Left Behind campaign which is calling on the Government to commit to free school meals for every primary school child in England. The Scottish and Welsh governments have already begun rolling out free school meals to primary school students and a similar scheme will be rolled out in London from September.

## 8. INTEGRATED PERFORMANCE REPORT MONTH 3

Ramona Duguid, Chief Operating Officer

### REFERENCES

Only PDFs are attached

8a. Board Cover Sheet - IPR - June 2023.pdf

8b. Intergrated Performance Report June M3 23-24 - FINAL.pdf

| | |
|---|---|
| **Name of meeting** | **Board of Directors** |
| **Date of Meeting** | **Wednesday 2nd August 2023** |
| **Title of report** | **Integrated Performance Report Month 3** |
| **Executive Lead** | **Ramona Duguid, Chief Operating Officer** |
| **Report author** | **Tommy Davies, Head of Performance and Operational Delivery** |

| **Purpose of the report** | |
|---|---|
| **To note** | |
| **For assurance** | **X** |
| **For discussion** | |
| **For decision** | |

| **Strategic ambitions this paper supports (please check the appropriate box)** | |
|---|---|
| **1. Quality care, every day** | X |
| **2. Person-led care, when and where it is needed** | X |
| **3. A great place to work** | X |
| **4. Sustainable for the long term, innovating every day** | X |
| **5. Working with and for our communities** | X |

| **Meetings where this item has been considered** | |
|---|---|
| Quality and Performance | 26.07.23 |
| Audit | |
| Mental Health Legislation | |
| Remuneration Committee | |
| Resource and Business Assurance | |
| Charitable Funds Committee | |
| People | |
| CEDAR Programme Board | |
| Provider Collaborative | |
| Other/external (please specify) | |

| **Management meetings where this item has been considered** | |
|---|---|
| Executive Team | |
| Executive Management Group | 24.07.23 |
| 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 | X |
| Workforce | X | Environmental | |
| Financial/value for money | X | Estates and facilities | |
| Commercial | | Compliance/Regulatory | X |
| Quality, safety and experience | X | Service user, carer and stakeholder involvement | X |

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

**SA1** Quality care, every day – We want to deliver expert, compassionate, person-led care
**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. (SA1)

**SA2** Person-led care, when and where it is needed – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals.
**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. (SA2)

**SA3** A great place to work – We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers.
**Risks 1694**
Inability to recruit the required number of medical staff or provide alternative ways of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high-class services. (SA3)

**SA4** Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled**.**
**Risk 1762** Restrictions in Capital expenditure imposed nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments. (SA4)

NHS
Cumbria, Northumberland,
Tyne and Wear
NHS Foundation Trust

# Integrated Performance Report

Patients | Quality | People | Person Led Care | Sustainability

## 2023-24 Month 3 (June 2023)

With YOU in mind

# Integrated Performance Report - Headline Commentary

## Headline Challenges

- **Statutory and Mandatory Training** – This metric has changed this month to measure the percentage of statutory and mandatory training meeting the standard. 9 out of 27 courses are achieving or above the required standard. Of the remainder, 6 are within 5% of the standard and 12 remain below standard.
- **Serious Incidents** – Despite the low numbers the incidents are of serious magnitude and are therefore included in the exception reporting.
- **Out of Area Placements -** off target. Supporting metrics:
    - **Clinically Ready for Discharge –** off standard and increased in the month
    - **Bed Occupancy –** Not meeting the standard
- **Crisis Urgent Referrals –** the last 4 month's performance has been below the normal range.
- **Psychiatric Liaison Referrals in ED within 1 hour** – Continues to deteriorate and remains lower than peers.
- **CYPS Neurodevelopmental treatment waits -** The demand for access to neurodevelopmental diagnostic services has increased faster than the available capacity.
- **All CYPS Waits for Treatment** and All **Adults and Older Adults Waits for Treatment -** Performance is low but has remained static over the last 7 months
- **CYPS Eating Disorder Routine –** Is slowly improving but has been off target for 24 months.
- **Live within our means –** The Trust is forecasting to deliver the plan of financial break-even at the end of the year. The major risk to delivery of financial plan is from increasing WTE numbers through Q1.

## Key focus areas of concern

- **Statutory and Mandatory Training**
- **Out of Area Placements**
- **Crisis Urgent referrals**
- **18 weeks for Treatment**
    - **All CYPS**
    - **CYPS Neurodevelopmental waits**
    - **All Adults and Older Adults**
- **Live within our means**

## Positive Assurance / Improvement

- **EIP (Early Intervention Psychosis)** remains consistently above the 14 day standard.
- **72 hour follow up** is meeting the 80% standard.
- **Information Governance training** met the required 95% compliance standard at 30th June 2023.

## Mitigations/actions

- **Training** – The majority of Training Standards are improving although recovery trajectories are being set across the localities for standards not being met. There is currently a review taking place of the list of training competencies and compliance standards.
- **Out of Area Placements –** The Inpatient Improvement Programme will deliver change throughout this financial year including four detailed improvement areas to improve quality and patient flow
- **Crisis Urgent referrals –**Work continues to ensure accurate recording of referral urgency and development of local guidance. A new Crisis dashboard has been rolled out which will help improve aware of performance.
- **Patients waiting in the Community over 18 weeks for treatment –** Work continues to review improvement actions within the weekly oversight group to improve waiting times across the Trust. A number of workshops have taken place to support the Transformation Programmes within CYPS and Community services.
- **CYPS Neurodevelopmental waits –** There is a focussed programme of work, workshops and actions to reduce the waits in these pathways that is currently underway. This will involve the ICB and our partners to enable the Trust to tackle the challenges together.
- **Live within our means -** 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.

# Core Trust Integrated Outcome Measures - Summary Overview

Reporting Period: Jun 2023

| | Ref | Indicator Name | Variation | Assurance | Performance | Standard | Plan | Risk Rating | Summary Narrative | Exec |
|---|---|---|---|---|---|---|---|---|---|---|
| Commitments | C01 | How was your experience? | Normal Variation | Consistently Fail | 87.3% | 95.0% | Internal | High (Action) | Below standard reflecting the newly set standard of 95% | SR |
| | C02 | Did we listen to you? | Normal Variation | Consistently Fail | 87.6% | 95.0% | Internal | High (Action) | Below standard reflecting the newly set standard of 95% | SR |
| | C03 | Were staff kind and caring? | Normal Variation | Achieve at Random | 93.4% | 95.0% | Internal | Med (Monitoring) | Below standard reflecting the newly set standard of 95% | SR |
| | C04 | Did you feel safe? | Normal Variation | Achieve at Random | 90.6% | 95.0% | Internal | Med (Monitoring) | Below standard reflecting the newly set standard of 95% | SR |
| | C05 | Were you given helpful information? | Normal Variation | Consistently Fail | 88.8% | 95.0% | Internal | High (Action) | Below standard reflecting the newly set standard of 95% | SR |
| People | P01 | Turnover | Concern | Achieve at Random | 10.8% | 10.0% | National | High (Action) | Increased since April 2022, North Cumbria significantly higher. | LS |
| | P02 | Sickness in Month | Normal Variation | Consistently Fail | 6.1% | 5.0% | National | High (Action) | Marginal increase across all localities | LS |
| | P03 | % of Training Compliance Achieved All Standards | Improvement | Consistently Fail | 33.3% | 85.0% | Internal | High (Action) | Methodology changed. 9 of 27 courses are achieving standard. | LS |
| | P04 | Appraisal rate | Improvement | Consistently Fail | 78.9% | 85.0% | Internal | High (Action) | Continually improving since July 2022. | LS |
| | P05 | % Clinical Supervision completed | Normal Variation | Consistently Fail | 55.2% | 80.0% | Internal | High (Action) | Improvement but remains below 85% 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 January 2023 to 65.7% in April 2023. | LS |
| Quality Care | Q01 | Restrictive intervention incidents | Normal Variation | No Standard | 14 | No Std | No Plan | Low (No Standard) | No significant change in 2 years | SR |
| | Q02 | Serious Incidents | Normal Variation | No Standard | 26 | No Std | No Plan | High (Action) | Despite low numbers, action is required due to magnitude | RN |
| | Q03 | Harm Incidents | Normal Variation | No Standard | 2,080 | No Std | No Plan | Low (No Standard) | Remains within expected range | RN |
| | Q04 | Safeguarding and Public Protection (SAPP) | Concern | No Standard | 1,668 | 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 | 19 | No Std | No Plan | Low (No Standard) | Showing consistent reduction below the average for 9 months | SR |
| | Q06 | Aggression and Violence | Normal Variation | No Standard | 1,472 | 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 | 56 | No Std | No Plan | Low (No Standard) | Reported below average (around 60) for the first time in 6 months | RN |
| | Q08 | Care Plans compliance | Improvement | Consistently Fail | 94.2% | 95.0% | Internal | Med (Monitoring) | Remains stable, close to standard | SR |
| | Q09 | Risk Assessments compliance | Concern | Achieve at Random | 94.7% | 95.0% | Internal | Med (Monitoring) | Below the standard of 95% for the 12th successive month | SR |
| | Q10 | CPA Completed review | Concern | Consistently Fail | 77.9% | 95.0% | Internal | High (Action) | Performance has deteriorated since April 2022 below standard. | SR |
| | Q11 | Staffing fill rates | Normal Variation | Achieve at Random | 118.1% | 120.0% | National | Med (Monitoring) | Reported within expected levels. | SR |
| Person Led Care | A01 | Out of Area Placement bed days | Normal Variation | Achieve at Random | 356 | 210 | LTP | High (Action) | Remains above set trajectory but reduction on last month | RD |
| | A02 | Bed Occupancy including leave (open beds on RiO) | Concern | Consistently Fail | 94.8% | 85.0% | National | High (Action) | Remains higher than expected bed usage | RD |
| | A03 | % Adult inpatients discharged with LOS > 60 days | Normal Variation | No Standard | 23.4% | No Std | LTP | Low (No Standard) | Increase in the month within expected range | RD |
| | A04 | % OP inpatients discharged with LOS > 90 days | Normal Variation | No Standard | 50.0% | No Std | LTP | Low (No Standard) | Remains consistent with previous months | RD |
| | A05 | Clinically Ready for Discharge (formerly DTOC) | Normal Variation | Consistently Fail | 10.1% | 7.5% | National | High (Action) | 1.3% increase from previous month and remains above the standard | RD |
| | A06 | Crisis % Very urgent seen within 4 hours (WAA&OP) | Normal Variation | No Standard | 36.0% | No Std | No Plan | Med (Monitoring) | 9 out of 25. Fluctuates due to low numbers. | RD |
| | A07 | Crisis % Urgent seen within 24 hours (WAA&OP) | Concern | No Standard | 81.3% | No Std | No Plan | Med (Monitoring) | 464 our of 571. Performance has dipped in the last four months. | RD |
| | A08 | % PLT ED Referrals seen within 1 hour | Concern | No Standard | 53.4% | No Std | LTP | Med (Monitoring) | Continued deterioration and remains lower than peers | RD |
| | A09 | % PLT Ward Referrals seen within 24 hours | Normal Variation | No Standard | 80.7% | No Std | LTP | Low (No Standard) | Fluctuates but remains between 71% and 84% | RD |
| | A10 | 72 hour Follow-Up | Normal Variation | Consistently Achieve | 91.9% | 80.0% | LTP | Low (On Track) | Consistently exceeds 80% standard | RD |
| | A11 | 18 weeks wait to Treatment Adults & Older Adults | Concern | No Standard | 72.0% | No Std | No Plan | Med (Monitoring) | Deterioration from Jul-21 to Jul-22. Remains steady since Jul-22. | RD |
| | A12 | 18 weeks waits to Treatment - All CYPS | Concern | No Standard | 46.1% | No Std | No Plan | Med (Monitoring) | 46% (3085 of 6693). Deterioration over the last 2 years | RD |
| | A13 | <18 wk waits to Treatment CYPS Neurodevelopmental | Normal Variation | No Standard | 41.8% | No Std | No Plan | Med (Monitoring) | 58% (2985 of 5126) have been waiting 18 weeks or longer | RD |
| | A14 | CYPS Eating Disorders (urgent referrals) | Improvement | Achieve at Random | 100.0% | 95.0% | LTP | Low (On Track) | Consistently meets the standard. | RD |
| | A15 | CYPS Eating Disorders (routine referrals) | Normal Variation | Achieve at Random | 77.3% | 95.0% | LTP | Med (Monitoring) | Decreased in month and remains below standard | RD |
| | A16 | EIP – starting treatment in 14 days | Normal Variation | Consistently Achieve | 87.9% | 60.0% | LTP | Low (On Track) | Consistently above the standard | RD |
| | A17 | Talking Therapies % Moving to Recovery (IAPT) | Normal Variation | Achieve at Random | 51.9% | 50.0% | LTP | Low (On Track) | Continues to meet the standard | RD |
| Sustainable | S01 | Live within our means (I&E Surplus/Deficit £) | SPC N/A | SPC N/A | 1.2M | 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 | 1.0M | 1.2M | No Plan | Low (On Track) | Capital programme overcommitted. | KS |
| | S03 | Cash balance compared to plan (£) | SPC N/A | SPC N/A | 43.6M | 24.4M | No Plan | Low (On Track) | Cash balance on plan due to additional monies. | KS |

# Commitments to our Carers & Patients - Headline Commentary

Reporting Period: Jun 2023

## Headline Challenges

- A change in standard from 85% to 95% was agreed to ensure the Trust sets a high expectation for patient satisfaction. This change means that all these measures are in exception.
- **How was your care? –** At 87.3%, this is not meeting the standard but the last 3 data points have seen an improvement.
- **Do we listen to you? –** At 87.6% this is not meeting the standard and has not changed significantly in 24 months
- **Were staff kind and caring? -** At 93.4% this is the closest to the 95% standard of all the measures but has only met the standard on three occasions in 24 months.
- **Do you feel safe? -** At 90.6% this is not meeting the standard and has not changed significantly in 24 months.
- **Were you given helpful information? –** At 88.8% this is not meeting the standard and has not changed significantly in 24 months. However, this month was the best performance in 18 months.

## Key focus areas of concern

- **Overall experience remains the lowest % score.**
- **People not feeling listened to remains a theme, especially in younger people and young adults.**
- **North Cumbria locality consistently scores below the Trust average for all 5 scorable questions.**

## Positive Assurance / Improvement

- Despite all the measures not meeting the standard and there not being any significant change over the last two years, all the standards have had a recent uptick in performance.

## Mitigations/actions

**Overall experience**

- Teams and wards are supported to access the 'Points of You' dashboard to understand what carers and patients are saying in real time.
- The Carers Promise is now live. There has been an awareness campaign to support its adoption by the Trust.
- Carer and Patient experience is a standing agenda item at locality Service User and Carer Experience meetings.
- Experience continues to be addressed at locality Quality Standards meetings.
- Numbers of completed surveys continue to rise which is positive and our performance across all areas has seen a recent uptick.
- Localities that have scores below Trust average have been made aware and are being supported in how to effectively explore the themes associated.

**People not feeling listened**

- Promotion of the You Said – We Did posters is ongoing at all levels of the Trust. Higher adherence should support teams to show they are responsive to the experience of people accessing services.
- The is a whole review of the Points of View process and reporting, with stakeholder and engagement and a plan to implement any changes by the end of 2023/24

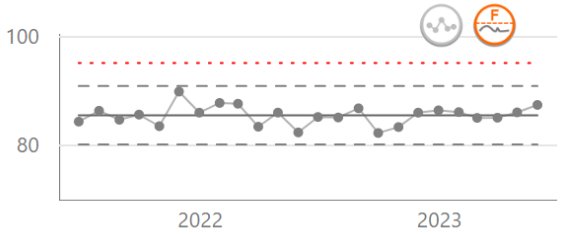
# Commitments to our Carers & Patients

Reporting Period: Jun 2023

How was your experience?

High (Action)

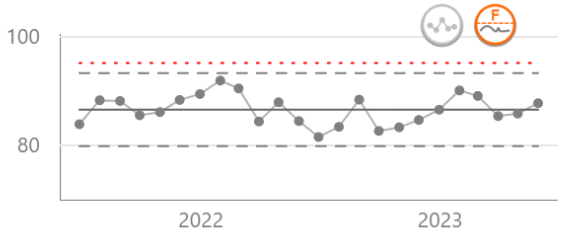
Ref - C01 Performance - 87.3% Standard - 95.0%




Did we listen to you?

High (Action)

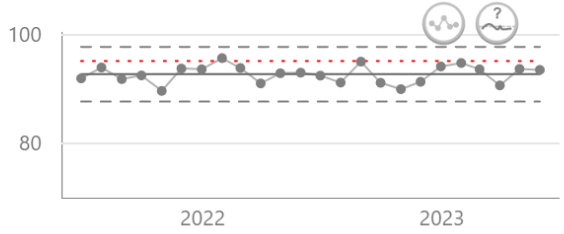
Ref - C02 Performance - 87.6% Standard - 95.0%




Were staff kind and caring?

Med (Monitoring)

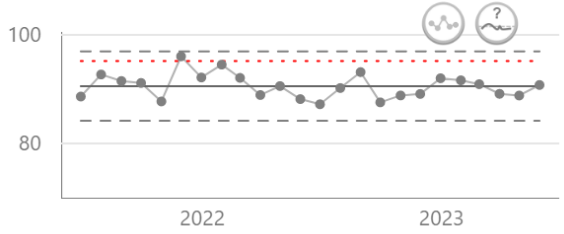
Ref - C03 Performance - 93.4% Standard - 95.0%




Did you feel safe?

Med (Monitoring)

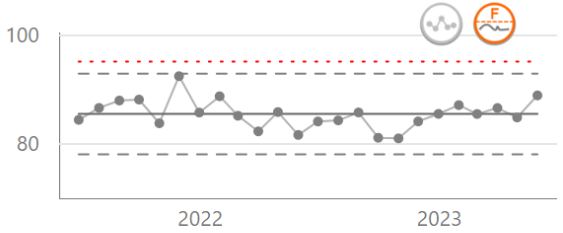
Ref - C04 Performance - 90.6% Standard - 95.0%




Were you given helpful information?

High (Action)

Ref - C05 Performance - 88.8% Standard - 95.0%



# Great Place to Work - Headline Commentary

Reporting Period: Jun 2023

## Headline Challenges

- **Sickness** – The data runs one month behind other data in the report. Confirmed sickness for May 2023 is reported at 6.1%. The provisional sickness for June is reported at 5.57% and has seen a reduction across all localities in June 2023 but remains above 5% target.
- **Statutory and Mandatory Training -** This metric has changed this month to measure the percentage of statutory and mandatory training meeting the standard. 9 out of 27 courses are achieving or above the required standard. Of the remainder 6 are within 5% of the standard and 12 remain below standard. Key challenges linked to clinical demand to release staff to undertake essential training. However, most of the standards are improving. Key challenges linked to clinical demand and ability to release staff to undertake essential training.
- **Clinical Supervision –** measure has been far below the standard for a significant number of months although it has started to show signs of improvement.

## Key focus areas of concern

- **Sickness**
- **Staffing resources**
- **Statutory and Mandatory Training**

## Positive Assurance / Improvement

- **Information Governance training** met the required 95% compliance standard at 30th June 2023.
- **Appraisal rates** are improving although not meeting the standard

## Mitigations/actions

**Sickness**

- Merging Wellness Support team workforce function with Localities. Promotion of wellbeing conversations to support local stress risk assessments, carers passports and WRAP plans.

**Staffing Resources**

- Localities have introduced local vacancy control processes in line with locality cost improvement plans. Giving tighter monitoring of requests. Corporate vacancy control process also introduced.

**Training competencies and compliance standards**

- The majority of Training Standards are improving although recovery trajectories are being set across the localities for standards not being met. The Training Needs Analysis tool will be updated with the modality of the training to support planning of training trajectories. There is also currently a review taking place of the list of training competencies and compliance standards.

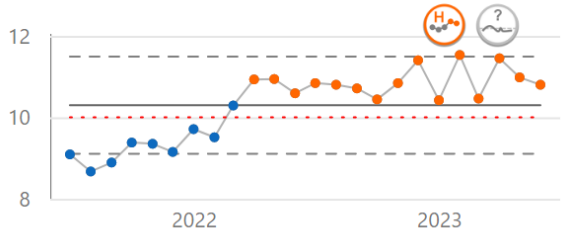
# Great Place to Work

Reporting Period: Jun 2023

### Turnover

**High (Action)**

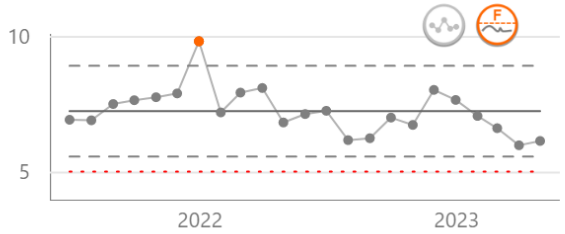
Ref - P01 Performance - 10.8% Standard - 10.0%




### Sickness in Month

**High (Action)**

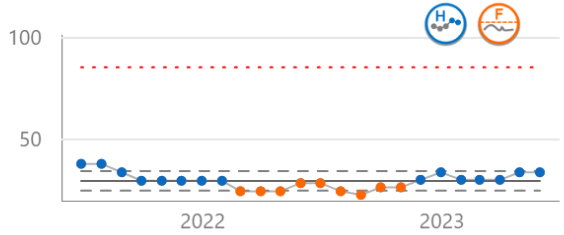
Ref - P02 Performance - 6.1% Standard - 5.0%




### % of Training Compliance Achieved All Standards

**High (Action)**

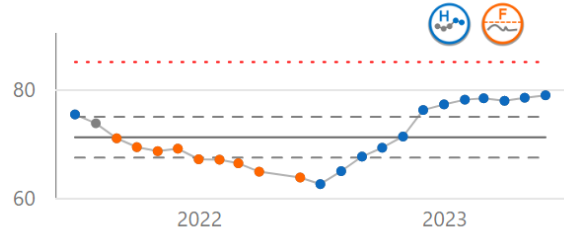
Ref - P03 Performance - 33.3% Standard - 85.0%




### Appraisal rate

**High (Action)**

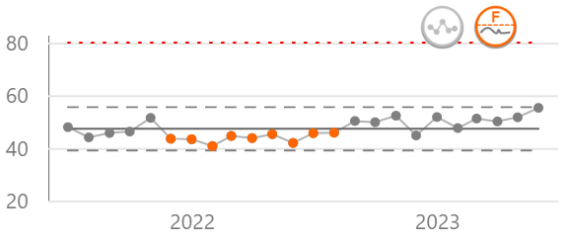
Ref - P04 Performance - 78.9% Standard - 85.0%




### % Clinical Supervision completed

**High (Action)**

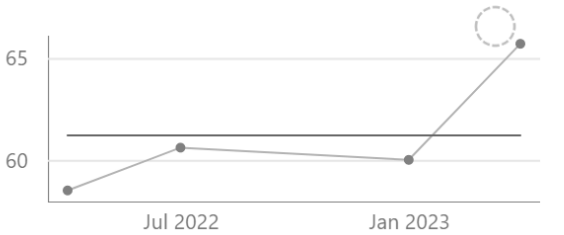
Ref - P05 Performance - 55.2% Standard - 80.0%




### People Pulse Health & Wellbeing satisfaction

**Low (No Standard)**

Ref - P06 Performance - 65.7% Standard - No Std



# Quality Care, Everyday - Headline Commentary

Reporting Period: Jun 2023

## Headline Challenges

- **Serious Incidents –** Despite the low numbers, the incidents are of serious magnitude and are therefore included in the exception reporting. There was a reduction in the number of Serious Incidents this month from May but no significant variance out with norm over last 2 years
- **Safeguarding and Public Protection -** In June. reported safeguarding activity breached the upper control (1628) for the 2nd consecutive Month, this was an increase from previous high in May (1459).
- **CPA Complete Review -** This has continually declined over the last two years
- **Staff Fill Rates –** this has reduced since last month but does not consistently meet the standard,

## Key focus areas of concern

- **Serious Incident**
- **Safeguarding and Public Protection**
- **CPA Completed Review**

## Positive Assurance / Improvement

- **Care Plan compliance** remains stable
- **Risk Assessment Compliance** slight improvement means this measure is getting closer to meeting the standard.
- **Patients in long Term Segregation and prolonged seclusion** continues to improve

## 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 Trust and ICB governance processes to ensure that learning is embedded.

**Safeguarding and Public Protection**

SAPP team continue to have oversight of all reported safeguarding incidents. An amendment to the data recording of outcome options via SAPP triage is to be implemented to better understand potential issues with reporting that may be impacting increased safeguarding figures.

**CPA Completed Review**

Teams have been informed that CPA process is continuing, and the requirement to record and verify a CPA review via the CPA status form is to continue.

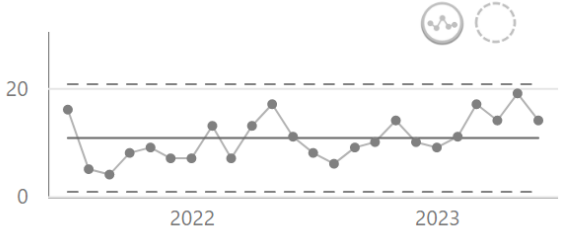
# Quality Care, Everyday

Reporting Period: Jun 2023

### Restrictive intervention incidents

**Low (No Standard)**

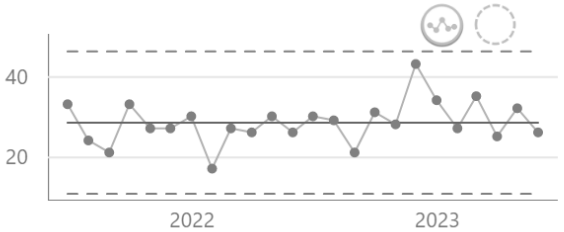
Ref - Q01 Performance - 14 Standard - No Std




### Serious Incidents

**High (Action)**

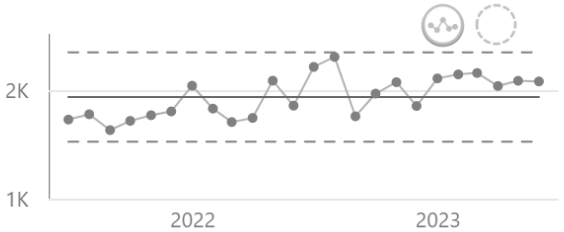
Ref - Q02 Performance - 26 Standard - No Std




### Harm Incidents

**Low (No Standard)**

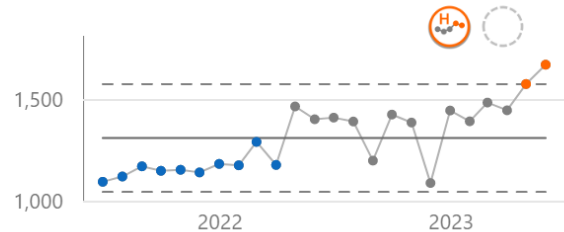
Ref - Q03 Performance - 2,080 Standard - No Std




### Safeguarding and Public Protection (SAPP)

**Med (Monitoring)**

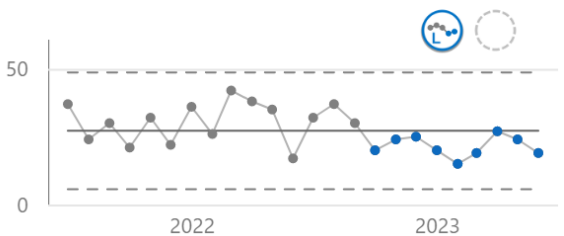
Ref - Q04 Performance - 1,668 Standard - No Std




### Long term segregation and prolonged seclusion

**Low (No Standard)**

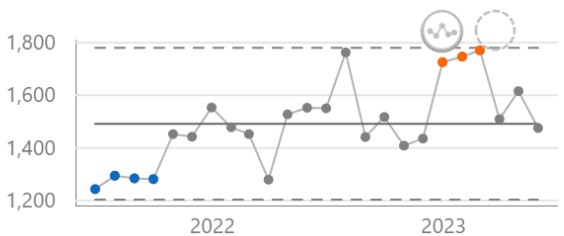
Ref - Q05 Performance - 19 Standard - No Std




### Aggression and Violence

**Med (Monitoring)**

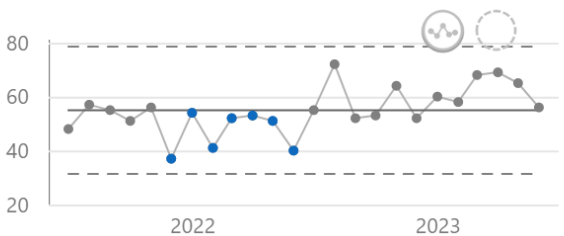
Ref - Q06 Performance - 1,472 Standard - No Std




### Number of Complaints

**Low (No Standard)**

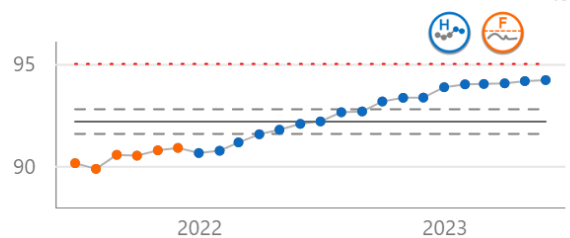
Ref - Q07 Performance - 56 Standard - No Std




### Care Plans compliance

**Med (Monitoring)**

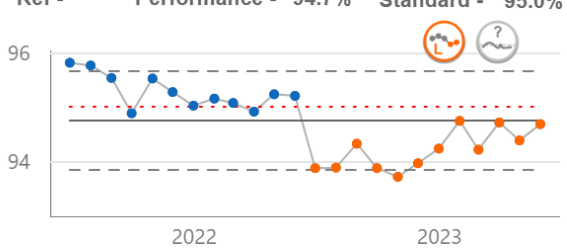
Ref - Q08 Performance - 94.2% Standard - 95.0%




### Risk Assessments compliance

**Med (Monitoring)**

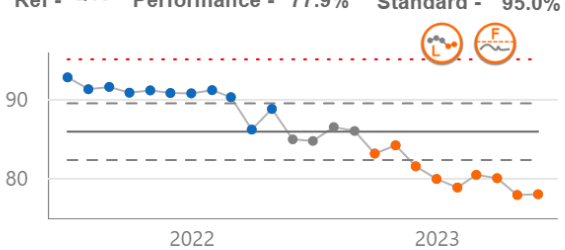
Ref - Q09 Performance - 94.7% Standard - 95.0%




### CPA Completed review

**High (Action)**

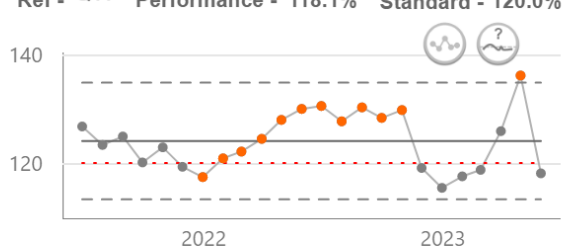
Ref - Q10 Performance - 77.9% Standard - 95.0%




### Staffing fill rates

**Med (Monitoring)**

Ref - Q11 Performance - 118.1% Standard - 120.0%



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

## Headline Challenges

**Out of Area Placements** are not meeting the agreed trajectory. Below are some of the supporting measures:

- **Bed Occupancy levels -** Not meeting standard
- **Clinically Ready for Discharge –** off standard consistently
- The indicators above are linked to wider housing and social care arrangements.

- **Crisis Urgent Referrals –** the last 4 month's performance has been below the normal range.
- **Psychiatric Liaison Referrals in ED within 1 hour** – Continues to deteriorate and remains lower than peers.
- All **CYPS Waits for Treatment** and All **Adults and Older Adults Waits for Treatment -** Performance has remained static over last 7 months
- **CYPS Neurodevelopmental waits -** The demand for access to neurodevelopmental diagnostic services has increased faster than the available capacity to supply NHS assessments and treatment for ASD/ADHD
- **CYPS Eating Disorder Routine –** Is slowly improving despite a dip in performance this month. It has been off target for 24 months.

## Key focus areas of concern

Of most concern

- **Out of Area Placements**
- **Crisis Urgent Referrals**
- **Patients waiting in the Community over 18 weeks for treatment**
- **CYPS Neurodevelopmental waits**

Of concern:

- **Clinically Ready for Discharge**
- **Bed Occupancy**

## Positive Assurance / Improvement

- **EIP services** remain consistently above the 14 day standard.
- **72hr follow up** after discharge is being met.

## Mitigations/actions

- **Out of Area Placements / Clinically Ready for Discharge / Bed Occupancy–** The Inpatient Improvement Programme will deliver change throughout this financial year including four detailed improvement areas to improve quality and patient flow
- **Crisis Urgent referrals –**Work continues to ensure accurate recording of referral urgency and development of local guidance. A new Crisis dashboard has been rolled out which will help improve aware of performance.
- **Patients waiting in the Community over 18 weeks for treatment –** Work continues to review improvement actions within the weekly oversight group to improve waiting times across the Trust. A number of workshops have taken place to support the Transformation Programmes within CYPS and Community services.
- **CYPS Neurodevelopmental waits –** There is a focussed programme of work, workshops and actions to reduce the waits in these pathways that is currently underway. This will involve the ICB and our partners to enable the Trust to tackle the challenges together.

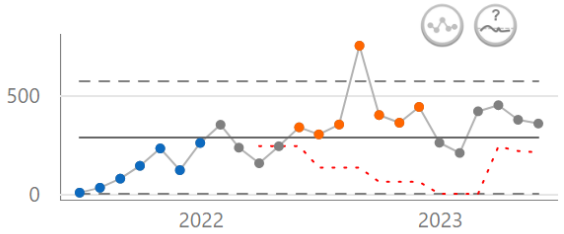
# Person Led Care, when and where it's needed

Reporting Period: Jun 2023

### Out of Area Placement bed days

High (Action)

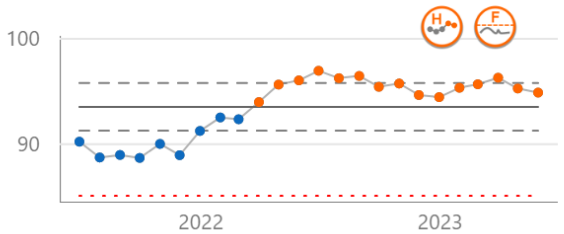
Ref - A01 Performance - 356 Standard - 210




### Bed Occupancy including leave (open beds on RiO)

High (Action)

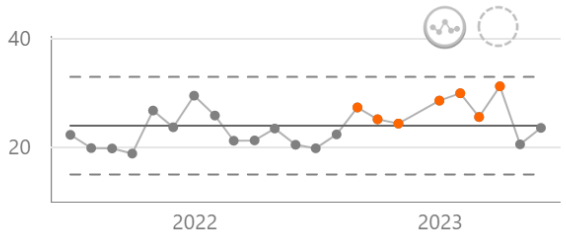
Ref - A02 Performance - 94.8% Standard - 85.0%




### % Adult inpatients discharged with LOS > 60 days

Low (No Standard)

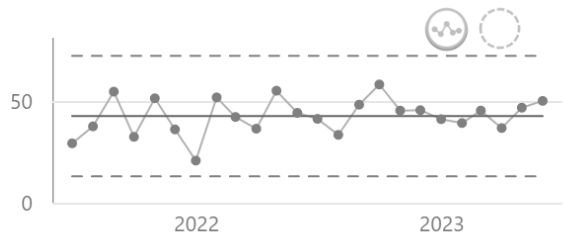
Ref - A03 Performance - 23.4% Standard - No Std




### % OP inpatients discharged with LOS > 90 days

Low (No Standard)

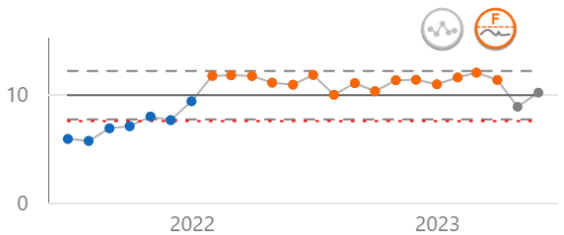
Ref - A04 Performance - 50.0% Standard - No Std




### Clinically Ready for Discharge (formerly DTOC)

High (Action)

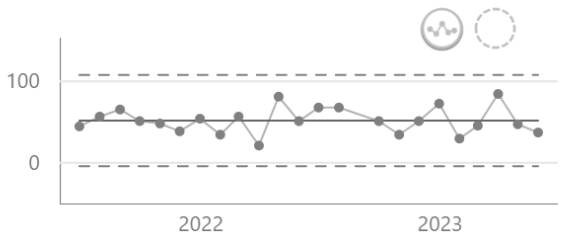
Ref - A05 Performance - 10.1% Standard - 7.5%




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

Med (Monitoring)

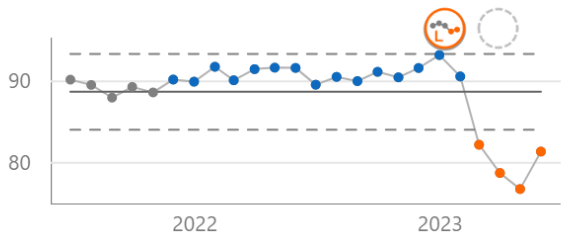
Ref - A06 Performance - 36.0% Standard - No Std




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

Med (Monitoring)

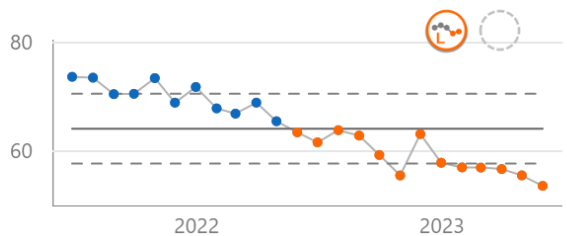
Ref - A07 Performance - 81.3% Standard - No Std




### % PLT ED Referrals seen within 1 hour

Med (Monitoring)

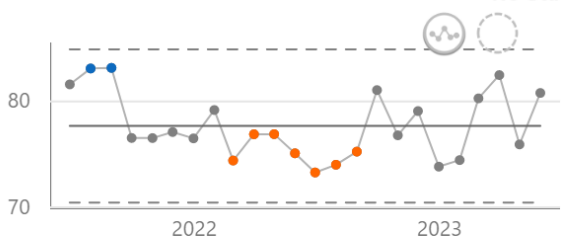
Ref - A08 Performance - 53.4% Standard - No Std




### % PLT Ward Referrals seen within 24 hours

Low (No Standard)

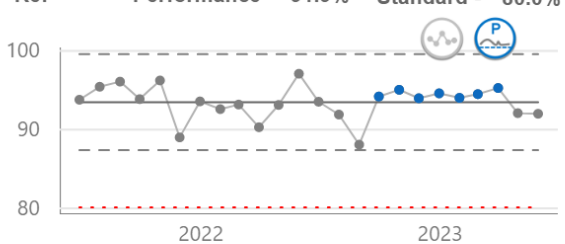
Ref - A09 Performance - 80.7% Standard - No Std




### 72 hour Follow-Up

Low (On Track)

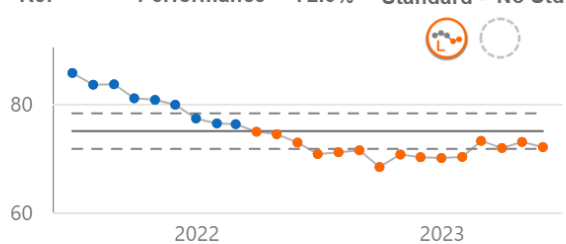
Ref - A10 Performance - 91.9% Standard - 80.0%




### 18 weeks wait to Treatment Adults & Older Adults

Med (Monitoring)

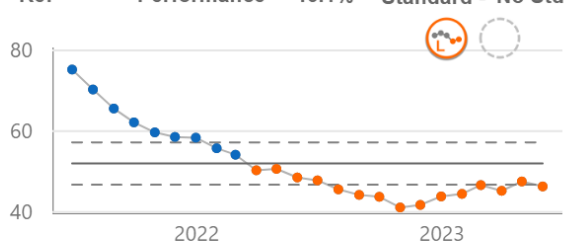
Ref - A11 Performance - 72.0% Standard - No Std




### 18 weeks waits to Treatment - All CYPS

Med (Monitoring)

Ref - A12 Performance - 46.1% Standard - No Std



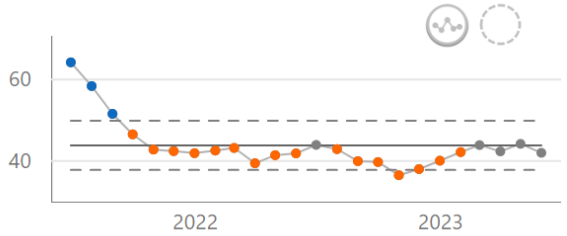
# Person Led Care, when and where it's needed

Reporting Period: Jun 2023

<18 wk waits to Treatment CYPS Neurodevelopmental

Med (Monitoring)

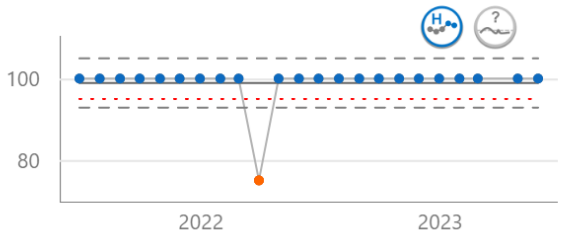
Ref - A13 Performance - 41.8% Standard - No Std




CYPS Eating Disorders (urgent referrals)

Low (On Track)

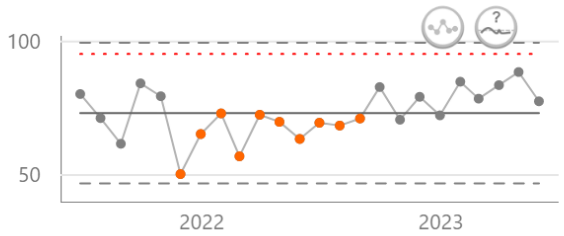
Ref - A02 Performance - 100.0% Standard - 95.0%




CYPS Eating Disorders (routine referrals)

Med (Monitoring)

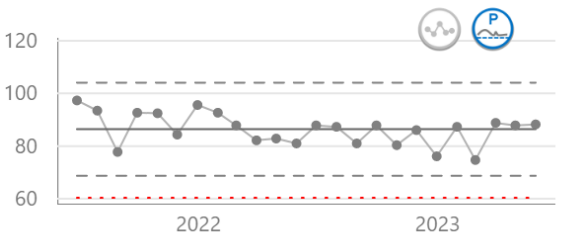
Ref - A15 Performance - 77.3% Standard - 95.0%




EIP – starting treatment in 14 days

Low (On Track)

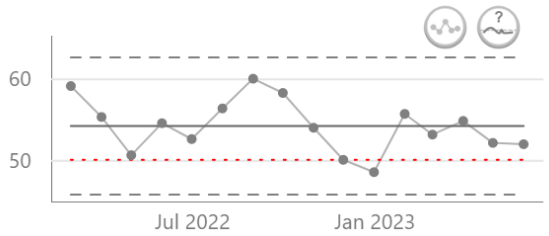
Ref - A16 Performance - 87.9% Standard - 60.0%




Talking Therapies % Moving to Recovery (IAPT)

Low (On Track)

Ref - A17 Performance - 51.9% Standard - 50.0%



# Sustainable for the Long Term - Headline Commentary

## Headline Challenges

- Trust financial position shows better than plan at month 3. Plan includes phasing adjustment to reflect phasing of efficiencies. On removal of the phasing adjustment the Trust is showing £3.1m overspend at the end of Q1.
- At the end of Q1 the Trust has spent £4.8m on agency staff against a plan of £4.2m and against the Trust's nationally applied agency ceiling of £3.6m.
- The Trust is forecasting to deliver the plan of financial break-even at the end of the year. The major risk to delivery of financial plan is from increasing WTE numbers through Q1.
- Cost trends need to change to deliver the financial forecast.
- There is significant pressure on several inpatient wards to deliver services within the revised baseline staffing establishments, all four inpatient CBUs are overspent at the end of Q1.

## Key focus areas of concern

- Year to date the Trust is overspent across key budgets
- Delivery of the Trust planned efficiencies is a risk to delivery of the Trusts planned financial break-even
- The level of WTE across the Trust (particularly temporary staffing)
- Trust cash balances will come under pressure from continued deficits, plan reflects surpluses in second half of the year. If the surpluses are not delivered cash will be further depleted.
- Capital schemes being reviewed to confirm delivery to configuration and timescales in current programme.
- Trust underlying financial position - planning 24/25

## Positive Assurance / Improvement

- Trust current cash balances are over plan from slippage in capital programme
- Senior Management commitment to improve financial position – focus of BDG on a monthly basis with specific financial reviews of areas of most concern
- Agency spend on downward trend though Q1 (April £1.8m, May £1.6m and June £1.4m)

## 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 for CEDAR scheme to support Trust cash balances

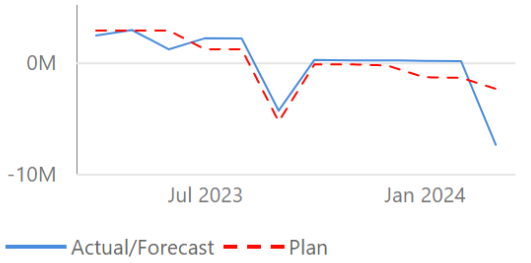
# Sustainable for the Long Term

Reporting Period: Jun 2023

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

**High (Action)**

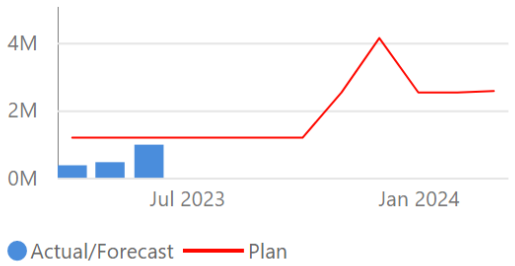
**Ref - S01 Actual/Forecast - 1.2M Plan - 2.87M**




### Capital spend compared to plan (£)

**Low (On Track)**

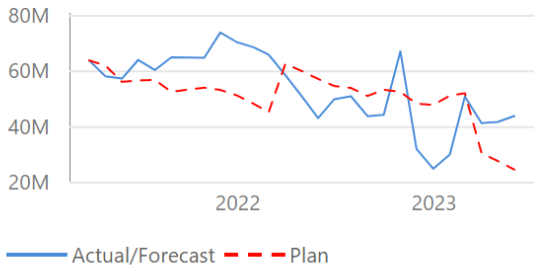
**Ref - S02 Actual/Forecast - 1.0M Plan - 1.19M**




### Cash balance compared to plan (£)

**Low (On Track)**

**Ref - S03 Actual/Forecast - 43.6M Plan - 24.4M**



# How was your experience?

Overall how was your experience with our service?

Risk Rating - **High (Action)**

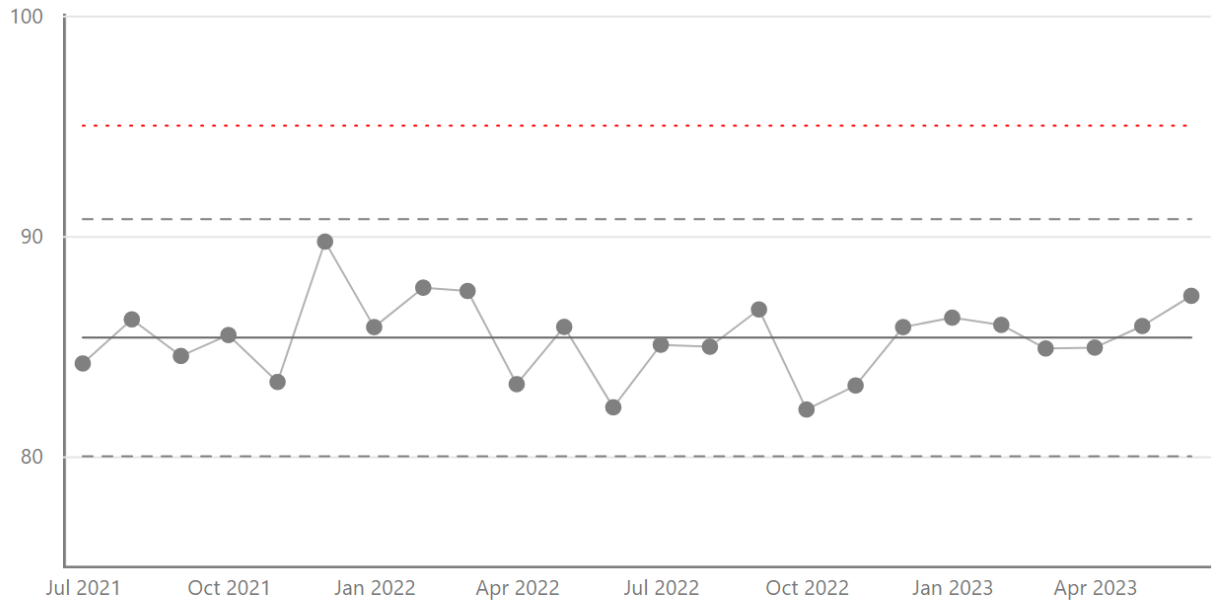
**Performance - 87.3%**

**Standard - 95.0%**

**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 |
|---|---|---|---|---|

No Locality breakdown currently available

## Feedback

**What the chart tells us?**

Performance is consistently between 80% and 91% averaging 85%. The agreed standard of 95% is unlikely to be achieved.

**Root Cause of the performance issue**

- Services in North Cumbria continue to get lower % scores than other localities, bringing down the overall %.
- Central locality had a below Trust average score this month.
- The 2 below Trust average scores took the Trust further away from the 95% target.

**Improvement Actions**

- Localities that have scores below Trust average have been made aware, as well as being supported in how to effectively explore the themes associated.

**Expected impact and by when**

- Ongoing during 2023-24

# Did we listen to you?

Did we listen to you when making decisions about care & treatment?

Risk Rating - **High (Action)**

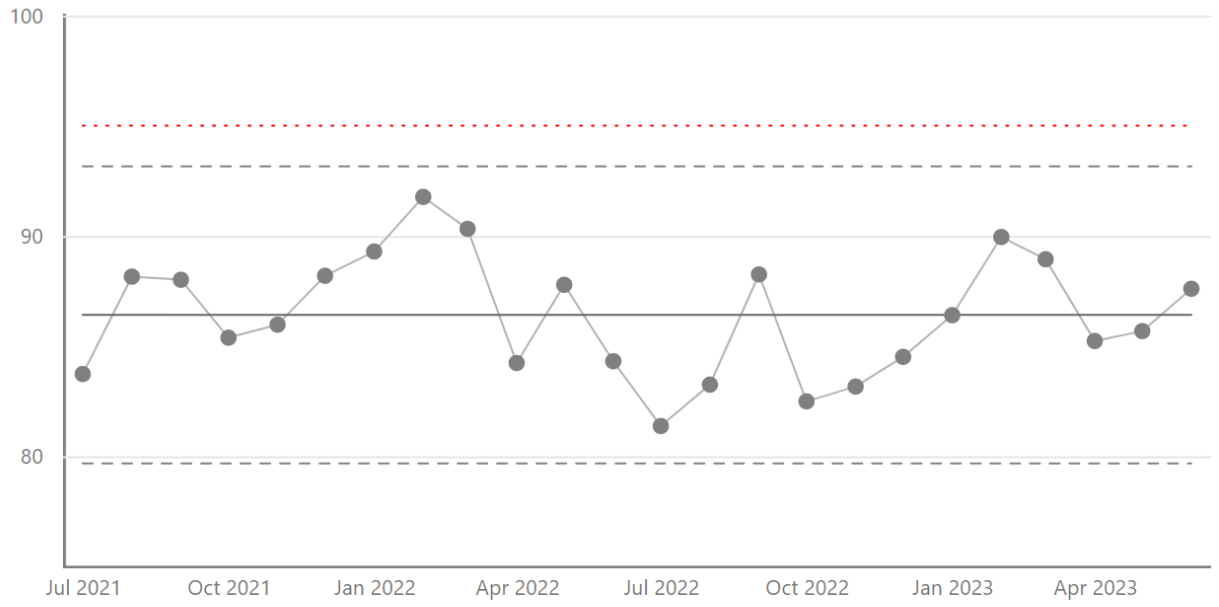
**Performance - 87.6%**

**Standard - 95.0%**

**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 |
|---|---|---|---|---|

No Locality breakdown currently available

## Feedback

**What the chart tells us?**

Performance is consistently between 80% and 93% averaging 86%. The agreed standard of 95% is unlikely to be achieved.

**Root Cause of the performance issue**

- People not feeling listened to is a consistent theme of feedback. Either getting this right or wrong makes a huge difference to people's experience of services.
- Younger people (age groups under 35 years old) make up the majority of people reporting not feeing listened to.

**Improvement Actions**

- The importance of supporting younger people to feel listened to is continually discussed at team/CBU and locality level. A cultural shift towards valuing the opinions of younger people is needed.
- Addressing closed cultures will support in addressing the necessity to listen to carers and patients.

**Expected impact and by when**

- Ongoing 2023-24

# Were staff kind and caring?

Were staff kind and caring?

Risk Rating - **Med (Monitoring)**

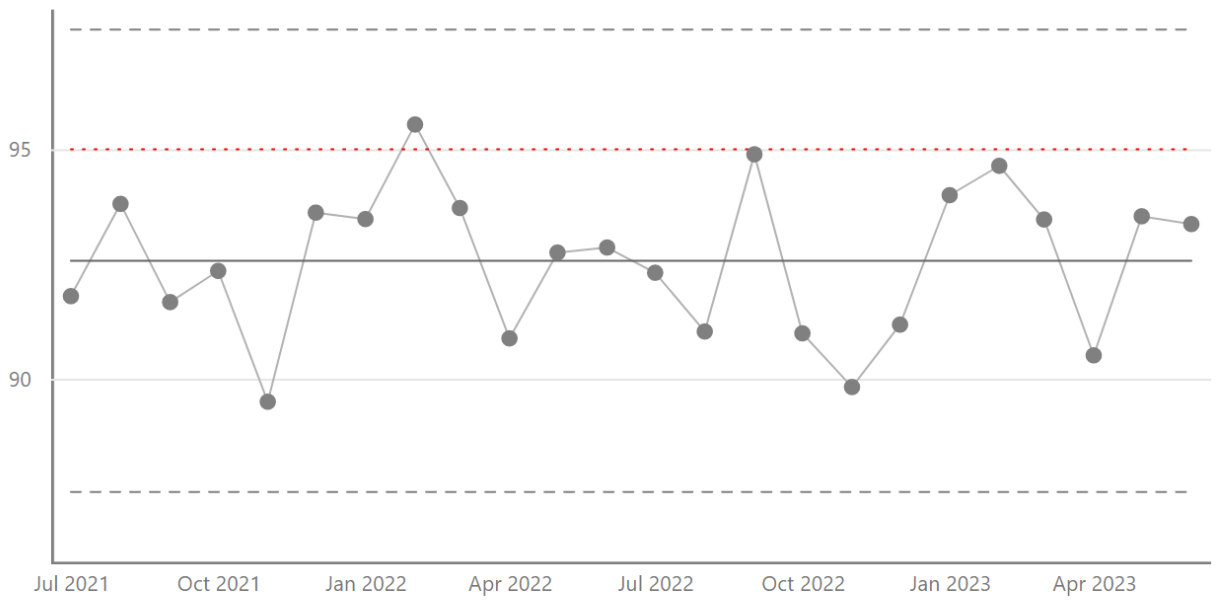
**Performance - 93.4%**

**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 |
|---|---|---|---|---|

No Locality breakdown currently available

## Feedback

**What the chart tells us?**

The standard of 95% 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**

- This is the question the Trust has received the best score for.
- 8 people said staff were not kind and caring, in comparison with 460 saying yes.
- There are 50 compliments associated with this specific question.

**Improvement Actions**

- This feedback from carers and patients should be shared across the Trust to support staff wellbeing and resilience.
- Compliments are available to all staff and efforts should be made to make sure a staff member who receives a compliment are aware.

**Expected impact and by when**

- Ongoing through 2023-24

# Did you feel safe?

Did you feel safe with our service?

Risk Rating - Med (Monitoring)

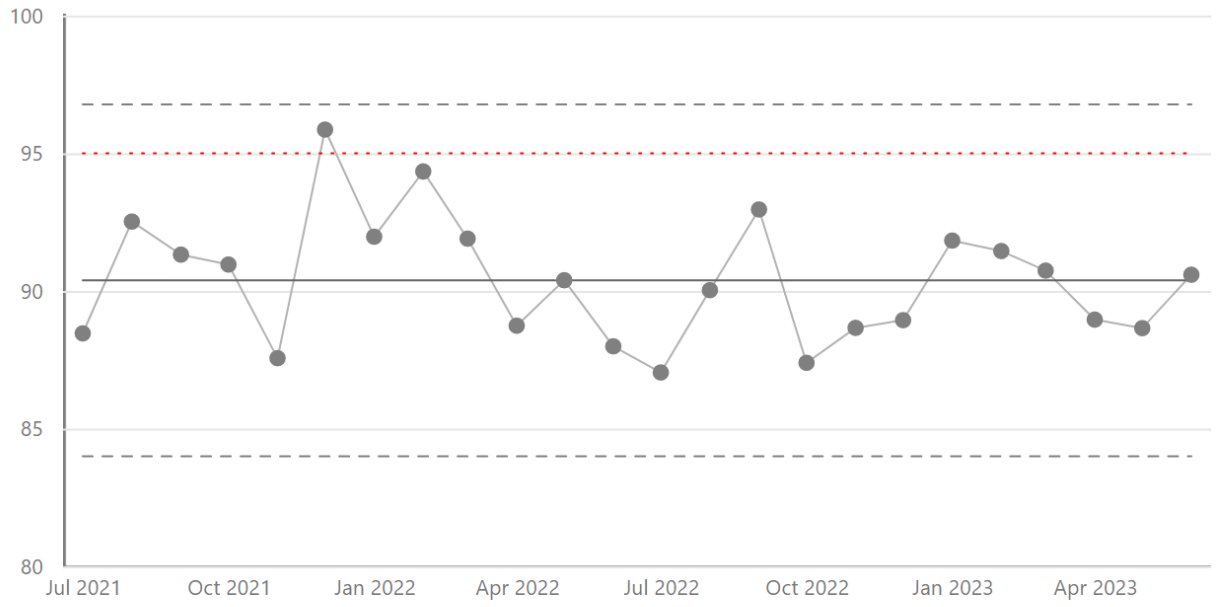
Performance - 90.6%

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 |
|---|---|---|---|---|

No Locality breakdown currently available

## Feedback

**What the chart tells us?**

The standard of 95% 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**

- 21 people reported not feeling safe during June. 450 people reported feeling safe.
- The majority of people reporting not feeling safe had accessed Community Treatments Teams (CYPS/Adult and Older Adult)

**Improvement Actions**

- CYPS/Adult and Older Adult Community Treatment Teams need to explore why people say they don't feel safe.

**Expected impact and by when**

- Ongoing through 2023-24

# Were you given helpful information?

Were you given information that was helpful?

Risk Rating - **High (Action)**

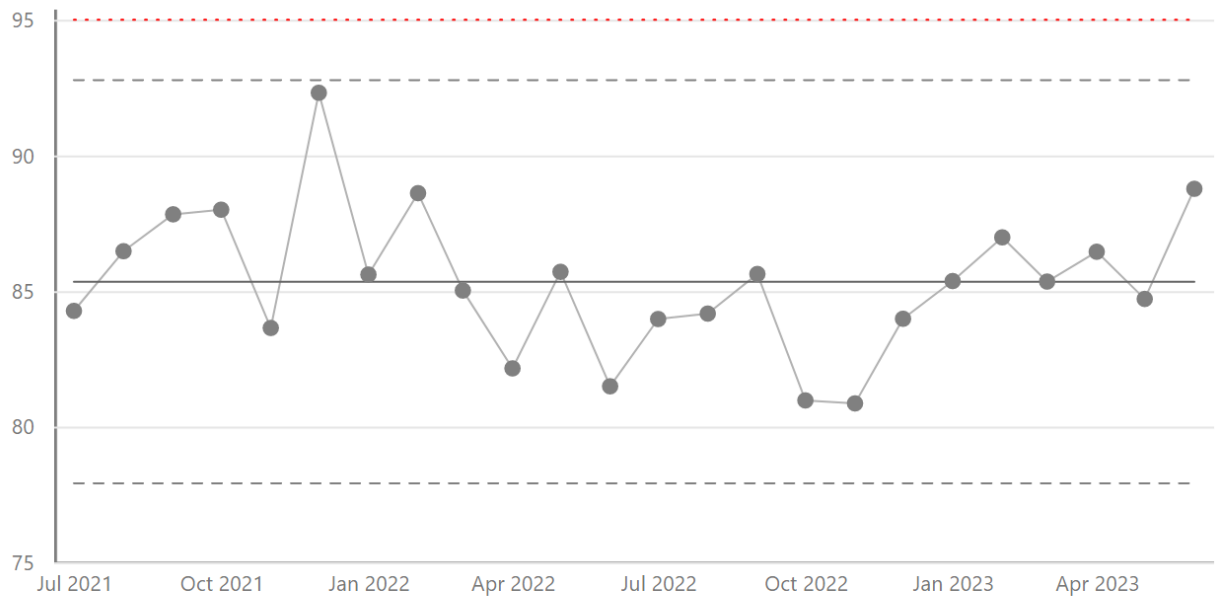
**Performance - 88.8%**

**Standard - 95.0%**

**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 |
|---|---|---|---|---|

No Locality breakdown currently available

## Feedback

**What the chart tells us?**

Performance is averaging around 85%. The agreed standard of 95% is unlikely to be achieved. Based on current trend.

**Root Cause of the performance issue**

- Of the 25 people saying 'no' to the questions, not receiving information that had been promised or being given poor quality information were the main themes.
- Health literacy rates are the lowest nationally within the CNTW footprint. Staff should routinely check that information is appropriate for those receiving it.

**Improvement Actions**

- Engagement with service users, carers and staff is due to commence during July 2023 to review the current POY survey. Accessibility and more choice around how people access the survey will be key considerations.
- A Health Literacy toolbox is available on the intranet for all staff. Awareness of this resource is ongoing, as is the development of the resource.

**Expected impact and by when**

- Ongoing through 2023-24

# Turnover

Turnover FTE 12 month rolling

**Risk Rating - High (Action)**

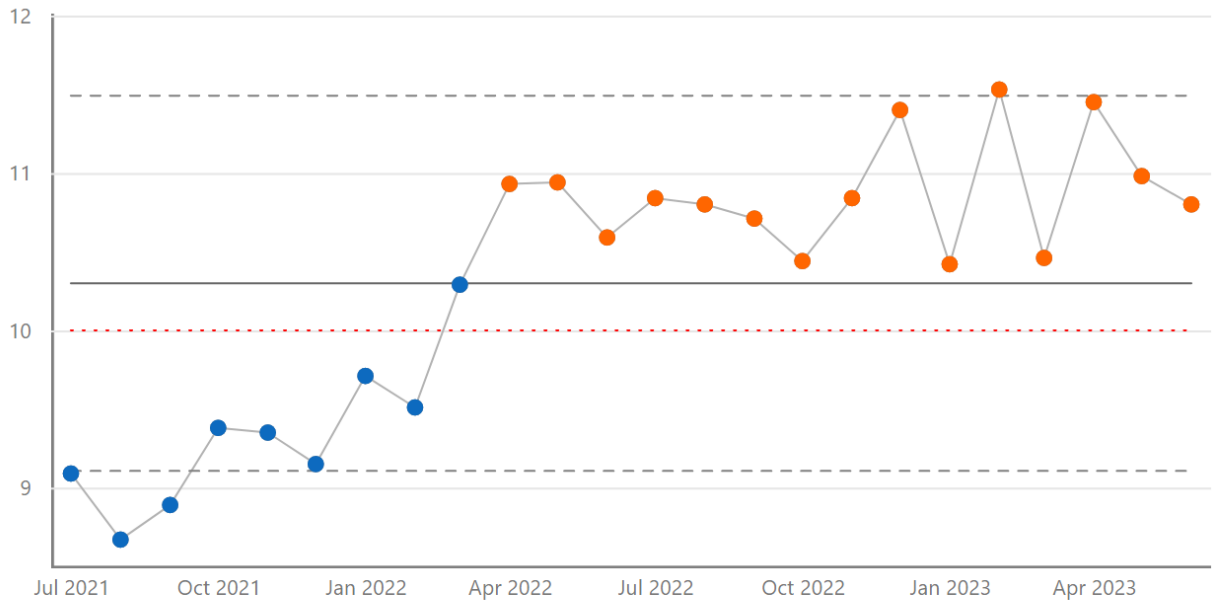
**Performance - 10.8%**

**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 | 10.1% | 10.0% | Normal Variation | Achieve at Random |
| North Cumbria Locality Care Group | 11.7% | 10.0% | Concern | Achieve at Random |
| North Locality Care Group | 8.6% | 10.0% | Normal Variation | Achieve at Random |
| South Locality Care Group | 9.1% | 10.0% | Normal Variation | Achieve at Random |

## Feedback

**What the chart tells us?**

The chart indicates a decrease in turnover consecutively since April. However, this is still above the 10% standard.

**Root cause of the performance issue?**

- Recruitment and Retention

**Improvement Actions?**

- Work undertaken to align vacancies with establishment information and introduction of local vacancy control processes.
- Retire and return requests reviewed and promoted to support retention
- Positive recruitment campaigns in North - development of local induction programmes within localities to support onboarding, creating networks of practice and efficiently manage new staff undertaking training
- North Cumbria piloting New Starters process - flow chart for managers
- Emailing staff on the Leavers report, inviting them to engage in an exit interview/questionnaire
- Encouraging staff through CMTs/QS&O's to undertake Quarterly People Pulse Survey
- Student nurse intake

**Expected impact and by when**

- Fill vacancies within 4-6 weeks
- Evaluate onboarding and New Starters process in 2-3 months
- Improved onboarding of staff, reduce incidents, dismissal through probationary period, improved staff engagement and sense of belonging – September National Staff Survey
- Increase response to exit questionnaire and Quarterly People Pulse Survey

# Sickness in Month

Percentage of in month sickness absence

Risk Rating - **High (Action)**

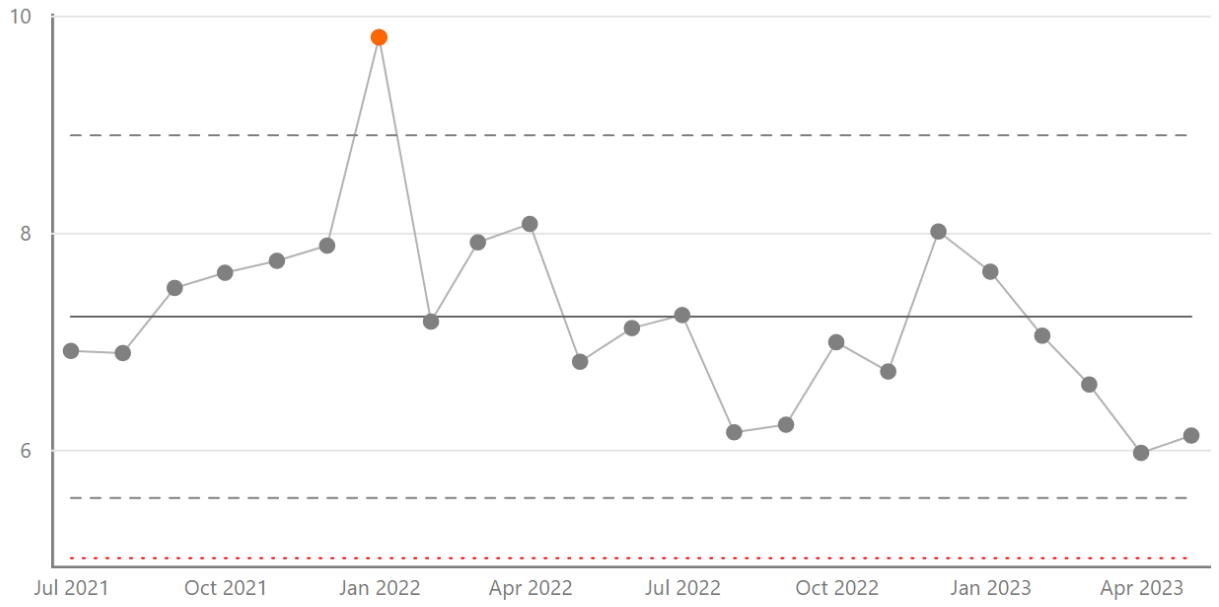
**Performance - 6.1%**

**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 | 6.6% | 5.0% | Normal Variation | Consistently Fail |
| North Cumbria Locality Care Group | 6.9% | 5.0% | Normal Variation | Consistently Fail |
| North Locality Care Group | 6.2% | 5.0% | Normal Variation | Consistently Fail |
| South Locality Care Group | 7.0% | 5.0% | Normal Variation | Consistently Fail |

## Feedback

**What the chart tells us**

The chart shows the confirmed sickness for May 2023 and is reported at 6.1%. The provisional sickness for June 2023 is reported at 5.57% remaining above the 5% target.

**Root cause of the performance issue**

- High mental health related absence
- High MSK absence
- Covid related absence

**Improvement Actions**

- Regular review of all absences ensuring relevant support in place and recovery focussed.
- Workforce support through short term sickness meetings and long term sickness reviews and workforce triage.
- Early intervention through Locality Workforce, with priority of MH and MSK occupational health referrals.
- Merging Wellness Support team workforce function with Localities.
- Increased support for staff through SPC (Staff Psychological Centre)
- Occupational health reminders
- Promotion of wellbeing conversations to support local stress risk assessments, carers passports and WRAP plans.

**Expected impact and by when**

- Improvement in keeping staff feeling well at work
- Early intervention
- Robust people management processes; including STS monitoring
- Reduction in Occupational Health DNA's

# % of Training Compliance Achieved All Standards

Risk Rating - **High (Action)**

% of Training Compliance Achieved All Standards

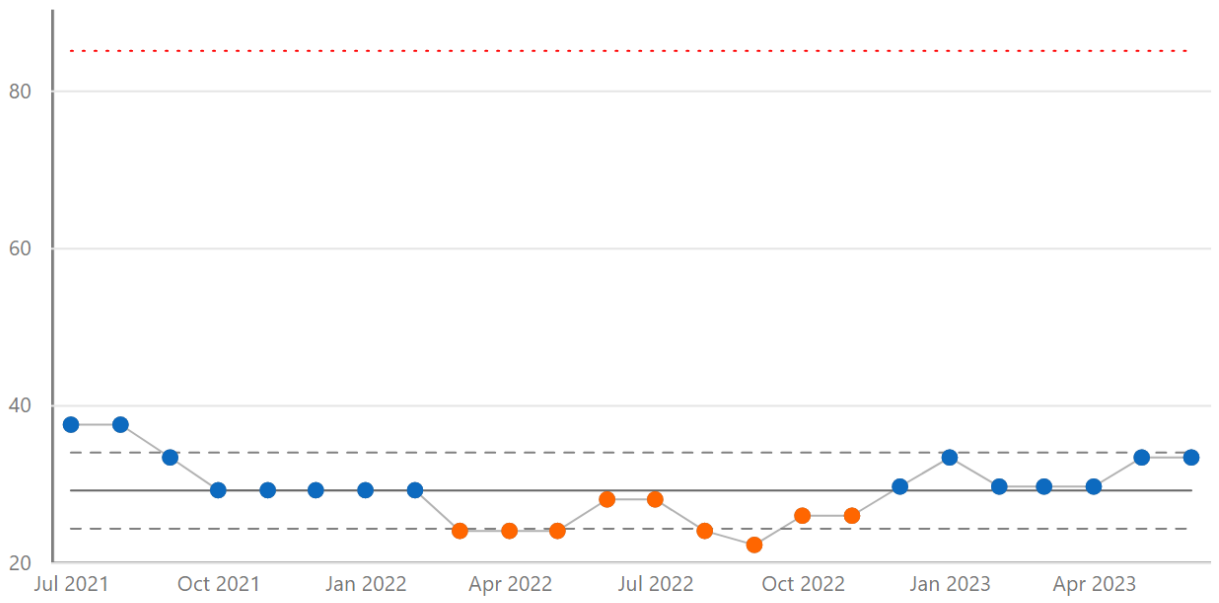
**Performance - 33.3%**

**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 | 54.2% | 85.0% | Improvement | Consistently Fail |
| North Cumbria Locality Care Group | 40.0% | 85.0% | Improvement | Consistently Fail |
| North Locality Care Group | 54.2% | 85.0% | Normal Variation | Consistently Fail |
| South Locality Care Group | 64.0% | 85.0% | Improvement | Consistently Fail |

## Feedback

**What the chart tells us?**

The % of training compliance achieved is reported at 33.3%. In June, 9 out of 27 statutory and mandatory courses are achieving the required standard of 85%.

**Root Cause of the performance issue**

- Capacity to release staff for training
- Late cancelations due to clinical activity
- Attachment of competencies to staff records - error identified

**Improvement Actions**

- Competency data to be updated in mass by IBM. Re-introduced process to prevent error reoccurring
- A review is being undertaken into the 50 training competencies, as only 29 have a compliance standard.
- The Training Needs Analysis tool will be updated with the modality of the training to support planning of training trajectories.
- Promotion of the modes of accessing training.
- Train the trainer for some programmes e.g. LD & Autism training
- Arranging bespoke training e.g. MHA MCA DoLS

**Expected impact and by when**

- Improvement in IG and LD & Autism training - 1-2 Months
- Potential changes to reporting and compliance requirements may see drop below 85% target.
- Correction of competency data may also have a negative impact on compliance

# Appraisal rate

Appraisal rate

Risk Rating - **High (Action)**

**Performance - 78.9%**

**Standard - 85.0%**

**Consistently Fail**

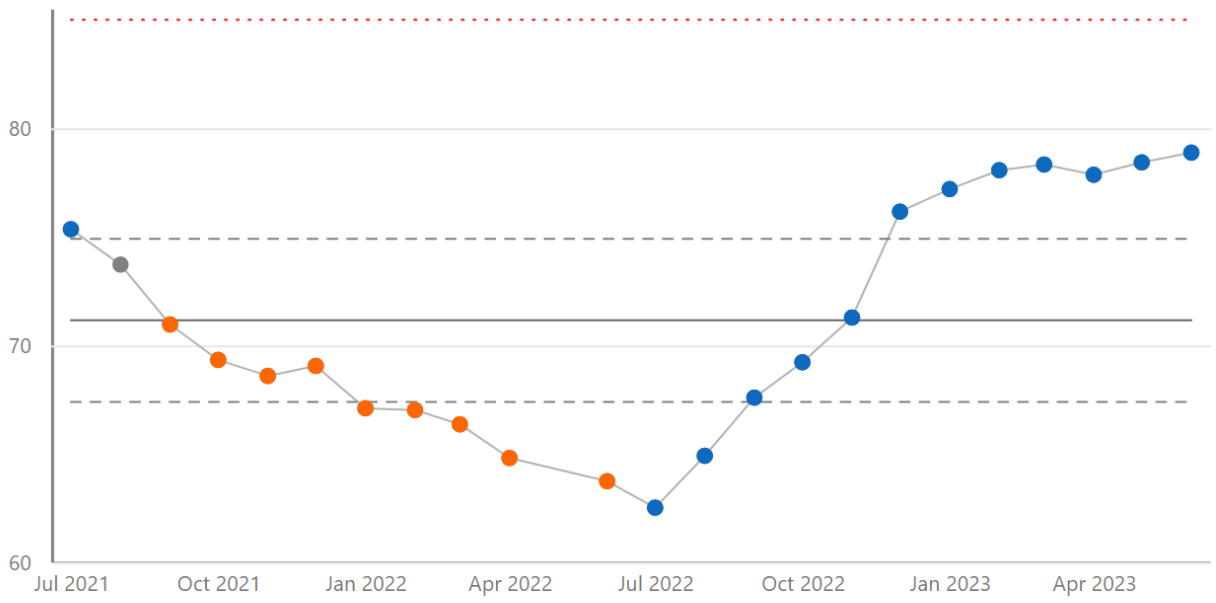
The standard for this indicator is outside the control limits

**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 | 79.9% | 85.0% | Improvement | Consistently Fail |
| North Cumbria Locality Care Group | 77.5% | 85.0% | Improvement | Consistently Fail |
| North Locality Care Group | 75.3% | 85.0% | Improvement | Consistently Fail |
| South Locality Care Group | 84.4% | 85.0% | Improvement | Consistently Fail |

## Feedback

**What the chart tells us**

The data shows the appraisal rate has increased over the last few months. However, this remains under 85% target.

**Root cause of the performance issue**

- Capacity to prepare and undertake appraisal
- Backlog from pandemic pause
- Late cancellations due to clinical capacity

**Improvement Actions**

- Promotion through Workforce Triage; discuss capacity and appropriate support, delegation and create realistic plans
- Promote value of Wellbeing Conversations to support staff free well at work, valued

**Expected impact and by when**

- Improved appraisal rate – ongoing

# % Clinical Supervision completed

Clinical Supervision

Risk Rating - **High (Action)**

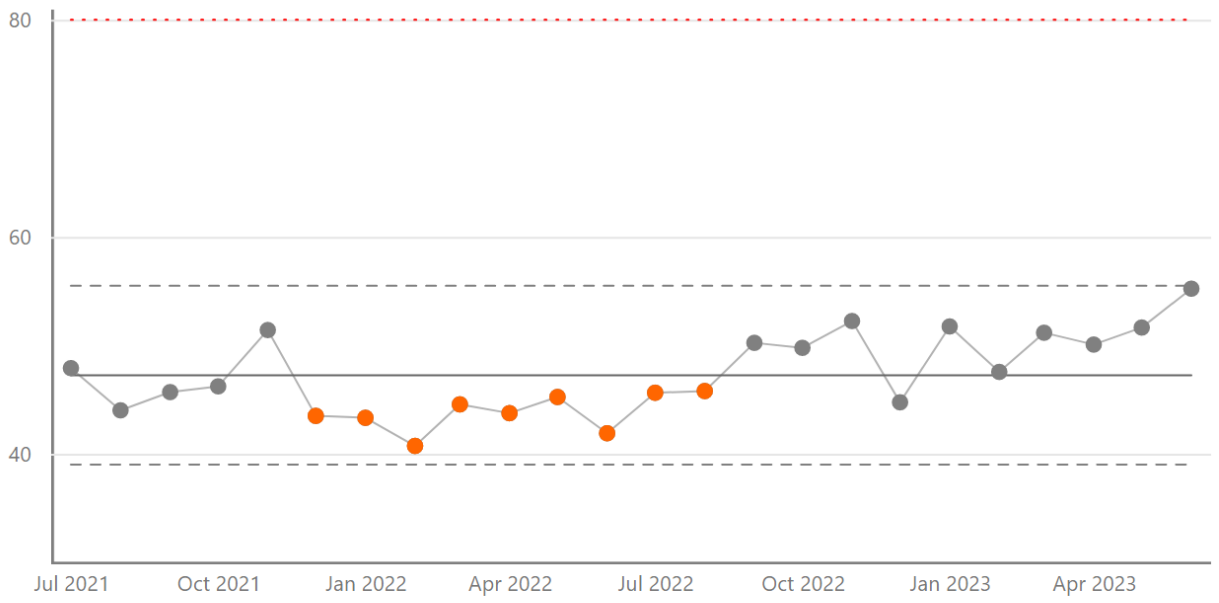
**Performance - 55.2%**

**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 | 56.3% | 80.0% | Normal Variation | Consistently Fail |
| North Cumbria Locality Care Group | 49.9% | 80.0% | Normal Variation | Consistently Fail |
| North Locality Care Group | 52.9% | 80.0% | Normal Variation | Consistently Fail |
| South Locality Care Group | 62.8% | 80.0% | Normal Variation | Consistently Fail |

## Feedback

**What the chart tells us**

The data shows there has been a consecutive increase in the appraisal percentage, currently 55.2%. However, this remains under 80% target.

**Root cause of the performance issue**

- Capacity to release staff to undertake supervision
- Late cancellations due to clinical capacity

**Improvement Actions**

- Training monitored through local CMT and QS&O meetings with CBU's
- Setting Training Trajectories with CBU leadership team
- Promotion of training trajectories through Workforce Triage

**Expected impact and by when**

- Improved completion rate – ongoing

# Serious Incidents

Number of Serious Incidents

Risk Rating - **High (Action)**

**Performance - 26**

**Standard - No Std**

**No Standard**

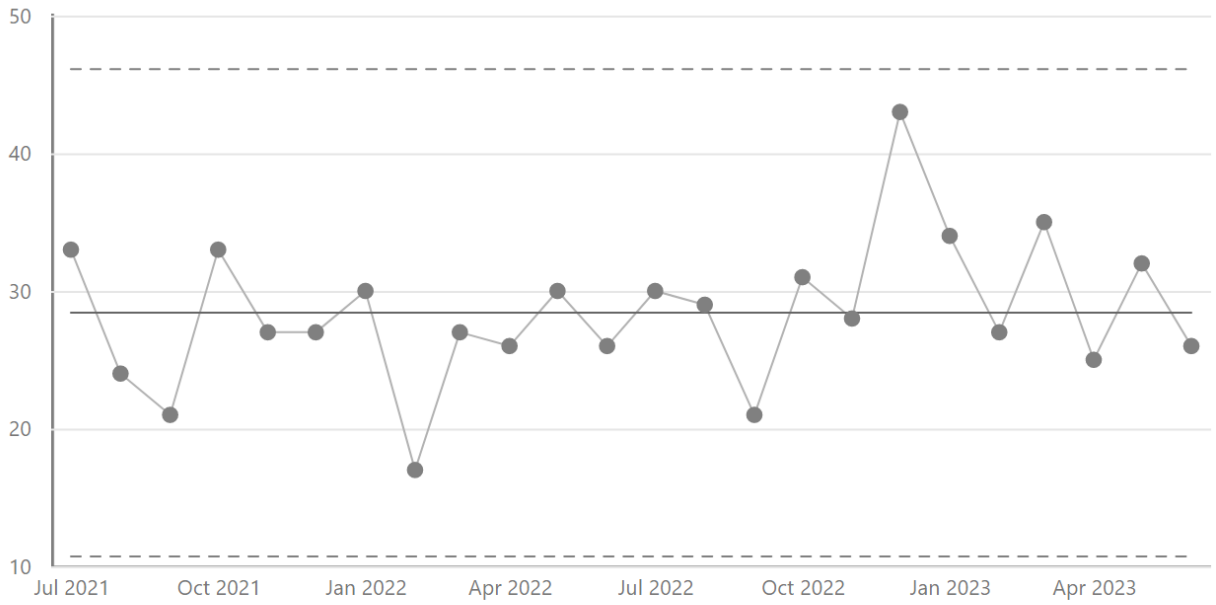
Assurance cannot be given for this indicator as there is no standard set

**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 | 8 | No Std | Normal Variation | No Standard |
| North Cumbria Locality Care Group | 2 | No Std | Normal Variation | No Standard |
| North Locality Care Group | 10 | No Std | Normal Variation | No Standard |
| South Locality Care Group | 5 | No Std | Normal Variation | No Standard |

## Feedback

**What the chart tells us**

There is no significant variation in the trend for the last two years

**Root Cause of the performance issue**

There is no significant variation in the trend for the last two years. June numbers are below the monthly average and a reduction from previous month. 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 Trust and ICB governance processes to ensure that learning is embedded.

Trust approach to Serious Incident investigation is currently under review as part of PSIRF implementation planning.

**Expected impact and by when**

Planned timescale for PSIRF implementation / transition  is currently November 2023

# Safeguarding and Public Protection (SAPP)

Safeguarding and Public Protection (SAPP)

Risk Rating - Med (Monitoring)

Performance - 1,668

Standard - No Std

**No Standard**

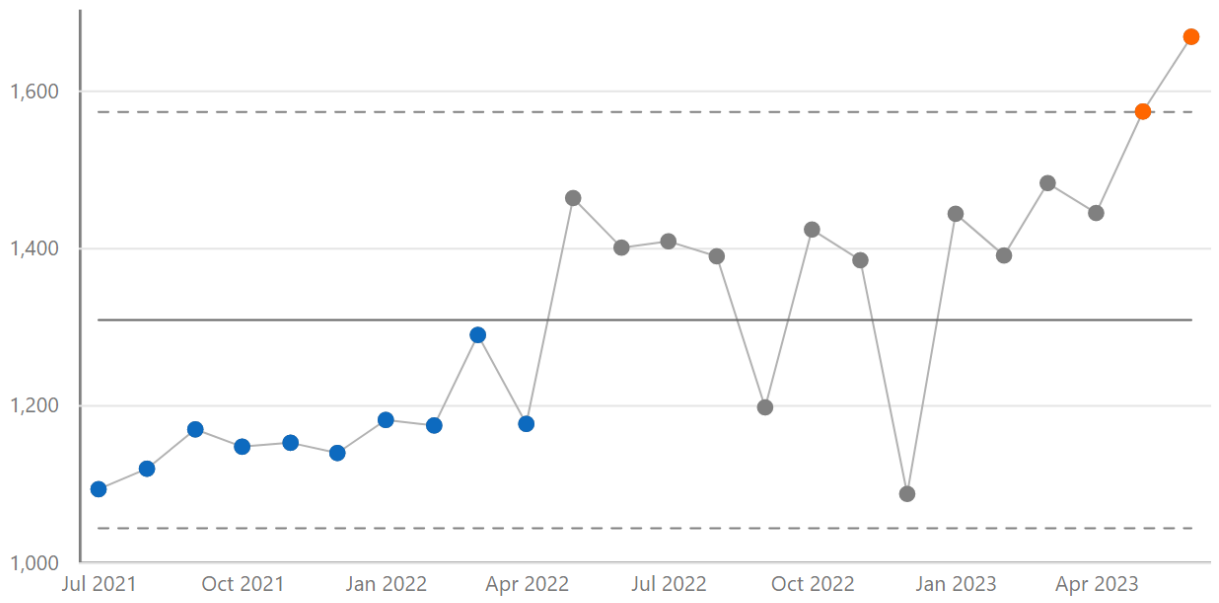
Assurance cannot be given for this indicator as there is no standard set

**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 | 511 | No Std | Concern | No Standard |
| North Cumbria Locality Care Group | 243 | No Std | Concern | No Standard |
| North Locality Care Group | 517 | No Std | Concern | No Standard |
| South Locality Care Group | 379 | No Std | Normal Variation | No Standard |

## Feedback

**What the chart tells us**

In June reported safeguarding activity breached the upper control (1628) for the 2nd consecutive Month, this was an increase from previous high in May (1459).

**Root Cause of the performance issue**

Increased safeguarding reporting generally 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 is felt to have increased reporting in some localities.

Sapp Triage have highlighted that not all safeguarding incident reports are not categorised correctly however better data is required to enable analysis of potential inaccurate safeguarding reporting

**Improvement Actions**

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

An amendment to the data recording of outcome options via SAPP triage is to be implemented to better understand potential issues with reporting that may be impacting increased safeguarding figures and potentially reducing figures in other incident categories such as Violence and Aggression.

**Expected impact and by when**

Identification of inaccurate reporting will allow targeted training and improvement around Safeguarding incident reporting to take place. Trail of additional outcome measure from triage to commence July and run till end Q2.

# Aggression and Violence

Aggression and Violence

Risk Rating - Med (Monitoring)

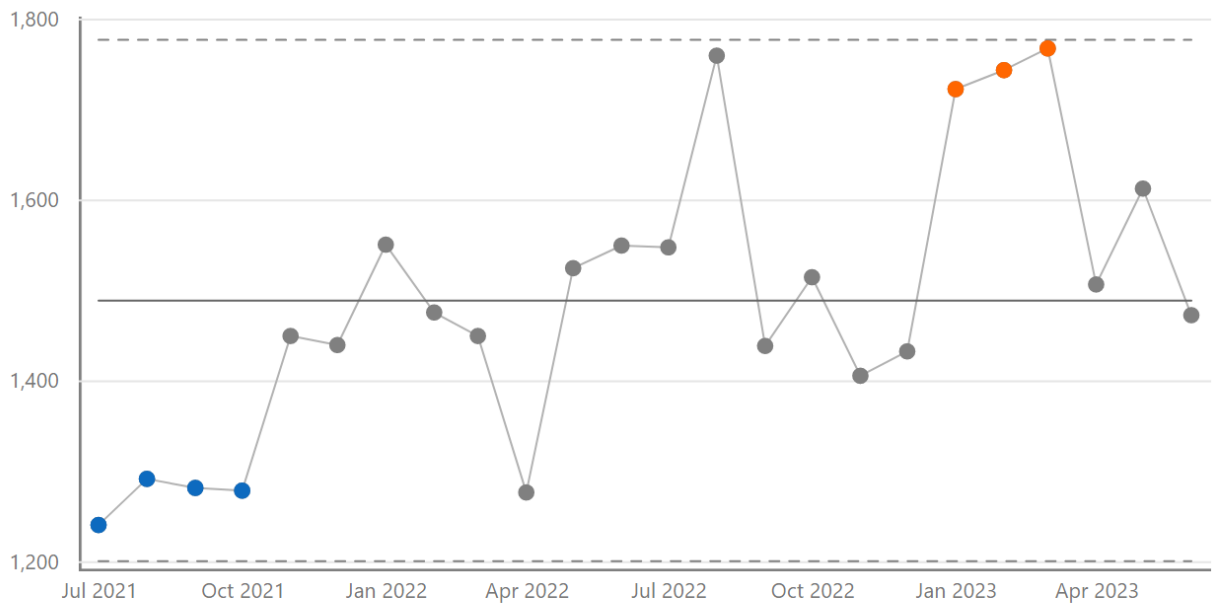
**Performance - 1,472**

**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 | 238 | No Std | Normal Variation | No Standard |
| North Cumbria Locality Care Group | 457 | No Std | Normal Variation | No Standard |
| North Locality Care Group | 409 | No Std | Normal Variation | No Standard |
| South Locality Care Group | 366 | No Std | Normal Variation | No Standard |

## Feedback

**What the chart tells us**

There were 1472 incidents of aggression and violence in June 2023.

**Root cause of the performance issue**

- Aggression and violence incidents for month 3 have reduced for the 1st time this financial year and the June figure is the lowest since last December.
- 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. We have also seen a 3.64% decrease on the same period last year which is encouraging

**Improvement Actions**

- In line with PSIRF developments Aggression and Violence incidents will be assessed and evaluated in line with workstream 4, for lower impact , non-serious impacts, to looks at all the causal factors with a subject expert team supporting.

**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. The Trust will soon see a new information flow, available to clinical teams that will show the direct impact from incidents including aggressions and violence incidents and the relationship to tertiary and physical interventions, this will be supported by the Safety Team, Talk 1st Team and the HOPES leads.

# Care Plans compliance

Care Plans compliance

Risk Rating - Med (Monitoring)

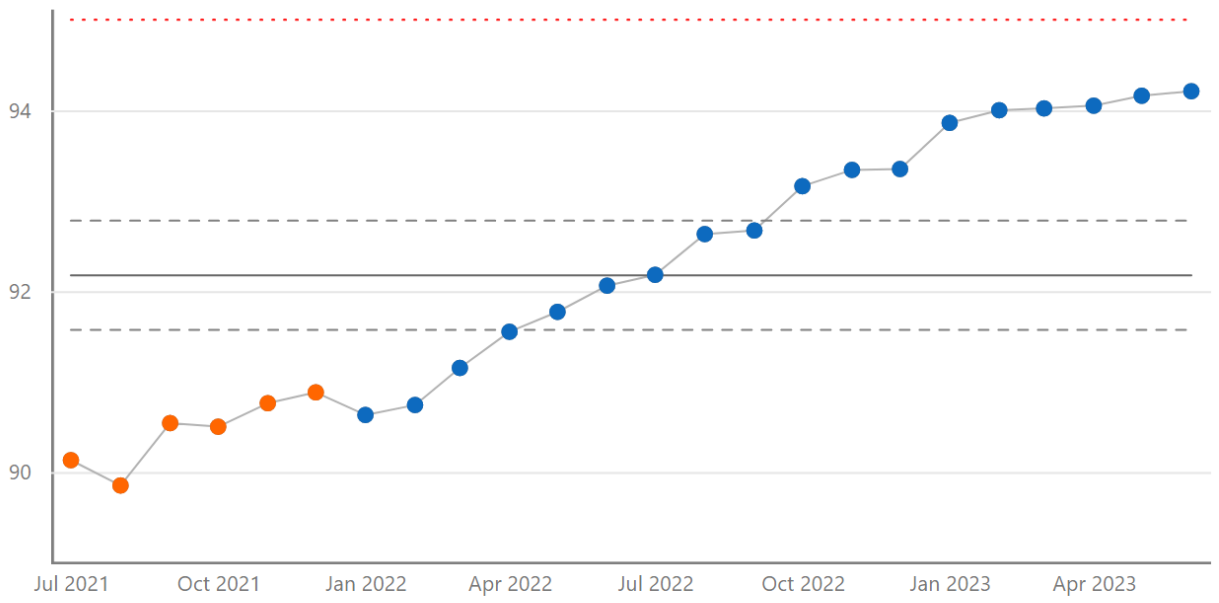
Performance - 94.2%

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 | 95.4% | 95.0% | Improvement | Consistently Fail |
| North Cumbria Locality Care Group | 87.1% | 95.0% | Improvement | Consistently Fail |
| North Locality Care Group | 96.9% | 95.0% | Improvement | Consistently Achieve |
| South Locality Care Group | 93.6% | 95.0% | Improvement | Consistently Fail |

## Feedback

**What the chart tells us**

This measure is sitting just below the 95% compliance at 94.2%

**Root Cause of the performance issue**

Feedback from teams suggests that care plans are often completed but not recorded on RiO accurately.

**Improvement Actions**

The new 4 week wait methodology uses care plans complete as a stop clock measure. Training and awareness sessions have been held with staff to ensure they know how to properly record care plans. In addition, a review of the metric definition is underway to evaluate if it is line with transformation. There is a programme of work linked to improving the quality of care planning.

**Expected impact and by when**

Improvement in the number of care plans completed and recorded on Rio by Q4 as new methodology becomes embedded.

# Risk Assessments compliance

Risk Assessments compliance

Risk Rating - **Med (Monitoring)**

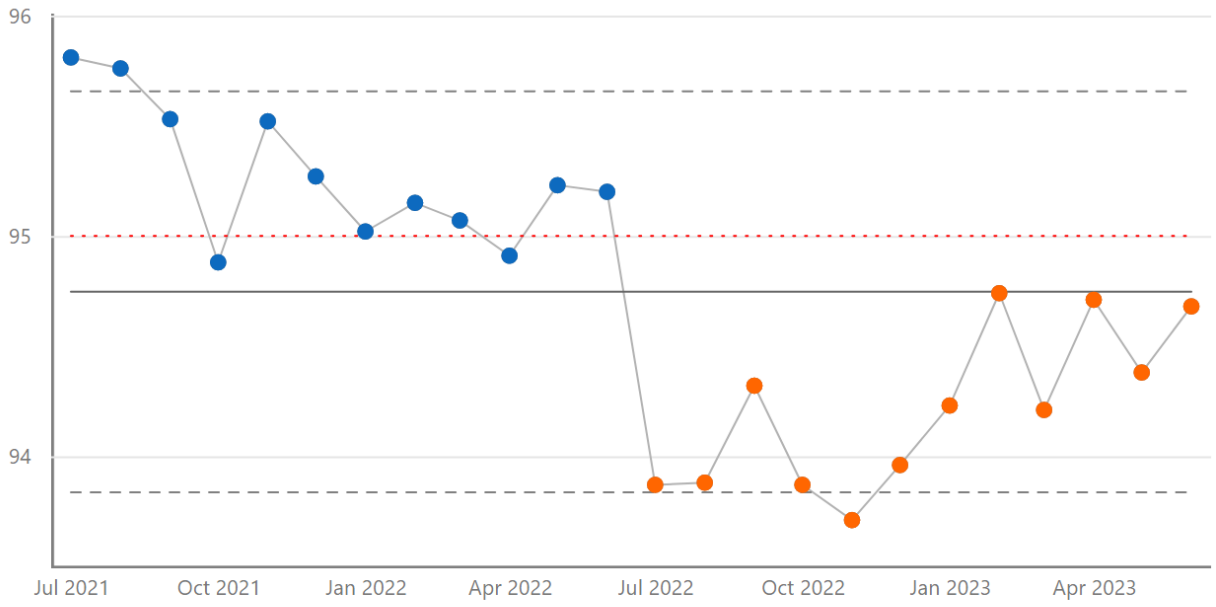
**Performance - 94.7%**

**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 | 96.6% | 95.0% | Improvement | Achieve at Random |
| North Cumbria Locality Care Group | 87.6% | 95.0% | Concern | Consistently Fail |
| North Locality Care Group | 97.8% | 95.0% | Normal Variation | Consistently Achieve |
| South Locality Care Group | 96.4% | 95.0% | Normal Variation | Consistently Achieve |

## Feedback

**What the chart tells us**

This measure is sitting just below the 95% compliance at 94.2%

**Root Cause of the performance issue**

Feedback from teams suggests that care plans are often completed but not recorded on RiO accurately.

**Improvement Actions**

The new 4 week wait methodology uses care plans complete as a stop clock measure. Training and awareness sessions have been held with staff to ensure they know how to properly record care plans. In addition, a review of the metric definition is underway to evaluate if it is line with transformation. There is a programme of work linked to improving the quality of care planning.

**Expected impact and by when**

Improvement in the number of care plans completed and recorded on Rio by Q4 as new methodology becomes embedded.

# 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.

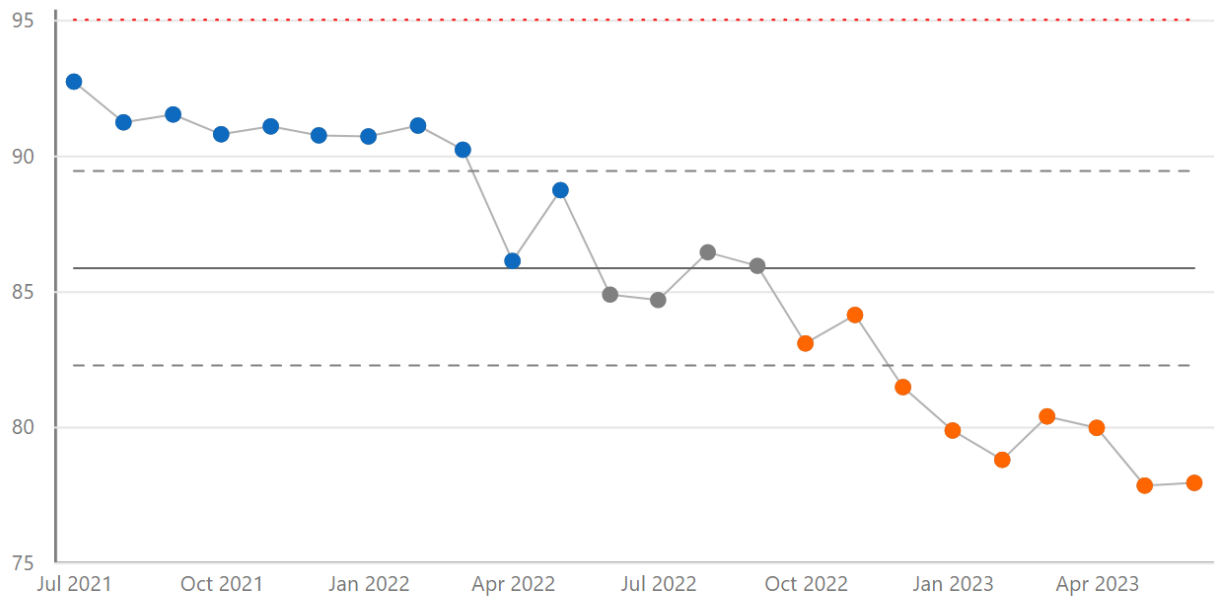
**Performance - 77.9%**

**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 | 85.7% | 95.0% | Concern | Achieve at Random |
| North Cumbria Locality Care Group | 47.8% | 95.0% | Concern | Consistently Fail |
| North Locality Care Group | 91.9% | 95.0% | Normal Variation | Achieve at Random |
| South Locality Care Group | 84.3% | 95.0% | Concern | Achieve at Random |

## Feedback

**What the chart tells us**

CPA completed review have fallen steadily over the last 2 year period remaining below the 95% standard

**Root Cause of the performance issue**

Due to known changes with CPA there is potential that focus has shifted. Reminders have been issued (i.e. via the weekly data sheet) to express this is still a trust priority area until such time when CPA ends.

CPA training hasn't been widely offered within CNTW for some time

Several teams which do not hold responsibility for CPA, such as PLT, IPS, Addictions and Adult ADHD and ASD diagnostic teams are still included in CPA metrics. They fail this measure when a service user is open to another team which has not completed CPA requirements for the individual. This is difficult for the teams to recover.

**Improvement Actions**

There has been a focus on process elements regarding CPA and ensuring this is complete with staff being reminded this is an important measure.

Raising awareness of the impacts on other teams when CPA requirements are not met by care coordinating team.

**Expected impact and by when**

Improvements should be seen over coming months due to increased/renewed focus.

# Staffing fill rates

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

Risk Rating - Med (Monitoring)

Performance - 118.1%

Standard - 120.0%

**Achieve at Random**

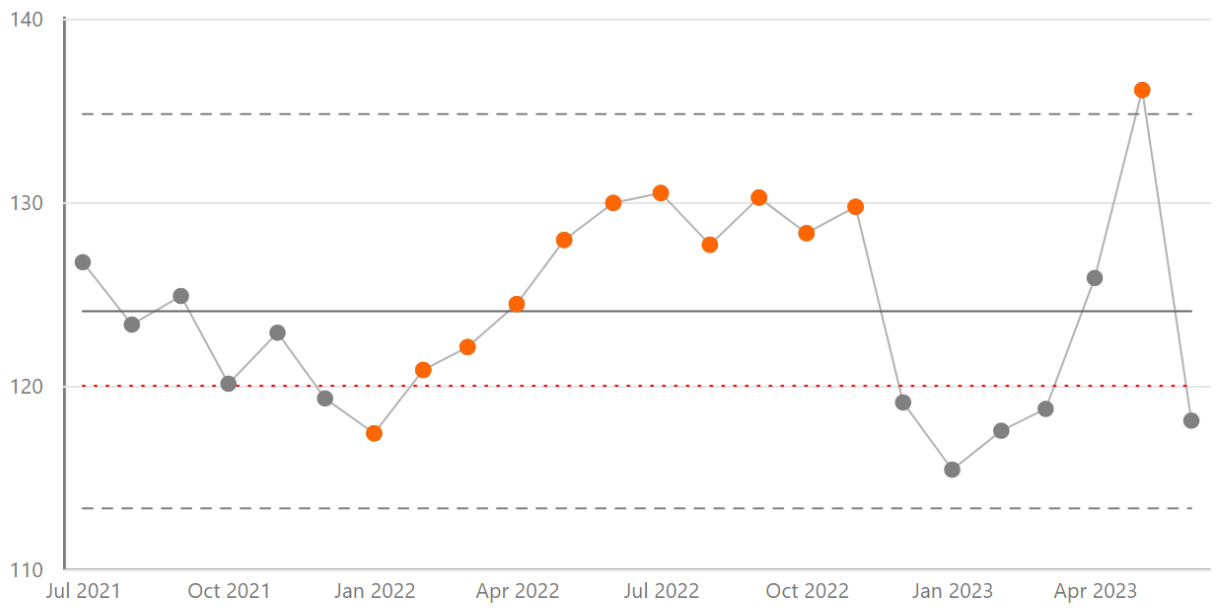
The standard for this indicator is within the upper and lower control limits

**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 | 118.6% | 120.0% | Normal Variation | Achieve at Random |
| North Cumbria Locality Care Group | 119.0% | 120.0% | Normal Variation | Achieve at Random |
| North Locality Care Group | 108.8% | 120.0% | Improvement | Achieve at Random |
| South Locality Care Group | 123.2% | 120.0% | Normal Variation | Achieve at Random |

## Feedback

**What the chart tells us**

Staffing fill rate was 118% in June 2023, returning within the expected range of 113% to 135%.

**Root Cause of the performance issue**

There remain vacancies across inpatient services

**Improvement Actions**

Recruitment activities continue

Rollout of new shift allocation software across wards

Reviews of all agency usage

**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 - 356**

**Standard - 210**

**Achieve at Random**

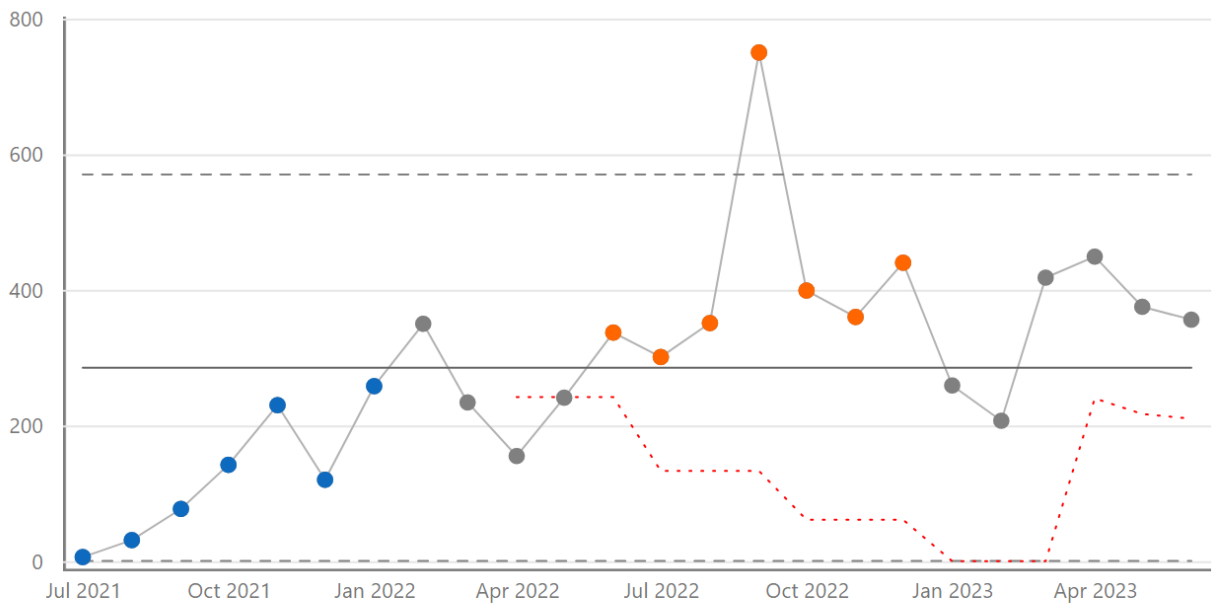
The standard for this indicator is within the upper and lower control limits

**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 356 Out of Area Placement bed days in June 2023 compared to the trajectory of 210 days for month 3.

**Root Cause of the performance issue**

Patients needing an inpatient admission when there are no appropriate CNTW beds available. The main pressure continues to be within Adult Acute beds due high bed occupancy rates and high rates of clinically ready for discharge caused by lack of social care and housing placements..

**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)

Risk Rating - **High (Action)**

Bed Occupancy including leave (open beds on RiO)

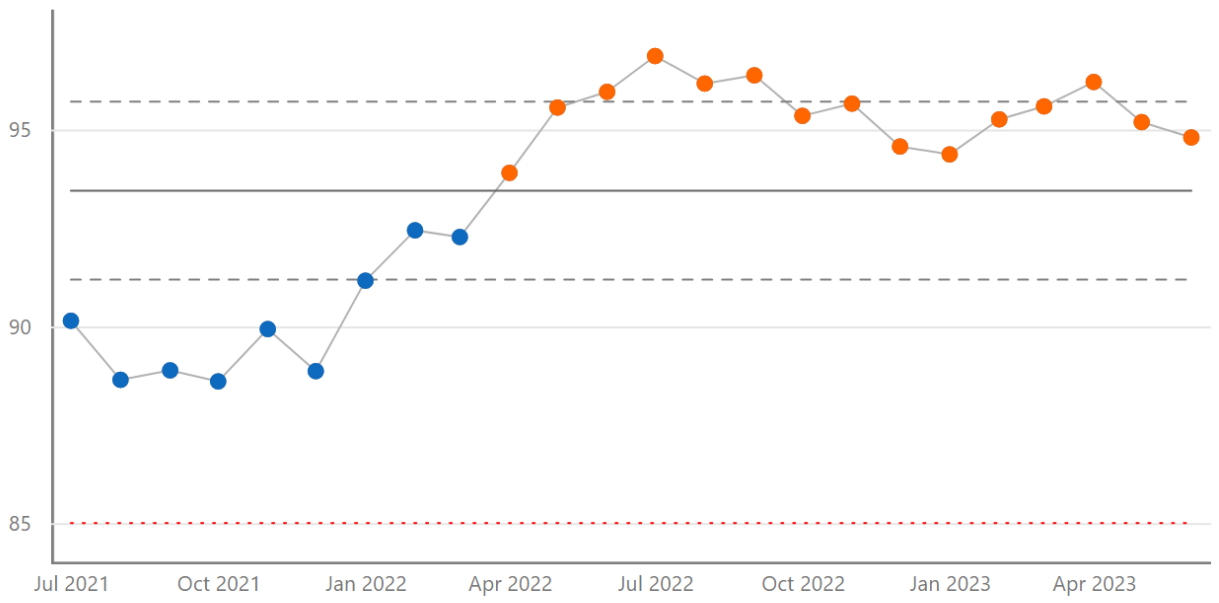
**Performance - 94.8%**

**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 | 94.7% | 85.0% | Concern | Consistently Fail |
| North Cumbria Locality Care Group | 89.5% | 85.0% | Concern | Achieve at Random |
| North Locality Care Group | 96.5% | 85.0% | Normal Variation | Consistently Fail |
| South Locality Care Group | 95.9% | 85.0% | Concern | Consistently Fail |

## Feedback

**What the chart tells us**

Bed occupancy reduced to 94.8% which is within the expected range of 91.2% to 95.7%, though still above the optimal level of 85%.

**Root Cause of the performance issue**

More bed days are used than originally planned due to lack of alternatives to beds and lack of social care and housing placements for patients required discharge. 6 wards worth of beds are occupied by patients who are Clinically Ready for Discharge.

**Improvement Actions**

New ward comparison data helps make comparisons of bed occupancy across different wards in locality and across the trust, however, this only highlights the known issues that bed occupancy is well above the 85% commissioned level.

**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)

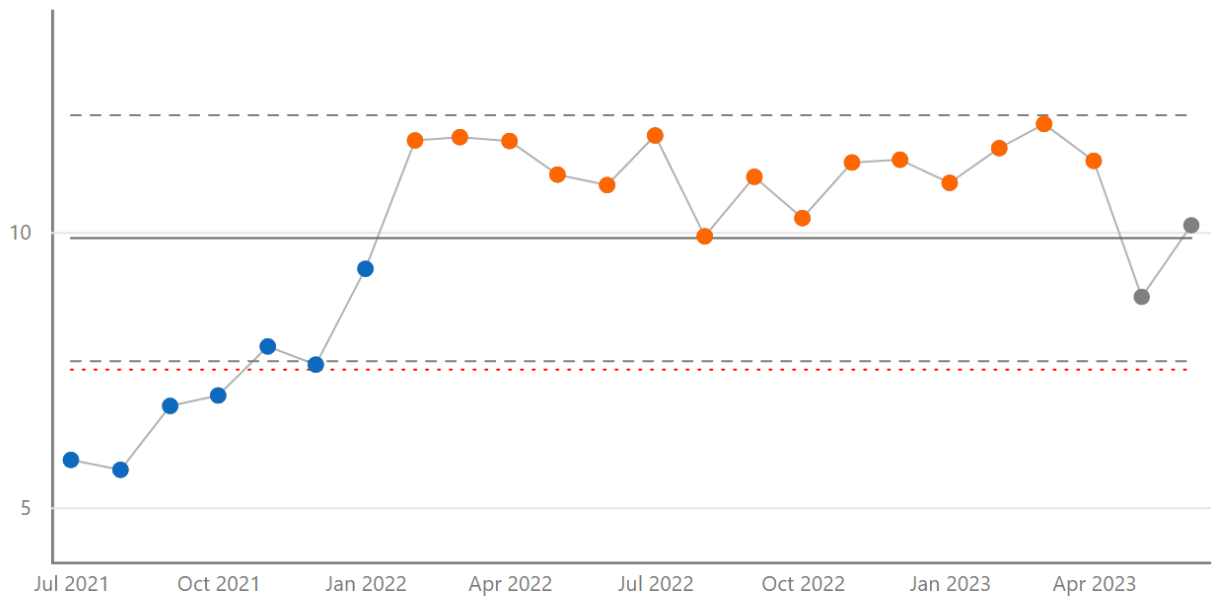
**Performance - 10.1%**

**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 | 5.1% | 7.5% | Concern | Consistently Achieve |
| North Cumbria Locality Care Group | 22.8% | 7.5% | Normal Variation | Consistently Fail |
| North Locality Care Group | 12.2% | 7.5% | Normal Variation | Achieve at Random |
| South Locality Care Group | 9.0% | 7.5% | Concern | Achieve at Random |

## Feedback

**What the chart tells us**

Performance was within the expected range of 7.6% to 12.1% in June 2023 but increased in the month to 10.1% from 8.8% reported in May 2023

**Root Cause of the performance issue**

Delays caused due to lack of alternatives to beds and lack of social care and housing placements. 6 wards worth of beds are occupied by patients who are Clinically Ready for Discharge.

**Improvement Actions**

- As reported last month – process remains similar
- Discharge plan for each patient in 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
- Work with Place and LA commissioners to better understand all commissioned housing provision/step-down support etc.

**Expected impact and by when**

Some areas have capital investments at Place to support flow such as building new properties (at scale) via commissioning and local authorities. However, this a long-term investment and not likely to impact for 18 months+

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

Risk Rating - **Med (Monitoring)**

% of referrals (Adults and OA) with a priority of Very Urgent who have an attended Direct Contact within 4 hours following receipt of the referral

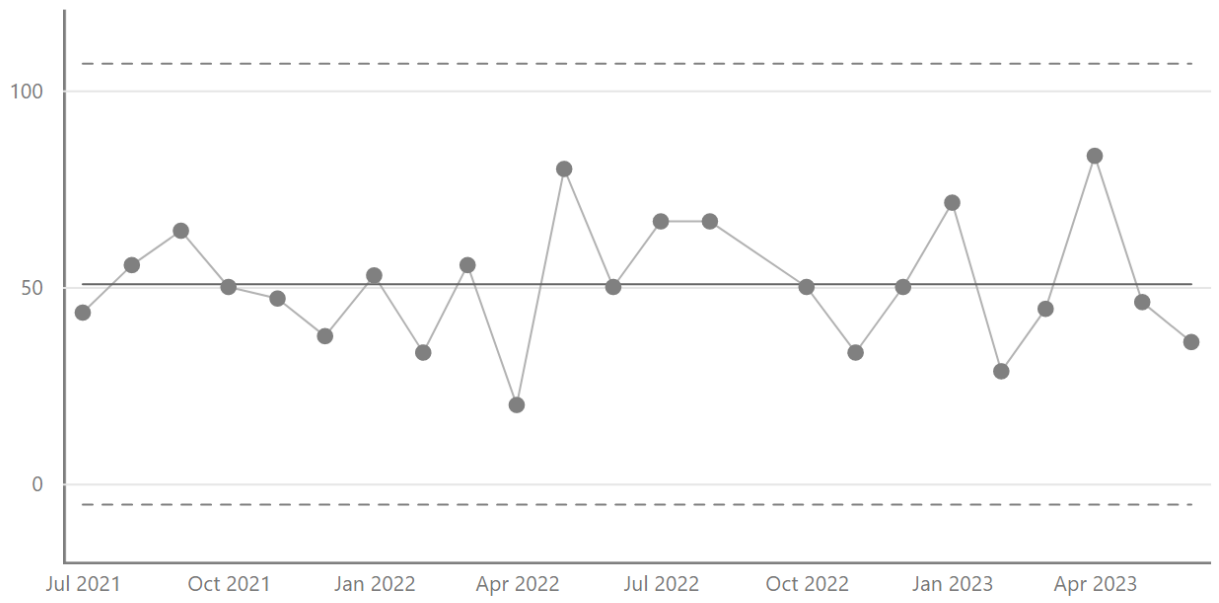
**Performance - 36.0%**

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




| Locality | Performance | Standard | Variation | Assurance |
|---|---|---|---|---|
| Central Locality Care Group | 27.8% | No Std | | No Standard |
| North Cumbria Locality Care Group | 33.3% | No Std | | No Standard |
| North Locality Care Group | 75.0% | No Std | Normal Variation | No Standard |
| South Locality Care Group | 100.0% | No Std | Normal Variation | No Standard |

## Feedback

**What the chart tells us**

Very urgent referrals seen within 24 hours decreased to 36.0% in June 2023.

**Root Cause of the performance issue**

- Data fluctuates due to low numbers
- The ability to respond in a timely way to crisis referrals.
- Difference in models across the Trust mean areas performance has variation
- Breaches of the standard may be where staff are unable to reach the patient or the patient does not attend

**Improvement Actions**

- Temp staff use to address staffing challenge across crisis services
- Monitoring (dashboards) of patients to achieve target
- Work ongoing at Trust level to look at recording of referral urgencies on initial receipt of referral and development of local guidance to accompany national definitions

**Expected impact and by when**

- Impact would be achieving target in all areas

# 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 - 81.3%**

**Standard - No Std**

**No Standard**

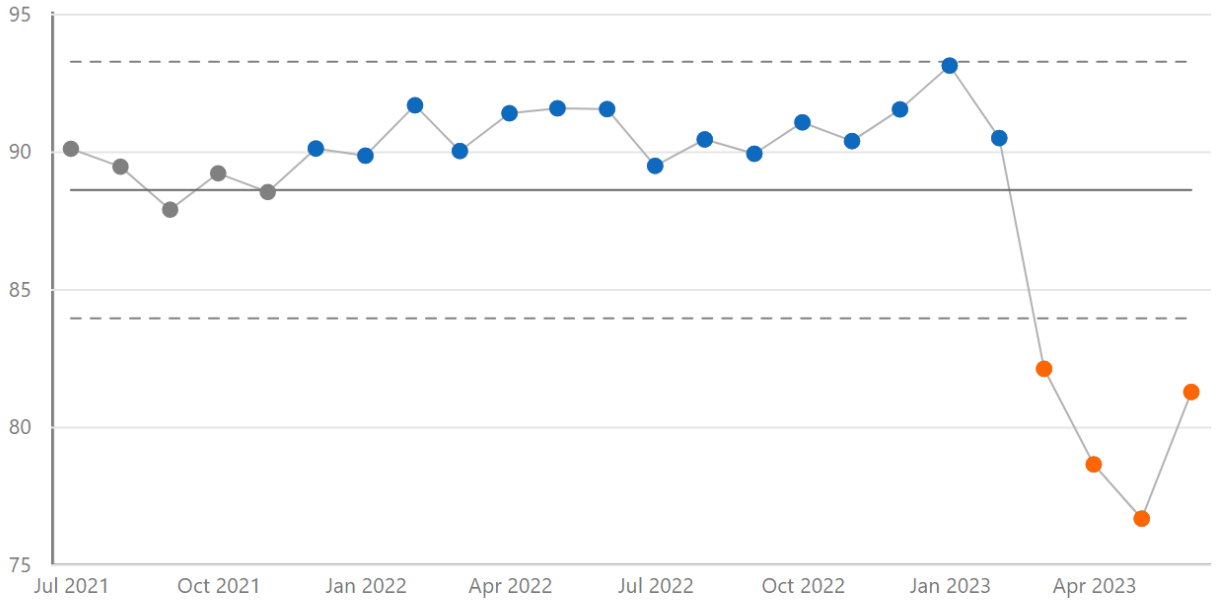
Assurance cannot be given for this indicator as there is no standard set

**Concern**

There is concern because this indicator is decreasing

**DQ - No Concern**

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




| Locality | Performance | Standard | Variation | Assurance |
|---|---|---|---|---|
| Central Locality Care Group | 85.1% | No Std | Normal Variation | No Standard |
| North Cumbria Locality Care Group | 83.3% | No Std | Concern | No Standard |
| North Locality Care Group | 73.3% | No Std | Normal Variation | No Standard |
| South Locality Care Group | 83.6% | No Std | Normal Variation | No Standard |

## Feedback

**What the chart tells us**

Urgent referrals seen within 24 hours increased to 81.3% in June 2023. This is below the expected range of 84% to 93% for the fourth successive month suggesting a change beyond the normal monthly variation.

**Root Cause of the performance issue**

- The ability to respond in a timely way to crisis referrals.
- Difference in models across the Trust mean areas performance has variation
- Breaches of the standard may be where staff are unable to reach the patient or the patient does not attend

**Improvement Actions**

- Temp staff use to address staffing challenge across crisis services
- Monitoring (dashboards) of patients to achieve target
- Work ongoing at Trust level to look at recording of referral urgencies on initial receipt of referral and development of local guidance to accompany national definitions

**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

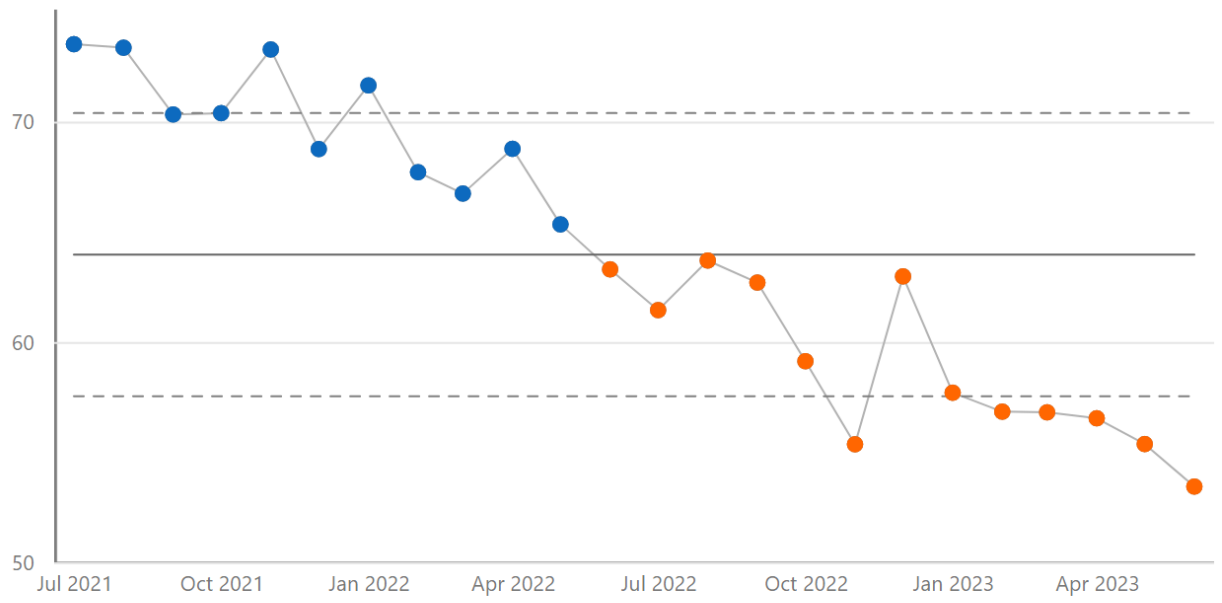
**Performance - 53.4%**

**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 | 41.4% | No Std | Concern | No Standard |
| North Cumbria Locality Care Group | 63.0% | No Std | Concern | No Standard |
| North Locality Care Group | 42.7% | No Std | Concern | No Standard |
| South Locality Care Group | 74.0% | No Std | Normal Variation | No Standard |

## Feedback

**What the chart tells us**

Performance was 53.4% in June 2023 which was below the expected range of 58% and 70%.

**Root Cause of the performance issue**

- Issue with ED staff referring to PLT when patient is not medically fit to be seen which then causes breach of target. Not all areas are commissioned to provide a 1hr response.
- This is difficult to provide fully 24/7 in some areas due to commissioning arrangements.
- Staffing (recruitment/retention/sickness) remains a challenge

**Improvement Actions**

- Temp staff use to address staffing challenge.
- Ongoing discussions with ED colleagues and Northumbria police force.
- Providing recording guidance to liaison teams when the patient is unable to be seen, but there is an active referral been made to the team.

**Expected impact and by when**

- Impact would be achieving 1hr target in all areas

# 18 weeks wait to Treatment Adults & Older Adults

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

Risk Rating - **Med (Monitoring)**

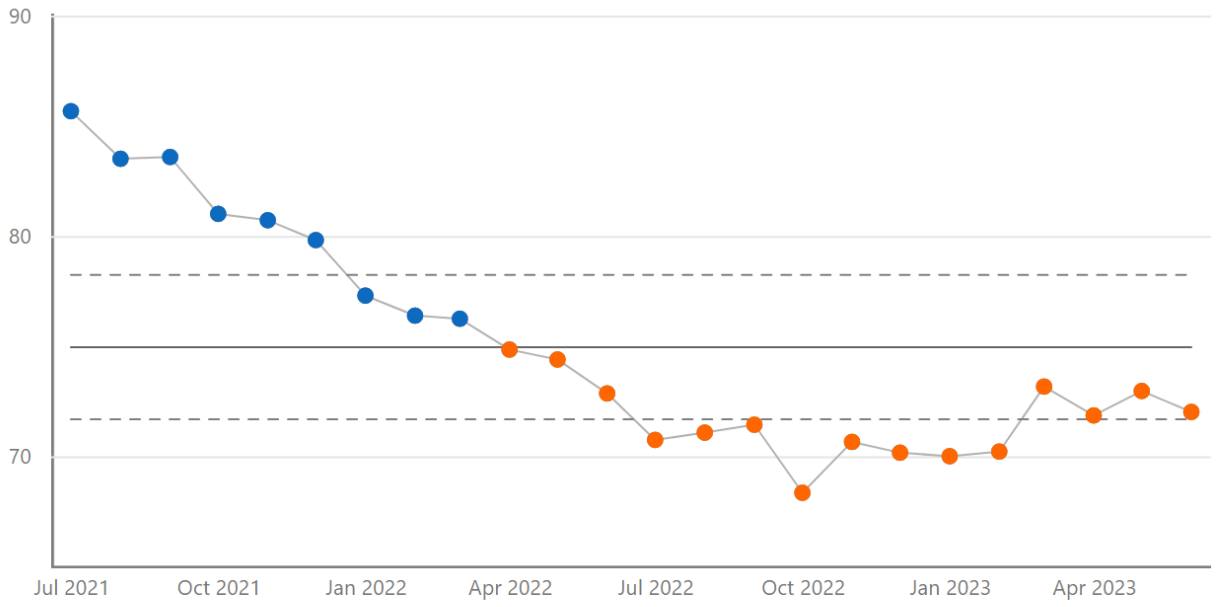
**Performance - 72.0%**

**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 | 81.0% | No Std | Normal Variation | No Standard |
| North Cumbria Locality Care Group | 55.8% | No Std | Concern | No Standard |
| North Locality Care Group | 83.7% | No Std | Concern | No Standard |
| South Locality Care Group | 77.6% | No Std | Normal Variation | No Standard |

## Feedback

**What the chart tells us**

Performance was at 72% in June 2023 and has remained similar since July 2022

**Root Cause of the performance issue**

- Increased referrals for Memory Assessment and delays with scans, for some areas this can be 14/16 weeks
- Staffing pressures resulting in significant floating caseloads (reallocations) in some teams, reducing the capacity for assessment and treatment of new referrals.
- Everyturn funding in South Tyneside ended and is not being renewed by Place; the impact of this to be seen

**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
- Focus weeks, carefully standing down non-essential work to increase appointments

**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 - 46.1%**

**Standard - No Std**

**No Standard**

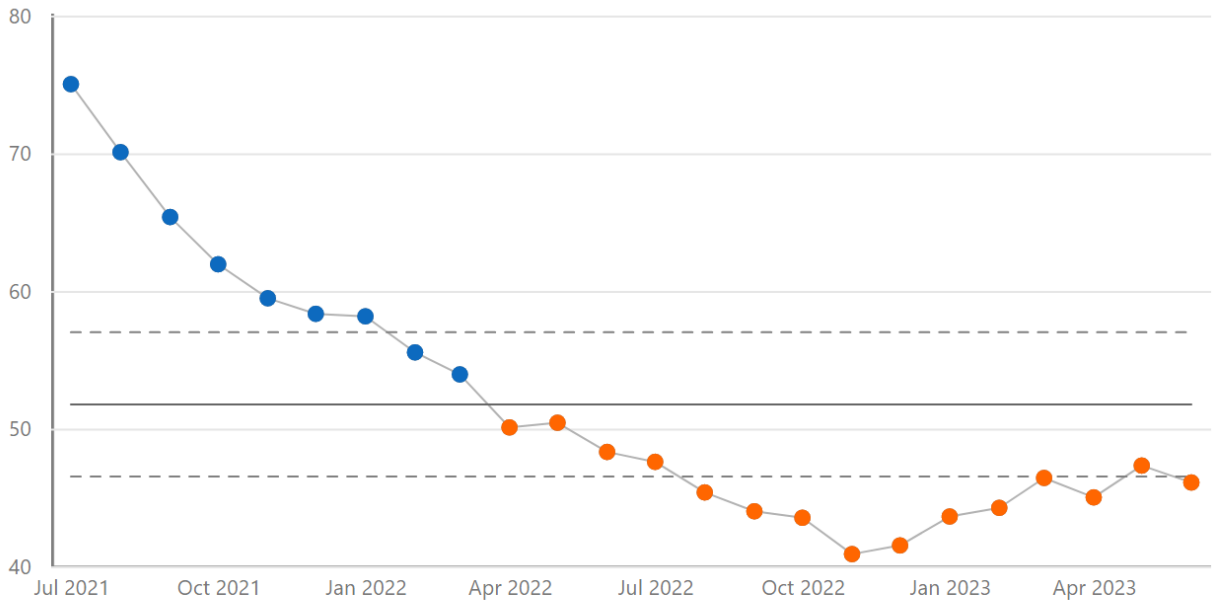
Assurance cannot be given for this indicator as there is no standard set

**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 | 38.0% | No Std | Concern | No Standard |
| North Cumbria Locality Care Group | 50.9% | No Std | Concern | No Standard |
| North Locality Care Group | 84.7% | No Std | Concern | No Standard |
| South Locality Care Group | 39.1% | No Std | Concern | No Standard |

## Feedback

**What the chart tells us**

Performance has decreased slightly this month to 46.1%

**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.
- Other system pressures create impact, for example, DNA/WNB rates within looked after children is higher due to staffing pressures in social care

**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.
- Work with system partners to review SPA and Getting Help pathways in Central.

**Expected impact and by when**

- Reduction in the number of people waiting over 4 weeks for help by Q4.
- Development of ITHRIVE in Sunderland over the next 12/18months

# <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)

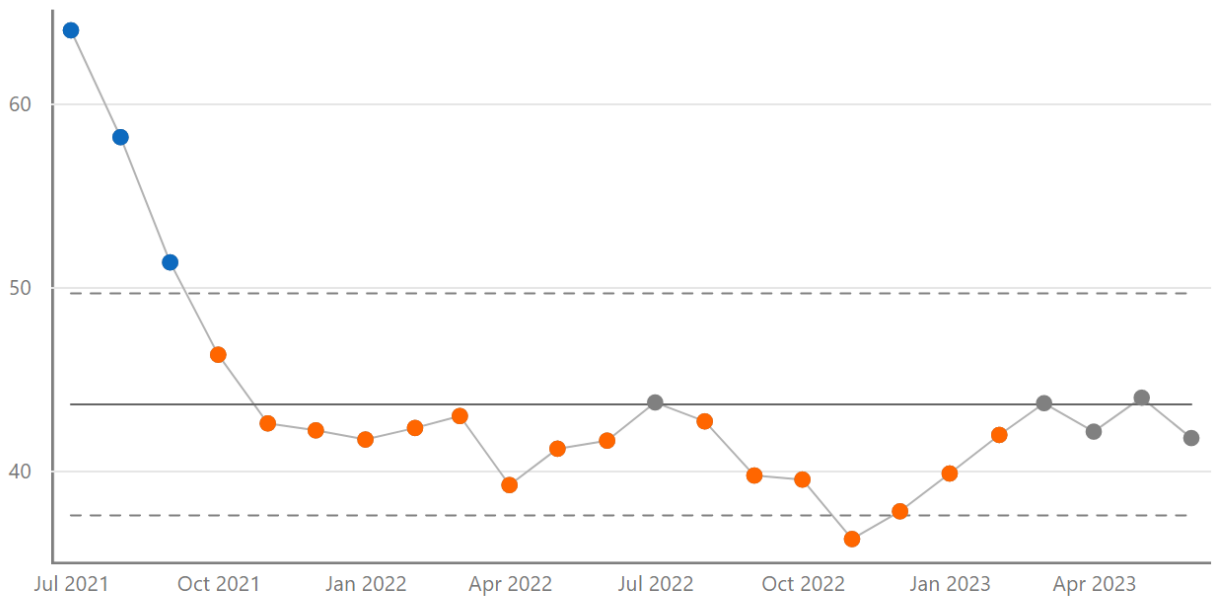
**Performance - 41.8%**

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




| Locality | Performance | Standard | Variation | Assurance |
|---|---|---|---|---|
| Central Locality Care Group | 32.9% | No Std | Normal Variation | No Standard |
| North Cumbria Locality Care Group | 44.1% | No Std | Concern | No Standard |
| North Locality Care Group | 82.9% | No Std | Concern | No Standard |
| South Locality Care Group | 31.5% | No Std | Concern | No Standard |

## Feedback

**What the chart tells us**

Performance was 41.8% in June 2023 remaining similar since November 2021

**Root Cause of the performance issue**

- Referrals are outstripping current capacity.
- Sharp increase in referrals over recent years.
- Increase in the number of CYPS who remain under CNTW care for ongoing monitoring following ADHD diagnosis.

**Improvement Actions**

- Trust wide CYPS neurodevelopment task and finish group to look at standardising practice.
- Implementing the actions of dedicated workstream.
- ICB agreed Welcome Event commencing from 31 July 23. Welcome Event agenda and presentation prepared.
- Pause on assessments during school holidays to address backlogs/ focus on caseload management etc (focus identified by each CYPS team depending on main pressures)
- Ongoing discussions with ICB colleagues to highlight issues.

**Expected impact and by when**

- Currently the forecast is that the waiting times will continue to increase

# 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)

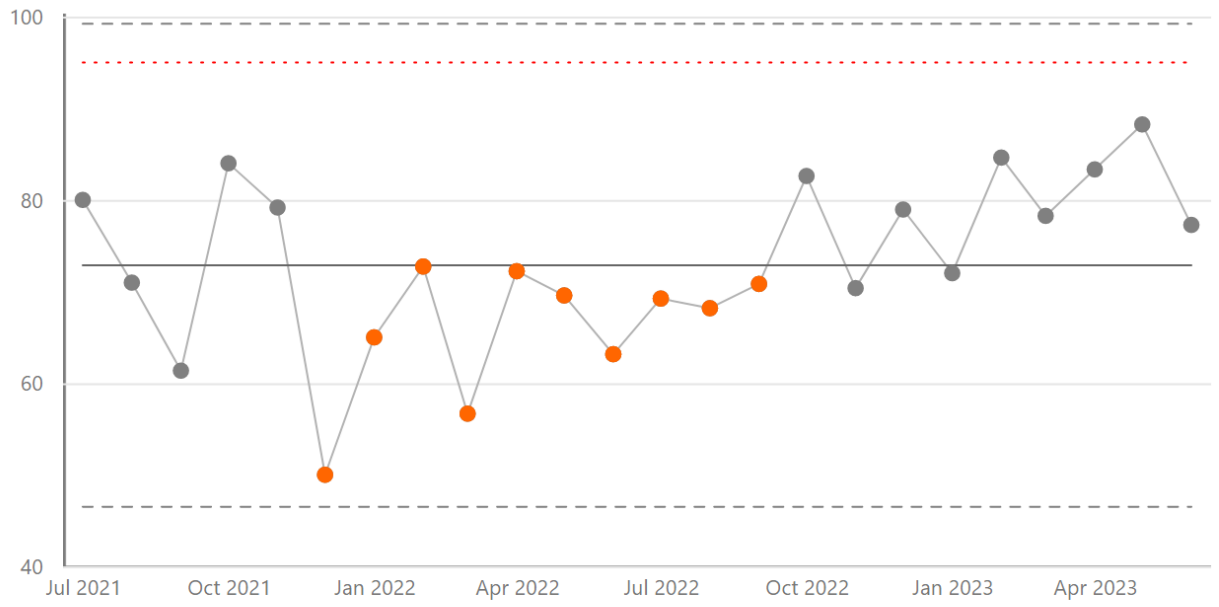
**Performance - 77.3%**

**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% | 95.0% | | |
| North Cumbria Locality Care Group | 81.0% | 95.0% | Normal Variation | Achieve at Random |
| North Locality Care Group | 100.0% | 95.0% | Improvement | Achieve at Random |
| South Locality Care Group | 0.0% | 95.0% | | |

## Feedback

**What the chart tells us**

77.3% of routine referrals waited <4 weeks in June 2023 which is within the expected range of 47% And 99%. This range suggests that the standard of 95% and the average of 73% 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 planned and delivered, the third meeting took place to looking at possible systemwide improvements. Attendees included CNTW, TEWV and Northumbria Healthcare, ICB and Provider Collaborative, 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 £)

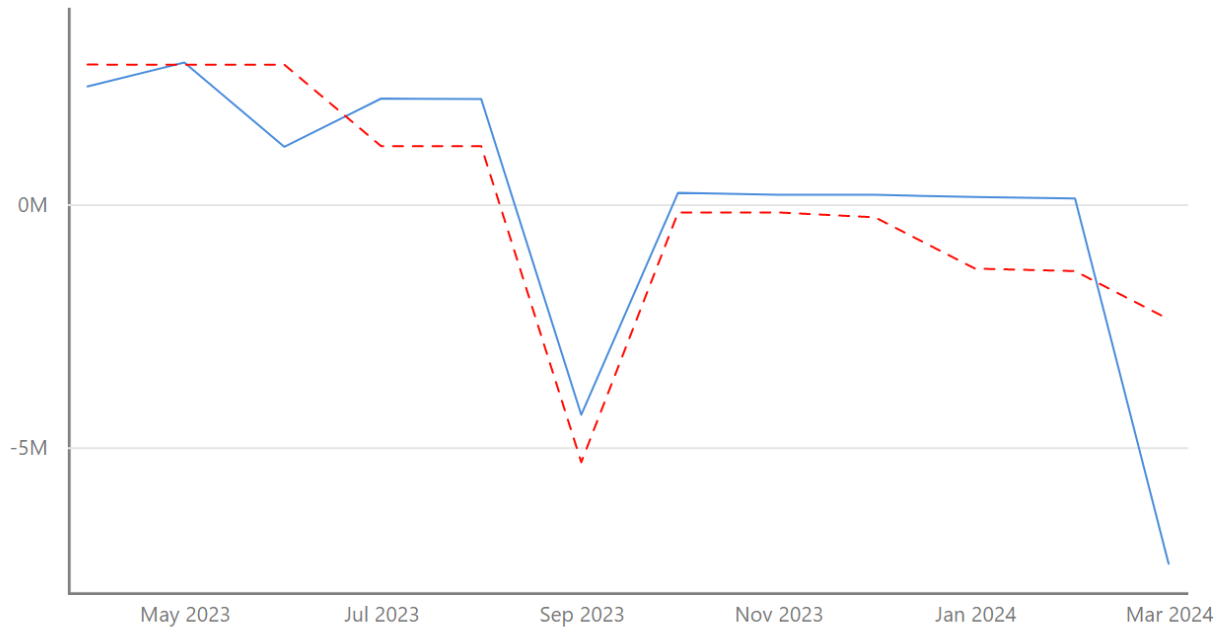
Risk Rating - **High (Action)**

**Actual/Forecast - 1.2M**
**Plan - 2.87M**

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 | 358 |
| North | 79 |
| North Cumbria | 126 |
| South | 284 |
| Corporate | -2537 |

## Feedback

**Root cause of the performance issue**

- Budget overspends across clinical groups (Central & South highlighted) driven from ward over establishments through Q1.
- Overspends across Corporate budgets, over established staffing budgets.

**Improvement Actions**

- Clinical groups engaged in daily staffing reviews for mental health wards.
- Areas of concern highlighted and managed through monthly BDG Finance meeting

**Expected impact and by when**

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

## 9. SERVICE USER AND CARER EXPERIENCE REPORT - QUARTER 1

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

### REFERENCES

Only PDFs are attached

9. BoD Service User and Carer Experience report Quarter 1 2023-24 EMG (003).pdf

| | |
|---|---|
| **Name of meeting** | **Board of Directors** |
| **Date of Meeting** | **Wednesday 2nd August 2023** |
| **Title of report** | **Service User and Carer Experience Report** |
| **Executive Lead** | **Sarah Rushbrooke** |
| **Report author** | **Paul Sams, Commissioning & Quality Assurance Feedback & Outcomes Lead** |

| **Purpose of the report** | |
|---|---|
| **To note** | |
| **For assurance** | |
| **For discussion** | **X** |
| **For decision** | |

| **Strategic ambitions this paper supports (please check the appropriate box)** | |
|---|---|
| **1. Quality care, every day** | x |
| **2. Person-led care, when and where it is needed** | x |
| **3. A great place to work** | x |
| **4. Sustainable for the long term, innovating every day** | x |
| **5. Working with and for our communities** | x |

| **Meetings where this item has been considered** | | **Management meetings where this item has been considered** | |
|---|---|---|---|
| Quality and Performance | x | 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 | | | |
| People | | | |
| 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 | x |
| Workforce | | Environmental | |
| Financial/value for money | | Estates and facilities | |
| Commercial | | Compliance/Regulatory | |
| Quality, safety and experience | x | Service user, carer and stakeholder involvement | x |

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

**CNTW Service User and Carer Experience Summary Report**

**Quarter 1 2023-24**

## Executive Summary

Service users and carers offered the highest numbers of feedback for a quarter through the Points of You (PoY) survey in its current iteration during quarter 1 2023-24.

A consultation period with service users, carers and staff to redevelop the PoY survey has commenced in July 2023 and will inform how we report service user and carer experience in the future. The new draft report is presented to Board today for comments and feedback regarding the content and presentation.

86.2% of people responding to the PoY survey felt they had been listened to when decisions were made around their care and treatment. A decrease on the score of 88.6% last quarter.

North Cumbria locality services continue to have service users and carers expressing less satisfaction with their experience of services than all other localities and in comparison to the Trust average.

The production of monthly 'You Said – We Did' posters by wards and teams remains disappointingly low, although some teams do this manually using a white board rather than printing them. All localities have this as a key focus through their Quality Standards meetings.

South locality increased their feedback by 32.5%, with 603 completed surveys during the quarter. This is a record return for any locality which is excellent.

## Recommendations

- Teams and wards should develop a strategy to support service users and carers to be aware of feedback options. There should be a reduction in the reliance on mailshot surveys as the main source of feedback. This should be a regular agenda item on locality Service User and Carer Groups where responses and themes should be discussed.
- Teams and wards should utilise the 'You Said – We Did' poster available to them monthly, through the PoY dashboard, to show they are responsive to service user and carer feedback.
- North Cumbria locality should explore why service users and carers are reporting a poorer than average experience of services and understand and encourage feedback from Lotus ward.
- As South locality have received record levels of feedback, this would be a good time to ensure teams and wards are being responsive to what it being said.

## Feedback Overview

The Points of You (PoY) survey remains the most popular way service users and carers offer feedback on their experience of services. As a result, most of this report will explore this feedback.

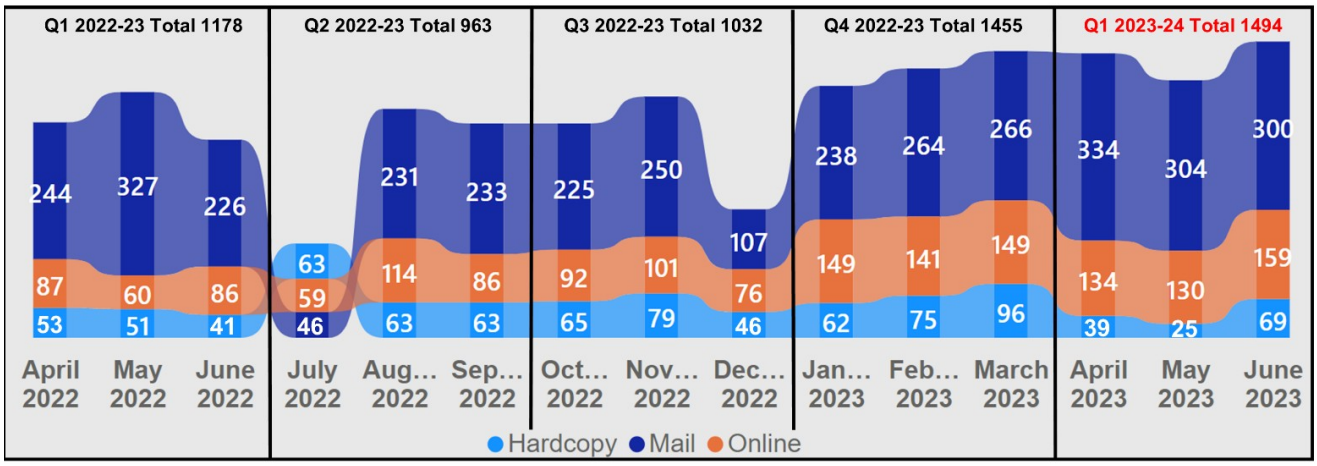
Service users and carers are also able to feedback their experience through Healthwatch, Care Opinion, the NHS website, CQC and through the complaints process internally and PALS. The last 2 options are reported locally and to the Trust through other assurance mechanism and reports.

These other ways to feedback are rarely used by service users and carers. There was no feedback offered through Healthwatch, Care Opinion or the NHS website, however when feedback is received the Trust responds promptly each time an experience is shared, however the numbers are too small to draw any theme or trend conclusions. With that said, the focus of this report will be PoY feedback.

The graph below shows the numbers of PoY surveys over the last 5 quarters, with the current quarter on the right-hand side.

Graph 1 shows that there has been a rise in feedback numbers for the last 4 quarters, with quarter 4 2022-23 and the quarter 1 2023-24 having the highest quarterly returns since the current PoY survey was introduced in September 2020.

The increase in survey returns is due to an increase in both mailshot and online surveys being completed by service users and carers. Some of the increase is attributable to people supporting service users to complete the online survey.



Graph 1. Feedback through PoY by quarter and survey type

991 (66.3%) of the 1494 surveys completed during the quarter came directly from service users. A further 186 (9.6%) were completed by someone on behalf of a service users. 255 (17.1%) surveys were completed by carers and 62 (4.1%) were completed by someone not specifying if they were a service user or carer.

| **Locality** | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | **Quarter 1** |
|---|---|---|---|---|---|

| | (2022-23) | (2022-23) | (2022-23) | (2022-23) | **(2023-24)** |
|---|---|---|---|---|---|
| South | 427 | 393 | 377 | 455 | **603 (+32.5%)** |
| Central | 306 | 240 | 269 | 453 | **448 (-1.1%)** |
| North Cumbria | 225 | 142 | 184 | 226 | **222 (-1.8%)** |
| North | 205 | 178 | 183 | 293 | **205 (-30%)** |
| Others* | 15 | 10 | 19 | 31 | **16 (-48.4%)** |

*teams not assigned to a locality

During the quarter only South locality experienced an increase in feedback received through the PoY survey. Central and North Cumbria localities had very similar survey numbers in comparison to the previous quarter, however North locality saw their feedback levels return to levels experienced in previous quarters after receiving their highest total for any quarter in quarter 4 of 2022-23.

The reduction in feedback for North locality for the most part the Children and Young People's Intensive Community Treatment Service (ICTS) - Northumberland & North Tyneside team going from 59 completed surveys during quarter 4 2022-23 to only 3 surveys during this quarter.

The Northumberland Community Learning Disability Community Treatment Team also saw a reduction in feedback, going from 31 surveys in quarter 4 2022-23 to 12 during this quarter.

It should be noted that the last time Lotus ward within Children and Young People's Services (CYPS) had any feedback was June 2022. It is recommended that the locality look to understand why and develop a plan to improve this.

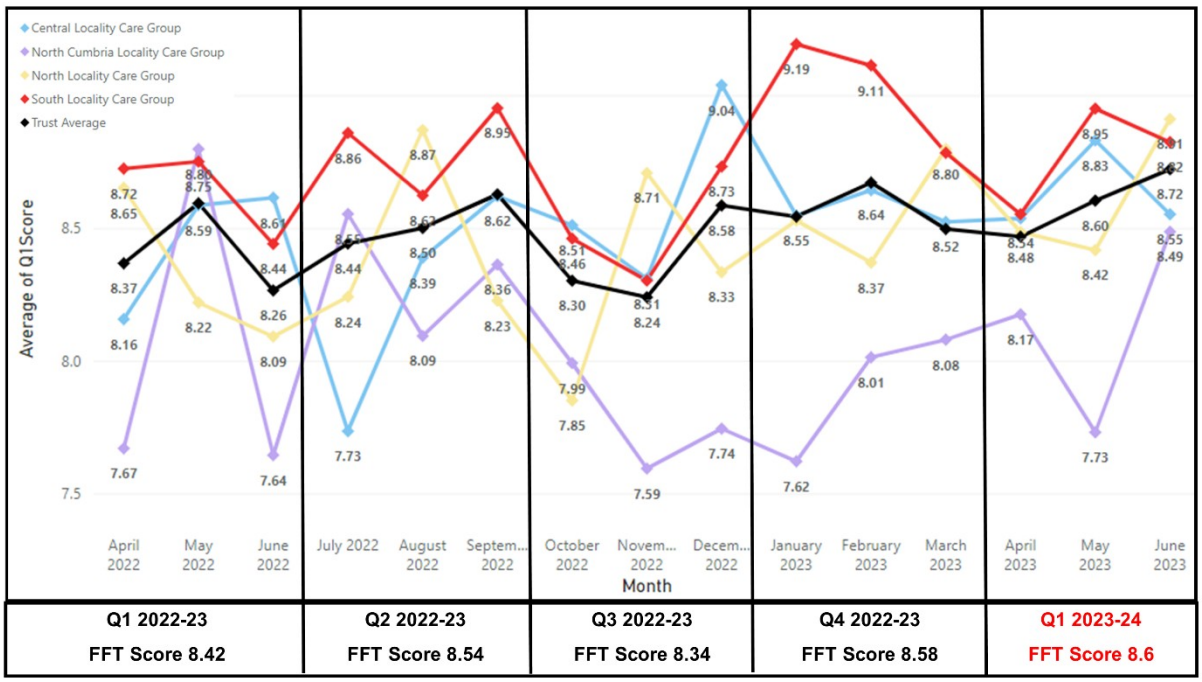
The PoY survey contains the Friends and Family Test (FFT) question as question 1 and is 'Overall, how was your experience with our service?'.

The response to this question offers a satisfaction score out of 10. During the first quarter of 2023-24 the average score for the Trust was 8.6. This is a slight increase on the score for quarter 4 of 2022-23, however it should be noted that this is the highest FFT score for 2 years, since a score of 8.69 in Quarter 4 2021-22.

Although the Trust average FFT score is at a 2 year high, only South locality had an average score that was higher than the Trust average during this quarter. The last time South locality had an average score below the Trust average was November 2020.

North Cumbria has again maintained an average score significantly below the Trust average for the 3rd consecutive quarter. The themes associated with this poorer reported experience are focused around communication, with staff and service user communication and not feeling listened to emerging as important sub-themes. These themes can be explored through the POY dashboard.

Central and North localities had average FFT scores above the Trust average for 2 of the 3 months this quarter. This gives them overall average scores for the quarter, with Central having a score of 8.64 and North having a score of 8.63.




The chart below shows the satisfaction rating by age demographic from people answering the FFT question and providing us with their age group.

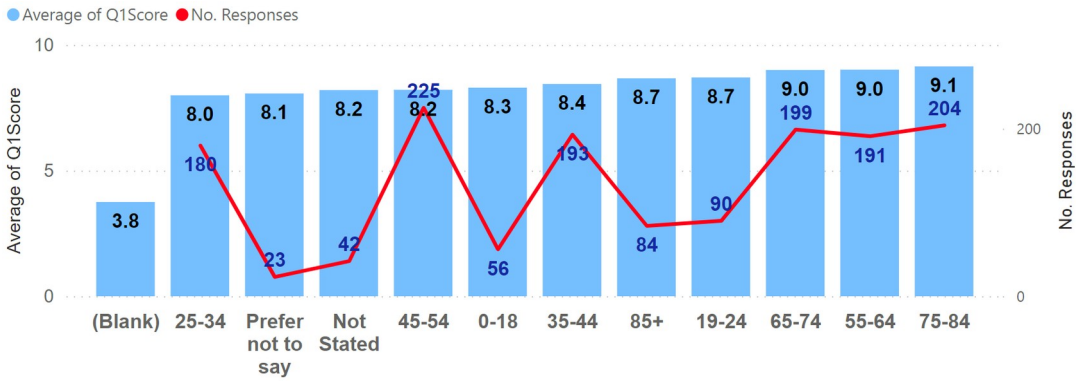
Excluding the groups that did not include their age, the 25-34 age group are reporting the worst experience, with a score of 8. This age group completed 180 surveys and it should be noted that of those 21 people they replied ‘Very Poor’ or ‘Poor’ when answering the FFT question.

When looking at which teams these negative responses are associated with, they are mostly community treatment teams and crisis teams. There is no one team that appears to have significant levels of negative responses to the FFT question.

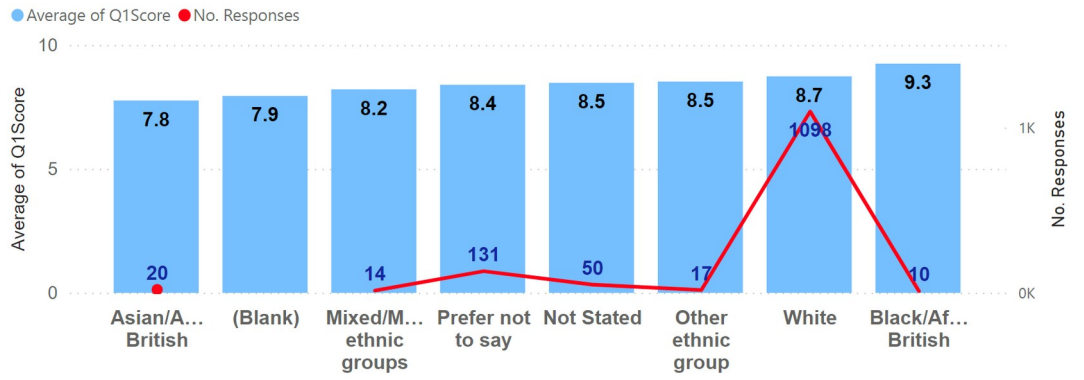
Adult mental health community service had the most people from this age group suggesting they are dissatisfied, with 5 responses about them.

People aged between 55-84 all had average scores over 9. They account for 593 (39.7%) responses between them. This suggests that services are more able, more often to support older service users and carers to have a more positive experience more of the time.

The positive themes of the experience of service users and carers can be explored in detail through the POY dashboard, however 3 main positive themes are evident, including Communications (710 positive comments of 1608 total), values and behaviours (708 positive comments of 1659 total) and patient care (598 comments of 1325 total). These themes can be used to further strengthen what we are doing to support a more positive experience for service users and carers.




The chart below shows satisfaction ratings by ethnicity for people answering the FFT question. Most of the feedback is from people choosing their ethnicity as white (1097 surveys or 73.4%), this is in keeping with the overall service user demographics, as 87.2% chose white as their ethnicity when accessing services. This group have an FFT score of 8.7, slightly above the average for the Trust.




Questions 4, 5, 6 and 7 also offer the opportunity to measure satisfaction of service users and carers, as well as offering the chance to explore who is having the best and worst experience of our services, through exploring the demographics, when they have been completed (Note Questions 2 and 3 are text only answers and will be discussed in the thematic analysis section).

Each quarter, one additional question will be discussed in detail alongside the FFT question. For quarter 1 the focus will be on question 4 ‘Did we listen when making decisions about care and treatment?’.

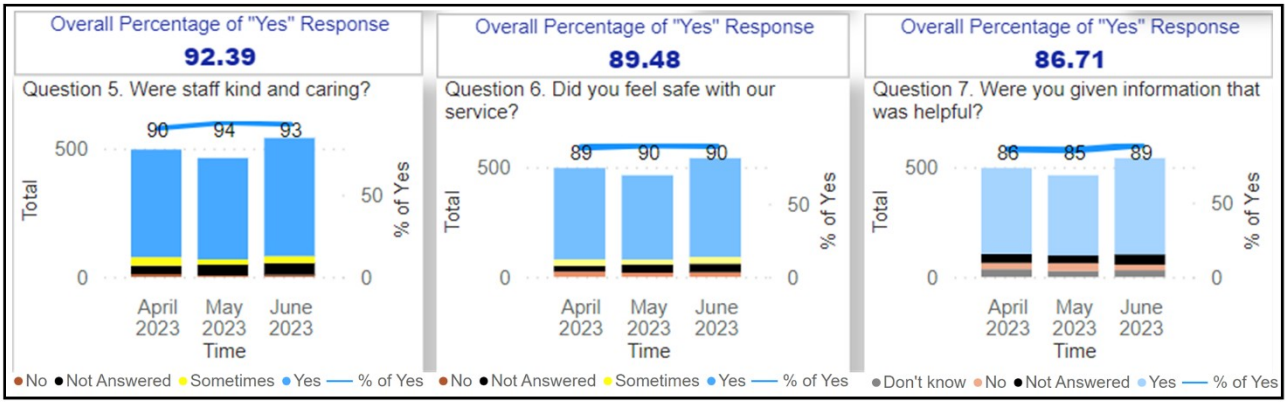
Below is an overview of Questions 5, 6 and 7 as they will not be explored in detail this quarter. This shows the monthly and quarterly percentage scores of people answering ‘Yes’ to each question.

For question 5 ‘Were staff kind and caring’ there was 1.7% reduction in people saying yes, when compared to the previous quarter. 92.4% (1,274 service users and carers) of people said yes they felt staff were kind and caring this quarter. 25 service users or carers said ‘No’ to this question during the quarter.

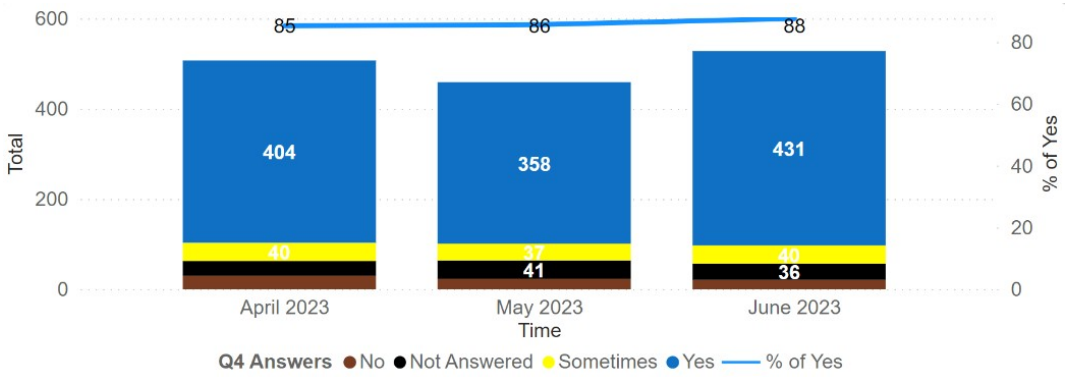
For question 6 ‘Did you feel safe with our service?’ there was a 1.7% reduction in people saying ‘Yes’ when they answered this question, when compared with the

previous quarter. 89.5% (1,250 service users and carers) of people said yes, they felt safe with our service. 64 service users or carers said ‘No’ to this question.

For question 7 ‘Were you given information that was helpful?’ there was a 0.8% increase in people saying ‘Yes’ when they answered this question when compared with the previous quarter. 86.7% (1,250 service users or carers) of people said yes, they felt they were given information that was helpful. 88 service users or carers said ‘No’ to this question.




Question 4 is ‘Did we listen to you when making decisions about care and treatment?’. Service users and carers have the option to answer ‘Yes’ ‘No’ and ‘Sometimes’ in response to this question.




The graph above shows how people responded to this question across the quarter. There is a notable upward trend, which is more impressive as June saw the highest number of people answering the question out of all of the months in the quarter.

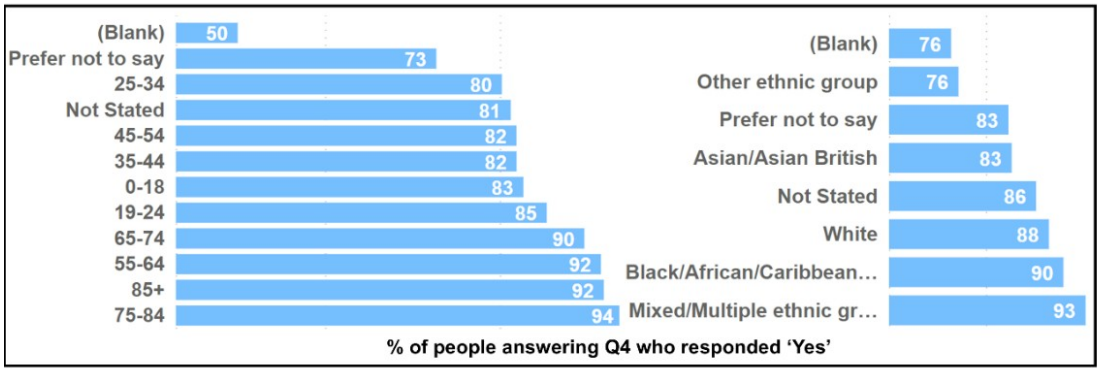
The graphs below show what percentage of people answered ‘Yes’ when responding to this question by demographic. The first shows age and ethnicity breakdowns and it is notable that there appears to be a split with people in the age groups of 54 and younger answering ‘Yes’ less often than the average for this quarter which is 86.2%.

People 55 and older all offered ‘Yes’ more often as their response in comparison to those under 54 years old, with the lowest score being 90% for the 65-74 age group and the highest score of 94% for the 75-84 age group.

When looking at ethnicity, people choosing not to tell us their ethnicity and people choosing 'other' as their ethnic group answered 'Yes' to question 4, more than 10% less often than the average for this question.

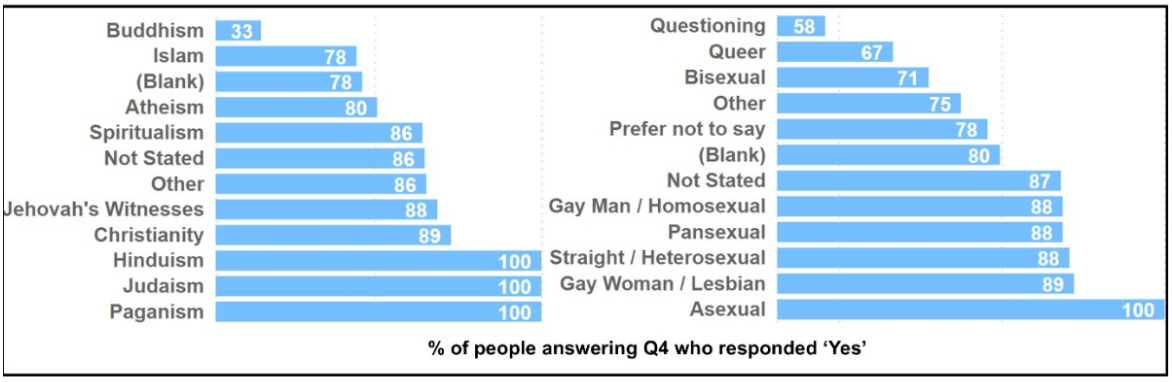
Most responses were from people choosing 'white' as their ethnic group, with 1,097 (73.6%) responses from this demographic. This group said 'Yes' 88% of the times they answered question 4, 2% above the Trust average for the question.

When looking at religion, people who chose Buddhism answered 'Yes' to question 4 least often, although this relates to 3 surveys across the quarter and all 3 appear to be from the same person, as all other demographics are the same for all 3. On 1 of the 3 occasions the person answered, 'Yes' and on the other 2 occasions they answered 'No'.




People choosing Islam as their religion offered a score significantly below the Trust average, with 78% answering 'Yes'. This related to 10 surveys and all related to mental health services, however they were across a number of services, with no service appearing more than once.

When looking at feedback from people choosing Islam as their faith, there have been relatively small numbers, 65, since September 2020 and the average percentage of people answering 'Yes' to this question is 87% overall.




When exploring the sexuality demographic, people choosing Questioning (12 surveys), Queer (3 surveys), Bisexual (25 surveys) and Other (29 surveys) all report feeling they were listened to less often than the average during the quarter.

These 4 groups account for 81 surveys, so not an insignificant number. When looking at teams receiving feedback from people identifying these 4 sexualities, there are 5 teams accounting for 64% of the feedback. The table above shows which service they are and how many times people using the 4 sexualities offered feedback to these services.

| CQC Core Service | Number of Surveys |
|---|---|
| Acute wards for adults of working age and PICU | 13 |
| Community-based MH services for adults of working age | 13 |
| Gender Identity Services | 12 |
| Specialist Community MH services for children and young people | 8 |
| Community MH Services for people with a learning disability or autism | 7 |

The 5 services in the table above received feedback 53 times during the quarter. When looking at their overall percentage of people answering 'Yes' to question 4, they have a combined score of 80.2%, which is 6% below the Trust average. It would be useful, given this information for these services to explore how to support more service users and carers to feel listened to.

**Thematic Analysis**

When completing a PoY survey, service users and carers can tell us about their experience in relation to the 7 questions. This generated 6,530 comments during the quarter that were themed. 75.25% (4914 comments) were positive in theme, with a further 2.2% (143) being a compliment about a person or a team. 15.3% (999 comments) were negative in theme and 7.26% (474 comments) were neutral comments.

The table below shows the main theme for the comments received, highlighting the dominant themes across quarter 1 2023-24 and allows a comparison across the previous 3 quarters.

Communications, patient care and values and behaviours continue to be the most often discussed themes across all 4 quarters shown, a situation that has continued across the life of the current PoY survey (introduced in September 2020).

The communication theme continues to be the main theme for positive and negative comments. This suggests strongly that this makes one of the biggest differences to service user and carer experience, both when we get things right and when we get it wrong. This theme should therefore be a focus for all teams and wards.

The main sub theme within the communication theme is 'being listened to', with 589 comments of the total comments for communications (2,172 in total) relating to this theme. Of the 586 comments, 474 (including 8 compliments) were positive in theme and 72 were negative in theme. The remainder (41) were neutrally themed.

| Theme Category | Quarter 2 2022-23 | | | | Quarter 3 2022-23 | | | | Quarter 4 2022-23 | | | | **Quarter 1 2023-24** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Compliment | Positive | Neutral | Negative | Compliment | Positive | Neutral | Negative | Compliment | Positive | Neutral | Negative | Compliment | Positive | Neutral | Negative |
| Access to Treatment or Drugs | | 0.61% | 4.40% | 2.04% | | 0.45% | 1.82% | 2.10% | | 0.70% | 2.99% | 3.34% | | 0.35% | 2.52% | 1.20% |
| Admissions and Discharges | | 0.18% | 1.17% | 0.73% | | 0.10% | | 1.21% | | 0.04% | 0.43% | 0.81% | | 0.04% | 1.05% | 0.80% |
| Appointments | 1.25% | 1.89% | 5.28% | 6.13% | | 1.66% | 5.00% | 5.85% | 1.02% | 1.76% | 3.85% | 3.61% | 2.04% | 2.34% | 1.89% | 4.98% |
| Clinical Treatment | | 0.58% | 2.35% | 1.17% | 0.67% | 0.39% | 1.36% | 0.44% | | 0.65% | 1.07% | 1.08% | | 1.10% | 0.84% | 1.10% |
| Communications | 25.00% | 29.52% | 28.74% | 36.35% | 30.00% | 35.57% | 32.73% | 42.27% | 29.08% | 33.12% | 23.29% | 36.10% | 29.93% | 32.74% | 32.49% | 36.55% |
| Facilities | | 1.04% | 4.99% | 4.23% | 0.67% | 1.20% | 5.91% | 5.96% | 0.51% | 1.00% | 3.63% | 6.77% | | 1.08% | 3.14% | 9.56% |
| Other | | 0.43% | 3.52% | 0.88% | | 0.06% | 5.45% | 0.11% | | 0.47% | 22.86% | 0.90% | | 0.24% | 16.56% | 0.60% |
| Patient Care | 33.75% | 34.28% | 31.09% | 25.69% | 25.33% | 29.60% | 33.64% | 24.28% | 30.61% | 30.93% | 29.06% | 25.27% | 16.33% | 26.93% | 24.32% | 21.71% |
| Prescribing | | 0.30% | 2.05% | 1.17% | | 0.13% | 0.91% | 0.88% | | 0.55% | 1.28% | 1.26% | | 0.39% | 0.84% | 1.00% |
| Privacy, Dignity and Wellbeing | | 0.88% | 0.88% | 0.15% | 1.33% | 0.16% | | | | 0.43% | 0.21% | 0.45% | | 0.08% | 0.42% | 0.40% |
| Staff Numbers | | 0.06% | 2.64% | 4.23% | | 0.06% | 2.27% | 2.54% | | 0.06% | 1.50% | 3.97% | | 0.04% | 1.47% | 3.19% |
| Trust Admin/ Policies/Procedures | | 0.21% | 0.29% | 0.73% | | 0.03% | | 0.33% | | 0.04% | 0.85% | 0.81% | | 0.20% | 0.63% | 0.40% |
| Values and Behaviours | 40.00% | 29.31% | 9.38% | 7.59% | 42.00% | 30.31% | 7.73% | 7.51% | 38.78% | 29.74% | 6.62% | 6.05% | 51.70% | 33.82% | 10.90% | 8.76% |
| Waiting Times | | 0.70% | 3.23% | 8.91% | | 0.26% | 3.18% | 6.51% | | 0.51% | 2.35% | 9.57% | | 0.65% | 2.94% | 9.76% |

The following are representative comments from the sub-theme 'Being Listened To':

Positive examples:

*'During the review Penny listened to both my father and myself when talking about care and treatment'* – Northumberland Memory Service

*'In relation to Dr Lesley Williams she is very good. Very thorough listening attentively to what I say and constructive in her reply'* - Neurorehabilitation Outpatient Team

*'team were very supportive and gave a lot of time listening and getting to understand how I felt'* - Psychiatric Liaison Team Newcastle

Negative examples:

*'not listening to my side, made assumptions. there were no care plans'* – Fellside

*'I put suggestions forward to help make my loved one comfortable and I was shut down with an excuse'* - Memory Matters and Later Life Service (West)

*'your way or no way'* - North Cumbria East Community Treatment Team

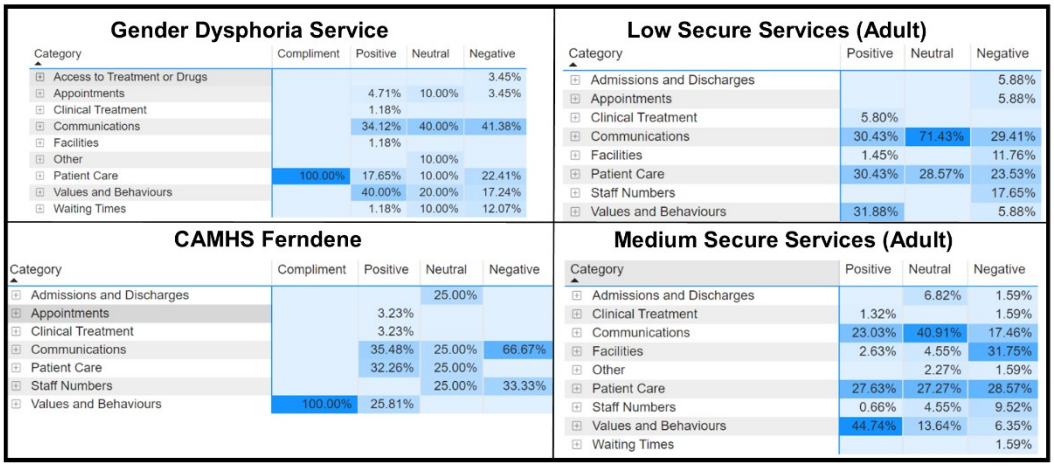
## Specialist Services

| Team | Apr-23 | May-23 | June-23 | Average FFT Rating |
|---|---|---|---|---|
| Perinatal Inpatient (Beadnell) | 0 | 0 | 3 | 10 |
| Mental Health and Deafness | 0 | 2 | 0 | 10 |
| Gender Dysphoria Service | 18 | 9 | 4 | 6.8 |
| Low Secure Services (Adult) | 10 | 9 | 1 | 8.1 |
| Medium Secure Services (Adult) | 17 | 27 | 17 | 8.4 |
| CAMHS Ferndene | 6 | 9 | 1 | 8.2 |
| Lotus Ward | 0 | 0 | 0 | No score available |
| CAMHS Medium Secure (Alnwood) | 0 | 0 | 2 | FFT not answered |
| Eating Disorders (Inpatient) | 0 | 0 | 0 | No score available |
| Eating Disorders (Day Service) | 0 | 0 | 0 | No score available |

Within specialist services, 3 services received no feedback at all. This should be addressed as a priority by the teams and can be supported by the Trust Feedback and Outcomes Lead to develop strategies.

A further 3 services have received small numbers of feedback during the quarter, Beadnell and the Mental Health and Deafness Service both received satisfaction scores of 10 through the FFT question.

The themes of the 4 services that received good levels of feedback are shown in the table below.



**Gender Dysphoria Service**

| Category | Compliment | Positive | Neutral | Negative |
|---|---|---|---|---|
| Access to Treatment or Drugs | | | | 3.45% |
| Appointments | | 4.71% | 10.00% | 3.45% |
| Clinical Treatment | | 1.18% | | |
| Communications | | 34.12% | 40.00% | 41.38% |
| Facilities | | 1.18% | | |
| Other | | | 10.00% | |
| Patient Care | 100.00% | 17.65% | 10.00% | 22.41% |
| Values and Behaviours | | 40.00% | 20.00% | 17.24% |
| Waiting Times | | 1.18% | 10.00% | 12.07% |

**Low Secure Services (Adult)**

| Category | Positive | Neutral | Negative |
|---|---|---|---|
| Admissions and Discharges | | | 5.88% |
| Appointments | | | 5.88% |
| Clinical Treatment | 5.80% | | |
| Communications | 30.43% | 71.43% | 29.41% |
| Facilities | 1.45% | | 11.76% |
| Patient Care | 30.43% | 28.57% | 23.53% |
| Staff Numbers | | | 17.65% |
| Values and Behaviours | 31.88% | | 5.88% |

**CAMHS Ferndene**

| Category | Compliment | Positive | Neutral | Negative |
|---|---|---|---|---|
| Admissions and Discharges | | | 25.00% | |
| Appointments | | 3.23% | | |
| Clinical Treatment | | 3.23% | | |
| Communications | | 35.48% | 25.00% | 66.67% |
| Patient Care | | 32.26% | 25.00% | |
| Staff Numbers | | | 25.00% | 33.33% |
| Values and Behaviours | 100.00% | 25.81% | | |

**Medium Secure Services (Adult)**

| Category | Positive | Neutral | Negative |
|---|---|---|---|
| Admissions and Discharges | | 6.82% | 1.59% |
| Clinical Treatment | 1.32% | | 1.59% |
| Communications | 23.03% | 40.91% | 17.46% |
| Facilities | 2.63% | 4.55% | 31.75% |
| Other | | 2.27% | 1.59% |
| Patient Care | 27.63% | 27.27% | 28.57% |
| Staff Numbers | 0.66% | 4.55% | 9.52% |
| Values and Behaviours | 44.74% | 13.64% | 6.35% |
| Waiting Times | | | 1.59% |

The most interesting anomaly for specialist services when looking at the themes is that staff numbers across the 4 services is a commented on theme, this is discussed less often when looking at feedback for all services.

When exploring this in more detail, the most common sub-theme is patients suggesting there needs to be more staff present on the ward and less reliance on agency staff.

It is notable that the percentage of people saying they felt safe for these services averages at 75%, below the Trust average of 89.5% for the same period.

## How are we responding to feedback?

Each team can create a You Said-We Did poster, using a template built into the PoY dashboard. This system was created to support teams and wards to be responsive to feedback and experience on a monthly basis, with a process designed to be easy to use and therefore not using up precious clinical time and resources.

This process has been, and continues to be discussed at Trust, Locality, CBU and team/ward level. With awareness sessions and support with user guides and good practice guidance being readily available.

Unfortunately for several reasons, this electronic process has not become part of everyday business, or it is being done manually through white boards, a process that is difficult to thematically review over time. This can be considered a missed opportunity in our drive to be responsive to the needs of service users and carers, as we develop our services to suit the needs of the people accessing them.

We are aware that teams and wards are responsive in other ways when they receive feedback. This system is a helpful tool to be able to show a methodical approach over time, something that would help when under the scrutiny of CQC inspections or PLACE visits.

During the quarter, South locality created the most posters with 29 being produced. The best month for South locality was in response to feedback received in May, when 25 teams created a poster.

Central locality created 15 posters during the quarter, with April and May seeing the most being produced, with 6 teams completing the process during both months.

Both North and North Cumbria localities had a poor uptake, with each creating only 4 posters during the quarter.

Posters for previous 3 months by locality

| Locality | Apr-2023 | May-2023 | Jun-2023 |
|---|---|---|---|
| Central Locality Care Group | 6 | 6 | 3 |
| North Cumbria Locality Care Group | 1 | 2 | 1 |
| North Locality Care Group | 2 | 2 | |
| South Locality Care Group | 8 | 15 | 6 |
| **Total** | **17** | **25** | **10** |

For support with Points of You and You Said-We Did, please get in touch with paul.sams@cntw.nhs.uk and copy in poy@cntw.nhs.uk and we will get back to you promptly.

## 10. SAFER CARE REPORT - QUARTER 1

Rajesh Nadkarni, Deputy Chief Executive / Medical Director

### REFERENCES

Only PDFs are attached

10. Safer Care Quarterly Report Q1 2023 24.pdf

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

| | |
|---|---|
| **Name of meeting** | **Board of Directors Meeting** |
| **Date of Meeting** | **2 August 2023** |
| **Title of report** | **Safer Care Report – Quarter 1 23/24** |
| **Executive Lead** | **Dr Rajesh Nadkarni - Executive Medical Director**<br>**Sarah Rushbrooke – Executive Director of Nursing, Therapies and Quality Assurance** |
| **Report author** | **Claire Thomas – Deputy Director, Safer Care**<br>**Anthony Deery – Deputy Chief Nurse**<br>**Peter Astbury – Associate Director, Safer Care** |
| **Purpose of the report** | |
| **To note** | |
| **For assurance** | **X** |
| **For discussion** | |
| **For decision** | |

| **Strategic ambitions this paper supports (please check the appropriate box)** | |
|---|---|
| **1. Quality care, every day** | X |
| **2. Person-led care, when and where it is needed** | X |
| **3. A great place to work** | X |
| **4. Sustainable for the long term, innovating every day** | X |
| **5. Working with and for our communities** | X |

| **Meetings where this item has been considered** | | | **Management meetings where this item has been considered** | |
|---|---|---|---|---|
| Quality and Performance | x | | 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 | | | | |
| People | | | | |
| 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 and experience | | Service user, carer and stakeholder involvement | |

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

# Safer Care Report – Quarter 1 2023/24

## Board of Directors Meeting

## Wednesday 2nd August 2023

### 1. Executive Summary

This is the Safer Care report for Quarter 1 2023/24. This report focusses on key metrics (such as those which are reported outside of the Trust) and now uses Statistical Process Control (SPC) charts which enable better data analysis and identification of areas that require further investigation or review. The narrative provides an analysis of the data while the 'key points' provides additional areas of note and assurance.

*Please note data is correct at the time of reporting but is subject to change.*

### 2. Risks and mitigations associated with the report

None to note by exception.

### 3. Recommendation/summary

Receive the paper for information only

**Name of author:**

Claire Thomas, Deputy Director, Safer Care

Anthony Deery, Deputy Chief Nurse

Peter Astbury, Associate Director, Safer Care

**Name of Executive Lead:**

Dr Rajesh Nadkarni, Executive Medical Director

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

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

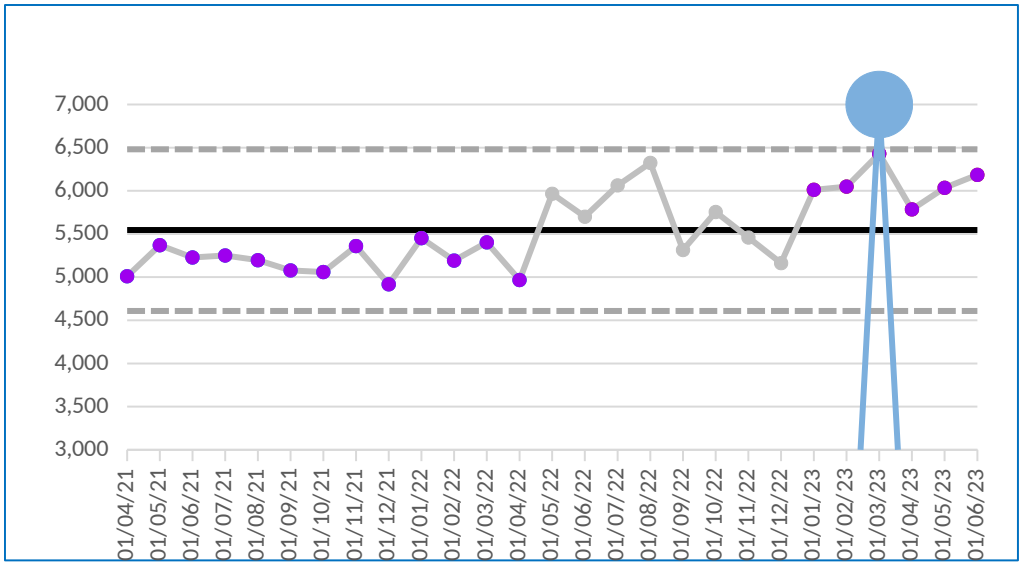
# Safer Care Quarterly Report

## July 2023

## Reporting Period: April to June 2023

With YOU in mind

## Section 1: Incidents

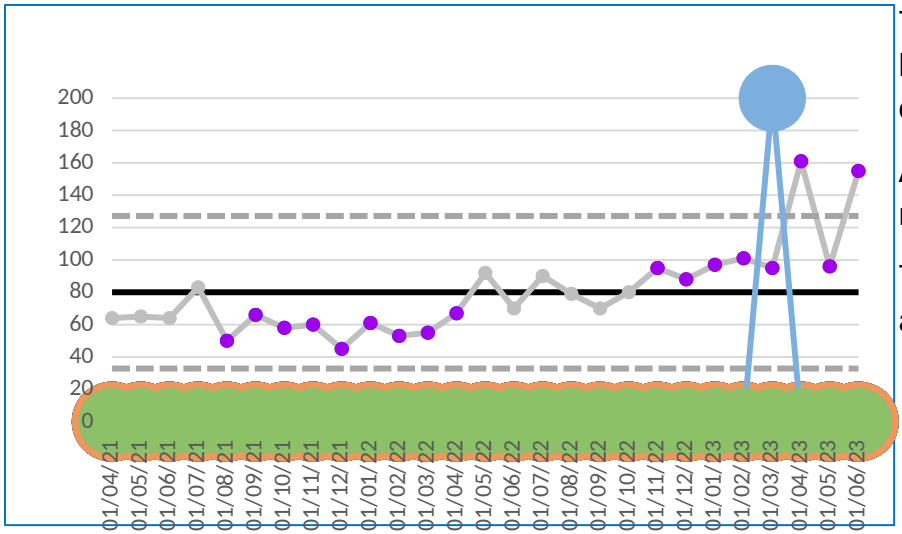



| Locality | April Variation | May Variation | Jun Variation | Q1 Output |
|---|---|---|---|---|
| Trust wide | | | | 6,035 |
| North | | | | 1,605 |
| Central | | | | 1,296 |
| South | | | | 1,464 |
| North Cumbria | | | | 1,537 |

- Total Trust wide reported incidents were in line with common variation in April and May. Special cause was triggered in June – following 6 months of incident numbers being higher than average.

- Locality level incidents remained at common variation in April and May in all localities with the exception of South, which continues to flag as special cause – high. This was linked to higher than usual incidents within Inpatients South which have been consistently higher than average since May 2022. In June, Central and North Cumbria flagged as special cause high correlating with access services in both localities showing consistently higher numbers for the last 6 months.

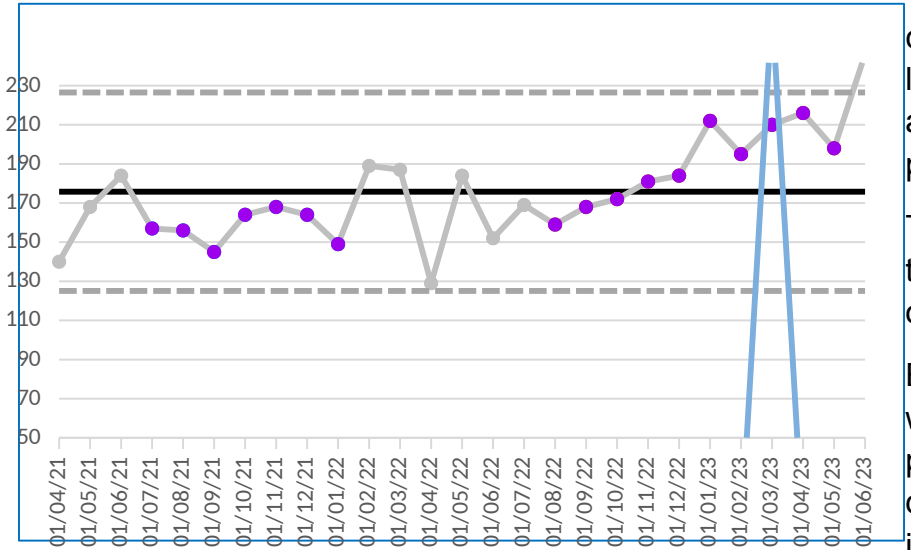
- Throughout this quarter Trustwide cause groups of Information Governance and Security flagged as special cause, both being more than average for the last 8 months. In June, Aggression and Violence incidents also flagged as special cause following 6 months of above average number of incidents. Service delivery cause group incidents have also increased, further work is being undertaken with Operations to understand this increase.




The IG Team have also identified the increase in IG incidents therefore there has been and will continue to be a real focus on IG responsibilities across the organisation.

An IG session has been delivered to the Trust via the Trustwide managers meeting.

The IG team have and will continue to run IG messages in the Trust Bulletin and are planning an IG campaign with support from communications.




There have been increases in reported Trust property damage by patients, which can happen based on new admissions, but also minor increase in staff reporting lost ID badges and lone working devices. This links to work undertaken following a lone worker device audit which identified several devices that been lost previously, which were then subsequently reported in the months of April/May.

There are also increases in body worn camera damage and loss compared to this time last year, which would be expected with increased availability and use on all wards.

Expectation that security incidents increase going forward in line with further work on loss detection / prevention around most assets that are in use on in-patient wards, such as staff attack fobs, cameras and as new guidance and dashboards are produced /utilised to detect loss and highlight areas for improvement.

## *Patient Safety Incident Framework – PSIRF*

➢ CNTW continues to work towards implementation of the new Patient Safety Incident Response Framework (PSIRF). CNTW, as an NHS Provider, are required to have PSIRF in place across the organisation by Autumn 2023.

➢ Project Support is now being Provided via Innovations.

➢ The 5 PSIRF Workstreams are now meeting regularly and progressing their work regularly updating the PSIRF Core group.

1. Engaging those affected (Patients, Families, staff)
2. Responding to incidents
3. Learning and Quality Improvement
4. Understanding our Patient Safety Data (PSIRP)
5. Oversight of PSIRF

➢ An introduction to PSIRF was presented to the Carer reference Group this quarter and will be followed up with an engagement event including Carers to help shape the CNTW's compassionate engagement of those effected by patient safety incidents as part of PSIRF.

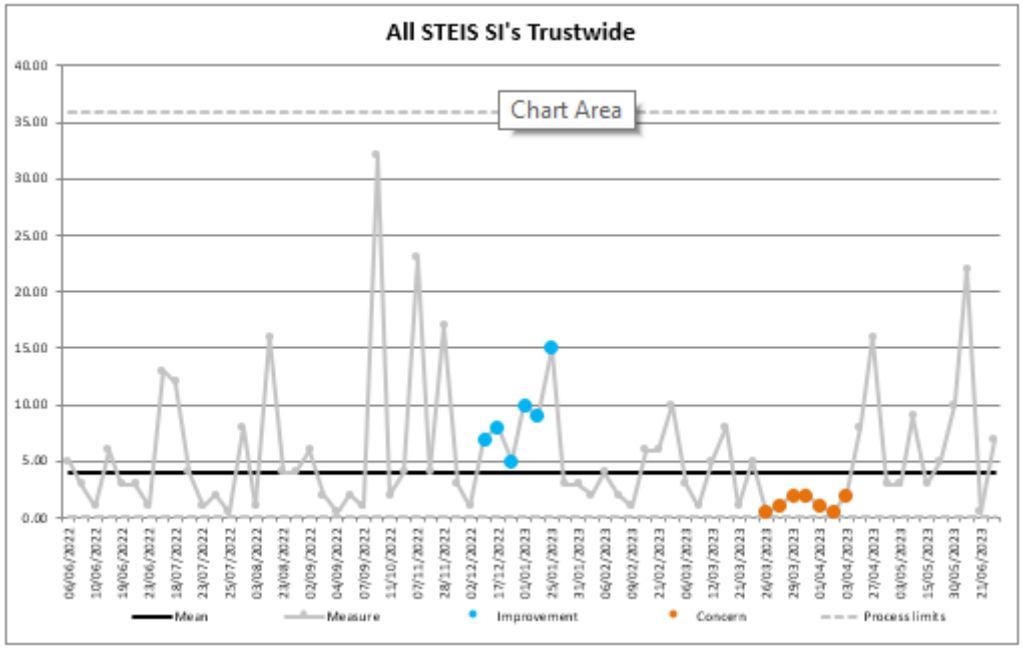
➢ The following timetable has been agreed as we progress towards implementation in Quarter 2.

- September 11th – Workshop with Workstream Lead's PSIRF core group and Trustwide Safety to review Workstream outputs and discuss CNTW safety priories and response methods to start to compile PSIRP (Patient Safety Incident Response Plan).

- September 25th – Presentation of draft PSIRP to EMG for discussion.

- September 29th – Presentation of PSIRP and implementation plan to Trust Leadership forum for further engagement and discussion.

## Section 2: Serious Incidents and Deaths




**This section now only includes STEIS reportable serious incidents (previously included serious incidents not meeting threshold for STEIS but deemed to require a level of formal review).**

**In line with NHSE/I Making Data Count guidance, T-Charts are now being used for rare events like STEIS reportable serious incidents. T-Charts measure time between incidents rather than number of incidents. High numbers relate to longer periods between incidents.**

*Please note serious incident numbers are correct at the time of reporting but are subject to change following any review subsequent to reports being released.*

| Locality | Variation - Apr | Variation - May | Variation - Jun | Total Q1 |
|---|---|---|---|---|
| Trustwide STEIS Reportable Incidents | | | | 15 |
| North Locality | | | | 3 |
| Central Locality | | | | 3 |
| South Locality | | | | 5 |
| North Cumbria Locality | | | | 4 |

**Key points:**

- Overall STEIS reportable incidents during quarter 1 were in line with common variation in reported incidents and no concerns flagged relating to the frequency.
- Twelve of the steis reported incidents were unexpected deaths one of which occurred in an inpatient ward, the others all occurred in community settings. Five of the unexpected deaths were via hanging which is in line with the National most common method.
    - Two of the steis reported incidents pertained to significant self harm which occurred in the community and one related to a service user sustaining a fractured neck of femur on an inpatient ward. no concerns flagged relating to frequency.

| Reviews of Deaths | Q1 22/23 | Q2 22/23 | Q3 22/23 | Q4 22/23 | Q1 23/24 |
|---|---|---|---|---|---|
| Deaths Reported into the LeDeR process | 13 | 22 | 13 | 16 | 22 |
| Complex Case Panel – No. Cases Heard | 0 | 4 | 0 | 0 | 2 |
| Prevention of Future Death Reports Received (Regulation 28) | 1 | 0 | 0 | 1 | 2 |
| Full StEIS Reportable Serious Incidents | 19 | 12 | 9 | 16 | 17 |
| LAAR's | 37 | 42 | 58 | 46 | 66 |
| Non StEIS Reportable Serious Incidents | 4 | 1 | 5 | 1 | 0 |
| 72 Hour Reports | 31 | 20 | 20 | 32 | 43 |
| Mortality Review | 20 | 33 | 19 | 38 | 21 |
| % of Serious Incidents closed within 60 days | 63% | 67% | 52% | 92% | 90% |

The above incidents are deaths that have been formally reviewed in line with CNTW review levels. The total does not reflect the numbers of Serious Incidents (SI's) as per the NHS Serious Incident Framework definition of an SI. That definition is only applicable to the Full StEIS reportable Serious Incidents.

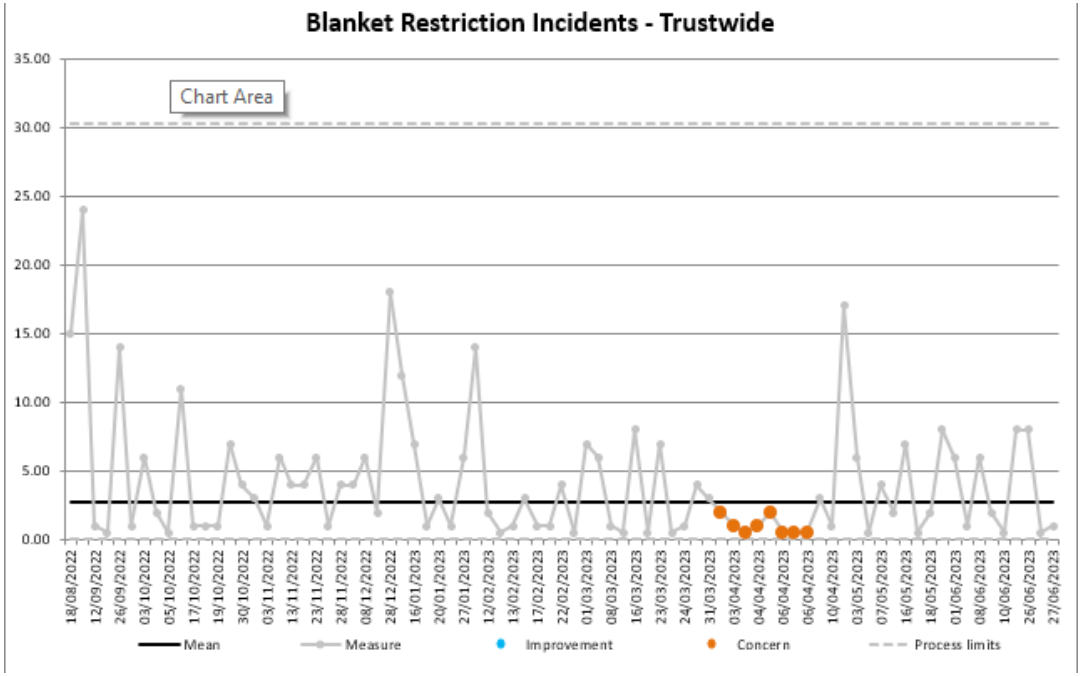
**Regulation 28 reports:**

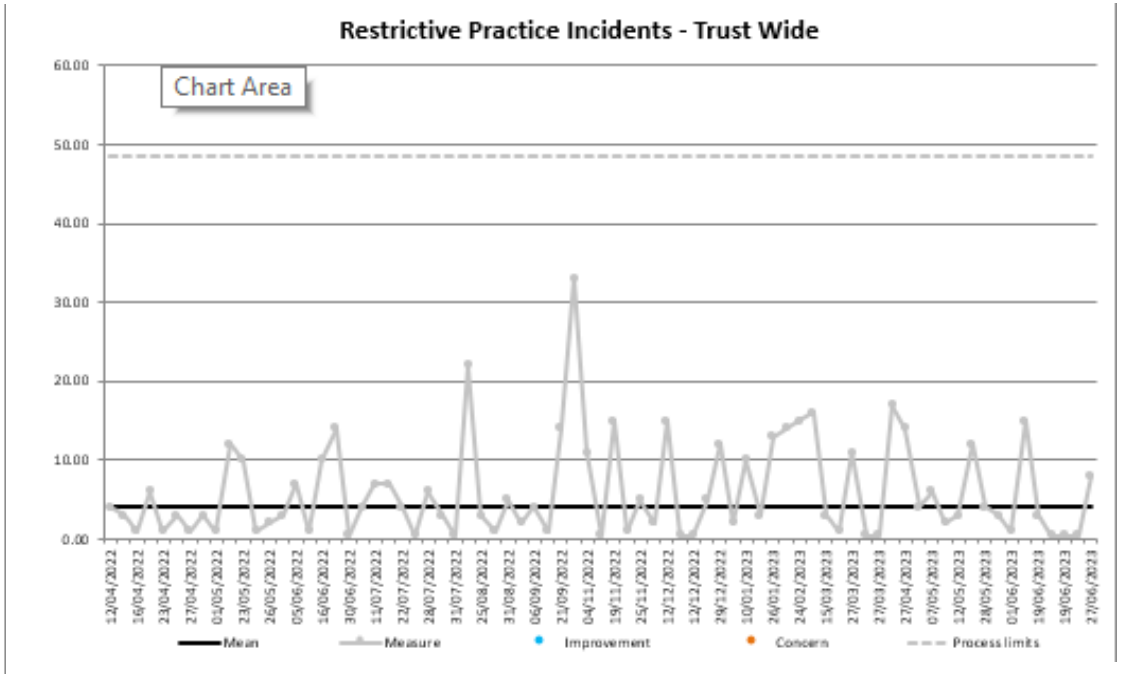
Regulation 28's are issued by Coroners who have a concern(s) that if not addressed could potentially lead to a similar incident reoccurring in future. From the date of issue, the recipient must respond to the Coroner within 56 days outlining what action has been taken to address the concern(s).

CNTW has received 2 Regulation 28 reports in this Quarter. The first was received on May 12th, 2023, From HM Coroner, Northumberland. CNTW reviewed the concerns and replied as expected within the expected timeframe. The second was received on June 12th, 2023, from HM

Coroner, Cumbria. CNTW have written to the Coroner acknowledging receipt and raising some concerns about the Trust's lack of involvement in the inquest process. The formal Regulation 28 response is currently being completed and will be submitted within the expected timeframe.

## *Section 3: Blanket Restrictions and Restrictive Practice:*




➢ At Trust level, reported blanket restriction and restrictive practice incidents have been in line with common variation in reported incidents month on month during quarter 1.

➢ Reported blanket restriction and restrictive practice incidents have also been in line with common variation across all localities during the period.

## *Section 4: Positive and Safe*

| | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Jun-23 | Total | Variance Apr_23 | Variance May_23 | Variance Jun_23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Restraint | 878 | 1156 | 813 | 791 | 686 | 585 | 832 | 913 | 792 | 702 | 654 | 679 | 9481 | | | |
| Prone | 122 | 135 | 110 | 93 | 87 | 85 | 90 | 100 | 119 | 109 | 112 | 105 | 1267 | | | |
| Seclusion | 134 | 123 | 112 | 115 | 105 | 114 | 120 | 99 | 93 | 101 | 91 | 116 | 1323 | | | |
| Assaults on Staff | 465 | 446 | 404 | 446 | 402 | 370 | 586 | 481 | 524 | 529 | 527 | 498 | 5678 | | | |
| MRE | 16 | 16 | 12 | 4 | 11 | 20 | 22 | 11 | 13 | 11 | 21 | 9 | 166 | | | |
| Self Harm | 1081 | 1325 | 972 | 1032 | 1091 | 818 | 983 | 1079 | 1047 | 1029 | 1052 | 1000 | 12509 | | | |
| VA | 1542 | 1759 | 1437 | 1515 | 1404 | 1420 | 1722 | 1740 | 1752 | 1504 | 1612 | 1472 | 18879 | | | |
| **Total** | 4238 | 4960 | 3860 | 3996 | 3786 | 3412 | 4355 | 4423 | 4340 | 3985 | 4069 | 3879 | 49303 | | | |

The Positive and Safe Care team have been rolling out human rights awareness training across all inpatient areas ,over 30 wards have received the cascade training. The training has been well received and evaluated; it is expected all wards will be completed by September.

Post Graduate Certificate in reducing restrictive interventions has just closed to applications the course is again significantly over prescribed.

The joint RRI conference with TEWV has been set for November.

Noted rises in prone restraint are related largely to Autism services (both Mitfords) and CYPS (Riding), work is ongoing to enhance roll out of Safety pods, all inpatient areas have ward restraint reduction action plans it should be noted that both areas are reporting significant rises in assaults on staff.

MRE continues to demonstrate reduction across the Trust. seclusion other than in the south locality has reduced moderately also.

## *Section 5: Long Term Seclusion*

The number of patients in long term seclusion (LTS) and prolonged seclusion (PS) during quarter 1 are shown in the table

| | Apr 23 | May 23 | Jun 23 |
|---|---|---|---|
| Long Term Segregation | 6 | 5 | 5 |
| Prolonged Seclusion | 6 | 9 | 8 |

**Data on e-seclusion records on RiO. Only those episodes of prolonged seclusion as of 08:00 every Friday morning are included in the figures*

**Patients in Long Term Segregation (as of 1st July)**

**CYPS - Ferndene**

- 3 cases (one commenced Nov 21, two Mar23)

**LD&A - Mitford**

- 2 cases (one commenced Aug 18, one Sept 22)

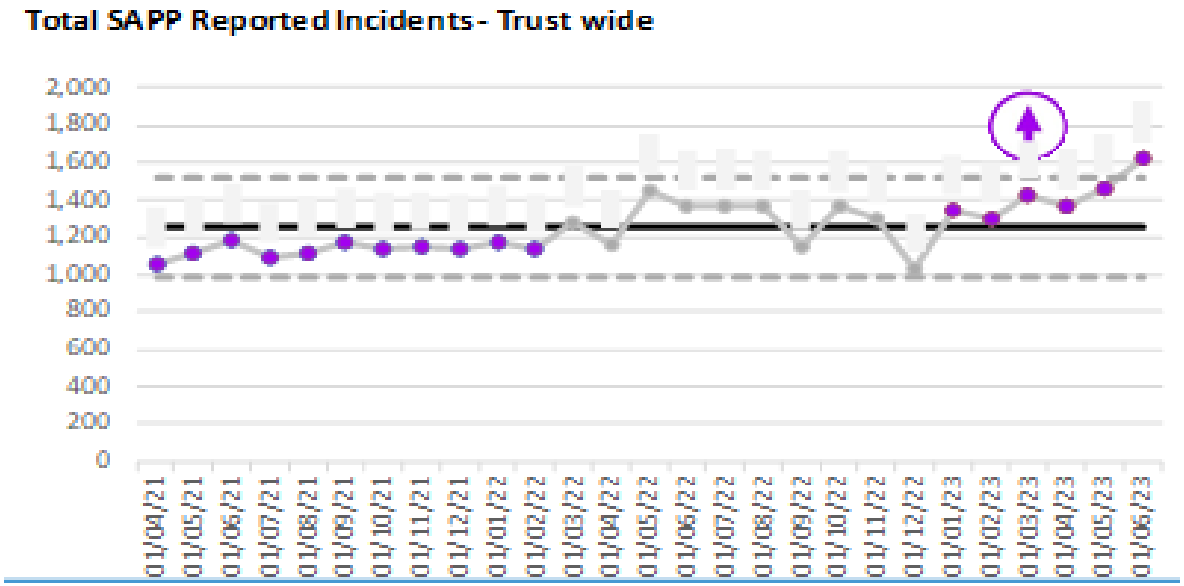
**Patients in Prolonged Seclusion (as of 1st July)**

- CYPS - Alnwood – 1 seclusion in LTS area continues (LTS commenced 2018 and seclusion commenced January 2023)
- LDA - Rose Lodge – 1 seclusion in LTS area continues (LTS commenced 2022 and seclusion commenced February 2023)

**Key Points:**

- During Q1 cases were reviewed by the LTS & PS Panel. This included a further review of all Independent Clinical Treatment Reviews (ICTRs).
- Each LTS case is actively supported with internal HOPE(S), this involves training, completion of a Barriers to Change Checklist, development of intervention targets, supervision and practice leadership.
- National HOPE(S) Team supporting cases at Mitford and Alnwood.
- Patients in seclusion at Alnwood are now over the age of 18 and awaiting placement in age-appropriate services. Second patient, whose LTS ended during Q1, is also over the age of 18. LTS Panel has escalated these cases to the Provider Collaborative and onward placements are still to be confirmed.
- HOPE(S) training continued to be rolled out across the Trust in Q1.
- National HOPES Conference 5th June Liverpool – CNTW Clinical staff presented two case histories. CNTW were invited to participate in NHSE video for national learning disability and autism week in June.

## *Section 6: Safeguarding and Public Protection*




***Key Points:***

Special Cause concern was highlighted in the month of June following 6 months of higher than average SAPP reported incidents with an especially high number in June.

Locality – Central, North & North Cumbria flagged high in June – 6 months above average

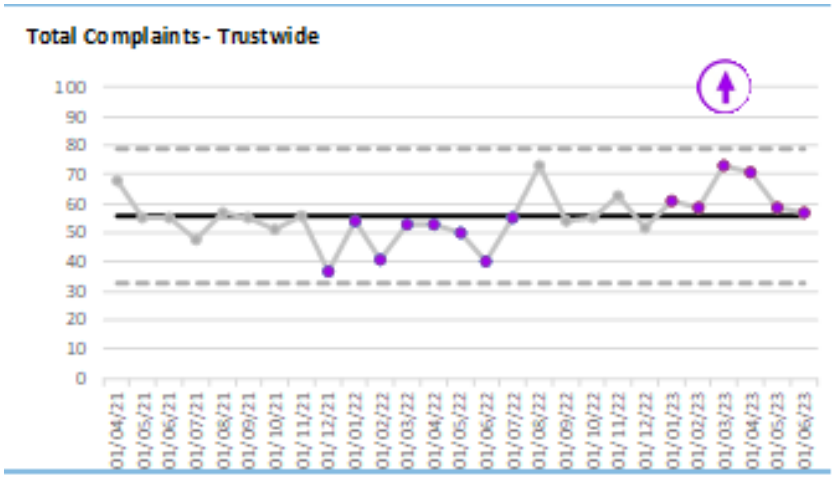
Increased safeguarding reporting generally is in line with national trends and linked to greater awareness because of the rollout of level 3 training.

In addition, the expected impact of focussed work of the SAPP team is felt to have increased reporting in some localities.

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

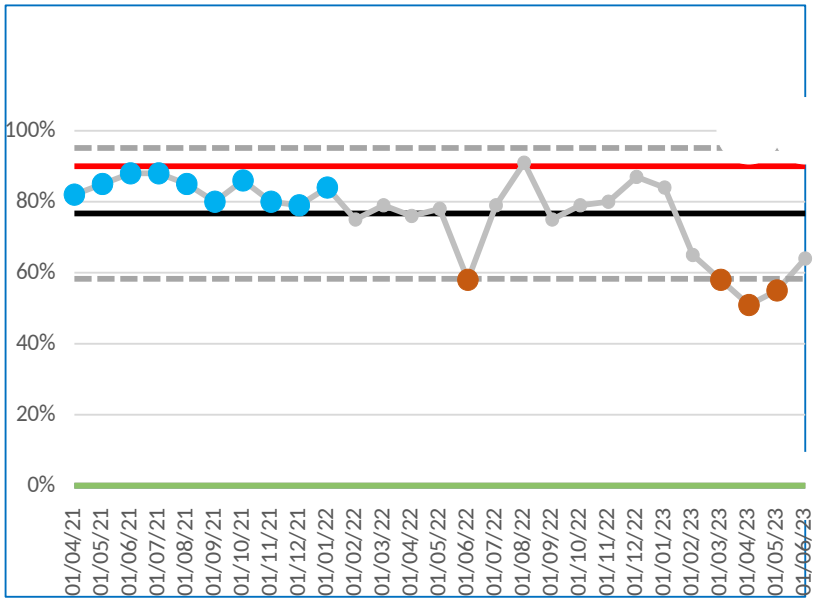
SAPP Triage have highlighted that not all safeguarding incident reports are not categorised correctly. An amendment to the data recording of outcome options via SAPP triage is to be implemented to better understand potential issues with reporting that may be impacting increased safeguarding figures and potentially reducing figures in other incident categories such as Violence and Aggression.

## *Section 7: Complaints and Claims*




**Key Points:**

- At Trust level, complaints during quarter 1 have flagged as a special cause concern, due to the numbers of complaints received being higher than average consistently for 6 months.
- This correlates to 6 months of higher than average complaints for South locality between the months of November 2022 and May 2023 – with complaints particularly involving Monkwearmouth.
- There has also been an increase in complaints regarding more specifically the waiting times for the Gender Dysphoria Service.




- Average Trustwide complaint compliance was 56.7% in quarter 1 (consistently below the target of 90%).
- A key underlying factor in the lower compliance rates seen in quarter 1 is ongoing lower capacity in the complaints team due to long term sickness and staffing vacancies. The vacancies have now been recruited and the team is up to full capacity with new staff members undergoing training.
- A review of the CNTW complaints process and resource is currently underway.
- Complaint compliance will now be scrutinised via TSG.

- Localities have been reminded to request extensions in advance of the response date, as once that date has passed an extension cannot be granted and the complaint shows out of time. This lowers the monthly compliance rate.

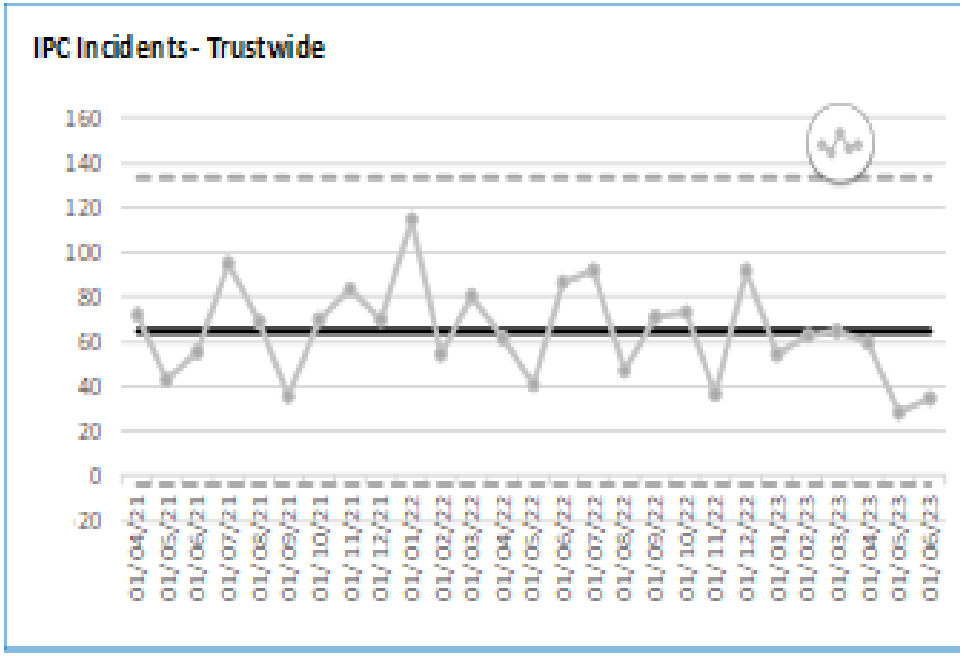
**Learning from PHSO investigations**

**PHSO investigation into complaint reference 5857**

| Date Notified | CNTW complaint Reference | PHSO Reference | Locality and Service | Details | Outcome |
|---|---|---|---|---|---|
| 12 June 2023 | 5857 | C-2093983 | Central<br><br>Newcastle West CTT | Patient A complained about the care and treatment provided by the Trust's mental health service at NWCTT. Patient A complains the Trust:<br>1. Did not know what Patient A needed every time they met the mental health team on six occasions, despite the clear letter from the Trust's Borderline Personality Disorder (BPD) hub<br>2. failed to send Patient A copies of letters it said it sent to their GP after every consultation with the Trust's mental health team<br>3. did not tell Patient A they were discharged from the Trust's mental health service until A telephoned it two to three months after they were discharged.<br><br>PHSO concluded:<br>1. The Trust wrongly understood and applied the March 2019 referral letter from its Centre for Specialist Psychological Therapies (CSPT), during the consultation in June.<br>2. It did not consider and discuss the request for a care coordinator or cognitive analytic therapy (CAT - as highlighted within the March 2019 referral letter) with Patient A during the consultation and explain whether they were suitable. If so, what options and resources were available. | Partially upheld – recommendations for a letter of apology for the distress caused, action plan to address the failings and a payment of £500.00 in recognition of the impact caused |

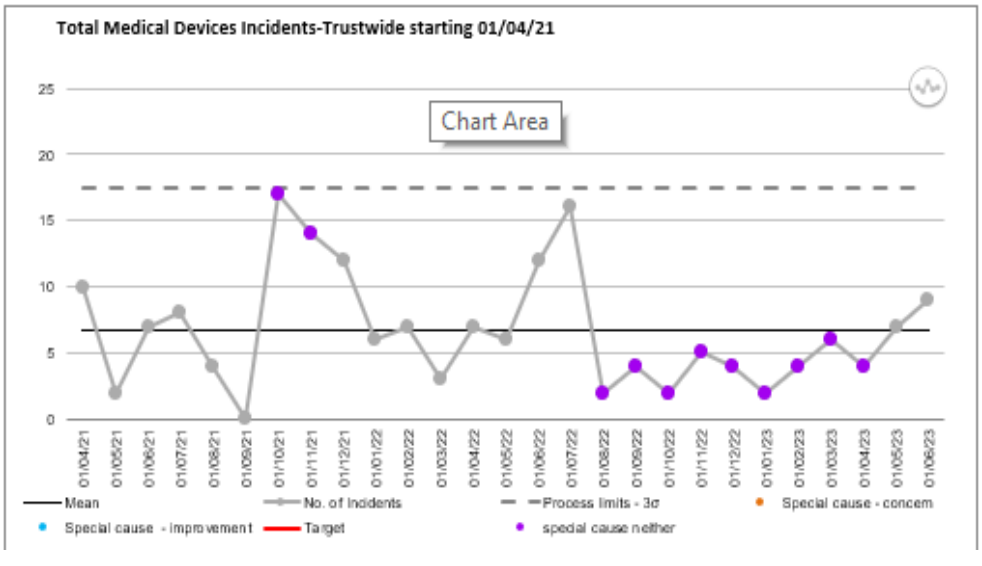
| | | | | | |
|---|---|---|---|---|---|
| | | | | 3. Did not provide sufficient explanation within its October clinic letter to why there was no role for NWCTT at that time.<br>4. Did not send Patient A a copy of the discharge letter and other clinical letters following consultations at the Trust. | |

## *Section 8: IPC and Medical Devices*




**The number of reported IPC incidents at Trust and Locality level has been in line with common variation during Quarter 1**.

- All Safeguard incident reports submitted during the Quarter were followed up by the IPC Team. IPC Incidents included advice around inoculation injuries including triage to Occupational Health, advice around management of infections including urinary tract infections and scabies, and environmental issues.
- Queries into the team are being managed by the IPC Triage system, which is working well. The Team also reviews open and closed IPC Incident Reports when they are sent through by the Patient Safety Team. There were 68 contacts received into the IPC Team in June. Queries were received via the telephone, safeguard incident reports, emails and direct from the Absence Line. Queries included therapeutic visits from animals to the wards, ventilation, management of infectious diseases, wound infections, water safety, cleaning & decontamination, and waste issues.
- During Quarter 1, the IPC Team reviewed the Inoculation Injuries Policy, the Outbreak Management PGN, and updated the Animals in Healthcare Environments PGN.




**There was a total of 20 medical devices incidents during quarter 1 of 2023/24. Month on month, these were in line with common variation in the number of reported incidents.**

Themes identified in reviewing these incidents continue to highlight the importance of clinical staff ensuring that integrity and functioning checks are undertaken on all clinical Medical Devices prior to use. This ensures prompt

fault reporting and maintenance issues and ensures a quick response to any repairs that are required, as well as ensuring compliance with safe Medical Device practice.

All incidents in this quarter have been reviewed by the PPE/Medical Devices Clinical Lead and outstanding maintenance issues have been resolved.

## *Section 9: Physical Health and Wellbeing*

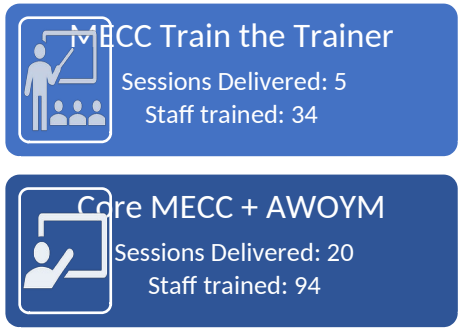
### Implementing MECC at CNTW

Making Every Contact Count (MECC) is a behaviour change approach that utilises the millions of day-to-day interactions that people have, to support them to make positive changes to their physical and mental health. It is well recognised that NHS staff have thousands of contacts every day with patients, their families and their carers, making them ideally placed to deliver opportunistic, consistent and concise healthy lifestyle information.

Implementing MECC training across the Trust aims to improve staff confidence in having opportunistic discussions with service users, thus supporting service users to make positive changes to their physical and mental health and ultimately close the inequality gap.

### Key Activities

- MECC training roll out recommenced in September 2022 following a hiatus due to Covid-19. The training includes a brief introduction to the A Weight Off Your Mind (AWOYM) Plan in order to raise awareness of the associated work and the rationale for tackling excess weight across the Trust. Since then, numbers of training sessions delivered and staff trained are as follows:



- In addition to a general programme of training dates training has also been offered to specific teams as a means of encouraging attendance. This approach has worked well and has made the training more accessible for staff by incorporating it into existing meetings or training/development sessions.
- CNTW MECC Trainers Forum set up to support staff trained as MECC trainers, particularly those who had received training prior to Covid and needed to update and refresh their knowledge and skills. Three sessions held to date, now provided on an ad hoc basis for those who require them, although the associated Teams chat forum is ongoing for sharing information and best practice.
- Partnership working between CNTW and Northumberland County Council, Newcastle City Council and Northumbria Healthcare NHS Foundation Trust to provide monthly MECC updates in relation to different topic areas – these have included alcohol awareness, oral health, physical activity and smoking cessation. Other sessions are planned for the forthcoming months.
- Working in partnership with Northumbria University to support a research study looking at the evaluation of MECC to support healthy weight within a mental health trust setting. There are various packages of work within this, including documentary analysis, surveys and interviews with staff and service users. We look forward to reviewing the findings of this research to inform practice in the future.
- CNTW presented a workshop at a regionwide MECC conference ('MECC: How do you reach 3 million people?') in June 2023 to highlight the work on the implementation to date and the involvement in the above research study.
- CNTW also presented at the Regional MECC Forum in July 2023 to MECC leads across the region about the work that CNTW have done in relation to the implementation of MECC.
- A MECC Implementation Plan had been developed with various strands of work included – this is now monitored through the CNTW Health Improvement and Public Health Meeting.
- The MECC approach has started to be incorporated into other training, such as 'Brief Interventions in Smoking Cessation for Mental Health Settings Training', to raise awareness of the benefits of utilising the MECC approach to support other key public health and wellbeing messages

**VTE Assessment Data:**

Whilst, as a Trust, we achieved 96% compliance overall, only 77% of risk assessments were completed on admission. The guidance from NHS England is 95% completion which we have achieved, however, NICE guidance suggests that completion should take place within 14 hours in order that prophylaxis/treatment medication can be commenced, if needed, as soon as possible. It does not appear from the current data that we currently achieve that. The report for this audit is currently in the process of completion.

As a Trust we are moving to a new pressure ulcer risk assessment tool in September, Safer Care are currently completing an audit on BRADEN completion, as this is the tool we have been using for several years. We then plan to audit the new tool, PURPOSE T, in December 2023 and March 2024 to evaluate its implementation and compliance.

Overall, VTE risk assessment and BRADEN risk assessment completion is improving – data from June sets the completion rate for VTE risk assessment at 80% (rising from 74% in May, 70% in April and 75% in March), and 85% for BRADEN risk assessment which remains the same as May, however, this is an improvement on the compliance in March and April which was reported as 82% and 83% respectively.

**QUIT Team:**

- At the end of June 23, 95 patients were still currently active with the service.
- For each month the 28 day review showed the following patients had successfully remained abstinent from smoking at 28 days

| | |
|---|---|
| April | 5 |
| May | 10 |
| June | 13 |

- A total of 26 patients have completed a 12 week programme of support.
- The service continues to offer training which is available to all staff across the Trust
- We continue to have Pilots running across 7 wards and 2 localities. These are continuing to be well received by the patients
- The QUITT collaborative continues to run. Our first project which was staff offering Very Brief Advice and undertaking a carbon monoxide reading at the well man/women clinics to try to engage patients into the service was not successful and did not generate any new or re-referrals to the service . We have now moved to our second project which is for the Tobacco Advisor to attend the weekly mutual help meeting to educate patients regarding the smokefree policy and informing them of support available. Patients who would like to engage with the advisor will be offered a refillable vape and support.
- The NHS staff offer continues to run with almost 500 CNTW staff signed up for support to stop smoking.
- A conference is being held for staff on 19th October at Hexham Abbey.

## 11. 5-POINT PLAN ADDICTION SERVICES

Rajesh Nadkarni, Deputy Chief Executive / Medical Director

presentation

### REFERENCES

Only PDFs are attached

11a. cover sheet 5 point plan June 2023 Final (004).pdf

11b. 5 Point Plan - Progress on a Page (v2 July 2023).pdf

| | |
|---|---|
| **Name of meeting** | **Board of Directors Public Meeting** |
| **Date of Meeting** | **2nd August 2023** |
| **Title of report** | **Addictions Development (5 Point) Plan – Progress Update** |
| **Executive Lead** | **Dr Rajesh Nadkarni** |
| **Report author** | **Dr Margaret Orange/David Muir/ Prof Eilish Gilvarry** |

| **Purpose of the report** | |
|---|---|
| **To note** | |
| **For assurance** | |
| **For discussion** | **x** |
| **For decision** | |

| **Strategic ambitions this paper supports (please check the appropriate box)** | |
|---|---|
| **1. Quality care, every day** | x |
| **2. Person-led care, when and where it is needed** | x |
| **3. A great place to work** | x |
| **4. Sustainable for the long term, innovating every day** | x |
| **5. Working with and for our communities** | x |

| **Meetings where this item has been considered** | |
|---|---|
| Quality and Performance | |
| Audit | |
| Mental Health Legislation | |
| Remuneration Committee | |
| Resource and Business Assurance | |
| Charitable Funds Committee | |
| Provider Collaborative/Lead Provider | |
| People | |
| CEDAR Programme Board | |
| Other/external (please specify) Addictions Strategic Clinical Network | x |

| **Management meetings where this item has been considered** | |
|---|---|
| Executive Management Group | |
| 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 | x | Reputational | x |
| Workforce | x | Environmental | |
| Financial/value for money | x | Estates and facilities | |
| Commercial | | Compliance/Regulatory | |
| Quality, safety and experience | x | Service user, carer and stakeholder involvement | x |

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

# Addictions Development (5 Point) Plan - Progress on a Page

**July 2023** (MO, v2)

## 1.Background, Drivers, and Opportunities

The harm caused by Drugs and Alcohol in the North East of England is extensive, affects all our communities and places pressure on many public services. We have a far bigger problem related to substance misuse than most other places in England and recent data from a range of sources highlights that this problem is increasing, and the North East continues to see statistically higher rates of harm than other areas. Alongside this, there is a high prevalence of co-occurring conditions in mental health and alcohol/drug treatment populations in community and prison settings.

These increasing harms and prevalence are occurring in a context of reduced funding and changing commissioning/procurement arrangements in the field of substance misuse. Some of the significant changes which are driving the need for change in the system are:

- **Commissioning changes** – LA commissioned, move to abstinence model (rather than maintenance), focus on successful completion, reduced funding, reduced NHS providers -third sector highest provider of services
- **Alcohol and Drug related harms**- increased morbidity and mortality – 20% increase in alcohol mortality, NE is double the national DRD rate
- **Coexisting mental health** -alcohol and drug dependence are common among people with mental health problems and the relationship between them is complex.
- **Changes to treatment services** – reduction of in-patient detoxification and significantly reduced funding

**However,** recent reviews of drug treatment services (**Dame Carol Black - DCB**), a new Drug Strategy (**From Harm to Hope**) bringing new investment, and a National **Drug and Alcohol Related Death Action Plan** have all revived the sector and allowed us the opportunity to improve and develop services with national and local support.

In order to continue to understand and respond to the challenges presented by the changing landscape in Addictions, and to ensure we continue to be seen as a leading specialist provider in the North East, CNTW developed an Addictions Improvement Plan to support a clear and structured approach to consolidate and improve our current offer, retain our existing services, and ensure we are well placed to take new opportunities as they emerge.

## 2. The Plan


1 Learning Lessons

Thematic Review of deaths 'in treatment' – All LAARs /SI
Thematic Review of all Actions from LAAR/SI (3 yr. period)
Review repeat themes – how is learning embedded?
Review of all Addiction Complaints

2 Review and develop Addiction Specialism

Review the impact of the changes in the Specialist Service approach compared to CBU approach- revise according to learning to ensure that Addictions are seen as a specialist provision in the Trust. Centralising key functions i.e., staffing, training, pathways, standards
Ensure a centralised approach to managing new business, reviewing tenders etc.

3 Improve awareness of addiction across the Trust

Embed the **'Everyone's job'** and **'no wrong door'** approach into the Trust ensuring Mental Health Services feel they have the confidence, competency, and capability to manage addiction issues in their service and feel supported by a specialist Trust wide Addiction Service as required.

4 Improve and standardise pathways

Ensure pathways for all localities have a clear and standardised offer for Alcohol and Drug presentations and that these offers have evidence based and agreed standards. Develop a clear approach to scaffolding from Addiction Services.
Review existing services for potential opportunity in relation to changing needs and national funding emerging i.e., provision of detoxification beds, provision of partial hospitalisation etc.

5 Improve workforce skills and competency

In line with the DCB review, ensure a clear Addictions Competency Framework for all roles in our Trust. All clinical/assessment staff should be aware of alcohol screening, how to undertake an Alcohol Use Disorders Identification Test (AUDIT), all inpatient staff should be aware of the management of addiction and detoxification.
Ensure that we have a clear workforce plan to support the competency framework with an annual general and specialist training offer.

## 3. Progress to date

### 1

- 3yr Review of all LAARs and learning (Deaths in Treatment)
- Homicide Review – Recommendations for service improvement
- Governance Dashboard – available quarterly and End of Year
- Quarterly Dashboard briefings for staff – locality/learning focussed

**Repeat Themes;** Naloxone (distribution and recording), Safeguarding (Professional Curiosity), Frequency/form of follow up, Core Documentation/FACE Risk Assessment, NoK/Duty of Candour

### 2

- CBU discussions around amalgamation of Addiction Services to Specialist Services v Locality model
- Recommended amalgamation based on challenges
- 'In principle' agreement for Addiction services to be brought back together as a 'Specialist Service'
- Decision to pursue and retain contracts
- National Profile maintained and increased

**Significant Links:** ICB – alcohol and mental health (Chair meetings), Commissioned to develop ICB Addictions (Alcohol) web-based training, National Alcohol Guidelines Steering Group, National Competency Framework Expert Group, National DRD Audit, OHID – Regional and National Links, Research – Injectable OST, Non-fatal overdoses, Publications – Alcohol and the Ageing

### 3

- Review of Policy – Relaunch with new language
- Trust training review - Establish training in co-occurring conditions – Train the Trainer model - Dual Diagnosis Forum
- BFOL in mental health (digital support)
- Increase in physical and respiratory care

**New Developments:** No Wrong Door, Everybody's Business approach, Policy approach in ICB taken from CNTW Policy, Digital Support for wider Trust

### 4

- Establish detoxification bed and detoxification coordinator
- Bed in place - >60 detoxes to date
- Out of area pathway established for complex presentations
- Scaffolding revised to support in-pt. settings/training

**Challenges:** Business case to expand number of detox beds – waiting list currently generated - 5 months.
Stigma - understanding of Addictions in Trust

### 5

- Training plan developed/delivered
- >1000 training places across range of topics
- ICB training commissioned – alcohol
- Role in national developments – competencies

**Achievements:** Role in National Competency development, awarded addiction Training budget to maintain annual training programme

## 4. Forthcoming Priorities

Whilst there has been significant investment in addiction services, this funding is time limited to March 2025 and there are clear expectations in relation to local metrics to maintain and attract future funding, these include:

| |
|---|
| **Decreasing Drug Related Death by 1000 by 2025 – this has a significant implication for services in the North East where Drug Related Death is rising year on year and majority of deaths are not in treatment** |
| **Increase numbers in treatment – decrease caseload sizes** |
| **Improving Continuity of Care for those leaving prison – 80% target** |
| **Increasing numbers of service users entering Residential Rehabilitation – these pathways are usually led by the LA** |

## 5.Going Forward

Alongside progress and ongoing action plan, to support forthcoming national priorities and secure future funding, activity is also planned in relation to the new metrics around;

| |
|---|
| **Train the Trainers for Northumbria Police – administration of naloxone – policy development – September 2023** |
| **Full staff training re Fire in the Home and links to Addiction – TWFRS – August 2023** |
| **Training for Primary Care – Storage and Administration of Naloxone – Autumn 2023** |
| **Audit/Research and service Development – Non-fatal overdoses** |

# 12. ANNUAL INFECTION, PREVENTION AND CONTROL ANNUAL REPORT 2022/23

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

## REFERENCES

Only PDFs are attached

12. IPC Annual Report 2022-23 FINAL_.pdf

| | |
|---|---|
| **Name of meeting** | Board of Directors |
| **Date of Meeting** | 2 August 2023 |
| **Title of report** | Annual Report on Infection Prevention and Control 2022 – 2023 |
| **Executive Lead** | Sarah Rushbrooke, Executive Director of Nursing, Therapies & Quality Assurance |
| **Report author** | Elizabeth Hanley, Associate Director Nursing & Quality; Kelly Stoker, Head of Infection Prevention and Control; Sam Cooke, Senior Infection Prevention and Control Nurse |

| **Purpose of the report** | |
|---|---|
| **To note** | ✓ |
| **For assurance** | ✓ |
| **For discussion** | |
| **For decision** | |

| **Strategic ambitions this paper supports (please check the appropriate box)** | |
|---|---|
| **1. Quality care, every day** | ✓ |
| **2. Person-led care, when and where it is needed** | ✓ |
| **3. A great place to work** | ✓ |
| **4. Sustainable for the long term, innovating every day** | ✓ |
| **5. Working with and for our communities** | ✓ |

| **Meetings where this item has been considered** | |
|---|---|
| Quality and Performance | ✓ |
| Audit | |
| Mental Health Legislation | |
| Remuneration Committee | |
| Resource and Business Assurance | |
| Charitable Funds Committee | |
| Provider Collaborative | |
| People | |
| CEDAR Programme Board | ✓ |
| Other/external (please specify) | |

| **Management 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 and experience | ✓ | Service user, carer and stakeholder involvement | |

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

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

# 2022/23 Annual IPC Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

## Contents

# Introduction

The Annual Report of the Director of Infection Prevention and Control (DIPC) provides the Infection Prevention and Control Committee, Quality and Performance Committee, and the Trust Board with a summary of activity relating to assurance and developments during 2022/23 relating to Infection Prevention and Control (IPC) across the Trust.

The IPC function carried out across the Trust meets statutory requirements and is in line with the Health and Social Act 2008. The Infection Prevention and Control Team is responsible for ensuring the delivery of the 2022/23 Infection Prevention and Control Annual Plan.

Following the COVID-19 pandemic which necessitated a significant IPC Team response in order to support the implementation of national guidance to ensure patient and staff safety, the IPC team has been working towards returning to 'business as usual' work streams with lessons learnt embedded from the pandemic, as we move into 2023.

## 1.1 Infection Prevention and Control team structure

The Infection Prevention and Control Team consists of:

- Director of Infection Prevention and Control (DIPC)
- Associate Director (Nursing and Quality)
- Head of Infection Prevention & Control
- Infection Prevention & Control Lead Nurses x 2WTE
- Infection Prevention & Control Nurses x 2WTE

Consultant Microbiologist/Infectious Disease Consultant support is obtained by a Service Level Agreement with Northumbria Healthcare Foundation Trust.

The IPC team has good working internal relationships with Clinical Business Units (CBUs), wards and clinical teams, in addition to external stakeholders within the Public Health Teams in Local Authorities and other regional Infection Control teams, which are vital to the success of preventative, responsive and effective IPC measures. These working relationships have been strengthened even further during the COVID-19 pandemic.

- This report is presented to the Board by the Director of Infection Prevention and Control (DIPC). Key Performance Indicators data is received by the Board on a quarterly basis in the quarterly Board Assurance Framework reports, the Safer Care report and by exception.
- The IPC Committee (chaired by the DIPC) meets quarterly, and reports to the Trustwide Quality and Performance Committee.
- The IPC Assurance Group meets monthly and is chaired by the Associate Director Nursing and Quality. The Assurance Group reports any exceptions into the IPC Committee.

## 1.2 Microbiology Support

The Trust holds arrangements for Microbiology services with Northumbria Healthcare NHS Trust, Newcastle Hospitals NHS Trust, Gateshead Health NHS Trust, South Tyneside and Sunderland Hospitals NHS Foundation Trusts and North Cumbria Integrated Care NHS Foundation Trust. Results are available through the electronic Integrated Clinical Environment (ICE) system. The Trust is assured that these services operate to the standards required for accreditation by the Clinical Pathology Accreditation (UK) Limited.

## 1.3 External Accreditation Bodies

Registration with the Care Quality Commission (CQC). The Trust received unconditional registration to the Health and Social Care Act and Associated Code of Practice in 2008 (2015)

# 2.0 Infection reporting and IPC Surveillance

Infection surveillance data is reviewed at each IPC Committee meeting and incident data is shared monthly within the Safer Care monthly report to the Trust Leadership Team and quarterly report to the Trust wide Quality and Performance Committee and the Trust Board.

## 2.1 MRSA bacteraemia and Clostridium difficile

Any incident where a patient develops a Methicillin-Resistant Staphylococcus aureus (MRSA) bacteraemia, or a Clostridium difficile toxin-positive infection isolated from a stool specimen whilst in CNTW will be investigated utilising Root Cause Analysis (RCA) methodology. The case will be reported through the IPC Committee and the Governance Subgroups and, where appropriate, through the National Reporting System.

As required, mechanisms exist to report data on Clostridium difficile and MRSA bacteraemia in the six-monthly performance report, which is reviewed by the Trust Board.

**Table 1:** IPC – KPI reporting.

| KPI | Detail | 2017/18 | 2018/19 | 2019/20 | 2020/ 21 | 2021 /22 | 2022/23 |
|---|---|---|---|---|---|---|---|
| **IPC-KPI 01** | Cases of MRSA bacteraemia | 0 | 0 | 0 | 0 | 0 | 0 |
| **IPC-KPI 02** | Cases of clinical clostridium difficile infections | 1 | 2 | 0 | 0 | 5 | 8 |

***Source: Trust records***

### MRSA bacteraemia

There were no cases of MRSA bacteraemia in the period 2022 / 2023.

### Clostridium Difficile infection

There was a total of eight Clostridium difficile infections cases identified within CNTW in 2022/23. Fifty percent of these were found to be Glutamate Dehydrogenase (GDH) positive

and toxin positive. For best practice, all reported cases were actively followed up. The root cause analysis for all cases were attributed to either the community or another hospital Trust. IPC precautions were implemented according to Trust policy.

**Reported diarrhoea and and/or vomiting outbreaks**

There have been several sporadic cases of diarrhoea and vomiting reported across the Trust, with one outbreak declared during 2022/2023 (patients only) and Norovirus was isolated.

Learning highlighted that each case was isolated in a timely manner with outbreak control measures implemented effectively and resolved within the expected timescale. Infection prevention and control measures including PPE, isolation, environmental cleaning, and handwashing were effective in preventing further spread.

## 2.2 IPC Dataset 2022/23

Table 2 table includes all incidents, suspected, and confirmed infections that are related to IPC. Notifications are reported to IPC team via the trust web-based electronic incident management system. Following notification, the IPC team triage and where required provide the necessary support and advice.

**Table 2:** Notifications via the trust web-based electronic incident management system.

| | Apr 2022 | May 2022 | Jun 2022 | Jul 2022 | Aug 2022 | Sep 2022 | Oct 2022 | Nov 2022 | Dec 2022 | Jan 2023 | Feb 2023 | Mar 2023 | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IPC45 COVID-19 Advice | 24 | 5 | 40 | 70 | 9 | 35 | 38 | 6 | 37 | 18 | 28 | 12 | **322** |
| IPC09 Suspected/ Confirmed Infection | 11 | 18 | 24 | 14 | 20 | 15 | 15 | 12 | 21 | 19 | 14 | 10 | **193** |
| IPC40 Urinary Tract Infection (UTI) | 8 | 8 | 5 | 4 | 7 | 14 | 6 | 7 | 13 | 3 | 6 | 12 | **93** |
| IPC23 Other | 6 | 2 | 12 | 3 | 10 | 4 | 6 | 4 | 7 | 6 | 5 | 15 | **80** |
| IPC41 Chest Infection | 2 | 1 | | | 4 | 3 | 1 | 4 | 6 | 3 | 3 | 4 | **31** |
| IPC42 Legionella Water Safety Test | 2 | 2 | 2 | 2 | | 1 | 3 | 3 | 4 | 3 | 1 | 3 | **26** |
| IPC06 Dental/Oral Infection | 2 | 3 | 2 | 1 | 2 | 1 | | 2 | | 1 | 2 | 3 | **19** |
| IPC07 Gastrointestinal (GI) Viral | 1 | 6 | 1 | | | 2 | 4 | | 1 | | | 1 | **16** |
| IPC24 Influenza Like Illness | | | | | | | 1 | | 8 | | | 1 | **10** |
| IPC25 Sepsis | 3 | | 1 | | | | 2 | | | | 1 | 2 | **9** |
| IPC19 Helminth (Worm) Infections | 3 | | 1 | | | | | | | 1 | | | **5** |
| IPC17 HIV | | | | | 1 | | | | | | 3 | | **4** |
| IPC20 Scabies | | | | | 1 | 1 | | | | 1 | 1 | | **4** |
| IPC26 C*. Difficile GDH +ve Toxin +ve | | | | | 1 | 1 | | 1 | | | | 1 | **4** |
| IPC02 MRSA: Infection | 2 | | | | | | | 1 | | | | | **3** |
| IPC04 Staphylococcal Infection | | 1 | | | | | | | | 2 | | | **3** |
| IPC27 C*. Difficile GDH +ve Toxin -ve | | | 1 | 1 | 1 | | | | | | | | **3** |
| IPC01 MRSA: Colonisation | 1 | | 1 | | | | | | | | | | **2** |
| IPC08 GI Bacterial | | | | | | 1 | | 1 | | | | | **2** |
| IPC12 Chickenpox | | | 1 | | | | | | | | 1 | | **2** |
| IPC13 Shingles | | | | | | | | | 1 | | | 1 | **2** |
| IPC21 Legionnaires Disease | | | | | | 1 | | | 1 | | | | **2** |
| IPC38 Confirmed Influenza | | | | | | | | | 1 | 1 | | | **2** |
| IPC16 Hepatitis - Type C | | | | | | | 1 | | | | | | **1** |
| IPC18 Fungal Infection | | | 1 | | | | | | | | | | **1** |
| IPC28 C*. Difficile GDH -ve Toxin -ve | | | | | 1 | | | | | | | | **1** |
| **Total** | **65** | **46** | **92** | **95** | **57** | **79** | **77** | **41** | **100** | **58** | **65** | **65** | **840** |

***Clostridium Difficile**

## 2.3 COVID-19

A total of 339 patients tested positive between April 2022 – March 2023 and each patient had a risk assessment completed to determine possible source of transmission. Of these 339 patients, the majority were categorised as community acquired; and those identified as nosocomial were identified through routine surveillance screening or because of outbreak surveillance screening.

During the same reporting period, the number of COVID-19 outbreaks declared is shown in Table 3. Fifty outbreaks were reported overall.

**Table 3: Outbreaks declared by locality**

| Locality | Total Number of outbreaks |
|---|---|
| South | 18 |
| Central | 14 |
| North | 13 |
| North Cumbria | 5 |
| **Total** | **50** |

Clusters and outbreaks were all risk-assessed and managed as per the Outbreak Management PGN and the COVID-19 PGN. In addition, all confirmed outbreaks were entered onto the NHSE National Outbreak Surveillance.

Outbreak management included convening outbreak meetings, IPC review meetings, daily ward contact with staff, and each outbreak concluded with a learning debrief.

Exceptions highlighted from the lessons learnt meetings included:

- Poor Ventilation on several wards
  - No mechanical ventilation and reliance on natural ventilation through the opening of windows. However, the opening of windows to allow for natural ventilation was not always possible in some clinical settings for security purposes.

- Poor IPC measures
  - Inconsistencies with clinical practices relating to Personal Protective Equipment (PPE) use, hand hygiene and cleaning of patient equipment.

- Lack of patient engagement
  - Resistance by patients to wear a face mask, when required.

- Community exposure
  - Patients having unescorted leave away from the ward increasing their exposure to community transmission.

- Inpatient testing programme
  - Delay in the testing of symptomatic patients and therefore a delay in implementing appropriate control measures which contributed to the

transmission of COVID-19, or the incorrect test being used (LFT rather than PCR).

## 3.0 Key achievements 2022/23

Changes to UKHSA guidance regarding COVID-19 have continued over the course of 2022/23 with significant changes being noted both nationally and locally, specifically in relation to PPE and the testing requirements for COVID-19. The team has continued to respond in a timely way, reviewing the position and supporting Gold Command with any operational changes required.

Any changes were managed through Gold Command, and communicated via the IPC Assurance Group members, and weekly communication bulletins, as well as the Trust communication policy plans.

The IPC team delivered bespoke training where identified as needed and also supported NTW Solutions, both with training needs and cleanliness audits across the Trust.

### 3.1 Infection Prevention and Control Practice Guidance notes (PGNs)

PGNs that required updating have been reviewed and finalised this financial year in line with the three yearly Trust requirement. See appendix 1.

### 3.2 Seasonal Influenza ('flu) Vaccination Campaign

The National flu immunisation programme 2022/23 was launched on the 10th October 2022. The model of delivery included clinics within each locality, as well as roving and peer vaccinators. Within each locality, there were appointed Vaccination Leads, who were Associate Nurse Directors. They had responsibility for both staff and patients in their locality to ensure they received all the required vaccination information and that they were well-informed regarding where they could access the vaccine, as well as ensuring patient consent was appropriately obtained and documented or supporting best interest decisions. The Covid-19 booster and 'flu vaccine was made available to all staff members, including key partners; employees of commissioned services; regular agency workers and health and care students on placement.

At the end of the campaign (March 2023) it was reported that 55.1% (3887) of all frontline staff had received a 'flu vaccine.

**Table 4:** Influenza vaccine - uptake by staff group

| Frontline Staff Group | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|
| Doctors | 80.25% | 69.7% | 62.9% |
| Qualified Nurses | 84.62% | 69.2% | 55.3% |
| All other professionally qualified staff | 88.96% | 78.0% | 65.3% |
| Support to clinical staff | 83.80% | 63.0% | 49.0% |

*Vaccination uptake over the last three years amongst frontline staff*

As in previous years, we offered vaccination to everyone working for CNTW and NTW Solutions, including all staff who deliver frontline care to our patients.

A total of 177 staff members were trained via e-learning from nursing and other professional groups in flu and COVID-19 vaccine administration.

## 3.3 COVID-19 Vaccination Programme 2022/23

The COVID-19 autumn booster was offered to individuals aged 50 years and older, residents in care homes for older people, those aged 5 years and over in a clinical risk group and health and social care staff. This was in line with Joint Committee on Vaccination and Immunisation (JCVI) recommendations.

The model of delivery included clinics within each locality and roving and peer vaccinators. Within each locality, there were appointed Vaccination Leads who were Associate Nurse Directors. They had responsibility for both staff and patients in their locality to ensure they received all the required vaccination information and that they were well-informed regarding where they could access the vaccine.

At the end of the campaign (February 2023) a total of 51.1% of staff members had received their autumn booster.

## 3.4 Training in Infection Prevention and Control

Staff employed by CNTW access the IPC training via e-Learning. The e-Learning programme is a national programme that fulfils statutory requirements. IPC training is currently a requirement of induction and at every three years thereafter for all staff. See appendix 2.

Bespoke sessions have been delivered via Teams by the IPC team when required to groups of staff who require specialist knowledge specifically in relation to the roles that they undertake.

Training performance reports have been monitored by each locality care group via their Quality and Performance meetings, IPCC, and IPC Assurance meetings.

## 3.5 Audit

The IPC team undertakes audits to measure the effectiveness of healthcare and service delivery against agreed standards to implement, where necessary, improvements and changes at individual, team, or service level. This includes joint cleanliness audits with Facilities and Estates colleagues on a rolling programme.

## 3.6 IPC Risk Assessments

It is a requirement that the Trust complies with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance .

Criterion 1 states that providers should demonstrate systems to manage and monitor the prevention and control of infection using risk assessments to consider the susceptibility of service users and any risks that their environment and other users may pose to them.

Inpatient and community services in CNTW have an IPC Risk assessment undertaken by a member of the IPC team, accompanied by a senior member of the nursing team of that ward / service.

This is an opportunity for the IPC team to observe practice and the environment to ensure practices comply with IPC PGNs and national guidance, as well as developing and maintaining good working relationships with staff and patients. See appendix 3.

The IPC Risk assessment was developed by combining audit tools from the Infection Control Nurses Association for Monitoring Infection Control Standards 2004 and the Infection Prevention Society Quality Improvement Tools for Mental Health tool 2013.

Each section has a percentage score which indicates the level of compliance.

The IPC risk assessment tool is currently being reviewed and developed into an electronic format and the assessments will continue to be undertaken as part of a rolling programme throughout the year. This format will allow for more detailed analysis and identifying themes, as well as decreasing the time taken to complete.

Following completion of the IPC Risk assessment an action plan is compiled, ensuring that any comments raised in the assessment are also included. The formulation of this action plan is the responsibility of the ward / service. The completed risk assessment is shared with the Ward Manager, Clinical Nurse Manager, and Associate Nurse Director for information and further action if required. Identified lessons learnt are discussed at the IPC Assurance meetings.

## 3.7 Decontamination and Medical Devices

### Decontamination

Contaminated equipment can lead to the spread of infection. Decontamination of equipment is addressed during IPC training and revisited at every opportunity with clinical staff. This reinforces the relevance and importance of the process.

The IPC Team continue to work closely with NTW Solutions to review and keep up to date with new cleaning products to ensure we are using the safest, most effective and value for money products.

### Medical Devices

The Clinical Lead for Medical Devices is part of the Nursing and Quality team. The IPC team and the Clinical Lead for Medical Devices work together to ensure that all medical devices are compliant with infection prevention & control standards in relation to cleaning.

## 3.8 Trust Water Safety Group

The DIPC, with support from the IPC team, has ensured that water safety standards have been met in 2022/23. The Trust Water Safety Group (TWSG) has continued to meet on a

regular basis throughout the year. The aim of the Trustwide group is to identify, analyse and propose remedies for risks relating to water safety (including Legionella).

Key themes highlighted from the Water Safety report include:

- Audits have been completed in all sectors and audit reports received. The results were overall of a high compliance, with some minor actions noted.
- All sectors continue to make progress through the identified actions and overall compliance is high.
- Risk assessments completed with 100% compliance. Any actions associated with those assessments are either completed or in progress.
- Training has now been delivered to all members of the TWSG and further training will be booked as necessary going forward.

The focus of the group remains the multi-disciplinary management of infrastructure and services to ensure prevention of contamination, swift eradication, or control and minimisation of water borne bacteria including Legionella.

## 3.9 Management Policies for Water Safety

The Trust has in place both Policies and Practice Guidance Notes (PGNs), which have been reviewed and ratified this year (appendix 1), along with specific Estates management procedures that encompass all issues associated with water safety.

## 3.10 Training for Water Safety

Both the Trust and NTW Solutions have continued to invest in specialist training for a wide range of staff, including, Estates Maintenance, Capital Projects, Facilities, and IPC nurses, with a number undertaking the detailed ILM Responsible Person course.

## 3.11 Risk Assessments and Audits

The Trust is maintaining the requirement of having risk assessments in place across all premises, reviewed on a biannual basis or when major changes take place. The Trust also continues to have independent management audits carried out by external specialists in Legionella Management and Water Safety and the team is regularly complimented on their high standards and recognisable cross-disciplinary working.

## 3.12 Annual Cleaning Services Report

Domestic services are provided by NTW Solutions Limited which is a completely owned subsidiary of the Trust. The cleanliness standards throughout the Trust have continued to remain consistently high, as evidenced by the monthly reports which reflect the inspections carried out during this reporting period.

There continues to be an excellent working relationship between Facilities staff, who are responsible for cleanliness and ward managers/nursing staff and the IPC Team. This co-operation helps to promote a team approach in maintaining high standards of cleanliness in clinical environments. It also assists in identifying at an early stage any problems, which enables them to be resolved in a timely way. Regular meetings take place between the senior Facilities Managers and the IPC Team. At these meetings any areas of concern are discussed, and actions agreed.

## 3.13 Cleanliness Audits

The cleanliness audits are carried out in all clinical areas monthly, and non-clinical areas less frequently, determined by the risk. Taking part in these audits are a Qualified nurse, Facilities supervisor, Estates officer and a member of IPC team, as appropriate. This approach of having a multi-disciplinary team undertake this work enables all factors that can impact on the standards of cleanliness to be examined and assists in ensuring that corrective action is undertaken in a timely way.

Despite a challenging time during the COVID-19 pandemic, the domestic services team progressed the cleaning strategy to ensure that the Trust continues to achieve full compliance with the new National Standards of Healthcare Cleanliness (NSoHC).

Cleanliness star ratings are also a new feature of the NSoHC. The star rating score enables greater transparency for the patients and public, allowing them to see the most recent cleanliness score of the area they are being treated or residing in.

### Staffing

The Domestic teams have consistently achieved the organisation's targets for all statutory and mandatory training and appraisals. There have been some occasions when sickness has exceeded target levels, at different times of the year, however, through careful monitoring of cleanliness conditions and management of staff, this has not led to any on-going drop in standards.

### Patient Led Assessments of the Care Environment (PLACE)

PLACE assessments were carried out between September – December 2022, with the results published at the end of March 2023. This was the first time a formal PLACE assessment had been carried out since 2019, due to the COVID-19 pandemic.

National Health Service England (NHSE), which manages the PLACE system, has stated that scores are not directly comparable with previous years due to question and weighting changes. However, across the six domains, the 2022 assessment placed CNTW above the national average for each domain.

When compared against the mental health / learning disability (MH/LD) peer group, the scores for the Cleanliness, Overall Food, Condition, Appearance and Maintenance remained above the average.

All areas were formally inspected, except for Lotus Ward in Middlesbrough, which was scheduled in for inspection, but this could not be included in the report as only one inspector was available on the day (the inspection was undertaken but did not meet the PLACE criteria for inspectors).

The full report will be presented to the relevant Board Committees in July 2023.

**Summary**

The IPC Team, alongside the NTW Solutions Limited, have worked with locality care groups and other services within the Trust, to ensure the safe and effective implementation of all IPC measures across the Trust during the 2022/23 period are in line with the statutory requirements of the Health and Social Care Act 2008.

The Board is asked to note the content of the Annual Report on Infection Prevention and Control 2022-2023.

## Appendix 1

## Infection Prevention and Control Practice Guidance Notes (PGNs) updated in 2022/23

| Document No: | Document Name | Author | Responsible Person | Version/Issue | Ratify Date | Issue Date | Review Date |
|---|---|---|---|---|---|---|---|
| CNTW(C)23 | Infection Prevention and Control Policy | Kelly Stoker | Sarah Rushbrooke | V07.1 | Nov-21 | Nov-21 | Nov-24 |
| IPC-PGN-02.1 | Standard Precautions | Samantha Cooke | Sarah Rushbrooke | V06 | Feb-21 | Feb-21 | Feb-24 |
| IPC-PGN-03.1 | Safe Use and Disposal of Sharps | Samantha Cooke | Sarah Rushbrooke | V05 | Jan-21 | Jan-21 | Jan-24 |
| IPC-PGN-04.1 | Hand Hygiene and the Use of Gloves | Samantha Cooke | Sarah Rushbrooke | V05 | Feb-22 | Feb-22 | Feb-25 |
| IPC-PGN-05 | Reporting and Notification of Infectious Diseases | Kelly Stoker | Sarah Rushbrooke | V06 | Mar-23 | Mar-23 | Mar-26 |
| IPC-PGN-08 | Isolation of Infected Patients in Hospital | Samantha Cooke | Sarah Rushbrooke | V05 | Jun-21 | Jun-21 | Jun-24 |
| IPC-PGN-09 | Precautions to be Taken After the Death of an Infected Patient | Samantha Cooke | Sarah Rushbrooke | V05 | Jun-21 | Jun-21 | Jun-24 |
| IPC-PGN-10 | Medical Devices and Equipment – Cleaning & Decontamination | Kelly Stoker | Sarah Rushbrooke | V06 | Jun-21 | Jun-21 | Jun-23 |
| IPC-PGN-13 | Lice, Fleas and Scabies Prevention | Samantha Cooke | Sarah Rushbrooke | V05 | Mar-21 | Mar-21 | Mar-24 |
| IPC-PGN-14.1 | IPC Considerations in the Purchase and Use of Equipment – Water Coolers and Ice Making Machines | Samantha Cooke | Sarah Rushbrooke | V06 | Jan-21 | Jan-21 | Jan-24 |
| IPC-PGN-17 | Transferring Patients with Known or Suspected Infectious Disease | Kelly Stoker | Sarah Rushbrooke | V05 | Aug-21 | Aug-21 | Aug-24 |
| IPC-PGN-22 | Prevention & Control of Clostridium Difficile in Hospital | Kelly Stoker | Sarah Rushbrooke | V07 | Jun-21 | Jun-21 | Jun-24 |
| IPC-PGN-27.1 | Water Safety – Management and Control of Legionella and Waterborne Bacteria | Kelly Stoker | Sarah Rushbrooke | V05 | Feb-23 | Feb-23 | Feb-26 |
| IPC-PGN-27.2 | Control of Legionella and Legionnaires Disease: Preventing the Accumulation of Stagnant Water | Kelly Stoker | Sarah Rushbrooke | V06 | Feb-23 | Feb-23 | Feb-26 |
| IPC-PGN-31 | Guidance for the Management of Patients with Suspected or Confirmed COVID-19 Infection | Samantha Cooke | Sarah Rushbrooke | V01 | Sep-21 | Sep-21 | Sep-23 |

## Appendix 2 – IPC training record 2022/23

| Executive Directorate > Business Unit > Service > Cost Centre (click on the Cost Centre for a detailed report showing all course details for all staff) | Total Staff | Training Complete | Due Exp |
|---|---|---|---|
| North Cumbria Locality Care Group | 1564 | 1477 | |
| North Locality Care Group | 1513 | 1449 | |
| Central Locality Care Group | 1776 | 1683 | |
| South Locality Care Group | 2213 | 2127 | |
| Chief Nurse | 118 | 105 | |
| Chief Executive | 35 | 33 | |
| Medical & Deputy Chief Executive | 605 | 404 | |
| Workforce & Organisational Development | 88 | 85 | |
| SUSPENSE | 550 | 448 | |
| Provider Collaboratives | 16 | 16 | |
| Chief Operating Officer | 262 | 250 | |
| Finance & Digital Services | 188 | 186 | |
| Total | 8928 | 8263 | |

Appendix 3

## IPC Risk Assessment April 2022 – March 2023

| Locality | Ward | Audit Score % | Compliance Rating |
|---|---|---|---|
| Central | Aidan | 93.5 | |
| Central | Akenside | 90 | |
| Central | Bede | 81.7 | |
| Central | Castleside | 85.2 | |
| Central | Castleside DU | 85 | |
| Central | Cuthbert | 92 | |
| Central | Elm House | 86 | |
| Central | Fellside | 82.3 | |
| Central | KDU Cheviot | 88.7 | |
| Central | KDU Lindisfarne | 91.7 | |
| Central | Lamesley | 87.9 | |
| Central | Lowry | 82 | |
| Central | Oswin | 95 | |
| Central | Tweed Low Secure | 86.9 | |
| Central | Tweed Rehab | 86.5 | |
| Central | Tyne MH | 94.5 | |
| Central | Tyne LD Rehab | 93.8 | |
| Central | Willow View | 92.5 | |
| Central | Hadrian KDU | 92.7 | |
| North | Alnmouth | 90.1 | |
| North | Embleton | 90.2 | |
| North | Bluebell Court | 84.6 | |
| North | Hauxley | 92.7 | |
| North | Kinnersley | 92.4 | |
| North | Mitford | 81.9 | |
| North | Mitford Bungalows | 92.6 | |
| North | Newton | 84.3 | |
| North | Warkworth | 85.6 | |
| North | Woodhorn | 87.1 | |
| South | Beckfield | 94 | |
| South | Longview | 91.8 | |
| South | Aldervale | 92.5 | |
| South | Clearbrook | 96.5 | |
| South | Springrise | 96.4 | |
| South | Shoredrift | 92.8 | |
| South | Bridgewell | 96 | |
| South | Roker | 88 | |
| South | Mowbray | 96.8 | |
| South | Cleadon | 88.5 | |
| South | Brooke House | 92.9 | |

| | | | |
|---|---|---|---|
| South | Rose Lodge | 92.7 | |
| South | Gibside | 88.5 | |
| South | Ward 1 | 95 | |
| South | Ward 2 | 87 | |
| South | Ward 3 | 91 | |
| South | Ward 4 | 93 | |
| South | Ward 31A | 65.2 | |
| South | Beadnell | 94.9 | |
| North Cumbria | Ashby | 94.6 | |
| North Cumbria | Edenwood | 90.1 | |
| North Cumbria | Redburn | 90.9 | |
| North Cumbria | The Riding | 92.8 | |
| North Cumbria | Hadrian 1 | 81.8 | |
| North Cumbria | Hadrian 2 | 88 | |
| North Cumbria | Lennox | 85 | |
| North Cumbria | Lotus Ward | 95.6 | |
| North Cumbria | Oakwood Assessment Unit | 92.8 | |
| North Cumbria | Ruskin | 81.3 | |
| North Cumbria | Yewdale Ward | 83.7 | |

The IPC team offered increased support to Ward 31A (red RAG rating) which included assistance with the formulation of an audit action plan, regular one-to-one sessions with the Ward Manager and clinical team to address any training needs or gaps in IPC knowledge, and a member of the IPC team spent a day working with the team to identify and resolve issues, as well as offer specialist IPC support. A re-audit of this area is planned for the end of June to ensure standards have been maintained following completion of the action plan.

Appendix 4

**Statement of Compliance with the Health and Social Care Act Code of Practice 2008**

This document details how Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust will protect service users, staff and visitors from Healthcare-Acquired Infections, and comply with the Health and Social Care Act 2008 Code of Practice, for the year 2022/23.

| **Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them** |
|---|
| **Statement**<br>• The Trust IPC policy incorporates the Trust statement reflecting its commitment to prevention and control of infection amongst service users, staff and visitors. This document also outlines the collective and individual responsibility for minimising the risks of infection and provides detail of the structures and processes in place to achieve this.<br>• The Trust has appointed a Director of Infection Prevention and Control accountable directly to the Chief Executive and Board.<br>• Effective prevention and control of infection is secured through an IPC team, assurance framework, annual work and audit programme, and surveillance and reporting system.<br>• The IPC team undertakes Route Cause Analyses for each case of MRSA bacteraemia and Clostridium Difficile infection identified. The results of root cause analyses, and action plans arising from them, are monitored through the quality standards meetings and the IPC Committee<br>• Training, information and supervision is delivered to all staff through either face-to-face or e-learning.<br>• There is an annual audit programme in place, approved by the Board, to ensure implementation of key policies and guidance. The Trust has developed an IPC specification for clinical areas, which details all the standards for IPC. Following a risk assessment, action plans for achieving compliance with the specification are developed where necessary.<br>• IPC team produces an infection prevention and control programme which set objectives for ensuring the safety of service users, staff and visitors, and identifies priorities for action over the year. The programme also includes audits to be undertaken to assure the Trust of compliance with key IPC policies. |

| **Criterion 2: The Trust provides and maintains a clean and appropriate environment in managed premises which facilitates the prevention and control of infection** |
|---|
| **Statement**<br>• The Trust lead for the provision of cleaning services is the Head of NTW Solutions.<br>• Ward Managers are accountable for the cleanliness standards on all in-patient areas.<br>• The Trust has a range of buildings ranging from new, purpose-built facilities to old or |

adapted facilities.

- The NTW Solutions strategy envisages all clinical areas achieving category B standard for buildings.
- Cleaning schedules detail the standard of cleanliness required and the frequency of cleaning. Cleaning schedules comply with the National Standards of Cleanliness. All schedules have been reviewed and will be signed off by IPC and ward managers. These schedules are displayed publicly in all clinical areas.
- The cleanliness of the environment is assessed through, weekly ward checks, monthly standardised cleaning audits (SYNBIOTIX audits) and annual PLACE assessments. The results of these assessments are made available to the Groups, the IPC committee and are available on the Trust intranet.
- The Trust has issued guidance on staff dress reflecting infection prevention and control and health and safety standards and requirements, including promoting good hand hygiene practice. The guidance includes advice on the correct laundering of uniforms and clothes worn at work.
- Trust policies include Legionella control, potable water management, waste, laundry and food & nutrition.
- The Trust does not undertake sterilisation procedures for any reusable medical devices. The Trust IPC-PGN-10 outlines disinfection and decontamination procedures. Wherever possible all medical devices are single use or single named patient use only

**Criterion 3: Provide suitable accurate information on infections to the service users and their visitors**

**Statement.**

- The Trust utilises a range of written information to inform service users and carers about general principles of infection control and specific infections. These include information produced by UK Health Security Agency (UKHSA), Department of Health and Social Care and others.
- World Health Organisation 5 moments has been incorporated into hand wash guidance.
- The annual IPC report includes information on the occurrence of infections in the Trust, and the general means by which infections are controlled within the Trust. This is publicly available on the Trust internet.
- Where it has been decided not to install alcohol hand gels at the entrance to wards visitors are advised by a poster to ask staff for access to hand washing facilities.
- During an outbreak of infection specific signs are displayed at the ward entrance to inform visitors.
- Specific display stands have been displayed during the winter months to discourage anyone with flu like/respiratory illness from visiting.

**Criterion 4: Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion**

**Statement**

- Arrangements are in place to prevent and control HCAI and demonstrate that responsibility for IPC is effectively devolved. This is detailed in the IPC policy and associated practice guidance notes. Staff have access to electronic versions of the IPC manual and core plans

and advice on infection prevention and control is available from IPC services from 0900 to 1700 each day. Advice on the specific treatment of infected patients is available from local microbiology departments or the regional infectious diseases unit.
- An IPC / Link worker network has been developed with the aim of ensuring that all areas have a link worker. There is an active training and support programme in place for IPC link workers.
- The Trust has access to the electronic reporting systems of most pathology departments (ICE).
- We have robust reporting systems with other trusts.
- Outbreak communication demonstrates accurate, timely communication with other departments e.g. Facilities, Estates and other healthcare providers.

**Criterion 5: Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.**

**Statement**

- All staff, contractors and others are offered written information, induction and access to IPC advice via NTW Solutions staff.
- It is recognised that IPC is everyone's business, and this responsibility is reflected in all job descriptions

**Criterion 6: Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection**

**Statement**

- Responsibility for infection prevention and control is detailed in the Trust IPC policy and is included in the job description of all staff.
- Mandatory training is provided via e-learning every three years for all staff, both clinical and non-clinical. All new staff receive IPC training in their induction programme.
- All staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient information on and training and supervision in Infection Prevention & Control.
- The IPC team has robust relationships with CBU Senior nurses and NTW Solutions.
- Regular updates on the Hygiene Code are given at appropriate meetings.
- All staff have the opportunity to have a flu / covid vaccination each year. Service users in risk groups who are inpatients are offered flu vaccination.

**Criterion 7: Provide or secure adequate isolation facilities.**

**Statement**

- IPC Practice Guidance Note (IPC-PGN 08) details the procedures to be followed to isolate a patient with a known or suspected infectious disease.
- The availability of a suitable isolation area in each in-patient area is part of the IPC

specification.

- Most in-patient areas in the Trust have single rooms suitable for the isolation of patients with infectious diseases. In the event of a service user requiring isolation, and that not being available on their own inpatient unit, arrangements would be made to transfer the service user to a clinical area where adequate isolation facilities are available.
- In the event of a large-scale outbreak of infection then affected service users would be cohort nursed in an identified area of an in-patient ward, or the entire in-patient ward would be regarded as an isolation area.

**Criterion 8: Secure adequate access to laboratory support as appropriate**

**Statement**

- The Trust does not provide laboratory services in-house.
- The Trust holds service level agreements or arrangements for microbiology services at Northumbria Healthcare NHS Trust, Newcastle Hospitals NHS Trust, Gateshead Health NHS Trust, South Tyneside and Sunderland NHS Foundation Trust and North Cumbria Integrated Care NHS Foundation Trust Results are available through the electronic ICE system.
- The Trust is assured that these services operate to the standards required for accreditation by Clinical Pathology Accreditation (UK) Limited.

**Criterion 9: Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.**

**Statement**

- The IPC nurses produce a range of practice guidance notes to assist staff implement adequate measures to control the transmission of infection and manage service users with infections. This guidance forms part of the Trust Infection and Control Policy and staff are expected to follow the guidance unless there is a compelling reason not to.
- Compliance with practice guidance notes is audited through the Quality Monitoring Tool, the IPC risk assessment, and the annual audit programme.
- The range of practice guidance notes covers the following topics:
- Standard infection control precautions
- Aseptic technique
- Outbreaks of communicable infections
- Isolation of service users
- Safe handling and disposal of sharps
- Prevention of occupational exposure to blood borne viruses, including prevention of sharps injuries
- Immunisation requirements of staff
- Management of occupational exposure to blood borne viruses and post exposure prophylaxis
- Closure of rooms, wards, departments, and premises to new admissions
- Environmental disinfection
- Decontamination of reusable medical devices

- Antimicrobial prescribing
- Single use
- Disinfection
- Control of outbreaks and infections associated with the following specific alert organisms:
    - MRSA
    - Clostridium difficile
    - Blood borne virus, including a viral haemorrhagic fever and Transmissible Spongiform Encephalopathy
    - Tuberculosis
    - Diarrhoeal infections
    - Legionella
- The following alert organisms are unlikely to be experienced within the spectrum of activity of a mental health and learning disability trust and currently the Trust does not have practice guidance notes covering these:
    - Glycopeptide Resistant Enterococci
    - Acinetobacter
    - Viral haemorrhagic fevers

## 13. ANNUAL REVALIDATION REPORT

Rajesh Nadkarni, Deputy Chief Executive / Medical Director

### REFERENCES

Only PDFs are attached

13. Medical Appraisal Revalidation AOA July 2023.pdf

| | |
|---|---|
| **Name of meeting** | **Board of Directors** |
| **Date of Meeting** | **Wednesday 2 August 2023** |
| **Title of report** | **Medical Appraisal/Revalidation Annual Board Report 2022-23** |
| **Executive Lead** | **Dr Rajesh Nadkarni, Executive Medical Director**<br>**Lynne Shaw, Executive Director of Workforce and OD** |
| **Report author** | **Professor Eilish Gilvarry, Deputy Medical Director** |

| **Purpose of the report** | |
|---|---|
| **To note** | |
| **For assurance** | **X** |
| **For discussion** | |
| **For decision** | |

| **Strategic ambitions this paper supports (please check the appropriate box)** | |
|---|---|
| **1. Quality care, every day** | X |
| **2. Person-led care, when and where it is needed** | |
| **3. A great place to work** | X |
| **4. Sustainable for the long term, innovating every day** | |
| **5. Working with and for our communities** | |

| **Meetings where this item has been considered** | |
|---|---|
| Quality and Performance | |
| Audit | |
| Mental Health Legislation | |
| Remuneration Committee | |
| Resource and Business Assurance | |
| Charitable Funds Committee | |
| People Committee | X |
| CEDAR Programme Board | |
| Other/external (please specify) | |

| **Management 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 | X |
| Workforce | X | Environmental | |
| Financial/value for money | X | Estates and facilities | |
| Commercial | | Compliance/Regulatory | X |
| Quality, safety and experience | X | Service user, carer and stakeholder involvement | |

| **Board Assurance Framework/Corporate Risk Register risks this paper relates to** |
|---|
| N/A |

**Board of Directors**
**Wednesday 2 August 2023**
**Medical Appraisal/Revalidation Annual Board Report 2022-23**

## 1. Executive Summary

This Report is the Annual submission of Medical Appraisal and Revalidation. The Board is asked to sign, after agreement, the Statement of Compliance. This Annual Report is to be reviewed by People Committee on 26 July 2023 and will then be submitted to the Trust Board on 2 August 2023 for agreement and sign off before being forwarded to NHS England.

**In brief:**

- Compliance for appraisals - 100% for 2022/23 (apart from exempt)
- 40 trained appraisers - all updated with training
- 47 doctors were recommended for Revalidation - 2 deferred, one on hold
- No issues of non-engagement
- CPD lunchtime sessions continue via Microsoft Teams and well attended
- External CPD events re-established

**Key issues, significant risks and mitigations**

- The Medical Development Team will ensure all doctors are updated on any national revalidation changes by linking with regional teams.
- The Medical Development Team will also ensure GMC Connect is updated to ensure all doctors have the appropriate connection to the Trust for Revalidation purposes.

**Recommendation/summary**

The Board of Directors is asked to note the content of this report prior to sign off of the statement of compliance at Section 7.

Dr Rajesh Nadkarni
Executive Medical Director
Deputy Chief Executive

Lynne Shaw
Executive Director of Workforce & OD

July 2023

# Designated Body Annual Board Report – Medical Appraisal/Revalidation 2022-2023

## Section 1 – General:

The Board of Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

| |
|---|
| 1. Dr Rajesh Nadkarni, Executive Medical Director/Deputy Chief Executive is the Responsible Officer for the Trust and St Oswald's Hospice. |

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

| |
|---|
| The Revalidation Team consists of: Professor Eilish Gilvarry, Deputy Medical Director, Dr Hermarette Van den Bergh, Associate Medical Director (Revalidation), Dr Sunil Nodiyal, Associate Medical Director (Appraisal), Dr Gill Bell, Associate Medical Director (Coaching), Medical Development Team and 40 trained and active appraisers – an increase of 1 from last year. |

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

| |
|---|
| The Medical Development Team regularly check with GMC Connect to ensure appropriate doctors are connected to the Trust and any doctors who have left the Trust have been disconnected. |

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

| |
|---|
| The following policies support the Revalidation Process and are regularly reviewed, updated and ratified:<br>• Medical Study Leave Policy due for review August 2023<br>• Clinical Supervision due for review August 2023<br>• Request for Change of Consultant due for review July 2023<br>• Medical Appraisal due for review September 2023<br>• Medical Job Planning due for review June 2024<br>• Handling Concerns about Doctors due for review November 2024<br>• Private Practice due for review May 2026 |

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

| |
|---|
| Due to work pressures and the pandemic, we have been unable to meet with South Tyneside and Sunderland NHS Foundation Trust to undertake the Peer Review but will look to arrange in 2023/24. |

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

The Locum Support Document/Checklist was previously updated and re-circulated to all Medical Managers. The document is also sent to the supervisor/ line manager each time a locum is appointed. The updated guidance from NHS England 'Supporting Locums & Doctors in Short-term Placements' has been reviewed. There have been additional documents implemented for use when booking locum doctors i.e.: agreed agency timetable, which provides details of the sessional work the doctor will be required to undertake, and is signed off by the supervising consultant, finance for costings and the actual locum doctor, so they know exactly what is expected when they report for work. This avoids any issues when it comes to authorising timesheets and working additional hours.

Updates to financial reporting has been introduced on agency spend. The process for booking agency doctors was revisited with Medical Leaders in July 2021. New structures are now in place for agency approval and these continue to be reviewed. While agency locums do not have access to study leave and the associated financial support, there is a full programme of local CPD within the organisation, which they have free access to. They are also encouraged to form part of a local peer group, where they have access to peer support and opportunity for Case Based Discussions.

# Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

There is a priming appraisal process in place to ensure all newly appointed doctors meet with the Medical Development Team and hold an initial meeting with a nominated appraiser to agree a Personal Development Plan (PDP) within the first 3 months of appointment. Since August 2022, this process has been strengthened by a member of the Team arranging this appointment prior to the Doctor's start date so the appointment can be held within the first month of appointment.

1 April 2022 to 31 March 2023
315- Doctors were due to complete appraisals during this period
302 - Completed during the period
13 - Exemptions due to Sickness, Maternity Leave, Career Breaks

Out of a total of 315 doctors in 2022/23 there were 302 Appraisals completed and 13 exemptions. No deferrals were made due to non-engagement.

The numbers outlined above are testament to our clinicians' commitment and engagement with the appraisal process and many thanks to all for this incredibly positive engagement. This is our 4th year with 100% compliance.

Agreement was reached that all Appraisals would not be held in the month of March and those due would move to January/February. This has worked well this year with no need for appraisals to be conducted at such short notice. There were still a few held in March due to exceptional circumstances.

Further, whilst the Trust continued to use the SARD system throughout, the emphasis was on reflection, personal wellbeing, and quality rather than quantity. All appraisers were regularly updated on national changes and expectations and all doctors were regularly informed of changes and expectations.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Not applicable

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

| |
|---|
| Medical Appraisal Policy is in place. The next review date is September 2023. Comments have been sought from the Appraisers to feed into any review of the Policy. |

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

| |
|---|
| Within the year 2022/23, there were 40 trained appraisers, following training and induction of 7 new appraisers. The total number also includes 2 appraisers from St Oswald's Hospice.<br><br>19 appraisers required Refresher Training during the year. An in-house training package was developed and delivered with great feedback received from participants. Due to absence, there is still one appraiser who requires refresher training, they will not undertake any appraisals until they have done so.<br><br>We had in-house training developed and planned for new Appraisers on 27 June 2023 following the appointment of a further 7 appraisers. |

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

| |
|---|
| All appraisers must attend a minimum of one Appraiser Development Group meeting which are held throughout the year to provide updates and discussion on relevant themes, though greater participation is recommended and encouraged. These themes include feedback from Regional RO/Appraisal Leads Meetings, SARD training sessions and individual appraisal feedback. However, all appraisers usually attend much more than the minimal standard and participate in the development groups with much reflection.<br><br>All appraisers complete formal training prior to taking up the role and attend formal refresher training at a minimum every 5 years. A central database of this training is updated accordingly by the Medical Development Team.<br><br>In the 2022/23 appraisal year, all appraisers attended at least one Appraiser Development Group.<br><br>Further, the team have links with the Regional Network to ensure we are appraised of all changes and developments. We bring these changes/updates to the CNTW appraiser group, and larger medical staffing cohort, via attendance and updates at the Medical Staff Committee meetings.<br><br>Action for next year: Continue with Appraiser Development Meetings, review appraiser training records and provide relevant updates when necessary, including refresher training for identified appraisers. The ASPAT Audit undertaken in 2022/23 will be discussed with the appraisal team to improve the quality of appraisal output and alignment with NHS England standards for appraisal. The meetings will address and focus on health and wellbeing and ongoing support through appraisal for all doctors, especially those particularly impacted by the pandemic and associated restrictions. The team also reviews the electronic appraisal platform regularly. |

**6.** The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

In accordance with the agreed Audit Programme for the financial year 2022/23, an audit of the appraisal output was undertaken for all new appraisers appointed during the period 2022/23 along with a random selection of Appraisers who carried out final appraisals prior to Revalidation recommendations using the NHS England approved audit tool ASPAT (Appraisal Summary PDP Audit Tool) as previously undertaken.

We are encouraged by the commitment of our clinicians and their continued engagement in the appraisal process, despite continuing workload pressures.

As with previous audits, the results and learning points will be discussed in the Appraiser Development Group, to facilitate quality improvement and greater compliance. Improvements in awareness raising of these developments has already been implemented in changes to the medical staff induction process.

## Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

| Cumbria, Northumberland Tyne and Wear NHS Foundation Trust | |
|---|---|
| Total number of doctors with a prescribed connection as at 31 March 2022 | 315 |
| Total number of appraisals undertaken between 1 April 2021 and 31 March 2022 | 302 |
| Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022 | 13 |
| Total number of agreed exceptions | 13 |

## Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

The Team aims for all revalidations to be submitted to the GMC at least 3 to 6 months prior to the revalidation due date. In the year 2022/23 there were 50 revalidations due. 47 were submitted with a Recommendation to Revalidate, 2 were deferred due to insufficient evidence (mostly patient/colleague feedback) and 1 doctor is on hold.

**2.** Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

All recommendations submitted were done so in a timely manner. Any deferral is discussed with the individual doctor concerned. A letter is issued to the doctor outlining the reasons for deferral. However, the revalidation requirements are discussed as part of the penultimate appraisal and plans to attain the relevant standards discussed. All appraisers are advised, at the penultimate appraisal, to inform the Medical Development Team of any concerns that have been identified if a doctor may not be on course for Revalidation.

We are up to date with all revalidations up to and including 1st September 2023. The Medical Development Team supported our clinicians by proceeding with the Revalidation evidence review process, despite GMC deferral, and recommended revalidation for all clinicians with sufficient evidence. Our aim was to recognise the work already done by

clinicians and to maintain the support, recognition, and development for clinicians. The numbers that were effectively able to revalidate early is evidence of the success of this approach.

## Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

The Policy 'Handling Concerns about Doctors' is regularly reviewed and next due for review in 2024. Support meetings are scheduled with all Medical Managers throughout the year to discuss themes and ensure adequate support/action plans are in place for those doctors where there are performance, competencies, or health issues. RO & Deputy RO meet regularly with the GMC Employment Local Advisor (ELA).

Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

The Trust adapted the MAG2022 model but continued to use the SARD template. SARD fully reflects all changes made to the MAG2022, to help doctors understand what they need to do to prepare for and participate in the appraisal, and to help appraisers ensure that any appraisal is carried out consistently and to a high standard. We regularly update all doctors of any changes to the systems through the Medical Staff Committee, individually with some doctors, provided links to the Academy of Medical Royal Colleges advice and with discussions with the Appraiser Development Group. We continue to implement the guidance from NHS England and GMC on refocusing/rebalancing the appraisal with greater flexibility e.g., preparation time, quality rather than quantity, emphasis on well-being and development, avoiding a tick box approach and recognition of the value of reflections - these often verbal rather than written reflections.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

There are regular Supporting Doctors/Handling Concerns management meetings (attended by Executive Medical Director, Deputy Medical Director, Group Medical Directors, Head of Medical Staffing, Recruitment, Development and Education & or Medical Staffing Manager). Some training is given during these meetings, e.g., Practitioner Performance Advice (PPA) and GMC proceedings. Any informal concerns are included in action plans and the doctor is asked to reflect and discuss this as part of their annual appraisal.

The Medical Development Team developed, in collaboration with Group Medical Directors, a sign off template, for medical managers to include in appraisal. This process was implemented during the year 2022/23 and ensures that performance management is linked with appraisal, and quality assured, without unduly disrupting the supportive element of appraisal process.

In line with the GMC report Fair to Refer, we reviewed the process above and include mechanisms to capture data on protected characteristics of clinicians under performance management.

**3.** There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

The Handling Concerns about Doctors Policy is regularly reviewed and updated with Capsticks LLP (HR Advisory Service) who are also involved in all levels of concerns about

doctors. Training is provided to all Medical and Operational Managers on the Handling Concerns about Doctors process. We approach performance issues sensitively, and ensure the doctor is supported at all stages of the process (both informal and formal). Themes and learning points on process are discussed and reflected upon with medical managers.

Action for next year: We continue to provide refresher training on the Policy/Process to new medical managers, to include making managers and doctors aware of 'Fair to Refer' Report.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

The Annual Revalidation Report is provided to the Trust Board which provides assurance and highlights any risks/concerns identified throughout the year. Medical Managers' Meetings are held to review any issues identified, with the Head of Medical Staffing, Recruitment, Development and Education, Workforce, and Capsticks in support, as required. This meeting reviews numbers within HCAD, sharing learning, areas of improvements and reflective practice. Non-Executive Directors are linked into any suspensions of medical staff as per the Policy. Regular meetings are held with GMC Employment Liaison Officers.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

All new doctors joining CNTW are subject to NHS Pre-Employment Checks of which one is to ensure satisfactory completion of Appraisal in the last 12 months. A Consent Form to request Revalidation information is sent to all new doctors which captures data on their previous RO name and address, last date of appraisal, previous revalidation. The doctor is also requested to provide a copy of their last appraisal or ARCP and list any relevant performance information. If any performance issues are identified the MPIT Form would be sent to the previous RO for further information.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

All policies are subject to Impact Assessment as part of the review process.

We continue to review our policies and processes in line with the Effective Clinical Governance for the Medical Profession self-assessment tool (GMC, 2018), and the following was implemented and/or agreed:

- Appraisee has a choice of appraiser: this is CNTW current practice within the Appraisal process. Since August 2022, newly appointed doctors will be contacted and discussion around the Appraisal process will be undertaken. At this point, the Medical Development Admin Team will discuss the allocation of an Appraiser with them.
- HCAD policy reviewed to ensure due consideration given to appropriate diversity and equality issues.

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

- Agreed to include in our Workplan a review of our data capturing processes to ensure we appropriately capture data on protected characteristics.
- Mentoring is actively encouraged for all new starters and anyone who requires or requests mentoring. New starters are asked if they would like to be allocated a Mentor prior to their commencement in post and the Medical Development Admin Team source an appropriate Mentor accordingly. All the mentors are expected to have regular training every 5 years to stay up to date and a list of qualified and up to date mentors is maintained by the Medical Development Team. A recent advert for Mentors has been successful with a further 6 being identified. Training will take place in July 2023.
- We plan to initiate a Mentor's Development Group, like our Appraiser Development Group.
- Following the appointment of Dr Gill Bell as Coaching Lead, we are developing a formal Programme for Medical Coaching.

## Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

As part of the Medical Recruitment process for all medical posts within the Trust (substantive, fixed term, and agency locums) the NHS Pre-Employment Checks are undertaken. This includes the doctor providing evidence on: Verification of ID, References, Occupational Health, DBS, Qualifications, GMC Registration, Right to Work, and where relevant Approved Clinician and Section 12 Status. Providing details of current Responsible Officer and a copy of Appraisal undertaken in the last 12 months.

## Section 6 – Summary of comments, and overall conclusion

General review of actions since last Board report - Actions still outstanding - Current Issues - New Actions: Overall conclusion:

**Actions for 2022/23 and completed:**

- CPD Events – we continued to run a full weekly CPD programme on a virtual platform. We regularly have attendance of over 120 on the calls. We have started to hold a number of face to face external full/half day events and look to develop these events.
- ASPAT Audit – completed for 22/23, with CNTW amendment. Results to be presented to Appraiser Development Group and learning points discussed.
- Update Medical Development Team Members & Appraisers with all National Developments- continued attendance with Regional Network.
- Discussion on personal well-being throughout all appraisals, assurance on this provided through update of ASPAT audit.
- Updating through multiple areas the new Medical Appraisal Guide 2022 and the implications for doctors.
- Full Review of HR/Project/Admin Support within the Medical Development Team (Workforce & OD) to ensure alignment with Postgraduate Medical Education, Medical Study Leave processes, Appraisal/Revalidation & Job Planning, Mentoring/Coaching, expansion of CPD events both internal & external, and overview of Performance Concerns.

**Overall conclusion:**

Progress was made on all domains of the Medical Development Team Local Workplan for 2022/23 and it has been updated for 2023/24 accordingly. Much thanks go to the Appraisers and the entire medical workforce, for their continued enthusiasm and engagement with the Appraisal/Revalidation process. We continue to have considerable pride in our work and achievements, and the flexibility we have been able to offer. Regular communication with the medical workforce remains a priority, as is the continuation and development of our CPD programme, through which we provide opportunities for development and support for revalidation.

The challenges for the team in the year ahead include:

- Continuing to deliver 'Face to Face' CPD events as well as continuing with On-Line CPD programme to include other professions, organisations & Primary Care
- Ensure transparency and fairness in all appraisals and any work performance issue.
- Maintain our usual links with NHS England to keep abreast with any changes and any review to the appraisal system.
- Embedding the changes made in the new Medical Appraisal Guide 2022 in the appraisal process and ensuring consistent quality of the process across the board.

Development of the mentoring and coaching strategy but challenges remain with its implementation, e.g., time constraints of mentors and ensuring all new medical staff are allocated a mentor for the first 12 months in post. All new mentors are now trained in-house with an ongoing active recruitment plan. The first in-house training session is to take place in July 2023.

**Summary**

In 2022/23 there were 315 doctors with a prescribed connection to the Trust.

302 doctors had a completed appraisal in support of their revalidation, and 13 doctors had adequate reasons for incomplete appraisals (such as long-term sickness or maternity leave). There were more appraisals completed – this related to some doctors leaving during the year and new doctors arriving. At the end of March 2023, the appraisal compliance for the Trust was at 100%.

As part of the revalidation process 47 doctors had positive recommendations made to the GMC within the year.

*Policy and guidance*

The relevant policies are:

- Medical Appraisal Policy and Medical Appraisal Practice Guidance NTW(C)33
- Medical Job Plan Policy CNTW(C)56
- Private Practice Policy CNTW(O)46
- Handling Concerns about Doctors Policy CNTW(HR)02
- Service Users requesting a Change of Medical Consultant or Second Opinion CNTW(C)42
- Clinical Supervision Policy CNTW(C)31
- Study Leave Policy for Medical Staff CNTW(FR)22

**Appraisers**

During the period 2022/23 the Trust had 40 fully trained appraisers who meet regularly to discuss current appraisal issues, calibrate their judgements, problem-solve and to share

good practice. Attendance and engagement with these meetings continue to increase, with positive feedback received from Appraisers regarding topics for discussion/debate.

We continue to update the SARD system as needed and communicate these changes to the appraiser group.

## 7 – Statement of Compliance:

The Board of Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body:

Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

**CPD – Update** Lunchtime / Half Day CPD Events – 1 April 2022 to 31 March 2023:

- **DVLA Update - 5 April 2022**
  Free Microsoft Teams CPD Event - 141 Delegates

- **An Introduction to Mental Health Presentations and Management for Social Prescribers & Non-Clinical Staff - 13 April 2022**
  Free Primary Care Mental Health CPD Event - 25 Delegates

- **HCAD from Clinician Perspective - 26 April 2022**
  Free Microsoft Teams CPD Event - 108 Delegates

- **Diversity & Inclusion Update - 3 May 2022**
  Free Microsoft Teams CPD Event - 90 Delegates

- **Diabetes and Endocrinology in Psychiatrists - 10 May 2022**
  Free Microsoft Teams CPD Event - 150 Delegates

- **Safety Planning - 11 May 2022**
  Free Primary Care Mental Health CPD Event - 17 Delegates

- **CYPS; Challenges & Opportunities - 17 May 2022**
  Free Microsoft Teams CPD Event - 131 Delegates

- **CYPS Part 2; Medication & More - 24 May 2022**
  Free Microsoft Teams CPD Event - 136 Delegates

- **Autoimmune Encephalitis Update 2022 - 25 May 2022**
  Half Day Psychosis Event (£40 charge) - 61 Delegates

- **Respectful Resolution – 31 May 2022**
  Free Microsoft Teams CPD Event - 105 Delegates

- **Gambling, Harm Prevention & Training - 14 June 2022**
  Free Microsoft Teams CPD Event - 111 Delegates

- **ECG - 20 June 2022**
  Delivered by Cardiologist - 15 Delegates

- **The Default Mode Network - 21 June 2022**
- Free Microsoft Teams CPD Event - 112 Delegates

- **C.A.L.M Bipolar - Co-Design & Co-Production of an app to aid mood monitoring in young people - 28 June 2022**
  Free Microsoft Teams CPD Event - 116 Delegates

- **What is Coaching; Process, Benefits and Applications - 5 July 2022**
  Free Microsoft Teams CPD Event - 116 Delegates

- **National Specialty Advisor for Autism; Overview of the programme & where we are? - 12 July 2022**
  Free Microsoft Teams CPD Event - 104 Delegates

- **Reducing Long Term Segregation; The HOPE(S) Approach - 6 September 2022**

Free Microsoft Teams CPD Event - 111 Delegates

- **Epilepsy in 2022; An Update - 13 September 2022**
  Free Microsoft Teams CPD Event - 147 Delegates

- **Consultant & SAS Doctors Induction - 15 September 2022**
  Consultant & Doctors Induction - 18 Delegates

- **How Shame Informs our Mental Health from an LGBT+ Perspective - 20 September 2022**
  Free Microsoft Teams CPD Event - 98 Delegates

- **Bipolar Depression; A focus on Psychopharmacology - 27 September 2022**
  Free Microsoft Teams CPD Event - 155 Delegates

- **Mental Health Services in the Australian Context; A Tale of Two Territories - 4 October 2022**
  Free Microsoft Teams CPD Event - 121 Delegates

- **Church Related Abuse & Moral Injury - 11 October 2022**
  Free Microsoft Teams CPD Event - 118 Delegates

- **Allied Health Professionals in CNTW – 18 October 2022**
  Free Microsoft Teams CPD Event - 98 Delegates

- **Introduction to CESR - 8 November 2022**
  Free Microsoft Teams CPD Event - 96 Delegates

- **An Update on High-Risk Prescribing - 15 November 2022**
  Free Microsoft Teams CPD Event - 142 Delegates

- **Mental Health Inequality and the Mental Health Act; What will it mean for you? - 22 November 2022**
  Free Microsoft Teams CPD Event - 104 Delegates

- **Perspectives on Lived Experience of Gender Diversity in the NRGDS - 29 November 2022**
  Free Microsoft Teams CPD Event - 142 Delegates

- **Diversity & Inclusion Update - 6 December 2022**
  Free Microsoft Teams CPD Event - 198 Delegates

- **Current Trends in the Diagnosis & Treatment of Alzheimer's Disease - 13 December 2022**
  Free Microsoft Teams CPD Event - 94 Delegates

- **A Net Zero NHS - 10 January 2023**
  Free Microsoft Teams CPD Event - 120 Delegates

- **Epilepsy in 2023; An Update - 17 January 2023**
  Free Microsoft Teams CPD Event - 128 Delegates

- **Trauma Informed Care, Security & Game Theory - 24 January 2023**
  Free Microsoft Teams CPD Event - 114 Delegates

- **Risk in Psychosis - 31 January 2023**
  Free Microsoft Teams CPD Event - 130 Delegates

- **Bipolar Depression; A focus on Psychopharmacology Part 2 - 7 February 2023**
  Free Microsoft Teams CPD Event - 128 Delegates

- **Long Term Segregation - 14 February 2023**
  Free Microsoft Teams CPD Event - 107 Delegates

- **Safety Planning - 28 February 2023**
  Free Microsoft Teams CPD Event - 126 Delegates

- **Deaf Awareness Update - 7 March 2023**
  Free Microsoft Teams CPD Event - 99 Delegates

- **HCAD from the Clinician Perspective - 14 March 2023**
  Free Microsoft Teams CPD Event - Cancelled due to strike action, rescheduled for 9 May 2023

- **Consultant & SAS Doctors Induction - 16 March 2023**
  Consultant & SAS Doctors Induction - Cancelled due to strike action, rescheduled for 22 June 2023

- **Patient Safety Incident Response Framework (PSIRF) Update - 21 March 2023**
  Free Microsoft Teams CPD Event - 112 Delegates

- **Medical Leadership Advanced; Module 1 - 24 March 2023**

- **Police Liaison & Mental Health Issues Update - 28 March 2023**
  Free Microsoft Teams CPD Event - 117 Delegates

- **Medical Leadership Introductory; Module 4 - 29 March 2023**

# 14. WORKFORCE RACE EQUALITY STANDARD AND WORKFORCE DISABILITY EQUALITY STANDARD

Lynne Shaw, Executive Director of Workforce and OD

## REFERENCES

Only PDFs are attached

14. WRES WDES Annual Report 2023 - Final.pdf

| | |
|---|---|
| **Name of meeting** | **Board of Directors** |
| **Date of Meeting** | **Wednesday 2 August 2023** |
| **Title of report** | **Workforce Race & Disability Equality Standard Annual Report 2023** |
| **Executive Lead** | **Lynne Shaw, Executive Director of Workforce & OD** |
| **Report author** | **Chris Rowlands – Equality, Diversity and Inclusion Lead**<br>**Emma Silver Price – Equality, Diversity and Inclusion Officer** |

| **Purpose of the report** | |
|---|---|
| **To note** | |
| **For assurance** | |
| **For discussion** | **X** |
| **For decision** | |

| **Strategic ambitions this paper supports (please check the appropriate box)** | |
|---|---|
| **1. Quality care, every day** | |
| **2. Person-led care, when and where it is needed** | |
| **3. A great place to work** | X |
| **4. Sustainable for the long term, innovating every day** | |
| **5. Working with and for our communities** | |

| **Meetings where this item has been considered** | |
|---|---|
| Quality and Performance | |
| Audit | |
| Mental Health Legislation | |
| Remuneration Committee | |
| Resource and Business Assurance | |
| Charitable Funds Committee | |
| People Committee | X |
| CEDAR Programme Board | |
| Other/external (please specify) | |

| **Management 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 | X | Environmental | |
| Financial/value for money | | Estates and facilities | |
| Commercial | | Compliance/Regulatory | X |
| Quality, safety and experience | X | Service user, carer and stakeholder involvement | |

| **Board Assurance Framework/Corporate Risk Register risks this paper relates to** |
|---|
| N/A |

**Board of Directors**
**Wednesday 2 August 2023**

# Workforce Race & Disability Equality Standard Annual Report 2023

## 1. Executive Summary

The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) support positive change for existing employees and enable a more inclusive environment for Black & Minority Ethnic (BME) and Disabled people working in the NHS. We are required to report our performance on these standards yearly and to address disparities via recommendations and action plans. The actions will align to the NHS England Equality, Diversity and Inclusion (EDI) Improvement plan, as well as the overall Trust Strategy and EDS 2022 findings.

## 2. Key issues, significant risks and mitigations

There are specific risks of Race Discrimination and Disability Discrimination under the Equality Act if policies and practices are not in line with legislation. There are reputational risks to the Trust if legislation and best practice is not followed which may have a detrimental effect on attraction and retention of staff.

## 3. Recommendation/summary

The Board of Directors is asked to note the content of the paper. Recommendations have been made to address areas which need improvement and will be considered alongside additional actions from the NHS EDI Improvement Plan which will be discussed at Trust Board in September.

**Christopher Rowlands**
Equality, Diversity & Inclusion Lead

**Lynne Shaw**
Executive Director of Workforce & OD

**Emma Silver Price**
Equality, Diversity & Inclusion Officer

12 July 2023

## Workforce Race Equality Standard (WRES)

The figures contained in the table below are a snapshot as of 31st March 2023, as well as findings from the most recent NHS Staff Survey which took place in Autumn 2022. It should be noted that these figures do not include NTW Solutions or Bank Staff. Later this year, we will be required to submit a WRES return for Bank and Medical Staff. Please see the appendices for all WRES data tables. At the audit date there were 7871 members of staff in the Trust. Of the 7871 there were 713 (558 in 2022) BME staff employed by the Trust. These staff made up 9.06% (7.5% in 2022) of our overall workforce. Latest data on Ethnicity from the 2021 Office for National Statistics Census shows the BME population across North East England is 6%.

## WRES 2023 recommendations

- Continue Trust-wide rollout of Respectful Resolution Framework.
- Implement ongoing support package for Cultural Ambassadors in partnership with Capsticks to continue overall improvement for staff entering formal disciplinary processes.
- Trust Board to review relevant data, identify EDI areas of concern, and prioritise EDI actions in annual appraisals.
- Develop a Race Pay Gap Report to identify actions and eliminate race pay gaps.
- Develop centralised Cultural Competency and Awareness training package to create inclusive team cultures and ensure psychological safety.
- Launch awareness/allyship initiatives.

| Metric | CNTW Figures for Latest Reporting Period | | | CNTW Figures for Previous Reporting Period | | | 2023 Trend |
|---|---|---|---|---|---|---|---|
| | White | BME | Comments | White | BME | Comments | |
| Non-clinical Staff | 1548 | 52 | BME 9.06% of total workforce | 1428 | 34 | BME 7.5% of total workforce | BME workforce has grown |
| Clinical Staff | 5387 | 509 | | 5133 | 367 | | |
| Medical Staff | 152 | 153 | | 176 | 157 | | |
| Non-Clinical Band 5 or below | 1243 | 43 | 3.2% BME non-Clinical staff | 1148 | 30 | 2.3% BME non-Clinical staff | 82.5% BME vs 77% white staff in Band 5 or below |
| Clinical Band 5 or below | 2566 | 374 | 8.6% BME Clinical staff | 2480 | 252 | 6.6% BME Clinical staff | 73.5% BME vs 47.6% white staff in Band 5 or below |
| Medical Consultant Grade | 116 | 88 | 50.2% BME Medical staff | 110 | 87 | 45.5% BME Medical staff | 43.1% BME vs 56.8% white Consultant Grade staff |
| Staff appointed from shortlisting | 1405 (4128 shortlisted) | 215 (1339 shortlisted) | White applicants 2.12 times more likely to be appointed | 648 (5828 shortlisted) | 139 (3115 shortlisted) | White applicants 2.5 times more likely to be appointed | Improvement over last 3 reporting periods |
| Staff entering formal disciplinary | 76 | 12 | BME staff 1.57 times more likely | 36 | 8 | BME staff 2.69 times more likely | Improvement over the last 2 reporting |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **process** | | | to be in formal process | | | to be in formal process | periods |
| **Staff accessing non-mandatory training & CPD** | Not recorded by Group Workforce Teams and therefore unable to be reported on. | | | Due to staff not accessing non-mandatory training during the pandemic, was not possible to calculate the figure. The 2020 return showed that BME staff were 1.5 times more likely than White staff to access non-mandatory training. | | | N/A |
| **% Staff experiencing bullying, harassment or abuse from patients, relatives or public** | 26.6% | 36.2% | | 29.4% | 44.6% | | Experience of both BME and white staff has improved between 2021 to 2022 |
| **% Staff experiencing bullying, harassment or abuse from staff** | 13.6% | 24.1% | | 15.5% | 25% | | Marginal improvements in the experience of white staff, however the figure for BME staff remains similar after decreasing slightly in 2020. |
| **% Staff believing organisation provides equal opportunities for career progression** | 68.2% | 50.2% | | 67.3% | 54.3% | | There has been an improvement for white staff but a fairly significant decrease for BME staff, the disparity between them has increased |
| **% Staff experiencing discrimination from manager, team lead or colleague** | 4.8% | 17.3% | | 5.1% | 14.4% | | There has been an improvement for white staff but a fairly significant increase for BME staff, the disparity between them has increased |
| **% Trust's Board membership compared to overall workforce** | 92.3% | 7.7% (overall workforce is 9.06% BME) | BME Board Members averaged 9.1% across | 92.9% | 7.1% (overall workforce is 7.5% BME) | BME Board Members averaged 8.2% across | The Trust Board is less representative of the overall BME workforce and this gap |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | North East and Yorkshire. (2022 National WRES) | | | North East and Yorkshire. (2021 National WRES) | may continue to increase as the workforce becomes more diverse |

**Key WRES learnings for focus:**

- BME staff make up 3.2% of the overall non-clinical workforce, yet 82.5% of BME staff are in band 5 or below. This is compared to 77% of white staff in band 5 or below.
- BME staff make up 8.6% of the overall clinical workforce, yet 73.5% of BME staff are in band 5 or below. This is compared to 47.6% of white staff in band 5 or below.
- Despite BME staff making up over half (50.2%) of the overall medical workforce, only 43.1% are at Consultant grade. This compares to 56.8% of white medical staff being at Consultant grade.
- The percentage of BME staff experiencing bullying, harassment or abuse from other staff remains high and has only decreased by 0.9%. The experience for white staff has improved.
- The percentage of BME staff believing the organisation provides equal opportunities for career progression has decreased by 4.1%. The result for white staff has improved and therefore the disparity between them has increased. The 2022 Staff Survey shows an 18% gap between BME and white staff believing the organisation provides equal opportunities for career progression (this gap was 13% in 2021).
- BME staff experiencing discrimination from a manager, team lead or colleague has increased by 2.9%. The result for white staff decreased and therefore the disparity between them has increased. The 2022 Staff Survey shows a 12.5% gap between BME and white staff experiencing discrimination from a manager, team lead or colleague (this gap was 9.3% in 2021).

**Workforce Disability Equality Standard (WDES)**

The figures contained in the table below are a snapshot as of 31st March 2023, as well as findings from the most recent NHS Staff Survey which took place in Autumn 2022. These figures do not include NTW Solutions Staff. It should be noted that the overall ESR figure of Disabled Staff employed by the Trust is 8.2%, this is considerably lower than the figure identified through the most recent NHS Staff Survey, where 33.5% of our workforce state that they live with a long term condition. The most recent figures for the disabled population of the North East (2021 Census) states that 21.2% of the population meets the criteria for disability as defined by the Equality Act. Disclosure of disability has increased by 116 from 2022, with the increase in 2021 being 146. We still have 11.3% (14.6% in 2021) of staff for whom we have no data on their disability status. Please see the appendices for all WDES data tables.

**WDES 2023 recommendations**

- Develop Managers' Toolkit for staff with disabilities and reasonable adjustments (WDES Innovation Fund).
- Specialist training for HR Staff (WDES Innovation Fund).
- Trust Board to review relevant data, identify EDI areas of concern, and prioritise EDI actions in annual appraisals.
- Review flexible working policy.
- Develop and implement an improvement plan to address health inequalities within the workforce.
- Work with Capsticks to improve availability of data for capability measures.

| Metric | CNTW Figures for Latest Reporting Period | | | CNTW Figures for Previous Reporting Period | | | Trend |
|---|---|---|---|---|---|---|---|
| | Disabled | Non-Disabled | Comments | Disabled | Non-Disabled | Comments | |
| **Overall workforce** | 648 | 6334 | Disabled Staff 8.2% of total workforce | 532 | 6347 | Disabled Staff 6.6% of total workforce | Disabled workforce has grown (increased reporting) |
| **Non-Clinical Band 5 or below** | 85.6% | 80.1% | 9% Disabled non-Clinical staff | 89.7% | 77.6% | 7% Disabled non-Clinical staff | For clinical & non-clinical, there are more Disabled staff at Band 5 or below than non-disabled staff |
| **Clinical Band 5 or below** | 50.9% | 48.1% | 8.1% Disabled Clinical staff | 47.8% | 42.9% | 6.6% Disabled Clinical staff | |
| **Medical consultant grade** | 58.8% | 61.8% | 6.2% Disabled Medical staff | 61.5% | 65.7% | 5.5% Disabled Medical staff | There are more non-disabled staff at Consultant Grade |
| **Staff Appointed from Shortlisting** | 58 (647 shortlisted) | 680 (14022 shortlisted) | Disabled staff are more likely to be appointed from shortlisting (0.54) | 65 (895 shortlisted) | 711 (10756 shortlisted) | Disabled staff are more likely to be appointed from shortlisting (0.91) | Improvement over the last 2 reporting periods |
| **Staff entering formal capability process** | **No figures available for 2023** | | | The calculation is based on a two-year rolling average. The relative likelihood has been calculated as 1.70, down from 3.72 in 2021. This means that disabled members of staff are 1.70 times more likely to enter a formal capability process compared to non-disabled members of staff. | | | |
| **% Staff experiencing bullying, harassment or abuse from patients, relatives or public** | 30.5% | 25.7% | | 34% | 28.8% | | Improvement over the last 2 reporting periods |
| **% Staff experiencing bullying, harassment or abuse from manager** | 8.1% | 4% | | 11.6% | 4.9% | | Improvement over the last 2 reporting periods |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **% Staff experiencing bullying, harassment or abuse from colleagues** | 15.8% | 9.5% | | 15.2% | 11.1% | | Slight increase for Disabled staff, despite improvement for non-disabled staff |
| **% Staff or colleagues reporting bullying, harassment or abuse at work** | 71.8% | 70.1% | | 66.1% | 67.7% | | Improvement over the last 2 reporting periods |
| **% Staff believing organisation provides equal opportunities for career progression** | 63.7% | 61.6% | | 68.8% | 68.9% | | Significant decrease for both Disabled and non-disabled staff |
| **% Staff who felt pressure from manager to work, despite not feeling well enough** | 18.1% | 11% | | 18% | 13.5% | | Slight increase for Disabled staff, despite improvement for non-disabled staff |
| **% Staff satisfied with extent that Organisation values their work** | 44.6% | 54.1% | | 45.5% | 51.1% | | Slight decrease for Disabled staff, despite improvement for non-disabled staff |
| **% Staff with long-lasting health condition or illness saying employer has made adequate adjustment(s) to carry out their work** | 81.9% | N/A | | 81.3% | N/A | | Improvement over the last 2 reporting periods |
| **% Trust's Board Membership Compared to Overall Workforce** | 7.1% | N/A | Compares with 8.2% overall Disabled workforce | 7.1% | N/A | Compares with 6.6% overall Disabled workforce | The Trust Board is less representative of the overall Disabled workforce and this gap may increase or decrease depending on disclosure rates |

**Key WDES learnings for focus:**

- Disabled staff make up 9% of the overall non-clinical workforce, yet 85.6% of Disabled non-clinical staff are in band 5 or below. This is compared to 80.1% non-disabled staff being in band 5 or below.
- Disabled staff make up 8.1% of the overall clinical workforce, yet 50.9% of Disabled clinical staff are at band 5 or below. This is compared to 48.1% non-disabled staff being in band 5 or below.
- The above two datasets show that across the clinical and non-clinical workforce, there are more Disabled staff in band 5 or below than non-disabled staff.
- Disabled staff make up 6.2% of the overall medical workforce and 58.8% are at Consultant Grade. This compares to 61.8% of non-disabled staff and therefore there are more non-disabled staff at Consultant Grade than Disabled staff.
- There has been a slight increase of Disabled staff experiencing bullying, harassment or abuse from colleagues, however there was a decrease for non-disabled staff. The 2022 Staff Survey shows a 6.3% gap in the experiences of Disabled and non-disabled staff (4.1% in 2021), therefore the disparity between them has increased.
- There has been a decrease for both Disabled and non-disabled staff believing the organisation provides equal opportunities for career progression, with a decrease of 5.1% and 7.3% respectively. The 2022 Staff Survey shows a gap between Disabled and non-disabled staff of 2.1% (0.1% in 2021).

# APPENDICES
# WRES & WDES DATA 2023

**Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce**

| | WHITE | BME | ETHNICITY UNKNOWN/NULL |
|---|---|---|---|
| **1a) Non Clinical workforce** | **Verified figures** | **Verified figures** | **Verified figures** |
| Under Band 1 | 11 | 1 | 0 |
| Band 1 | 1 | 0 | 0 |
| Band 2 | 231 | 5 | 2 |
| Band 3 | 482 | 21 | 6 |
| Band 4 | 332 | 9 | 2 |
| Band 5 | 186 | 7 | 1 |
| Band 6 | 136 | 4 | 3 |
| Band 7 | 75 | 4 | 1 |
| Band 8A | 52 | 0 | 0 |
| Band 8B | 34 | 1 | 0 |
| Band 8C | 2 | 0 | 0 |
| Band 8D | 1 | 0 | 0 |
| Band 9 | 1 | 0 | 0 |
| VSM | 4 | 0 | 0 |

| | WHITE | BME | ETHNICITY UNKNOWN/NULL |
|---|---|---|---|
| **Clinical workforce** | **Verified figures** | **Verified figures** | **Verified figures** |
| Under Band 1 | 0 | 0 | 0 |
| Band 1 | 1 | 0 | 0 |
| Band 2 | 10 | 1 | 0 |
| Band 3 | 1596 | 243 | 10 |
| Band 4 | 369 | 24 | 3 |
| Band 5 | 590 | 106 | 7 |
| Band 6 | 1449 | 71 | 23 |
| Band 7 | 895 | 39 | 7 |
| Band 8A | 269 | 14 | 4 |
| Band 8B | 110 | 7 | 1 |
| Band 8C | 77 | 3 | 1 |
| Band 8D | 19 | 1 | 0 |
| Band 9 | 1 | 0 | 0 |
| VSM | 1 | 0 | 0 |
| Consultants | 116 | 88 | 0 |
| *of which Senior medical manager* | 0 | 1 | 0 |
| Non-consultant career grade | 27 | 52 | 0 |
| Trainee grades | 9 | 12 | 0 |
| Other | 0 | 0 | 0 |

**Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce**

**Relative likelihood of staff being appointed from shortlisting across all posts**

| | WHITE | BME | ETHNICITY UNKNOWN/NULL |
|---|---|---|---|
| | Verified figures | Verified figures | Verified figures |
| Number of shortlisted applicants | 4128 | 1339 | 0 |
| Number appointed from shortlisting | 1405 | 215 | 0 |
| Relative likelihood of appointment from shortlisting | 34.04% | 16.06% | 0% |
| Relative likelihood of White staff being appointed from shortlisting compared to BME staff | 2.12 | | |

**Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation**

| | WHITE | BME | ETHNICITY UNKNOWN/NULL |
|---|---|---|---|
| Number of staff in workforce | 7087 | 713 | 71 |
| Number of staff entering the formal disciplinary process | 76 | 12 | 0 |
| Likelihood of staff entering the formal disciplinary process | 1.07% | 1.68% | 0.00% |
| Relative likelihood of BME staff entering the formal disciplinary process compared to White staff | | 1.57 | |

**Relative likelihood of staff accessing non-mandatory training and CPD**

| | WHITE | BME | ETHNICITY UNKNOWN/NULL |
|---|---|---|---|
| Number of staff in workforce | 7087 | 713 | 71 |
| Number of staff accessing non-mandatory training and CPD: | No figures provided for 2023. | | |
| Likelihood of staff accessing non-mandatory training and CPD | | | |
| Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff | | | |

**Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months**

| | WHITE | ALL OTHER ETHNIC GROUPS |
|---|---|---|
| Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months | 26.6% | 36.2% |
| Total Responses | 3269 | 229 |

**Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**

| | WHITE | ALL OTHER ETHNIC GROUPS |
|---|---|---|
| Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months | 13.6% | 24.1% |
| Total Responses | 3262 | 228 |

**Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion**

| | WHITE | ALL OTHER ETHNIC GROUPS |
|---|---|---|
| Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion | 68.2% | 50.2% |
| Total Responses | 3239 | 225 |

**Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in last 12 months**

| | WHITE | ALL OTHER ETHNIC GROUPS |
|---|---|---|
| Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in last 12 months | 4.8% | 17.3% |
| Total Responses | 3260 | 225 |

**Percentage difference between the organisations' Board voting membership and its overall workforce**

| | White | BME | Unknown |
|---|---|---|---|
| Total Board Members | 13 | 1 | 0 |
| Voting Board Members | 13 | 1 | 0 |
| Exec | 5 | 1 | 0 |
| NED | 8 | 0 | 0 |

**Trust Board BME 7.7%**
**Trust Workforce BME 9.06%**

**Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce**

| | Disabled | % Disabled | Non-disabled | % Non-disabled | Unknown/Null | % Unknown/Null | Total |
|---|---|---|---|---|---|---|---|
| **1a) Non Clinical Staff** | | | | | | | |
| Under Band 1 | 2 | 16.7% | 9 | 75% | 1 | 8.3% | 12 |
| Bands 1 | 0 | 0% | 1 | 100% | 0 | 0% | 1 |
| Bands 2 | 23 | 9.7% | 198 | 83.2% | 17 | 7.1% | 238 |
| Bands 3 | 44 | 8.6% | 414 | 81.3% | 51 | 10% | 509 |
| Bands 4 | 36 | 10.5% | 288 | 84% | 19 | 5.5% | 343 |
| Bands 5 | 20 | 10.3% | 157 | 80.9% | 17 | 8.8% | 194 |
| Bands 6 | 8 | 5.6% | 118 | 82.5% | 17 | 11.9% | 143 |
| Bands 7 | 3 | 3.8% | 71 | 88.8% | 6 | 7.5% | 80 |
| Bands 8a | 6 | 11.5% | 42 | 80.8% | 4 | 7.7% | 52 |
| Bands 8b | 0 | 0% | 30 | 85.7% | 5 | 14.3% | 35 |
| Bands 8c | 0 | 0% | 2 | 100% | 0 | 0% | 2 |
| Bands 8d | 0 | 0% | 1 | 100% | 0 | 0% | 1 |
| Bands 9 | 0 | 0% | 1 | 100% | 0 | 0% | 1 |
| VSM | 4 | 100% | 0 | 0% | 0 | 0% | 4 |
| Other (e.g. Bank or Agency) Please specify in notes. | | | | | | | |
| Cluster 1: AfC Bands <1 to 4 | 105 | 9.5% | 910 | 82.5% | 88 | 8% | 1103 |
| Cluster 2: AfC bands 5 to 7 | 31 | 7.4% | 346 | 83% | 40 | 9.6% | 417 |
| Cluster 3: AfC bands 8a and 8b | 6 | 6.9% | 72 | 82.8% | 9 | 10.3% | 87 |
| Cluster 4: AfC bands 8c to VSM | 4 | 50% | 4 | 50% | 0 | 0% | 8 |
| Total Non-Clinical | 146 | | 1332 | | 137 | | 1615 |

**Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce**

| | Disabled | % Disabled | Non-disabled | % Non-disabled | Unknown/Null | % Unknown/Null | Total |
|---|---|---|---|---|---|---|---|
| **1b) Clinical Staff** | | | | | | | |
| Under Band 1 | 0 | 0% | 0 | 0% | 0 | 0% | 0 |
| Bands 1 | 1 | 100% | 0 | 0% | 0 | 0% | 1 |
| Bands 2 | 6 | 54.55% | 5 | 45.45% | 0 | 0% | 11 |
| Bands 3 | 136 | 7.36% | 1435 | 77.61% | 278 | 15.04% | 1849 |
| Bands 4 | 40 | 10.10% | 326 | 82.32% | 30 | 7.58% | 396 |
| Bands 5 | 63 | 8.96% | 536 | 76.24% | 104 | 14.79% | 703 |
| Bands 6 | 143 | 9.27% | 1239 | 80.30% | 161 | 10.43% | 1543 |
| Bands 7 | 69 | 7.33% | 792 | 84.17% | 80 | 8.50% | 941 |
| Bands 8a | 20 | 6.97% | 248 | 86.41% | 19 | 6.62% | 287 |
| Bands 8b | 1 | 0.85% | 113 | 95.97% | 4 | 3.39% | 118 |
| Bands 8c | 1 | 1.23% | 69 | 85.19% | 11 | 13.58% | 81 |
| Bands 8d | 3 | 15% | 17 | 85% | 0 | 0% | 20 |
| Bands 9 | 0 | 0% | 1 | 100% | 0 | 0% | 1 |
| VSM | 0 | 0% | 1 | 100% | 0 | 0% | 1 |
| Other (e.g. Bank or Agency) Please specify in notes. | 0 | | 0 | | 0 | | 0 |
| Cluster 1: AfC Bands <1 to 4 | 183 | 8.1% | 1766 | 78.2% | 308 | 13.6% | 2257 |
| Cluster 2: AfC bands 5 to 7 | 275 | 8.6% | 2567 | 80.5% | 345 | 10.8% | 3187 |
| Cluster 3: AfC bands 8a and 8b | 21 | 5.2% | 361 | 89.1% | 23 | 5.7% | 405 |
| Cluster 4: AfC bands 8c to VSM | 4 | 3.9% | 88 | 85.4% | 11 | 10.7% | 103 |
| Total Clinical | 483 | 8.1% | 4782 | 80.3% | 687 | 11.5% | 5952 |
| Medical & Dental Staff, Consultants | 11 | 5.42% | 143 | 70.44% | 49 | 24.14% | 203 |
| Medical & Dental Staff, Non-Consultants career grade | 7 | 8.86% | 58 | 73.42% | 14 | 17.72% | 79 |
| Medical & Dental Staff, trainee grades | 1 | 4.35% | 19 | 82.61% | 3 | 13.04% | 23 |
| Total Medical and Dental | 19 | 6.23% | 220 | 72.13% | 66 | 21.64% | 305 |
| Number of staff in workforce | 502 | | 5002 | | 753 | | 6257 |

**Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts**

| | Disabled | Non-disabled |
|---|---|---|
| Number of shortlisted applicants | 647 | 14022 |
| Number appointed from shortlisting | 58 | 680 |
| Likelihood of shortlisting/appointed | 0.089 | 0.048 |
| Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff | 0.54 | |

**Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure**

| | Disabled | Non-disabled |
|---|---|---|
| Total Number of Staff | No figures provided for 2023. | |
| Average number of staff entering the formal capability process over the last 2 years. (i.e. Total divided by 2.) | | |
| Likelihood of staff entering the formal capability process | | |
| Relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff | | |

**Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months**

| | Disabled | Non-disabled |
|---|---|---|
| Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months | 30.5% | 25.7% |
| Total Number of Responses | 1172 | 2335 |

**Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months**

| | Disabled | Non-disabled |
|---|---|---|
| Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months | 8.1% | 4.0% |
| Total Number of Responses | 1171 | 2318 |

**Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months**

| | Disabled | Non-disabled |
|---|---|---|
| Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months | 15.8% | 9.5% |
| Total Number of Responses | 1166 | 2311 |

**Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it**

| | Disabled | Non-disabled |
|---|---|---|
| Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it | 71.8% | 70.1% |
| Total Number of Responses | 408 | 663 |

**Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion**

| | Disabled | Non-disabled |
|---|---|---|
| Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion | 63.7% | 68.8% |
| Total Number of Responses | 1159 | 2314 |

**Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties**

| | Disabled | Non-disabled |
|---|---|---|
| Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties | 18.1% | 11% |
| Total Number of Responses | 746 | 964 |

**Percentage of staff satisfied with the extent to which their organisation values their work**

| | Disabled | Non-disabled |
|---|---|---|
| Percentage of staff satisfied with the extent to which their organisation values their work | 44.6% | 54.1% |
| Total Number of Responses | 1179 | 2329 |

**Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work**

| | Disabled |
|---|---|
| Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work | 81.9% |
| Total Number of Responses | 701 |

**Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work**

| | Disabled | Non-disabled |
|---|---|---|
| Staff engagement score (0-10) | 7.0 | 7.3 |
| Total Number of Responses | 1179 | 2338 |

## 15. GUARDIAN OF SAFE WORKING HOURS REPORT - QUARTER 1

Rajesh Nadkarni, Deputy Chief Executive / Medical Director

### REFERENCES

Only PDFs are attached

15. GOSW Quarter 1 Report July 2023.pdf

| | |
|---|---|
| **Name of meeting** | **Board of Directors** |
| **Date of Meeting** | **Wednesday 2 August 2023** |
| **Title of report** | **Guardian of Safe Working Quarterly Report – April to June 2023- Q1** |
| **Executive Lead** | **Dr Rajesh Nadkarni, Executive Medical Director**<br>**Lynne Shaw, Executive Director of Workforce & OD** |
| **Report author** | **Dr Clare McLeod, Guardian of Safe Working** |

| **Purpose of the report** | |
|---|---|
| **To note** | |
| **For assurance** | **X** |
| **For discussion** | |
| **For decision** | |

| **Strategic ambitions this paper supports (please check the appropriate box)** | |
|---|---|
| **1. Quality care, every day** | x |
| **2. Person-led care, when and where it is needed** | |
| **3. A great place to work** | x |
| **4. Sustainable for the long term, innovating every day** | |
| **5. Working with and for our communities** | |

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

| **Management 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 | x |
| Workforce | x | Environmental | |
| Financial/value for money | | Estates and facilities | |
| Commercial | | Compliance/Regulatory | x |
| Quality, safety and experience | x | Service user, carer and stakeholder involvement | |

| **Board Assurance Framework/Corporate Risk Register risks this paper relates to** |
|---|
| N/A |

**Board of Directors**
**Wednesday 2 August 2023**

**Guardian of Safe Working Quarterly Report**
**April to June 2023 – Q1**

## 1. Executive Summary

This is the Quarterly report for the period April to June 2023 for Safe Working Hours which focuses on Junior Doctors. The process of reporting has been built into the new junior doctor contract and aims to allow Trusts to have an overview of working practices of junior doctors as well as training delivered.

The new contract is offered to new trainees' as they take up training posts, in effect this will mean for a number of years we will have trainees employed on two different contracts. It is also of note that although we host over 160 trainee posts, we do not directly employ the majority of these trainees.

There are currently 169 trainees working into CNTW with 169 on the new Terms and Conditions of Service via the accredited training scheme via Health Education England. There are an additional 13 trainees employed directly by CNTW working as Trust Grade Doctors or Teaching/Research/Clinical Fellows.

**High level data**

Number of doctors in training (total): 169 Trainees (as at 4 July 2023)

Number of doctors in training on 2016 TCS (total): 169 Trainees (as at 4 July 2023)

Amount of time available in job plan for guardian to do the role: This is being remunerated through payment of 1 Additional Programmed Activity

Admin support provided to the guardian (if any): Ad Hoc by Medical Education Team

Amount of job-planned time for educational supervisors: 0.5 PAs per trainee

Trust Guardian of Safe-working Hours: Dr Clare McLeod

## 2. Key issues, significant risks and mitigations

- 12 Exception Reports raised during the period April to June 2023. 11 were due to hours & rest and 1 due to missing an educational opportunity. TOIL was granted for 6, payment was made for 4 and 2 are yet to be responded to.
- 1 Agency Locum was booked during the period covering vacant posts.
- 228 shifts lasting between 4hrs and 12hrs were covered by internal doctors.
- On 5 occasions during the period the Emergency Rotas were implemented (either by rota collapse or training rota covering a shift).
- 5 IR1s submitted due to insufficient handover of patient information.
- 4 Fines received during the quarter due to minimum rest requirements between shifts not being met.

**Exception reports (with regard to working hours)**

| | | Exception Reports Received April to June 2023 | | | | |
|---|---|---|---|---|---|---|
| Grade | Rota | Apr | May | June | Total Hours & Rest | Total Education |
| CT1-3 | St Nicholas | 0 | 0 | 0 | 0 | 0 |
| CT1-3 | Hopewood Park | 0 | 0 | 0 | 0 | 0 |
| CT1-3 | RVI/CAMHS | 0 | 0 | 0 | 0 | 0 |
| CT1-3 | NGH/CAV | 0 | 0 | 0 | 0 | 0 |
| CT 1-3 | St George's Park | 2 | 0 | 0 | 2 | 0 |
| CT 1-3 | GHD/MWM | 0 | 0 | 0 | 0 | 0 |
| CT 1-3 | Cumbria | 0 | 0 | 1 | 1 | 0 |
| ST4+ | North of Tyne | 1 | 1 | 1 | 3 | 0 |
| ST4+ | South of Tyne | 1 | 0 | 0 | 1 | 0 |
| ST4+ | CYPS (NR) | 0 | 1 | 4 | 4 | 1 |
| **Total** | | **4** | **2** | **6** | **11** | **1** |

**Work schedule reviews**

During the period April to June 2023 there have been 12 Exception Reports submitted from Trainees. 11 for hours and rest and 1 for missed educational opportunity; the outcome of which was that TOIL was granted for 6 cases, payment made for 4 cases and 2 cases still to be responded to.

**a) Locum bookings – Agency**

| Locum bookings (agency) by department | | | |
|---|---|---|---|
| Site | April | May | June |
| RVI | 0 | 0 | 1 |
| **Total** | **0** | **0** | **1** |

| Locum bookings (agency) by grade | | | |
|---|---|---|---|
| | April | May | June |
| F2 | 0 | 0 | 0 |
| CT1-3 | 0 | 0 | 1 |
| ST4+ | 0 | 0 | 0 |
| **Total** | **0** | **0** | **1** |

| Locum bookings (agency) by reason | | | |
|---|---|---|---|
| | April | May | June |
| Vacancy | 0 | 0 | 0 |
| Sickness/other | 0 | 0 | 1 |
| **Total** | **0** | **0** | **1** |

### a) Locum work carried out by trainees

| Area | Number of shifts worked | Number of shifts paid at enhanced rate | Number of shifts to cover sickness | Number of shifts to cover OH adjustments | Number of shifts to cover special leave | Number of shifts to cover a vacant post |
|---|---|---|---|---|---|---|
| SNH | 17 | 16 | 5 | 12 | 0 | 0 |
| SGP | 23 | 11 | 5 | 16 | 0 | 2 |
| Northgate | 14 | 2 | 2 | 10 | 0 | 2 |
| MWM/GHD | 36 | 11 | 17 | 3 | 0 | 16 |
| Hopewood Park | 35 | 19 | 4 | 7 | 0 | 24 |
| RVI | 24 | 6 | 24 | 0 | 0 | 0 |
| NGH | 36 | 18 | 12 | 22 | 1 | 1 |
| Cumbria | 25 | 7 | 9 | 16 | 0 | 0 |
| North of Tyne | 4 | 2 | 0 | 4 | 0 | 0 |
| South of Tyne | 14 | 0 | 10 | 4 | 0 | 0 |
| CAMHS | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **228** | **92** | **88** | **94** | **1** | **45** |

* 92 shifts were offered at an enhanced rate of £50 for 1st & £60 for 2nd on call rotas

### b) Vacancies

| Vacancies by month | | | | |
|---|---|---|---|---|
| Area | Grade | April | May | June |
| SGP | CT | 0 | 0 | 0 |
| | GP | 1 | 1 | 1 |
| | F2 | 0 | 0 | 0 |
| RVI | CT | 2 | 2 | 2 |
| | GP | 0 | 0 | 0 |
| | F2 | 0 | 0 | 0 |
| HWP | CT | 0 | 0 | 0 |
| | GP | 2 | 2 | 2 |
| | F2 | 0 | 0 | 0 |
| MWH/GHD | CT | 0 | 0 | 0 |
| | GP | 2 | 2 | 2 |
| | F2 | 0 | 0 | 0 |
| **Total** | CT | **2** | **2** | **2** |
| | GP | **5** | **5** | **5** |
| | F2 | **0** | **0** | **0** |

### c) Emergency Rota Cover

Emergency Rota cover is arranged when no cover can be found from either Agency or current Trainees. The Rotas are covered by 2 trainees rather than 3 and payment is made to the 2 trainees providing cover at half rate.

| Emergency Rota Cover by Trainees/Consultant* | | | | |
|---|---|---|---|---|
| | Rota | April | May | June |
| Sickness/Other | NOT | 0 | 0 | 0 |
| | SOT | 0 | 0 | 0 |
| | SGP | 0 | 0 | 0 |
| | Northgate | 0 | 0 | 0 |
| | SNH | 0 | 1 | 0 |
| | RVI | 0 | 0 | 0 |
| | GHD/MWM | 0 | 0 | 0 |
| | Cumbria | 0 | 0 | 0 |
| | HWP | 0 | 0 | 1 |
| | NGH | 0 | 0 | 0 |
| **Total** | | **0** | **1** | **1** |

An Emergency Rota cover is arranged when no cover can be found from either Agency or current Trainees. If cover is identified and filled in a timely manner there is no need for a Rota collapse.

**d) Training Rota Cover**

The training rota doctor can be asked to cover a gap in the standard rota to prevent the use of the emergency rota cover with the provision of alternative opportunities for this training.

| Training Rota Cover by First on-call Trainees | | | | |
|---|---|---|---|---|
| | Rota | April | May | June |
| Sickness/Other | SGP | 0 | 0 | 0 |
| | SNH | 1 | 0 | 0 |
| | RVI | 0 | 0 | 0 |
| | GHD/MWM | 0 | 0 | 0 |
| | HWP | 1 | 0 | 0 |
| | NGH | 0 | 1 | 0 |
| **Total** | | **2** | **1** | **0** |

**e) Fines**

There were 4 fines issued during this quarter due to 4 separate trainees breaching the 13 hour shift limit and having less than 11 hours rest between shifts. The spending of this money has not been discussed yet, it will be discussed in the next GOSW forum in July.

**Issues Arising**

There have been twelve exception reports submitted in this quarter; this figure is in keeping with numbers in the previous quarter but slightly lower than the same period in 2022 when seventeen exception reports were submitted. The number of exception reports submitted by higher trainees is more than previously which is encouraging as reporting is consistently less complete in this group, both in CNTW and across the country. The increase is mainly in resident on-call shifts (four this quarter in comparison to four over the whole of 2022) with the exception reporting on non-resident on-call rotas fairly stable. The increase is spread across different rotas and different trainees and relates to busy shifts when doctors stayed late to complete assessments and documentation; my impression having reviewed the reports and spoken to some of the trainees involved, is that this represents more complete reporting rather than a change in workloads.

We did not see a change or increase in numbers of exception reports over the periods of industrial action which is reassuring.

There have been four fines issued this quarter. These were all in different rotas and involving different trainees and represent busy shifts when the doctors stayed late to complete work that could not be handed over. Given that these incidents relate to different rotas I am confident that this does not represent a concern in a particular area, but more likely a better representation of some twilight and long day shifts and more complete reporting. There will be a discussion at the forum on 7 July to decide how to spend the money to the benefit of current trainees.

The Increase in number of shifts covered by Internal locums due to sickness, adjustments or rota gaps has remained stable this quarter, but with a reduction in the use of agency locums. The need for use of both the Emergency rota and the training / back up rota to cover shifts has significantly fallen this quarter which is encouraging. There were only three occasions when the doctor on the training / back up rota was required to cover a gap and only two occasions when the emergency rota was used.

IR1s are collated by Medical Education staff and the Director of Medical Education (DME) and are reviewed through the GoSW forum. There is a continued gradual fall in numbers which I think reflects improvement in practice.

Parking at some CNTW sites has been a problem for doctors and other staff, but St George's Park has been raised at the last two GoSW forums as especially difficult with trainees struggling to find a place to park and being in receipt of fines.

The GoSW forum has continued as a hybrid model since COVID restrictions were eased and plans to continue to run this way making it more accessible for all trainees to attend.

**3. Recommendation/summary**

Work continues to increase the completeness of Exception Reporting and change the culture of under-reporting. Trainees are encouraged to complete an exception report as necessary.

We will continue to encourage trainees to report episodes of Insufficient Medical Handover and promote good practice and feedback progress to clinicians throughout the Trust.

There has been a fall this quarter in the use of the emergency cover rota, the training / back up rota and of agency locums, although the use of internal locums to cover gaps remains stable. Work is in place to look to reduce the number of rota gaps which should further reduce the need for locum cover and the emergency rotas.

The Board of Directors is asked to receive the report for assurance.

Dr Clare McLeod
Guardian of Safe Working

Dr Rajesh Nadkarni
Executive Medical Director

Lynne Shaw
Executive Director of Workforce & OD

4 July 2023

## 16. BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK UPDATE (Q1)

Debbie Henderson, Director of Communications and Corporate Affairs

### REFERENCES

Only PDFs are attached

- 16 a. BoD - BAF Risk Exception Report - Q1 23-24.pdf
- 16b. Appendix 2 BAF  Risk Register Q1 23-24.pdf
- 16c. Appendix 1 - Trust-wide Risk Management Appetite Report - Q2 22-23.pdf
- 16d. Appendix 3 Clinical Audit.pdf
- 16e.  Appendix 4 Internal Audit.pdf
- 16f. Appendix 5 Movement report Q1.pdf

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

| | |
|---|---|
| **Name of meeting** | Board of Directors Meeting |
| **Date of Meeting** | 2 August 2023 |
| **Title of report** | Board Assurance Framework (BAF) Exception Report |
| **Executive Lead** | Debbie Henderson, Director of Communications and Corporate Affairs |
| **Report author** | Yvonne Newby, Risk Management Lead |

| **Purpose of the report** | |
|---|---|
| **To note** | √ |
| **For assurance** | √ |
| **For discussion** | √ |
| **For decision** | |

| **Strategic ambitions this paper supports (please check the appropriate box)** | |
|---|---|
| **1. Quality care, every day** | X |
| **2. Person-led care, when and where it is needed** | X |
| **3. A great place to work** | X |
| **4. Sustainable for the long term, innovating every day** | X |
| **5. Working with and for our communities** | X |

| **Meetings where this item has been considered** | |
|---|---|
| Quality and Performance | X |
| Audit | X |
| Mental Health Legislation | X |
| Remuneration Committee | |
| Resource and Business Assurance | X |
| Charitable Funds Committee | |
| People | X |
| CEDAR Programme Board | |
| Other/external (please specify) | |

| **Management 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 | X |
| Financial/value for money | X | Estates and facilities | |
| Commercial | | Compliance/Regulatory | X |
| Quality, safety, effectiveness and experience | X | Service user, carer and stakeholder involvement | |

| Board Assurance Framework/Corporate Risk Register risks this paper relates to |
|---|
| **Mental Health Legislation Committee** |
| **SA1** Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day.<br>**Risk 1691** As a result of not meeting statutory and legal requirements regarding Mental Health Legislation this may compromise the Trust's compliance with statutory duties and regulatory requirements. (SA1) |
| **Quality and Performance Committee** |
| **SA1** Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day.<br>**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) |
| **SA1** Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day.<br>**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. (SA1) |
| **SA2** Person-led care, when and where it is needed – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals.<br>**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. (SA2) |
| **People Committee** |
| **SA3** A great place to work – We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers.<br>**Risks 1694**<br>Inability to recruit the required number of medical staff or provide alternative ways of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high-class services. (SA3) |
| **Provider Collaborative Committee** |
| **SA1** Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day.<br>**Risk 1831** Due to the failure of third-party providers there is a risk that this may place pressure on CNTW which could result in the Trust not being able to manage effectively impacting on the quality of care to existing services users (SA1) |

| |
|---|
| **SA5** Working with and for our communities – We will create trusted, long-term partnerships that work together to help people and communities.<br>**Risk 2041**: Inability to influence the changing NHS structural architecture leading to adverse impacts on clinical care that could affect the sustainability of MH and disability services. (SA5) |

| **Resource and Business Assurance Committee** |
|---|
| **SA5** Working with and for our communities – We will create trusted, long-term partnerships that work together to help people and communities.<br>**Risk 1680** If the Trust were to acquire service level and additional geographical areas this could have a detrimental impact on CNTW as an organisation. (SA5) |
| **SA4** Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled.<br>**Risk 1687**: That we do not manage our resources effectively in the transition from COVID planning to ongoing sustainability and delivery of our transformation programme. (SA4) |
| **SA4** Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled**.**<br>**Risk 1762** Restrictions in Capital expenditure imposed nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments. (SA4) |
| **SA4** Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled.<br>**Risk 1853** The climate and ecological change is affecting the physical and mental health of current and future generations and adaptation plan to be in place regarding the infrastructure and preparedness for extreme weather. The delivery of the Green Plan is paramount to reduce the impact of climate change. (SA4) |

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

**Report to the Board of Directors Meeting**
**2 August 2023**
**Board Assurance Framework (BAF)**

## 1. Executive Summary

The Trust Board Assurance Framework identifies the strategic ambitions and key risks facing the organisation in achieving the strategic ambitions.

This paper provides:

- A summary of the overall number and grade of risks contained in the BAF.
- A detailed description of the BAF level risks including:
  - Any changes made to the BAF including mitigations, controls and actions
  - Recommendations to close BAF risk 1831
  - Alignment of the Trusts Risk Appetite to each risk
  - Alignment of internal/clinical audits against risks
  - Risk score movement trend chart for each risk.
- A copy of the Trusts Risk Appetite table is attached as **appendix 1.**
- A copy of the BAF is included as **appendix 2**.
- A copy of Clinical Audit Plan 2022/2023 as **appendix 3**.
- A copy of Internal Audit Plan 2022/2023 as **appendix 4.**
- A high-level copy of changes to the BAF for 2022/2023 as **appendix 5.**

## 2. Key issues, significant risks, and mitigations

As mentioned in the Quarter 4 report there is still an increase in risks being reported at Directorate and Locality Level which will now be reported through Executive Manage Group (EMG) on a quarterly basis. All risks that exceed the risk appetite will be reported in EMG.

A report has been created which informs the Risk Management Lead of any new risks which have been added to Web Risk Register within the last 7 days. This enables any quality issues to be identified and amended immediately.

Three monthly Quality Risk Reports are being provided to Localities/Directorates on a rota basis to assist with quality issues with existing risks.

## 3. Recommendation/summary

### Recommendation

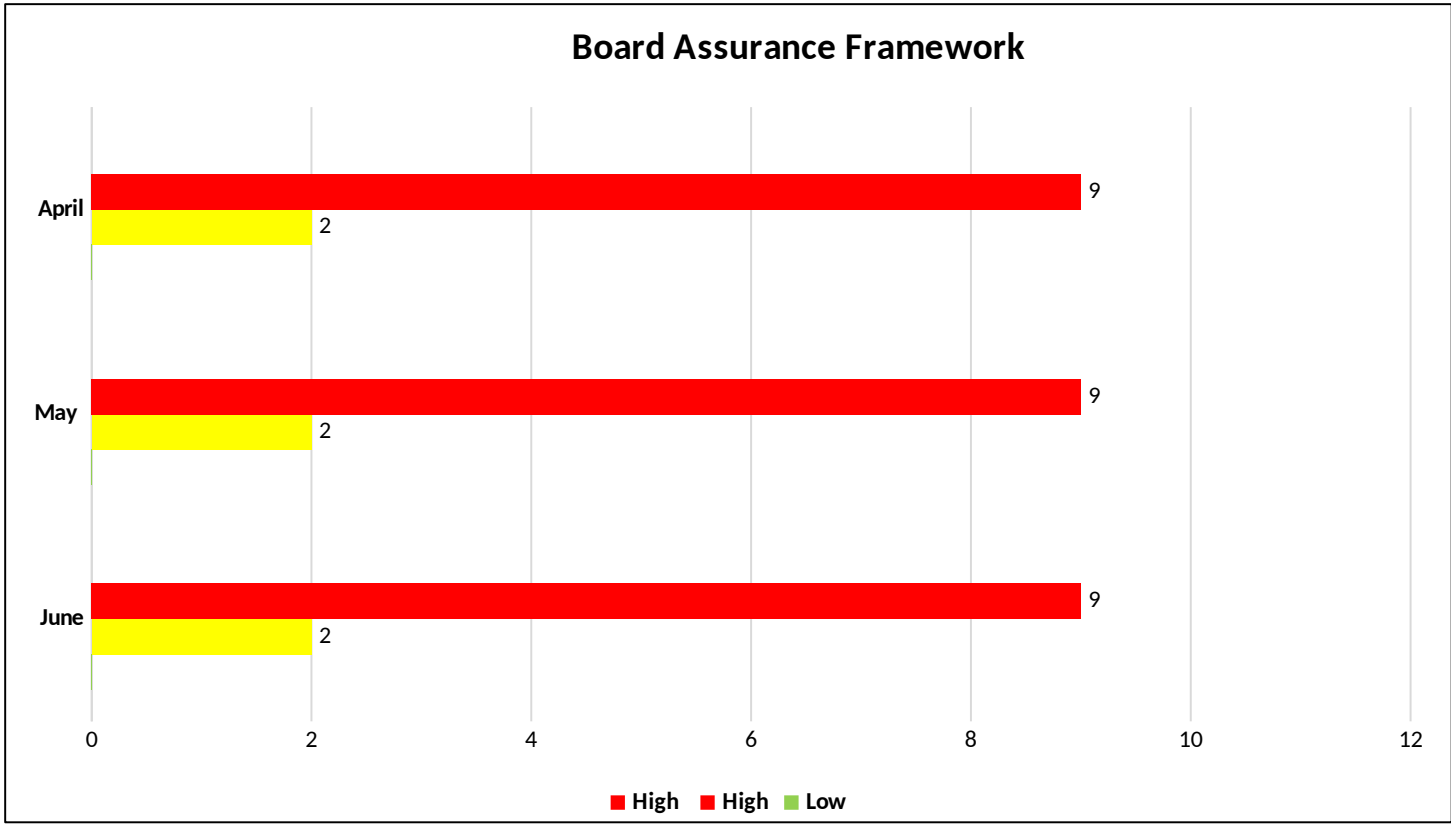
The Trust Board are asked to:

- Note the changes and approve the BAF.
- Note the risks which have exceeded a risk appetite and be assured that the Board Committees have appropriate oversight of risks.
- **Approve** the closure of risk 1831 – detailed in section 1.7 of the report.
- Provide any comments of feedback.

## 1.0 Board Assurance Framework

The graphs below show a summary of both the overall number and grade of risks held on the Board Assurance Framework Risk Register as at end of June 2023 and which risk appetite categories the risks are aligned to.

Each risk category has an assigned risk tolerance score. The risk tolerance score highlights when a risk is below, within or has exceeded a risk appetite tolerance. There are currently 11 risks on the BAF and nine risks which have exceeded a risk appetite tolerance, two are within the risk appetite there are no risks below the risk appetite.

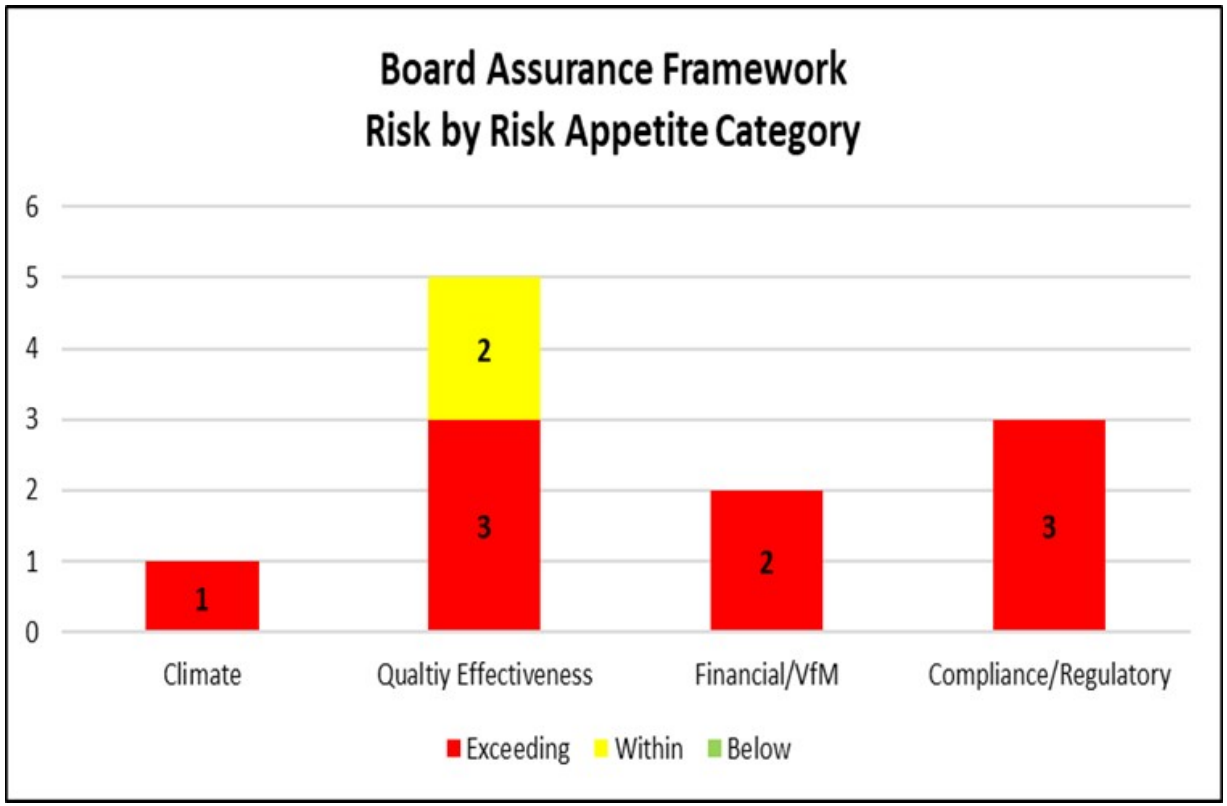



### 1.1. Risk Appetite

The below table shows risks by risk appetite category. The highest risk appetite category is Quality defined as Effectiveness which is the delivery risks that may compromise of outcomes.

Each risk category has an assigned risk tolerance score. The risk tolerance score highlights when a risk is below, within or has exceeded a risk appetite tolerance. There are currently 11 risks on the BAF and 9 risks which have exceeded a risk appetite tolerance, two are within the risk appetite and 0 risks are below the risk appetite.

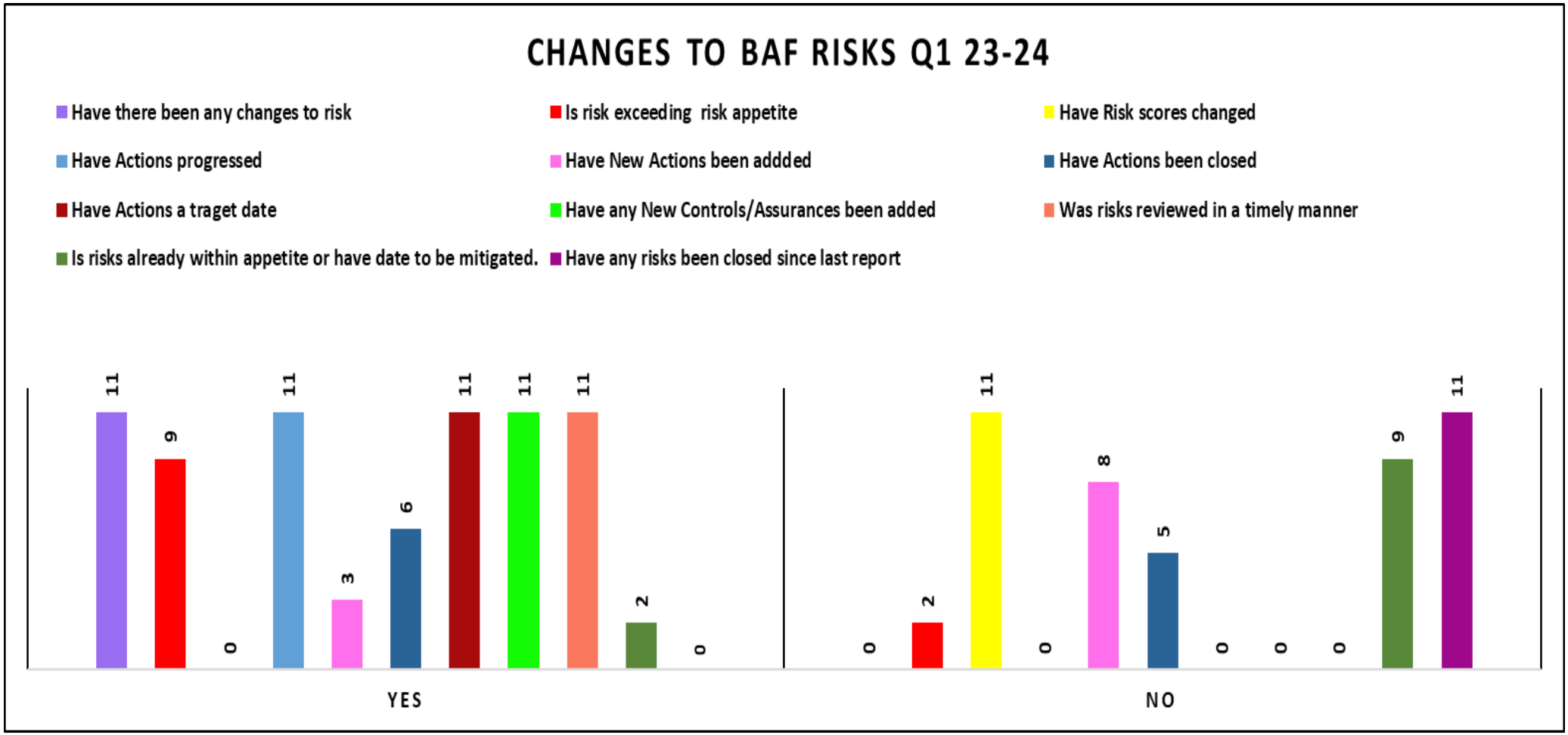
The table below shows all BAF risks which have exceeded the risk appetite in Q1.






**1.2 Changes to BAF Q1**

The chart below gives a breakdown of the changes to BAF risk register in Q1.






A detailed description of each BAF risk which has **exceeded a risk appetite** can be found below. Action plans are in place to ensure these risks are managed effectively and these are reported to the relevant Board Sub-Committees for oversight and assurance.

| Number | Date | Description | I | L | Risk Rating | Owner | Risk Group | Risk Register Type | Risk Type |
|---|---|---|---|---|---|---|---|---|---|
| 1680 | 09/10/2018 | If the Trust were to acquire additional services and geographical areas this could have a detrimental impact on CNTW as an organisation. (SA5)<br>**SA5** Working with and for our communities - We will create trusted, long-term partnerships that work together to help people and communities. | 4 | 3 | 12 | Kevin Scollay | Compliance/Regulatory (6-10) | Commissioners | RBAC |
| 1683 | 15/03/2018 | 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<br>**SA1** Quality care, every day - We want to deliver expert, compassionate, person-led care in every team, every day. | 4 | 4 | 16 | Ramona Duguid | Quality Effectiveness (6-10) | Treatment | Q&P |
| 1687 | 15/03/2018 | That we do not manage our resources effectively in the transition from COVID planning to ongoing sustainability and delivery of our key programmes. SA4<br>**SA4** Sustainable for the long term, innovating every day - We will be a sustainable, high performing organisation, use our resources well and be digitally enabled. | 5 | 4 | 20 | Kevin Scollay | Financial/Value For Money (12-16) | Efficiency | RBAC |
| 1688 | 15/03/2018 | 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. SA 5<br>**SA1** Quality care, every day - We want to deliver expert, compassionate, person-led care in every team, every day. | 5 | 4 | 20 | Ramona Duguid | Compliance/Regulatory (6-10) | CQC | Q&P |
| 1691 | 29/10/2018 | As a result of not meeting statutory and legal requirements regarding Mental Health Legislation this may compromise the Trust's compliance with statutory duties and regulatory requirements. SA1<br>**SA1** Quality care, every day - We want to deliver expert, compassionate, person-led care in every team, every day. | 4 | 3 | 12 | Rajesh Nadkarni | Compliance/Regulatory (6-10) | MH Legislation | MHL Group |
| 1694 | 06/11/2018 | Inability to recruit the required number of medical staff or provide alternative ways of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high class services. (SA3)<br>**SA3** A great place to work - We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers. | 4 | 3 | 12 | Ramona Duguid | Quality Effectiveness (6-10) | Services | People Committee |
| 1762 | 07/11/2019 | Restrictions in Capital expenditure due to national limits and the Trusts own cash availability may lead to increasing risk of harm to patients when continuing to use sub optimal environments (SA4)<br>**SA4** Sustainable for the long term, innovating every day - We will be a sustainable, high performing organisation, use our resources well and be digitally enabled. | 5 | 4 | 20 | Kevin Scollay | Financial/Value For Money (12-16) | Sustainability | RBAC |
| 1836 | 01/06/2020 | 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. (SA2)<br>**SA2** Person-led care, when and where it is needed - We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals. | 4 | 3 | 12 | Ramona Duguid | Quality Effectiveness (6-10) | Services | Q&P |
| 1853 | 24/09/2020 | The climate and ecological change is affecting the physical and mental health of current and future generations and adaptation plan to be in place regarding the infrastructure and preparedness for extreme weather. The delivery of the Green Plan is paramount to reduce the impact of climate change. (SA4)<br>**SA4** Sustainable for the long term, innovating every day - We will be a sustainable, high performing organisation, use our resources well and be digitally enabled. | 4 | 3 | 12 | James Duncan | Climate & Ecological Sustainability (6-10) | Green Plan | RBAC |

A detailed description of each BAF risk which are **within a risk appetite** can be found below. Action plans are in place to ensure these risks are managed effectively.

| Number | Date | Description | I | L | Risk Rating | Owner | Risk Group | Risk Register Type | Risk Type |
|---|---|---|---|---|---|---|---|---|---|
| 1831 | 01/06/2020 | Due to the failure of third-party providers there is a risk that this may place pressure on CNTW which could result in the Trust not being able to manage effectively impacting on the quality of care to existing services users (SA1)<br>**SA1** Quality care, every day - We want to deliver expert, compassionate, person-led care in every team, every day. | 3 | 3 | 9 | Kevin Scollay | Quality Effectiveness (6-10) | Services | Provider Collaborative |
| 2041 | 21/09/2021 | Inability to influence the changing NHS structural architecture leading to adverse impacts on clinical care that could affect the sustainability of MH and disability services. SA5<br>**SA5** Working with and for our communities - We will create trusted, long-term partnerships that work together to help people and communities. | 4 | 2 | 8 | Kevin Scollay | Quality Effectiveness (6-10) | Services | Provider Collaborative |

### 1.3. Risk Escalations to the BAF/CRR

There have been no risks escalated to the BAF in Q1.

### 1.4. Risks to be de-escalated

There have been no BAF risks deescalated in Q1.

### 1.5 Internal Audit relating to Risk Management & Board Assurance Framework

Audit One completed Audit CNTW 202223 01, Risk Management and BAF in May 2023. This audit tested the application of controls in respect of risk management and the BAF and included a review of any changes since the last review i.e., changes to BAF format or approach, changes to risk management policy or process. The review of issues raised in the previous audit review were confirmed as being actioned and addressed.

In relation to the BAF compliance with the following areas of best practice was tested:

- Ownership and accountability of each element of the BAF during 22/23 (Executive lead and Committee reviews for each area).
- Ensuring the content has been kept current and up to date.
- Reporting of the BAF to the Board and Audit Committee sufficiently during the year and sufficient consideration has been given to the issues and risks.
- That risk management activity is clearly positioned in the BAF so that it contributes to the assurance provided.
- That risks are aligned to strategic objectives and priorities.

In relation to the risk management process, this audit tested compliance with the processes for risk identification, analysing/assessing risks and evaluating/scoring risks at Clinical Business Unit (CBU)/Divisional level, speciality, and Group/corporate level. The process for the escalation and de-escalation of risks from department to CBU/divisional, from department to speciality and from CBU/divisional to Group/corporate level was also tested.

In this instance Internal Audit have concluded that overall assessment of the BAF and risk management process, governance, and internal control arrangements provide a **Good** level of assurance. The implementation and embedding of the management actions agreed as part of the audit will move this from good to substantial assurance.

**1.6 BAF risk 1688 transferred Ramona Duguid**

As of July 2023, Kevin Scollay, Executive Director of Finance was identified as responsible Executive Lead for BAF 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)*. This risk has been transferred to Ramona Duguid, Chief Operating Officer.

**1.7 Recommending closure of BAF risk 1831**

The Board of Directors are asked to approve the closure of BAF risk 1831 *(due to the failure of third-party providers, there is a risk that this may place pressure on CNTW which could result in the Trust not being able to manage effectively impacting on the quality of care to existing services users)*. Contract information is now discussed at BDG Finance Group. This is an opportunity for the locality groups to have input into contracting processes and make the contracting team aware of new contracts being entered into. It is felt that this risk can now be closed.

**1.8 Risk Management Strategy, Risk Management Policy, and refresh to the Board Assurance Framework**

The Director of Communications and Corporate Affairs and Risk Management Lead has commenced a review of the Board Assurance Framework, Risk Management Policy and Risk Management Strategy for the next 5 years to be aligned to the new Trust ‘With You in Mind’ strategy and organisational priorities agreed by the Board in July 2023. The review is expected to be complete in August, with a proposal for Board agreement and roll out in September 2023.

Executive Lead: Debbie Henderson, Director of Communication and Corporate Affairs
Report author: Yvonne Newby, Risk Management Lead
Date: 24 July 2023

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

**Appendix 2**

# BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER 2023-2024 Quarter 1

# BAF Report

NHS
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NHS Foundation Trust

| Risk Description: | Risk Rating: | Likelihood | Impact | Score | Rating |
|---|---|---|---|---|---|
| As a result of not meeting statutory and legal requirements regarding Mental Health Legislation this may compromise the Trust's compliance with statutory duties and regulatory requirements. SA1 | Risk on identification (29/10/2018): | 3 | 4 | 12 | Moderate |
| | Residual Risk (with current controls in place): | 3 | 4 | 12 | Moderate |
| | Target Risk (after improved controls): | 2 | 4 | 8 | Low (Yellow) |
| SA1 Quality care, every day - We want to deliver expert, compassionate, person-led care in every team, every day. | **Risk Appetite (the amount of Risk NTW will accept)** | Compliance/Regulatory | | | Breach |

| Controls & Mitigation (what are we currently doing about the risk) | Assurances/ Evidence (how do we know we are making an impact) | Gaps in Controls (Further actions to achieve target risk) |
|---|---|---|
| 1 Integrated Governance Framework | 1 Independent review of governance | Final Internal Audit report CNTW-2021-22/02 Governance Arrangements LTSP - Assurance rating - Reasonable some moderate remedial action required. |
| 2 Trust Policies and Procedures relating to relevant acts and practice | 2 Compliance with policy/training requirements NTW181957 Compliance review of MHA Rights - Good Level - Feb 19 | |
| 3 Decision making framework | 3 Decision making framework document | Awaiting the Government response to the consultation to then know what changes will take effect within the Mental Health Legislation |
| 4 Performance review/integrated performance reports | 4 Reports to Board and sub committees | |
| 5 Mental health legislation committee | 5 Minutes of mental health legislation committee | Improvement review of MHA Training: Q1 - Q4 23/24<br>Updated figures from Training Dashboard:-<br>Q1 23/24 - 70.3% snapshot |
| 6 New process in place for monitoring themes from MHA Reviewer visits through MHL Steering Group | 6 MHL Group papers and updates | |
| 7 CQC MHA Reviewer session delivered at learning and development group in November 2018 | 7 Minutes and papers from Learning and Development Group | |
| 8 Internal Audit 18/19 | 8 NTW 2018/19/57 Compliance Review of MHA - Patient Rights. Good. | |

| | | | | |
|---|---|---|---|---|
| | | | NTW 2018-19/58 Compliance Review of Mental Health Act - Rolling Programme - CTO - Substantial | |
| 2 | Effectiveness of reporting on themes from MHA Reviewer visits | 2 | Mental Health Legislation Steering Group. CQC compliance Group will now review themes and this will be carried out monthly. | |
| 3 | Regular review and monitoring of CQC themes raised with Groups at the Mental Health Steering Group and BDG | 3 | Mental Health Legislation Steering Group. CQC compliance Group will now review themes and this will be carried out monthly. | |
| 4 | Mental Health Act Reform Consultation ended on 21 April and CNTW submitted their response to the proposed changes on 20 April 2021 to the Government | 4 | The Government published the response to Reforming the MHA in July 2021. Currently no implementation date and most likely a few years off due to Covid. | |
| 5 | Working Task Sub Group to monitor remote assessments and support the digitalisation of the MHA - | 5 | Reported and monitored by IMG and BDG | |
| 6 | At a glance boards. | 6 | Report will be used to monitor compliance with consent to treatment provisions within part 4a of the MHA. | |
| 7 | Internal Audit CNTW 2021- 22/07 Performance Management report (SA5) | 7 | CNTW 2021- 22/07 Performance Management Report (SA5) | |
| 8 | Supreme Court ruling in the MM case in 2018. Ability to discharge detained patients (managed by LD Clinical Services) | 8 | The High Court decision made on 09.11.21. Provides a legal mechanism to enable capable restricted patients who need to be deprived of their liberty in the community, to live in the community on extended section 17 leave even if | |

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

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|---|---|---|---|---|
| | | this means there is no element of hospital treatment. | | |
| 2 | Internal Audit - CNTW 2022-23 26 Mental Health Act - Delegation of Statutory Functions | 2 | Final Report - Good Assurance given | |
| 3 | Internal Audit - CNTW 2021-22 08 - Consent to Examination or Treatment - Electroconvulsive Therapy (ECT) | 3 | Final Report - Good Assurance given | |
| 4 | Internal Audit - CNTW 22-23 01 Risk Management & BAF | 4 | Final report - Good Assurance given | |

**Ref:** 1691v.39

**Risk Owner:** Rajesh Nadkarni

**Next Review Date:** 04/10/2023

**Review/Comments:**

06/07/2023 - Yvonne Newby - Q1 snapshot figure added to action.

# BAF Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

| Risk Description: | Risk Rating: | Likelihood | Impact | Score | Rating |
|---|---|---|---|---|---|
| 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 | Risk on identification (15/03/2018): | 4 | 4 | 16 | Moderate |
| | Residual Risk (with current controls in place): | 4 | 4 | 16 | Moderate |
| | Target Risk (after improved controls): | 1 | 4 | 4 | Very Low |
| SA1 Quality care, every day - We want to deliver expert, compassionate, person-led care in every team, every day. | **Risk Appetite (the amount of Risk NTW will accept)** | Quality Effectiveness | | | Breach |

| Controls & Mitigation (what are we currently doing about the risk) | Assurances/ Evidence (how do we know we are making an impact) | Gaps in Controls (Further actions to achieve target risk) |
|---|---|---|
| 1 UEC and IP Programme of work refreshed and updated for 2022/23 deliverables | 1 Monthly updates to BDG | Staffing shortages continue to be challenging in key areas, thus impacting on consistent core MDT within ward teams. |
| 2 Monthly BDG discussion on delivery and impact of UEC and IP programme | 2 Daily admissions/patient flow dashboard now live | Bed occupancy remains high with significant DTOC in older persons and learning disabilities. |
| 3 Ward Manager forum established. | 3 Improvement outcomes dashboard drafted to support impact of work. | Crisis team capacity and input to look at overall alternatives to admission. |
| 4 Inpatient essential staffing review commenced. | 4 Report when review completed. | Admission and Discharge policy drafted but not yet launched. |
| 5 Daily safe staffing huddles in place | 5 Emails detailing staffing issues. | Regularly monitor bed availability, consider use of decant beds as a contingency, further work on the bed census to timely discharge. Where appropriate the greater use of rehabilitation beds to free up acute beds. |
| 6 Clinical Audit CA-19-0035 - Trust wide Safeguarding Adults Audit. Good Practice | 6 Clinical Audit final report | |
| 7 Locality daily patient flow meetings remain in place with morning report out for all patients waiting for admission. | 7 Emails | |
| 8 Review of quality flags daily to prioritise clinical need. | 8 Emails | |

## BAF Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

| | | |
|---|---|---|
| 1 Weekly patient tracker meetings in place | 1 Patient tracker | CA-21-0012 - Nutrition policy audit - Moderate areas of concern re Audit is due in Q3 23/24. |
| 2 Weekly DTOC and increased capacity for discharge implemented. | 2 DTOC Report | |
| 3 Internal Audit - CNTW 22-23 01 Risk Management & BAF | 3 Final report - Good level of assurance given | |

**Ref:** 1683v.31

**Risk Owner:** Ramona Duguid

**Next Review Date:** 04/10/2023

**Review/Comments:**

# BAF Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

| Risk Description: | Risk Rating: | Likelihood | Impact | Score | Rating |
|---|---|---|---|---|---|
| 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. SA 1 | Risk on identification (15/03/2018): | 3 | 5 | 15 | Moderate |
| | Residual Risk (with current controls in place): | 4 | 5 | 20 | High (Red) |
| | Target Risk (after improved controls): | 1 | 5 | 5 | Very Low |
| SA1 Quality care, every day - We want to deliver expert, compassionate, person-led care in every team, every day. | **Risk Appetite (the amount of Risk NTW will accept)** | Compliance/Regulatory | | | Breach |

| Controls & Mitigation (what are we currently doing about the risk) | Assurances/ Evidence (how do we know we are making an impact) | Gaps in Controls (Further actions to achieve target risk) |
|---|---|---|
| 1 Integrated Governance Framework | 1 IIntegrated Governance Framework | CA-21-0038 - The Safe Prescribing of Rapid Tranquilisation (RT) - Final report minor areas of concerns - re-audit is due in Q3 24-25 |
| 2 Trust policies and procedures | 2 Compliance with policy and procedures | CA-22-063.01 Safeguarding Adults at Risk Final Report - Moderate areas of concern re-audit is due in Q3 23/24. |
| 3 Compliance with NICE | 3 Internal Audit - rolling programme | |
| 4 CQC Compliance Group and Compliance Steering Group - re-started fortnightly | 4 Reports and updates to board sub committees | CA-21-0012 - Nutrition policy audit - moderate areas of concern re-audit is due in Q2 23/24. |
| 5 Performance reviewed/integrated commissioning and assurance reports | 5 Reports/updates to board sub committees | CA-21-0001: Allied Health Professional (AHP) Continuing Professional Development (CPD) Audit 2021 |
| 6 Accountability Framework - Quarterly meetings | 6 Accountability Framework document | Final Report CA-20-006 (NCAP EIP) Actions identified in Clinical Audit report. CA-21-0031 |
| 7 Regulatory framework of CQC NHSI | 7 NTW18-19 - 19/05 CQC Internal Audit (well-led) - Process Substantial Assurance | |
| 8 Agreement of Quality Priorities | 8 Monitored via reports/updates | |
| 9 Monitoring of MHA Reviewer Visit actions and themes | 9 MHA Reviewer Visit Database | |

# BAF Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

| | | | | |
|---|---|---|---|---|
| 1 | Clinical Audit Report - CA-21-0010 Long-Term Segregation 2020-2021. | 1 | Clinical Audit final report - 10 September 2021 | NCAP EIP Re-Audit 2021-2022 low risk rating. |
| 2 | Clinical Audit Report CA - 18-0003 Clinical Supervision Audit. Good Practice | 2 | Clinical Audit final report - 1 April 2021 | CA-21-0019 - Body maps audit - Trust wide but led in North Cumbria |
| 3 | Recovery Plan including a half year review. | 3 | Copy of recovery Plan | CA-21-0022 NICE (Baseline Assessment) QS127 Obesity:Clinical Assessment & Management |
| 4 | CA-19-0036 National Audit of Care at End of Life | 4 | Final Report 10.03.23 - Good level of Assurance | CA-21-0032 NICE (Implementation) NG134 Depression in CYPS - Areas of Concern |
| 5 | CA-21-0026 - Naso Gastric Tube Feeding Audit | 5 | Final Report 10.03.23 - Good level of Assurance | |
| 6 | Internal Audit Report - CNTW 2022-2023 14 Performance Management & Reporting | 6 | Final Report 15.05.23 - Substantial level of Assurance | |
| 7 | Internal Audit - CNTW 22-23 01 Risk Management & BAF | 7 | Final report - Good level of assurance given | |

**Ref:** 1688v.66

**Risk Owner:** Ramona Duguid

**Next Review Date:** 05/08/2023

**Review/Comments:**

11/07/2023 - Kevin Scollay - Reviewed today. Risk has been transferred from Kevin Scollay to Ramona Duguid. Actions updated and new target dates set.

# BAF Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

| Risk Description: | Risk Rating: | Likelihood | Impact | Score | Rating |
|---|---|---|---|---|---|
| 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. (SA2)<br><br>SA2 Person-led care, when and where it is needed - We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals. | Risk on identification (01/06/2020): | 3 | 4 | 12 | Moderate |
| | Residual Risk (with current controls in place): | 3 | 4 | 12 | Moderate |
| | Target Risk (after improved controls): | 1 | 4 | 4 | Very Low |
| | **Risk Appetite (the amount of Risk NTW will accept)** | Quality Effectiveness | | | Breach |

| Controls & Mitigation (what are we currently doing about the risk) | Assurances/ Evidence (how do we know we are making an impact) | Gaps in Controls (Further actions to achieve target risk) |
|---|---|---|
| 1 Trust oversight meeting in place to support mental health community transformation in line with NHS LTP. | 1 Investment plans in place and agreed across local systems. | Maturity of PCN and secondary care relationships. |
| 2 Locality leadership meetings with system partners established across place. | 2 Increase in additional roles across PCNs and regular reporting into BDG on governance framework for new roles. | System re-organisation and development of place based teams whilst achieving core offer across all of CNTW community services. |
| 3 PCN recruitment and additional roles in progress. | 3 Report on access and waiting times challenges to BDG. | Ability to balance recruitment to new roles whilst not destabilising core services. |
| 4 Waiting times for community access reviewed monthly with focus on long waiters and challenged pathways in place. | 4 Commissioning and QA report to Q&P. | Staff fragility and shortages within community teams affecting ability to invest in new roles and meet demand for existing care co-ordination. |
| 5 Clinical Audit CA-19-0033 Caseload Management - Central Locality. Good Practice | 5 Clinical Audit final report. | Ability to engage with other parts of the system to achieve LTP goals |

# BAF Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

| | | | | |
|---|---|---|---|---|
| 1 | Clinical Audit CA-19-0035 - Trust wide Safeguarding Adults Audit. Good Practice | 1 | Clinical Audit final report | Delivery of new access standards for community care. |
| 2 | BDG realigned to provide monthly oversight of CMHT delivery. | 2 | Commissioning and QA report to BDG and TLT. ARRS and Primary care governance framework to support current and new roles. | |
| 3 | CMHT deliverables for 22/23 realigned and updated to focus on core community model, delivering CPA changes and primary care interface & relationships. | 3 | CMHT deliverables for 22/23 | |
| 4 | Internal Audit - CNTW 22-23 01 Risk Management & BAF | 4 | Final report - Good level of assurance given | |

**Ref:** 1836v.22

**Risk Owner:** Ramona Duguid

**Next Review Date:** 04/10/2023

**Review/Comments:**

28/04/2023 - Yvonne Newby - Reviewed today. One control/assurance added. Risk will now be reviewed quarterly. No other changes to risk.

# BAF Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

| **Risk Description:** |
|---|
| That we do not manage our resources effectively in the transition from COVID planning to ongoing sustainability and delivery of our key programmes. SA4<br><br>SA4 Sustainable for the long term, innovating every day - We will be a sustainable, high performing organisation, use our resources well and be digitally enabled. |

| **Risk Rating:** | **Likelihood** | **Impact** | **Score** | **Rating** |
|---|---|---|---|---|
| Risk on identification (15/03/2018): | 3 | 5 | 15 | Moderate |
| Residual Risk (with current controls in place): | 4 | 5 | 20 | High (Red) |
| Target Risk (after improved controls): | 2 | 5 | 10 | Low (Yellow) |
| **Risk Appetite (the amount of Risk NTW will accept)** | Financial/Value For Money | | | Breach |

| **Controls & Mitigation (what are we currently doing about the risk)** | **Assurances/ Evidence (how do we know we are making an impact)** | **Gaps in Controls (Further actions to achieve target risk)** |
|---|---|---|
| 1 Integrated governance framework | 1 Annual Governance Statement, Quality Account ,Annual plans | To review impact and need of weekly agency reporting ahead of the end of March 2023. |
| 2 Annual Financial Plan 22/23 | 2 Annual Financial Plan 22/23 submitted | To develop plans to reduce agency spend to 1 million a month by 31.03.23. Including Board report 29.11.22. |
| 3 Financial and Operating procedures | 3 Policy/PGN NTW1718 26 Payroll expenditure ,NTW 1718 39 Cashier | Internal Audit Report - CNTW 2022/23 22 Temporary Staffing Costs - Reasonable assurance with moderate remedial actions required |
| 4 Quality Goals and Quality Account | 4 External audit of Quality Account | |
| 5 Accountability Framework | 5 Accountability Framework Reports | |
| 6 Quarterly review of financial delivery | 6 Quarterly review delivered at RBAC | |
| 7 Programme agreed for capacity to care and Trust Innovations capacity expanded | 7 Capacity to care programme, report to BDG and Executive Management Group (EMG) | |
| 8 Going Concern Report | 8 Going Concern Report - Audit Committee April 2022 | |

# BAF Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

| | | | | |
|---|---|---|---|---|
| 1 | NTW 18/19 Internal Audit | 1 | NTW 1819 25 Single Oversight Framework, Substantial, April 2019<br>NTW 1819 37 Procurement: Good, July 2019<br>NTW 1819 38 Compliance Review of Key Financial Systems: Good, May 2019<br>NTW 18/19 43 Risk based audit of charitable funds - Substantial, August 2018<br>NTW18/19 41 Risk based audit payroll - Substantial, November 2018<br>NTW18/19 40 Central arrangements managing patient monies - Substantial, February 2019 | |
| 2 | Quarterly Reporting of operational plan to Trust Leadership Team(TLT) for August 2021 onwards | 2 | Trust Leadership Team(TLT) papers re quarterly reporting | |
| 3 | Internal Audit of CNTW Key Finance Systems (202122 03). | 3 | Final report dated 20.07.22 good level of assurance. | |
| 4 | Recovery Plan went to October Board including a half year review. | 4 | Copy of Recovery Plan | |
| 5 | Internal Audit - CNTW 22-23 01 Risk Management & BAF | 5 | Final report - Good level of assurance given | |

**Ref:** 1687v.46

**Risk Owner:** Kevin Scollay

**Next Review Date:** 15/08/2023

**Review/Comments:**

06/06/2023 - Yvonne Newby - Reviewed today. Actions updated and new target dates set. One control/assurance added.

# BAF Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

| Risk Description: |
|---|
| Restrictions in Capital expenditure due to national limits and the Trusts own cash availability may lead to increasing risk of harm to patients when continuing to use sub optimal environments (SA4)<br><br>SA4 Sustainable for the long term, innovating every day - We will be a sustainable, high performing organisation, use our resources well and be digitally enabled. |

| Risk Rating: | Likelihood | Impact | Score | Rating |
|---|---|---|---|---|
| Risk on identification (07/11/2019): | 3 | 5 | 15 | Moderate |
| Residual Risk (with current controls in place): | 4 | 5 | 20 | High (Red) |
| Target Risk (after improved controls): | 1 | 5 | 5 | Very Low |
| **Risk Appetite (the amount of Risk NTW will accept)** | Financial/Value For Money | | | Breach |

| Controls & Mitigation (what are we currently doing about the risk) | Assurances/ Evidence (how do we know we are making an impact) | Gaps in Controls (Further actions to achieve target risk) |
|---|---|---|
| 1 Financial planning budgets | 1 Reported and in minutes of Executive Management Group (EMG) and RBAC | Capital Strategy for North Cumbria and Rose Lodge to be developed, to be incorporated into ICS strategy prioritisation for national capital funding |
| 2 Working capital management | 2 Reported through and in minutes of Executive Management Group (EMG) and RBAC | |
| 3 Going Concerns Reporting | 3 Discussed and in minutes of Audit Committee | |
| 4 OBC approved nationally - CEDAR business case including inherent improvement to revenue position | 4 Agreement of long term plan as part of CEDAR OBC - Approved by the Board (minutes) | |
| 5 CEDAR Programme Board established with key partners | 5 Minutes of CEDAR Programme Board | |
| 6 Business case approved interim solutions for WAA, Newcastle and Gateshead - Building programme in place | 6 Business Case document | |
| 7 Operational mitigations: Additional staffing at Rose Lodge. Interim funding for North Cumbria. Integrated Care Facility | 7 Minutes of Executive Management Group (EMG) meeting | |

# BAF Report

| | | | | |
|---|---|---|---|---|
| | in Newcastle | | | |
| 2 | ICS support nationally and funding identified | 2 | ICS bid document | |
| 3 | Asset sales now identified | 3 | Standard reporting at Executive Management Group (EMG) and RBAC | |
| 4 | CEDAR Business Case FBC - bridging loan agreed | 4 | CEDAR Business Case | |
| 5 | Capital Plan for 21/22 agreed by the Board as part of the Annual Financial Plan | 5 | Board papers and Capital Plan | |
| 6 | Clinical Audit CA-19-0035 - Trust wide Safeguarding Adults Audit. Good Practice | 6 | Clinical Audit final report | |
| 7 | Internal Audit - CNTW 22-23 01 Risk Management & BAF | 7 | Final report - Good level of assurance given | |

**Ref:** 1762v.28

**Risk Owner:** Kevin Scollay

**Next Review Date:** 24/10/2023

**Review/Comments:**

02/05/2023 - Kevin Scollay - Reviewed today. Action 5551 has been completed and closed. One control/assurance added. No other changes made to risk.

# BAF Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

| Risk Description: |
|---|
| The climate and ecological change is affecting the physical and mental health of current and future generations and adaptation plan to be in place regarding the infrastructure and preparedness for extreme weather. The delivery of the Green Plan is paramount to reduce the impact of climate change. (SA4)<br><br>SA4 Sustainable for the long term, innovating every day - We will be a sustainable, high performing organisation, use our resources well and be digitally enabled. |

| Risk Rating: | Likelihood | Impact | Score | Rating |
|---|---|---|---|---|
| Risk on identification (24/09/2020): | 4 | 4 | 16 | Moderate |
| Residual Risk (with current controls in place): | 3 | 4 | 12 | Moderate |
| Target Risk (after improved controls): | 2 | 4 | 8 | Low (Yellow) |
| **Risk Appetite (the amount of Risk NTW will accept)** | Climate & Ecological Sustainability | | | Breach |

| Controls & Mitigation (what are we currently doing about the risk) | Assurances/ Evidence (how do we know we are making an impact) | Gaps in Controls (Further actions to achieve target risk) |
|---|---|---|
| 1 Commitment of CNTW - Declared Climate Emergency | 1 CNTW Climate Health Programme | Routine reporting of carbon intensive activity, sustainable transport measures and single use plastic is underdeveloped. |
| 2 Plan to reduce carbon omission to net zero by 2040. Opportunities for decarbonisation funding actively sought. | 2 Minutes of Executive Management Group (EMG has replaced TLT) | Develop a training resource to incorporate climate, ecological and social business into a business case |
| 3 Executive Management Group meeting - monthly | 3 Minutes of Executive Management Group (EMG has replaced TLT) | Progressing a staff engagement programme. |
| 4 The Board approved Green Plan has annual objectives which are monitored via TLT and RBAC. | 4 Minutes of Executive Management Group (EMG has replaced TLT) | |
| 5 Internal Audit - CNTW 22-23 01 Risk Management & BAF | 5 Final report - Good level of assurance given | |

# BAF Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

**Ref:** 1853v.20

**Risk Owner:** James Duncan

**Next Review Date:** 04/10/2023

**Review/Comments:**

20/06/2023 - Yvonne Newby - Reviewed today. One control/assurance added. Actions will be reviewed in September 23 as Trust Green Plan won't be refreshed until after the Strategy is launched.

# BAF Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

| Risk Description: | Risk Rating: | Likelihood | Impact | Score | Rating |
|---|---|---|---|---|---|
| If the Trust were to acquire additional services and geographical areas this could have a detrimental impact on CNTW as an organisation. (SA5) | Risk on identification (09/10/2018): | 4 | 4 | 16 | Moderate |
| | Residual Risk (with current controls in place): | 3 | 4 | 12 | Moderate |
| | Target Risk (after improved controls): | 2 | 4 | 8 | Low (Yellow) |
| SA5 Working with and for our communities - We will create trusted, long-term partnerships that work together to help people and communities. | **Risk Appetite (the amount of Risk NTW will accept)** | Compliance/Regulatory | | | Breach |

| Controls & Mitigation (what are we currently doing about the risk) | Assurances/ Evidence (how do we know we are making an impact) | Gaps in Controls (Further actions to achieve target risk) |
|---|---|---|
| 1 Joint Programme Board | 1 Minutes of meetings | Achievement of North Cumbria CQC must do improvement areas Q4. |
| 2 Due Diligence | 2 Due Diligence report | Agree Estates Strategy for North Cumbria |
| 3 Exec Leadership | 3 Identified Exec Lead | CQC Inspection Steering Group set up in April to review all outstanding areas of improvement (Must Dos and Should Dos) |
| 4 Specific Capacity Identified | 4 Identified CNTW Team | |
| 5 Clear Oversight by Trust Board | 5 Board Development sessions and Papers | |
| 6 Secured workforce to deliver services | 6 Identified staff | Executive Management Group to receive monthly updates on outstanding areas of improvement. |
| 7 Implementation plan developed | 7 Implementation planning paper | |
| 8 Contract agreed and completed | 8 Contract report- Reviewed RBAC | Board of Directors to receive more regular updates on the position around Must Dos on a Quarterly basis Q1 (23/24) due 04.07.23 |
| 9 Monthly Implementation Group | 9 Minutes and reports from meeting | |
| Maintain oversight during the establishment of Lotus Ward | Closed Trust Board | |
| North Cumbria 2 years on Presentation, presented to Council | Copy of presentation | |

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

| | | | |
|---|---|---|---|
| | of Governors 25.11.21 | | |
| 2 | Pressures on Systems across the whole organisation presentation to the Board 23.11.21 | 2 Copy of presentation. | |
| 3 | Internal Audit - CNTW 22-23 01 Risk Management & BAF | 3 Final report - Good level of assurance given | |

**Ref:** 1680v.63

**Risk Owner:** Kevin Scollay

**Next Review Date:** 15/08/2023

**Review/Comments:**

06/06/2023 - Yvonne Newby - Reviewed today. One action 8337 completed and closed. 3 new actions added 11634,11635 & 11636. One action updated and new target date set. One control/assurance added.

# BAF Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

| **Risk Description:** | **Risk Rating:** | **Likelihood** | **Impact** | **Score** | **Rating** |
|---|---|---|---|---|---|
| Inability to recruit the required number of medical staff or provide alternative ways of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high class services. (SA3)<br><br>SA3 A great place to work - We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers. | Risk on identification (06/11/2018): | 4 | 4 | 16 | Moderate |
| | Residual Risk (with current controls in place): | 3 | 4 | 12 | Moderate |
| | Target Risk (after improved controls): | 2 | 4 | 8 | Low (Yellow) |
| | **Risk Appetite (the amount of Risk NTW will accept)** | Quality Effectiveness | | | Breach |

| **Controls & Mitigation (what are we currently doing about the risk)** | **Assurances/ Evidence (how do we know we are making an impact)** | **Gaps in Controls (Further actions to achieve target risk)** |
|---|---|---|
| 1 Workforce strategy | 1 Delivery of workforce strategy | Executive Awareness of International recruitment through Medical Director, Trust aware for medical recruitment as a whole through medical managers |
| 2 RPIW Medical Recruitment | 2 RPIW Medical Recruitment outcomes papers | CA-22.063.01 - Safeguarding Adults at Risk |
| 3 NTW International recruitment competency process | 3 NTW International recruitment competency documents | Difficulties recruiting registered and unregistered nursing staff. |
| 4 OPEL Framework | 4 OPEL Framework Documents | Risk to be discussed at the Medics Meeting and actions to be updated re: medical staffing |
| 5 MDT Collegiate Leadership Team in place | 5 MDT Leadership advice and support available | |
| 6 All seven fellowship international recruits arrived into the Trust in December 2018 | 6 All still in post and deployed across the Trust | |
| 7 The medical recruitment functions have been moved to the medical staffing team | 7 The medical staffing team manage the medical recruitment function | |
| 8 Medical Induction Programme | 8 Delivery of medical induction programme | |

# BAF Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

| | | |
|---|---|---|
| 1 Clinical Audit CA-19-0035 - Trust wide Safeguarding Adults Audit. Good Practice | 1 Clinical Audit final report | |
| 2 Internal Audit - CNTW 22-23 01 Risk Management & BAF | 2 Final report - Good assurance given | |

**Ref:** 1694v.32

**Risk Owner:** Ramona Duguid

**Next Review Date:** 05/08/2023

**Review/Comments:**

30/06/2023 - Yvonne Newby - Reviewed today. One action 10235 completed and closed. 3 actions updated and new target dates set. One control/assurance added. No other changes made to risk.

# BAF Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

| Risk Description: | Risk Rating: | Likelihood | Impact | Score | Rating |
|---|---|---|---|---|---|
| Due to the failure of third-party providers there is a risk that this may place pressure on CNTW which could result in the Trust not being able to manage effectively impacting on the quality of care to existing services users (SA1) | Risk on identification (01/06/2020): | 4 | 3 | 12 | Moderate |
| | Residual Risk (with current controls in place): | 3 | 3 | 9 | Low (Yellow) |
| | Target Risk (after improved controls): | 1 | 3 | 3 | Very Low |
| SA1 Quality care, every day - We want to deliver expert, compassionate, person-led care in every team, every day. | **Risk Appetite (the amount of Risk NTW will accept)** | Quality Effectiveness | | | Within Risk Appetite |

| Controls & Mitigation (what are we currently doing about the risk) | Assurances/ Evidence (how do we know we are making an impact) | Gaps in Controls (Further actions to achieve target risk) |
|---|---|---|
| 1 Sign Subcontracts | 1 To complete | Set up contract meeting to monitor Trust contracts with third party providers and manage any associated issues. |
| 2 Clear Service Specifications | 2 To complete | |
| 3 Contract monitoring meetings | 3 Minutes of Contract monitoring meetings | |
| 4 Governance Arrangement through to Board - New Sub Committee of the Board established to monitor Lead Provider Collaborative. | 4 Board approved Governance arrangements | |
| 5 Internal Audit NTW1718/22 | 5 Risk Based Audit of Commissioning Income Contracts and Monitoring Arrangements 16 January 2018 | |
| 6 Provider Collaborative Lead Provider Committee | 6 Provider Collaborative Reporting | |
| 7 CNTW 202122/13 -Internal Audit Advisory Review - Provider Collaborative. | 7 Final Report Internal Audit Advisory Review - Provider Collaborative. | |
| 8 Internal Audit Report - CNTW 2022/23 05 Management of | 8 Final Report Internal Audit Report - CNTW | |

| | | | |
|---|---|---|---|
| | Service Level Agreements - Substantial level of assurance | 2022/23 05 Management of Service Level Agreements | |
| 2 | Internal Audit - CNTW 22-23 01 Risk Management & BAF | 2 Final report - Good level of assurance given | |

**Ref:** 1831v.33

**Risk Owner:** Kevin Scollay

**Next Review Date:** 17/08/2023

**Review/Comments:**

11/07/2023 - Kevin Scollay - Contract information is now discussed at BDG finance this is an opportunity for the locality groups to have input into contracting processes and make the contracting team aware of new contracts being entered into. Risk to be closed after risk has been to Board for approval to close.

# BAF Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

| Risk Description: | Risk Rating: | Likelihood | Impact | Score | Rating |
|---|---|---|---|---|---|
| Inability to influence the changing NHS structural architecture leading to adverse impacts on clinical care that could affect the sustainability of MH and disability services. SA5 | Risk on identification (21/09/2021): | 4 | 4 | 16 | Moderate |
| | Residual Risk (with current controls in place): | 2 | 4 | 8 | Low (Yellow) |
| | Target Risk (after improved controls): | 2 | 4 | 8 | Low (Yellow) |
| SA5 Working with and for our communities - We will create trusted, long-term partnerships that work together to help people and communities. | **Risk Appetite (the amount of Risk NTW will accept)** | Quality Effectiveness | | | Within Risk Appetite |

| Controls & Mitigation (what are we currently doing about the risk) | Assurances/ Evidence (how do we know we are making an impact) | Gaps in Controls (Further actions to achieve target risk) |
|---|---|---|
| 1 Executive and Group leadership embedded at place. | 1 Part of Place Based Leadership Models influencing models of care. | Look to increase LP models across Trust footprint. |
| 2 Leadership of ICS MH Workstream. | 2 Regular updates to Executive Management Group (EMG which had replaced TLT) and Board. | CA-21-0001: Allied Health Professional (AHP) Continuing Professional Development (CPD) Audit 2021 |
| 3 Membership of other ICS workstreams (LD, Acute pathways). | 3 Regular updates to Executive Management Group (EMG which had replaced TLT) and Board. | |
| 4 Partnership in place across ICS for MHLDA Specialised Services. | 4 PB Papers and PC Committee oversight | |
| 5 Lead Provider Models for pathways e.g. CYPS, IAPT, Veterans, Substance Misuse. | 5 PB Papers and PC Committee oversight. | |
| 6 Medical Director member of Integrated Care Board (ICB) | 6 Regular updates to Executive Management Group (EMG which had replaced TLT) and Board. | |
| 7 Internal Audit - CNTW 22-23 01 Risk Management & BAF | 7 Final report - Good level of assurance given | |

**Ref:** 2041v.20

**Risk Owner:** Kevin Scollay

**Next Review Date:** 15/10/2023

**Review/Comments:**

11/07/2023 - Kevin Scollay - Reviewed today. Action update and new target set. Will be looking to close risk at next review.

## Select a risk appetite category based on the impact of your identified risk

**Risk Appetite Statement**

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust recognises that its long-term sustainability depends upon the delivery of its strategic ambitions and its relationships with its service users, carers, staff, public and partners. As such, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust will not accept risks that materially provide a negative impact on quality (safety, experience and effectiveness).

However, CNTW has a greater appetite to take considered risks in terms of their impact on organisational issues. CNTW has a greater appetite to pursue Commercial opportunities, partnerships, clinical innovation, Financial/Value for Money and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated and/or it is in the best interests of the population we serve.

| Category | Risk Appetite | Risk Appetite Score |
|---|---|---|
| Clinical Innovation | CNTW has a **MODERATE** risk appetite for Clinical Innovation that does not compromise quality of care. | **12-16** |
| Commercial | CNTW has a **HIGH** risk appetite for Commercial gain whilst ensuring quality and sustainability for our service users. | **20-25** |
| Compliance/Regulatory | CNTW has a **LOW** risk appetite for Compliance/Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements. | **6-10** |
| Financial/Value for money | CNTW has a **MODERATE** risk appetite for financial/VfM which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements. | **12-16** |
| Partnerships, including new system working (ICS, ICP and PLACE) | CNTW has a **HIGH** risk appetite for partnerships which may support and benefit the people we serve. | **20-25** |
| Reputation | CNTW has a **MODERATE** risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation. | **12-16** |
| Quality Effectiveness | CNTW has a **LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users. | **6-10** |
| Quality Experience | CNTW has a **LOW** risk appetite for risks that may affect the experience of our service users. | **6-10** |
| Quality Safety | CNTW has a **LOW** risk appetite for risks that may compromise safety. | **6-10** |
| Climate and Ecological Sustainability | CNTW has a **LOW** risk appetite for risks that may result in the harming of the environment which could lead to harm to the health and safety of the service users, carers and staff and the population we serve | **6-10** |

## Appendix 3

| Most Recent Old Style Reference | IDNUM | Newest Reference Number | Audit Title | Audit Priority | Clinical Audit Programme Category | Locality/CBU (for CBU specify locality also) | 22-23 | 23-24 | BAF / DIR Risk Aligned to Audit |
|---|---|---|---|---|---|---|---|---|---|
| CA-21-0001 | CA-xx-001 | CA-23-001 | CPD audit for AHPs (Trustwide) | Should do | Trust Priority | Trustwide | | Re-audit due Q4 | BAF 1688 SA1<br>BAF 2041 SA5 |
| CA-21-0011 | CA-xx-011 | CA-22-011.05 | Seclusion Annual Audit | Must do | Trust Priority | Trustwide | Closed | Registered | BAF 1688 SA1 |
| CA-21-0012 | CA-xx-012 | CA-23-012.02 | Nutrition policy audit | Must do | Trust Priority | Trustwide | Closed | Re-audit due Q2 | BAF 1688 SA1 |
| CA-21-0019 | CA-xx-019 | CA-22-019.01 | Body maps audit - Trustwide but led in North Cumbria | Must Do | CQC/NICE | Trustwide | Closed | | BAF 1688 SA1 |
| CA-21-0023 | MM-xx-023 | MM-22-023.01 | The safe use of opiates within CNTW (PGN-PPT-PGN 18) | Should Do | Trust Priority | Trustwide | Closed | | BAF 1688 SA1 |
| CA-21-0031 | NA-xx-031 | | National Clinical Audit of Psychosis (NCAP) 21-22 EIP Re-Audit | Must do | National | Trustwide | Closed | | BAF 1688 SA1 |
| CA-21-0032 | NI-xx-032 | | NICE (Implementation) NG134 Depression in Children & Young People Re-Audit | Must do | NICE Implementation | Trustwide | Closed | | BAF 1688 SA1 |
| CA-21-0038 | CA-xx-038 | CA-23-038.01 | The Safe Prescribing of Rapid Tranquilisation (RT) | Must Do | MM Priority | Trustwide | Closed | Re-audit due Q3 | BAF 1688 SA1 |
| CA-21-0039 | CA-xx-039 | CA-22-039.05 | Physical Health Monitoring following Rapid Tranquilisation | Must do | CQC/NICE | Trustwide | Closed | Closed & Reauditing | BAF 1688 SA1 |
| CA-19-0035 | CA-xx-063 | CA-22-063.01 | Safeguarding adults at Risk | Should do | Trust Priority | Trustwide | Closed | Re-audit due Q3 | BAF 1688 SA1 |
| NA | CA-xx-072 | | Care Planning including relapse/contingency planning (personalised/collaborative) | Should Do | CBU Priority | North Locality | Withdrawn | | |
| NA | CA-xx-073 | CA-22-073 | Recording of supervision in clinical records | Should Do | CBU Priority | North Locality - Community | Registered | | BAF 1836 SA2<br>BAF 1688 SA1 |
| NA | CA-XX-103 | CA-23-103 | A Clinical Audit to access the Braden Scale Completion | Should Do | Trust Priority | Trustwide | | Registered | BAF 1688 SA1 |

| Internal Audit 2022/2023 | | | | | | |
|---|---|---|---|---|---|---|
| | 2023/2024 | | | | | |
| | Q1 | Q2 | Q3 | Q4 | Target Date | BAF/Directorate Ref |
| **Governance, Risk and Performance** | | | | | | |
| Risk Management & Board Assurance Framework | | | | * | Apr-24 | All BAF |
| Governance Arrangements | | * | | | Oct-23 | SA1 |
| **Finance, Contracting & Capital** | | | | | | |
| Key Finance System | | | * | | Jan-24 | BAF 1687 SA4 |
| **Human Resources & Workforce** | | | | | | |
| Pre Employment Checks | | | * | | Jan-24 | SA3 |
| Onboarding Process<br>(Excludes Bank & Agency which was covered during 2022-23) | | | * | | Jan-24 | SA3 |
| Allocate – North Cumbria Locality | | | | * | Jun-24 | |
| **Technology Risk Assurance: IM&T & Information Governance** | | | | | | |
| Data Security & Protection Toolkit – Interim Assessment June 2023 Submission | * | | | | Oct-23 | SA4 |
| Data Security & Protection Toolkit – Interim Assessment June 2024 Submission | | | | * | Oct-24 | SA4 |
| Cyber Assurance: Penetration Testing (external facing network devices) | | * | | | Oct-23 | |
| Cyber Assurance Data Centre Security St Nicholas Hospital | * | | | | Oct-23 | |
| Cyber Assurance Back up Solution | | | * | | Jun-24 | |
| **Data Quality** | | | | | | |
| Performance Management & Reporting | | | | * | Jun-24 | |
| **Quality & Clinical Governance** | | | | | | |
| Medical Devices | | | * | | Jan-24 | |
| CQC Action Plan North Cumbria Locality | | * | | | Oct-23 | |

**Follow Up Audits**

**All final audit reports issued with an assurance level of 'Reasonable' and 'Limited' will be followed up (once management have confirmed that all recommendations have been implemented). Furthermore, a year end exercise will be undertaken to review the status of all high-graded recommendations raised during the year.**

**Audit Management**

- Annual Planning
- Audit Committee Reporting & Attendance
- Head of Internal Audit Annual Report & Opinion
- Management & External Audit Liaison

| Review Area - Additional Assurances and Advisory | 2023/2024 | | | | | |
|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | Target Date | BAF/Directorate Ref |
| **Governance, Risk and Performance** | | | | | | |
| Provider Collaborative | * | | | | Oct-23 | |
| Green Plan | | * | | | Oct-23 | |
| Business Continuity Plans | | * | | | Oct-23 | |
| Organisational Change Management | | | | | | |
| **Finance, Contracting & Capital** | | | | | | |
| Budgetary Control – Locality Level | | | * | | Apr-24 | |
| Capital Programme – Reporting & Control | | | * | * | Jan-24 | |
| Cost Improvement Programme | | * | | | Oct-23 | |
| **Human Resources & Workforce** | | | | | | |
| Disciplinary Processes | | | * | | Jan-24 | |
| Bank & Agency – Pre-Employment Screening & Local Onboarding Process | | | | * | Jun-24 | |
| Recruitment of Bank Staff | | | * | | Jan-24 | |
| **Quality & Clinical Governance** | | | | | | |
| Patient Safety Incident Response Framework (PSIRF) | * | | | | Oct-23 | |
| MHA – Consent - CTO | | * | | | Oct-23 | |
| MHA – S136 Place of Safety | | | | * | Apr-24 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Technology Risk Assurance: IM&T & Information Governance** | | | | | | |
| Omnicell System – Security and Management Controls | | | * | | Apr-24 | |
| TRAC System Security | | | | * | Apr-24 | |
| **IM&T & Information Governance** | | | | | | |
| Benchmarking | | | | | TBC | |
| **NWT Solutions** | | | | | | |
| Data Security Protection Toolkit | | | | * | Jun-24 | |
| Key Performance Indicators (KPIs) | | | | * | Apr-24 | |
| Penetration Testing | * | | | | Oct-23 | |
| Business Change | * | | | | Oct-23 | |
| Contracting in Accordance with SFIs | | * | | | Jan-24 | |

**Appendix 5**

| Board Assurance FrameWork 2023-2024 | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BAF Movement Chart 2023 - 2024 | | | | | | | | | | | | | | | | |
| Strategic Ambition | Risk No. | Risk Description | Executive Lead | Sub Committee | Review Frequency | Risk Appetite | Risk Scores | | | | | | Gaps in Controls within Q4 | | |
| | | | | | | | Q1 | Q2 | Q3 | Q4 | Target Score | Expected date risk to be mitigated and brought within the risk category appetite. | Open Actions | Added Actions | Closed Actions |
| SA1 Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day. | 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) | Ramona Duguid | Q&P | Quarterly | Quality Effectiveness (6-10) | 16 ⟷ | | | | 4 | There is currently no expected date for this risk being brought within risk category appetite. It will continue to be monitored on a quarterly basis and brought within the risk category appetite as soon as practicable. | 5 | 0 | 0 |
| | 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. (SA1) | Ramona Duguid | Q&P | Monthly | Compliance/ Regulatory (6-10) | 20 ⟷ | | | | 5 | There is currently no expected date for this risk being brought within risk category appetite. It will continue to be monitored on a quarterly basis and brought within the risk category appetite as soon as practicable. | 9 | 1 | 6 |
| | 1691 | As a result of not meeting statutory and legal requirements regarding Mental Health Legislation this may compromise the Trust's compliance with statutory duties and regulatory requirements. (SA1) | Rajesh Nadkarni | MHL Group | Quarterly | Compliance/ Regulatory (6-10) | 12 ⟷ | | | | 8 | There is currently no expected date for this risk being brought within risk category appetite. It will continue to be monitored on a quarterly basis and brought within the risk category appetite as soon as practicable. | 3 | 0 | 0 |
| | 1831 | Due to the failure of third-party providers there is a risk that this may place pressure on CNTW which could result in the Trust not being able to manage effectively impacting on the quality of care to existing services users (SA1) | Kevin Scollay | Provider Collaborative | Monthly | Quality Effectiveness (6-10) | 9 ⟷ | | | | 3 | This risk is already within the risk category appetite. Risk to be closed after risk has been to Board for approval to close in August2023. | 1 | 0 | 0 |
| SA2 Person-led care, when and where it is needed – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals. | 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. (SA2) | Ramona Duguid | Q&P | Quarterly | Quality Effectiveness (6-10) | 12 ⟷ | | | | 4 | There is currently no expected date for this risk being brought within risk category appetite. It will continue to be monitored on a quarterly basis and brought within the risk category appetite as soon as practicable. | 6 | 0 | 0 |

| Board Assurance FrameWork 2023-2024 | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BAF Movement Chart 2023 - 2024 | | | | | | | | | | | | | | | | |
| Strategic Ambition | Risk No. | Risk Description | Executive Lead | Sub Committee | Review Frequency | Risk Appetite | Risk Scores | | | | | | Gaps in Controls within Q4 | | |
| | | | | | | | Q1 | Q2 | Q3 | Q4 | Target Score | Expected date risk to be mitigated and brought within the risk category appetite. | Open Actions | Added Actions | Closed Actions |
| SA.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. | 1694 | Inability to recruit the required number of medical staff or provide alternative ways of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high class services. (SA3) | Ramona Duguid | Peoples Committee | Quarterly | Compliance/ Regulatory (6-10) | 12 ⟷ | | | | 8 | There is currently no expected date for this risk being brought within risk category appetite. It will continue to be monitored on a quarterly basis and brought within the risk category appetite as soon as practicable. | 5 | 0 | 0 |
| SA.4 Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our reSustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled. | 1687 | That we do not manage our resources effectively in the transition from COVID planning to ongoing sustainability and delivery of our transformation programme. (SA4) | Kevin Scollay | RBAC | Quarterly | Fiancial/Value for Money (12-16) | 20 ⟷ | | | | 10 | There is currently no expected date for this risk being brought within risk category appetite. It will continue to be monitored on a quarterly basis and brought within the risk category appetite as soon as practicable. | 4 | 1 | 2 |
| | 1762 | Restrictions in Capital expenditure imposed nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments. (SA4) | Kevin Scollay | RABC | Quarterly | Fiancial/Value for Money (12-16) | 20 ⟷ | | | | 5 | There is currently no expected date for this risk being brought within risk category appetite. It will continue to be monitored on a quarterly basis and brought within the risk category appetite as soon as practicable. | 1 | 0 | 2 |
| | 1853 | The climate and ecological change is affecting the physical and mental health of current and future generations and adaptation plan to be in place regarding the infrastructure and preparedness for extreme weather. The delivery of the Green Plan is paramount to reduce the impact of climate change. (SA4) | James Duncan | RBAC | Quarterly | Climate & Ecologial Sustainability (6-10) | 12 ⟷ | | | | 8 | There is currently no expected date for this risk being brought within risk category appetite. It will continue to be monitored on a quarterly basis and brought within the risk category appetite as soon as practicable. | 3 | 0 | 0 |

| Board Assurance FrameWork 2023-2024 | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BAF Movement Chart 2023 - 2024 | | | | | | | | | | | | | | | |
| Strategic Ambition | Risk No. | Risk Description | Executive Lead | Sub Committee | Review Frequency | Risk Appetite | Risk Scores | | | | | | Gaps in Controls within Q4 | | |
| | | | | | | | Q1 | Q2 | Q3 | Q4 | Target Score | Expected date risk to be mitigated and brought within the risk category appetite. | Open Actions | Added Actions | Closed Actions |
| SA5 Working with and for our communities – We will create trusted, long-term partnerships that work together to help people and communities. | 1680 | If the Trust were to acquire additional services and geographical areas this could have a detrimental impact on CNTW as an organisation. (SA5) | Kevin Scollay | RBAC | Monthly | Compliance/ Regulatory (6-10) | 12 ⟷ | | | | 8 | There is currently no expected date for this risk being brought within risk category appetite. It will continue to be monitored on a quarterly basis and brought within the risk category appetite as soon as practicable. | 3 | 0 | 0 |
| | 2041 | Inability to influence the changing NHS structural architecture leading to adverse impacts on clinical care that could affect the sustainability of MH and disability services. (SA5) | Kevin Scollay | Provider Collaborative | Monthly | Quality Effectiveness (6-10) | 8 ⟷ | | | | 8 | This risk is now within the risk categorey appetite. Will be looking to close risk at next review in October 2023 | 2 | 0 | 1 |

| | |
|---|---|
| | Below Tolerated Risk Score |
| | Within Tolerated Risk Score |
| | Breaching Tolerated Risk Score |

## 17. NHSE/I SINGLE OVERSIGHT FRAMEWORK COMPLIANCE REPORT

Ramona Duguid, Chief Operating Officer

### REFERENCES

Only PDFs are attached

17. NHS Improvement System Oversight Framework - Quarter 1 2023-24.pdf

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

| | |
|---|---|
| **Name of meeting** | **Board of Directors** |
| **Date of Meeting** | **2nd August 2023** |
| **Title of report** | **Quarter 1 2023/24 update - NHS Improvement System Oversight Framework** |
| **Executive Lead** | **Ramona Duguid, Chief Operating Officer** |
| **Report author** | **Allan Fairlamb, Deputy Director of Commissioning & Quality Assurance**<br>**Chris Cressey, Deputy Director of Finance & Business Development** |

| **Purpose of the report** | |
|---|---|
| **To note** | |
| **For assurance** | **X** |
| **For discussion** | |
| **For decision** | |

| **Strategic ambitions this paper supports (please check the appropriate box)** | |
|---|---|
| **1. Quality care, every day** | X |
| **2. Person-led care, when and where it is needed** | X |
| **3. A great place to work** | X |
| **4. Sustainable for the long term, innovating every day** | X |
| **5. Working with and for our communities** | X |

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

| **Management 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 | X |
| Workforce | | Environmental | |
| Financial/value for money | X | Estates and facilities | |
| Commercial | | Compliance/Regulatory | X |
| Quality, safety and experience | X | Service user, carer and stakeholder involvement | X |

**BOARD OF DIRECTORS**

**2nd August 2023**

**Quarterly Report – Oversight of Information Submitted to External Regulators**

## PURPOSE

To provide the Board with an oversight of the information that has been shared with NHS Improvement and other useful information in relation to Board and Governor changes and any adverse press attention for the Trust during Quarter 1 2023-24.

## BACKGROUND

NHS Improvement using the System Oversight Framework have assessed the Trust for Quarter 1 of 2023-24 as segment 1 – maximum autonomy. At Month 3 the Trust has agreed with the Trust Board and ICS that financial outturn for the financial year is to breakeven.

A summary of the Trust ratings since the start of financial year 2016-17 are set out below:

| | Q1 & 2 16-17 | Q3 & Q4 16-17 | Q1 – Q4 17-18 | Q1 –Q4 18-19 | Q1 & Q2 19-20 | Q3 & Q4 19-20 | Q1 – Q4 20-21 | Q1 – Q4 21-22 |
|---|---|---|---|---|---|---|---|---|
| Single Oversight Framework Segment | n/a | 2 | 1 | 1 | 1 | 1 | 1 | 1 |
| Use of Resources Rating | n/a | 2 | 1 | 3 | 3 | 2 | *2 | *2 |
| Continuity of Services Rating | 2 (Q1) & 3 (Q2) | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Governance Risk Rating | Green | n/a | n/a | n/a | n/a | n/a | n/a | n/a |

*Please note since Quarter 1 2020/21 the Use of Resources Rating is related to Quarter 4 2019/20 due to suspension of this rating during COVID-19.

## Key Financial Targets & Issues

A summary of delivery at Month 3 against our high level financial targets and risk ratings, as identified within our financial plan for the current year, and which is reported in our monthly returns is shown in the tables below (Finance returns are submitted to NHSI on a monthly basis): -

| | Month 3 | | |
|---|---|---|---|
| **Key Financial Targets** | **Trust Plan** | **Actual** | **Variance/ Rating** |
| I&E – Surplus /(Deficit) | £3.4m | £6.5m | £3.1m |
| Agency Spend | £4.2m | £4.8m | £0.6m |
| Cash | £24.4m | £43.6m | (£19.2m) |
| Capital Spend | £3.5m | £1.7m | £1.8m |

## Risk Rating

The interim financial arrangements put in place during COVID-19 have resulted in the suspension of the Use of Resources rating including the requirement for a Board Assurance statement to be completed if a trust is reporting an adverse change in its forecast out-turn position.

## Workforce Numbers

The workforce template provides actual staff numbers by staff group. The table below shows a summary of the information provided for Quarter 1 2023-24. Workforce returns are submitted to NHSI monthly.

| Summary Staff WTE | Apr | May | June |
|---|---|---|---|
| | Actual WTE | Actual WTE | Actual WTE |
| Non-medical Clinical | 5,499.06 | 5453.26 | 5470.61 |
| Non-medical Non-Clinical | 2,171.73 | 2,164.76 | 2,180.97 |
| Medical & Dental | 419.05 | 438.89 | 434.08 |
| **Total WTE Substantive** | **8,089.84** | **8,056.91** | **8,085.66** |
| Bank | 293.42 | 283.17 | 276.01 |
| Agency | 395.14 | 308.12 | 331.78 |
| **Total WTE all staff** | **8,778.40** | **8,648.20** | **8,693.45** |

## Agency Information

The Trust must report agency shift numbers to NHS Improvement monthly. The table below shows the number of agency shifts, the number above price cap and the number of off-framework shifts reported during Quarter 1 2023-24. The Trusts level of agency use at Quarter 1 is in breach of the allocated ICB agency cap.

| | Apr | | | May | | | June | | |
|---|---|---|---|---|---|---|---|---|---|
| | Shifts Filled by Agency | On Framework Above Price Cap | Off Framework | Shifts Filled by Agency | On Framework Above Price Cap | Off Framework | Shifts Filled by Agency | On Framework Above Price Cap | Off Framework |
| Medical | 510 | 95 | 12 | 508 | 95 | 24 | 543 | 102 | 24 |
| Nursing | 726 | 424 | 0 | 629 | 387 | 0 | 658 | 494 | 0 |
| Support to Nursing | 4,207 | 14 | 0 | 3,893 | 28 | 0 | 3,814 | 61 | 0 |
| Admin | 28 | 0 | 0 | 50 | 0 | 0 | 61 | 0 | 0 |
| Scientific, Therapeutic & Technical | | | | | | | 27 | 27 | 0 |
| **TOTAL** | **5,471** | **533** | **12** | **5,080** | **510** | **24** | **5,103** | **684** | **24** |

At the end of June, the Trust was paying 27 medical staff above price caps and 9 of the consultants are being paid over £100 per hour so are separately reported to NHS Improvement.

**GOVERNANCE**

There is no longer a requirement to submit a governance return to NHS Improvement; however, there are specific exceptions where the Trust are required to notify NHS Improvement and specific items for information, it is these issues that are included within this report.

**Board & Governor Changes Q1 2023-2024**

Board of Directors:

No changes

Council of Governors:

Cumbria University - Michelle Garner
Carer Governor Learning Disability Services – Rosie Lawrence
Carer Governor Children and Young Peoples Services, Shannon Fairhurst
Local Authority, Newcastle City Council – Miriam Mafemba
Local Authority, North Tyneside Council, Jane Shaw
Local Authority, South Tyneside – Ruth Berkely

Outgoing Governors:

None to note

Present vacancies

Carer – Neuro Disability service
Local Authority Cumbria
Service User – LD Service
Service User - CYPS
Carer Governor - CYPS

**Never Events**

There were no never events reported in Quarter 1 2023 - 2024 as per the DH guidance document.

**Other items for consideration**

As well as the items noted in the report above the Trust also completes submissions to NHSI for the following data:-

Weekly
- Total number of bank shifts requested/total filled (from October 17)

Monthly
- Care Hours Per Patient Day.
- Estates and Facilities Costs

Annually

- NHSI request information for corporate services national data collection on an annual basis. This data includes information in relation to Finance, HR, IM&T, Payroll, Governance and Risk, Legal and Procurement. This information will be used to update information within Model Hospital on an annual basis.

Carter Review

- Community and Mental Health (Productivity) – Community services
- Corporate Benchmarking – First submission in 16/17.

**RECOMMENDATIONS**

To note the information included within the report.

**Allan Fairlamb, Deputy Director of Commissioning & Quality Assurance**
**Chris Cressey, Deputy Director of Finance & Business Development**
**July 2023**

## 18. INTEGRATED CARE SYSTEM / INTEGRATED CARE BOARD UPDATE

James Duncan, Chief Executive

## 19. FINANCE REPORT

Kevin Scollay, Executive Director of Finance

### REFERENCES

Only PDFs are attached

19. 2324 - Mth 3 Finance Report Board (003).pdf

| | |
|---|---|
| **Name of meeting** | **Board of Directors Meeting** |
| **Date of Meeting** | **Wednesday 2nd August 2023** |
| **Title of report** | **Month 3 Finance Report** |
| **Executive Lead** | **Kevin Scollay, Executive Director of Finance** |
| **Report author** | **As Above** |

| **Purpose of the report** | |
|---|---|
| **To note** | **x** |
| **For assurance** | |
| **For discussion** | |
| **For decision** | |

| **Strategic ambitions this paper supports (please check the appropriate box)** | |
|---|---|
| **1. Quality care, every day** | |
| **2. Person-led care, when and where it is needed** | |
| **3. A great place to work** | |
| **4. Sustainable for the long term, innovating every day** | x |
| **5. Working with and for our communities** | |

| **Meetings where this item has been considered** | |
|---|---|
| Quality and Performance | |
| Audit | |
| Mental Health Legislation | |
| Remuneration Committee | |
| Resource and Business Assurance | |
| Charitable Funds Committee | |
| Provider Collaborative/Lead Provider | |
| People | |
| Provider Collaborative | |
| CEDAR Programme Board | |
| Other/external (please specify) | |

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

| **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 and experience | | Service user, carer and stakeholder involvement | |

| **Board Assurance Framework/Corporate Risk Register risks this paper relates to** |
|---|
| 1687 – Managing resources effectively, 1762 – Restrictions in capital expenditure |

# Month 3 Finance Report

## 1. Executive Summary

1.1 A **The Trust has generated a £6.5m deficit year to date**. No non recurrent flexibilities are included in this position. Neither is any benefit from anticipated land sales.

1.2 This deficit is **£2.1m ahead of the financial plan submitted to NHSE at Month 3**. This plan is phased to deliver deficits in the first 6 months of the year and surpluses for the second half of the year. Internal budgets are phased more ambitiously and assumes delivery more evenly through the year. The Trust must improve its expenditure run rate from Q2 onwards to achieve financial balance this year.

1.3 **Agency costs are higher than both the agency ceiling and planned levels**. At the end of Q1 the Trust has spent £4.8m on agency staff against a plan £4.2m and the against the Trust's nationally applied agency ceiling of £3.6m.

1.4 **Expenditure on the Trust capital programme is £1.8m lower than planned** at Month 3 but is forecasting to deliver against plan for the year.

1.5 **The Trust has a cash balance of £43.6m** at the end of Month 3 which is ahead of plan. The Trust has seen a slight increase cash from last month, due to changes in working balances and being behind on the capital programme.

## 2. Key Financial Targets

2.1 Table 1 highlights the key financial metrics for Month 3.

**Table 1**

| | Month 3 | | |
|---|---|---|---|
| **Key Financial Targets** | **Trust Plan** | **Actual** | **Variance/ Rating** |
| I&E – Surplus /(Deficit) | (£8.6m) | (£6.5m) | £2.1m |
| Agency Spend | £4.2m | £4.8m | £0.6m |
| Cash | £24.4m | £43.6m | (£19.2m) |
| Capital Spend | £3.5m | £1.7m | £1.8m |

## 3. Financial Performance

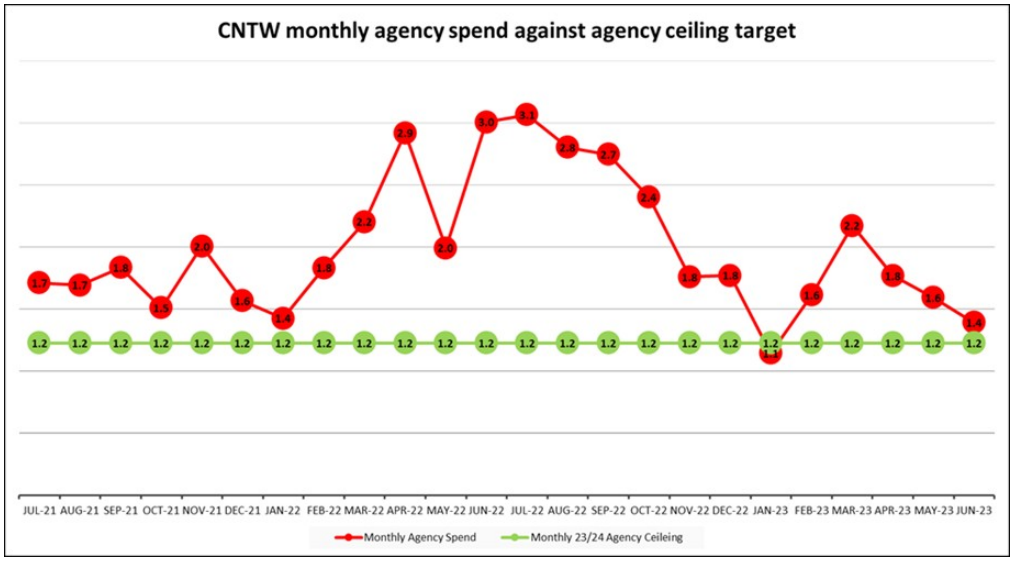
### Income and Expenditure

3.1 At the end of Month 3 the Trust has reported a £6.5m deficit on Income and Expenditure, which is ahead of the plan submitted to NHSE by £2.1m. 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 £1.4m, this improves further on the previous months agency costs. Costs remain above the Trust budget year to date (due to prior month overspending), but is in line with monthly budgeted levels of c£1.4m per month. Agency costs are higher than the 3.7% agency cap of c£1.2m as well as the prior year ambition to reduce to £1m per month.

**Graph 1**



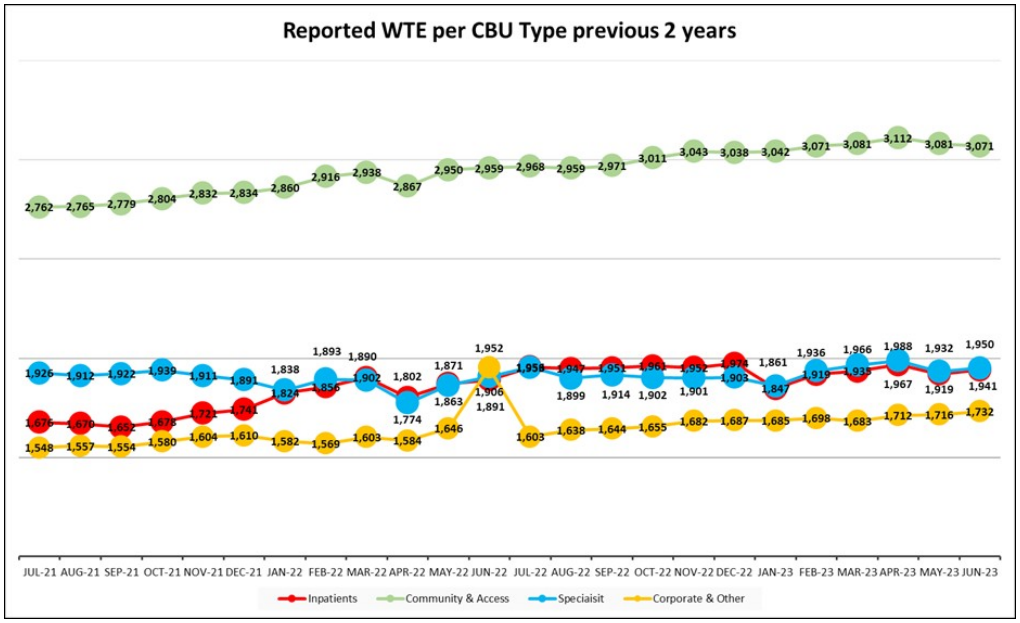

3.4 Agency costs have been a focus for the Trust in managing it's overall financial position for a number of reasons. These inlcude;

- 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 June 2021. Usage of WTEs has increased slightly since last month by 45 WTEs.

**Table 3**

| | Jun-21 | Jun-22 | Mar 23 | Apr-23 | May-23 | Jun-23 | Change from Last mth | Change from Last year end | Change from Last 12 mths | Change from Last 24 mths |
|---|---|---|---|---|---|---|---|---|---|---|
| North | 1,335 | 1,433 | 1,550 | 1,569 | 1,506 | 1,520 | 14 | -30 | 87 | 185 |
| Central | 1,631 | 1,703 | 1,763 | 1,784 | 1,753 | 1,759 | 6 | -4 | 56 | 128 |
| South | 1,905 | 2,075 | 2,134 | 2,165 | 2,146 | 2,147 | 0 | 12 | 71 | 242 |
| N Cumbria | 1,399 | 1,545 | 1,535 | 1,548 | 1,528 | 1,536 | 8 | 1 | -9 | 137 |
| | **6,269** | **6,757** | **6,982** | **7,066** | **6,933** | **6,962** | **29** | **-20** | **205** | **692** |
| Corporate & Other | 1,528 | 1,619 | 1,668 | 1,712 | 1,716 | 1,732 | 16 | 63 | 113 | 204 |
| | **7,797** | **8,376** | **8,650** | **8,778** | **8,648** | **8,693** | **45** | **43** | **317** | **896** |

3.8 The Trust has made payments in connection to the NHS pay award in June 2023. The Trust has assessed the impact at c£1.9m pressure annually above funded levels. 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 | 24.4 | 43.6 | (19.2) |

4.1 Cash balances at the end of June were £19.2m 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 Underspending on the capital plan year to date is also supporting better than expected cash balances.

4.4 The 2023/24 financial plan includes non-cash transactions to support delivering financial break-even, this means that cash levels are expected to fall over the year, 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 | 3.5 | 1.7 | (1.8) | 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 3 is £0.4m which is £1.8m 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. The income and expenditure position includes an assumption around recognising benefits from the full value of these sales.

## 6. Recommendations

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

## 20. FREEDOM TO SPEAK UP GUARDIANS

Fran Howe and Stephen Hyde

verbal update

## 21. QUALITY AND PERFORMANCE COMMITTEE

Darren Best, Chair

verbal update

## 22. AUDIT COMMITTEE

David Arthur, Chair

verbal update

## 23. RESOURCE AND BUSINESS ASSURANCE COMMITTEE

Paula Breen, Chair

verbal update

## 24. MENTAL HEALTH LEGISLATION COMMITTEE

Michael Robinson, Chair

verbal update

## 25. PROVIDER COLLABORATIVE COMMITTEE

Michael Robinson, Chair

No meeting has been held during the period

## 26. PEOPLE COMMITTEE

Brendan Hill, Chair

verbal update

## 27. CHARITABLE FUNDS COMMITTEE

Louise Nelson, Chair

verbal update

## 28. COUNCIL OF GOVERNORS' ISSUES

Ken Jarrold, Chairman

## 29. QUESTIONS FROM THE PUBLIC

Ken Jarrold, Chairman

## 30. ANY OTHER BUSINESS

Ken Jarrold, Chairman

## 31. DATE AND TIME OF NEXT MEETING

Wednesday 6th September 2023
1:30 - 3:30pm
Trust Board Room, St Nicholas Hospital and Microsoft Teams