Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

BOARD OF DIRECTORS PUBLIC MEETING

6 September 2023

13:30 GMT+1 Europe/London

Trust Board Room and via Teams

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1. AGENDA

Ken Jarrold, Chairman

REFERENCES

Only PDFs are attached

BoD Agenda Public SEPT 2023 FINAL.pdf

Board of Directors PUBLIC Board Meeting Agenda

Board of Directors PUBLIC Board meeting Venue: Trust Board Room, St Nicholas Hospital and via MS Teams	Date: Wednesday 6 September 2023 Time: 1:30pm– 3:30pm

	Item	Lead	
1.1	Welcome and Apologies for Absence	Ken Jarrold, Chairman	Verbal
2	Service User / Carer / Staff Story	Guest Speaker	Verbal
3	Declarations of Interest	Ken Jarrold, Chairman	Verbal
4	Minutes of the meeting held 2 August 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 4)	Ramona Duguid, Chief Operating Officer	Enc
9	CQC Must Do Report	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance	Enc
10	Roselodge update	Ramona Duguid, Chief Operating Officer	Enc
11	Verdict in the trial of Lucy Letby	Rajesh Nadkarni, Deputy Chief Executive / Medical Director	Enc

With YOU in mind

12	**Acute inpatient mental health care for adults and older adults**	**James Duncan, Chief Executive**	**Enc**
Workforce issues			
13	**Workforce Race Equality Standard and Workforce Disability Equality Standard**	**Lynne Shaw, Executive Director of Workforce and OD**	**Enc**
Regulatory / compliance issues			
14	**Constitution amendment**	**Debbie Henderson, Director of Communications and Corporate Affairs**	**Enc**
Strategy, planning and partnerships			
15	**Integrated Care System/Integrated Care Board update**	**James Duncan, Chief Executive**	**verbal**
16	**Finance Report**	**Kevin Scollay, Executive Director of Finance**	**Enc**
Key item			
17	**Medical Assistant Programme**	**Bruce Owen, Consultant Psychiatrist and Director of Medical Education**	**Pres**
Committee updates			
18	**Quality and Performance Committee** *No meeting held during the period*	**Darren Best, Chair**	**N/A**
19	**Audit Committee** *No meeting held during the period*	**David Arthur, Chair**	**N/A**
20	**Resource and Business Assurance Committee** *No meeting held during the period*	**Paula Breen, Chair**	**N/A**
21	**Mental Health Legislation Committee** *No meeting held during the period*	**Michael Robinson, Chair**	**N/A**

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

Date and Time of Next Meeting:

Wednesday 4th October 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 2ND AUGUST 2023

Ken Jarrold, Chairman

REFERENCES

Only PDFs are attached

4. Public Minutes 3 August 2023 DRAFT FINAL.pdf

Minutes of the Board of Directors meeting held in Public
on 2 August 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
Brendan Hill, Non-Executive Director
Louise Nelson, Non-Executive Director
Michael Robinson, Non-Executive Director
Paula Breen, Non-Executive Director (online)

James Duncan, Chief Executive
Rajesh Nadkarni, Deputy Chief Executive / Medical Director
Ramona Duguid, Chief Operating Officer
Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality
Kevin Scollay, Executive Director of Finance
Lynne Shaw, Executive Director of Workforce and Organisational Development
Margaret Orange, Associate Director – Addictions Governance (item 11)
David Muir, Group Director – North Cumbria Locality (item 11)
Eilish Gilvarry, Deputy Medical Director for Revalidation and Appraisal (Item 11)
Fran Howe, Freedom to Speak Up Guardian (Item 20)
Stephen Hyde, Freedom to Speak Up Guardian (Item 20)

In attendance:
Debbie Henderson, Director of Communication and Corporate Affairs
Kirsty Allan, Corporate Governance Manager (minute taker)
Jack Wilson, Corporate Engagement Assistant
Sam Volpe, Health Reporter Chronicle Live
Fiona Grant, Service User Governor, Adults Services (online)
Tom Rebair, Service User Governor, Adult Services and Deputy Lead Governor
Russell Bowman, Service User Governor, Neuro-Disability Services (online)
Jane Noble, Carer Governor, Adult Services
Evelyn Bitcon, Public Governor, Cumbria (online)
Wendy Pattison, Local Authority Governor, Northumberland County Council (online)
Ruth Berkley, Local Authority Governor, South Tyneside Council (online)
Danny Cain, Staff Governor, Non-Clinical
Emma Silver-Prince, Staff Governor, Non-Clinical

1. **Welcome and apologies for absence**

Ken Jarrold welcomed everyone to the meeting with no apologies to note.

2. **Declarations of interest**

None to note.

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

Ken Jarrold extended a warm welcome and thanks to Darren McGregor who shared his personal journey.

4. **Minutes of the meeting held 5th July 2023**

The minutes of the meeting held on 5th July 2023 were considered.

Brendan Hill referred to Page 5 and the need to standardise terminology used for Board Committees and Sub-Committees.

Approved:

- **The minutes of the meetings held 5 July 2023 were approved with the amendment noted above.**

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

Evelyn Bitcon referred to Page 3, under Quality, Clinical and Patient Issues and enquired if the Involvement Bank and Governors could be included in the work of the community transformation programme. James Duncan confirmed there will be opportunities to be involved in the work.

6. Chairman's update

Ken Jarrold reflected on discussions held in the previous meeting on the current financial challenges within the Trust including staffing levels and service pressures highlighting this is a very difficult time for the NHS and for the Trust. Ken provided assurance that the Board continue to focus on this as a key priority.

Ken Jarrold thanked Margaret Adams who Chairs and Leads the Service User and Carer Reference Group for a remarkable meeting focusing on Autism and related issues. Paula Breen referred to the meeting and references that ADHD and ASD services are not provided in North Cumbria. It was noted that different localities have individual commissioning for different services. Ken advised that discussions with commissioners within North Cumbria continue and Ramona Duguid agreed to discuss ongoing plans with Paula.

Ken encouraged everyone to attend the meetings of the Service User and Carer Reference Group.

Resolved:

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

7. Chief Executive's Report

James Duncan referred to the General Medical Council National Survey where this year's results show CNTWs performance in the top 10% nationally for trainees and the top 5% for junior doctor training. This data and information highlighted within the Guardian of Safe Working Hours report shows the importance the Trust places in ensuring that we support juniors' doctors who are a very important part of the workforce. James also referred to ongoing Industrial Action and the challenges the Trust is facing due to the ongoing national dispute regarding pay. It is hoped there will be a national resolution and James provided assurance that the Trust is doing everything possible to ensure services remain safe during episodes of Industrial Action while continuing to support consultants and junior doctors during this time. James thanked all medical staff for their efforts, and the management and operational teams for the work done to ensure that services are safe through the strike action.

James highlighted the national update on acute inpatient mental healthcare for adults and older adults where NHS England has published guidance setting out its vision for inpatient services noting that it is reflected in the Trust's Strategy 'With You in Mind' and the Trust's transforming services agenda.

James provided highlights from the rest of the report which included the NHS Long Term Workforce Plan, Public Accounts Committee report on improving NHS mental health services and the impact of cost-of-living crisis on schoolchildren in the UK.

Michael Robinson commented on the inpatient acute mental health care report showing the importance of partnership working in relation to the Trust's service provision, and the whole patient journey being dependent upon on relationships with the third sector. Ken Jarrold agreed that working in partnership is critical as the Trust cannot deliver high quality services on its own.

Brendan Hill referred to the Public Accounts Committee report on NHS mental health services and asked to have sight of the recommendations made to the Government highlighted within the report. The link will be circulated to the Board.

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

Quality, Clinical and Patient Issues

8. Monthly Integrated Performance Report (Month 1)

Ramona Duguid presented the report and highlighted a continued deterioration around crisis performance particularly in referrals seen within 24 hours. A deep dive has commenced with key areas of work, which includes a review of quality and recording as well as capacity, particularly within the North and North Cumbria localities.

Psychiatric Liaison Team performance shows a deterioration in referrals seen within one hour, which is particularly concentrated in the Royal Victoria Infirmary in Newcastle. Detailed work is ongoing to understand the difference in performance as well as working closely with colleagues in Accident and Emergency Departments reviewing referral pathways and data recording. Ramona suggested undertaking a deep dive into this area of work at the Quality and Performance Committee.

Ramona described the Trust position around the Children and Young People's Neurodevelopmental pathway. This has been escalated to the North East and North Cumbria Integrated Care Board (NENC ICB) with a positive response received in terms of the urgent system-wide work required to review the pathway. There has been a significant amount of internal improvement work around the pathway and a detailed review is to be undertaken by the Quality and Performance Committee.

Sarah Rushbrooke noted a shift in the commitment to service user and carer experience with a decision to change the compliance standard from 85% to 95%.

Lynne Shaw referred to a slight improvement in the staff absence rate. The Trust is currently reviewing the Trusts Occupational Health provision and wider wellbeing offer. The Trust will be commencing a tender process for a new Occupational Health Provider from the new financial year where there will be a focus on wider mental and physical wellbeing support.

Lynne made the Board aware of ongoing work to review statutory training needs across the organisation to ensure they remain fit for purpose.

Louise Nelson referred to the new style report being clearer to read, however noted the report continues to highlight the non-completion of CPA reviews which is a fundamental part of an individual's care and treatment.

Louise noted the assurance recently provided at Quality and Performance Committee regarding person led care and lack of discharge planning and noted that as well as data available, her role as a hospital manager has provided insight into how people can deteriorate due to lack of discharge planning. Louise asked that this be considered in doing everything we can to provide the right care and treatment to those who need it.

Darren Best noted that the Quality and Performance Committee continues to receive monthly exception report on waiting times and various mitigating actions.

Jane Noble referred to the discussion on effective discharge planning being crucially important but mentioned it can have an adverse effect and provided examples of patients being on leave and not having a bed to return to. Jane also mentioned her work with the Trust on collaborative working with the Psychiatric Liaison Team.

Ken Jarrold commended the new style of the report which clearly shows the challenges the Trust is facing and requested a more focused discussion at the September Board meeting regarding Psychiatric Liaison referrals due to the rapid deterioration in performance.

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

Action:
- **A focus on Psychiatric Liaison Referrals at September Board.**

9. Service User and Carer Experience Report – Quarter 1

Sarah Rushbrooke referred to the report and was delighted to report the highest level of feedback within the quarter since the implementation of Points of You. Sarah congratulated the South Locality who received a significant improvement in their responses.

Paul Sams, Feedback and Outcomes Lead had commenced a review on the range of ways the Trust can receive service user and carer feedback. Sarah noted the lack of feedback received from Lotus ward, which is a service for young people at Middlesbrough, and noted the challenges in receiving feedback from young people in general. The review will include this as a key area of focus. Paul will also focus on the North Cumbria Locality in terms of opportunities to increase feedback within these services.

Darren Best referred to the Patient Safety Incident Response Framework (PSIRF) and the importance of triangulating the use of the information received in terms of learning outcomes which are developed into policies, strategies, and actions.

Sarah welcomed feedback on the new style of the report.

Resolved:
- **The Board received the Service User and carer Experience Report – Q1**

10. Safer Carer Report – Quarter 1

Rajesh Nadkarni referred to the report and highlighted a notable increase in incidents relating to information governance and damage or loss to property.

Work has been undertaken associated with Long Term Segregation (LTS) with figures remaining consistent throughout the quarter and each LTS case is actively supported with the HOPEs model.

There has been an increase in safeguarding incidents which is in-line with national trends and linked to greater awareness because of the rollout of Level 3 training.

Rajesh highlighted the implementation of Making Every Contact Count (MECC) which is a behaviour change approach utilising every interaction to support people to make positive changes to their physical and mental health. This training aims to improve staff confidence in having opportunistic discussions with services users to make positive changes to their physical and mental health and continuing to work to close the inequality gap.

Resolved
- **The Board received the Safer Carer Report – Q1**

11. 5-point Plan Addictions Services

Margaret Orange presented an update on the Addictions Development 5-Point Plan, progress to date and forthcoming priorities for the service.

Margaret noted that alcohol mortality has increased by 20% with the North East shown to be double the national average for drug-related deaths which has consistently risen in the last 10 years.

Commissioning has moved to local authority public health commissioning which has brought with its requirement to undertake a competitive approach to the tendering of services every 3-5 years. This can be highly disruptive to the continuity of services.

Margaret provided an update on Naloxone, a drug to be given to those suffering from an opioid overdose to reverse the effects of the overdose, which can be given immediately in a life-threatening situation. In partnership with Northumbria Police, a train the trainer course will be provided to police trainers to deliver the training to every police officer within the constabulary who will start to carry Naloxone.

Darren Best congratulated the team on the work around Naloxone from a public safety and partnership working perspective. Darren queried the rationale of in-house detoxification rather than the service being provided by other organisations who may specialise in this area. Margaret advised that the decision to bring the service in-house was based on funding opportunities at that point in time. No other service in the North East offered detoxification services.

Eilish Gilvarry suggested that detoxification should be medically managed and as such, advised that it is best placed provided within a psychiatric unit who have 24-hour medical cover.

Evelyn Bitcon thanked Margaret for the presentation and asked if North Cumbria would benefit from this work and if it had been developed in collaboration with the community and voluntary sector looking at the social effects of drug and alcohol abuse. David Muir confirmed CNTW do not provide drug and alcohol services across the whole Trust footprint. Services in North Cumbria are provided by a different provider.

Ruth Berkley asked if the service is also reviewing gambling as an addiction given the concern regarding the increase in the number of young people being impacted by gambling addiction. Margaret Orange stated that the service does not currently include gambling addiction as there are services already available elsewhere, however there are ongoing discussions with commissioners regarding pilot projects around screening and advice for gambling addiction.

Ken Jarrold thanked Margaret Orange, Eilish Gilvarry and David Muir for providing a valuable update to the Board on the work which is ongoing with the service.

12. Annual Infection, Prevention and Control Annual Report 2022/23

Sarah Rushbrooke referred to the report which was presented to Quality and Performance Committee on 26th July.

Resolved • **Board received the Annual Infection, Prevention and Control Annual Report 2022/23**

13. Annual Revalidation Report

Rajesh Nadkarni referred to the annual submission of medical appraisal and revalidation data and highlighted 100% compliance for appraisals. Within the 2022/23 year, there were 40 trained appraisers which included appraisers from St Oswald's Hospice.

Rajesh explained the organisation creates an environment which delivers effective clinical governance with issues raised taking into consideration compassion, well-being, and recommendations from the General Medical Council (GMC).

Resolved: • **Board received and noted the Annual Revalidation Report prior to sign off of the statement of Compliance.**

Workforce issues

14. Workforce Race Equality Standard and Workforce Disability Equality Standard

Due to time commitments, it was agreed to defer this item until September.

15. Guardian of safe working hours report – Q1

Rajesh Nadkarni referred to the report and noted there were no concerns raised in relation to safety as part of business as usual and during the periods of Industrial Action.

Resolved:
- **Board received and noted the Guardian of safe working hours report – Q1**

Regulatory / Compliance Issues

16. Board Assurance Framework and Corporate Risk Register update Q1

Debbie Henderson referred to the report but noted the ongoing review of the Board Assurance Framework and Board level risks in the context of the Trust's new Strategy and annual priorities. The revised risks will be shared with the Committee Chairs and Audit Committee prior to final discussion at the September Board Away Day.

The risks outlined in the Board Assurance Framework have been reviewed at discussed at the relevant Board sub-committees at the July meetings and the Audit Committee reviewed the Framework in its entirety.

Debbie sought approval of the recommendation from the Provider Collaborative and Lead Provider Committee to close Risk 1831 due to a sufficient level of assurance and controls being in place.

Resolved
- **The Board received the Board Assurance Framework and Corporate Risk Register update Q1 with Board approval to close Risk 1831.**

17. NHSE/I Single Oversight Framework Compliance Report

Ramona Duguid referred to the report to be taken as read with no significant issues to note.

Resolved:
- **Board received the NHSE/I Single Oversight Framework Compliance Report**

Strategy, planning and partnerships.

18. Integrated Care System / Integrated Care Board update

No significant issues to note.

19. Finance Report

Kevin Scollay referred to the report which reported a £6.5m deficit at the end of Month 3 which is ahead of the plan submitted to NHS England. The Trust continues to forecast a breakeven position. Cost improvement plans are phased in quarters 3 and 4 which are expected to be delivered through a combination of recurrent and non-recurrent measures. Some of these measures are non-cash releasing in nature and consequently cash levels are expected to fall on delivery of the plan. Agency costs have remained a focus for the Trust in managing its overall financial position with costs improving further on previous months.

Ken Jarrold thanked Kevin Scollay for the update which reflected more detailed discussions in Board development session and highlighted the very challenging position for the Trust.

Resolved
- **The Board received and noted the Finance Report.**

Key Item for Discussion

20. Freedom to Speak up Guardians update

Fran Howe and Stephen Hyde provided an update on their personal journeys including their appointment as Freedom to Speak Up Guardians (FTSUG). They provided an overview of some issues which have been raised through the FTSU process.

Stephen referred to a recent report published from the National Guardians Office which highlights fear and futility being the main reason why people may not wish to speak up. The recent staff survey results showed a minority of people feeling scared they will suffer detriment if they speak out but more so futility in terms of the perception of a lack of action resulting from raising issues.

The key themes of concerns raised relate to effective communication and behaviours from managers and colleagues as well as staff wellbeing with a rise in people speaking up regarding protective characteristics not being protected due to racism, disability, being neurodiverse or a lack of candour towards that individual.

James Duncan thanked Stephen and Fran for an excellent presentation and the importance of their role in the context of the Trust strategy and the commitment to our staff.

Brendan Hill noted that the People Committee are reviewing the themes identified and the process for managing concerns in a kind, humane and understanding way.

Ruth Berkley commended the courage of the organisation in their commitment to the FTSUG role as vital in encouraging people to come forward and be honest, with the organisation prepared to hear what people have to say. Ruth stated that the pressure on the NHS is unprecedented which can also manifest in the behaviours of people but as an organisation, the focus should be on the culture you want to create and as the organisation is vast there is a need for consistency in approach.

Rajesh Nadkarni mentioned the Trust is implementing an approach to 'Just Culture' and asked Stephen and Fran to provide an update at a future People Committee on the themes to assess what difference a 'Just Culture' is making.

Lynne Shaw thanked Stephen and Fran for the excellent work they are doing and the difference they are making to staff.

David Arthur referred to futility and what the plans will be to feed back the actions taken to those raising concerns so that confidence can be gained in this regard. Stephen advised that the managers review the concerns and the outcomes with the FTSUG role acting as a signposting role. Fran explained an anonymous feedback form has also been developed.

Ken Jarrold thanked Stephen and Fran for an excellent presentation.

Resolved
- **The Board received and update from Freedom to Speak up Guardians**

Board sub-committee minutes and Governor issues for information

21. Quality and Performance Committee

Darren Best provided an update from the meeting held 26th July. Darren confirmed Louise Nelson has agreed to Chair Quality and Performance Committee from October when Darren moves into the

Chairs role. The Committee welcomed Jane Noble as Governor representative to the meeting as well as Tom Rebair who attended as deputy to Anne Carlile.

An exception report continues to be received on actions to address waiting times and noted the increasing number of Children and Young People waiting over 18 weeks. Darren mentioned there are 261 people who have been waiting for over two years and the Committee have requested further information on those people. It is noted waiting times within older adults are decreasing slightly with exception of North Cumbria.

There was a quality focus on patient experience learning from serious case reviews which highlighted the amount of work the Trust is undertaking across all local authorities. From a regional perspective the NENC ICB are reviewing a more streamlined approach of how Trusts engage with safeguarding.

22. Audit Committee

David Arthur advised the Committee met on 26 July where a review on the implementation of Patient Safety Incident Response Framework (PSIRF) system was undertaken and is progressing well. An in-depth review of the process on digitalisation of clinical records was also provided.

A focused review of the People Committee's management of risks was provided by Brendan Hill as Chair of the People Committee. This included an overview of the proposed new risks as part of the Board Assurance Framework review.

A review of the External Audit follow-up letter and their final report on the closure of the 2022/23 accounts was undertaken.

The Committee also reviewed the performance of External Auditors where an agreement was reached to propose an extension to the External Audit contract provided by Mazars until June 2024. At that point, a full tender process will be required. The proposal for extension will be submitted to the September meeting of the Council of Governors for approval.

23. Resource and Business Assurance Committee

Paula Breen provided an update following the meeting held 26 July which focused on the Trusts financial performance and associated risks.

Paula noted that a reduction in Whole Time Equivalent (WTE) posts was required with measures introduced to manage recruitment including a freeze on corporate posts and the implementation of an Executive panel to approve corporate posts and requests for re-banding. The measures have been communicated widely by the Chief Executive across the organisation.

24. Mental Health Legislation Committee

Michael Robinson provided an update following the July meeting. Ramona Duguid and Rajesh Nadkarni are considering how to address issues arising from failure to comply with legislation highlighted in the Integrated Performance report in relation to consent. Sarah Rushbrooke is working on a new combined report focusing on CQC 'must do" actions and actions from CQC reviewer visits. Michael mentioned a gradual increase in levels of compliance with Mental Health Act (MHA) training and it was suggested a refresher for both the Board and Governors on legislation and how the Mental Health Act works in practice would be beneficial.

25. Provider Collaborative Committee

No meetings have been held during the period.

26. People Committee

Brendan Hill advised the Committee met on 26 July and mentioned continued progress on the use of agency and bank costs as well as a review of the increase in WTE posts during the pandemic. Sickness absence has reduced slightly and challenges relating to compliance with training standards was discussed in terms of supporting the release of staff from clinical duties.

The Committee have reviewed the Board Assurance Framework risks aligned to the People Committee.

The Committee received their first staff story from Paula Chapman, Ward Manager from a specialist neurorehabilitation service based at Walkergate Park.

27. Charitable Funds Committee

Louise Nelson advised the Committee met on the 19 July and confirmed the plans to relaunch of the SHINE Fund is progressing well to be launched in Autumn. A presentation was received from Casenove with the Committee reviewing other investment opportunities and funding bids applications continue to be reviewed monthly.

28. Council of Governors issues

Ken Jarrold referred to very good one to ones with new Governors to the Council, Jane Shaw Local Authority Governor for North Tyneside council and Ruth Berkley, Local Authority Governor for South Tyneside Council. Ken confirmed a nominated Governor from Cumberland Council, Councillor Elaine Lynch has been appointed.

Evelyn Bitcon thanked Fran Howe and Stephen Hyde and referred to the recent Council of Governors Quality meeting and expressed disappointment at the outcome report relating to North Cumbria and proposed at that meeting of Cumbria Governors and Non-Executive Directors take place to review these further. Ken Jarrold confirmed he would take a personal interest in supporting the meeting and a date will be confirmed soon.

29. Any Other Business

There were no issues to note.

30. Questions from the public

There were no questions from the public.

Date and time of next meeting

Wednesday, 6 September 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 6 Sept 2023.pdf

Board of Directors Meeting held in public

Action Log as at 6 September 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 (12)	CQC Must Do Report	Updated report to include fundamental actions with older actions reporting to Quality and Performance Committee	Sarah Rushbrooke	September 2023	
02.08.23 (8)	Integrated Performance Report	A focussed discussion on Psychiatric Liaison Referrals to be undertaken	Ramona Duguid/ Rajesh Nadkarni	September 2023	
05.07.23 (7)	CE Report	Discussion on the Institute for Public Police Research Health and Care Workforce Assembly report to be undertaken at a future Board meeting	James Duncan	TBC	
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 September 2023 v2.pdf

Name of meeting	Board of Directors
Date of Meeting	6th September 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		Management meetings where this item has been considered	
Quality and Performance		Executive Team	
Audit		Executive Management Group	
Mental Health Legislation		Business Delivery Group	
Remuneration Committee		Trust Safety Group	
Resource and Business Assurance		Locality Operational Management Group	
Charitable Funds Committee			
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

Meeting of the Board of Directors
Chief Executive's Report
Wednesday 6th September 2023

Trust updates

Visit from NHS England Deputy Director of Mental Health Nursing

On 23rd August 2023, the Trust hosted a visit from Dr Emma Wadey, Deputy Director of Mental Health Nursing in NHS England Chief Nursing Officer's team.

Dr Wadey met with colleagues at CNTW Academy where she heard about the Trust's work on apprenticeships, preceptorships, and continuous professional development for our clinicians. She also met with Dr Nicola Clibbens, Associate Professor of Nursing, who discussed the Trust's strategy around promoting nursing research and development and the practical steps being taken to progress this. Dr Wadey also heard from Claire Thomas, Deputy Director Safer Care, who explained the Trust's approach around the new Patient Safety Incident Response Framework (PSIRF). Dr Wadey met with Sarah Rushbrooke, Executive Director of Nursing and visited some of the on-site services at Hopewood Park Hospital, Sunderland including Longview Ward and the Horticultural Centre.

Following her visit Dr Wadey shared her feedback with us: 'I thoroughly enjoyed my visit to your services, I was made to feel very welcome and was incredibly impressed by the professionalism, care and commitment I observed…I left with a warm heart and totally inspired'.

Trust welcomes social work trainees

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) is set to welcome social work trainees as part of a national programme. For the first time, CNTW is taking on trainees from the Think Ahead programme which works to strengthen the contribution of social work in mental health settings. Think Ahead works with the NHS and local authorities to widen the pool of talent entering mental health social work and to create a community of advocates for social approaches in both mental health services and across society. The programme has 140 trainees this year who will be placed in teams across the country.

The two-year programme will see the trainees spend a year learning on the job and then a year working as newly qualified social workers whilst completing their assessed year of employment. At the end of the programme, trainees will receive a Postgraduate Diploma as well as a master's degree in social work. During their time at CNTW, our four trainees will work across inpatient and community forensics services. They will complete a portfolio of work to meet the Professional Capabilities Framework needed to become qualified social workers. If successful, the trainees will be registered with Social Work England and offered positions within the Trust. The Trust already employs around 120 qualified social workers.

Regional updates

NENC Child Health and Wellbeing Network publishes regional inequalities framework

The NENC Child Health and Wellbeing Network and Young Advisors to the network have worked collaboratively to produce a North East and North Cumbria (NENC) CORE20Plus5 for Children and Young People Framework. The NENC framework does not aim to replace the national CORE20Plus5 framework, but to complement it by applying a regional lens and support the alignment of regional and national priorities. It provides a framework for the implementation of the CYP CORE20Plus5 across the region.

National updates

Major Conditions Strategy case for change and strategic framework

The Department for Health and Social Care (DHSC) published an interim case for change and strategic framework for the forthcoming Major Conditions Strategy for England, which is expected to be published in early 2024. The document sets out the evidence underpinning the strategy and provides an overview of initial plans for action over the next five years. It will focus on addressing six major conditions: mental ill health, dementia, cancer, cardiovascular disease (including stroke and diabetes), musculoskeletal disorders, and chronic respiratory disease. Together these six conditions drive over 60% of mortality and morbidity in England, and patients increasingly experience two or more of these conditions at the same time.

The strategic framework underpinning the final strategy focuses on five areas: primary prevention, secondary prevention, early diagnosis, prompt and urgent care, long term care and treatment in both NHS and social care settings. It also identifies five high-impact areas for priority action:

1. Rebalancing the health and care system, over time, towards a personalised approach to prevention through the management of risk factors
2. Embedding early diagnosis and treatment in the community
3. Managing multiple conditions effectively – including embedding generalist and specialist skills within teams, organisations and individual clinicians
4. Seeking much closer alignment and integration between physical and mental health services
5. Shaping services and support around the lives of people, giving them greater choice and control where they need and want it and real clarity about their choices and next steps in their care.

The final strategy will also explore interventions to improve the physical health of people with mental health conditions, the mental health of people with physical health conditions, pain management, medicines management, and end of life care. It will outline specific plans to improve holistic care across physical and mental health pathways.

Mental ill health driving rise in young people claiming disability benefits

The Institute for Fiscal Studies published a new report about disability inequalities which suggests that the increase in young people claiming disability benefits is being driven by a rise in mental health issues. There has been a significant increase in claim rates among working age adults over the past decade, with a particularly large increase among people in their 20s and 30s. The proportion of 30-year-olds claiming disability benefits doubled between 2002 and 2022, whereas the proportion of adults over 60 claiming disability benefits has remained constant over the same period. The IFS also found a large increase in the proportion of school-age children receiving disability benefits, which is mostly accounted for by increases in claims related to learning disabilities, behavioural disorders and ADHD. Health-related benefit receipt is particularly high in regions like the North East and Yorkshire and Humber where the labour market is weaker – health outcomes follow a regional pattern and the weak labour market magnifies these inequalities and increases the likelihood of health-related benefits claims.

Large gaps between population need and investment in public services in England

The Institute for Fiscal Studies published a report funded by the Health Foundation estimating the level of funding for key public services – NHS, local government, schools, police and public health - in each local authority area in England in 2022-23. In 2022-23 spending on these key services amounted to more than £245bn, equivalent to £4,310 per person. The report compares the relative levels of funding different areas receive to estimates of their relative spending needs. The report suggests there are large differences between the share of funding areas receive, and the share they would receive if funding was allocated in line with need. This is particularly true in relation to local government spending, following repeated delays to plans to reform the funding system. Researchers also found that NHS funding is relatively well-targeted towards estimated spending needs, with two-thirds of areas receiving a share of funding within 5% of their share of estimated needs. This reflects the fact that NHS funding is allocated based on relatively up-to-date assessments of needs.

8. INTEGRATED PERFORMANCE REPORT MONTH 4

Ramona Duguid, Chief Operating Officer

REFERENCES

Only PDFs are attached

8a. Cover Sheet - IPR.pdf

8b. IPR Trust Report - Month 4 2023.pdf

Name of meeting	Board of Directors
Date of Meeting	6th September 2023
Title of report	Integrated Performance Report Month 4
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		Management meetings where this item has been considered	
Quality and Performance		Executive Team	
Audit		Executive Management Group	21.08.23
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	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

With YOU in mind

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)

Integrated Performance Report

Patients | Quality | People | Person Led Care | Sustainability

2023-24 Month 4 (July 2023)

With YOU in mind

Integrated Performance Report - Headline Commentary

Headline Challenges

- **Commitments to our Carers & Patients –** All five patient satisfaction measures reported in the IPR are below standard, the lowest performance relates to the 'Points of You' question 'Were you given helpful information?'
- **Staff fill rates -** Measure is off track despite a trend of improvement. Updated to include both day and night fill rates.
- **% of Training Compliance (Courses with a standard) –** Only 9 of 27 courses are achieving or above the required standard.
- **Serious Incidents -** Despite the low numbers the incidents are of serious magnitude and therefore an exception with actions is in the report.
- **Out of Area Placements/Clinically Ready for Discharge/ Bed Occupancy -** All reported off target, however, performance has improved in month across these measures.
- **Crisis Very Urgent Referrals seen within 4 hours –** At 43%, very low numbers means performance fluctuates significantly.
- **Crisis Urgent Referrals seen within 24 hours -** The last five month's performance has been below the normal range.
- **Psychiatric Liaison Referrals in ED within 1 hour -** Performance has decreased over a 24 month period and continues to remain lower than peers.
- **All CYPS Waits for Treatment -** Percentage of waiters has deteriorated since August 2021 but remained static since May 2022. Numbers waiting is at 3,788 and rising sharply, with the vast majority on neurodevelopmental pathways.
- **<18 weeks to Treatment - CYPS Neurodevelopmental waits -** Percentage seen within 18 weeks remains low and the actual number waiting is over 3,222 and continues to rise every month.
- **Live within our means -** Trust financial position shows better than plan at month 4. Plan includes phasing adjustment to reflect phasing of efficiencies.

Key focus areas of concern

- **% of Training Compliance (Courses with a standard)**
- **Crisis Very Urgent Referrals seen within 4 hours**
- **Crisis Urgent Referrals seen within 24 hours**
- **Psychiatric Liaison Referrals in ED within 1 hour**
- **<18 weeks to Treatment - CYPS Neurodevelopmental waits**
- **Live within our means**

Positive Assurance / Improvement

- **EIP (Early Intervention Psychosis)** remains consistently above the standard of 60%.
- **72 hour follow up** remains consistently above the 80% standard.

Despite the following inpatient flow measures not being on track, there has been positive improvement in the last few months across all five:

- **Out of Area Placement Bed Days**
- **Bed Occupancy**
- **Clinically Ready for Discharge**
- **% Adult inpatient discharged with LOS >60 days**
- **% Older Persons inpatients discharged with LOS >90 days**

Mitigations/actions

- **% of Training Compliance (Courses with a standard) -** A review is taking place of the training competencies and compliance standards. Performance has reduced in the month due to competency data being updated in mass by IBM, trajectories for improvement being agreed for each CBU.
- **Crisis Very Urgent Referrals seen within 4 hours / Crisis Urgent Referrals seen within 24 hours -** Developing a new Crisis model is one of the four core pillars of the Urgent and Inpatient Transformation Programme,. This will involve, improving the 136 suite flow, developing alternatives to admission, community interface, discharge model/in-reach and the development of 111 for Mental Health. There is also a monthly performance focus with operational leads regarding the Crisis measures at an Access Oversight Group. *Recovery plan being put in place.*
- **Psychiatric Liaison Referrals in ED within 1 hour -** The challenges are in North and Central, with the South and North Cumbria performing in line with national averages. There is improvement work to standardise processes, including simplifying recording methods. There is also a monthly performance focus with operational leads regarding Psychiatric Liaison at an Access Oversight Group. *Recovery plan being put in place.*
- **<18 weeks to Treatment - CYPS Neurodevelopmental waits -** Waiting times immediate recovery work is taking place, each of the four localities have engaged with their staff teams and developed locality waiting times recovery plans for implementation across the six weeks of the school summer holidays, July to September, when referrals into the service reduce. *Recovery plan being in place.*
- **Live within our means -** Groups / Departments highlighted areas under review to impact on financial performance. BDG monthly finance focus sessions are in place to agree actions to impact on the Trust financial position. Daily staffing reviews taking place across inpatient areas.

Core Trust Integrated Outcome Measures - Summary Overview

Reporting Period: Jul 2023

Domain	Ref	Indicator Name	Variation	Assurance	Performance	Standard	Plan	Risk Rating	Summary Narrative	Exec
Commitments	C01	How was your experience? (FFT)	Normal Variation	Consistently Fail	86.0%	95.0%	Internal	High (Action)	Decreased in the month	SR
	C02	Did we listen to you? (PoY)	Normal Variation	Consistently Fail	86.4%	95.0%	Internal	High (Action)	Slight decrease in the month	SR
	C03	Were staff kind and caring? (PoY)	Normal Variation	Achieve at Random	94.0%	95.0%	Internal	Med (Monitoring)	Slight improvement and reported just below standard	SR
	C04	Did you feel safe? (PoY)	Normal Variation	Achieve at Random	90.4%	95.0%	Internal	Med (Monitoring)	Reported below standard but remaining stable	SR
	C05	Were you given helpful information? (PoY)	Normal Variation	Consistently Fail	82.8%	95.0%	Internal	High (Action)	Large decrease in the month, remaining below standard	SR
People	P01	Turnover	Concern	Achieve at Random	10.6%	10.0%	National	High (Action)	Decreased for 4th consecutive month, moving closer to standard	LS
	P02	Sickness in Month	Improvement	Consistently Fail	5.7%	5.0%	National	High (Action)	Closer to standard, reported at lowest point for 2 years	LS
	P03	% of Training Compliance (Courses with a Standard)	Improvement	Consistently Fail	33.3%	100.0%	Internal	High (Action)	9 out of 27 courses are achieving standard	LS
	P04	Appraisal rate	Improvement	Consistently Fail	79.7%	85.0%	Internal	High (Action)	Continual increase since July 2022	LS
	P05	% Clinical Supervision completed	Improvement	Consistently Fail	54.2%	80.0%	Internal	High (Action)	Decreased across all localities in the month	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	10	No Std	No Plan	Low (No Standard)	Decreased in month remains within expected range	SR
	Q02	Serious Incidents	Normal Variation	No Standard	19	No Std	No Plan	High (Action)	Despite low numbers, action is required due to magnitude	RN
	Q03	Harm Incidents	Concern	No Standard	2,090	No Std	No Plan	Med (Monitoring)	Last 7 months performance reported above 24 month average	RN
	Q04	Safeguarding and Public Protection (SAPP)	Concern	No Standard	1,596	No Std	No Plan	Med (Monitoring)	Reported above the mean average for 7th consecutive month	RN
	Q05	Long term segregation and prolonged seclusion	Normal Variation	No Standard	13	No Std	No Plan	Low (No Standard)	9 out of last 10 months reported below average	SR
	Q06	Aggression and Violence	Normal Variation	No Standard	1,454	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	76	No Std	No Plan	Low (No Standard)	Increased in the month, remaining within expected range	RN
	Q08	Care Plans compliance	Improvement	Consistently Fail	94.4%	95.0%	Internal	Med (Monitoring)	Increased in month, close to standard	SR
	Q09	Risk Assessments compliance	Normal Variation	Achieve at Random	94.9%	95.0%	Internal	Med (Monitoring)	Increased in month, close to standard	SR
	Q10	CPA Completed review	Concern	Consistently Fail	78.8%	95.0%	Internal	High (Action)	Continual decrease from May 2022.	SR
	Q11	Staffing fill rates	Improvement	Consistently Fail	124.2%	120.0%	National	High (Action)	Reported above standard, day & night rates included	SR
Person Led Care	A01	Out of Area Placement bed days	Normal Variation	Achieve at Random	212	186	LTP	High (Action)	Decreased for 5th consecutive month	RD
	A02	Bed Occupancy including leave (open beds on RiO)	Normal Variation	Consistently Fail	93.3%	85.0%	National	High (Action)	Decreased in the month, remains above the optimal level of 85%	RD
	A03	% Adult inpatients discharged with LOS > 60 days	Normal Variation	No Standard	20.9%	No Std	No Plan	Low (No Standard)	Decrease in the month, within expected range	RD
	A04	% OP inpatients discharged with LOS > 90 days	Normal Variation	No Standard	28.6%	No Std	No Plan	Low (No Standard)	Decreased in the month within expected range	RD
	A05	Clinically Ready for Discharge (formerly DTOC)	Normal Variation	Consistently Fail	10.2%	7.5%	National	High (Action)	Decreased in month below upper control limit	RD
	A06	Crisis % Very urgent seen within 4 hours (WAA&OP)	Normal Variation	No Standard	43.3%	No Std	No Plan	Med (Monitoring)	13 out of 30, fluctuates due to low numbers	RD
	A07	Crisis % Urgent seen within 24 hours (WAA&OP)	Concern	No Standard	76.4%	No Std	No Plan	Med (Monitoring)	492 out of 644. Performance has dipped in last 5 months	RD
	A08	% PLT ED Referrals seen within 1 hour	Concern	No Standard	54.7%	No Std	LTP	Med (Monitoring)	Decreased over 24 months period and remains lower than peers	RD
	A09	% PLT Ward Referrals seen within 24 hours	Normal Variation	No Standard	80.4%	No Std	LTP	Low (No Standard)	Fluctuates but remains between 71% and 84%	RD
	A10	72 hour Follow-Up	Normal Variation	Consistently Achieve	90.2%	80.0%	LTP	Low (On Track)	Consistently exceeds 80% standard	RD
	A11	<18 weeks wait to Treatment Adults & Older Adults	Concern	No Standard	69.9%	No Std	No Plan	Med (Monitoring)	30.1% (1766 of 5864) have been waiting 18 weeks or longer	RD
	A12	<18 weeks waits to Treatment - All CYPS	Concern	No Standard	43.9%	No Std	No Plan	Med (Monitoring)	56.1% (3778 of 6732) have been waiting 18 weeks or longer	RD
	A13	<18 wk waits to Treatment CYPS Neurodevelopmental	Normal Variation	No Standard	39.2%	No Std	No Plan	Med (Monitoring)	60.8% (3222 of 5296) 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 met the standard for 13 months	RD
	A15	CYPS Eating Disorders (routine referrals)	Normal Variation	Achieve at Random	83.3%	95.0%	LTP	Med (Monitoring)	Increased in the month but remains below standard	RD
	A16	EIP – starting treatment in 14 days	Normal Variation	Consistently Achieve	83.3%	60.0%	LTP	Low (On Track)	Consistently exceeds 60% standard	RD
	A17	Talking Therapies % Moving to Recovery (IAPT)	Normal Variation	Achieve at Random	48.3%	50.0%	LTP	Med (Monitoring)	North Cumbria recovery rate below standard	RD
Sustainable	S01	Live within our means (I&E Surplus/Deficit £)	SPC N/A	SPC N/A	2.2M	1.2M	No Plan	High (Action)	23/24 forecast under significant pressure	KS
	S02	Capital spend compared to plan (£)	SPC N/A	SPC N/A	0.9M	1.2M	No Plan	Low (On Track)	Capital programme overcommitted	KS
	S03	Cash balance compared to plan (£)	SPC N/A	SPC N/A	43.1M	17.7M	No Plan	Low (On Track)	Cash balance on plan due to additional monies	KS

Commitments to our Carers & Patients - Headline Commentary

Reporting Period: Jul 2023

Headline Challenges

Friends and Family Test Question

- **How was your experience? (FFT)** - At 86.0% this is not meeting standard and has decreased in the month. The latest national published FFT score for England is reported at 87% (Feb 23).

Points of You Questions

- **Do we listen to you?** - At 86.4% this remains below standard and has slightly decreased in the month. People not feeling listened to remains a theme especially in younger people and young adults
- **Were staff kind and caring?** - At 94.0% this measure is closest to standard receiving the best scores out of all the questions.
- **Do you feel safe?** - At 90.4% this remains below standard and has not significantly changed in 24 months.
- **Were you given helpful information?** - At 82.8% this has the lowest score of all questions.

Key focus areas of concern

- **How was your experience (FFT)**
- **Were you given helpful information? (PoY)**
- **Do we listen to you? (PoY)**

Positive Assurance / Improvement

Targets are not currently being met for all these measures. However, there is a continued effort to increase and respond to feedback within the Trust to support the improvement of services.

Were staff kind and caring? - this measure is at 94% improving and only 1% off the 95% target this month.

Mitigations/actions

How was your experience? (FFT)

- Teams and wards are supported to access the Points of You dashboard to understand what carers and patients are saying in real time.
- Service User and Carer 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, meaning we are hearing from more people.
- Service User and Carer involvement needs to be part of service development and improvement work.

Were you given helpful information? (PoY)

- Raising staff awareness of the Health Literacy tool box is ongoing.
- Leaflet compliance is discussed at Involvement and Experience meetings.

Do we listen to you? (PoY)

- 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.
- Efforts to raise awareness have seen a steady rise in completion.
- Some teams produce their own You Said-We Did posters on their ward/team boards. Currently this information is captured centrally and is shared with localities as requested but access will be available to all wards/teams when the new dashboards roll out.
- Engagement continues with service users, carers and staff to develop an updated version of the Points of You survey has commenced. Any changes will be implemented by end of 2023/24.

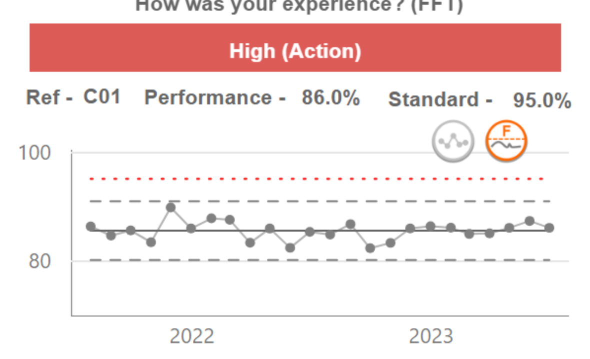
Commitments to our Carers & Patients

Reporting Period: Jul 2023

How was your experience? (FFT)

High (Action)

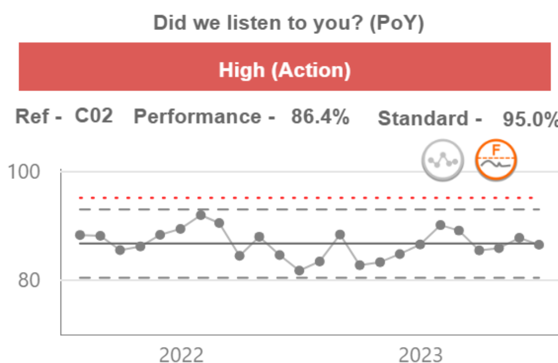
Ref - C01 Performance - 86.0% Standard - 95.0%



Did we listen to you? (PoY)

High (Action)

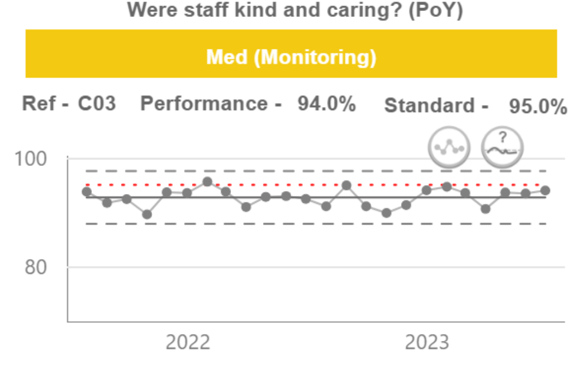
Ref - C02 Performance - 86.4% Standard - 95.0%



Were staff kind and caring? (PoY)

Med (Monitoring)

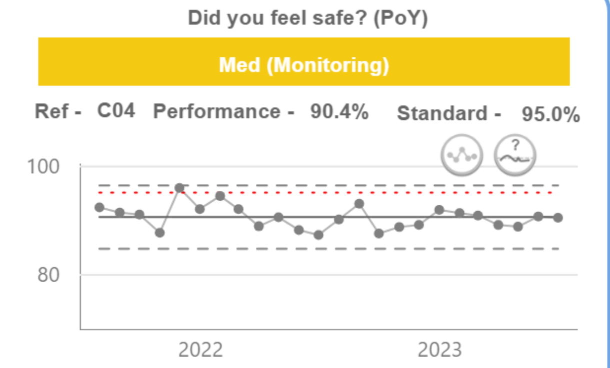
Ref - C03 Performance - 94.0% Standard - 95.0%



Did you feel safe? (PoY)

Med (Monitoring)

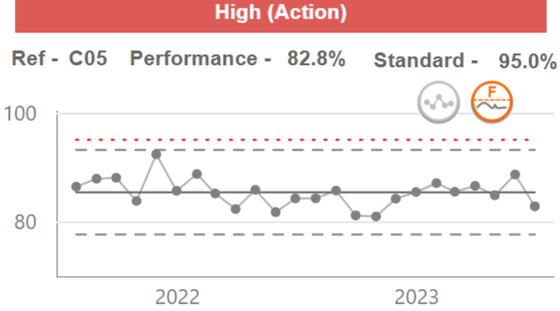
Ref - C04 Performance - 90.4% Standard - 95.0%



Were you given helpful information? (PoY)

High (Action)

Ref - C05 Performance - 82.8% Standard - 95.0%



Great Place to Work - Headline Commentary

Reporting Period: Jul 2023

Headline Challenges

- **Sickness** - The chart shows the confirmed sickness for June 2023 which is reported at 5.7%, the lowest point for 2 years. The provisional sickness for July 2023 is reported at 5.89%.
- **% of Training Compliance (Courses with a standard)** - In July, 9 out of 27 courses are achieving or above the required standard. Of the remainder 18 remain over 5% below standard.
  - A review is taking place of the training competencies and compliance standards. Performance has reduced in the month due to competency data being updated in mass by IBM, trajectories will be agreed for each CBU by August 23.
- **Clinical Supervision** - this has been well below the standard for a significant number of months although it has started to show small signs of improvement.
- **Appraisals** - Consistent improvement over last 12 months though remains below standard.

Key focus areas of concern

- **Sickness**
- **Staffing resources**
- **% of Training Compliance (Courses with a standard)**

Positive Assurance / Improvement

- No measures are on track within this area, but positive improvement is reported with:
  - **Turnover**
  - **Sickness**
  - **Appraisals**
  - **Clinical Supervision**

Mitigations/actions

Sickness

- Promotion of wellbeing conversations to support local stress risk assessments, carers passports and WRAP plans, with dedicated locality resource.
- Locality introduction of dedicated Workforce support for absence review points.

Staffing Resources

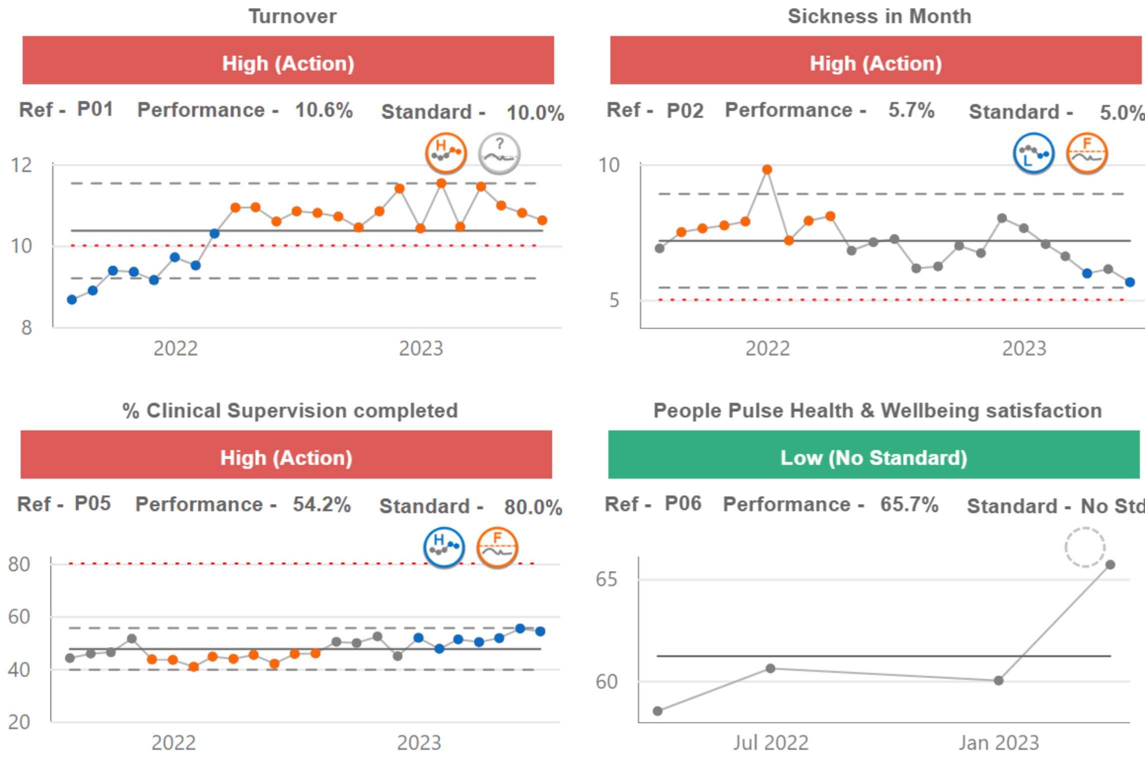
- Localities and corporate areas have introduced local vacancy control processes in line with locality cost improvement plans. Giving tighter monitoring of requests.

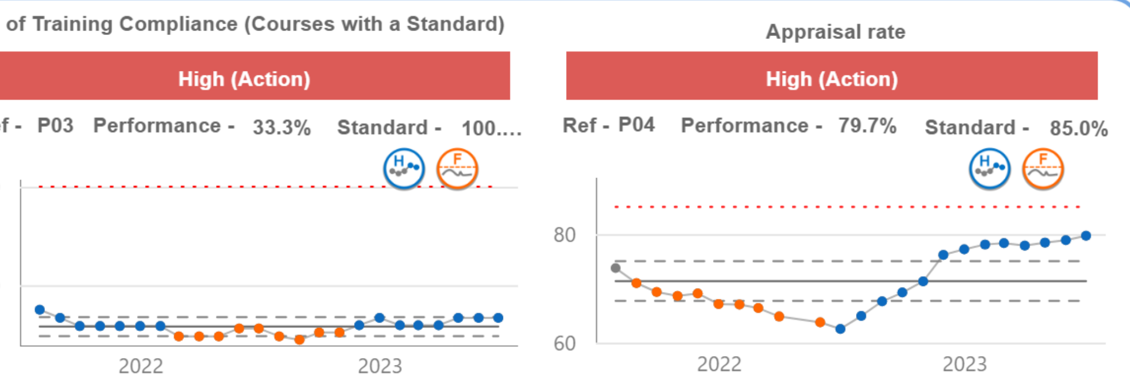
% of Training Compliance (Courses with a standard)

- The Training Needs Analysis tool has been updated with the modality of the training and trajectories being set.
- Setting of training competencies and standards across all areas working in partnership with Heads of Commissioning and Quality Assurance.
- Continuous proactive engagement with services around Information Governance training.

Great Place to Work

Reporting Period: Jul 2023





Quality Care, Everyday - Headline Commentary

Reporting Period: Jul 2023

Headline Challenges

- **Serious Incidents** - There was a decrease in the number of Serious Incidents this month from June but no significant variance out with norm over the last 2 years.
- **Safeguarding and Public Protection** - This is the seventh consecutive month where activity was above the mean average and is therefore highlighted as potential Special Cause variation.
- **CPA Complete Review** - This has increased over the last 3 months although remains significantly below standard.
- **Staff fill rates** - Measure is off track despite a trend of improvement. Updated to include both day and night fill rates.

Key focus areas of concern

- **Serious Incident**
- **Safeguarding and Public Protection**
- **CPA Completed Review**
- **Staff fill rates**

Positive Assurance / Improvement

- **Care Plan compliance** remains stable but showing as continually increasing (almost at standard).
- **Risk Assessment Compliance** slight increase in month and this measure is almost meeting the standard.
- **Patients in long Term Segregation and prolonged seclusion** continues to decrease.

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. Improved training and recording could have led to an increase in the reporting.

CPA Completed Review

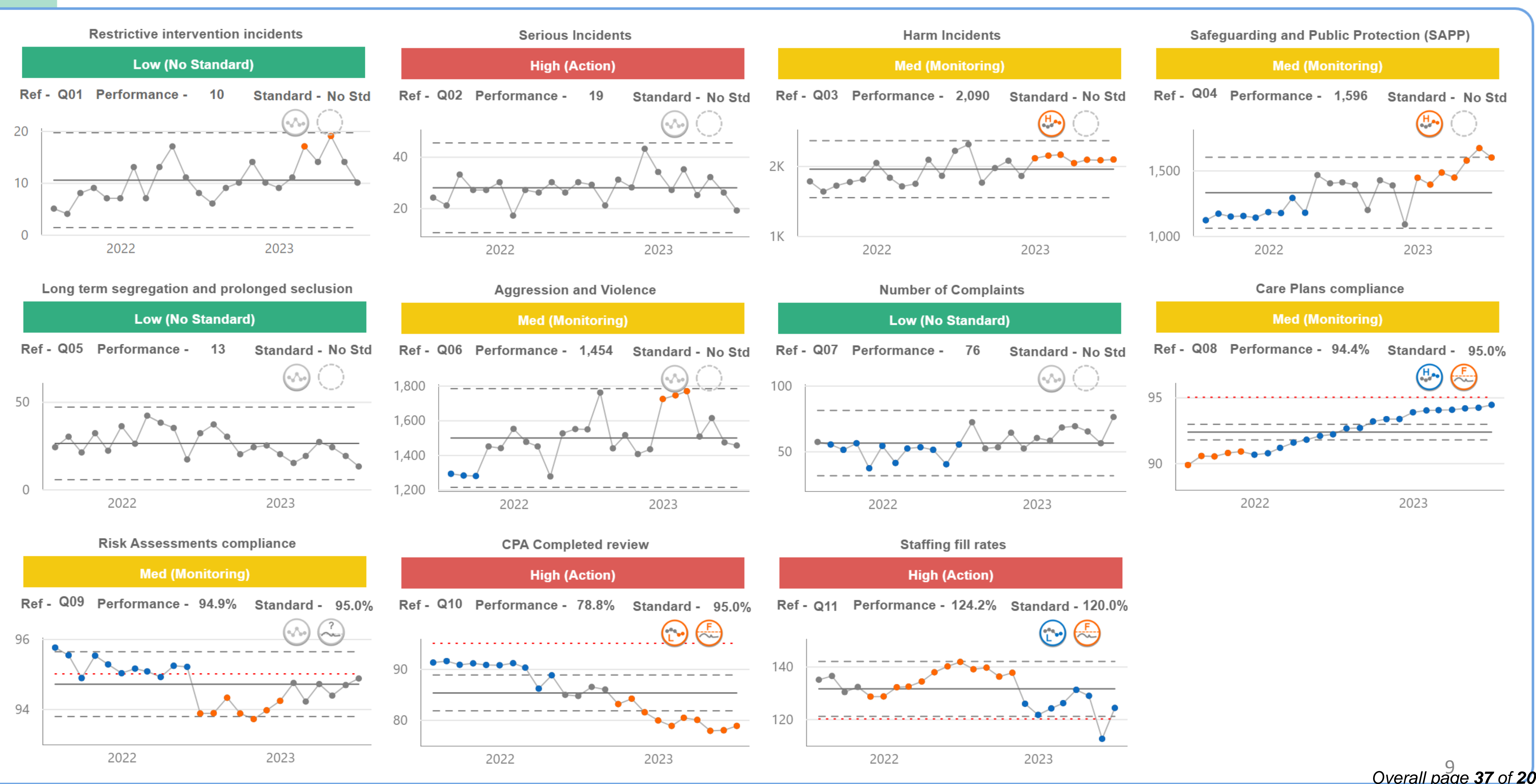
Small increases over the last 3 months highlight that Teams are aware and actioning the requirement to record and verify a CPA review via the CPA status form.

Staff Fill Rates

There is a comprehensive programme of work to reduce the total WTE usage on wards.

Quality Care, Everyday

Reporting Period: Jul 2023



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

Headline Challenges

- **Out of Area Placements/Clinically Ready for Discharge/Bed Occupancy** - All reported off target, however, performance has improved in month across these measures.
- **Crisis Very Urgent Referrals seen within 4 hours** - Very low numbers means performance fluctuates significantly.
- **Crisis Urgent Referrals seen within 24 hours** - The last 5 month's performance has been below the normal range.
- **Psychiatric Liaison Referrals in ED within 1 hour** - Performance has decreased over a 24 month period and continues to remain lower than peers.
- **All CYPS Waits for Treatment** - Percentage of waiters has deteriorated since August 2021 but remained static since May 2022. Numbers waiting is at 3,788 and rising sharply, with the vast majority on neurodevelopmental pathways.
- **<18 weeks to Treatment - CYPS Neurodevelopmental waits** - Percentage seen within 18 weeks remains low and the actual number waiting is over 3,222 and continues to rise every month.
- **CYPS Eating Disorder Routine** - Is slowly increasing despite a dip in performance this month. It has been off target for 24 months.

Key focus areas of concern

Of most concern

- **Crisis Urgent Referrals**
- **Psychiatric Liaison Referrals in ED within 1 hour**
- **CYPS Neurodevelopmental waits**

Of concern:

- **CYPS Eating Disorder Routine**

Positive Assurance / Improvement

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

Despite the following inpatient flow measures not being on track, there has been positive improvement in the last few months across all five:

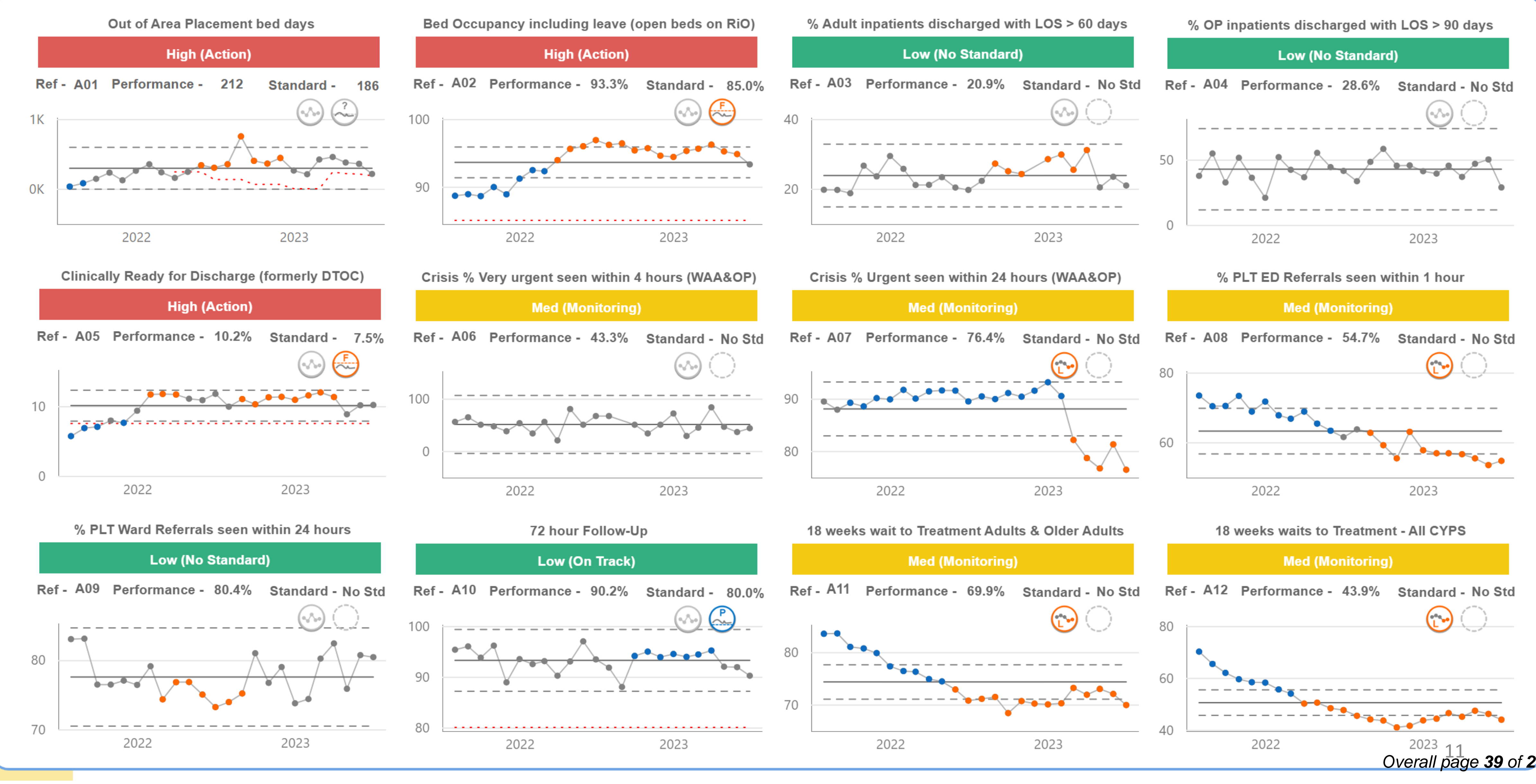
- **Out of area Placement Bed Days**
- **Bed Occupancy**
- **Clinically Ready for Discharge**
- **% Adult inpatient discharged with LOS >60 days**
- **% OP inpatients discharged with LOS >90 days**

Mitigations/actions

- **Crisis Very Urgent Referrals seen within 4 hours / Crisis Urgent Referrals seen within 24 hours -** Developing a new Crisis model is one of the four core pillars of the Urgent and Inpatient Transformation Programme,. This will involve, improving the 136 suite flow, developing alternatives to admission, community interface, discharge model/in-reach and the development of 111 for Mental Health. There is also a monthly performance focus with operational leads regarding the Crisis measures at an Access Oversight Group. *Recovery plan being put in place.*
- **Psychiatric Liaison Referrals in ED within 1 hour -** The challenges are in North and Central, with the South and North Cumbria performing in line with national averages. There is improvement work to standardise processes, including simplifying recording methods. There is also a monthly performance focus with operational leads regarding Psychiatric Liaison at an Access Oversight Group. *Recovery plan being put in place.*
- **<18 weeks to Treatment - CYPS Neurodevelopmental waits -** Waiting times immediate recovery work is taking place, each of the four localities have engaged with their staff teams and developed locality waiting times recovery plans for implementation across the six weeks of the school summer holidays, July to September, when referrals into the service reduce. *Recovery plan being in place.*
- **CYPS Eating Disorder Routine -** The Trust have been engaging in the ICB improvement programme for CYPS ED services, linked to the 22/23 SDIP and are in receipt of the report which makes recommendations to the ICB regarding the future of CYPS ED services and will be providing a response to this document.

Person Led Care, when and where it's needed

Reporting Period: Jul 2023



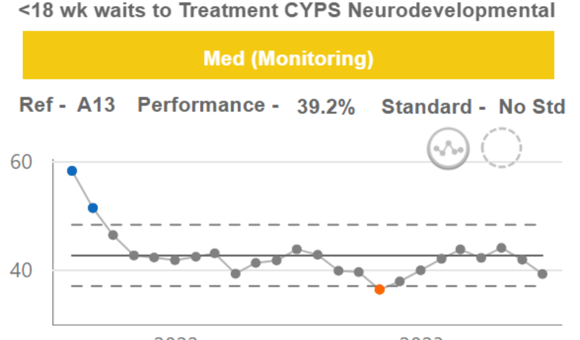
Person Led Care, when and where it's needed

Reporting Period: Jul 2023

<18 wk waits to Treatment CYPS Neurodevelopmental

Med (Monitoring)

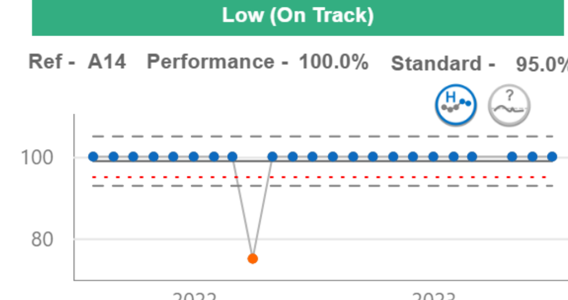
Ref - A13 Performance - 39.2% Standard - No Std



CYPS Eating Disorders (urgent referrals)

Low (On Track)

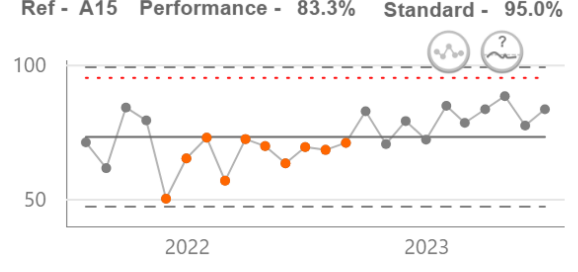
Ref - A14 Performance - 100.0% Standard - 95.0%



CYPS Eating Disorders (routine referrals)

Med (Monitoring)

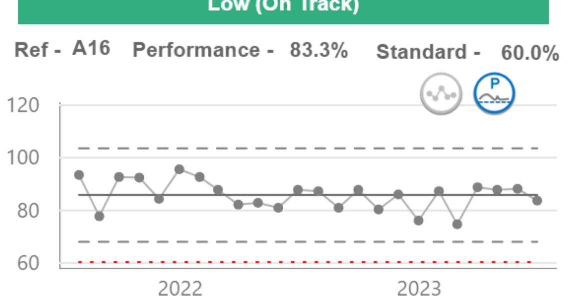
Ref - A15 Performance - 83.3% Standard - 95.0%



EIP – starting treatment in 14 days

Low (On Track)

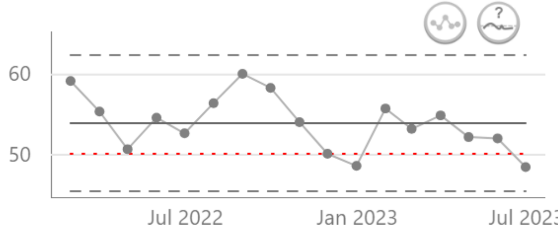
Ref - A16 Performance - 83.3% Standard - 60.0%



Talking Therapies % Moving to Recovery (IAPT)

Med (Monitoring)

Ref - A17 Performance - 48.3% Standard - 50.0%



Sustainable for the Long Term - Headline Commentary

Headline Challenges

- Trust financial position shows better than plan at month 4. Plan includes phasing adjustment to reflect phasing of efficiencies. On removal of the phasing adjustment the Trust is showing £4.8m overspend at the end July (month 4).
- At the end of month 4 the Trust has spent £6.2m on agency staff against a plan £5.6m and against the Trust's nationally applied agency ceiling of £4.8m.
- 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 WTE numbers, which remain over planned levels.
- 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.

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 Trust 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

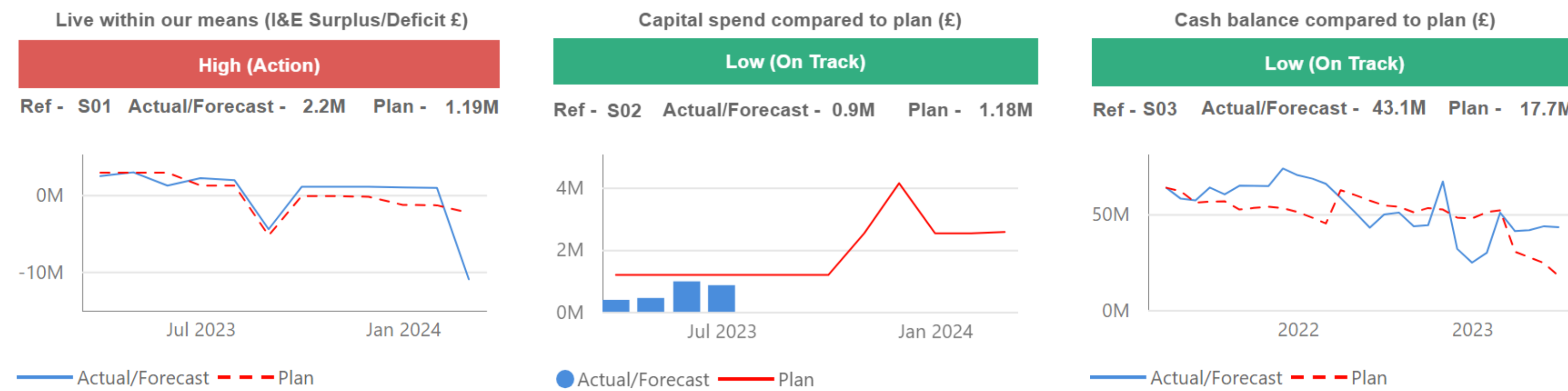
- Trust current cash balances are over plan from slippage in capital programme.
- Senior Management commitment to improve financial position - focus of BDG on a monthly basis with specific financial reviews of areas of most concern.
- Agency spend on downward trend though Q1 (April £1.8m, May £1.6m and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

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 the financial forecast.
- Daily staffing reviews taking place across inpatient areas.
- Pursuing capital funding for CEDAR scheme to support Trust cash balances.

Sustainable for the Long Term

Reporting Period: Jul 2023



C01 - How was your experience? (FFT)

Risk Rating - **High (Action)**

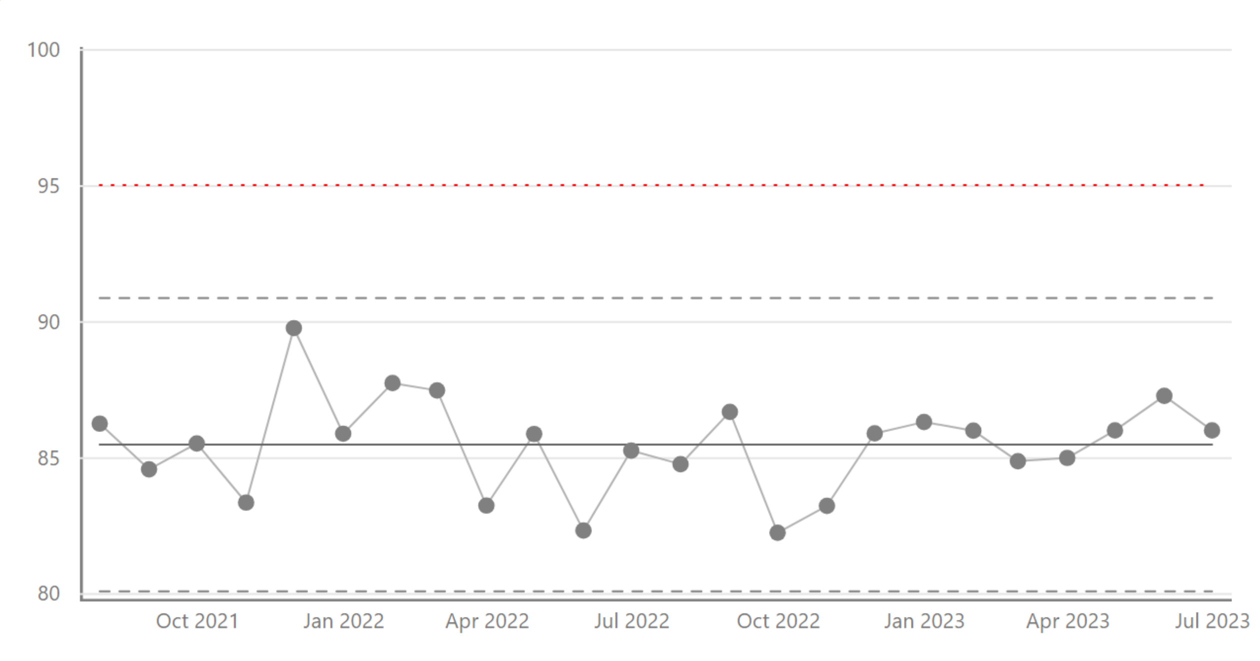
Overall how was your experience with our service? (FFT)

Performance - 86.0%
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
Central Locality Care Group	83.4%	95.0%	Normal Variation	Consistently Fail
North Cumbria Locality Care Group	85.8%	95.0%	Normal Variation	Consistently Fail
North Locality Care Group	87.1%	95.0%	Normal Variation	Achieve at Random
South Locality Care Group	87.4%	95.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Performance of 86% for July was within the expected range of 80% to 91% which remains below the standard of 95%. (latest national published FFT score is reported for February 2023 at 87%). If nothing changes then we will consistently fail this measure.

Root Cause of the performance issue

- All service users and carers have the ability to share their experience through answering this question. Not all people have a positive experience, although the vast majority do. Being responsive to the positive and negative themes from team right through to Trust level is most important here.

Improvement Actions

- Awareness of the feedback options and how they are accessed through the Points of You dashboard continues through Quality Standards meetings at Trust and Locality level as well as in Service User and Carer Experience meetings, again at Trust and Locality level are seeing results, in an upturn in completed surveys and completed You Said-We Did posters.
- Engagement to develop a new version of the service user and carer experience survey started this month. It is hoped that engaging to develop a survey with questions people want to answer could increase completion of surveys going forward.

Expected impact and by when

Improvement towards the standard and increased feedback received during 2023-24.

C02 - Did we listen to you? (PoY)

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

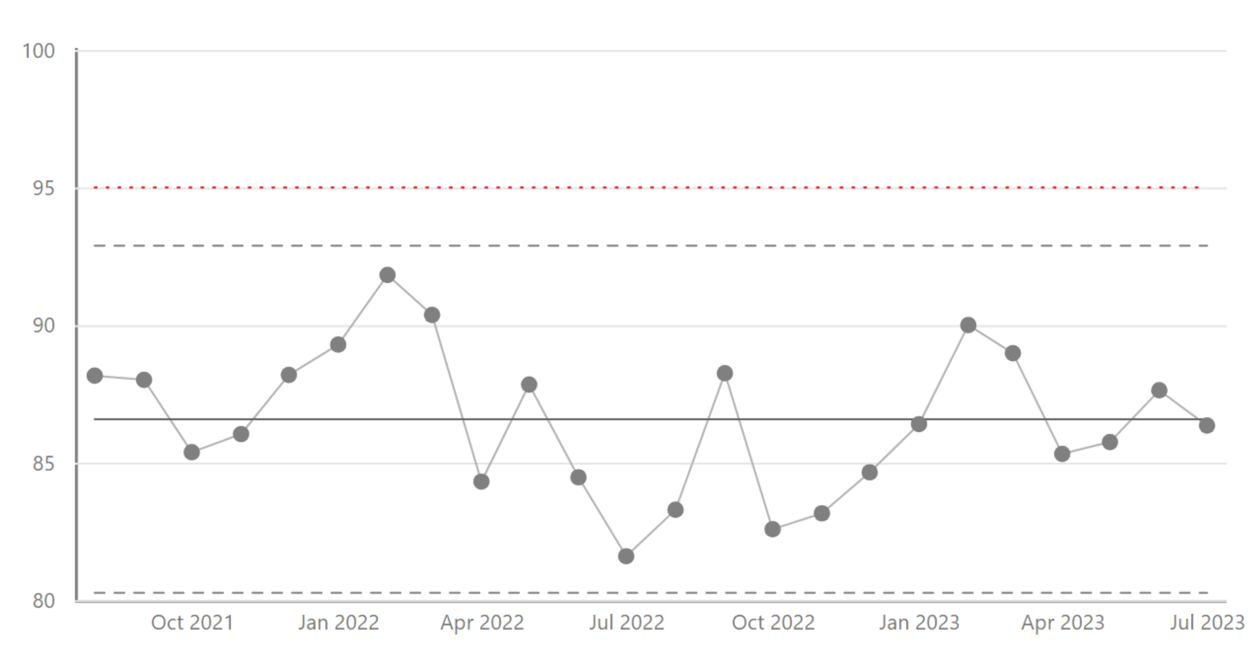
Risk Rating - High (Action)

Performance - 86.4%
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
Central Locality Care Group	83.2%	95.0%	Normal Variation	Achieve at Random
North Cumbria Locality Care Group	82.9%	95.0%	Normal Variation	Achieve at Random
North Locality Care Group	89.1%	95.0%	Improvement	Achieve at Random
South Locality Care Group	88.8%	95.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Performance of 86.4% for July was within the expected range of 80% to 93% which remains below the standard of 95%.

Root Cause of the performance issue

- Services in North Cumbria continue to get lower % scores than other localities, bringing down the overall %.
- Being listened to remains the most important sub theme within the communications theme, for positive and negative comments.

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.
- Teams should explore what service users and carers are telling them around the being listened to themed comments, with the aim of doing more of what people like and less of what is leading to a negative experience.

Expected impact and by when

Improvement towards the standard and increased feedback received during 2023-24.

C03 - Were staff kind and caring? (PoY)

Were staff kind and caring? (PoY)

Risk Rating - **Med (Monitoring)**

Performance - 94.0%

Standard - 95.0%

Achieve at Random

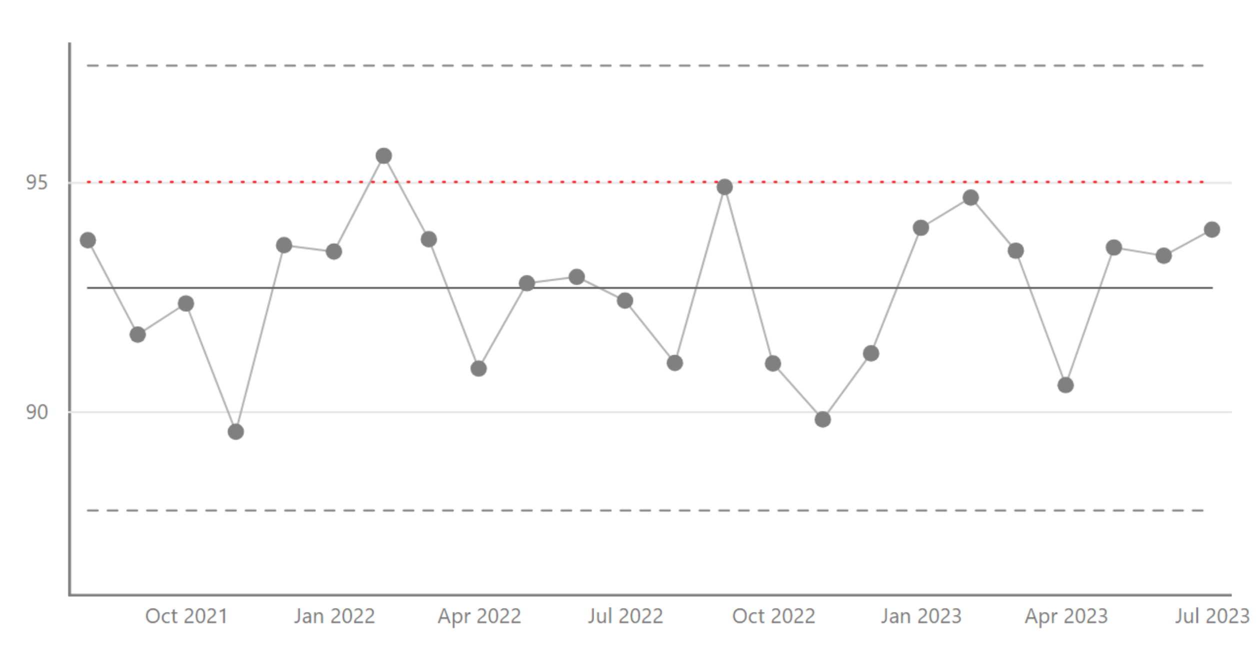
The standard for this indicator is within the upper and lower control limits

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	90.2%	95.0%	Normal Variation	Achieve at Random
North Cumbria Locality Care Group	91.7%	95.0%	Normal Variation	Achieve at Random
North Locality Care Group	95.7%	95.0%	Improvement	Achieve at Random
South Locality Care Group	97.8%	95.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Performance of 94% for July was within the expected range of 87% to 98%. The standard of 95% falls within the expected range suggesting that we will sometimes meet the standard, but not consistently.

Root Cause of the performance issue

- This is the question the Trust has received the best score for.
- 14 people said staff were not kind and caring, in comparison with 477 saying yes.

Improvement Actions

- This feedback from carers and patients should be shared across the Trust to support staff wellbeing and resilience.
- Responses to this question are overwhelmingly positive. Efforts should be made to make staff aware of this, to support resilience and satisfaction.

Expected impact and by when

Improvement towards the standard and increased feedback received during 2023-24.

C04 - Did you feel safe? (PoY)

Risk Rating - **Med (Monitoring)**

Did you feel safe with our service? (PoY)

Performance - 90.4%

Standard - 95.0%

Achieve at Random

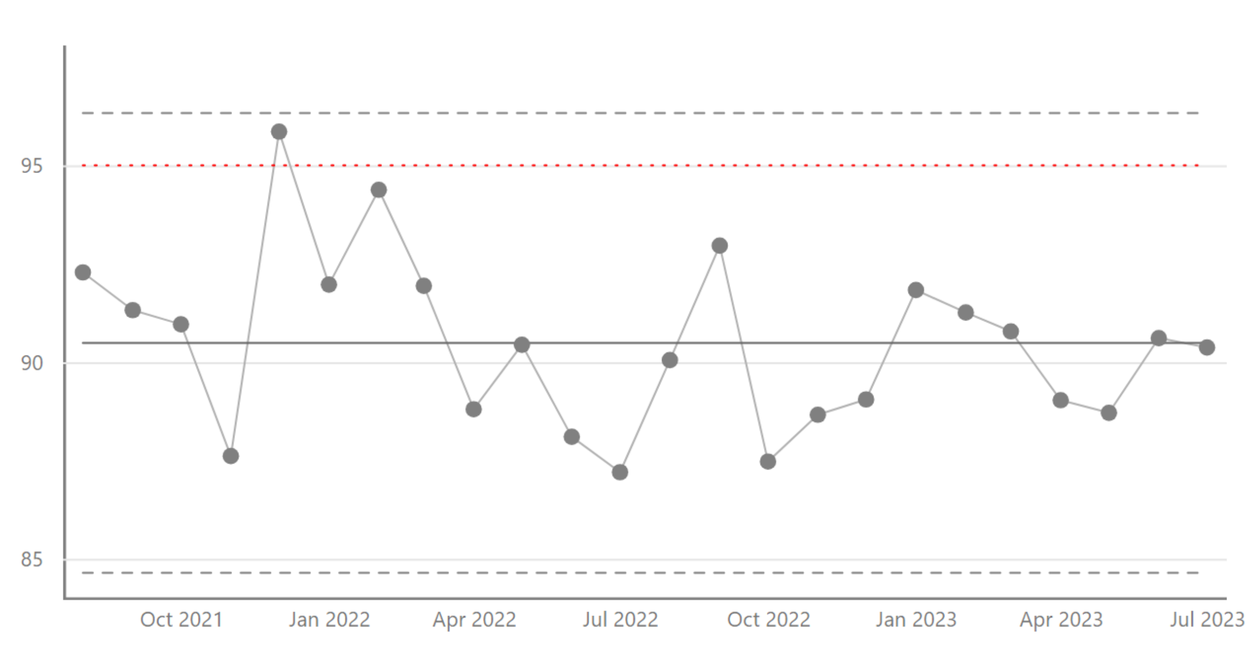
The standard for this indicator is within the upper and lower control limits

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
Central Locality Care Group	89.0%	95.0%	Normal Variation	Achieve at Random
North Cumbria Locality Care Group	88.9%	95.0%	Normal Variation	Achieve at Random
North Locality Care Group	90.4%	95.0%	Improvement	Achieve at Random
South Locality Care Group	92.2%	95.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Performance of 90.4% for July was within the expected range of 84% to 97%. The standard of 95% falls within the expected range suggesting that we will sometimes meet the standard, but not consistently.

Root Cause of the performance issue

- 21 people reported not feeling safe during July. 464 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 would benefit from exploring why people say they don't feel safe.

Expected impact and by when

Improvement towards the standard and increased feedback received during 2023-24.

C05 - Were you given helpful information? (PoY)

Were you given information that was helpful? (PoY)

Risk Rating - **High (Action)**

Performance - 82.8%

Standard - 95.0%

Consistently Fail

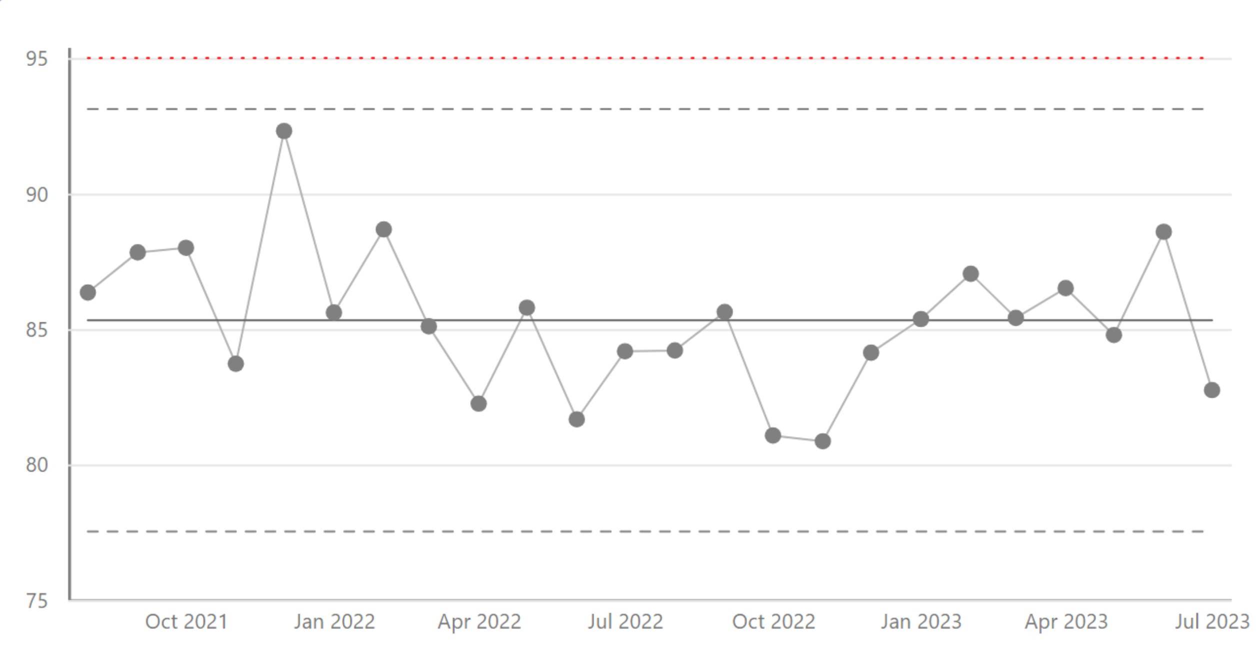
The standard for this indicator is outside the control limits

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
Central Locality Care Group	82.0%	95.0%	Normal Variation	Achieve at Random
North Cumbria Locality Care Group	78.4%	95.0%	Normal Variation	Achieve at Random
North Locality Care Group	80.9%	95.0%	Normal Variation	Achieve at Random
South Locality Care Group	85.6%	95.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Performance of 82.8% for July was within the expected range of 77% to 94% which remains below the standard of 95%.

Root Cause of the performance issue

- Health literacy rates are the lowest nationally within the CNTW footprint. Staff should routinely check that information is appropriate for those receiving it.
- Of the 46 people saying 'no' to the questions, an increase from the 25 offering this response last month, not receiving information that had been promised or being given poor quality information was the main themes.

Improvement Actions

- Engagement on a new survey began during this month. Accessibility and more choice around how people access the survey will be key considerations.
- A Health Literacy tool box is available on the intranet for all staff. Awareness of this resource is ongoing, as is the development of the resource.
- Leaflet compliance discussed at Involvement and Experience meetings.

Expected impact and by when

Improvement towards the standard and increased feedback received during 2023-24.

P01 - Turnover

Turnover FTE 12 month rolling

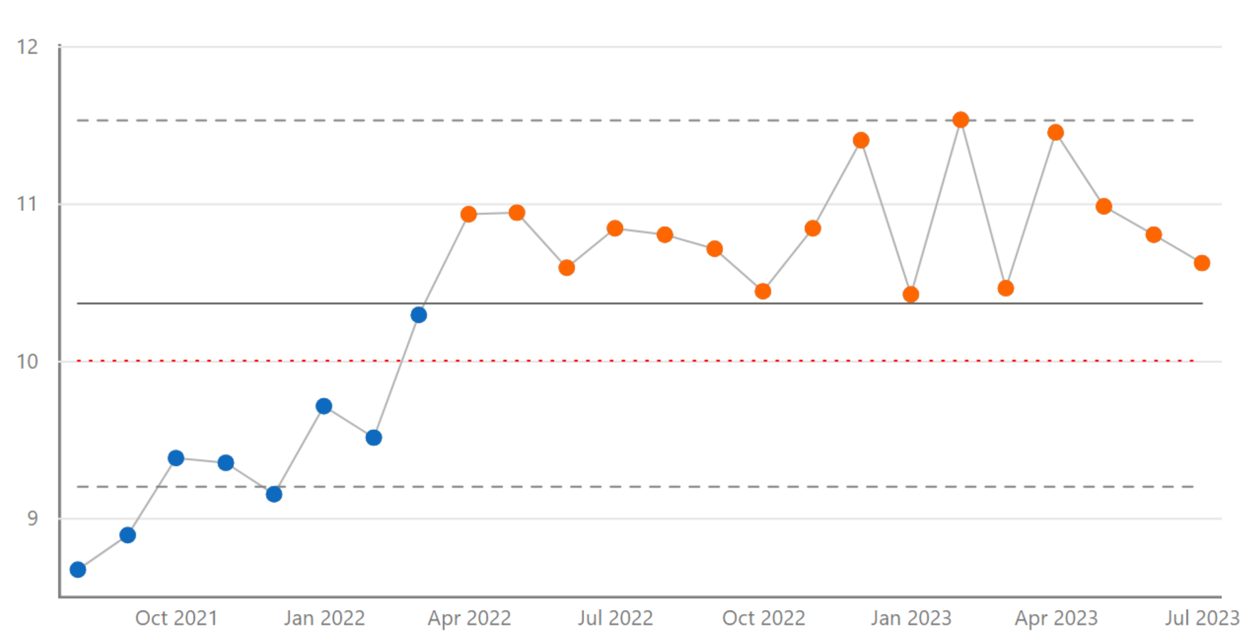
Risk Rating - **High (Action)**

Performance - 10.6%
Standard - 10.0%

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

Concern
There is concern because this indicator is increasing

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



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	9.6%	10.0%	Normal Variation	Achieve at Random
North Cumbria Locality Care Group	11.9%	10.0%	Normal Variation	Achieve at Random
North Locality Care Group	8.7%	10.0%	Improvement	Achieve at Random
South Locality Care Group	8.8%	10.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Turnover of 10.6% in July was consistent with expected range but as it has remained above the mean average since April 2022 it is highlighted as potential Special Cause variation.

Root cause of the performance issue

- Recruitment and Retention & staff health and wellbeing.

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.
- Emailing staff on Leavers report, inviting them to engage in an exit interview/questionnaire.
- Aim to fill vacancies within 4-6 weeks.
- Evaluate onboarding and New Starters process in 2-3 months.
- Face to face induction.
- Increase response to exit questionnaire and Quarterly People Pulse Survey to gather robust data to enable to localities to understand issues in more detail

Expected impact and by when

Turnover to decrease across localities with standard maintained.

P02 - Sickness in Month

Percentage of in month sickness absence

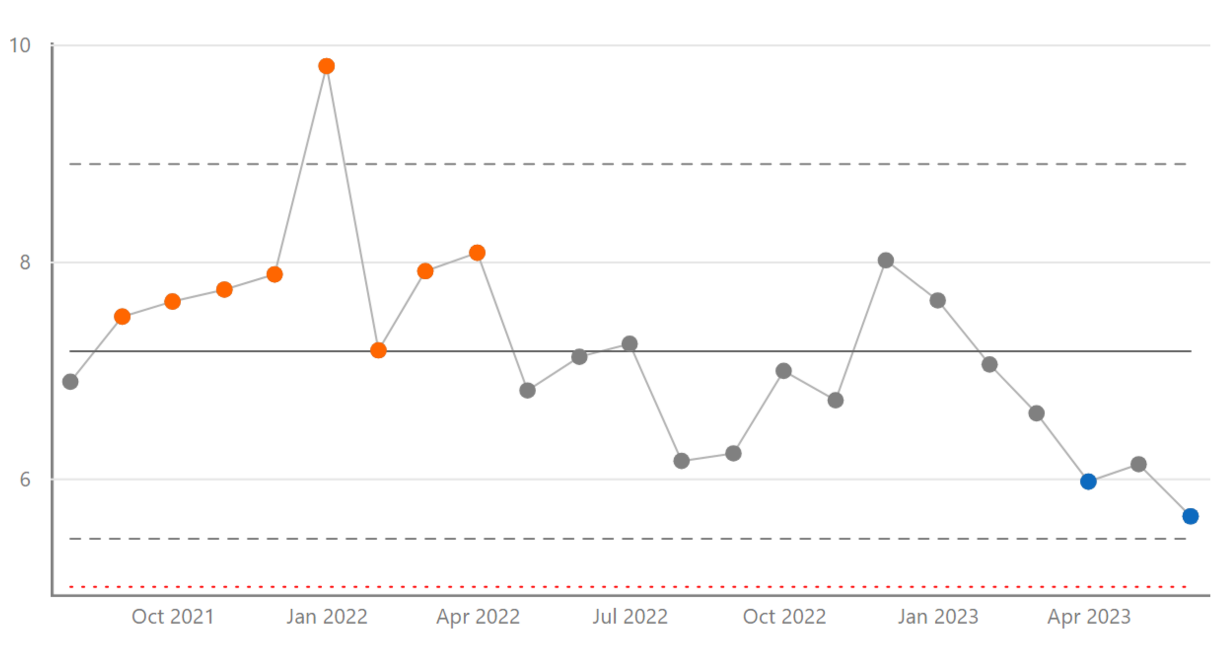
Risk Rating - **High (Action)**

Performance - 5.7%
Standard - 5.0%

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

Improvement
This indicator is decreasing 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	5.9%	5.0%	Normal Variation	Consistently Fail
North Cumbria Locality Care Group	6.4%	5.0%	Normal Variation	Consistently Fail
North Locality Care Group	5.7%	5.0%	Normal Variation	Consistently Fail
South Locality Care Group	6.1%	5.0%	Improvement	Consistently Fail

Feedback

What the chart tells us

The chart shows the confirmed sickness for June 2023 and is reported at 5.7%. The provisional sickness for July 2023 is reported at 5.89% remaining above the 5% target.

Root cause of the performance issue

- High mental health related absence
- High MSK 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 prioritisation of MH and MSK occupational health referrals.
- Wellness Support team workforce function with Localities.
- 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.
- ESR Supervisor Self Service (Limited Access).

Expected impact and by when

- Keeping staff feeling well at work.
- Exploring temporary adjustments to duties.
- Robust people management processes; including STS monitoring.
- Reduction in Occupational Health DNA's.

P03 - % of Training Compliance (Courses with a Standard)

Risk Rating - **High (Action)**

% of Training Compliance (Courses with a Standard)

Performance - 33.3%

Standard - 100.0%

Consistently Fail

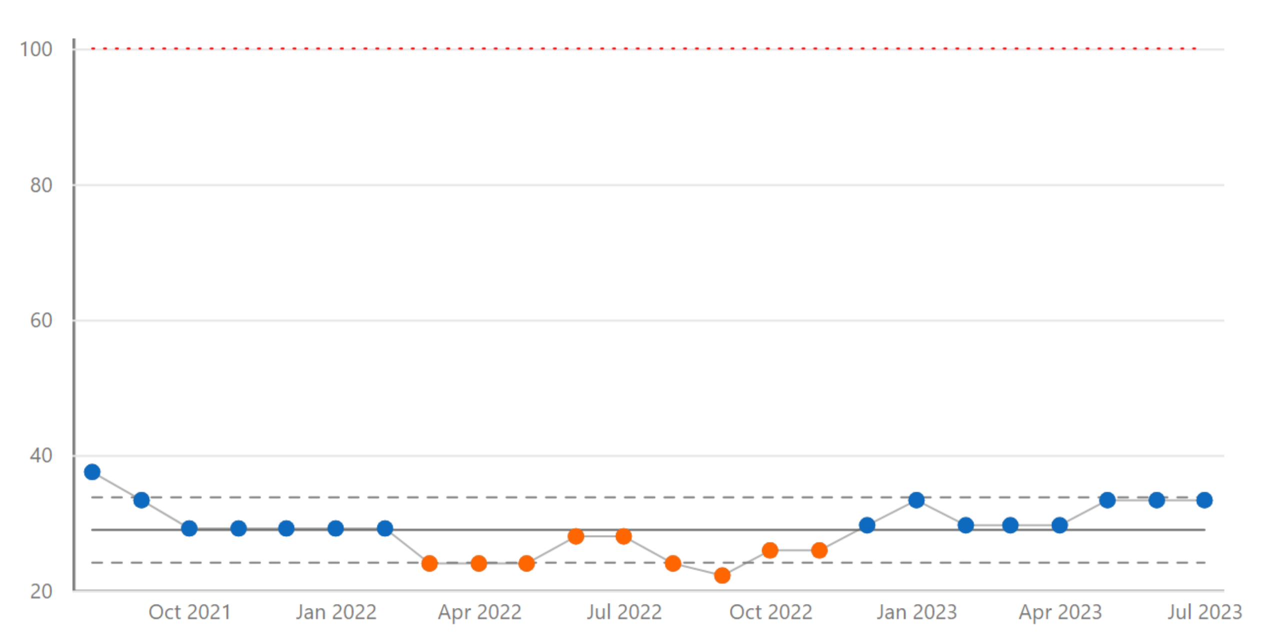
The standard for this indicator is outside the control limits

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	40.0%	100.0%	Normal Variation	Consistently Fail
North Cumbria Locality Care Group	26.9%	100.0%	Improvement	Consistently Fail
North Locality Care Group	44.0%	100.0%	Normal Variation	Consistently Fail
South Locality Care Group	42.3%	100.0%	Normal Variation	Consistently Fail

Feedback

What the chart tells us

Training Compliance was at 33.3% for July which was within the expected range of 24% to 34%. In July, 9 out of 27 % of training courses with a standard are achieving the required standard of 85%.

Root Cause of the performance issue

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

Improvement Actions

- Competency data was updated in mass by IBM.
- A review is being undertaken into the 50 training competencies, as only 29 have a compliance standard.
- The Training Needs Analysis tool completed with the modality of the training to support planning of training trajectories.
- Promotion of the modes of accessing training.
- Train the trainer for some core programmes to deliver in place.
- Arranging bespoke training.

Expected impact and by when

As a result of the training update taking place during July, performance is expected to decrease. Trajectories in relation each CBUs performance will be reviewed and agreed during July and August as the correction of competency data will have a negative impact on compliance.

P04 - Appraisal rate

Appraisal rate

Risk Rating - **High (Action)**

Performance - 79.7%

Standard - 85.0%

Consistently Fail

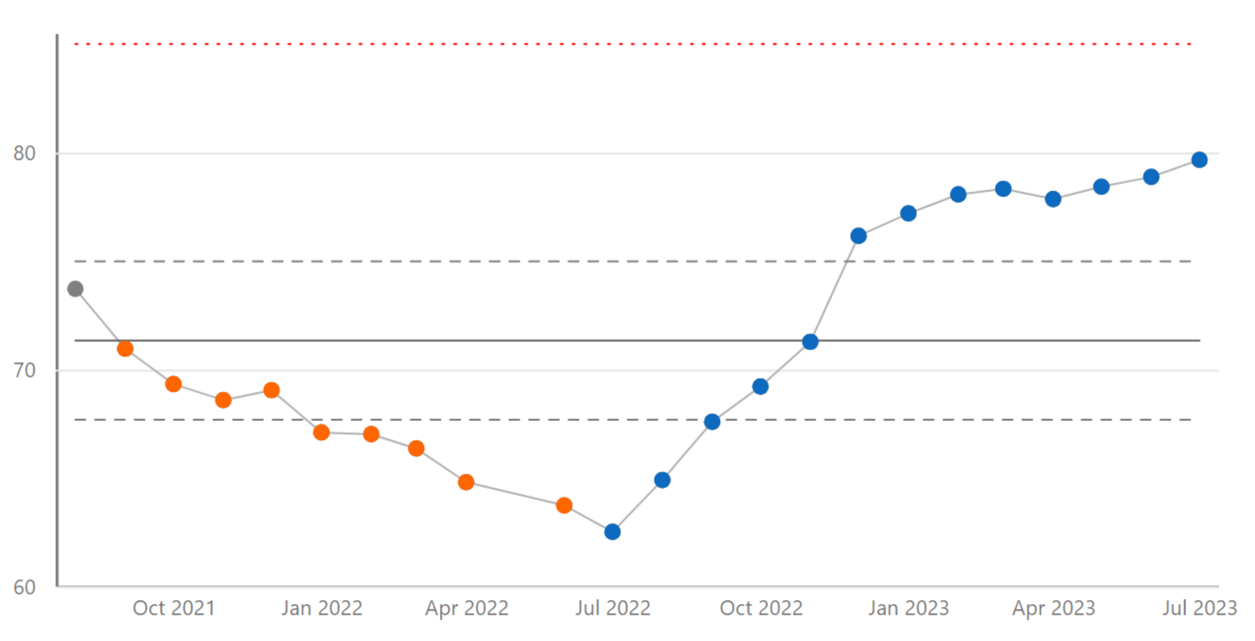
The standard for this indicator is outside the control limits

Improvement

This indicator is increasing which shows improvement

DQ - No Concern

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



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	78.4%	85.0%	Improvement	Consistently Fail
North Cumbria Locality Care Group	77.6%	85.0%	Improvement	Consistently Fail
North Locality Care Group	76.3%	85.0%	Improvement	Consistently Fail
South Locality Care Group	84.9%	85.0%	Improvement	Consistently Fail

Feedback

What the chart tells us

The appraisal rate was 79.7% in July which was the 12th consecutive monthly increase.

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 CBU meetings and Workforce Triage; discuss capacity and appropriate support, delegation.

Expected impact and by when

Improved appraisal rate – ongoing.

P05 - % Clinical Supervision completed

Risk Rating - **High (Action)**

Clinical Supervision

Performance - 54.2%

Standard - 80.0%

Consistently Fail

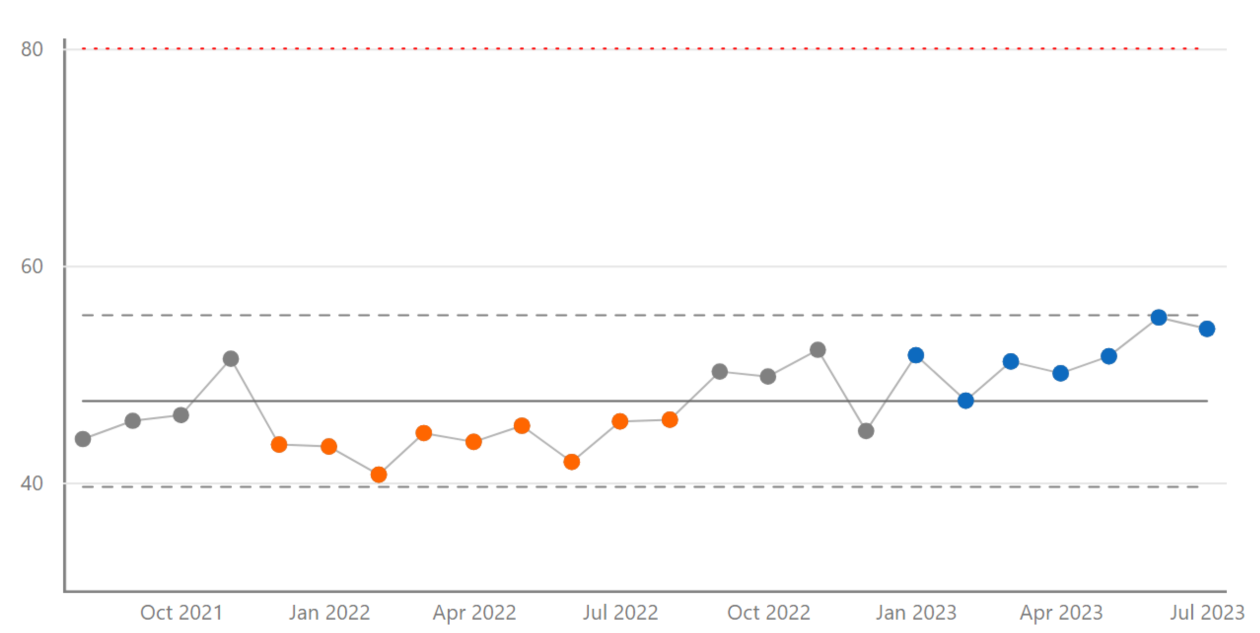
The standard for this indicator is outside the control limits

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	56.5%	80.0%	Improvement	Consistently Fail
North Cumbria Locality Care Group	47.3%	80.0%	Normal Variation	Consistently Fail
North Locality Care Group	50.4%	80.0%	Improvement	Consistently Fail
South Locality Care Group	61.8%	80.0%	Normal Variation	Consistently Fail

Feedback

What the chart tells us

Performance of 54.2% in July was consistent with the expected range of 39% to 56%, and was the seventh consecutive month above the mean average of 47.5%

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 Clinical Management Groups and Quality Standards and Operational meetings with CBU's.
- Setting expectations with CBU leadership team and re-embed.
- Establishing recording and data issues.

Expected impact and by when

Improved completion rate – ongoing.

Q02 - Serious Incidents

Risk Rating - **High (Action)**

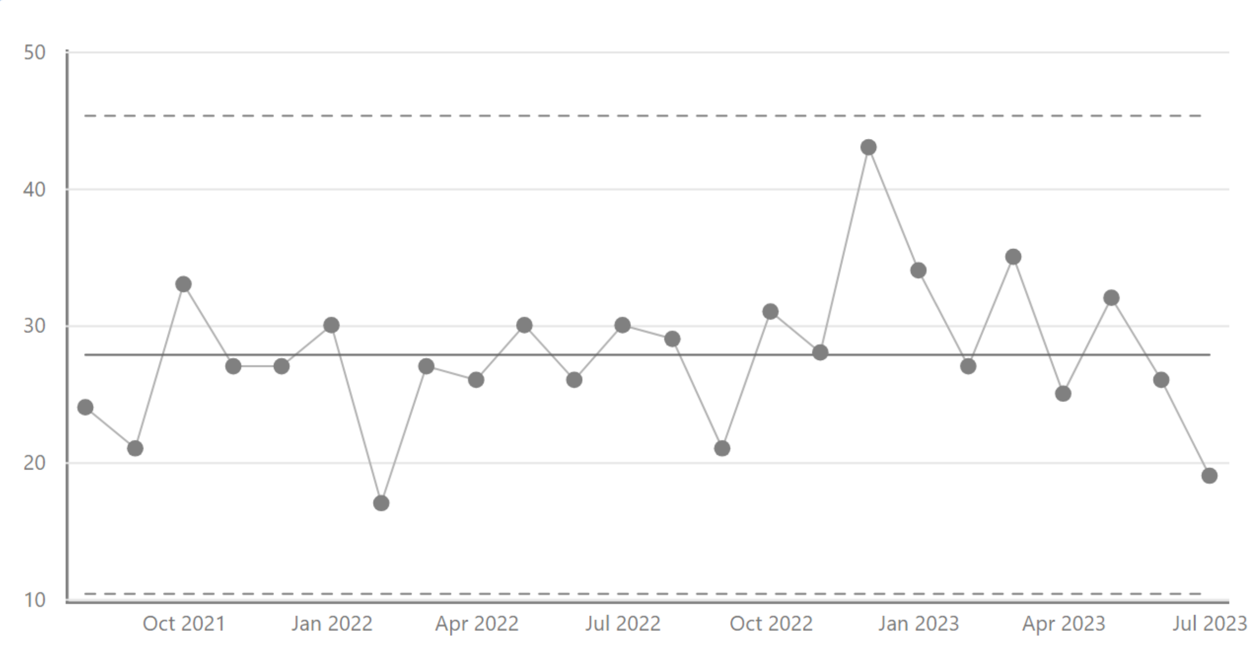
Number of Serious Incidents

Performance - 19
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	3	No Std	Normal Variation	No Standard
North Cumbria Locality Care Group	2	No Std	Normal Variation	No Standard
North Locality Care Group	9	No Std	Normal Variation	No Standard
South Locality Care Group	5	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

19 serious incidents recorded within July was consistent with the wide expected range of 10 and 46 such incidents per month.

Root Cause of the performance issue

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

The Trust and ICB 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.

Q03 - Harm Incidents

Harm Incidents

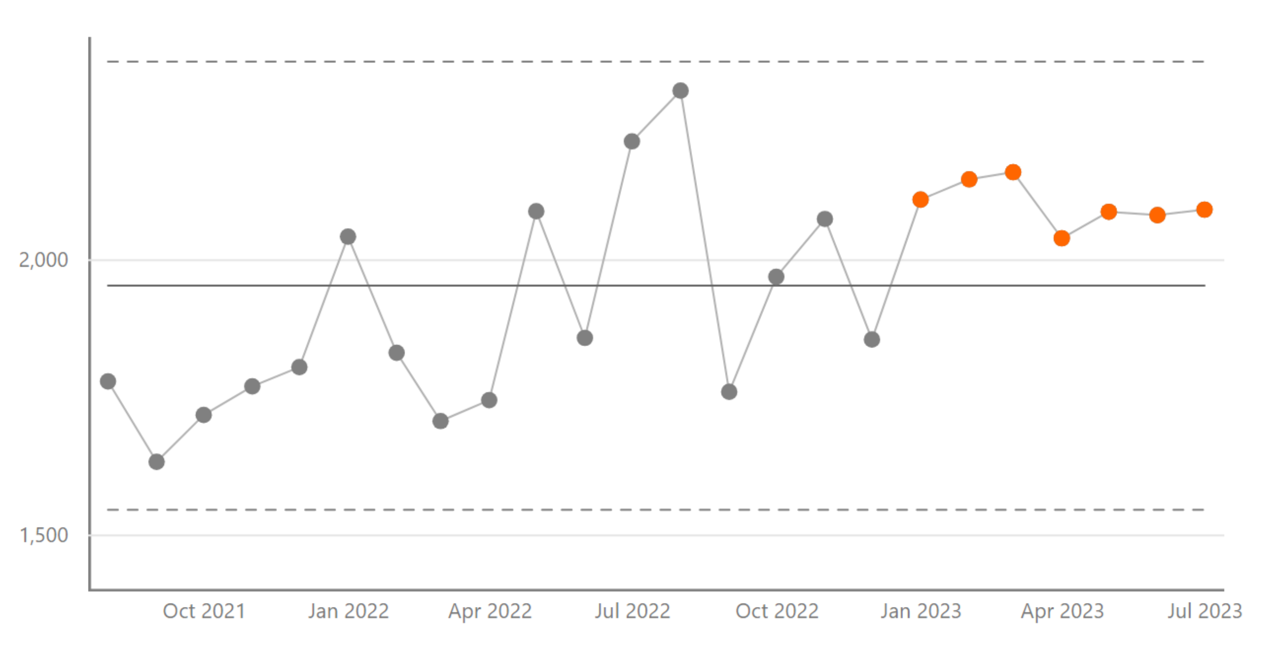
Risk Rating - **Med (Monitoring)**

Performance - 2,090
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	517	No Std	Concern	No Standard
North Cumbria Locality Care Group	450	No Std	Normal Variation	No Standard
North Locality Care Group	578	No Std	Normal Variation	No Standard
South Locality Care Group	525	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

Gradual increase over last 2 years, 2,090 harm incidents recorded in July was consistent and within the expected range.

Root Cause of the performance issue

The Trust has a positive reporting culture with sustained increases in reported incidents each year. The increase in harm incidents is in line with increases in total incident reporting. Approximately 65% of all reported incidents are no harm incidents where learning, reflection and review occurs when no harm has occurred.

Improvement Actions

PSIRF development work will review how the Trust manages, reviews and learns from reported incidents. This will include staff training which will aim to improve the quality of reported incidents.

Expected impact and by when

The PSIRF work may not affect the number of incidents reported but will improve the quality of reports and improvement actions

Safeguarding and Public Protection (SAPP)

Ref - Q04 Risk Rating - **Med (Monitoring)**

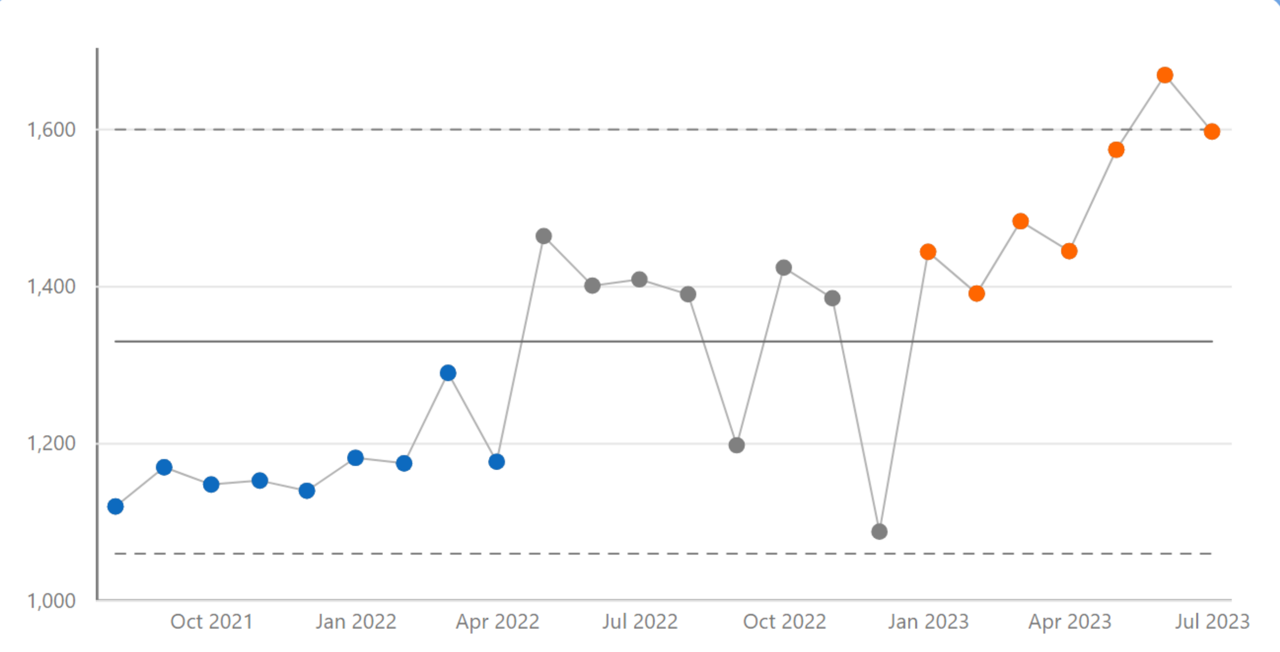
Safeguarding and Public Protection (SAPP)

Performance - 1,596
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	526	No Std	Concern	No Standard
North Cumbria Locality Care Group	221	No Std	Concern	No Standard
North Locality Care Group	478	No Std	Concern	No Standard
South Locality Care Group	360	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

Reported safeguarding activity in July fell just within the recalculated Upper Control Limit. It is the seventh consecutive month where activity was above the mean average and is therefore highlighted as potential Special Cause variation.

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 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. Trial of additional outcome measure from triage commenced this month and will run till end Q2.

Q06 - Aggression and Violence

Aggression and Violence

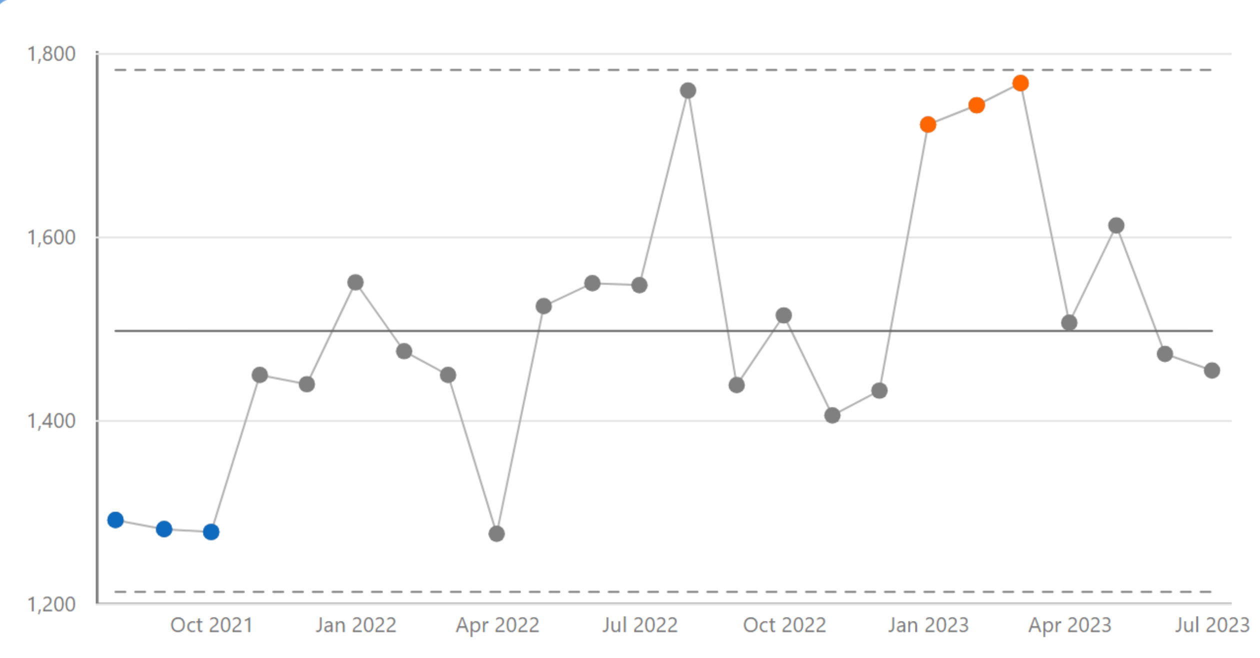
Risk Rating - **Med (Monitoring)**

Performance - 1,454
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	210	No Std	Improvement	No Standard
North Cumbria Locality Care Group	451	No Std	Concern	No Standard
North Locality Care Group	495	No Std	Normal Variation	No Standard
South Locality Care Group	287	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

There were 1,454 recorded incidents of aggression and violence during July which falls within the calculated expected range of 1,212 and 1,782 incidents.

Root Cause of the performance issue

July's incident total continues the downward trend for aggression and violence incidents within the Trust, reported from June's activity. It can still be seen from assessing the data that the high reporting areas of the Trust are autism in-patient services and children's in-patient services. We have also seen a downward trend for all incidents in the month of July for the first time since April 2022. This is also a decrease of 92 incidents on the same period last year.

Monitoring of the most common incident of aggression and violence which is physical assault of staff by patient continues to be monitored and this need to be considered in line with reducing restrictive interventions.

Improvement Actions

Work continues on the development of a standard framework of assessment for all non serious incidents in line with the PSIRF transition plan. Specific to aggression and violence incidents a new development is also underway to further evaluate incident and intervention data down to patient level in line with an updated talk 1st dashboard, this has received positive feedback from clinicians , HOPES and positive and safe team.

Expected impact and by when

Continually under review and plan to publish in September 2023.

Q08 - Care Plans compliance

Risk Rating - **Med (Monitoring)**

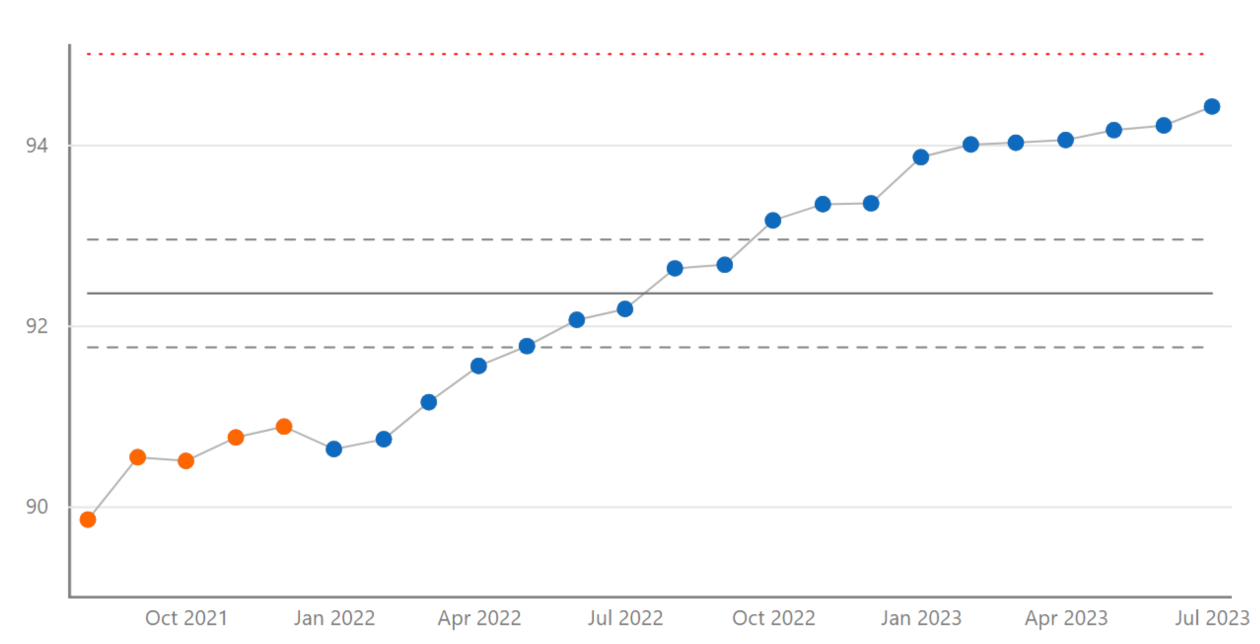
Care Plans compliance

Performance - 94.4%
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	95.9%	95.0%	Improvement	Consistently Fail
North Cumbria Locality Care Group	87.0%	95.0%	Improvement	Consistently Fail
North Locality Care Group	96.9%	95.0%	Improvement	Consistently Achieve
South Locality Care Group	93.7%	95.0%	Improvement	Consistently Fail

Feedback

What the chart tells us

Performance of 94.4% in July fell just below the standard of 95%.

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.

Q09 - Risk Assessments compliance

Risk Assessments compliance

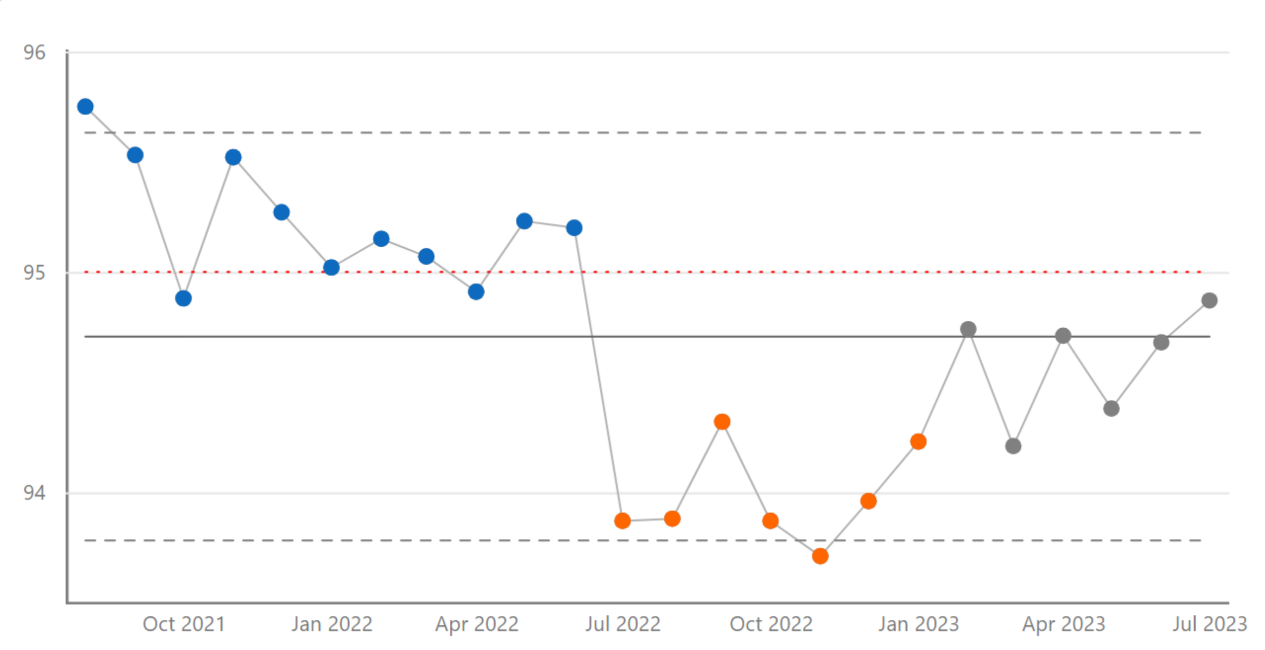
Risk Rating - **Med (Monitoring)**

Performance - 94.9%
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	97.4%	95.0%	Improvement	Achieve at Random
North Cumbria Locality Care Group	86.6%	95.0%	Concern	Consistently Fail
North Locality Care Group	97.7%	95.0%	Normal Variation	Consistently Achieve
South Locality Care Group	96.9%	95.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Performance of 94.9% in July fell just below the standard of 95%.

Root Cause of the performance issue

Some risk assessments have not been reviewed for over 12 months for patients on CPA due to demand and capacity issues within community treatment teams.

Improvement Actions

This metric is now reported just below standard with an increase in reported performance over the last 3 months following actions implemented within the localities.

Expected impact and by when?

The metric is expected to continue to improve and reach the target during Q2.

Q10 - 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 - 78.8%

Standard - 95.0%

Consistently Fail

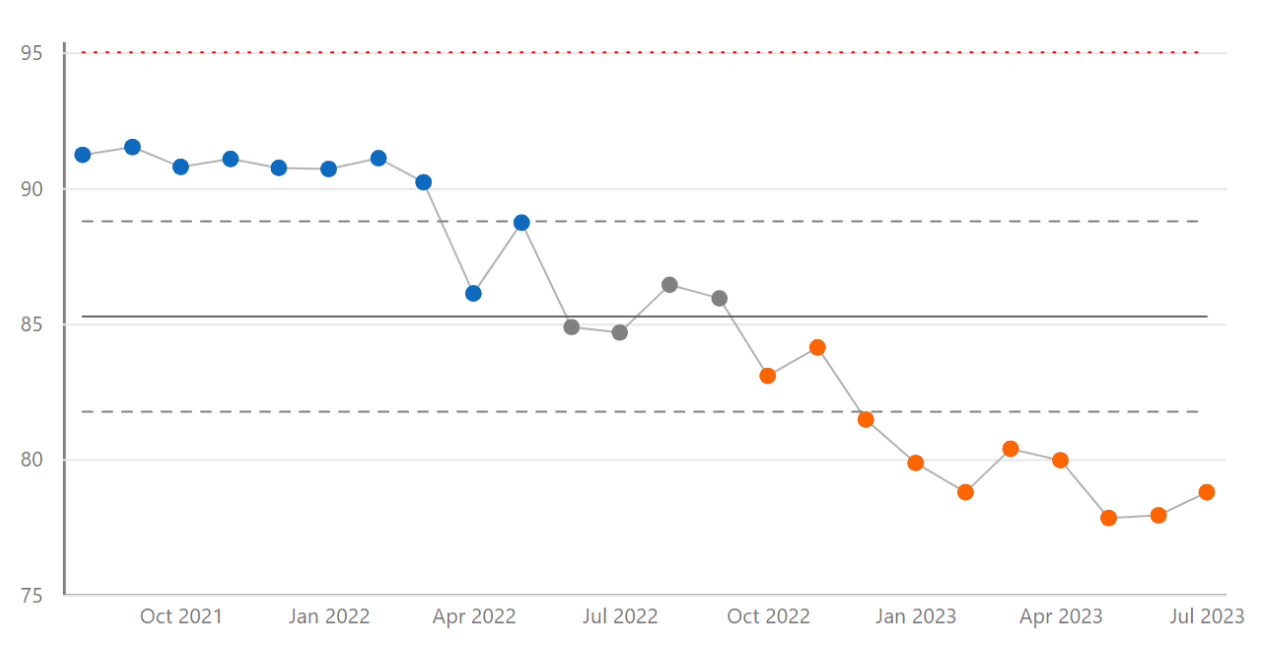
The standard for this indicator is outside the control limits

Concern

There is concern because this indicator is decreasing

DQ - Investigation

There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	88.1%	95.0%	Concern	Achieve at Random
North Cumbria Locality Care Group	48.0%	95.0%	Concern	Consistently Fail
North Locality Care Group	91.5%	95.0%	Normal Variation	Achieve at Random
South Locality Care Group	84.1%	95.0%	Concern	Achieve at Random

Feedback

What the chart tells us

CPA completed reviews have fallen steadily over the last 2 year period and remain 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.

Q11 - Staffing fill rates

Risk Rating - **High (Action)**

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

Performance - 124.2%

Standard - 120.0%

Consistently Fail

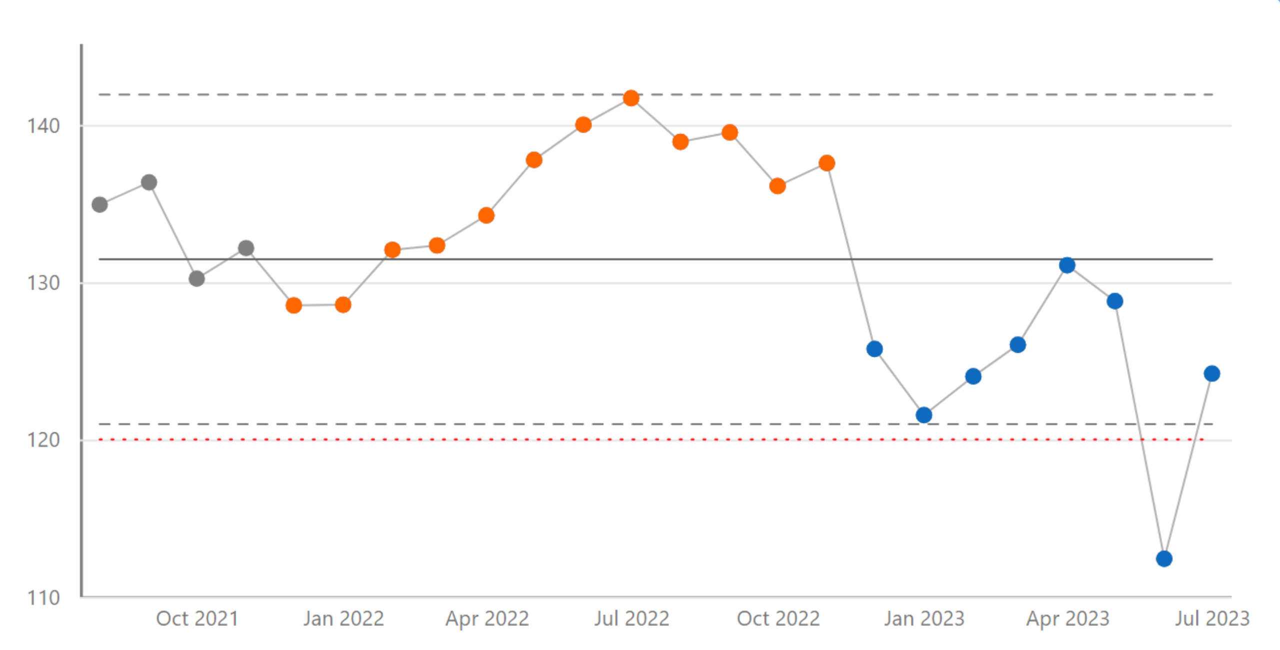
The standard for this indicator is outside the control limits

Improvement

This indicator is decreasing 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	126.9%	120.0%	Improvement	Consistently Fail
North Cumbria Locality Care Group	124.2%	120.0%	Improvement	Achieve at Random
North Locality Care Group	106.4%	120.0%	Improvement	Achieve at Random
South Locality Care Group	135.6%	120.0%	Normal Variation	Consistently Fail

Feedback

What the chart tells us

Staffing fill rate was 124.2% in July 2023, returning within the expected range of 121% to 142%.

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.

A01 - Out of Area Placement bed days

Out of Area Placement bed days

Risk Rating - **High (Action)**

Performance - 212
Standard - 186

Achieve at Random

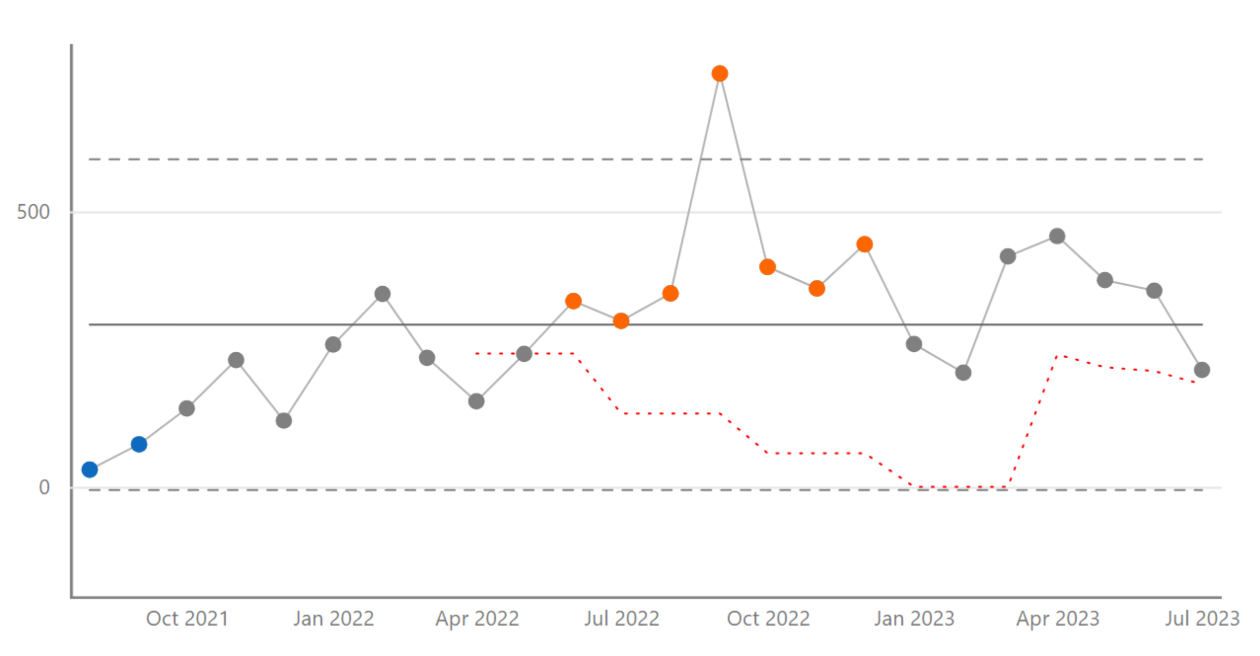
The standard for this indicator is within the upper and lower control limits

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 212 Out of Area Placement bed days in July 2023, the number of Out of Area bed days reported has reduced for the 5th consecutive month and moving towards meeting the agreed trajectory.

Root Cause of the performance issue

Patient needing an inpatient admission when there are no appropriate CNTW beds available. The main pressure continues to be within Adult Acute beds.

Improvement Actions

Working with Local Authorities to ensure there are effective discharge process in place to ensure that there are minimal barriers to discharge ensure an efficient flow through wards.

Continuous learning and development, sharing practices between wards to improve the therapeutic milieu impacting the length of stay.

Community transformation and improving services to prevent emergency admissions.

Expected impact and by when

Reduction in the number of Out of Area beds usage.

A02 - Bed Occupancy including leave (open beds on RiO)

Risk Rating - **High (Action)**

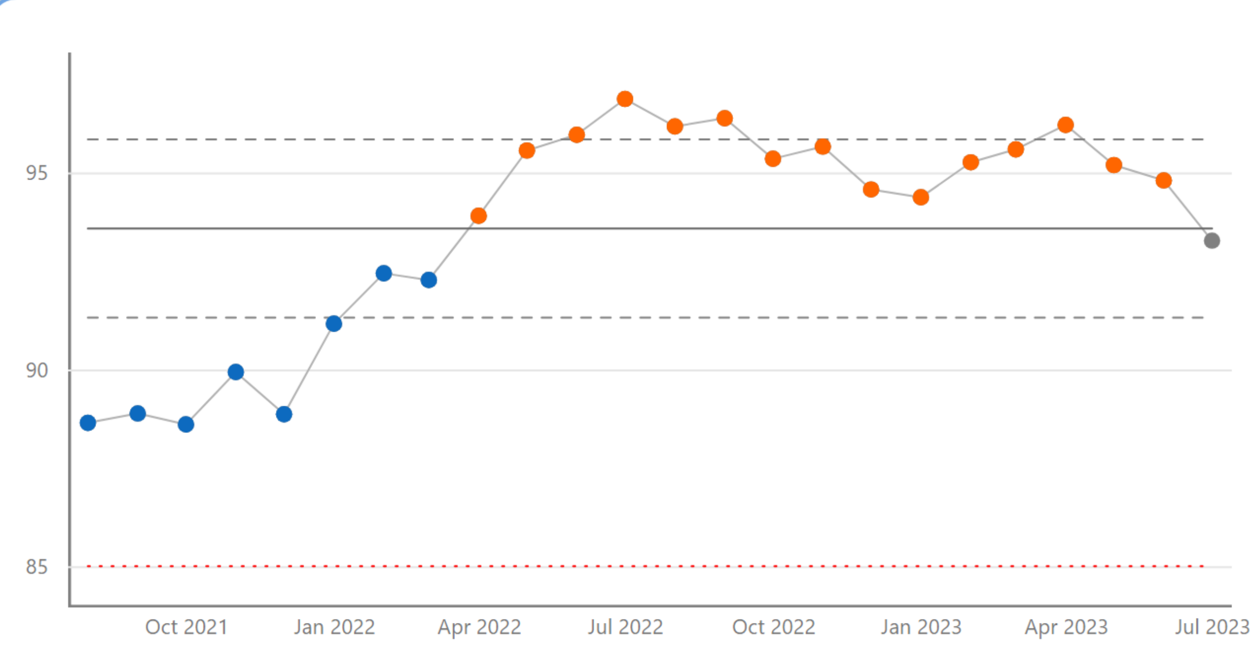
Bed Occupancy including leave (open beds on RiO)

Performance - 93.3%
Standard - 85.0%

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	93.8%	85.0%	Normal Variation	Consistently Fail
North Cumbria Locality Care Group	85.1%	85.0%	Normal Variation	Achieve at Random
North Locality Care Group	95.4%	85.0%	Normal Variation	Consistently Fail
South Locality Care Group	94.7%	85.0%	Normal Variation	Consistently Fail

Feedback

What the chart tells us

Bed occupancy reduced to 93.3% which is within the expected range of 91.3% to 95.9%, though still above the optimal level of 85%. It was the first month since March 2022 where it fell below the mean average of 93.6%.

Root Cause of the performance issue

More bed days are used than originally planned.

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.

A transformation programme is underway across community services, an outcome of this work will be to better deliver services to patients which will impact on the demand for beds.

Expected impact and by when

Reduction in the number of bed days required by 31/03/2024.

A05 - Clinically Ready for Discharge (formerly DTOC)

Risk Rating - **High (Action)**

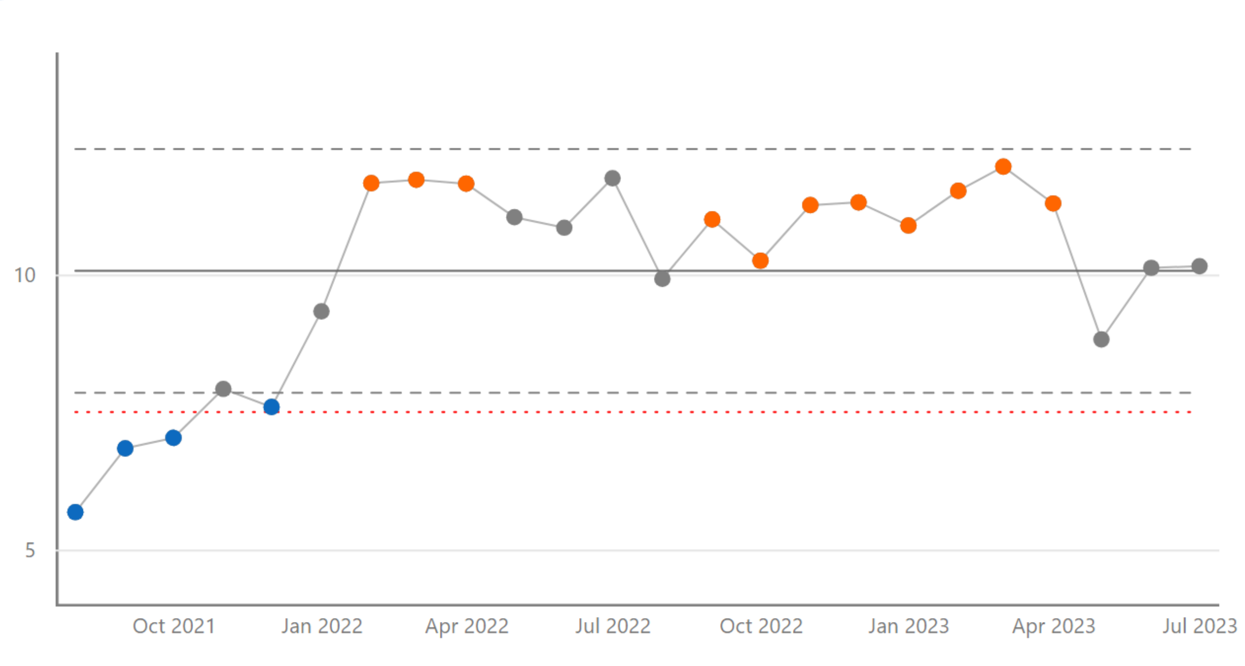
Percentage of patients clinically Ready for Discharge (formerly DTOCs) at the end of the month (Q&P Metric 298: Current Delayed Transfers of Care days (Incl Social Care)

Performance - 10.2%
Standard - 7.5%

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

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

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



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	6.6%	7.5%	Concern	Consistently Achieve
North Cumbria Locality Care Group	17.4%	7.5%	Normal Variation	Consistently Fail
North Locality Care Group	13.9%	7.5%	Normal Variation	Achieve at Random
South Locality Care Group	8.7%	7.5%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

In the month, 10.2% of patients were reported as clinically ready for discharge. This measure will consistently fail without change.

Root Cause of the performance issue

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

Improvement Actions

- A discharge plan for each patient is 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.
- Exploration of use of CNTW estate to provide non-hospital based rehab/step-down in partnership with VSCE.
- 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+.

A06 - Crisis % Very urgent seen within 4 hours (WAA&OP)

Risk Rating - **Med (Monitoring)**

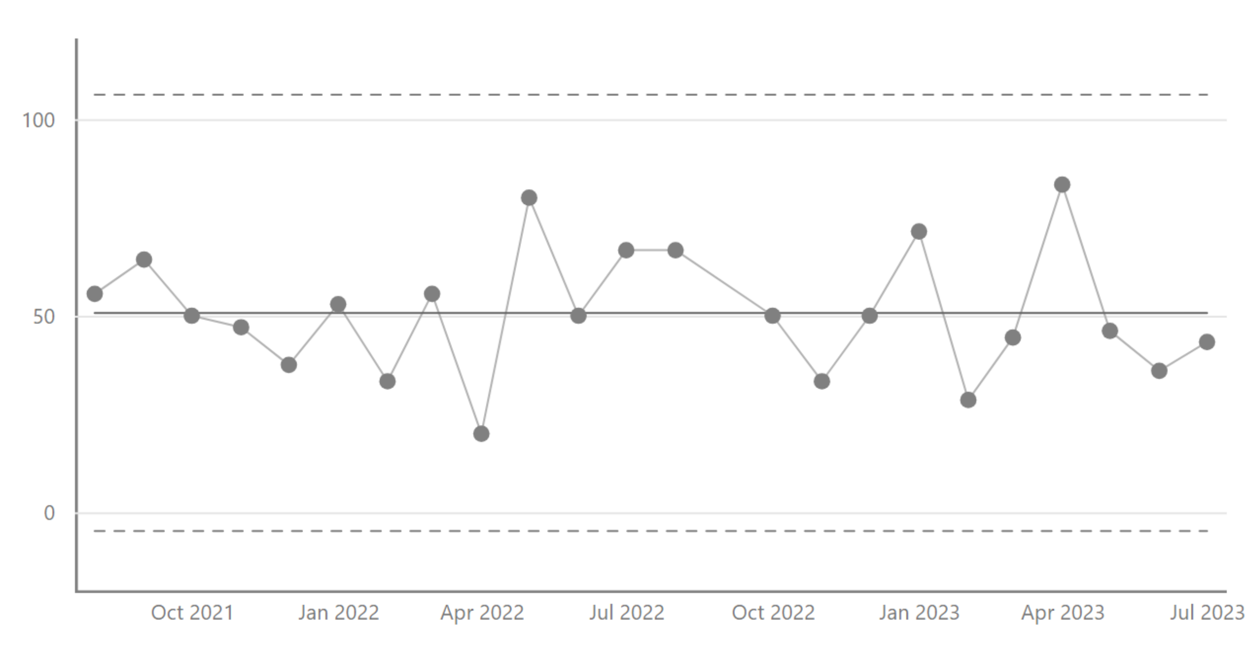
% of referrals (Adults and OA) with a priority of Very Urgent who have an attended Direct Contact within 4 hours following receipt of the referral

Performance - 43.3%
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	57.1%	No Std		No Standard
North Cumbria Locality Care Group	36.8%	No Std		No Standard
North Locality Care Group	50.0%	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 increased to 43.3% in July 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

- Temporary 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.

A07 - Crisis % Urgent seen within 24 hours (WAA&OP)

Risk Rating - **Med (Monitoring)**

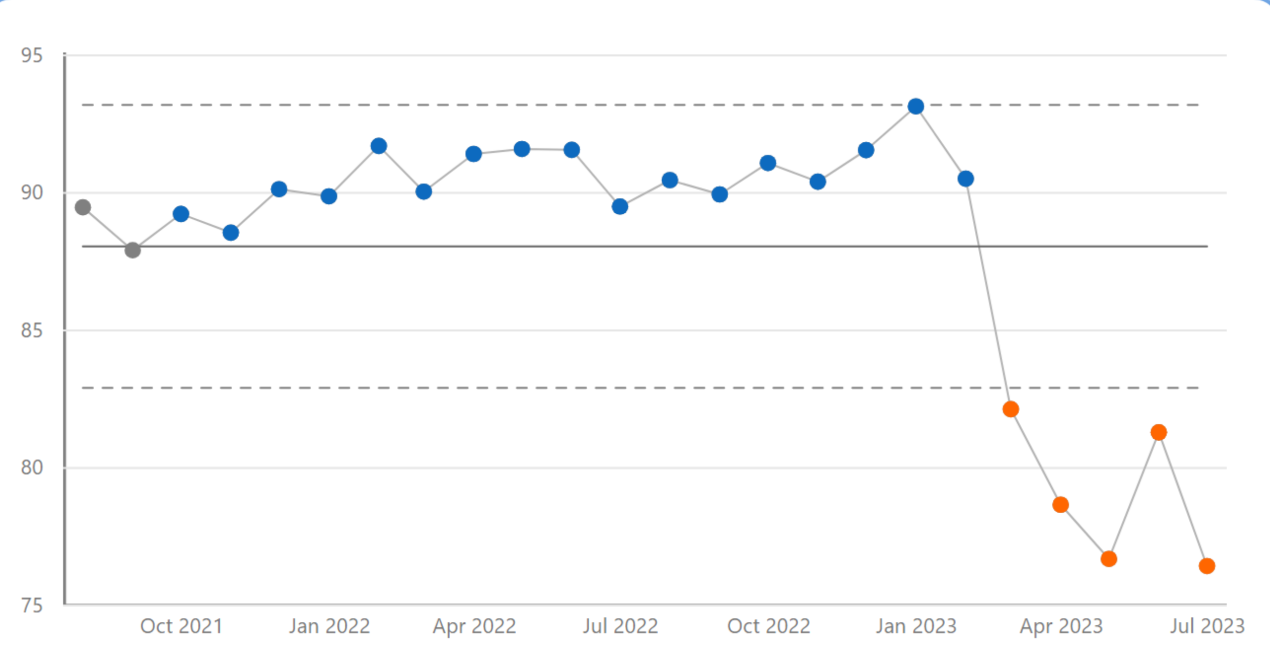
% of Urgent referrals to crisis service seen within 24 hours (Adults and OA)

Performance - 76.4%
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	84.3%	No Std	Normal Variation	No Standard
North Cumbria Locality Care Group	80.0%	No Std	Concern	No Standard
North Locality Care Group	56.0%	No Std	Concern	No Standard
South Locality Care Group	85.9%	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

Urgent referrals seen within 24 hours decreased to 76.4% in July. This is below the expected range of 83% to 93% for the fifth successive month suggesting a significant change since February 2023 based on expected 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

- Temporary 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.

A08 - % PLT ED Referrals seen within 1 hour

Risk Rating - Med (Monitoring)

% Psychiatric Liaison Team Emergency Dept Referrals seen within 1 hour

Performance - 54.7%

Standard - No Std

No Standard

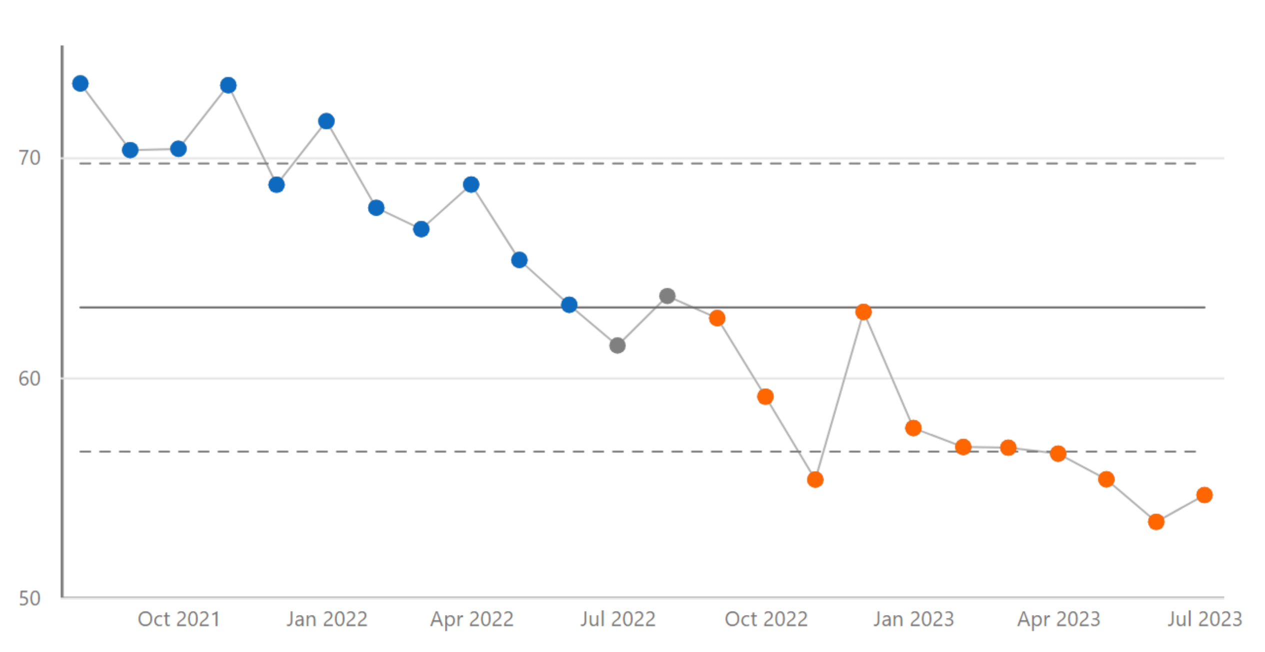
Assurance cannot be given for this indicator as there is no standard set

Concern

There is concern because this indicator is decreasing

DQ - No Concern

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



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	40.9%	No Std	Concern	No Standard
North Cumbria Locality Care Group	73.1%	No Std	Normal Variation	No Standard
North Locality Care Group	35.2%	No Std	Concern	No Standard
South Locality Care Group	77.9%	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

Performance was 54.7% in July which was below the expected range of 56% to 70%. It was also the 11th consecutive month where performance fell below the 24-month mean average of 63% suggesting a significant change.

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.
- Staffing (recruitment/retention/sickness) remains a challenge.
- Geography of general and community hospitals cause an issue within North locality due to distance staff may need to travel.
- Significant increase in number of referrals in areas.

Improvement Actions

- Temporary 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.

A11 - 18 weeks wait to Treatment Adults & Older Adults

Risk Rating - **Med (Monitoring)**

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

Performance - 69.9%

Standard - No Std

No Standard

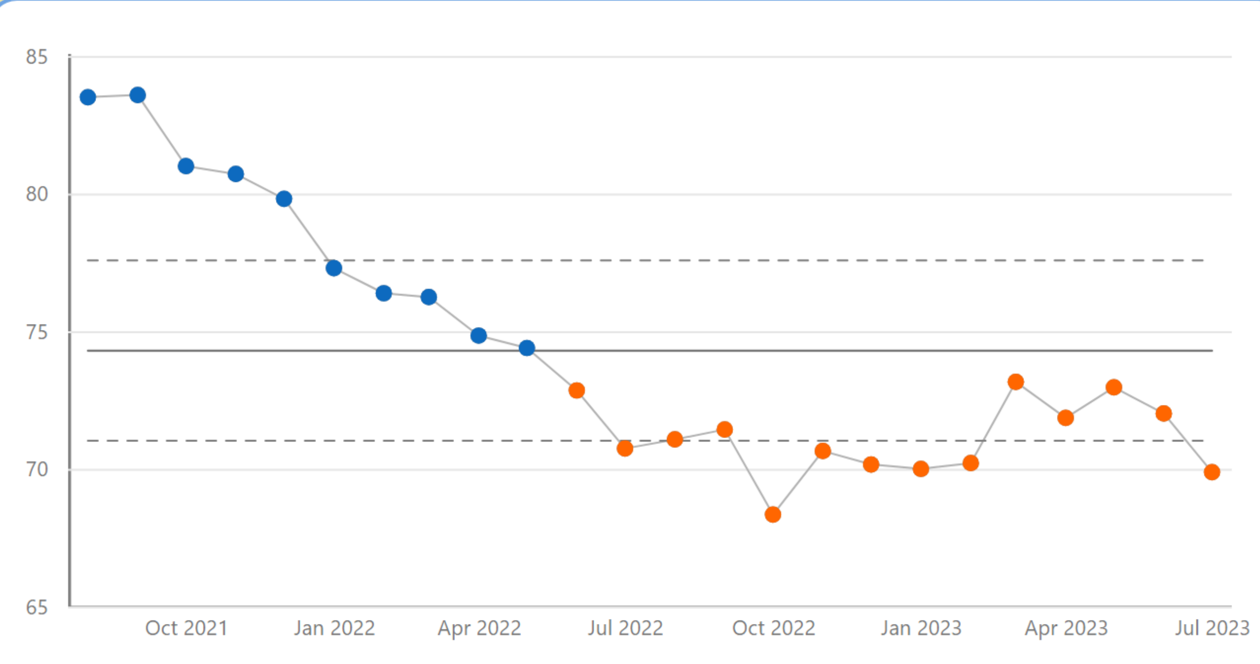
Assurance cannot be given for this indicator as there is no standard set

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	80.8%	No Std	Improvement	No Standard
North Cumbria Locality Care Group	50.7%	No Std	Concern	No Standard
North Locality Care Group	82.1%	No Std	Concern	No Standard
South Locality Care Group	79.0%	No Std	Improvement	No Standard

Feedback

What the chart tells us

Performance was at 69.9% in July 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.

Improvement Actions

- Waiting list initiatives with Everyturn in Gateshead, Sunderland and North Cumbria.
- Ongoing data quality work e.g. unoutcomed appointments which could then move waiters through the system.
- 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.

A12 - 18 weeks waits to Treatment - All CYPS

Risk Rating - **Med (Monitoring)**

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

Performance - 43.9%

Standard - No Std

No Standard

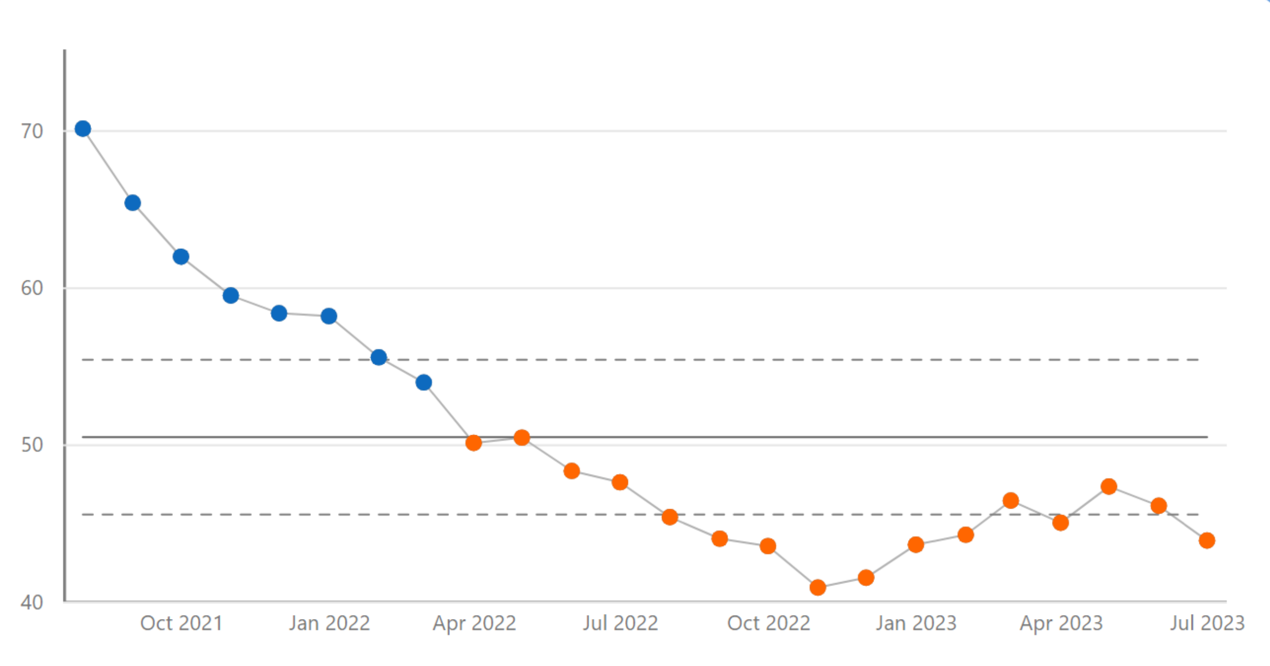
Assurance cannot be given for this indicator as there is no standard set

Concern

There is concern because this indicator is decreasing

DQ - Investigation

There have been data quality concerns rasied with indicator



Locality	Performance	Standard	Variation	Assurance
Central Locality Care Group	35.8%	No Std	Normal Variation	No Standard
North Cumbria Locality Care Group	46.4%	No Std	Concern	No Standard
North Locality Care Group	81.8%	No Std	Concern	No Standard
South Locality Care Group	42.4%	No Std	Concern	No Standard

Feedback

What the chart tells us

Performance decreased slightly to 43.9% in July.

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, Did Not Attend/Were Not Brought 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.

A13 - <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 - 39.2%

Standard - No Std

No Standard

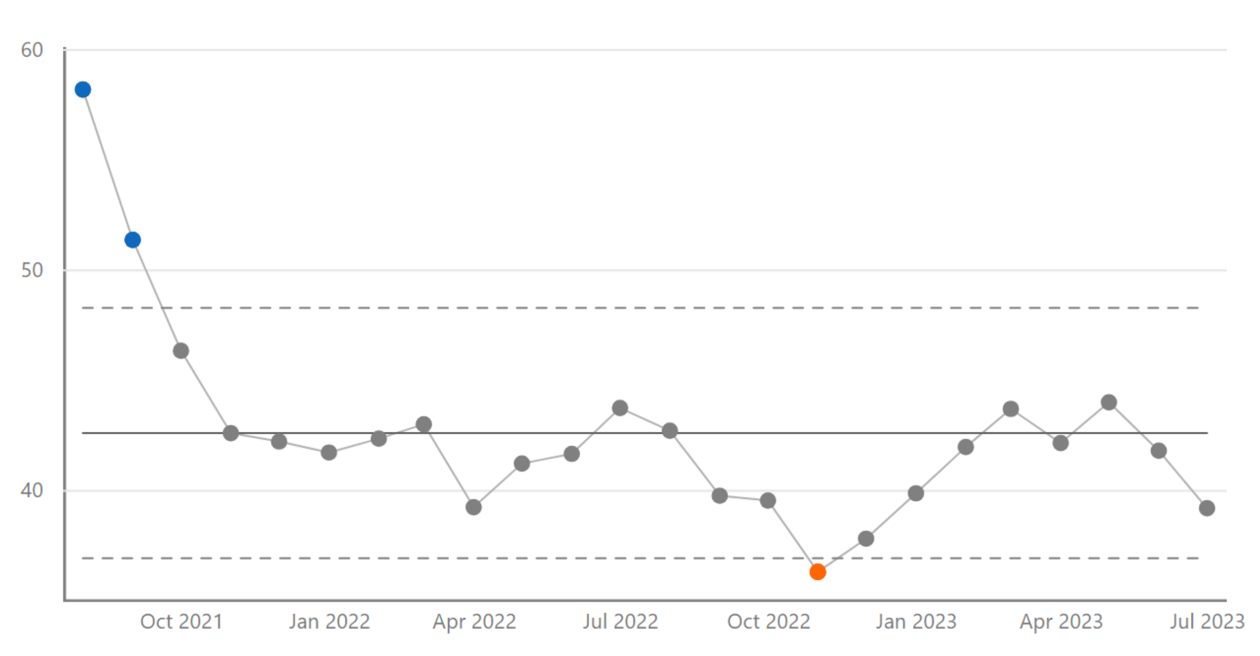
Assurance cannot be given for this indicator as there is no standard set

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	30.8%	No Std	Normal Variation	No Standard
North Cumbria Locality Care Group	41.3%	No Std	Concern	No Standard
North Locality Care Group	80.4%	No Std	Concern	No Standard
South Locality Care Group	32.9%	No Std	Concern	No Standard

Feedback

What the chart tells us

Performance was 39.2% in July and has remained 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.
- The commencement of Welcome Events as agreed by ICB will be underway. Families will be invited to attend these events so the assessment process and expectations can be relayed helping to alleviate any anxieties they may have whilst providing contact details for the families. The agenda and presentation have been 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.

A15 - CYPS Eating Disorders (routine referrals)

Risk Rating - **Med (Monitoring)**

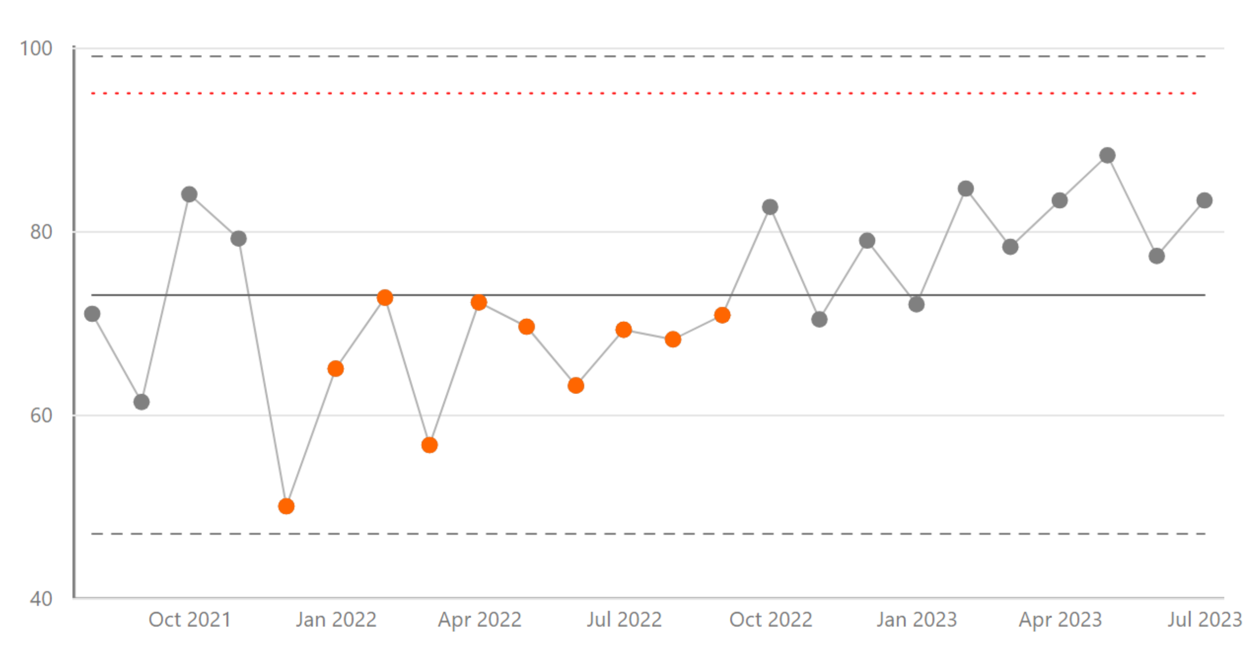
Percentage of eating disorder CYPS referrals that waited <= 4 weeks routine completed (Q&P Metric 1865)

Performance - 83.3%
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	82.4%	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

83.3% of routine referrals waited <4 weeks in July which is within the expected range of 47% and 99%. This range suggests that the standard of 95% will rarely be achieved.

Root Cause of the performance issue

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

Improvement Actions

- The Trust have been engaging in the ICB improvement programme for CYPS ED services, linked to the 22/23 SDIP and are in receipt of the report which makes recommendations to the ICB regarding the future of CYPS ED services and will be providing a response to this document.

Expected impact and by when

- The report will be considered by the ICB Board in August following which new service specifications and other changes will require agreement.
- Reduction in the number of people waiting over 4 weeks for help by Q4.

A17 - Talking Therapies % Moving to Recovery (IAPT)

Risk Rating - **Med (Monitoring)**

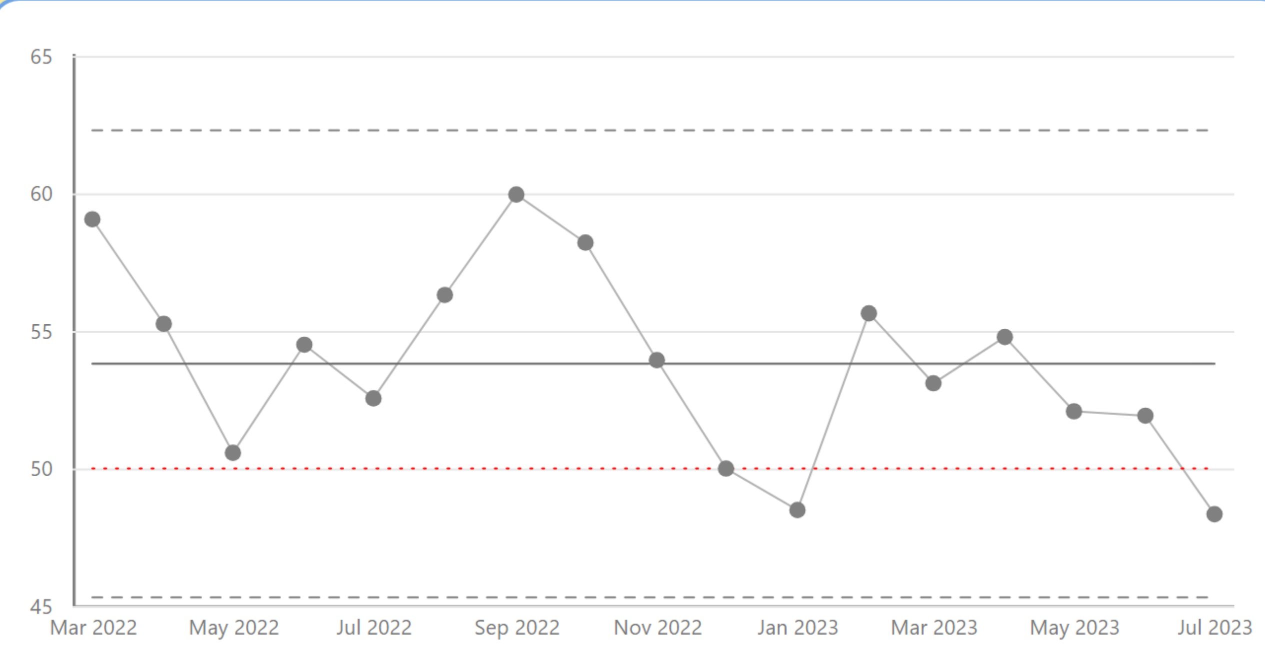
Talking Therapies % Moving to Recovery (formerly IAPT)

Performance - 48.3%
Standard - 50.0%

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
North Cumbria Locality Care Group	41.4%	50.0%	Normal Variation	Achieve at Random
South Locality Care Group	58.5%	50.0%	Normal Variation	Achieve at Random

Talking Therapies service commissioned in Sunderland and North Cumbria only

Feedback

What the chart tells us

Performance has decreased to 48.3% and is reported below the 50% standard. Reported below standard for North Cumbria locality only.

Root Cause of the performance issue

In North Cumbria the recovery rate has variability due four main factors, patient engagement with therapies, sickness, access to therapy, vacancies. On average, the service has above 50% recovery, however at over the past 17 months, the service has been under the standard 3 times.

Improvement Actions

North Cumbria has very robust reporting and monitoring around TT performance they have developed these services over many years, the fluctuations in the recovery rate are addressed each monthly to identified if there are any common cause factors that may result in the trend continuing. There are a number of actions underway in relation to improving access to therapies delivered by HI practitioners.

Expected impact and by when

It is expected the recovery rate will be above 50% the following month.

S01 - Live within our means (I&E Surplus/Deficit £)

Risk Rating - **High (Action)**

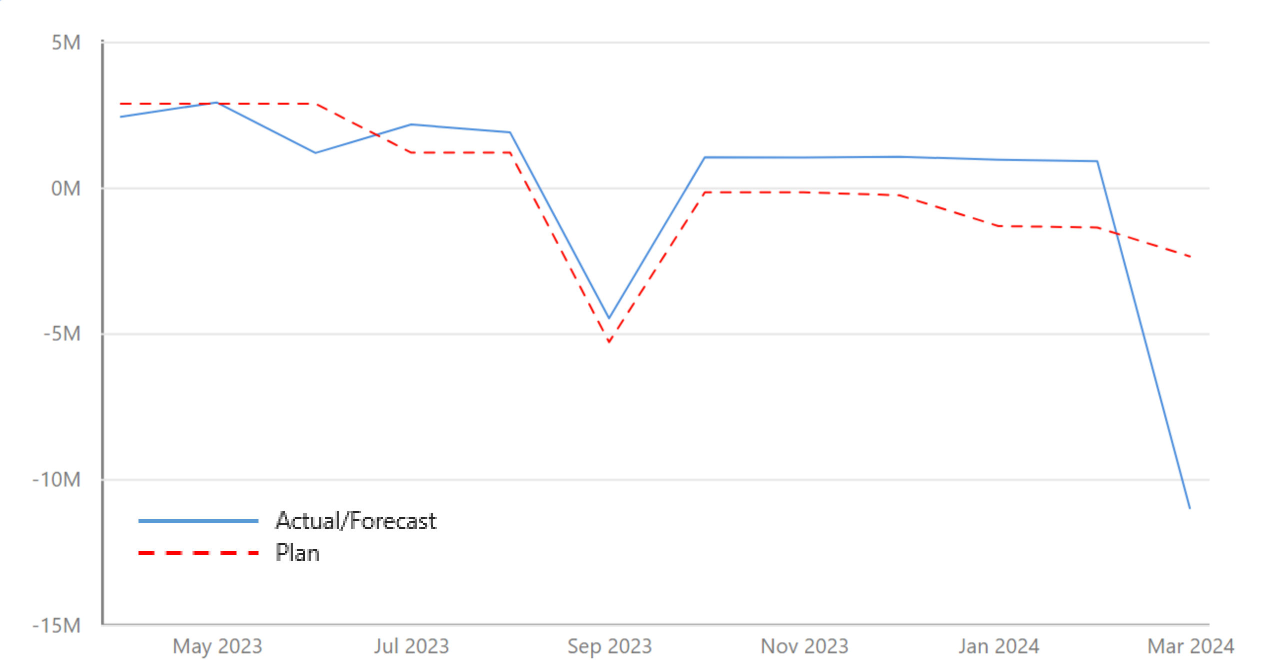
Live within our means (I&E Surplus/Deficit £)

Actual/Forecast - 2.2M
Plan - 1.19M

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	344
North	80
North Cumbria	-141
South	-38
Corporate	718

Feedback

- Budget overspends across clinical groups (Central & South highlighted) driven from ward over establishments.
- 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.

9. CQC MUST DO REPORT

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

REFERENCES

Only PDFs are attached

9. CQC Must Do Action Plans Final.pdf

Name of meeting	Board of Directors
Date of Meeting	Wednesday 6 September 2023
Title of report	CQC Must Do Action Plan Update
Executive Lead	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance
Report author	Vicky Wilkie, CQC Compliance and Governance Manager

Purpose of the report	
To note	
For assurance	X
For discussion	
For decision	X

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		Executive Team	
Audit		Executive Management Group	X
Mental Health Legislation		Business Delivery Group	
Remuneration Committee		Trust Safety Group	
Resource and Business Assurance		Locality Operational Management Group	
Charitable Funds Committee		CQC Inspection Steering Group	X
People		CQC Quality Compliance Group	X
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	X	Reputational	X
Workforce	X	Environmental	X
Financial/value for money	X	Estates and facilities	X
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 Working Together With Service Users And Carers We Will Provide Excellent Care. Supporting People on Their Personal Journey To Wellbeing. Risk 1683 There is a risk that high quality, evidence based safe services will not be provided if there are difficulties accessing inpatient services in a timely manner due to bed pressures

resulting in the inability to sufficiently respond to demands (SA1.4).
SA5 The Trust Will Be The Centre Of Excellence For Mental Health And Disability.
Risk 1688 Due to the compliance standards set from NHSI, CQC and for Legislation there is a risk that we do not meet and maintain standards which could compromise the Trust's statutory duties and regulatory requirements (SA5).
SA4 The Trust’s Mental Health And Disability Services Will Be Sustainable And Deliver Real Value To The People Who Us Them.
Risk 1836 A failure to develop flexible robust Community Mental Health Services may well lead to quality and service failures which could impact on the people we serve and cause reputational harm (SA4).

Update on CQC Must Do Action Plans

Board of Directors

Wednesday 6th September 2023

1. Executive Summary

This report provides an update on the 20 remaining areas of improvement (Must Do action plans) which were received following inspections undertaken between 2018 and 2022, including the most recent inspection to the adult acute admission wards on the Campus for Ageing and Vitality hospital site in Newcastle.

- This report seeks approval from the Board that there is sufficient evidence and assurance to close 4 action plans linked to body maps, training, staffing and risk management plans (see Appendix 1).

- Appendix 2 provides an update on the work that continues to address each of the remaining action plans. The revised timeframes will be kept under review and every effort made to shorten these where possible.

- Monthly updates on areas for improvement from previous inspection activity (including CPFT and NTW) are provided to the Executive Management Group and Board of Directors. Below is a breakdown of those that remain open and those that have been closed:

	Must Dos		
	Open	Closed	Total
NTW	1	2	3
CPFT	11	26	37
CNTW CYPS 2020	1	0	1
CNTW LD 2020	0	5	5
CNTW LD 2022	4	4	8
CAV 2022	3	0	3
Total:	**20**	**37**	**57**

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

2. Risks and mitigations associated with the report

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

3. Recommendation

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

Board members are asked to:

- Approve the closure of 4 action plan listed within appendix 1.
- Note the updates on all 57 CQC Must Do action plans within (including impact changes for those closed).

Author:
Vicky Wilkie, CQC Compliance and Governance Manager

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

31st August 2023

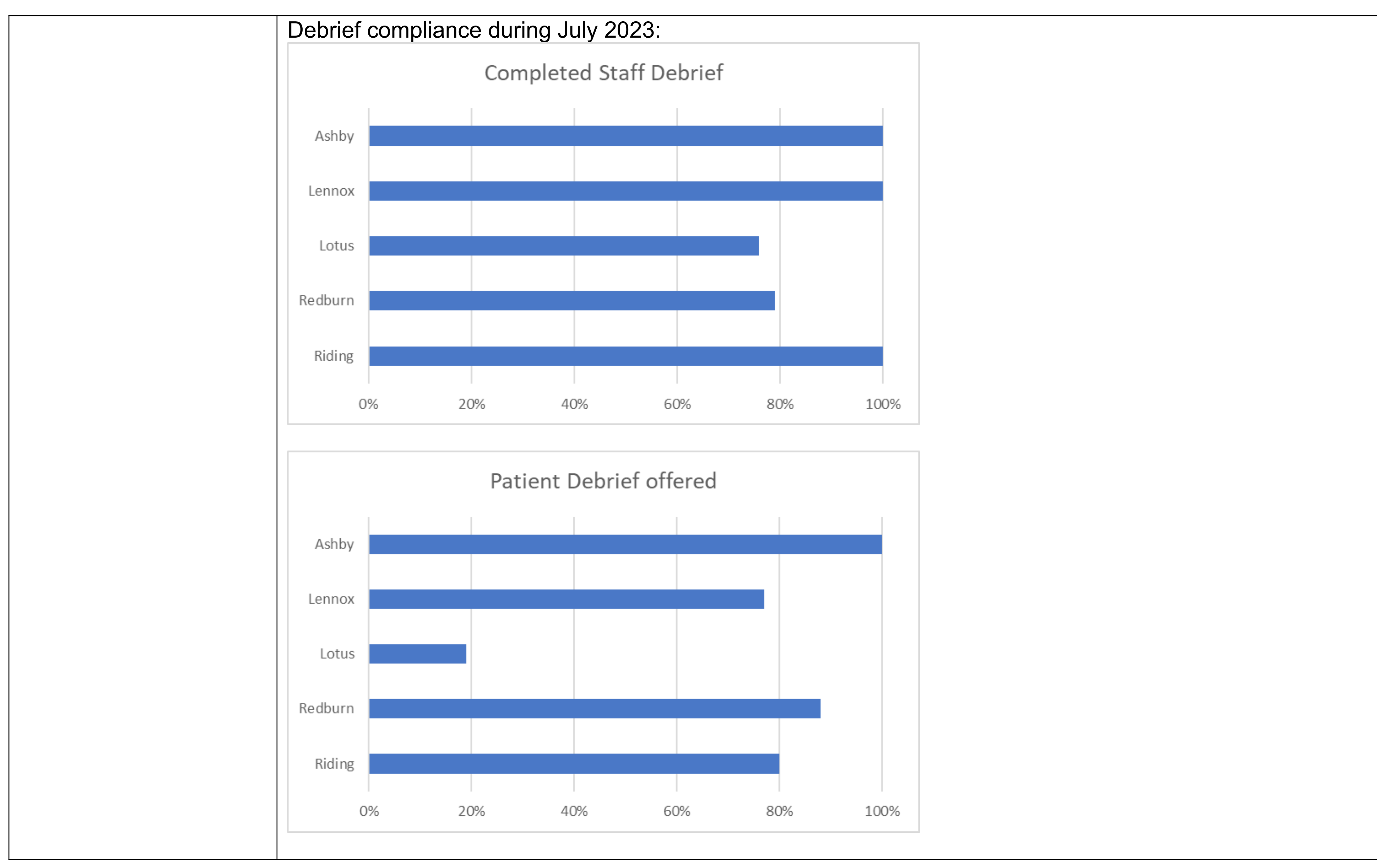
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	Core service, year and organisation	Must do	Evidence of Impact
Regulation 18 Staffing	LDA wards Year: 2022 Org: CNTW	Staff did not receive training in learning disabilities or autism. [This must do is linked to the must do relating to Cheviot staffing].	Complete and continue to monitor alongside other breach of regulation linked to Learning Disability and Autism training for adult acute admission wards. LD & Autism wards 100% 75% 50% 25% 0% 80% 78% 19% 19% 01-Sep-22 01-Oct-22 01-Nov-22 01-Dec-22 01-Jan-23 01-Feb-23 01-Mar-23 01-Apr-23 01-May-23 01-Jun-23 01-Jul-23 Learning Disability Tier 1 % Training Compliance Autism Core Capabilities: Tier 1 & 2 Training Compliance
Regulation 18 Staffing	Adult acute wards Year: 2019 Org: CPFT	The trust must deploy sufficient numbers of qualified, competent, skilled and experienced staff to meet the needs of patients care and treatment.	Complete. • No staffing issues identified through Mental Health Act Reviewer visits during that last 24 months. • 2 mental health nurses arrived in April 2023. • 2 AHPs (OTs) arrived week commencing 10th July 2023. • The following additional workforce to commence from September

			2023. ◦ Student allocations: 10 B5 Preceptee nurses allocated to North Cumbria, 5 to inpatient services, 5 to community ◦ International recruits: 10 nurses to Carlton Clinic, 3 nurses to Yewdale, 3 medics ◦ 23/24 planning: 5 mental health nurses arriving and will commence in September/October, 4 medics arriving who are allocated to North Cumbria ◦ More mental health nurse interviews are taking place in August for North Cumbria
Regulation 12 Safe Care and Treatment	LDA wards Year: 2019 Org: CPFT	The provider must ensure that all staff complete body maps and carry out and record physical observations following the use of restraint and ensure that there is a rationale recorded for any 'as required' medication being administered following the use of restraint [Linked to rapid tranquilisation task and finish group].	Complete. • No concerns identified during core service inspection of Learning Disability and Autism wards in 2022. • Recent changes have been made to the incident reporting form with a prompt added for reporters to remember to update the body map information in the patient's clinical records. Also, if PMVA is selected the type of restraint will be prompted. • Evidence from Groups that body mapping work/audit findings has been taken to the Quality Standards meetings and assurance obtained about the standard of this. • Task and Finish Group will continue to meet to review/monitor audit action plan.
Regulation 12 Safe Care and Treatment	CAV wards Year: 2022 Org: CNTW	The trust must ensure that all staff are aware of patients risks and risk management plans on all wards.	Complete. Daily Risk handover documentation has extended to include Lowry ward.

<table>
<tr><td colspan="2">Must Do Theme: (3) Restrictive practices, seclusion and long term segregation</td><td>Lead:
David Muir, Group Director</td></tr>
<tr><td colspan="2">Planned timescale for closure:
30 June 2023 (30 September 2023)</td><td>Status:
Further action required to make improvements</td></tr>
<tr><td>Must Do:</td><td>CAMHS wards
Year: 2020
Org: CNTW</td><td>The Trust must review the use of restraint and mechanical restraint in the Children and Young People’s Inpatient Services. The use of mechanical restraint should be used as a last resort in line with Department of Health Positive and Proactive Care. There should be a clear debrief process for the team after an incident and for the person who has been restrained.</td></tr>
<tr><td>What the report identified at the time, including what the level of performance was at the time of inspection.</td><td colspan="2">High use of MRE and low compliance with staff and patient incident debriefs.</td></tr>
<tr><td>What is performance today?</td><td colspan="2">MRE use since the inspection:

Intervention Incidents By Month
0 5 10 15
Average: 5
Jan 2021: 4; Feb 2021: 11; Mar 2021: 9; Apr 2021: 12; May 2021: 7; Jun 2021: 7; Jul 2021: 4; Aug 2021: 2; Sep 2021: 19; Oct 2021: 8; Nov 2021: 4; Dec 2021: 6; Jan 2022: 6; Feb 2022: 1; Mar 2022: 1; Apr 2022: 3; May 2022: 1; Jun 2022: 6; Jul 2022: 3; Aug 2022: 1; Dec 2022: 3; Jan 2023: 1; Feb 2023: 3; Mar 2023: 3; Apr 2023: 4; May 2023: 8; Jun 2023: 3; Jul 2023: 7; Aug 2023: 2</td></tr>
</table>

Debrief compliance during July 2023:



Actions to be taken forward during Quarter 2	- All wards are now using an end of day debrief form which will capture the smaller incidents, more significant incidents such as PMVA / MRE / Seclusion / assaults and will be picked up by the staff member allocated on the de-brief rota. Team files with documentation and the rota set up. - Recent changes have been made to the incident reporting form with a prompt added for reporters to capture debrief information at the time of reporting. - MRE event planned for 16 August 2023.
Assurance mechanisms	- Improvement in compliance has been seen. - Agreement at Board for Trust approach to RRI/MRE planned for October 2023. - Outline plan and timeline to be shared with CQC.

Must Do Theme: (3) Restrictive practices, seclusion and long term segregation		**Lead:** **Dennis Davison, Associate Director**
Planned timescale for closure: **30 June 2023 (30 September 2023)**		**Status:** **Completion of works**
Must Do:	LDA wards Year: 2022 Org: CNTW	People in seclusion on Lindisfarne ward did not have privacy and dignity because staff who were not providing direct care entered the seclusion area regularly.
Actions to be taken forward during Quarter 2	- Continue to roll out of training and awareness regarding HOPE's model. Staff are aware that when seclusion room is in use access should be for those managing the patient. - Completion of transfer of services from KDU to Sycamore Unit.	
Assurance mechanisms	Linked to Opening of Sycamore and will be closed.	

Must Do Theme: (4) Appraisal and Training		**Lead:** **David Muir, Group Director**
Planned timescale for closure: **30 June 2023 (30 September 2023)**		**Status:** **Further action required to make improvements**
Must Do:	Community CYPS Year: 2018 Org: CPFT	The trust must ensure that staff complete the mandatory training courses relevant to this service in line with trust policy to meet the trusts training compliance targets.

What the report identified at the time, including what the level of performance was at the time of inspection.	The compliance for attendance at mandatory training course was 72% overall. Of the mandatory training courses listed, 12 failed to achieve the trust target. On transfer: The North Cumbria Locality to ensure there are clear plans in place to monitor arrangements ensuring training is accessible to wards and teams. The CPFT training data was not migrated across to CNTW so compliance for the locality started at 0% on 1st October 2019.
What is performance today?	6 courses are currently failing to meet the standard (Medicines Management, Clinical Supervision, Information Governance (Data Security Awareness), PMVA Breakaway, MHA/MCA/DOLS combined and Rapid Tranquilisation).
Actions to be taken forward during Quarter 2	Focus on the teams who are not currently achieving the agreed target.
Assurance mechanisms	• Well Led Reviews • Quality Standards meetings • BDG Workforce

Must Do Theme: (4) Appraisal and Training		**Lead:** **David Muir, Group Director**
Planned timescale for closure: **30 June 2023 (30 September 2023)**		**Status:** **Further action required to make improvements**
Must Do:	LDA wards Year: 2019 Org: CPFT	The provider must ensure that staff complete their mandatory and statutory training.
What the report identified at the time, including what the level of performance was at the time of inspection.	Staff on the ward had not completed their local induction or mental health legislation training. The provider reported that only 57% of staff had completed their local induction and 12.5% had completed their mental health legislation training. Ten other modules were below the provider's 85% compliance target. On transfer: The North Cumbria Locality to ensure there are clear plans in place to monitor arrangements ensuring training is accessible to wards and teams. The CPFT training data was not migrated across to CNTW so compliance for the locality started at 0% on 1st October 2019.	
What is performance	12 courses are currently failing to meet the standard (Fire, Safeguarding Children level 3, Clinical Risk and	

today?	Suicide Prevention, Autism Core Capabilities, Safeguarding Adults level 2 & 3, Medicines Management, Learning Disability Tier 1, PMVA Basic, MHA/MCA/DOLS Combined, Safeguarding Children level 2 and Seclusion)
Actions to be taken forward during Quarter 2	Focus on the teams who are not currently achieving the agreed target.
Assurance mechanisms	• Well Led Reviews • Quality Standards meetings • BDG Workforce

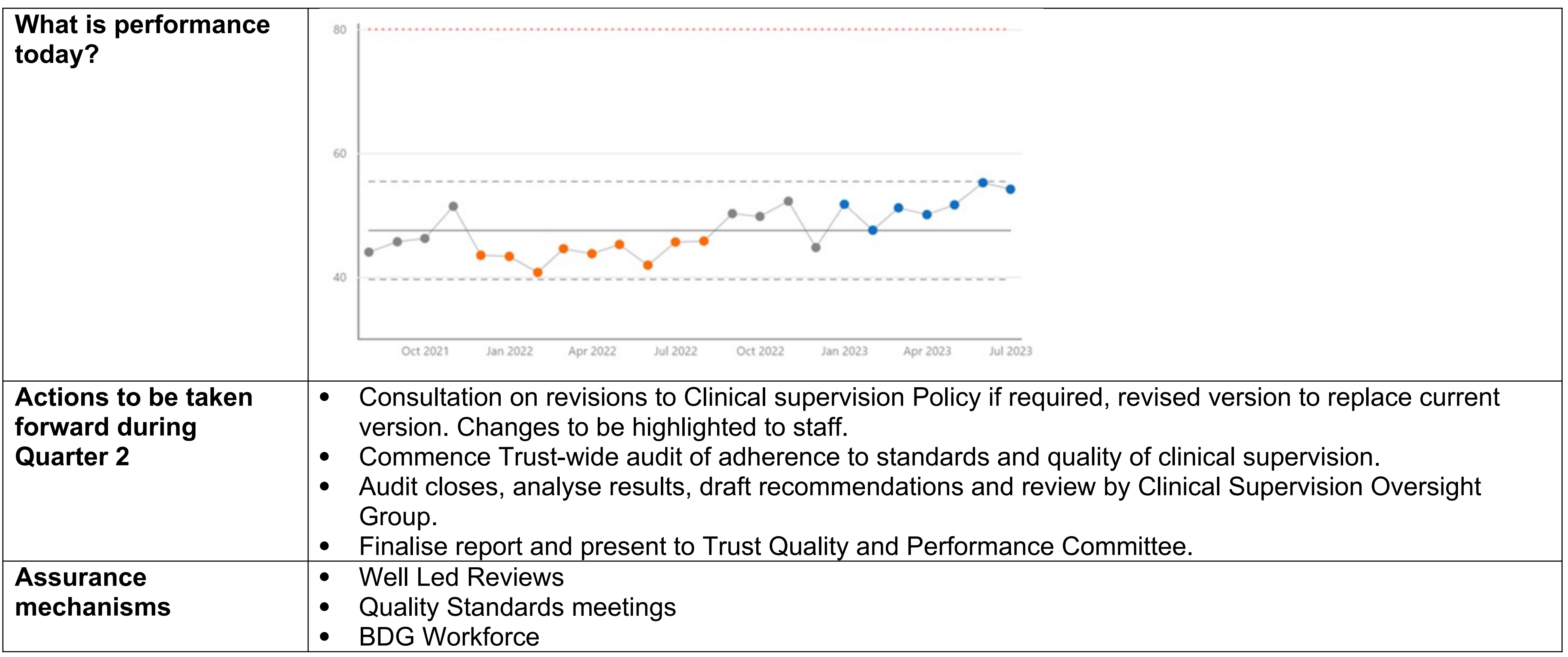
Must Do Theme: (4) Appraisal and Training		**Lead:** **Russell Patton, Deputy Chief Operating Officer**
Planned timescale for closure: **30 December 2023**		**Status:** **Further action required to make improvements**
Must Do:	CAV wards Year: 2022 Org: CNTW	The trust must ensure that the wards have suitably qualified and experienced staff to support all admissions including training in specialist autism and learning disabilities.
What the report identified at the time, including what the level of performance was at the time of inspection.	Learning Disability and Autism training compliance was poor.	
What is performance today?	Training compliance is below the Trust standard.	
Actions to be taken forward during Quarter 2	• Continue to promote Learning Disability and Autism training programme within mainstream Adult Acute wards this quarter. • Provide focussed management support in those clinical areas where compliance remains problematic. • Work with staff agency providers to ensure that there is adequate provision of an acceptable Learning Disability and Autism training package for all agency staff.	
Assurance	• Fortnightly meetings with the Deputy COO, the respective Associate Directors and reps from training	

mechanisms	department to review compliance and trajectories • Well Led Reviews • Quality Standards meetings • BDG Workforce

Must Do Theme: (5) Clinical supervision		**Lead:** **David Muir, Group Director**
Planned timescale for closure: **30 June 2023 (30 December 2023)**		**Status:** **Further action required to make improvements**
Must Do:	Community OP Year: 2018 Org: CPFT	The trust must ensure that all staff receive clinical and management supervision and that it is documented. The trust must ensure that supervision figures are shared appropriately with senior managers.
What the report identified at the time, including what the level of performance was at the time of inspection.	Clinical and management supervision was not always taking place in line with trust policy. There was no central monitoring of compliance with the supervision policy. On transfer: Within CPFT staff were either not receiving regular supervision or this was not recorded accurately. The Trust had no clear way to monitor supervision quantity and quality. The commentary and evidence provided is limited to maintain a paper-based system, until the arrival of a more robust system within North Cumbria Locality. Clinical supervision training dates throughout 2020 have been organised. CQC Compliance Officer collates clinical supervision data for all wards and teams. This is collated manually by requesting ward and team managers complete an excel spreadsheet and forward the data to a central mailbox at the end of each month. Over the last 6 months CNTW has been developing an on-line clinical supervision recording system which links to our dashboards – this is still being embedded. Roll out of the system to North Cumbria Locality TBC. North Cumbria using CNTW Supervision Policy.	
What is performance today?	Clinical supervision below the Trust standard (58%).	
Actions to be taken forward during Quarter 2	New clinical manager in post who will be reviewing current supervision arrangements to ensure staff aligned with supervisor.	
Assurance	• Well Led Reviews	

mechanisms	• Quality Standards meetings • BDG Workforce

Must Do Theme: (5) Clinical supervision			**Lead:** **Esther Cohen-Tovee, Director of AHPs & Psychological Services**
Planned timescale for closure: **30 December 2023**			**Status:** **Further action required to make improvements**
Must Do:	Trust-wide Year: 2019 Org: CPFT	The trust must ensure it continues its development of staff supervision and the board have clear oversight of both quantity and quality of supervision.	
What the report identified at the time, including what the level of performance was at the time of inspection.	Staff supervision was not taking place consistently. Not all teams recorded staff supervision figures. The senior management team did not have oversight of staff supervision figures. Supervision figures were not collated centrally. Senior managers were reliant online managers to inform them of any discrepancies. On transfer: Within CPFT staff were either not receiving regular supervision or this was not recorded accurately. The Trust had no clear way to monitor supervision quantity and quality. The commentary and evidence provided is limited to maintain a paper-based system, until the arrival of a more robust system within North Cumbria Locality. Clinical supervision training dates throughout 2020 have been organised. CQC Compliance Officer collates clinical supervision data for all wards and teams. This is collated manually by requesting ward and team managers complete an excel spreadsheet and forward the data to a central mailbox at the end of each month. Over the last 6 months CNTW has been developing an on-line clinical supervision recording system which links to our dashboards – this is still being embedded. Roll out of the system to North Cumbria Locality TBC. North Cumbria using CNTW Supervision Policy.		

What is performance today?	
Actions to be taken forward during Quarter 2	• Consultation on revisions to Clinical supervision Policy if required, revised version to replace current version. Changes to be highlighted to staff. • Commence Trust-wide audit of adherence to standards and quality of clinical supervision. • Audit closes, analyse results, draft recommendations and review by Clinical Supervision Oversight Group. • Finalise report and present to Trust Quality and Performance Committee.
Assurance mechanisms	• Well Led Reviews • Quality Standards meetings • BDG Workforce

Must Do Theme: (5) Clinical supervision		**Lead:** **David Muir, Group Director**
Planned timescale for closure: **30 June 2023 (30 December 2023)**		**Status:** **Further action required to make improvements**
Must Do:	LDA wards Year: 2019 Org: CPFT	The provider must ensure that all staff receive regular supervision.
What the report identified at the time,	Staff did not receive regular supervision. Since August 2018, out of the 24 staff members on the ward, nine had not received any supervision and 14 others had only received supervision between one and three	

including what the level of performance was at the time of inspection.	times. On transfer: Within CPFT staff were either not receiving regular supervision or this was not recorded accurately. The Trust had no clear way to monitor supervision quantity and quality. The commentary and evidence provided is limited to maintain a paper-based system, until the arrival of a more robust system within North Cumbria Locality. Clinical supervision training dates throughout 2020 have been organised. CQC Compliance Officer collates clinical supervision data for all wards and teams. This is collated manually by requesting ward and team managers complete an excel spreadsheet and forward the data to a central mailbox at the end of each month. Over the last 6 months CNTW has been developing an on-line clinical supervision recording system which links to our dashboards – this is still being embedded. Roll out of the system to North Cumbria Locality TBC. North Cumbria using CNTW Supervision Policy.
What is performance today?	Clinical supervision and management supervision is below Trust standard (35% and 23%).
Actions to be taken forward during Quarter 2	• Compliance data to be discussed each month in ops huddle and monitored month on month for improvement. • Figures will be discussed in HR triage monthly. • Clinical nurse manager discusses with ward managers in monthly supervision.
Assurance mechanisms	• Well Led Reviews • Quality Standards meetings • BDG Workforce

Must Do Theme: (9) Environmental issues		**Lead:** **Russell Patton, Deputy Chief Operating Officer**
Planned timescale for closure: **30 June 2023 (30 December 2023)**		**Status:** **Completion of works**
Must Do:	LDA wards Year: 2022 Org: CNTW	There were issues with the environments on some of the wards. [This must do is linked to the must do relating to seclusion rooms].
Actions to be taken forward during Quarter 2	• Essential works to be carried out to improve the internal fabric of the building at Mitford Bungalows (redecoration, replacement of fixtures and fittings and flooring). This work is being prioritised for completion throughout September.	

	• Business case to be developed that demonstrates the benefits of an upgrade of Mitford Bungalows which will require capital funding. • Complete refurbishment of Edenwood and transfer patients from Acorn ward which is scheduled to take place at the end of September.
Assurance mechanisms	Quality Standards meetings

Must Do Theme: (9) Environmental issues		**Lead:** **Russell Patton, Deputy Chief Operating Officer**
Planned timescale for closure: **30 June 2023 (30 September 2023)**		**Status:** **Completion of works**
Must Do:	LDA wards Year: 2022 Org: CNTW	There was no nurse call alarm system on Cheviot, Lindisfarne, Tyne or Tweed wards. [This must do is linked to the must do relating to prone restraint].
Actions to be taken forward during Quarter 2	Transfer of services to Sycamore.	
Assurance mechanisms	Linked to opening of Sycamore	

Must Do Theme: (9) Environmental issues		**Lead:** **Dennis Davison, Associate Director**
Planned timescale for closure: **30 June 2023 (30 September 2023)**		**Status:** **Completion of works**
Must Do:	LDA wards Year: 2022 Org: CNTW	Three seclusion rooms did not meet the requirements which meant they were not fit for purpose. [This must do is linked to the must do relating to environments].
Actions to be taken forward during Quarter 2	• Resolution to be found (IPad option) to address privacy issues on Tweed ward whilst patients are in seclusion. • Opening of Sycamore.	
Assurance	Linked to opening of Sycamore	

mechanisms	

Must Do Theme: (9) Environmental issues		**Lead:** **David Muir, Group Director**
Planned timescale for closure: **30 September 2023**		**Status:** **Completion of works**
Must Do:	Adult acute wards Year: 2019 Org: CPFT	The provider must maintain premises in good condition and suitable for the purpose for which they are being used.
Actions to be taken forward during Quarter 2	Completion of works on Hadrian 1 and Yewdale courtyard.	
Assurance mechanisms	Quality Standards meetings	

Must Do Theme: (9) Environmental issues		**Lead:** **Anna English, Group Director**
Planned timescale for closure: **30 July 2024**		**Status:** **Completion of works**
Must Do:	CAV wards Year: 2022 Org: CNTW	The trust must ensure that the premises are fit for purpose.
Actions to be taken forward during Quarter 2	• Retro fit windows at Hadrian is now complete. • Car parking secured to the side of Hadrian so staff no longer need to walk through site. • Redecoration continues throughout the clinic during August.	
Assurance mechanisms	Quality Standards meetings	

Must Do Theme: (11) Staffing levels	**Lead:**

		Dennis Davison, Associate Director
Planned timescale for closure: **30 June 2023 (30 September 2023)**		**Status:** **Completion of works**
Must Do:	LDA wards Year: 2022 Org: CNTW	Cheviot ward did not have enough staff on shifts to meet the staffing requirements for enhanced observations. [This must do is linked to the must do relating to LD&A training].
Actions to be taken forward during Quarter 2	• Staff to be identified for allocation to Alwinton (Cheviot, Lindisfarne equivalent in new MSU). • Completion of transfer of services from KDU to Sycamore Unit.	
Assurance mechanisms	Linked to opening of Sycamore	

Must Do Theme: (12) Physical health and Rapid tranquilisation		**Lead:** **David Muir, Group Director**
Planned timescale for closure: **30 September 2023**		**Status:** **Further action required to make improvements.**
Must Do:	Adult acute wards Year: 2018 Org: NTW	The trust must ensure that staff monitor the physical health of patients following the administration of rapid tranquilisation.
	Adult acute wards Year: 2019 Org: CPFT	The trust must ensure staff monitor patients’ physical health including, following rapid tranquilisation, in accordance with national guidance, best practice and trust policy.
	Adult acute wards Year: 2019 Org: CPFT	The trust must ensure they have effective systems and processes to assess, monitor and improve care and treatment. This includes identifying, individually assessing and reviewing, blanket restrictions, clear oversight of staff supervision and ensuring all physical health monitoring is completed as required. [This must do is also linked to blanket restrictions and staff supervision]
	LDA wards Year: 2019	The provider must ensure that all staff review patients’ observations following the use of rapid tranquilisation to comply with the provider’s rapid tranquilisation policy and National

	Org: CPFT	Institute of Health and Care Excellence guidance.
What the report identified at the time, including what the level of performance was at the time of inspection.	In acute wards for adults of working age and psychiatric intensive care units, staff were not always monitoring the physical health of patients after rapid tranquilisation. Review 'The Management of Rapid Tranquillisation' Policy (NTW(C) 02) to ensure it reflects contemporary, high quality care delivery and provides accurate and appropriate clarity regarding duties, accountability and responsibilities.	
What is performance today?	The audit has evidenced little improvement despite ongoing training and communications being provided on the subject.	
Actions to be taken forward during Quarter 2	• Continued monitoring via Localities of the Rapid Tranquillisation monitoring form. • Ongoing rollout of training across localities to ensure compliance increases. • All adult wards now live with the Rapid Tranquilisation NEWS form. This will need continued monitoring to ensure embedded and for any further glitches to worked through by digital / informatics • PEWS to added onto RiO. • Rapid Tranquilisation Policy review.	
Assurance mechanisms	This one needs urgent action through revised Physical health monitoring compliance levels now looking at improvement trajectories	

CLOSED MUST DOS:

<table>
<tr><th colspan="2">Must Do Theme: (1) Personalisation of care plans</th><th colspan="2">Lead: Sheree McCartney, Group Nurse Director</th></tr>
<tr><td colspan="3"></td><td>Status:</td></tr>
<tr><td>Community LD
Year: 2016
Org: CPFT</td><td colspan="2">The trust must ensure that care plans are person-centred, holistic and presented in a way that meets the communication needs of people using services that follows best practice and guidance.</td><td rowspan="3">Closed by Board of Directors on 3 August 2022.</td></tr>
<tr><td>Community OP
Year: 2018
Org: CPFT</td><td colspan="2">The trust must ensure that all patients have comprehensive and up to date care plans and risk assessments. Care plans and risk assessments must be regularly reviewed, and information must be used to inform each document.</td></tr>
<tr><td>Community CYPS
Year: 2018
Org: CPFT</td><td colspan="2">The trust must ensure that care planning takes place with young people and is recorded in an accessible format that young people can understand. Care plans must be shared with young people and their carers where appropriate.</td></tr>
<tr><td>Trust-wide</td><td colspan="3">The work around personalisation of care planning to continue due to the repeated concerns and internal intelligence received during Quarter 3 & 4.</td></tr>
<tr><td colspan="4">Actions taken at Trust-wide level during Quarter 4 & 1:</td></tr>
<tr><td colspan="4">• Full audit took place at the end of 2022 and the final report and action plans were signed of at Clinical Effectiveness Committee in May 2023 which showed areas of concern remain.
• Devised locality specific action plans which are monitored through Locality Quality Standards meetings following outcome of recent audit.
• Personalised care plan training continued to be rolled out. Each locality has a rolling training programme which is monitored by the locality Operational Support Manager and reported into the monthly Quality Standards meeting.
• Recirculation of posters and materials to be displayed in wards promoting personalised care planning. Assurance provided from Associate Nurse Directors that these are in place and being displayed.
• Article was posted in the Trust Bulletin on 23 May 2023 to promote the recent audit, findings and next steps.
• Agreed Working Group of the Inpatient Quality Framework to set up with a focus around the quality of care plans.</td></tr>
<tr><td colspan="4">Planned future actions to be taken at Trust-wide level during Quarter 2 & 3 23/24:</td></tr>
<tr><td colspan="4">• Trust-wide care planning group established as part of the Inpatient Quality Framework Group attended by locality Associated Nurse Directors chaired by Sheree McCartney, Group Nurse Director they met on 16 June 2023. Second meeting to take place in July.
• Identified training needs across all teams, and all members of MDT – ongoing roll out.
• There is some ongoing work with the RiO build to consider a care plan evaluation as part of this.
• The care plan audit tool is to be updated to reflect the training and requirements.
• Additional RiO Sub Group to be stood up to include Mike Jones to look specifically at care planning.</td></tr>
</table>

- Associate Nurse Directors to work with Mark Campbell to mock up a RiO care plan, considering what we need, in what place on RiO, and to also consider if we can include care need specific hyperlinks in care plans, to direct staff to specific policies/PGN's.
- Consideration to be given as to whether the care coordination documentation / care plan can pull through to the care plan section and impact positively on reporting.
- Ongoing roll out of the personalised care planning training this has been added to dashboards so compliance can be monitored, there is currently some data quality issues which are being rectified to ensure all training that has taken place is captured accurately.
- Continue to include this as a standing agenda item on locality Quality Standards meetings and locality CQC Compliance meetings.

Evidence of Impact:

- The metric for the number of current service users who have discussed their care plan remains similar to the Quarter 4 position:
  - North Cumbria Locality – 87% (March), 87% (June)
  - North Locality – 96% (March), 97% (June)
  - Central Locality – 95% (March), 95% (June)
  - South Locality – 93% (March), 93% (June)
- No issues reported through MHA reviewer visits during Quarter 1.

Must Do Theme: (2) Blanket restrictions	**Lead: Bill Kay, Group Nurse Director**	
		Status:
Adult Acute wards Year: 2018 Org: NTW	The trust must ensure that blanket restrictions are reviewed and ensure that all restrictions are individually risk assessed.	Closed by Board of Directors on 3 November 2021.
Adult Acute wards Year: 2019 Org: CPFT	The trust must ensure that blanket restrictions are all reviewed and individually risk assessed.	

Evidence of Impact:

- No issues reported through MHA reviewer visits during Quarter 1.
- Review of Trust Policy.

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

		Directors on 7 June 2023.
Evidence of Impact:		
No issues reported through MHA reviewer visits during Quarter 1.		

Must Do Theme: (4) Training and Appraisals		**Lead: David Muir, Group Director**
		Status
Community LD Year: 2016 Org: CPFT	The trust must ensure that all staff have an annual appraisal.	Action plan closed by Board of Directors on 5 July 2023.
Evidence of Impact:		
Integrated Performance Report.		

Must Do Theme: (6) Risk registers		**Lead: Debbie Henderson, Director of Communications and Corporate Affairs**
		Status:
Trust-wide Year: 2019 Org: CPFT	The trust must ensure it continues to make progress against the trust risk register and board members and members of staff understand the process of escalating risks to the board through the board assurance framework.	Closed by Board of Directors on 5 August 2020.
Crisis MH teams Year: 2019 Org: CPFT	The trust must ensure systems and processes are established and operating effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients.	
Evidence of Impact:		
• Cycle of risk register review through Executive Management Team (previously Trust Leadership Team). • Review and update of Risk Management Strategy received by Board in November 2020. Current review deferred to reflect 2023 strategy and priorities. • Board Development session in February 2021 to review risks, identify any emerging risks to be added to BAF, review risk appetite categories and scoring. • Future Strategy With you in Mind launched May/June 2023. • Risk Management Strategy to be taken to the September 2023 Board meeting		

Must Do Theme: (7) Documentation of Consent and Capacity		**Lead: Bruce Owen, Mental Health Legislation Steering Group Chair**
		Status:
Community OP Year: 2018 Org: CPFT	The trust must ensure that consent to treatment and capacity to consent is clearly documented in patient's records.	Closed by Board of Directors on 3 August 2022.
Evidence of Impact:		
No issues reported through MHA reviewer visits during Quarter 1.		

Must Do Theme: (8) Collecting and acting on feedback from service	**Lead: Allan Fairlamb, Head of Commissioning & Quality Assurance**

users and carers		
		Status:
Community CYPS Year: 2018 Org: CPFT	The trust must ensure that quality monitoring takes place to measure service performance, outcomes and progress and ensure feedback from young people and their carers is incorporated into this.	Closed by Board of Directors on 5 August 2020.
Evidence of Impact:		
Quarterly report to Board on patient feedback.		

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

Must Do Theme: (10) Risk assessment and record management		Lead: David Muir, Group Director
		Status:
Community LD Year: 2016 Org: CPFT	The trust must ensure that staff complete and record patient's risk assessments consistently evidencing contemporaneous care records for patients who use services.	Closed by Board of Directors on 3 August 2022.
Community CYPS	The service must ensure that all young people receive a thorough risk assessment which is recorded	

Year: 2018 Org: CPFT	appropriately in accordance with the trusts policies and procedures to ensure safe care and treatment.	
MH crisis teams Year: 2019 Org: CPFT	The trust must ensure systems and processes are established to maintain the records of each patient accurately, completely and contemporaneously.	

Evidence of Impact:

- The metric (101) for service users with a risk assessment undertaken/reviewed in the last 12 months remains similar to previous quarters:
  - North Cumbria Locality – 89% (March), 89% (June)
  - North Locality – 98% (March), 98% (June)
  - Central Locality – 97% (March), 97% (June)
  - South Locality – 97% (March), 97% (June)

- The metric (102) for service users with identified risks who have at least a 12 monthly crisis and contingency plan remains similar to previous quarters:
  - North Cumbria Locality – 84% (March), 83% (June)
  - North Locality – 96% (March), 96% (June)
  - Central Locality – 94% (March), 95% (June)
  - South Locality – 94% (March), 94% (June)

- Compliance for clinical risk and suicide prevention training standards at Quarter 4:
  - North Cumbria Locality – 82% (March), 83% (June)
  - North Locality – 83% (March), 84% (June)
  - Central Locality – 84% (March), 85% (June)
  - South Locality – 86% (March), 89% (June)

- No issues reported through MHA reviewer visits during Quarter 1.

Must Do Theme: (11) Staffing levels	**Themed Lead: Anthony Deery, Deputy Chief Nurse and Locality Group Directors**	
Planned timescale for closure: 31 March 2023		**Status:**
Community CYPS Year: 2017 Org: CPFT	The trust must ensure that there are a sufficient number of appropriately skilled staff to enable the service to meet its target times for young people referred to the service.	Closed by Board of Directors on 3 August 2022.
MH crisis teams Year: 2019 Org: CPFT	The trust must ensure there is always a dedicated member of staff to observe patients in the health-based places of safety.	Closed by Board of Directors on 3 August 2022.
LDA wards Year: 2019 Org: CPFT	The provider must ensure that all patients have regular access to therapeutic activities to meet their needs and preferences.	Closed by Board of Directors on 3 August 2022.
Rose Lodge Year: 2022 Org: CNTW	The service must ensure that the ward has enough suitably trained and qualified staff on each shift.	Closed by Board of Directors on 7 June 2023.

Evidence of Impact:

• Vacancy levels. • Safer staffing reports. • One staffing concern was raised during a MHA reviewer visit in Quarter 1.

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

Must Do Theme: (14) Staff engagement	**Lead: Anna Williams, Group Nurse Director**	
		Status:
Adult acute wards Year: 2019 Org: CPFT	The trust must ensure staff working on Rowanwood feel supported, valued and respected following serious incidents beyond ward level.	Closed by Board of Directors on 3 August 2022.
Evidence of Impact:		
Staff survey results and local action plans.		

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

• Review results of POMH Quarter 1 re-audit.

Must Do Theme: (17) Bed Management	**Lead: Andy Airey, Group Director**	
		Status:
Adult acute wards Year: 2019 Org: CPFT	The trust must continue to look at ways of reducing out of area placements and the management of bed availability to ensure this meets the needs of people requiring the service.	Closed by Board of Directors on 3 August 2022.
Evidence of Impact:		
The number of OAP days have increased this quarter in Sunderland, South Tyneside and North Cumbria localities. Trust-wide OAP days have increased from 976 (in Quarter 4) to 1189 and relates to 73 patients. • Sunderland – 207 (March), 325 (June) • South Tyneside – 16 (March), 155 (June) • Newcastle Gateshead – 381 (March), 169 (June) • Gateshead – 248 (June) • Northumberland – 155 (March), 62 (June) • North Tyneside – 90 (March), 33 (June) • North Cumbria – 127 (March), 400 (June)		

Must Do Theme: (18) Section 17 Leave	**Lead: Bruce Owen, Mental Health Legislation Steering Group Chair**	
		Status:
OP wards Year: 2019 Org: CPFT	The provider must ensure that all section 17 leave forms are individually completed for each patient and show consideration of patient need and risks.	Closed by Board of Directors on 4 August 2021.
Evidence of Impact:		
• Compliance with Section 17 leave expiry dates continues to improve. • No issues reported through MHA reviewer visits during Quarter 1.		

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

10. ROSELODGE UPDATE

Ramona Duguid, Chief Operating Officer

REFERENCES

Only PDFs are attached

10. Roselodge Update Board Sept 23 - Final Version.pdf

Name of meeting	Board of Directors meeting
Date of Meeting	Wednesday 6th September 2023
Title of report	Rose Lodge Assessment & Treatment Unit Update
Executive Lead	Ramona Duguid, Chief Operating Officer
Report author	Andy Airey, Group Director, South Locality

Purpose of the report	
To note	X
For assurance	X
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		Executive Team	X
Audit		Executive Management Group	
Mental Health Legislation		Business Delivery Group	X
Remuneration Committee		Trust Safety Group	
Resource and Business Assurance		Locality Operational Management Group	X
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	X	Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	
Quality, safety and experience	X	Service user, carer and stakeholder involvement	

Board Assurance Framework/Corporate Risk Register risks this paper relates to
Not Applicable.

Rose Lodge - Assessment and Treatment Unit Update

Report to the Board of Directors
Wednesday 6th September 2023

1. Executive Summary

Rose Lodge is a commissioned 12 bedded, assessment and treatment unit situated in the Hebburn area of South Tyneside covering CNTW boundaries. The unit provides assessment, diagnosis and evidence-based interventions for health challenges that may be a consequence of a learning disability and / or autism. There is a clear focus on those with the most complex needs whose support requirements are not able to be met by mainstream services. Following previous updates to the Board, this report provides an update on the continued quality improvements at Rose Lodge.

1.1 Material points for Board members to note in this report.

- A Rose Lodge Incident Management Group (IMG) was established on the 22nd of April 2021 to provide a focussed forum to address and manage the issues of concern raised during a MHAR visit on the 12th of April 2021.This group met monthly and focused on the completion, review, and implementation of key actions to successfully address concerns raised by the CQC and lead commissioner.

- The South Locality leadership team, with the support of the Chief Operating Officer and the Lead Responsible Commissioner (South Tyneside CCG), took the decision to temporarily close Rose Lodge to admissions on the 3rd of March 2022.

- Following quality improvements made by the team the IMG was stood down on the 16th of May 2022 and a Quality Improvement Group (QIG) was established on the 6th of June 2022.

- Following the development of the clinically lead admission process, and consultation across the wider system, Rose Lodge was re-opened to admissions in July 2022.

- In January 2023, and, in light of the further significant quality improvements made, the QIG was taken into the inpatient CBU and continues to coordinate all quality improvement activity via the Rose Lodge Development Framework.

- There are currently 5 patients residing at Rose Lodge, 3 of whom are identified as clinically ready for discharge (previously known as delayed transfer of care, DTOC) and are therefore not within active treatment.

- Violence towards staff has historically resulted in significant staff sickness, wellbeing pressures and recruitment and retention challenges.

- To address the ongoing recruitment challenges on Rose Lodge the team have undertaken bespoke recruitment campaigns for Band 5 and Band 3 staff and have successfully recruited to all nursing posts.

- The CQC attended Rose Lodge on the 21st of February 2023 to complete a Mental Health Act Reviewer Visit (MHAR). The ward received formal feedback following the MHAR. Overall, the feedback was positive, areas for improvement identified by the CQC have clear action plans in place.

2. Overview of Current Position / Quality Improvements.

Patient population

- There are currently 5 patients residing at Rose Lodge, 3 of whom are identified as clinically ready for discharge (CRFD), previously known as delayed transfer of care, (DTOC) and are therefore not within active treatment.

- Due to complexity of need, resulting in significant risks of physical assault towards patients and staff, one patient (admitted in December 2021, identified as CRFD) is currently cared for within the parameters of the long-term seclusion policy. The patient has access to his bedroom, a lounge area and access (on a rota) to the outside yard area. The team are working with the national HOPES team to ensure constant review of the situation, identification of barriers to change and delivery of evidence-based interventions. This has resulted in significant improvements in the patient's daily life which includes regular visits out of Rose Lodge to local beaches, the Zoo and McDonald's fast-food restaurant with staff and family members. This will remain in place until a specialist community placement is identified, this is however some significant time away.

- On the 18th of July 2023 the NENC ICB senior intervenor panel, led by the senior intervenor *, reviewed this patient's care pathway in support of the Rose Lodge clinical and operational team. The team advised that they were listened to and that the patients' needs were clearly presented and discussed. The panel understood the challenges regarding the inability to gain a timely discharge and the panel provided a helpful summary with some suggested areas for local system focus.

- The seclusion continues to be reviewed in line with the CNTW policy, with a clear plan, and in recognition of the significant therapeutic progress made, to end long term seclusion at the end of September 2023.

** The national Senior Intervenors pilot project was set up to support local services to plan for discharge, guide where there is challenge and agree actions to facilitate a reduction in restrictions. The ultimate goal of the Senior Intervenors is to establish and oversee a robust plan for discharge from both long-term segregation and hospital. The Senior Intervenor's work focuses on cases where progress is not being made and there is concern for the individual's wellbeing. The Senior Intervenor works with people on a case-by-case basis to find solutions to barriers that may be preventing the individual from moving to less restrictive settings or into the community.*

Recruitment

- Following a number of bespoke recruitment events the service have successfully recruited to all nursing posts. This has resulted in significant reduction in the use of temporary staffing within the service.

Internal Mock CQC Visit

- A mock internal CQC inspection was undertaken at Rose Lodge on the 6th of June 2023. This went well, identifying some areas for improvement, which the team are addressing via a detailed action plan. A number of areas of good practice were identified and included: (Fuller detail included at appendix 1).
  - Good oversight from external parties- regular visits by host commissioner and relevant ICB for all patients.
  - Good links with Local Authority safeguarding team and joint review of incidents via CCTV where appropriate.
  - Comprehensive risk assessments and management plans in place.
  - Good interactions with staff and patients observed.
  - Good multi-disciplinary working.

Environmental Improvements

- The clinical and operational team continue to work closely with NTW solutions to maintain high environmental standards at Rose Lodge (including weekly walk arounds) and the estates works recommended during the last CQC MHAR visit have been completed.

- The significant redesign of the outside courtyard area, to enhance therapeutic use, is underway and will be completed by October 2023. Access for patients has been maintained during this period of works.

Quality Network for Learning Disability (QNLD) accreditation.

- The Rose Lodge team are formally working towards accreditation with the QNLD. The review of the service against the standards for Accreditation of Inpatient Assessment and Treatment units for adults with Intellectual Disability will take place at the end of September 2023. This will further support Rose Lodge in the evaluation and improvement of management processes and standards of care.

Review of the Rose Lodge Clinically Led Admission Process.

- The clinically led admission process was developed by the clinical team and agreed by the system to facilitate the reopening of Rose Lodge to admissions in July 2022, following the temporary closure in March 2022.

- The team have undertaken a 12-month review of the process, identifying a significant improvement in the way referrals for active assessment and treatment are received and reviewed, with clear purpose of admission identified, including MDT to MDT discussion, and where need for admission is identified as being required, how admissions are planned and accepted.

Patients Leave.

- As part of their care pathway and in support of progress to discharge, patients have been accessing events in the local community, including attendance at leisure centres and discos, as well as one patient, who is currently supported in long term seclusion, having day leave with family members and staff.

Cultural Celebration Day

- In celebration of the cultural diversity within the team working within Rose Lodge, the staff team, with support from the Trust equality and diversity officer, arranged and hosted a cultural awareness day on Saturday the 22nd of April 2023, involving both staff and patients. Staff attended with the aim of celebrating and learning more about all of the cultural backgrounds of their peers and reported that this had helped in achieving a sense of being closer together as a team.
  An anonymous comment box was placed in the communal room and the below are just a few of many received:
  - "Really lovely day, enjoyed learning about everyone's traditions and generally spending time with the team out with a working day".
  - "Brilliant event, absolutely enjoyed it and hoping for more such events for a positive break from hectic routine".
  - "Absolutely amazing experience and a definite eye opener. Such a brilliant way to learn more about your colleagues".

  The next session was then held on Clearbrook, a day is also planned for Brook House and then for the remaining 9 wards before holding a second day at Rose Lodge in the future.

Safe Space Sessions

- In addition to the Cultural Celebration Day, the Rose Lodge team have invited staff networks to attend Rose Lodge and host a safe space. The Safe Space Project comes from the need to have open conversations with colleagues to ensure a safe and inclusive workplace culture. It was an opportunity to unite and collaborate to create meaningful change in both the workplace and society. Partnered with the Staff Networks and the EDI (Equality, Diversity & Inclusion) Team, this initiative aimed to create safe environments for conversations where staff are not afraid to ask those questions that perhaps they are worried about asking, as well as looking to gain a better understanding of their peers. The event held in August 2023 was well attended by staff. A bespoke training package will be created for Rose Lodge, informed by the themes identified during the day at Rose Lodge and also from a similar event held on Beckfield PICU. This initiative may be repeated in the future based on staff feedback.

Commissioner / Provider Relationships

- Building on an established series of joint meetings the Rose Lodge clinical and operational team now meet quarterly with the ICB host commissioner to review relationships and enhance joint working. This is valued by both the service and ICB lead commissioner.

Enhanced Staff Induction Process.

- Coordinated via the Rose Lodge QIG, the team at Rose Lodge have developed a local induction package to support with the staff induction process. This has enhanced the process of induction by ensuring staff have dedicated time, when they commence work at Rose Lodge, to undertake a full induction to the ward, including specialist training (learning disability and autism), a clear understanding of the patients care plans, what to expect form Rose Lodge and an opportunity to meet all staff peers. It has been well received by new starters to the service, who have commented that they feel included in the ward team from day one. This is now being reviewed further for inclusion within the other wards in the inpatient CBU.

Staff well-being Initiatives.

- The team at Rose Lodge have been working with partners and have made significant progress in supporting existing staff and promoting staff wellbeing. The focus has been on staff training, recruitment and retention, wellbeing, and reduction in staff sickness.

- Rose Lodge has held a number of service specific wellbeing days for all staff, facilitated by a local charity. This has provided a space for staff to reflect on achievements and challenges over the past 12 months and identify what wellbeing support is required / would be beneficial in the coming 12-month period.

- The service has also arranged for staff side representatives to attend Rose Lodge on a weekly basis to meet with staff on a confidential and supportive basis.

Staff Training

- Staff at Rose Lodge have prioritised the Learning Disability and Autism training and are performing above the Trust standard, compliance at 30th August 2023 was reporting Learning Disability Tier 1 at 88.6% and Autism core capabilities Tier 1 and 2 at 86.7%. The service has a clear plan to have all staff attend the Positive Behavioural Support (PBS) training, delivery of which is supported by those with a lived experience.

- The service is working towards a clear plan to ensure that all Band 5 & Band 6 Nursing staff within Rose Lodge have a personal and professional development plan in place, led and supported by a senior and experienced lead nurse.

Leadership activity

- The inpatient CBU Associate Director and Associate Psychological Director and Trust Academy are supporting the ongoing Rose Lodge leadership team development, supported by national CPD funding.

Quality Improvement Group

- The Rose Lodge QIG continues to focus on quality improvement and is chaired by the inpatient CBU Associate Director. The agreed Terms of Reference for this group focuses on:

  - Operational management of Rose Lodge including off duty and agency use, risk management, admissions, and discharges
  - Staff wellbeing including recruitment, retention, and staff development.
  - Quality standards including safeguarding, incidents reporting and management, quality metrics and clinical service delivery.

  The meeting continues to meet monthly and is well attended by the leadership team, CNTW safeguarding, lead commissioner, associate director of operations, nursing, and psychology.

- The CBU provide assurance on the ongoing delivery of the quality improvement / CQC action plans to the Group Directors via the weekly locality safety meeting and the monthly quality standards meeting.

- **Mental Health Act Reviewer Visit**

The CQC attended Rose Lodge on the 21st of February 2023 to complete the Mental Health Act Reviewer Visit (MHAR). The ward received formal feedback following the MHAR, actions are being coordinated / addressed via the MHA Provider Action Statement.

Conclusion

A significant amount of quality improvement activity, initially led by the Rose Lodge Incident Management and Quality Improvement Groups and now via the CBU led Quality Improvement Group, has been undertaken since the original CQC MHAR visit in April 2021.

The pausing of admissions between March and July 2022 and the development of the clinically led admission process in 2022 provided clarity on the role and function of the service and as such the service has been able to focus on assessment and treatment of those with complex needs, as opposed to responding to unplanned community placement breakdowns. Previously these placement breakdowns had led to inappropriate admission of patients to the service without active treatment needs, subsequently experiencing significant lengths of stay due to the lack of specialist community placements.

Although this requires ongoing focus, system partners have been more engaged with the service and, as a result of their involvement in the quality improvement work undertaken since 2021, now generally view the unit more as part of a pathway as opposed to a default location for those experiencing community placement breakdowns.

Numerous quality improvements have resulted for patients, their families and carers and the staff team from the quality improvement approach taken at Rose Lodge, highlighted in the Mock CQC visit in June 2023 and the Quality Network (QNLD) review process, progressing towards accreditation. Staff recruitment has improved significantly via the bespoke recruitment activity, the focus upon staff wellbeing and the services role clarification, reducing the need for temporary staffing which in turn has had a positive impact upon quality and safety of care delivery.

Recommendation

The Board of Directors are asked to:

a) RECEIVE the paper for information.
b) SUPPORT the ongoing quality improvement process coordinated by the Rose Lodge Quality Improvement Group.

Author: Andy Airey Group Director, South Locality
Executive Lead: Ramona Duguid Chief Operating Officer, CNTW

6th September 2023

Supporting appendices to this report:
Appendix 1. Mock CQC Visit feedback, 6th June 2023:

Appendix 1.

Rose Lodge - Assessment and Treatment Unit Update

Report to the Board of Directors Wednesday 6th September 2023

Mock CQC Visit feedback, 6th June 2023:

Safe

- The ward has a large staff complement across a range of disciplines, which includes ward manager and a specialist nurse. The team is supported by 1.5 days nurse consultant and 0.6 wte consultant psychologist. There is a full time B5 psychology assistant, and a full time B6 OT with a B4 OT assistant, a full time SALT assistant, a band 5 exercise therapist and three exercise therapists part time. There is a full time B3 activity facilitator one part time B7 music therapist.

Effective

- Formulation meeting on the ward attended by 9 staff. This was well organised and systematic. The formulation process was well explained from psychologist who led the session and introduced staff. Positive feedback given around patient's presentation. Views of parents and care provider detailed in formulation discussion. Information collated prior to meeting.
- Clinical progress notes were easy to follow and showed a full range of professionals making notes.
- Majority of staff training metrics were noted to be above the Trust standard.

Caring

- Focus was given to the management of 'long term seclusion' for one individual detained under section 3 MHA. Staff were able to handover his care and clinical management describing a range of challenging behaviours and the different management/care strategies that had been utilised to date. Currently care straddles seclusion and long-term segregation but there is good evidence of care planning, carer involvement, efforts to ensure safety is balanced with ensuring restrictions are limited to what is purposeful and necessary. Space afforded to the individual whose care is being managed with this strategy is significant and CCTV monitoring utilised. Care staff were able to describe how they enact the care plan and how they participated in evaluations.
- Staff were caring and compassionate being observed to support patients as required. Staff sought to minimise anxieties by making appropriate introductions.

Responsive

- Integration into South Tyneside locality includes accessing local facilities and shops and working actively with the safeguarding team at the council.
- Inpatients are supported to maintain contact with family via the telephone.

Well Led

- Leadership team consists of the ward manager, nurse specialist, nurse cons, cons psychologist and one of the con psychiatrists. There is a weekly staff meeting with minutes emailed to all staff including those not in attendance. The Rose lodge leadership team also meet with senior members of the CBU and they form a development project for the ward. South Tyneside commissioners commission an expert by experience who visits the ward up to three times each weekly and has a monthly engagement meeting notes from the ExBE visits are cited prominently in the wobble room and elsewhere on the ward.
- There is a monthly quality improvement group and each individual patient has an ICB/local authority assurance visit.

11. VERDICT IN THE TRIAL OF LUCY LETBY

Rajesh Nadkarni, Deputy Chief Executive / Medical Director

presentation

REFERENCES

Only PDFs are attached

11a Board cover sheet Verdict LL.pdf

11b. letter-verdict-in-the-trial-of-lucy-letby.pdf

Name of meeting	Board of Directors
Date of Meeting	Wednesday 5th September 2023
Title of report	Verdict in the trial of Lucy Letby
Executive Lead	Rajesh Nadkarni, Deputy Chief Executive / Medical Director
Report author	

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	
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		Executive Management Group	
Audit		Business Delivery Group	
Mental Health Legislation		Trust Safety Group	
Remuneration Committee		Locality Operational Management Group	
Resource and Business Assurance			
Charitable Funds Committee			
Provider Collaborative/Lead Provider			
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	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

Classification: Official

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 August 2023

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

Publication reference: PRN00719

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

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communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

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12. ACUTE INPATIENT MENTAL HEALTH CARE FOR ADULTS AND OLDER ADULTS

James Duncan, Chief Executive

REFERENCES

Only PDFs are attached

12a. Inpatient Guidance Board paper Sept 2023.pdf

12b. Appendix 1. NHS England » Acute inpatient mental health care for adults and older adults.pdf

Report to the Board of Directors
Wednesday 6 September 2023

Name of meeting	Board of Directors meeting
Date of Meeting	Wednesday 6th September 2023
Title of report	National Guidance for acute inpatient mental healthcare for adults and older adults
Executive Lead	Anna Foster, Trust Lead for Strategy and Sustainability
Report author	James Duncan, 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

Board Sub-committee meetings where this item has been considered		Management Group meetings where this item has been considered	
Quality and Performance		Executive Team	
Audit		Executive Management Group	
Mental Health Legislation		Business Delivery Group	
Remuneration Committee		Trust Safety Group	
Resource and Business Assurance		Locality Operational Management Group	
Charitable Funds Committee			
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	X	Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness	x	Service user, carer and stakeholder involvement	

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

Report to the Board of Directors
Wednesday 6 September 2023

National Guidance for Acute Inpatient Mental Healthcare for Adults and Older Adults

Background

NHS England has recently published comprehensive guidance on acute inpatient mental health care for adults and older adults (Appendix 1).

Following this best-practice guidance will have wide-ranging implications across a range of Trust services and functions. However, the guidance is welcomed as its underlying principles align with and complement the Trust's new strategy, 'With you in mind'.

Summary

The national guidance supports the aspirations outlined in the NHS Long Term Plan and acknowledge the current pressures that acute inpatient mental health wards face (demand, acuity, workforce pressures).

The guidance sets out an aspirational vision for inpatient care that addresses other operational and quality issues, for example, delays accessing care or being discharged, being placed out of area, disproportionate use of restrictive interventions and variations in care for people with protected characteristics.

The national guidance is welcomed because it is bold, ambitious and recognises the need for radical change – complementing the vision outlined in CNTW's new strategy, 'With you in mind'. The core principles that run throughout the national guidance mirror those that underpin our own strategy, advocating care that is trauma informed, rights-based, least restrictive, joined-up, personalised and addresses inequalities.

The guidance is detailed and signposts the reader to many sources of best practice, this serving as a useful reference tool. There are detailed definitions of terms used, for example, explaining what is meant by terms such as 'purposeful admissions' and 'therapeutic inpatient care'. The guidance is clearly structured as follows:

Four key principles:

- Personalised care and shared decision making
- Care that advances health equality
- Trauma-informed care
- Joined-up partnership working

To be applied across the three key stages of an inpatient admission:

- Purposeful admissions
- Therapeutic inpatient care
- Proactive discharge planning and effective post-discharged support

Enabled by:

- A fully multidisciplinary, skilled and supported workforce
- Continuous improvement of the inpatient pathway

While many of the standards set out in the guidance are already in place across CNTW, there is still much to do and delivering care in-line with this guidance would also deliver our own strategic ambitions. Considerations of this guidance plus our own strategic ambitions should be made in all future decisions regarding the provision of inpatient services. There will be significant implications for models of care, for workforce skill-mix, training, and planning, and for long term estates planning, for example:

- The guidance makes it clear that the scope of acute inpatient mental health wards for adults and older people should accommodate the needs of people with a learning disability, autistic people, people with dementia, people from racialised and ethnic minority backgrounds, people with a co-occurring drug or alcohol problem, people who have experienced trauma, LGBT+ people and people who have been given a diagnosis of 'personality disorder';
- The role of community-based services in preventing and supporting admissions is described;
- There are significant implications for the training of all staff working in inpatient areas;
- Workforce plans must take into account the recommendations around workforce skill-mix, although the guidance does not provide recommended staffing numbers;
- There are some recommendations around seven day working, for example, to support effective discharge;
- The recommendations around out of area care and maintaining community links could have implications for commissioning and estates decisions about optimum geographical locations for services, alongside financial implications regarding funding cost of transport and accommodation to facilitate visits to people placed out of area;
- The role of the electronic patient record in delivering effective care is highlighted frequently throughout the guidance.

Recommendations

It is recommended that the Board notes the publication of the national guidance and recognises its significance as an enabler of high quality care that will support the delivery of the Trust's new strategy.

Anna Foster
Trust Lead for Strategy and Sustainability
August 2023

Date published: 18 July, 2023
Date last updated: 18 July, 2023

Acute inpatient mental health care for adults and older adults

Guidance to support the commissioning and delivery of timely access to high quality therapeutic inpatient care, close to home and in the least restrictive setting possible.

Publication (/publication)

Content

- Summary
- Purpose of this guidance
- Key elements of the inpatient pathway
- Principles of effective inpatient care
- Effective care across the inpatient pathway
- Key enablers of effective inpatient care
- Appendix 1: Legal obligations and inpatient mental health standards
- Appendix 2: Summary of key actions that need to take place across a person's inpatient journey
- Appendix 3: Holistic assessments
- Appendix 4: Example steps as part of the Red to Green approach
- Appendix 5: Skills and competencies for the inpatient workforce
- List of abbreviations
- Contributors to this guidance

Summary

In 2019, the NHS Long Term Plan (https://www.longtermplan.nhs.uk/areas-of-work/mental-health/) was published, together with the NHS Mental Health Implementation Plan (https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/), which set out ambitious, funded plans, to transform mental health services. Shortly after this, the COVID-19 pandemic began, which had a major impact across the health system, including mental health services. As a result of pandemic pressures and the increases in cost of living currently facing households, inpatient mental health services have experienced sustained rises in demand and acuity, which have been particularly challenging due to the current workforce pressures across the NHS.

While adult and older adult acute inpatient mental health teams continue to work hard to deliver high quality care in line with the commitments set out in the NHS Long Term Plan and NHS Mental Health Implementation Plan, feedback from those who work in and access these services indicates that while some people have positive experiences, others can experience issues accessing care that truly meets their needs and supports their recovery. This can include delays to accessing inpatient care and to being discharged, people being placed out of area where it can be challenging for friends and family to visit and disproportionate use of restrictive interventions. Furthermore, issues with the quality of care disproportionately affect certain groups of people, including people from ethnic minorities, people who have a learning disability, and autistic people.

It is vital that every person who needs acute inpatient mental health care receives timely access to high quality, therapeutic inpatient care, close to home and in the least restrictive setting possible. To support this, NHS England has produced this guidance to set out its vision for effective care in adult and older adult acute inpatient mental health services, together with resources and suggestions to support delivery. In this vision:

- Care is personalised to people's individual needs, and mental health professionals work in partnership with people to provide choices about their care and treatment, and to reach shared decisions.
- Admissions are timely and purposeful – When a person requires care and treatment that can only be provided in a mental health inpatient setting and cannot be provided in the community, they receive prompt access to the best hospital provision available for their needs, which is close to home, so that they can maintain their support networks and community links. The purpose of the admission is clear to the person, their carers, the inpatient team and any supporting services.
- Hospital stays are therapeutic – People receive timely access to the assessments, interventions and treatments that they need, so that their time in hospital delivers therapeutic benefit. Care should be delivered in a therapeutic environment and in a way that is trauma-informed, working with people to understand any traumatic experiences they have had, and how these can be supported in hospital, in a way that minimises retraumatisation.
- Discharge is timely and effective – People are discharged to a less restrictive setting as soon as their purpose of admission is met and they no longer require care and treatment that can only be provided in hospital. For this to happen, there needs to be discharge planning from the very start of a person's admission. There also needs to be a range of community support available and supported living options which meet different needs and enable people to maintain their wellbeing and live as independently as possible after discharge.
- Care is joined up across the health and care system – inpatient services work in a cohesive way with partner organisations, at admission, during a person's inpatient stay and to support an effective discharge, so that people are supported to stay well when they leave hospital.
- Services actively identify and address inequalities that exist within their local inpatient pathway, in partnership with people from affected groups and communities. This must include ensuring that people are not prevented from accessing or receiving good quality acute mental health inpatient care simply because of a disability, diagnostic label or any other protected characteristic.
- Services grow and develop the acute inpatient mental health workforce in line with national workforce profiles (https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/), so that inpatient services can offer a full range of multi-disciplinary interventions and treatment. Staff wellbeing, training and development should be supported, so that inpatient services are a great place to work and staff are enabled to offer compassionate, high quality care.
- There is continuous improvement of the inpatient pathway – services strive to improve by 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.

We know that across the country there are services already delivering care that meets a number of these aims. With both the substantial investment in mental health services as part of the NHS Long Term Plan, the Government setting out its intention to reform the Mental Health Act (MHA) in the draft Mental Health Bill (https://www.gov.uk/government/publications/draft-mental-health-bill-2022), and the recent establishment of NHS England's Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme (https://www.england.nhs.uk/mental-health/mental-health-learning-disability-and-autism-inpatient-quality-transformation-programme/), now presents a significant opportunity to ensure that across all elements of this guidance, services are delivering care that is of a standard that we would all be proud of, and always puts people accessing services and those close to them at its heart.

Some perspectives on what good quality care means to people who have personal experience of acute mental health inpatient care, either directly or as a carer, are illustrated by these quotes:

"I would like to have staff on the ward who are compassionate and engaged, who understand my whole holistic and individual needs, and provide therapies and various activities that are meaningful, helpful, are of interest to me, and which feel comfortable for me to do. They should also help me to get better and plan my aftercare so that I can manage when I leave hospital."

"For me, ideal inpatient care is when staff are willing to meet me and my loved ones where we are at each day, without expectations or demands. It's about the service understanding how the small and large decisions that they make can impact my relative and her wider network, and the service being willing to work with us to identify and achieve the best outcomes for my relative, understanding that her needs change and fluctuate."

"Co-production needs to be at the heart of inpatient care. I want to see clinicians and professionals working with me and my carers as equal partners, to develop, deliver and keep under review the best possible inpatient care for my needs. I want to see mental health inequality addressed, through people with lived experience supporting services to meet the needs of people from diverse communities."

“If I need to be admitted, I would like inpatient care that is person-centred and provided in a recovery-focused environment. My admission should be as short as possible so as to not cause unnecessary trauma and there need to be more places that I can go to if I can’t go straight home when I’m ready to leave hospital. The power structures in inpatient settings also have to change, so that power is shared with people on the ward, particularly when they are from a marginalised group.”

Purpose of this guidance

This is the first time that NHS England has published national policy guidance outlining its vision for inpatient mental health care for adults and older adults, including people who also have dementia, an alcohol or drug problem, a learning disability, autism and any other individual needs. The guidance is intended to support integrated care systems (ICSs) and providers of mental health acute wards and psychiatric intensive care units (PICUs) to meet the ambitions for acute mental health care set out in the NHS Long Term Plan (https://www.longtermplan.nhs.uk/areas-of-work/mental-health/) and NHS Mental Health Implementation Plan (https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/), alongside existing legislation and acute mental health standards (see Appendix 1 (https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/#appendix-1-legal-obligations-and-inpatient-mental-health-standards)).

It is hoped that this document will support partnership working between inpatient mental health services and crisis resolution home treatment teams (CRHTTs), community-based mental health and learning disability teams, and other services, including social care providers, local authorities, independent sector providers and voluntary, community and social enterprise (VCSE) sector organisations.

The guidance has been developed in partnership with frontline clinicians and people who have lived experience of accessing inpatient services, either directly or as a carer (see contributors to this guidance (https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/#contributors-to-this-guidance)).

Key NHS Long Term Plan (https://www.longtermplan.nhs.uk/areas-of-work/mental-health/) commitments for adult acute mental health inpatient services:

- Eliminate all inappropriate adult acute mental health out of area placements (a definition of these can be found on the FutureNHS platform (https://future.nhs.uk/connect.ti/AdultMH/view?objectId=76863813) (requires login).
- Improve the therapeutic offer from inpatient mental health services by enhancing access to therapeutic interventions and activities.
- Increase the level and mix of staff on acute mental health inpatient wards, including improving access to peer support workers, psychologists, occupational therapists, social workers, housing experts and other relevant professionals during admission.
- Reduce avoidable long lengths of stay in adult acute mental health inpatient settings (including for people with a learning disability and autism), so that people are not staying in hospital any longer than necessary.
- Reduce the number of people with a learning disability and autistic people in mental health inpatient settings, so that by March 2024, there are no more than 30 adults with a learning disability and/or autism in an inpatient setting, per one million adults.
- Ensure that all inpatient care commissioned by the NHS meets the Learning Disability Improvement Standards (https://www.england.nhs.uk/learning-disabilities/about/resources/the-learning-disability-improvement-standards-for-nhs-trusts/).
- Further information on several of these commitments can be found in the NHS Mental Health Implementation Plan 2019/20 – 2023/24 (https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/). Across the delivery of all of these commitments, consideration must be given to reducing the associated inequalities, involving people in decisions about their care and adapting interventions and activities to meet individual needs and preferences.

Key elements of the inpatient pathway

The diagram on the following page illustrates the key elements that underpin effective acute mental health inpatient care. It is made up of four key principles, three key stages and two key enablers.

The three key stages relate to pre-admission, during the hospital stay and discharge, while the four key principles and the two key enablers apply across the inpatient pathway. Below this diagram, there is also a brief memorandum of the key actions that need to be taken within 72 hours of a person's admission to hospital. Further detail on each of the components of the diagram can be found in the sections of the guidance that follow; a summary is also provided in Appendix 2 (https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/#appendix-2-summary-of-key-actions-that-need-to-take-place-across-a-person-s-inpatient-journey).

KEY ELEMENTS OF THE INPATIENT PATHWAY

THREE KEY STAGES

Purposeful admissions

People are only admitted to inpatient care when they require assessments, interventions or treatment that can only be provided in hospital, and if admitted, it is to the most suitable available bed for the person's needs and there is a clearly stated purpose for the admission.

Therapeutic inpatient care

Care is planned and regularly reviewed with the person and their chosen carer/s, so that they receive the therapeutic activities, interventions and treatments they need each day to support their recovery and meet their purpose of admission.

Proactive discharge planning and effective post-discharge support

Discharge is planned with the person and their chosen carer/s from the start of their inpatient stay, so that they can leave hospital as soon as they no longer require assessments, interventions or treatments that can only be provided in an inpatient setting, with all planned post-discharge support provided promptly on leaving hospital.

TWO KEY ENABLERS

A fully multidisciplinary, skilled and supported workforce.

Continuous improvement of the inpatient pathway.

Using data, co-production and quality improvement methodology.

(https://www.england.nhs.uk/wp-content/uploads/2023/07/image.png)

Key actions that need to have taken place within 72 hours of admission:

- Person's electronic patient record (EPR) reviewed (including identifying any recorded advance choices and reasonable adjustments required); checking back key information from the person's EPR with them and their chosen carer/s and noting any changes/updates.
- Holistic assessment completed and uploaded to the person's EPR.
- Purpose of admission statement and estimated discharge date (EDD) agreed with the person and their chosen carer/s and uploaded to the person's EPR.
- Interventions and treatment for physical and mental health conditions commenced/maintained, and a physical health check completed.
- Formulation review completed and care planning (https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/#care-formulation-and-planning) begun.
- Discharge planning begun – identifying what needs to happen for discharge to occur.

Please note, the term chosen carer/s is used throughout this guidance to indicate that the person should be able to choose who to involve in their care, which may include friends as well as family, and could change over time. For people detained under the MHA, there are additional processes related to a person's Nearest Relative, which must be followed. (NB this may change if and when the draft Mental Health Bill (https://www.gov.uk/government/publications/draft-mental-health-bill-2022?utm_medium=email&utm_campaign=govuk-notifications-topic&utm_source=8df3be5e-ff2b-412c-a481-6f9cf54c2c6f&utm_content=immediately) is passed into law, including the term changing to Nominated Person.)

Principles of effective inpatient care

This section explains the four key principles that are at the heart of good inpatient care. These principles should underpin the delivery of care across a person's entire experience of the inpatient pathway, which begins pre-admission and includes the planning and facilitation of access to effective post-discharge support. In addition to these principles, all services need to be delivered in line with other guidelines, care standards and legislation (see Appendix 1 for details), including the, Equality Act (2010) (https://www.legislation.gov.uk/ukpga/2010/15/contents), Human Rights Act (1998) (https://www.legislation.gov.uk/ukpga/1998/42/contents), Mental Health Units (Use of Force) Act (2018) (https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018/mental-health-units-use-of-force-act-2018-statutory-guidance-for-nhs-organisations-in-england-and-police-forces-in-england-and-wales), the Mental Health Act (1983) (https://www.legislation.gov.uk/ukpga/1983/20/contents) (MHA) and the Mental Capacity Act (2005) (https://www.legislation.gov.uk/ukpga/2005/9/contents) (MCA).

Personalised care, including shared decision-making

Personalised care involves supporting a person in a way that takes account of their preferences, meets individual needs (including any reasonable adjustments required), enables the person to realise their aspirations, and draws on the person's strengths. NHS England's model for personalised care can be accessed on the NHS England website (https://www.england.nhs.uk/personalisedcare/comprehensive-model-of-personalised-care/).

Delivering personalised care requires those providing inpatient mental health care to work as equal partners with the person and their chosen carer/s to reach shared decisions (https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making) about the next steps in the person's care. It also involves recognising that even when in crisis or acutely unwell, people are experts in their own lives and have valuable contributions to make about the support that they need both before, during and after their hospital stay. This approach to personalised care is illustrated in the extract below, which was developed by lived experience members of NHS England's Adult Mental Health Advisory Network:

"…if we are going to truly change things for the better, we need to think about people as a whole – what makes up their lives, and their needs, wants and ambitions…These varied and personal needs must be reflected in the support and treatment we receive from public services too.

Here we should be striving for needs based, not diagnosis-based care and treatment…we also need to empower and enable clinicians to work with us to understand our needs as a whole person before agreeing a course of actions to keep us well. We need choice and to practice shared decision-making." Published in the Department of Health and Social Care's Mental Health and Wellbeing Plan: Discussion Paper (https://www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence/mental-health-and-wellbeing-plan-discussion-paper#statement-from-the-lived-experience-advisory-network-at-nhs-england-and-improvement).

Here are some steps that can be taken to support every person in inpatient settings to receive personalised care, which empowers them to make choices about their care and aids their recovery:

- Ensure that the assessment and care planning process is holistic (see further information in the care planning section (https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/#care-formulation-and-planning) and Appendix 3 (https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/#appendix-3-holistic-assessments)) and covers the person's needs, strengths and aspirations. Assumptions about a person's needs, preferences or abilities should not be made based on a disability, diagnostic label or protected characteristic.
- As far as possible, follow any advance choices that a person has made, which outline their preferences for future care and treatment. Any deviations from a person's advance choices need to be clearly explained to the person and/or their chosen carer/s, and recorded.
- Ask the person who is best placed to act as their chosen carer/s and to contribute to discussions about their needs, wishes and aspirations – bearing in mind this may not always be a relative.
    - Explore and record the person's preferences as to what aspects of their care they would like their chosen carer/s involved and the types of information they would like to be shared with their chosen carer/s (and explain the circumstances in which their preferences may not be followed – see pages 78-82 of the MHA Code of Practice (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF) for further information (which includes information on confidentiality whether people are or are not detained in hospital)
    - Check with the person's chosen carer/s that they are comfortable taking on this role and provide them with information about sources of support for carers.
    - In cases where a person does not want certain individuals (eg family members) involved in their care, or for information to be shared with them, this must be respected (within the limits of legislation – see link to the code of practice above for further information). However, these family members should still be given general information about what to expect from inpatient care and the opportunity to discuss their views about the person's needs.
- Ask the person and their chosen carer/s about their communication preferences and identify how these preferences will be met while the person is in hospital, to ensure that people fully understand their rights (including rights under the MHA) and are able to play an active role in their care and discharge planning. For example, this may involve providing access to interpreters, providing information in a range of formats (eg in translation, large print, Braille and Easy Read format, using Augmentative and Alternative Communication (https://www.communicationmatters.org.uk/what-is-aac/), and using video clips and visual diagrams to aid understanding.
- Further information on the requirements for organisations providing NHS care and/or publicly-funded adult social care to make health and social care information accessible, can be found here: Accessible Information Standard (https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/).
- Make it part of ward practice to ask people their preferences, offer them choices about their care and treatment, and regularly check with the person about whether their current care plan is working for them. If the person says that further support is needed to help them to recover, take active steps to put this support in place. Where a person is detained under the MHA or lacks mental capacity to make specific decisions according to the MCA, it may be necessary to make some decisions on the person's behalf, following processes in the relevant legislation. However, there should continue to be a focus on seeking to elicit people's wishes and preferences and giving people as much choice as possible about their care and treatment.
- Make sure people have access to and are supported to meet with independent advocates (including as required under the MHA/MCA) and peer support workers/lived experience practitioners, with a diverse range of experiences and appropriate cultural competency. Ensure that people are aware that they can speak to advocates/peer support workers/lived experience practitioners to gain more information about their rights, how the mental health system works, and for support with communicating their needs, wishes and aspirations.
- Do not use blanket restrictions (https://restraintreductionnetwork.org/wp-content/uploads/2021/10/RRN_PL_tool.pdf) – rules that are applied to everyone regardless of individual risk. Decisions should be made on an individual basis as far as possible. Where there are limits imposed by national restrictions, organisational policy or individual risk assessments, staff members should creatively explore ways of meeting the person's needs and wishes, while still adhering to policies and risk assessments.

The National Institute for Clinical Excellence (NICE) has produced useful guidance on shared decision-making (https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making) and advocacy (https://www.nice.org.uk/guidance/ng227/chapter/Recommendations#effective-advocacy).

Care that advances health equality

The NHS is committed to ensuring that everyone receives high quality health care, regardless of their background. There is also a legal duty to advance equality, diversity and inclusion for everyone accessing health services, as laid out in the Equality Act (https://www.legislation.gov.uk/ukpga/2010/15/contents), including meeting reasonable adjustments. NHS England has set out its plan to deliver more equitable access, experience and outcomes in mental health services in its Advancing Mental Health Equalities Strategy (https://www.england.nhs.uk/publication/advancing-mental-health-equalities-strategy/). As part of this, a Patient and Carer Race Equality Framework (PCREF) (https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/), to improve experiences of mental health services among racialised and ethnically and culturally diverse communities, has been developed and is beingrolled out for implementation in 2023.

At present, there are significant health inequalities (https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/) experienced by people in terms of their access to, experience of, and outcomes from acute inpatient mental health services and it is vital that action is taken at all levels to protect and advance health equality. A wide range of groups may experience inequalities in inpatient mental health services. ICSs and providers of inpatient mental health services are expected to use data and intelligence (including national data sets such as the National Mental Health, Dementia and Neurology Intelligence Network (https://fingertips.phe.org.uk/profile-group/mental-health) and the dashboards linked in this guidance, as well as local intelligence from people with lived experience and complaints data) to identify and monitor groups within their local population who have poorer access, experience, and outcomes from care. A co-production approach should be used to work with these communities to make tangible progress in reducing identified health inequalities.

To support progress in advancing health equality, the following sections provide some ideas on how to enhance the support that is provided to specific groups. These groups have been given additional focus in this guidance based on national-level evidence about the inequalities that they face and information available about some of the actions that can be taken to support these groups in inpatient mental health services. NHS England is however committed to developing further resources to support systems to address the wider inequalities that exist.

When reading the following information, it is important to recognise that people's identities and experiences are multifaceted, and that being a member of multiple groups that experience inequalities may compound poorer experiences of care. Group-level considerations should therefore always be applied in the context of seeing and treating people as individuals, and working with people to put in place personalised care.

People from racialised and ethnic minority communities

People from racialised and ethnic minority backgrounds experience systemic barriers to accessing care and receiving inpatient support that meets their needs. In developing some suggestions to improve the care offered to people from racialised and ethnic minority communities, it is acknowledged that this term encompasses a wide range of people with very different cultural backgrounds and identities. These suggestions are therefore general, with the underpinning aim to centre care on people's individual needs in relation to their race, ethnicity and culture:

- At admission, ask people and their chosen carer/s about how they understand their mental health condition, and plan with them how their cultural, religious, and spiritual needs (including associated dietary preferences) can be best supported while they are in hospital. Check in regularly to find out if these needs are being met.
- Provide key information in different languages and ensure ready access to independent interpreters (instead of relying on family members to translate).
- Provide access to culturally appropriate advocates and peer support workers/lived experience practitioners that reflect racialised and ethnic minority communities, as well as specialist input from VCSE sector organisations and faith-based groups.
- Ensure there are clear routes for reporting racism and discrimination, originating either other people on the ward or staff, as well as for accessing support when racist or discriminatory behaviour is experienced.

- Provide training to support staff to develop their cultural competency and the skills needed to plan and deliver care in a way that is culturally appropriate and does not make assumptions about people's needs based on their appearance or characteristics.
- Monitor key metrics (eg length of stay, rates of detention) by ethnicity and collect feedback on people's experiences of care and use this information to inform action to improve the cultural appropriateness of care.
- Embed the changes outlined in the Patient and Carer Race Equality Framework (PCREF) (https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/) across all aspects of policy, procedure and practice.

People with a learning disability and autistic people

People with a learning disability and autistic people may experience inpatient care that is not adjusted to their needs and they are also disproportionately more likely to experience restrictive interventions while in hospital. For these reasons, the NHS Long Term Plan (https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/a-strong-start-in-life-for-children-and-young-people/learning-disability-and-autism/) made a commitment to reduce the number of people with a learning disability and autistic people in mental health inpatient settings by the end of 2023/24 and work is also underway to reduce long-term segregation and restrictive practice (https://www.england.nhs.uk/learning-disabilities/about/reducing-long-term-segregation/).

To improve the support that people with a learning disability and autistic people receive:

- Ensure that people who are at risk of admission are included on local Dynamic Support Registers and that they have a Care (Education) and Treatment Review (C(E)TR) (https://www.england.nhs.uk/learning-disabilities/care/ctr/care-education-and-treatment-reviews/https:/www.england.nhs.uk/learning-disabilities/care/ctr/care-education-and-treatment-reviews/) in the community pre-admission (or if this is not possible, within 28 days of admission) and that the findings of the C(E)TR inform care planning and delivery.
- Work with the person and their chosen carer/s to understand the person's individual needs and traits, including those relating to communication, interaction, routine, repetition, predictability, food, the sensory environment and any activities or objects that will help their wellbeing. Identify and action the reasonable adjustments that are needed (working with specialist learning disability and autism professionals and other duly qualified professionals, as required) and record key preferences as an alert on the person's EPR. If someone has a Hospital Passport (https://www.mencap.org.uk/advice-and-support/health-coronavirus/health-guides), this should also be used to inform communication with the person and the support they are offered.
- *(Particularly for autistic people)* Make adaptations to the ward environment to create low sensory areas (eg using quiet door closers, replacing overhead fluorescent lights and fitting dimmer switches). See this resource pack (https://www.england.nhs.uk/publication/sensory-friendly-resource-pack/) from NHS England and these principles (https://www.ndti.org.uk/assets/images/Sensory-Friendly-Ward-Principles.pdf) from the National Development Team for Inclusion (NDTi) for more information.
- Ensure that for all people aged up to 25 who have an Education, Health and Care (https://www.gov.uk/children-with-special-educational-needs/extra-SEN-help#:~:text=An%20education%2C%20health%20and%20care,support%20to%20meet%20those%20needs.) (EHC) Plan, it is followed as far as possible during the person's hospital admission and as part of discharge planning, and updated where necessary.
- Ensure all staff working in services registered with the CQC have attended mandatory training on learning disability and autism that is appropriate to their role, in line with the Health and Care Act (2022).
- *(Particularly for autistic people)* Use the Green Light Toolkit (https://www.ndti.org.uk/resources/green-light-toolkit)to regularly audit the service and use the toolkit's resources to improve care for autistic people.

Useful resources include:

- NHS England's Learning Disability Improvement Standards (https://www.england.nhs.uk/learning-disabilities/about/resources/the-learning-disability-improvement-standards-for-nhs-trusts/) which support NHS trusts to measure and improve the quality of care they provide to people with a learning disability and autistic people.
- The Health Equality Framework (https://www.ndti.org.uk/resources/publication/the-health-equality-framework-and-commissioning-guide1), which supports services to measure their effectiveness in terms of addressing the inequalities experienced by people with a learning disability.

- The national service model (https://www.england.nhs.uk/wp-content/uploads/2015/10/service-model-291015.pdf) for people with a learning disability and autistic people who display behaviour that challenges and guidance to support the implementation of the model (https://www.england.nhs.uk/wp-content/uploads/2017/02/model-service-spec-2017.pdf).

People with a co-occurring alcohol and/or drug problem

Alcohol and drug dependence are common among people with mental health problems and are a significant factor in admission and prolonged length of hospital stay. In addition, people with co-occurring mental health and alcohol or drug use problems often experience poor health and earlier death (https://pubmed.ncbi.nlm.nih.gov/21440382/). From 2009 to 2019, 47% of people in the UK who died by suicide and were in contact with mental health services, also had issues with alcohol dependency, and 37% with drug addiction (https://documents.manchester.ac.uk/display.aspx?DocID=60521). Services should act on the principles of 'no wrong door' and 'everybody's job' so that people can access holistic care for both their mental health and alcohol/drug use problems, delivered by staff working in inpatient settings and/or in partnership with specialist addiction services. Here are some suggestions to support this:

- Work in partnership with community alcohol and drug treatment services to provide coordinated care and discharge planning. This may include embedding drug and alcohol workers and peer support workers/lived experience practitioners that have experience of alcohol and drug problems within inpatient teams.
- Screen all people for alcohol and drug use, using a recognised screening tool such as ASSIST-Lite (https://www.gov.uk/government/publications/assist-lite-screening-tool-how-to-use).
- Train all ward staff in how to screen for drug and alcohol use, and to assess and identify alcohol and drug dependence, withdrawal symptoms, and associated acute health needs and risks, including increased risk of suicide.
- Where required, provide medically assisted withdrawal for alcohol or drug dependence and medication to avoid drug withdrawal (eg opioid substitution therapy), delivered promptly by staff with specialist addiction competencies.
- Deliver harm reduction interventions, including take home naloxone to reduce risk of overdose and referral for transient elastography to detect liver disease, to people who need them.
- Safely manage and monitor people who are acutely intoxicated on the ward, being cognisant of the increased risks of intoxication, while at the same time ensuring the person is not excluded.
- Ensure that all people with co-occurring alcohol and drug problems are able to access care in line with relevant clinical guidelines, including those from the NICE (https://www.nice.org.uk/guidance/cg120) and Public Health England (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf).

LGBT+ communities

LGBT+ people are more likely to develop mental health problems than non-LGBT+ people, including being more likely to develop depression and anxiety and being at higher risk of experiencing suicidal thoughts and engaging in suicidal behaviour and self-harm. The reasons why there are higher rates of mental health problems are complex, but one contributory factor is that LGBT+ people often experience prejudice and discrimination, which can also occur when they are in hospital. Some things that can improve the care that LGBT+ people receive in inpatient settings, include:

- Having clear posters and signage within services to show that they are LGBT+ friendly, to help create an open environment.
- Using inclusive language and not making assumptions about people's relationships and gender (including assuming that the gender recorded in their medical record is correct). At admission, it is good practice to sensitively ask people about their sexual orientation and gender identity, and record their preferences (including what pronouns the person uses, which may vary depending on whether they are with family members, friends, with staff members or other people on the ward). The person's name and pronouns should be respected, including managing this with other people on the ward.
- Identifying what support the person needs in relation to their sexual orientation and gender identity during their hospital stay. For example, this could include having access to peer support workers/lived experience practitioners that are LGBT+, linking people in to support from VCSE sector organisations, and ensuring continued access to gender affirming care (eg hormone replacement therapy, access to appropriate clothes and prostheses).
- Allocating trans individuals to the appropriate ward, in line with guidance on same-sex accommodation (https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/05/NEW-Delivering_same_sex_accommodation_sep2019.pdf).

- Providing appropriate privacy for personal care and being aware of why this might be specifically important if the person is trans/non-binary/gender fluid.
- Being trauma-informed and aware of how someone's sexual orientation or gender identity may have impacted on their mental health.
- Having clear procedures for responding appropriately to any reports of homophobic or transphobic abuse or sexual safety incidents.
- Providing training (eg ally training), which helps the inpatient team to understand the challenges that people who are LGBT+ experience within healthcare and society and how to ensure inpatient care is inclusive of LGBT+ people's needs.
- Further information for healthcare professionals on providing inclusive care for LGBT+ individuals can be found in the ABC of LGBT+ Inclusive Communication (https://www.kcl.ac.uk/nmpc/assets/research/projects/abc-lgbt-inclusive-communication.pdf).

Older adults and people with dementia

Older adults and people with dementia are particularly vulnerable to delirium, falls, poor nutrition and functional decline while in hospital, all of which can result in increased length of stay. This can be exacerbated by difficulties in identifying the required community-based support to enable timely discharge. For example, in 2021/22, length of hospital stay in older adult acute inpatient mental health services was around 80 days nationally compared to around 40 days in general adult acute services.

To support older adults and people with dementia effectively, ensure that there is:

- Engagement with the person's chosen carer/s on admission and in all discussions about the person's care and discharge. Carers can bring helpful insights about the person's needs, for example, in relation to their daily routine, communication preferences, sensory needs, food preferences, and any activities or objects that will help the person's wellbeing.
- A process in place to ensure that older adults with dementia arrive and leave hospital with their 'This is me' (https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/background-docs/24-thisisme.pdf) form; and that older adults living in a care home arrive and are discharged with their Red Bag (https://www.england.nhs.uk/wp-content/uploads/2018/06/quick-guide-redbag-hospital-transfer-v1.pdf); and that the information contained within these resources is used to tailor the person's care to their needs.
- Access to all the items the person needs to improve their communication and independence, eg glasses, working hearing aids and walking aids.
- Specific focus placed on strengths, life goals and aspirations (including employment) when planning and delivering care, as these can be overlooked for older adults.
- Regular review of physical health conditions and medications, to ensure that the person's physical health needs are met and are not impacting negatively on their mental health, and to check that any physical health medications are not interacting with the person's mental state and with any psychotropic medications that the person is taking.
- Access to interventions and activities that take into account any physical or cognitive needs, including dementia.
- Early discussion about the intended discharge location with the person and their chosen carer/s. Online and printed information should be provided to support decision making if someone requires new accommodation or a placement, and proactive action taken to put this in place. For people with dementia, in particular, it can help if they are able to visit the intended discharge location prior to discharge if it is new to them, and discharges late in the day should be avoided, as this can increase disorientation.
- Access to specialist advice and support, eg geriatricians, palliative care, occupational therapists and physiotherapists (to aid rehabilitation), and social care staff (who can help to facilitate complex discharges).
- Appropriate signage, lighting, soft furnishings and flooring on the ward, to maximise independence for people with dementia. In addition, curtains should be closed in the evening as reflections in windows can be misinterpreted and cause distress.

There may be occasions, based on clinical judgement, when it is appropriate to admit an older adult to a general adult ward (eg because they are well known to staff there) or to admit a younger adult to an older adult ward (eg because of physical health issues such as incontinence issues that would be best managed there). Where an older adult is admitted to a general adult ward, their frailty and acuity should be considered in the risk assessment, and reasonable adjustments made. Adjustments should also be made when a younger adult is admitted to an older adult ward, to ensure the person receives care that is appropriate for their needs.

People who are given a diagnosis of 'personality disorder'

People who are given a diagnosis of personality disorder have particularly poor experiences of inpatient care, including facing prejudices and assumptions about what is driving their distress, and potentially unsafe exclusionary practices. Some people given this diagnosis think that the personality disorder construct is inappropriately applied and feel that it overshadows and invalidates the real issues leading to distress, self-harm and suicidal ideation, and therefore the construct in itself causes further harm.

Some actions that can be taken to improve the care for people given a diagnosis of personality disorder are:

- Listening to how people describe and understand their distress, mirroring their language and offering care based around their mental health needs rather than diagnostic labels, in recognition that some people who are given a diagnosis of personality disorder do not agree with the construct.
- Recognising the role that trauma may have played in a person's life and their current mental health needs, and seeking to understand how to support them best while they are in hospital, in a way that minimises triggers and retraumatisation. This will involve building therapeutic relationships, offering validating, compassionate support, and working with the person to understand their triggers and how to increase their sense of safety and control while in hospital. See the trauma-informed care section for further detail.
- Emphasising to people that they have a choice over the treatments and interventions they receive and that they can decline treatments if they do not want them (within the limits set out in the MHA and MCA).
- Ensuring staff working in inpatient settings have received training on personality disorders, co-delivered with people with lived experience of the diagnosis.
- Arranging for a trauma specialist and peer support worker/lived experience practitioner to meet people currently experiencing long hospital stays to identify what additional support the person needs to return home and stay well in the community.
- Ensuring that all care is delivered in line with NICE guidelines (https://www.nice.org.uk/guidance/cg78) and quality standards (https://www.nice.org.uk/guidance/qs88/chapter/List-of-quality-statements), and that members of inpatient teams attend and apply Knowledge and Understanding Framework (KUF) (https://www.kuftraining.org.uk/) training on the ward.

People admitted out of area

People that are placed in an inpatient service outside their local area have longer lengths of stay on average, poorer clinical outcomes (including increased risk of suicide) and poorer experience of care. This is often due to the negative impact of being out of area on the continuity of their care and reduced contact with people in their support network. When someone is placed out of area, the care they receive should be as close as possible to the care they would have received locally. This includes:

- The person's named key worker staying in contact with the person and visiting the person in hospital as regularly as they would have if the person was in hospital in their local trust.
- The person receiving support to maintain regular contact with their chosen carer/s and support network. This must include funding the costs of transport and accommodation to facilitate visits, as well as supporting the use of technology to aid remote communication.
- Supporting the person, as far as possible, to engage in their usual activities and to maintain their responsibilities (eg the upkeep of their home).
- Peer support workers/lived experience practitioners from the person's local trust keeping in regular contact (minimum weekly).
- The local hospital team maintaining involvement with the person's care, with the aim of returning the person to their local hospital as soon as a bed becomes available, unless this would be disruptive and unhelpful to the person's recovery.

When a person is admitted out of area, data must be flowed about the admission by the sending and receiving provider. Further information about how to do this can be found in this webinar (https://digital.nhs.uk/news/events/2021-events/mental-health-services-dataset---out-of-area-placements-oaps-webinar). In addition, the FutureNHS platform (https://future.nhs.uk/AdultMH/view?objectID=31055152) (requires login) provides access to webinars held with NHS trusts that have had success in reducing the number of people placed of area, as well as the definition of an out of area placement, and details of continuity of care principles. ICSs are expected to monitor compliance with these principles where there is out of area bed use.

Trauma-informed care

Many adults and older adults accessing mental health services and particularly people requiring an inpatient admission, will have experienced trauma at some point in their lives. Furthermore, when people are admitted to hospital, and particularly when a person is detained under the MHA or is subject to a restrictive intervention, it is often accompanied by feelings of loss of power and control, and can be traumatic. It is therefore important that services work to ensure that the support that is offered in hospital is underpinned by a trauma-informed approach (https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice), both in terms of the way that care pathways are organised and how care is delivered.

Trauma-informed care first involves recognising that many people in contact with mental health services will have experienced trauma. Staff should talk to the person and their chosen carer/s to understand the role that trauma has played in a person's life and how it is currently impacting their life and wellbeing. In discussing people's life experiences and traumas with them, it is important to remember that for some people, asking them to recount their personal story and traumatic experiences, can in itself be retraumatising. Therefore, it is important to make use of what is already known and recorded about a person (eg in their EPR) and give the person choice about whether they wish to discuss these aspects of their life again.

To help restore feelings of control, active efforts should be made to give the person as much choice as possible while they are in hospital, and to work in close collaboration with the person, so that they are at the centre of their care planning. This should include gaining an understanding of how to support the person in a way that reduces the likelihood that they will be triggered or further traumatised by being in hospital, as well as coming to shared decisions with the person about whether they need specific support to help them process any traumatic experiences that they have had.

The physical and emotional environment on the ward should also promote feelings of safety and recovery and members of the inpatient team should work to build therapeutic relationships with people that are based on trust, respect and compassion. For this to happen, it is essential that there is a positive ward culture, where the use of restrictive interventions, including restraint and seclusion, is not seen as standard practice, and where restrictive interventions are used, it is as a last resort, proportionate to the situation and for the minimum time necessary. Managers should undertake regular reviews of practice, to ensure that where restrictive interventions are used, it is absolutely necessary and is applied proportionately.

Furthermore, in order that members of the inpatient team are able to promote positive ward cultures and build therapeutic relationships that keep individual stories at the heart of care delivery, it is essential that their own wellbeing is supported. Services should have processes in place, including reflective practice and supervision, which help team members to process their own thoughts, feelings and reactions to situations that have occurred on the ward, as well as any traumatic experiences they have had outside work (see the workforce section for further details).

The following links provide information to support services to transform the culture of inpatient wards to make them trauma-informed, both in terms of supporting people in a way that recognises and is responsive to the trauma that they may have previously experienced, and in terms of helping to ensure that inpatient care does not itself unintentionally lead to people experiencing new traumas (for example, as a result of inappropriate and disproportionate use of a restrictive intervention):

- Central and North West London NHS Foundation Trust's webpages on trauma-informed approaches (https://www.cnwl.nhs.uk/services/mental-health-services/cnwl-trauma-informed-approaches-tia).
- The Power Threat Meaning Framework (https://www.bps.org.uk/member-networks/division-clinical-psychology/power-threat-meaning-framework), developed by a network within the Division of Clinical Psychology at the British Psychological Society, which can be used to support a trauma-informed understanding of human distress.
- The Centre for Mental Health and the Mental Health Foundation's guide to providing effective trauma-informed care for women (https://www.centreformentalhealth.org.uk/publications/engaging-complexity).
- Surrey and Borders NHS Foundation Trust's trauma-informed care toolkit for carers (https://www.bild.org.uk/wp-content/uploads/2021/02/Trauma-Informed-Care-Toolkit-pdf-SABP.pdf), which has a specific focus on people with a learning disability, as well as these webpages from The Challenging Behaviour Foundation on trauma support for people with a learning disability (https://www.challengingbehaviour.org.uk/information-and-guidance/when-things-go-wrong/trauma-support/).
- The Reducing Restrictive Practice Collaborative (https://www.rcpsych.ac.uk/improving-care/nccmh/quality-improvement-programmes/MHSIP-reducing-restrictive-practice/reducing-restrictive-practice), Restraint Reduction Network (https://restraintreductionnetwork.org/toolsandresources/) and Safewards project (https://www.safewards.net/) (see also Safewards

Victoria (https://www.health.vic.gov.au/practice-and-service-quality/safewards-victoria)) webpages, which provide practical information on interventions that can support reductions in conflict and restrictive practice on wards.

- NHS England's webpages on reducing long term segregation and restrictive practice (https://www.england.nhs.uk/learning-disabilities/about/reducing-long-term-segregation/) for people with a learning disability and autistic people, who disproportionately experience these practices. This details information on a number of initiatives including Independent Care (Education) and Treatment Reviews, the HOPE(S) model and the Senior Intervenors Project.
- The Sexual Safety Collaborative (https://www.rcpsych.ac.uk/improving-care/nccmh/quality-improvement-programmes/sexual-safety-collaborative) – includes guidance and ideas for changing practice to improve sexual safety in inpatient mental health settings.
- Guidance from the Department of Health and Social Care (https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018) setting out the measures that NHS hospitals and independent hospital providing NHS-funded care must take as part of the Mental Health (Use of Force) Act (2018) to prevent inappropriate use of force in mental health units, including training requirements for staff.

Joined up partnership working

Inpatient services that work closely with a range of other services (see box below for examples) in a collaborative and coordinated way, are more likely to meet people's varied needs, contributing to improved experiences and outcomes from care and reducing avoidable time spent in hospital. It is particularly important that where someone is transferred from another service, for example, children and young people's mental health services, that there is strong coordination of care, so that the transition is as supportive as possible.

As part of the initial assessment and admissions process, it is important to read the person's EPR to identify who they currently receive support from and which services they are in contact with, and to check this back with the person and their chosen carer/s. Resources such as the Circles of Support (https://www.hse.ie/eng/services/list/4/disability/newdirections/a%20guide%20to%20circles%20of%20support.pdf) can be used to help identify the key individuals, communities and services in a person's life.

It is also important to find out and record people's preferences about what types of information is shared with the people and services that support them and how they would like them involved in their inpatient care and discharge. The circumstances in which these preferences may not be followed should be explained (see pages 78-82 of the MHA Code of Practice (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF) (which includes information on confidentiality whether people are or are not detained in hospital). Where people require reasonable adjustments or have additional needs that fall outside the remit of inpatient mental health services, expertise may need to be sought from specialist services (eg learning disability, autism, drug and alcohol teams). Commissioning arrangements should enable easy referral and responsive input from such teams.

Many people who are admitted to hospital will already be in contact with a community-based mental health or learning disability team and have a named key worker. On admission, anyone without a named key worker should be assigned one within 72 hours, wherever possible. Key workers should maintain contact with the person while they are in hospital and pass on any information that is useful for the person's care, to help avoid the person having to undergo repeat assessments and retell their story, which can be frustrating and trigger past traumas. The key worker should also work closely with the inpatient team, CRHTT, and any other key services or parties, to identify and put in place the support that the person will need to be discharged and to maintain their wellbeing in the community (including working with local authorities to plan Section 117 (https://www.rethink.org/advice-and-information/rights-restrictions/mental-health-laws/section-117-aftercare-under-the-mental-health-act-1983/) aftercare, where applicable). It is important that this is done early and in partnership with other services so that the person's discharge from hospital to the community is as smooth as possible.

Here are some actions that can be taken to embed effective partnership working:

- Ensure there are clear pathways between services (eg between physical health and mental health services) and joint working arrangements are agreed with partner organisations, which include information on the management of transitions (eg from children and young people's inpatient services to adult inpatient services).
- Review the inpatient mental health pathway to understand how partnership working is currently functioning and how to strengthen it. For example, this could involve senior system partners and lived experience practitioners coming together on a quarterly basis to review performance data and local intelligence, assess where there are pressures across the pathway and identify actions to drive improvement.

- Integrate members of key partners organisations, for example, social workers and housing officers, as part of the ward team's staffing establishment.
- Ensure cross-service attendance at key meetings (eg care planning and discharge meetings, and other reviews). This should include representatives from the local CRHTT, the person's named key worker from the community-based mental health or learning disability team and any other key partners in the person's care (see box below for examples), as well as anyone that the person and their chosen carer/s feel it would be helpful to have in these meetings.
- Hold joint training between services that work with one another, where relevant, to understand the types of expertise that different services and professionals offer, as well as to reflect on and improve joint working processes. As an example, this could be used to share reflections about what more could be done to avoid escalation to admission, or to identify situations in which people are better cared for in the community.
- Develop clear escalation protocols with cross-agency partners, which set out when and how to raise issues to senior managers – the protocols should clearly identify where senior responsibility sits along with contact details to enable timely escalation to occur. Escalation protocols should exist for occasions when there are long waits in A&E, challenges in locating inpatient provision for urgent admissions, and delayed discharges from hospital. These protocols should be developed and maintained by the ICS, with input and agreement from NHS mental health providers and relevant partners included in the box below, who are key to the operation of the local pathway. More information about Section 140 compliant escalation protocols is set out in this section of the guidance.

Key services for effective partnership working in inpatient mental health care

Please note, this is not intended to be exhaustive.

- CRHTTs
- Community-based mental health teams
- A&E, psychiatric liaison and diversion services
- Primary care
- Pharmacy services
- Services addressing sexual health and physical health needs (including community health, intermediate care and frailty services for older adults)
- Children and young people's mental health services
- Community learning disability services and specialist autism services
- Gender identity services
- Drug and alcohol services
- Specialist trauma services
- Local authorities, in particular, Approved Mental Health Professional (AMHP) services, expert housing teams, and children and adult social care teams, including safeguarding specialists and those responsible for conducting needs assessments (https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/getting-a-needs-assessment/) and arranging Section 117 aftercare (https://www.rethink.org/advice-and-information/rights-restrictions/mental-health-laws/section-117-aftercare-under-the-mental-health-act-1983/) (in partnership with integrated care boards (ICBs)
- Housing services (offering home adaptations and short- and long-term housing options)
- Rehabilitation services providing advice and specialist intervention
- Carers support services
- Financial support services providing advice on benefits and funding of ongoing care
- Employment support services
- Education services – including schools and further and higher education providers
- Criminal justice agencies, including probation and the police
- Independent sector providers (especially where people are placed in a non-NHS inpatient service)
- VCSE sector organisations providing advocacy services, peer support, community crisis alternatives, and in-reach services for specific groups, including people from racialised and ethnic minority communities.

Effective care across the inpatient pathway

For people to have the best recovery possible, they need to receive effective care from pre-admission, during their hospital stay and after discharge. This includes ensuring:

- **Admissions are purposeful** – people are only admitted to inpatient care when they require assessments, interventions or treatment that can only be provided in hospital, and if admitted, it is to the most suitable inpatient service provision available for the person's needs and there is a clearly stated purpose for the admission.
- **Their inpatient care delivers therapeutic benefit** – care is planned and regularly reviewed with the person and their chosen carer/s, so that they receive the therapeutic activities, interventions and treatments they need each day to support their recovery and meet their purpose of admission.
- **Their discharge is proactively planned and effective** – the person's discharge is planned with them and their chosen carer/s from the start of their inpatient stay, so that they can leave hospital as soon as they no longer require assessments, interventions or treatments that can only be provided in an inpatient setting, with all planned post-discharge support provided promptly on leaving hospital.

The sub-sections that follow explain each of these stages of the inpatient journey in more detail.

Purposeful admissions

Ensuring that people are only admitted to inpatient care when they require assessments, interventions or treatment that can only be provided in hospital, and if admitted, it is to the most suitable available inpatient service provision for the person's needs, and there is a clearly stated purpose for the admission.

Deciding whether an inpatient admission is required, or the person could be supported through a less restrictive community-based acute care model

When people are in crisis, they require prompt access to the right support, in the best setting for their needs. For people with a learning disability and autistic people, a C(E)TR should normally take place pre-admission, in line with current policy (https://www.england.nhs.uk/learning-disabilities/care/ctr/care-education-and-treatment-reviews/), to understand the person's needs and determine if they could be met in the community or whether they require an inpatient admission. For people who do not have a learning disability or autism, a holistic face-to-face assessment (see Appendix 3 (https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/#appendix-3-holistic-assessments)) should be conducted to understand the person's care needs and preferences in relation to treatment.

This assessment should include identifying who the person's chosen carer/s are and what their views are about the person's care. To avoid the person needing to retell their story, the person's EPR should be reviewed at the earliest opportunity, ideally prior to their initial assessment, to gather information from any prior assessments and care plans and to identify any advance choices. This information should be checked back with the person and their chosen carer/s in case there have been changes.

Based on the assessment and taking the person's wishes into consideration as far as possible, a decision should be made about whether it would be better for the person to be admitted to hospital (including admission under the MHA) or whether it would be better for the person to be supported in the community. This may through support from a community-based acute mental health service, such as a CRHTT, acute day service or crisis house, or an intensive support team, for people with a learning disability (examples of community-based alternatives to inpatient care can be found in the case studies section on the FutureNHS platform (https://future.nhs.uk/AdultMH/view?objectId=51768613) (requires login). Given that long lengths of stay in hospital can in themselves be harmful, decision-making needs to explicitly consider whether a hospital admission is essential because the person requires assessments, interventions and/or treatment that can only be provided in hospital and could not be delivered through community-based acute services.

Though it will not always be the case, often receiving care and treatment at home or in a less restrictive community setting can lead to a better experience of care because it means that the person can more easily maintain existing routines, access to their usual support network and can stay in a more familiar location. This is illustrated in the extract below from someone who experienced a mental health crisis:

“Fortunately, one nurse who was caring for me went above and beyond to see that I was not admitted. He talked to my wife, who deemed it would be better for me to be cared for at home. No one else did this or took it upon themselves to find out my background and what happened that brought me to this point. The nurse was persistent with their encouragement and support and fought long and hard to ensure the wrong decisions were not made. I even remember him challenging the doctor who wanted to admit me… All these things had a huge impact on my recovery and eventually helped me to start caring for myself again.”

There are two main models used by providers to assess whether an inpatient admission is required, or the person could be supported through a community-based acute model:

- CRHTTs conducting all assessments for acute care, because of their expertise in knowing the care and treatment options available locally, including community-based acute care and inpatient care.
- A trusted assessor model in which CRHTTs are responsible for conducting most acute care assessments (eg those that come in via referrals to the CRHTT or the single point of access), but other teams, eg psychiatric liaison and community-based mental health teams, may complete assessments and CRHTTs then base decision-making about the most appropriate care option on this assessment and do not have to see the person face-to-face.

Regardless of which model is used, it is important that:

- Repeat assessments by different services are reduced wherever possible, as well as the need for people to wait for teams to arrive to conduct assessments.
- CRHTT clinicians are empowered to lead decision-making, working in close partnership with the person and their chosen carer/s and partner services, whose expertise may be useful to reach decisions about the most appropriate care setting. For example, involving AMHPs early on in the assessment process can support consideration of less restrictive alternatives to detaining people under the MHA. To help partnership working in relation to deciding the most appropriate care setting:
- There should be a policy setting out roles and responsibilities in relation to crisis and acute assessments, which provides details of inpatient and community-based acute services available locally, together with key referral information.
- There should be regular reviews of need versus capacity across the different inpatient and community-based acute services available locally, to ensure the system is set up to meet the current population need.
- CRHTTs, psychiatric liaison teams, inpatient teams and AMHP services should aim to operate as part of one wider team, communicating regularly in relation to team capacity and presentations in the community and A&E. This helps to build relationships and trust and enables more informed decision-making around the most appropriate care setting.
- Where someone needs to be assessed under the MHA, there should be clear protocols in place locally for securing the necessary input from Section 12 approved doctors (https://www.legislation.gov.uk/ukpga/1983/20/section/12) and an AMHP in a timely way, and ensuring all key information is communicated to support the assessment.
- All services involved in conducting assessments (including CRHTTs, psychiatric liaison services and AMHPs) that feed into decisions around admission, meet regularly to share feedback and to address issues, so that all parties have confidence that admission decisions are being made appropriately, consistently and in people’s best interests.
- There is senior clinical oversight to check that there is clarity and consistency around decision-making in relation to whether people receive community-based acute care or are admitted to hospital.

Agreeing a purpose of admission

When it is judged that an inpatient admission is required, the reasons identified for this should be formalised in a purpose of admission statement, which clearly articulates why an inpatient stay is needed and the aims of the admission (see box below for example statements). Evidence from local quality improvement initiatives has shown that when a purpose of admission is recorded, it reduces the risk of people staying in hospital longer than needed. Furthermore, the intended reforms to the MHA, outlined in the draft Mental Health Bill (https://www.gov.uk/government/publications/draft-mental-health-bill-2022?utm_medium=email&utm_campaign=govuk-notifications-topic&utm_source=8df3be5e-ff2b-412c-a481-6f9cf54c2c6f&utm_content=immediately), include new detention criteria requiring admissions to provide therapeutic benefit. By recording a purpose of admission, it helps to ensure that the inpatient team is clear on the therapeutic benefit that an admission should achieve and can work with the person, their chosen carer/s and any relevant partner services to achieve it.

Formalising a purpose of admission should be done for each person admitted to hospital, regardless of the time of day or who is doing the assessment, and should follow a consistent process that is established by the provider (eg incorporating it into initial assessment forms). It should be uploaded to the person's EPR, together with an EDD. The purpose of admission and the EDD should also be shared with the person, and where appropriate, with their chosen carer/s and relevant partner services.

Examples of good (*) and poor quality (×) purpose of admission statements
* Ayele, who is being supported by the Early Intervention in Psychosis service, is having a relapse in the community following a breakup with her partner, and has stopped taking her clozapine medication. It is known that re-starting Ayele on medication at home will not be successful and therefore hospital admission will be used to identify why she stopped taking the clozapine medication, including whether any aspects of her care plan need changing to address the reasons identified. One thing that Ayele mentioned at admission was feeling lonely so her ongoing care plan will need to include support in helping her to address this. EDD: 14 days. * Krish has been receiving treatment for a diagnosis of bipolar disorder from a community mental health team, alongside support from his local drug treatment service. He was doing well with managing his bipolar and drug use, until the death of his uncle. On Friday, he attended the local A&E, having made a serious attempt to take his own life. He had not taken his daily medication for more than four days. An admission is required to re-establish his medication and to understand what would help him to manage his bereavement. This support will then be put in place as part of his ongoing care plan. EDD: 21 days. * Reggie has recently become homeless and has been brought to a health-based place of safety by the police, because he was displaying a high level of mental distress in public. He is not known to mental health services. Reggie has been assessed as requiring admission under Section 2 of the MHA. Admission will be used to assess his mental state and identify his strengths, needs and aspirations, including how he usually manages in his day to day life, why he became homeless and what factors contributed to his mental health crisis. This will inform his ongoing care plan, including setting out which pharmacological, psychological, social and practical interventions are required to support Reggie's recovery in the community. EDD: 21 days. × Mike required admission under Section 3 of the MHA. EDD: unknown. × Aarvi has been admitted to maintain their safety. EDD: Will be discharged once risk assessment shows it is safe to discharge Aarvi.

Arranging prompt access to the most suitable hospital provision for the person's needs

It is expected that when someone requires an admission, they will receive prompt access to the most suitable inpatient service that is available for their needs and begin receiving inpatient support as swiftly as possible. If someone is experiencing an unacceptably long wait for an inpatient bed and this has not been resolved through routine processes such as bed management meetings, then system-wide escalation protocols should be followed. These escalation protocols should be developed and shared with multi-agency partners (eg local authority, police and A&E departments) and must be compliant with Section 140 of the MHA (https://www.legislation.gov.uk/ukpga/1983/20/section/140), which is a duty on local NHS commissioning bodies to provide every local social service authority with a list of hospitals that can receive urgent mental health admissions, and enable applications under the MHA, if necessary. On a regular basis, including after an escalation protocol has been activated, multi-agency reviews should take place to help identify what more can be done to unlock capacity across the system and help ensure that people can access inpatient mental health services in a timely way when they need them.

Other than in exceptional circumstances, it is usually best for people to be admitted to their local acute inpatient mental health service, so that they can more easily maintain contact with friends, family and local community care teams. There are a small number of circumstances in which it is appropriate to admit someone out of area who requires a non-specialist acute mental health admission. These are:

- personal choice
- an emergency admission (eg where someone is visiting or on holiday in another area of the country)
- safeguarding concerns if the person was to be placed in their local hospital

- the person being a member of staff at the local trust.

Where one of these reasons applies, admission to a non-local hospital should be facilitated.

Where someone is admitted out of area and none of these reasons apply (ie it is an inappropriate out of area admission (https://future.nhs.uk/connect.ti/AdultMH/view?objectId=76863813)), this should be communicated to the senior responsible clinicians within the local provided, and the good practice suggestions provided earlier in this document should be followed. Furthermore, as soon as clinically appropriate, the person should be transferred back to their local hospital, unless there is a good reason not to (eg it will disrupt the person's continuity of care, or the person wants to remain in the current hospital setting).

Therapeutic inpatient care

Care is planned and regularly reviewed with the person and their chosen carer/s so that they receive the therapeutic activities, interventions and treatments they need each day to support their recovery and meet their purpose of admission. Purposeful care in a therapeutic environment supports people to get better more quickly and reduces avoidable time spent in hospital.

Once a person has been admitted to hospital, they should receive care that delivers therapeutic benefit throughout their inpatient stay. This section of the guidance covers some of the key areas that acute mental health services should focus on to deliver high quality, therapeutic inpatient care.

Care formulation and planning

To understand and plan the support and interventions that an individual needs to meet their purpose of admission and to receive therapeutic inpatient care, a formulation review should take place within 72 hours of admission. The purpose of this formulation review is to build on information from the person's EPR, including any prior assessments, existing care plans and recorded advance choices, to develop a holistic and compassionate understanding of the individual. This includes their current experiences and difficulties, what led to their admission and the reasons behind why they are showing signs of mental distress (including any current or past trauma). The formulation review should also look at the person's treatment and support preferences, what they want their recovery to look like, their strengths, and any protective factors (eg supportive relationships, activities, and routines) that will help them to get better.

Building on the formulation process, a care plan should be co-produced (https://www.nice.org.uk/guidance/ng53/resources/tailored-resources-4429245855/chapter/3-co-producing-comprehensive-care-plans-that-meet-peoples-changing-needs#the-guideline-and-legislation-3) with the person and their chosen carer/s (please note, it will be a statutory requirement for people detained under the MHA to have a Care and Treatment Plan, if and when the draft Mental Health Bill (https://www.gov.uk/government/publications/draft-mental-health-bill-2022?utm_medium=email&utm_campaign=govuk-notifications-topic&utm_source=8df3be5e-ff2b-412c-a481-6f9cf54c2c6f&utm_content=immediately) is passed into law). The care plan should include information on the assessments, interventions and activities that will be delivered while the person is in hospital and any considerations in terms of the way that the support is delivered. As part of early discharge planning, the care plan should also include information on what support will be needed after discharge (including housing and social care) to support the person's recovery and maintain and improve their longer-term wellbeing. See the Discharge section for further details.

To ensure that everyone is clear on the actions that will support the person's recovery and their role in delivering this, the written care plan should be uploaded to the person's EPR and shared with the person, and where appropriate, their chosen carer/s and any other relevant parties. The copy that is shared should be in a format that is accessible (eg free of acronyms and jargon), and where required, provided in alternative formats, such as in translation.

Both formulation and care planning work best when it is a collaborative process between the person, their chosen carer/s, the inpatient multi-disciplinary team (MDT) and representatives from partner services who know the person well and are involved in supporting the person (eg the person's named key worker, housing officer or advocate). An atmosphere of shared learning should be created, with equal value placed on the perspectives of each person involved. For some services, co-producing care plans (https://www.nice.org.uk/guidance/ng53/resources/tailored-resources-4429245855/chapter/3-co-producing-comprehensive-care-plans-that-meet-peoples-changing-needs#the-guideline-and-legislation-3) will involve a shift in the way that teams usually work, to one in which the power to make decisions is shared with the person and their chosen carer/s.

In some cases, the person may not be ready or able to be fully involved in co-producing (https://www.nice.org.uk/guidance/ng53/resources/tailored-resources-4429245855/chapter/3-co-producing-comprehensive-care-plans-that-meet-peoples-changing-needs#the-guideline-and-legislation-3) their formulation review or care plan, particularly at the start of their admission. In these instances, it is still important that the inpatient team listens to the person, offers the person choices and seeks to find out their needs and preferences, drawing on information including from their chosen carer/s, named key worker and EPR. As soon as it is possible, it is vital that the inpatient team engages the person fully in co-producing (https://www.nice.org.uk/guidance/ng53/resources/tailored-resources-4429245855/chapter/3-co-producing-comprehensive-care-plans-that-meet-peoples-changing-needs#the-guideline-and-legislation-3) and refining their care plan. Where there are reasons that care cannot be delivered in line with the person or their chosen carer/s preferences, this should be clearly explained to them, recorded in the person's EPR and revisited at a later stage, wherever possible.

Delivering therapeutic activities and interventions

In line with their purpose of admission and care plan, each person should receive access to the assessments, activities, interventions and treatment that they need, which aid their recovery and improve their ability to respond to future crises. The additional funding allocated to therapeutic inpatient care through the NHS Long Term Plan (https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/) is intended to support providers to achieve this, particularly through increasing the number of therapeutic staff in inpatient settings, including occupational therapists, peer support workers and psychologists, who can support the delivery of a range of activities and interventions.

Interventions

As part of person-centred care planning, the evidence-based interventions that the person will receive in hospital should be agreed with the person and their chosen carer/s. These interventions should meet the person's holistic needs (pharmacological, psychological, social and practical), and be delivered in a way that is culturally appropriate and adjusted to meet individual needs. For example, for people with a learning disability and autistic people, this could include providing one-to-one support to enable participation.

The range of interventions that should be offered on wards, and delivered to people based on their individual needs and care plans, includes:

- Physical health support
  - On admission, any known physical health conditions should be identified, and any existing treatment/management plan should be continued in hospital (appropriate advice should be sought if any changes are needed).
  - A physical health check should be completed within 72 hours of admission. This should consider height and weight, heart rate and blood pressure, blood glucose and lipid profile, the physical effects of medication, sexual health, use of cigarettes, alcohol and drugs, and any other areas depending on clinical need (without rescreening for conditions that are already known and which the person is receiving treatment for). Assessments should be optional (except where clinically necessary), the reasons for doing them clearly explained, and they should be conducted sensitively to avoid discomfort and distress.
  - A physical health plan should be developed with the person and their chosen carer/s based on the physical health check. This may cover diet and exercise, treatment to manage long-term conditions (eg diabetes, cardiovascular disease), sexual health, smoking cessation, and alcohol and drug use (including detox and managing withdrawal).

- Psychotherapy – people's need for psychology input, including ongoing therapy when the person leaves hospital, should be assessed as part of care and discharge planning. This guide (https://acpuk.org.uk/new-guidance-on-psychological-services-within-the-acute-adult-mental-health-care-pathway/) from the Association of Clinical Psychologists and the British Psychological Society provides useful information on psychology input across the acute mental health pathway, while this quality statement (https://www.nice.org.uk/guidance/qs142/chapter/Quality-statement-4-Tailoring-psychological-interventions) from NICE provides specific information in relation to psychological interventions for people with a learning disability.
- Relapse prevention – individual or group support, particularly for people who are approaching discharge, to help establish strategies for managing their physical and mental health after leaving hospital (including identifying individual triggers and early warning signs of worsening mental health, and how to manage these) as well as to plan their daily routine and identify personal goals for after discharge.

- Medication – regular medication reviews (every 2-3 days) should take place throughout a person's admission, which involve working collaboratively with the person to consider medication type, dosage, interactions and side effects. These resources from NHS England on STOMP (Stopping over medication of people with psychotropic medications) (https://www.england.nhs.uk/learning-disabilities/improving-health/stomp/) can help services to reduce the overuse of psychotropic medication for people with a learning disability and autistic people.
- Peer/lived experience support – group or individual support, provided by peer support workers/lived experience practitioners, with a diverse range of experiences (eg in terms of cultural background, age, diagnosis).
- Education and employment support – considering support to access training, higher and further education, apprenticeships and paid and voluntary work.
- Financial support – including use of the Breathing Space debt relief scheme (https://www.gov.uk/government/publications/debt-respite-scheme-breathing-space-guidance-on-mental-health-crisis-breathing-space) and guidance on benefits and funding of ongoing care.
- Housing support – for example, this could involve meeting with an in-reach housing officer to discuss accommodation options post-discharge, if the person is not able to return to where they were living pre-admission.
- Specialist support and interventions to meet individual needs, particularly for groups that experience inequalities within the local acute pathway. These may be delivered through VCSE sector services.

Activities

To supplement these interventions, there should be a programme of activities and groups that help to improve people's physical and mental wellbeing. These activities and groups should run daily on each ward, including at weekends and in the evenings.

The types of activities and groups available should be co-produced with people who are currently on the ward and people who have used inpatient services, to suit a variety of interests and needs. There should be age-appropriate and single sex activities offered, and a focus on ensuring that activities are culturally appropriate and appropriately adapted to meet the needs of groups that are identified as experiencing health inequalities. Providers may wish to commission VCSE sector services to support these aims.

It is important that while encouraging participation in activities and interventions, individuals are both given the choice to decline taking part, based on their interests and what they think will be of therapeutic benefit to them. Equally, people should not be denied access to therapeutic activities and interventions based on a disability, diagnostic label or another protected characteristic, including inappropriate judgements about the likely effectiveness of an intervention based on any characteristic.

Examples of the types of activities and groups that may be offered are as follows (this is not intended to be exhaustive):

- Daily ward meetings that are run in partnership with people on the ward and allow people to share their ideas and input into decisions about the running of the ward.
- Daily exercise, fitness classes and other activities that keep people active, eg dance, walking groups, yoga.
- Gardening groups and other activities providing access to the outdoors.
- Life skills groups, which may cover areas such as communication skills, developing positive relationships, diet and healthy eating, money management, sleep hygiene, stress management, and using digital technology.
- Creative activities, eg arts and crafts, music.
- Contact with animals, eg bringing pets onto wards.
- Religious or spiritual groups, including opportunities for prayer and to celebrate festivals.
- Relaxation groups, eg aromatherapy, massage, reflexology.

The Star Wards website (https://www.starwards.org.uk/) contains additional information about many of these and other therapeutic activities, and how to deliver them.

In addition to the activities and interventions above, each person should receive support to help stay connected to friends and family and regular one-to-one contact with a named contact within the inpatient team (or another member of the inpatient team that they have developed rapport with). This helps to ensure that there is a consistent person on the ward that the person can share their feelings and experiences with.

Systems should also ensure that special consideration is given to supporting any dependants under 18 years old and that there is good provision of support for carers, including access to group psychoeducation (see NICE guidance (https://www.nice.org.uk/guidance/ng53/chapter/recommendations)) and support for their wellbeing and wider needs. This may be offered through local carers' support services, and where needed, through arranging a carer's assessment (https://www.nhs.uk/conditions/social-care-and-support-guide/support-and-benefits-for-carers/carer-assessments/). Further information about good practice in terms of involving carers in a person's support can be found in The Triangle of Care Guide to Best Practice in Mental Health Care in England (https://carers.org/downloads/resources-pdfs/triangle-of-care-england/the-triangle-of-care-carers-included-second-edition.pdf). This resource includes a self-assessment tool, which services can use to assess how well they are working with carers and where improvements could be made.

Using the Red to Green approach

The Red to Green (https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/12/rig-red-green-bed-days.pdf) approach is a helpful tool that can be used to support the allocation of tasks that are needed to deliver a person's care plan (including ensuring that people receive the activities and interventions they need to recover), and to facilitate a timely and successful discharge from hospital. Under this approach, a 'red day' is recorded when a person receives little or no value-adding care, while a 'green day' is recorded where a person receives purposeful care that progresses their recovery and path to leaving hospital. Further detail on what constitutes a red and green day is as follows:

- A red day should be recorded if any of the following criteria are met:
  - The person is receiving care that could be provided in a non-acute inpatient setting.
  - There are delays to discharging someone or transferring their care to a more appropriate service.
  - The person does not receive active care or treatment that day.
  - Requested or planned assessments, interventions or treatments are not delivered.
  - The person is on leave without a clear timeframe or rationale for what the leave is intended to achieve.
- A green day does not mean the person is ready for discharge, it means that they are receiving the care and treatment that they need to progress their recovery and there are no barriers or delays to them accessing this support. A green day can only be recorded if all of these criteria are met.
  - The person is receiving care that can only be provided in an acute inpatient setting.
  - The person receives value-adding care that day, eg assessments, interventions or treatment that supports their recovery and path towards discharge.
  - All care that is planned or requested is completed by the end of the day.

The Red to Green approach is centred around daily MDT board rounds (https://www.youtube.com/watch?v=GIN8Yvy3GwY), in which the status of each person on the ward is rapidly reviewed and tasks assigned that will support the person's recovery and path towards discharge. An example of the steps that may be followed as part of the Red to Green approach can be found in Appendix 4.

Where the Red to Green approach is used, a central database should be kept of the number of red days and the causes of these red days, including delays to receiving therapeutic treatment and being discharged. This information should be reviewed regularly and openly, including by members of senior management, to understand and address common causes of red days. While external delays tend to be well recorded, this process can help to identify the source of internal delays, which local clinical and operational teams can address through escalating internally and through co-production and quality improvement projects.

Details about how Cheshire and Wirral Partnership NHS Foundation Trust have used the Red to Green approach to improve patient flow, can be found in this poster (https://www.england.nhs.uk/north/wp-content/uploads/sites/5/2018/05/Project-to-improve-flow-through-mental-health-inpatient-services-Red2Green.pdf) and video (https://www.youtube.com/watch?v=V6nPz7SVV8g&t=40s).

Reviewing and updating care plans

As well as daily reviews as part of the Red to Green approach, there should also be frequent care plan reviews with the person and their chosen carer/s, with input from relevant members of the MDT and partner services. The focus of these reviews should be to find out how the person and their chosen carer/s feel about the support that is being provided, ensure that the person is receiving purposeful and therapeutic care (ie the assessments, interventions and treatment they need) and if not, to update the person's care plan and ensure the right support is put in place. Where care has not progressed as agreed, it is important to acknowledge this and explain the actions that are being taken to address this.

These reviews are also a good opportunity to check and update the person's purpose of admission and discuss when the person is expected to leave hospital (their EDD), including checking with the person and their chosen carer/s about whether there have been any changes in the support that the person needs in order to be practically and emotionally ready to leave hospital.

In addition, for people with a learning disability and autistic people, commissioners are required to undertake regular face-to-face monitoring visits every eight weeks for adults that are in an inpatient setting, and on a six weekly basis for young adults aged up to 25, who have an EHC Plan.

Meeting the purpose of admission

If a Red to Green or care planning review shows that the purpose of admission is close to being met and/or the person will soon no longer need care that can only be provided in hospital (for example, they could leave hospital with support from a CRHTT), additional focus should be given to planning their discharge and post-discharge support.

The therapeutic environment

The final aspect of therapeutic inpatient care is ensuring that the environment in which care is delivered is conducive to recovery. By making the ward environment feel safe, inviting and accessible, including to people who require reasonable adjustments, for example as a result of a physical disability, learning disability and autism, it helps people to feel cared about and to have a better experience of being in hospital, which in turn enables recovery.

The suggestions given below for improving the inpatient environment draw on work undertaken by the Mental Health Team at NHS England, the Star Wards project (https://www.starwards.org.uk/), the work of the NDTi, who developed ten principles for 'Sensory Friendly Wards (https://www.ndti.org.uk/assets/images/Sensory-Friendly-Ward-Principles.pdf)', and the Autism Team at NHS England who developed this Sensory-Friendly Resource Pack (https://www.england.nhs.uk/publication/sensory-friendly-resource-pack/). As some of the work on sensory friendly wards has the potential to improve the experience of people in inpatient settings, regardless of whether they have sensory differences or not, they have been adapted for inclusion here. Please note, the points below should be read in conjunction with the Health Building Note for adult acute mental health units (https://www.england.nhs.uk/publication/adult-mental-health-units-planning-and-design-hbn-03-01/).

Involvement

- Involve people (both current inpatients and people with recent experience of inpatient care) in reviewing the ward environment and work with them using a co-production approach to improve the therapeutic spaces. This should involve reviewing the kitchen areas, canteen and the quality of food provision, including whether it meets dietary requirements and cultural and sensory needs. Information to support reviews of the environment can be found on the Patient-Led Assessment of the Care Environment website (https://digital.nhs.uk/data-and-information/areas-of-interest/estates-and-facilities/patient-led-assessments-of-the-care-environment-place).
- Identify, as part of care planning, what will help the person feel as comfortable as possible during their hospital stay. This may include having access to their favourite possessions, and items that help the person to relax or engage with their hobbies (as well as a safe place, such as a locker, to store their belongings). It is important to conduct risk assessments around personal items, but all requests should be considered on an individual basis and blanket bans (eg due to fire regulations or infection control) should be avoided as far as possible.

Meeting sensory and cognitive needs

- Change fluorescent lighting for alternatives, such as halogen or ‘warm white’ light emitting diodes (LEDs), and make sure lighting does not buzz or flicker. See these resources (https://www.ndti.org.uk/resources/publication/lighting) from NDTi for further information on sensory friendly LED lighting.
- Identify ways to reduce noise on the ward, for example by using soft furnishings, acoustic vinyl flooring, sound absorbing panels and soft door closers and giving people access to noise cancelling headphones. Ward alarms can be swapped for ‘silent’ alarms that significantly reduce noise on the ward, while still alerting staff.
- Neutralise smells where possible, for example, from cleaning and laundry products, other people and food. Ways to do this include using unscented cleaning products, supporting people to choose their own laundry products, masking unwanted smells using preferred scents and shutting doors around mealtimes. However, for people with dementia, it can be helpful to have food smells on the ward as it acts as a cue that it is mealtime; decisions around how to manage this need to consider and balance the varied needs of people on a ward.
- Ensure there is clear signage on wards, eg using contrasting colours, clear typeface and incorporating visual cues or symbols, that aids comprehension among people with varied needs. Examples of clear signage developed for people with dementia can be found on the Alzheimer’s Society website (https://www.alzheimers.org.uk/dementia-professionals/resources-professionals/resources-gps/dementia-friendly-signage).

Attractive and engaging shared spaces

- Provide information and leaflets about the ward and local and national resources, for example via a resource table or wall.
- Ensure everyone has access to quiet space (eg a relaxation or sensory room), space for prayer, and outdoor space, at all times of day. Other spaces that can enhance the inpatient environment include sensory gardens, gyms, music rooms, computer rooms and libraries, and having spaces where people can cook or prepare their own food.
- Make sure there are comfortable seats and dining chairs for all people on the ward to use.
- Address any damage to the ward environment (eg graffiti, broken windows) and repair or replace any damaged items promptly (ideally within days, wherever possible).
- Make the environment as homely as possible, for example by providing board games, televisions (more than one so that there is a choice of programmes), laptops, books and magazines (in different languages), and by playing soft music (or making headphones available) to people on the ward.
- Consider how the décor could be improved using artwork, cushions, indoor plants and by painting the walls.
- Make the visitor room inviting, for example using artwork and having games and magazines available.

Ensuring privacy, dignity and safety

- NHS England has made a national commitment to end the use of dormitories in mental health facilitates, supported by capital funding that will continue in 2023/24 (https://www.england.nhs.uk/publication/2022-23-priorities-and-operational-planning-guidance/). This will mean that soon all people in inpatient settings will have access to their own bedroom and many more people will have access to their own ensuite.
- Ensure that there are suitable facilities for people in line with NHS England’s guidance on same-sex accommodation (https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/05/NEW-Delivering_same_sex_accommodation_sep2019.pdf).
- Address all safety issues that pose immediate risks to people, including ligature points and other infrastructure concerns. To support this, capital funding was made available in 2022/23 to support urgent safety projects (https://www.england.nhs.uk/publication/2022-23-priorities-and-operational-planning-guidance/).
- Use the practices and interventions developed as part of the Reducing Restrictive Practice Collaborative (https://www.rcpsych.ac.uk/improving-care/nccmh/quality-improvement-programmes/MHSIP-reducing-restrictive-practice/reducing-restrictive-practice) and Safewards project (https://www.safewards.net/) (see also Safewards Victoria (https://www.health.vic.gov.au/practice-and-service-quality/safewards-victoria)), and resources from the Restraint Reduction Network (https://restraintreductionnetwork.org/toolsandresources/) to support reductions in conflict and restrictive practice on wards.
- Use the guidance (https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/sexual-safety-collaborative/sexual-safety-collaborative---standards-and-guidance.pdf?sfvrsn=1eb6a5b7_2) and resources that the National Collaborating Centre for Mental Health developed as part of the Sexual Safety Collaborative (https://www.rcpsych.ac.uk/improving-care/nccmh/sexual-safety-collaborative) to improve sexual safety on wards.

It should also be noted that all NHS mental health trusts are now smoke-free environments. While there are challenges with implementing this in inpatient mental health settings, smoking is one of the biggest drivers of years of life lost in people with mental health needs. Therefore, reducing the amount that people smoke while on the ward, preventing people from taking up smoking and inhaling secondhand smoke, and supporting people to give up smoking while in inpatient services, has the potential to deliver significant health benefits.

Currently, tobacco dependency treatment services are being rolled out to inpatient mental health settings, with an ambition that everyone who smokes and is admitted to hospital overnight will be able to access treatment for their tobacco dependence. Systems are targeting services to those with the greatest need, which is anticipated to encompass all mental health inpatient services. Where services are commissioned, this should also include step down care post-discharge, which could include commissioned services in specialist community mental health settings. Providers should also reach a position on the use of vaping devices on hospital premises, noting that an evidence review published by the Office for Health Improvement and Disparities (https://www.gov.uk/government/publications/nicotine-vaping-in-england-2022-evidence-update) found that vaping devices are effective in supporting people to stop smoking, but are not completely harm-free. People who have never smoked should be discouraged from using them.

Effective discharge planning and post-discharge support

The person's discharge is planned with the person and their chosen carer/s from the start of their inpatient stay, so that they can leave hospital as soon as they no longer require assessments, interventions or treatments that can only be provided in an inpatient setting, with all planned post-discharge support provided promptly on leaving hospital.

There has been a significant focus on timely and effective discharges from acute inpatient mental health settings in recent years. The is because staying in hospital for longer than necessary can be harmful for people, so the aim is for people to only spend as long in hospital as needed to receive the therapeutic interventions and treatment that they require. For this model to work, there needs to be an active focus on delivering therapeutic care in inpatient settings (as outlined in the previous section) and on identifying what needs to be put in place for a person to be practically and psychologically ready for discharge. There also needs to be a range of community support services and housing provision available that can facilitate discharge and support people to continue their recovery, meet their personal goals and maintain their wellbeing once they leave hospital.

Some people with lived experience and their carers have said that they do not like the term 'discharge' as it conveys a sudden ending, and one in which they feel they may be left without the support they need. This may lead to some people feeling reluctant about being discharged from hospital. As the term discharge is used widely across the health sector, it is used throughout the guidance. However, the expectation in this guidance is that when someone is discharged from inpatient mental health services, they will receive a follow-up within 72 hours of leaving hospital, they may receive support from the local CRHTT to leave hospital, and they will receive ongoing support from a community-based mental health or learning disability team and potentially other support services (further information is provided in this section). To ensure the right support is in place when the person is ready to leave hospital and the transition from hospital to home is smooth and coordinated, the person's discharge plan should be developed with the person and their chosen carer/s from the start of their inpatient stay.

When to discharge someone

In this section a distinction is made between the point at which a person is 'clinically ready for discharge' (CRFD) and the actual point at which it is possible to discharge the person (ie when the ongoing care and treatment that they need in the community or less restrictive setting is also available).

Clinically ready for discharge

The point at which someone is CRFD is reached when: the MDT conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting.

There are three key criteria, which need to be met, before the MDT can make this decision:

- There must be a clear plan for the ongoing care and support that the person requires after discharge, which covers their pharmacological, psychological, physical health, social, cultural, housing and financial needs, and any other individual needs or wishes.

- The MDT must have explicitly considered the person and their chosen carer/s' views and needs about discharge and involved them in co-developing a discharge plan.
- The MDT must have involved any services external to the provider in their decision-making, where these services will play a key role in the person's ongoing care, eg social care teams and housing teams.

A webinar providing further information on the definition of CRFD can be found on the FutureNHS platform (https://future.nhs.uk/AdultMH/view?objectID=30987920) (requires login).

There may be occasions where the MDT are not able to reach a consensus that someone is CRFD or partner services may not agree with the MDT's decision. All providers should have a rapid escalation process in place that can be followed in such cases. There may also be situations where the person or their chosen carer/s do not think the person is ready for discharge. In these cases, it is important to take the time to understand the reasons for this, identify alternative solutions and take any further steps needed to make sure the person feels ready for discharge. For example, this could include visiting the proposed discharge location and meeting the staff there. If not resolved, the rapid escalation process should be followed and this process should be clearly explained to the person and their chosen carer/s.

The point at which it is possible to discharge

Once the CRFD definition is met, it should be recorded as such in EPR systems. However, it does not necessarily mean the person can be discharged, for example, if the right support is not available in the community at that time.

The point at which it is possible to discharge someone is reached when the person is considered CRFD and the ongoing care and support agreed in the person's discharge plan can be delivered according to the agreed timescales following discharge. To make this decision, the person's discharge plan needs to have been reviewed and updated with the person and their chosen carer/s, and the role of each party in providing post-discharge support clearly articulated. For example, it should be clear what assessments, interventions and support will be provided by the CRHTT, community-based mental health or learning disability team and other services, and when; and what the person and their chosen carer/s are responsible for, checking in particular that the person's chosen carer/s feel able to take on these responsibilities.

In situations where someone is deemed CRFD, but it is not possible to discharge them, the person must continue receiving interventions, activities and other support in hospital, so that they remain CRFD and can be discharged as soon as the appropriate support has been put in place for them.

Once the final decision has been made that it is possible to discharge someone:

- At least 48 hours' notice of this discharge date should be given to the person, their chosen carer/s and any services (both NHS and non-NHS services) that will be involved in the person's ongoing care.
- Their risk assessment should be updated, to include information on how any risks to self or others will be managed in the community or less restrictive discharge location. In line with NICE guidance on self-harm (https://www.nice.org.uk/guidance/ng225), risk assessment tools and scales should not be used to predict future suicide or repetition of self-harm, or to decide who should be discharged. Instead, person-centered approaches to safety planning should be used that involve the person and their nominated carer/s and consider individual needs, risks and contexts and personal feelings of safety. Once updated, the risk assessment should be uploaded to a clearly accessible place on the person's EPR.
- A face-to-face follow-up meeting should be arranged for within 72 hours of discharge (see details below).
- The person should be given clear information about how to access crisis support after discharge, both during and outside standard working hours. This should include providing direct contact details for the CRHTT.
- Relevant information relating to the person's discharge, which may include a copy of their discharge plan, should be shared with services that will be involved with the person's ongoing care and treatment after discharge. The person's discharge summary should also be shared with the person's GP and other relevant parties, where appropriate, within a week of discharge.

Support after discharge

When someone leaves adult acute mental health inpatient care, they should receive:

1. A follow-up within 72 hours of discharge

Every person discharged from an adult mental health inpatient service (excluding specialised services commissioned by NHS England) should be followed-up by a CRHTT or community-based mental health team within 72 hours. This is because the National Confidential Inquiry into Suicide and Safety in Mental Health (https://sites.manchester.ac.uk/ncish/) (NCISH) has found that there is an increased risk of dying by suicide within three days of discharge from hospital. Follow-ups should be arranged pre-discharge (including providing written details of when, where and who the follow-up will take place with) and should take place face-to-face wherever possible. If the follow-up indicates that the person needs additional support, action should be taken promptly to put this in place. Resources to support effective 72 hour follow-ups can be found on the FutureNHS platform (https://future.nhs.uk/AdultMH/view?objectID=30987920) (requires login).

2. Prompt access to planned support

In the majority of cases, people are expected to return to their home or alternative accommodation in the community when they are discharged from hospital, with any further assessments and ongoing, interventions, treatment and support that they require provided in their home or local community. Services need to work together to make the transition from hospital to home as joined up as possible, with the support outlined in the person's discharge plan provided according to agreed timelines.

Support from NHS mental health services

When a person is discharged, they may receive short-term intensive home treatment from a CRHTT to facilitate discharge, and it is expected that they will receive ongoing support from a community-based mental health team. Support should commence within the timescales stated in the person's discharge plan (in the case of discharge supported by a CRHTT, a first visit should happen within 24 hours of discharge).

If not already included in a person's discharge plan or EPR, the CRHTT and/or the community-based mental health team are expected to support the person to:

- Develop advance choices, which set out any preferences that the person has for their care and treatment, should they be admitted to an inpatient mental health setting again. This may involve signposting the person to access additional support from an advocate or a VCSE organisation, which can help with the development of advance choices. Advance choices should be recorded and uploaded to a clearly accessible place in the person's EPR.
- Create a crisis plan that is uploaded to the person's EPR, containing information about the signs that the person is experiencing or approaching a crisis, where and how they can seek help (including outside standard working hours), and information on their support and treatment preferences.
- Access other support that will help maintain the person's wellbeing and prevent future crises, such as psychoeducation and peer support.

Support from other services

According to people's needs, as agreed in a person's discharge plan, some people may receive additional support from services such as drug and alcohol services, community learning disability teams, palliative care, housing services, social care services, specialist autism services and VCSE sector services.

Funded packages of care

A smaller proportion of people may require and be entitled to a funded care package, in order that they can access:

- Support for social care needs (including domiciliary care).
- Community-based rehabilitation.
- A short-term placement in a step-down service or supported accommodation.
- A longer-term/permanent placement in a supported accommodation or residential care home.

This may be funded via:

- Section 117 aftercare (https://www.legislation.gov.uk/ukpga/1983/20/section/117) – available to people who have been detained under section 3, 37, 47, 48 or 45A, or have been placed on a community treatment order (CTO) or conditional discharge. If someone is entitled to Section 117 aftercare, notification of their admission should be made to the local authority.
- The Better Care Fund (https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/better-care-fund/)
- Personal budgets (https://www.nhs.uk/conditions/social-care-and-support-guide/money-work-and-benefits/personal-budgets/) (which are local authority funded), personal health budgets (https://www.england.nhs.uk/personalisedcare/personal-health-budgets/) (which are NHS funded) and integrated personal budgets and personal health budgets (https://www.england.nhs.uk/publication/integrated-personal-budgets-and-personal-health-budgets/) (which include funding from both a local authority and the NHS). These budgets are intended to give people greater choice and flexibility in organising and managing their own care, in line with an agreed care plan. Please note, people eligible for after care services under Section 117 of the MHA have a right to a personal health budget; further details can be found in NHS England's Personal Health Budget Quality Framework (https://www.england.nhs.uk/long-read/personal-health-budget-phb-quality-framework/). It is important that those eligible are informed of this right.
- NHS Continuing Healthcare (https://www.nhs.uk/conditions/social-care-and-support-guide/money-work-and-benefits/nhs-continuing-healthcare/)
- NHS trust discharge initiatives – which may fund home adaptations, equipment and short-term placements.

Members of inpatient teams and independent advocates should make people aware of the different options for funding ongoing care (including personal budgets), and where there are different options available, individuals and their chosen carer/s should be supported to understand how the different options work, so that they can make the best choice for their circumstances (particularly where a person will be self-funding their care).

Local protocols should be developed and agreed between NHS organisations, local authorities and other relevant partners, which detail the escalation process that should be followed where there are difficulties reaching an agreement about funding ongoing care. These escalation protocols should include information on arrangements for putting in place interim funding to enable people to leave hospital when clinically ready, and details of the procedures for agreeing longer-term funding, which ensure that no one is left without the support at the end of the interim funding period. Where local escalation protocols are activated, this should be clearly communicated to the person and their chosen carer/s and they should be involved in conversations about progress to resolve the situation and next steps.

Considerations for an effective discharge

The following can support effective discharges from hospital:

1. Commission robust community and housing support

NHS bodies and local authorities need to commission effectively so that there is the required housing and health and social care support available in the community to meet the needs of the local community and enable people to be discharged. This includes commissioning step-down services, which provide a bridge between inpatient care and living independently in the community, and services that meet the needs of specific populations that experience health inequalities within the local pathway.

Resources to support this include:

- this resource pack (https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2FAdultMH%2Fviewdocument%3Fdocid%3D154113029%26fid%3D30987920) (requires login) produced by NHS England and partners, including the Local Government Association and the Association of Directors of Adult Social Services (ADASS). The pack includes information on funding opportunities and good practice examples relating to mental health accommodation-based support.
- the national Building the Right Support plan (https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf) to develop community services and close inpatient facilities for people with a learning disability and/or autistic people who display behaviour that challenges, and the accompanying Building the Right Home guidance for commissioners (https://www.england.nhs.uk/learningdisabilities/wp-content/uploads/sites/34/2015/11/building-right-home-guidance-housing.pdf).

2. Plan early and throughout a person’s inpatient stay

Discharge planning should begin at the start of a person’s admission, or a soon as practically possible afterwards. In line with Section 91 of the Health and Care Act (2022) (https://www.legislation.gov.uk/ukpga/2022/31/section/91/enacted), discharge planning should involve the person and their chosen carer/s. It should also involve any services that may be involved in a person’s care after discharge, including social care. As part of discharge planning, it is important to identify early what needs to happen for the person to feel practically and psychologically ready for discharge (while recognising that this may change over the course of the person’s time in hospital). The person and their chosen carer/s should be given information about their discharge options, the opportunity to ask questions about these options and should be involved in co-developing a discharge plan.

Some key areas that should be proactively considered and addressed as part of discharge planning, include:

- Understanding what the person’s chosen carer/s are able and willing to do once the person they care for is discharged (eg whether they are happy for the person to live with them) and what support the chosen carer/s needs to be able to fulfil this role. This is particularly important when considering young carers and people with other caring responsibilities. Where a carer’s assessment (https://www.nhs.uk/conditions/social-care-and-support-guide/support-and-benefits-for-carers/carer-assessments/) is needed, this should be organised with the relevant local authority in a timely way so as to not delay discharge. Alternatively, the assessment may be completed after discharge, as long as it is not a new caring duty or there are increased care needs.
- Housing – assessing whether the person can return to the place they lived before they were admitted to hospital, and if so, what steps need to take place to make this possible (eg securing their tenancy, making any repairs or adaptations). If it is no longer possible or suitable for the person to live there, then prompt contact and referral should be made to the local authority housing services (including the homelessness team if the person is homeless or at risk of homelessness) and proactive action taken to secure a suitable home that meets the person’s individual needs (including preferences in terms of location). In some cases, step-down accommodation may be arranged ahead of permanent accommodation being identified.
- Funded packages of care – identifying any care needs that may require ongoing support within the home, in sheltered accommodation or a care home. This is particularly relevant in relation to older adults, who have longer lengths of hospital stay on average, which can be the result of delays in securing appropriate social care. Once ongoing care and support needs are identified, referral should be made promptly to the relevant agency (eg the local authority) and assessments should be arranged early, so that funding can be agreed and a package of support can be put in place as soon as the person is ready to leave hospital. Where someone is entitled to Section 117 aftercare (https://www.rethink.org/advice-and-information/rights-restrictions/mental-health-laws/section-117-aftercare-under-the-mental-health-act-1983/), there should be early liaison with the local authority to begin planning the aftercare that is needed.
- Mental capacity and liberty protection safeguards for people who lack mental capacity and meet the criteria for being deprived of liberty.
- Medicines and equipment – some medicines, eg opiate substitutes, need to be arranged well in advance of discharge to avoid delays to discharge.
- Travel home/to the discharge location – especially if this is in a rural location. Travel may be through a carer picking the person up, a VCSE sector service, or where relevant eligibility criteria are met, via non-emergency patient transport services. Consideration should also be given to whether a person needs to be accompanied and who can do this, if a carer is not available.
- Immediate needs at the point of discharge, eg completing deep cleans of the person’s home, having keys to gain access, food, electricity and gas, and any other ‘settle in’ support required.

For people with a learning disability and autistic people, the 12-point discharge plan, which can be found in Appendix 7 of the Dynamic Support Register and Care (Education) and Treatment Review policy (https://www.england.nhs.uk/wp-content/uploads/2023/01/PR1486-Dynamic-support-register-and-Care-Education-and-Treatment-Review-policy-and-guide.pdf) should be used to ensure appropriate steps are in place to support a timely discharge. Systems are expected to use this plan, and this will be monitored via the Assuring Transformation dataset.

3. Develop strong partnerships locally

Strong partnerships should be built between inpatient services and NHS and non-NHS services that need to be routinely involved in discharge planning, decision-making and providing post-discharge support. This includes CRHTTs, community-based mental health and learning disability teams, social services (who can provide expertise about people's longer-term care needs and options and support shared decision-making by making sure that people and their chosen carer/s are aware of the implications of the options), housing services and VCSE organisations (who may provide discharge support services such as settle in support or peer support). Examples of other services that will need to be a key part of discharge processes, depending on individual circumstances and needs, can be found in this section.

To support partnership working, there should be policies outlining roles and responsibilities in relation to discharge planning discharge decision-making and providing post-discharge support, which include a named person responsible for discharge process in each organisation.

4. Arrange leave to prepare people for discharge

Arranging leave (including Section 17 leave (https://www.legislation.gov.uk/ukpga/1983/20/section/17) for people detained under the MHA) can help the person and the inpatient team decide if the person is ready for discharge and gives the person the opportunity to make any preparations needed for leaving hospital (eg preparing their home). The period of leave should be short-term, and if it goes well, discharge should be promptly facilitated.

5. Keep a consistent focus on inpatient flow

Providers that have had success in ensuring timely discharges, consistently report that executive or senior leadership oversight of patient flow along the inpatient pathway has been key to this success. Some of the actions taken to support patient flow and discharge from hospital include:

- Using the Red to Green approach – see this section for details.
- Enabling discharge seven days a week, by having consultant cover at weekends or using criteria-led/nurse-led discharge (https://www.england.nhs.uk/urgent-emergency-care/improving-hospital-discharge/criteria-led-discharge/).
- Holding operational meetings multiple times a week to look across the system at who is expected to be admitted, and discharged and planning for this accordingly. This should include regular meetings (weekly or more frequently) with system partners to unblock delays to discharge.
- Focusing on people who have been in hospital for more than 60 days to identify what needs to happen to discharge them. Some providers have 'long stay' or discharge teams who specifically look at this.
- Using Multi-Agency Discharge Events (https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/12/rig-multi-agency-discharge.pdf) where there are complex discharges requiring agreement across multiple partners, and also following locally agreed escalation procedures where there are concerns about delayed discharges. Where escalation has been required, this should be reviewed to understand what could have been done differently.
- Using hospital performance data, eg length of hospital stay, number of people CRFD who have not been discharged, reasons for delayed discharges and reasons for readmission within six months, in order to monitor the effectiveness of local discharge arrangements and identify improvements.

Key enablers of effective inpatient care

There are a wide range of enablers operating both within and outside the hospital setting that can help to support the delivery of good quality inpatient care. The enablers included in this section are:

- having a fully multi-disciplinary, skilled and supported workforce, and
- continual improvement of the inpatient pathway through using data, co-production and quality improvement methodology.

These were selected as they are both key to facilitating the delivery of care in line with the principles and stages included in this guidance.

A fully multi-disciplinary, skilled and supported workforce

For people accessing acute mental health services to receive caring and compassionate support, which meets people's holistic needs and delivers therapeutic benefit, it is essential that inpatient teams are appropriately skilled are well supported, and include staff from a range of different professional groups. Additional funding has been made available as part of the NHS Long Term Plan (https://www.longtermplan.nhs.uk/areas-of-work/mental-health/) to improve staffing levels and skills mix in adult acute inpatient mental health settings, though workforce submissions show that at a national-level, this has not resulted in the expected workforce growth. Though there are currently significant workforce pressures, particularly in mental health, it is vital that efforts are made to strengthen the inpatient workforce. The subsections that follow provide guidance to support this, and should guide decisions about how the NHS Long Term Plan funding for acute inpatient mental health services is used. (https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/)

Staffing levels

Staffing levels have a critical impact on people's experience of inpatient care, for example, affecting the activities and interventions that are on offer and whether people can leave the hospital grounds. It is therefore crucial that inpatient services have sufficient staffing levels and there is not an over-reliance on temporary staff, which impacts on the ability for people to build up a relationship with the inpatient staffing team. Recommended full-time equivalents (FTEs) for different staffing groups are not included in this guidance, because determining the right staffing model for a given population involves assessing a range of local factors and no single model will be applicable to all areas. However, in line with the fundamental safer staffing principles set out in the National Quality Board's guidance (https://www.england.nhs.uk/publication/national-quality-board-guidance-on-safe-staffing/), and Developing Workforce Safeguards Guidance (https://www.england.nhs.uk/wp-content/uploads/2021/04/Developing-workforce-safeguards.pdf), all staffing establishments should be reviewed biannually using a triangulated approach, utilising evidence-based workforce planning tools, professional judgement of the clinical team, review of quality and safety outcomes, and benchmarking with peers. The validated, evidence-based workforce planning tool for inpatient mental health services is the Mental Health Optimal Staffing Tool (https://www.innovahealthtec.com/mhost#:~:text=The%20Mental%20Health%20Optimal%20Staffing%20Tool%20%28MHOST%29%20is,to%20ensure%20that%20ward%20establishments% The tool is free for NHS trusts in England to use and can be licensed via https://www.innovahealthtec.com (https://www.innovahealthtec.com/). Further resources from NHS England on safe staffing in mental health services can be accessed on the NHS England website (https://www.england.nhs.uk/nursingmidwifery/safer-staffing-nursing-and-midwifery/safe-staffing-improvement-resources-for-specific-settings/#men).

Multi-disciplinary inpatient teams

There is growing evidence of the importance of having inpatient teams made up of varied staffing groups. Analysis by NHS Benchmarking has indicated that there is a relationship between the number of therapeutic staff and length of stay on wards. NHS England has also found that NHS providers with a lower average length of hospital stay compared to the national average, have higher overall numbers of staff and higher numbers of peer support workers and allied health professionals, per inpatient bed.

Using the funding made available for acute inpatient mental care as part of the NHS Long Term Plan (https://www.longtermplan.nhs.uk/areas-of-work/mental-health/), there is a real opportunity to increase the variety of roles represented in ward teams or with dedicated ward time. This includes, but is not limited to, roles such as occupational therapists, peer support workers/lived experience practitioners, psychology professionals (including clinical associates), activity coordinators, housing officers and social workers.

Providers should work with people and carers of people who have used local inpatient services, and members of inpatient teams, to identify which staffing models will best meet the needs of the local community. This may include looking at how to ensure the NHS Workforce Race Equality Standard (https://www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/equality-standard/) is being met and that the workforce is representative of the population it serves, and how to increase the representation of therapeutic roles on wards in the evenings and at weekends. In seeking to achieve this second aim, it should be recognised that this may take long-term planning and require innovative approaches, such as employing people to work across inpatient and community settings and recruiting to new roles like clinical associate psychologists.

For a team to be truly multi-disciplinary, it is critical for a culture to be created where the value of different professions and perspectives is recognised, and the sharing of skills and expertise is actively encouraged. People in leadership roles are particularly important for setting this culture. They can do this through prioritising training or reflective practice that promotes a shared understanding of different roles, ensuring all key decision-making meetings are multi-disciplinary, and facilitating interactions in a way that demonstrates that different opinions and expertise

are valued. In particular, supporting non-medical professionals (including lived experience practitioners/peer support workers) to take up leadership positions can help to embed a truly multi-disciplinary approach. This includes supporting non-medical professionals to take up roles as Responsible Clinicians and consultants, as well as senior leadership positions within providers.

Details of the additional workforce required by each ICS to deliver the NHS Long Term Plan (https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/) ambitions for therapeutic inpatient care, as well as the funding allocated to each clinical commissioning group (CCG)/ICS between 2019/20 and 2023/24 to support this, can be found on the FutureNHS platform (https://future.nhs.uk/connect.ti/MHLTPat/view?objectId=122625509) (requires login). Any skill mix change or introduction of new roles must be supported by a Quality Impact Assessment (QIA) to assess and mitigate against any potential impact on quality. This should be signed off by the Chief Nurse and Medical Director and include clear monitoring arrangements.

Skills and competencies

This guidance does not aim to offer a comprehensive list of skills and competencies for staff working in acute inpatient mental health settings, as these will vary across professional groups and depend on seniority. There are however a number of skills highlighted in this guidance, including cultural competency, that all staff should demonstrate in their daily practice. A compilation of these skills and competencies can be found in Appendix 5 (https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/#appendix-5-skills-and-competencies-for-the-inpatient-workforce).

Opportunities should be made available to staff for skill development, through training, mentoring and shadowing. People in leadership positions have an important role to play in terms of enabling this to happen and for creating a culture that embraces learning and feedback. This may include forging links with other services, eg learning disability and autism teams, who can support the inpatient team to develop competencies for responding to individual needs. For nursing staff, development may be supported by Professional Nurse Educators (https://www.england.nhs.uk/nursingmidwifery/delivering-the-nhs-ltp/mental-health-nursing/#:~:text=The%20Professional%20Nurse%20Educator%20(PNE,preceptee%20nurses%20and%20student%20nurses.), who are specifically employed to develop and deliver clinical practice education.

Staff wellbeing and psychological safety

It can be highly challenging to support people who are experiencing acute levels of mental distress. For staff members to be able to respond consistently with compassion and understanding and offer the best levels of therapeutic care, they need to be well supported, both on an individual and team level. Where staff are valued and well supported, there is also likely to be lower turnover, fewer vacancies and less reliance on bank and agency staff.

Those in leadership positions have an important role to play in terms of developing and maintaining a team dynamic that is valuing, respectful and empowering for all, and for creating an open culture in which team members feel able to ask questions and receive guidance on what is and is not good practice. This open culture must also include ensuring that team members understand how to raise concerns about poor practice (eg through having clear whistleblowing policies and putting in place Freedom to Speak up Guardians (https://www.england.nhs.uk/ourwork/freedom-to-speak-up/)) and feel comfortable to do so. Where concerns are raised, team members should feel confident that they will be taken seriously by management and swift action taken to address identified issues.

Leaders also have a key role to play in ensuring each team member receives regular supervision and reflective practice. Team members should receive clinical restorative supervision at least monthly, which includes reflection on their own practice and that of the wider service, as well as their wellbeing and any challenging situations that they have encountered. There should also be regular group reflective practice within teams, led by an appropriately qualified mental health clinician, such as a therapist or Professional Nurse Advocate. The Professional Nurse Advocate (PNA) programme (https://www.england.nhs.uk/nursingmidwifery/delivering-the-nhs-ltp/professional-nurse-advocate/) is training thousands of nurses to facilitate restorative supervision to their colleagues within and outside nursing, including one PNA in every adult inpatient mental health setting. By having regular team supervision and space for reflection, it helps to build supportive relationships between staff members, allows differing perspectives and approaches to be shared, and enables improvements to practice to be identified and put in place.

There may be occasions where staff require additional support for their own wellbeing. Colleagues, managers and other staff support services, such as occupational health and HR, should be aware of the support services that they can signpost people to in such cases.

Workforce resources

Resources that can support effective staffing in mental health settings, include:

- This webinar (https://future.nhs.uk/AdultMH/view?objectID=36364528) (requires login) hosted by NHS England providing an update on the NHS Long Term Plan ambition and funding available to improve acute inpatient staffing.
- NHS England e-learning on Fundamentals of Safer Staffing (https://www.e-lfh.org.uk/programmes/fundamentals-of-safer-staffing/)
- University College London (UCL)'s competency framework for adult and older adult acute mental health inpatient care (https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/competence-frameworks/delivering)
- The Mental Health Core Skills Education and Training Framework (https://www.skillsforhealth.org.uk/images/services/cstf/Mental%20Health%20CSTF.pdf)
- The Mental Health Nurse's Handbook (https://www.england.nhs.uk/publication/the-mental-health-nurses-handbook/)
- The Royal College of Occupational Therapists' Informed View on Mental Health Rehabilitation (https://www.rcot.co.uk/about-occupational-therapy/rcot-informed-views)
- Peer Support Worker Competency Framework (https://www.hee.nhs.uk/our-work/mental-health/new-roles-mental-health/peer-support-workers)
- The British Psychological Society and Association of Clinical Psychologists' guidelines for psychological services within the acute adult mental health care pathway, (https://acpuk.org.uk/new-guidance-on-psychological-services-within-the-acute-adult-mental-health-care-pathway/) which includes information on workforce development.
- The National Collaborating Centre for Mental Health and the Positive Practice in Mental Health Collaborative's report covering workforce wellbeing, recruitment and retention in mental health services (https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/ppimh-report---a-happy-healthy-workforce.pdf?sfvrsn=25749e62_0)
- The NICE guideline on mental wellbeing at work (https://www.nice.org.uk/guidance/ng212).

Continuous improvement of the inpatient pathway

Some of the most effective inpatient mental health services are those that embrace change, where there is a culture of continuous learning and development, to identify what more can be done to improve the inpatient pathway. Three key mechanisms that can promote continuous improvement are: co-production, quality improvement methodology, and using data to inform service provision.

Co-production

Co-production should be at the heart of all aspects of how the inpatient pathway is designed, delivered and monitored. To ensure that the inpatient pathway meets the needs of people accessing inpatient services, it is vital that people who have used inpatient services and people that care for them, are involved and able to influence the development and improvement of the pathway. This should include representation from people belonging to groups that experience health inequalities and who may not traditionally become involved in co-production activities, and people who have experienced transitions between services in order to strengthen these pathways.

For co-production to be genuine and meaningful, it requires people who have used inpatient services, their carers, and people involved in delivering services, to come together as equal, reciprocal partners, from the very start of a piece of work to its conclusion. Everyone involved should be enabled and empowered to use their unique and diverse experiences and skills to shape the delivery of inpatient services, with decision-making power shared across the group. Providers should appropriately reward people's time, put in place reasonable adjustments that enable people to participate fully, and have mechanisms for reviewing whether co-production is taking place across all aspects of inpatient policy, provision and practice. Providers should also consider having lived experience roles at all levels within their organisations (including senior management level), in line with NICE guidance on shared decision making (https://www.nice.org.uk/guidance/ng197/chapter/Recommendations#embedding-shared-decision-making-at-an-organisational-level), in order to build capacity for embedding co-production across services.

Some resources to support the use of co-production throughout the design and delivery of inpatient services include:

- This article from the Lancet Psychiatry – From Preproduction to Coproduction: COVID-19, whiteness, and making black mental health matter (https://pubmed.ncbi.nlm.nih.gov/33189219/)
- NHS England's resources (https://www.england.nhs.uk/learning-disabilities/about/get-involved/involving-people/why-is-it-important-to-involve-people/) on involving people with a learning disability and autistic people in the design and development of services.
- NDTi's practical guide to Progressing Transformative Co-production in Mental Health (https://www.ndti.org.uk/assets/files/MH_Coproduction_guide.pdf)
- The New Economics Foundation's publications, including: Public Services Inside Out (https://neweconomics.org/2010/04/public-services-inside).
- The Point of Care Foundation's experience-based co-design toolkit (https://www.pointofcarefoundation.org.uk/resource/experience-based-co-design-ebcd-toolkit/)
- The Royal College of Psychiatrist's Working Well Together resource (https://www.rcpsych.ac.uk/improving-care/nccmh/other-programmes/coproduction)
- The Social Care Institute for Excellence's guide and practical examples of how to do co-production. (https://www.scie.org.uk/publications/guides/guide51/)
- Think Local Act Personal's information about co-production and links to practical examples (https://www.thinklocalactpersonal.org.uk/co-production-in-commissioning-tool/co-production/In-more-detail/what-is-co-production/), ladder of co-production (https://www.thinklocalactpersonal.org.uk/_assets/COPRODUCTION/Ladder-of-coproduction.pdf) and top 10 tips for co-production (https://www.thinklocalactpersonal.org.uk/_assets/COPRODUCTION/1_page_profile_for_coproduction_2.pdf).

Quality improvement

Quality improvement methodology is increasingly used in mental health settings. One of the key features of quality improvement is the use of Plan-Do-Study-Act (PDSA) cycles, which involve developing change ideas, testing these changes and using data to review their impact and decide next steps (eg refining the idea and re-testing on the ward, testing a successful change in a larger number of services, or not proceeding with the change idea). It is important to note that not all change ideas will lead to a demonstrable improvement, however, they will still generate valuable learning to inform future quality improvement work.

Quality improvement works most effectively where there is buy-in for the process at a senior level, but it is frontline teams, together with service users and carers, who lead the process of change. This helps to ensure team-wide buy-in for implementation, and also helps to improve teams' motivation and engagement.

Useful resources to support providers to embed use of quality improvement across the inpatient mental health pathway include:

- NHS England's quality improvement resources (https://www.england.nhs.uk/sustainableimprovement/qsir-programme/qsir-tools/).
- The King's Fund's resources on quality improvement in mental health (https://www.kingsfund.org.uk/projects/quality-improvement-mental-health-care)
- Royal College of Psychiatrists' quality improvement guide for trainees and trainers (https://www.rcpsych.ac.uk/docs/default-source/training/training/ptc/rcpsych_qi_guide_trainees_2019_lr_f.pdf?sfvrsn=e5c832f1_2)
- East London Foundation Trust's quality improvement webpages (https://qi.elft.nhs.uk/)

In addition, the Royal College of Psychiatrist's Centre for Quality Improvement (https://www.rcpsych.ac.uk/improving-care/ccqi) offers a number of relevant accreditation schemes and quality networks that support services to carry out regular peer- and self-review of the quality of care, which may inform quality improvement initiatives.

Using data to inform service provision

Data is key to understanding how the inpatient pathway is working and for identifying changes that could be made to improve the pathway and being able to demonstrate whether any changes made have led to a measurable improvement. One of the key recommendations from the Getting It Right First Time (GIRFT) report for adult crisis and acute care (https://www.gettingitrightfirsttime.co.uk/medical-specialties/mental-health-adult-crisis-and-acute-mental-health/) was that services regularly analyse their routine data and share the findings, in order to target and develop improvement work.

The data collected should include measures of how inpatient services and the wider acute pathway is operating, as well as information on the experiences and outcomes of people who have received inpatient care, including both clinician and patient reported outcome measures. There should also be a focus on data that looks at inequalities across the pathway (see this guide from NHS Digital (https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/submit-data/data-quality-of-protected-characteristics-and-other-vulnerable-groups/reporting-on-mental-health-equality?key=) on improving reporting of data related to equalities). Frontline teams, people who have used inpatient services, their carers and senior management should all be regularly involved in reviewing data and using it to shape delivery decisions, which drive improvements in access, capacity and flow, care quality, experience and outcomes.

At a national-level, NHS England is working to improve the use of data in acute mental health services and monitors indicators including:

- Number of inappropriate out of area placements.
- Number and percentage of admissions involving people not known to services.
- Number of mental health related A&E attendances, and the percentage of A&E waits lasting over 12 hours.
- Percentage of people on community mental health team caseloads who are admitted to hospital.
- Percentage of admissions involving detention under the MHA.
- Percentage of available adult and older adult acute beds that are occupied at any one time.
- Occupied adult and older adult acute bed days per 100,000 weighted mental health population.
- Average acute mental health length of hospital stay, and the rate of admissions per 100,000 weighted mental health population lasting over 60 days for working age adults and 90 days for older adults.
- Number of people who are CRFD who are occupying inpatient beds.
- Percentage of 72 hour follow-ups completed for people leaving acute inpatient care.
- Number of FTE staff members belonging to different professional groups per inpatient bed.

More details on the rationale for monitoring these metrics is set out in Appendix 6. As part of the drive to improve data quality, NHS England has also produced several dashboards which report data at national, regional, ICS and provider level, with several metrics broken down by demographic indicators, such as age, deprivation and ethnicity. The dashboards are frequently updated, and are accessible to those with an NHS login via the FutureNHS platform (https://future.nhs.uk/connect.ti/MHRH/view?objectId=26200112). Some of the indicators in the dashboards are included to support improvements in data quality, but the aim is that in future they may be published and used to better understand activity and performance.

Appendix 1: Legal obligations and inpatient mental health standards

As well as implementing the components of good quality acute inpatient care included in this guidance, each person who is accessing inpatient mental health care should have their legal rights respected, regardless of their background, social status or mental health presentation. The obligations that should be adhered to include:

- the Care Act 2014 (https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted)
- the Data Protection Act 2018 (https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted)
- the Equality Act (https://www.legislation.gov.uk/ukpga/2010/15/contents) 2010
- the Human Rights Act 1998 (https://www.legislation.gov.uk/ukpga/1998/42/contents)
- the Mental Capacity Act 2005 (https://www.legislation.gov.uk/ukpga/2005/9/contents)
- the Mental Capacity Act 2005: Code of Practice (https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice)
- the Mental Health Act (https://www.legislation.gov.uk/ukpga/1983/20/contents) 1983
- the Mental Health Act 1983: Code of Practice (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF)
- the Mental Health Units (Use of Force) Act 2018 (https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018)
- the UK General Data Protection Regulation (GDPR) (https://www.legislation.gov.uk/eur/2016/679/contents) 2021
- the Common Law Duty of Confidentiality

- the Accessible Information Standard (https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/)
- Duty of Care and Safeguarding (https://www.england.nhs.uk/publication/safeguarding-children-young-people-and-adults-at-risk-in-the-nhs-safeguarding-accountability-and-assurance-framework/) responsibilities

Please note, as part of plans to reform the Mental Health Act (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/951398/mental-health-act-white-paper-web-accessible.pdf), the Department of Health and Social Care and the Ministry of Justice has published a draft Mental Health Bill (https://www.gov.uk/government/publications/draft-mental-health-bill-2022?utm_medium=email&utm_campaign=govuk-notifications-topic&utm_source=8df3be5e-ff2b-412c-a481-6f9cf54c2c6f&utm_content=immediately) setting out proposed reforms to the Mental Health Act (1983). Although these reforms are not yet in statue, preparatory work should begin now to ensure that services are in a position to comply with the legal changes that are due to be introduced in the coming years.

All inpatient mental health care should also be delivered in line with key quality standards and guidance, including:

- The Caldicott Principles (https://www.gov.uk/government/publications/the-caldicott-principles#:~:text=Every%20use%20of%20confidential%20information,and%20under%20the%20common%20law.)
- Royal College of Psychiatry Standards for:
    - Inpatient Mental Health Services (https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/ccqi-resources/rcpsych_standards_in_2019_lr.pdf?sfvrsn=edd5f8d5_2)
    - Acute Inpatient Services for Working Age Adults (https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/aims/standards-for-acute-inpatient-services-for-working-age-adults---7th-edition.pdf?sfvrsn=66d6904f_7)
    - PICUs (https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/picu/picu-qn-standards-qnpicu/qnpicu-standards-for-psychiatric-intensive-care-units-2020-(2nd-edition)-v2a38355b0f61d4b46ba68b586c46bdf1e.pdf?sfvrsn=e09e1ee8_2)
- NICE guidance on:
    - Advocacy services for adults with health and social care needs (https://www.nice.org.uk/guidance/ng227/chapter/Recommendations#legal-right-to-advocacy)
    - Coexisting severe mental illness and substance misuse: assessment and management in healthcare settings (https://www.nice.org.uk/guidance/cg120)
    - Self-harm: assessment, management and preventing recurrence (https://www.nice.org.uk/guidance/NG225)
    - Service user experience in adult mental health: improving the experiences of care for people using adult NHS mental health services (https://www.nice.org.uk/guidance/cg136)
    - Shared decision making (https://www.nice.org.uk/guidance/ng197)
    - Transition between inpatient mental health settings and community or care home settings (https://www.nice.org.uk/guidance/ng53)
- Public Health England guidance on:
    - Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf)
- NHS England's
    - Learning Disability Improvement Standards (https://www.england.nhs.uk/learning-disabilities/about/resources/the-learning-disability-improvement-standards-for-nhs-trusts/)

Appendix 2: Summary of key actions that need to take place across a person's inpatient journey

As well as the key actions listed below, if someone is detained under the MHA, then Mental Health Act legislation (https://www.legislation.gov.uk/ukpga/1983/20/contents) and the accompanying Code of Practice (https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983) should be followed. If someone is deemed to not have mental capacity to make specific decisions, then the Mental Capacity Act (https://www.legislation.gov.uk/ukpga/2005/9/contents) and accompanying Code of Practice

(https://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpgacop_20050009_en.pdf) should be followed. All other relevant legislation and guidelines should also be followed.

From the point of presentation to within 72 hours of admission

- Holistic assessment conducted to understand the person's needs. This assessment should build on information contained within the person's EPR, including any recorded advance choices and reasonable adjustments.
- Decision reached, considering as fully as possible the person's preferences (including any ACDs), those of their chosen carer/s, and the views of relevant partner services, that the person's needs can only be met in an inpatient setting and cannot be supported in the community. For people with a learning disability and autistic people, a C(E)TR (https://www.england.nhs.uk/learning-disabilities/care/ctr/care-education-and-treatment-reviews/) should take place pre-admission to support this decision (or if this is not possible, within 28 days of admission).
- Purpose of admission discussed and agreed with the person and their chosen carer/s and uploaded to the person's EPR.
- Prompt access facilitated to the most suitable hospital provision available for the person's needs.
- Formulation review completed to gain an in-depth understanding of the person, the circumstances leading up to their admission and what will help them to recover. This, together with recorded ACDs and the findings of C(E)TRs (for people with a learning disability and autistic people), should be used as the basis to co-develop a personalised care plan with the person and their chosen carer/s, which should then be uploaded to the person's EPR.
- Discharge planning begun with person and their chosen carer/s, including identifying any factors that could delay discharge (eg housing, social care), agreeing an EDD and an intended discharge destination, and uploading these to the person's EPR.
- Interventions and treatment for physical and mental health conditions commenced or maintained, and a physical health check completed.

During the hospital stay

- Daily reviews (eg using the Red to Green approach) completed to check the person is receiving prompt access to the assessments, interventions and treatment they require, in line with their purpose of admission and care plan. Assessments, interventions and treatments should be adapted to meet reasonable adjustments and the needs of people from groups who experience health inequalities.
- Purpose of admission, care plan, discharge plan and EDD reviewed and updated regularly with the person and their chosen carer/s. If the purpose of admission is close to being met, additional focus should be given to discharge planning.
- Any factors that could delay discharge (eg need for step-down provision, home adaptations, housing, supported living or care home placement), reviewed every two to three days and proactively addressed with partner services.
- Monitoring visits completed by commissioners every eight weeks for adults with a learning disability and autistic people, and every six weeks for young adults aged up to 25, who have an EHC Plan.

At and following discharge

- Person-centred discharge plan refined with the person and their chosen carer/s. The plan should set out who is responsible for providing the assessments, interventions and treatments that the person will receive after leaving hospital and when the person can expect to receive this support.
- Discharge facilitated promptly once a decision is reached that the person is CRFD (ie the person does not require any further assessments, interventions and/or treatments, which can only be provided in the current inpatient setting), and that it is possible to discharge them (ie because the planned post-discharge support is available at that time). If a person is CRFD, but it is not possible to discharge them, they should continue receiving the interventions, activities and other support that they need in hospital to remain CRFD, so that they can be discharged as soon as planned discharge support is in place.
- At least 48 hours' notice of the decision to discharge given to the person, their chosen carer/s and any services (eg community-based mental health and learning disability teams, CRHTTs, housing services, social services) that will be involved in the person's ongoing care.
- Risk assessment updated and uploaded to the person's EPR which includes information on how any risks to self or others will be managed once the person is discharged.

- Follow-up meeting arranged pre-discharge, including providing written details of when, where and who the follow-up will take place with.
- Clear information provided to the person and their chosen carer/s about how to access crisis support after discharge (including direct contact details for the CRHTT).
- Prompt access provided to all planned post-discharge support included in the person's discharge plan. The person should also be supported to develop ACDs and a crisis plan, if they were not developed ahead of discharge.
- Follow-up completed (face-to-face wherever possible) within 72 hours of discharge for all adults discharged from an inpatient mental health service, excluding specialised services commissioned by NHS England. (NB this has been included in the NHS Standard Contract (https://www.england.nhs.uk/wp-content/uploads/2021/12/3-nhs-standard-contract-fl-service-conditions.pdf) since 2020/21.) If the follow-up indicates additional support is required, action is taken promptly to put this in place.
- Relevant information relating to a person's discharge (which may include a copy of the person's discharge plan) shared with services involved in the person's ongoing care and treatment. Discharge summary shared with the person's GP and other relevant parties, where appropriate, within a week of discharge.
- Multi-Agency Discharge Events (https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/12/rig-multi-agency-discharge.pdf) used where there are complex discharges requiring agreement across multiple partners, and follow locally agreed escalation procedures where there are concerns about delayed discharges.

Appendix 3: Holistic assessments

During the assessment and formulation process (completed within 72 hours of admission), the inpatient team should work with the person, their chosen carer/s and representatives from partner services to gather information on the areas listed below. Information contained in the person's EPR should also be reviewed at the earliest opportunity, in order to build on their existing care plan and avoid duplication of information gathering, while at the same time recognising that the EPR may not be fully up-to-date or reflective of their current needs, and therefore information should be checked with the person and/or their chosen carer/s.

The areas that should be covered as part of a holistic assessment process, in a way that meets individual needs, include:

- Mental health symptoms and experiences, and the meaning of these for the person.
- The reasons/circumstances leading to the person presenting to services, including any previous experiences of traumatic and adverse events, and any additional support that could have helped to prevent their mental health worsening.
- Treatment preferences – what the person thinks may help them now and what has helped them and not been helpful in the past, considering a range of intervention types as well as the way in which support is delivered.
- The person's skills, strengths and aspirations, and any protective factors and coping strategies that they use to manage their mental health.
- The person's usual routine and ability to carry out daily living activities.
- Current medication for physical and mental health conditions, and their experience of these medications.
- Use of drugs and alcohol, assessed using a ecognized screening tool, such as ASSIST-Lite (https://www.gov.uk/government/publications/assist-lite-screening-tool-how-to-use). The Clinical Institute Withdrawal Assessment Alcohol Scale Revised (CIWA-Ar) and the Clinical Opiate Withdrawal Scale (COWS) may be used to assess severity of alcohol/opiate withdrawal.
- Sleeping pattern.
- Diet and dietary requirements, including those relating to cultural or sensory needs.
- Physical health conditions and disabilities, including details of the person's current treatment/management plan, and any aids or reasonable adjustments needed.
- Cognitive impairment, and any aids or adjustments needed.
- Sensory preferences and any aids or adjustments needed.
- Communication preferences and any aids or adjustments needed.
- Social and family relationships – who is important in the person's life, who they would like to keep in contact with and see while in hospital and what support arrangements need to be put in place (eg for any pets and dependents).
- Support services – which health, social care and other services the person is already in contact with, what information they would like shared with these services and how they would like these services involved in their inpatient care and plans for discharge.

- Housing and financial circumstances. This may include making use of the Breathing Space (https://www.gov.uk/government/publications/debt-respite-scheme-breathing-space-guidance-on-mental-health-crisis-breathing-space) debt relief scheme and making any arrangements needed to secure their home and ensure bills are paid while the person is in hospital.
- Employment, training and education, and any information that needs to be shared with employers or education/training providers while in hospital.
- Interests and hobbies, and how these can be supported while in hospital.
- Culture, race, ethnicity and how this can be supported while in hospital.
- Religion and spirituality, and how this can be supported while in hospital.
- Sexual orientation and gender identity and how LGBT+ people can be supported while in hospital.
- The person's preferences as to who they would like involved in their care (their chosen carer/s), what types of information are routinely shared with their chosen carer/s, what aspects of their care they would usually like their chosen carer/s involved in (eg care planning), and whether their chosen carer/s have any support needs.
- Any belongings they would like with them in hospital (eg books, music, or sensory items).
- Any safeguarding or risk issues, including risk to self and others. Following NICE guidance on self-harm (https://www.nice.org.uk/guidance/ng225), risk assessment tools and scales should not be used to predict future suicide or repetition of self-harm, to decide who should be offered treatment, or to decide who should be discharged. Instead, person-centered approaches to safety planning should be used that involve the person and their nominated carer/s and take into account individual needs, risks and contexts and personal feelings of safety.

Appendix 4: Example steps as part of the Red to Green approach

Step 1

At the start of each day, record each person on the ward as having a red day.

Step 2

At the morning board round, rapidly review each person's purpose of admission and EDD:

- If the purpose of admission has been met and the person could be effective cared for in the community, identify what steps need to occur to facilitate their discharge.
- If the purpose of admission has not been met and the person still requires inpatient treatment, identify what support the person needs (assessments, interventions, treatment), to progress their recovery.

Step 3

Agree and allocate the actions that members of the MDT will complete that day. Record the allocated actions during the board round, together with information on discharge readiness and any barriers to discharge or delays to treatment.

Step 4

Following the board round, the ward administrator sends round the agreed actions to the person who is responsible for completing them (which may include people outside the inpatient team).

Step 5

Following the afternoon board round, review whether the actions allocated have been completed, and if not, what has caused the delays, and determine whether the person is having a red or green day. Record the red and green statuses during the board round, together with information on discharge readiness and any barriers to discharge or delays to treatment.

Step 6

If someone has been recorded as on a red day for 72 hours or more and the MDT cannot resolve the problems that are causing this, then it should be escalated in line with agreed procedures.

Appendix 5: Skills and competencies for the inpatient workforce

This list of skills and competencies for delivering high quality acute inpatient mental health care has been compiled from the contents of this guidance. It is therefore not exhaustive and does not include profession or discipline specific skills.

- Understanding of good practice in relation to legal obligations, eg the Equality Act, Human Rights Act, MCA, MHA and the Mental Health Units (Use of Force) Act and safeguarding. In relation to the Mental Health Units (Use of Force) Act, this includes the ability to apply techniques for avoiding or reducing the use of force and restrictive practice and the impact of these practices when used (see further details from the Department of Health and Social Care). In terms of safeguarding responsibilities, this includes the ability to identify and respond appropriately to safeguarding concerns (including disclosures of historical or recent sexual abuse) and follow agreed reporting procedures.
- Understanding of good practice in relation to legal obligations, eg the Equality Act, Human Rights Act, MCA, MHA and the Mental Health Units (Use of Force) Act and safeguarding. In relation to the Mental Health Units (Use of Force) Act, this includes the ability to apply techniques for avoiding or reducing the use of force and restrictive practice and the impact of these practices when used (see further details from the Department of Health and Social Care). In terms of safeguarding responsibilities, this includes the ability to identify and respond appropriately to safeguarding concerns (including disclosures of historical or recent sexual abuse) and follow agreed reporting procedures.
- Understanding of data protection legislation and the common law duty of confidentiality, and in particular their application to situations involving the use and disclosure of information about adults and older adults in acute inpatient mental health settings.
- Understanding of when hospital-based acute care is most appropriate for an individual and when community-based acute care would be the most suitable option (including to facilitate discharge).
- Able to write clear purpose of admission statements and use these to inform care and discharge planning.
- Able to work in partnership with people and their chosen carer/s to ensure that they receive personalised support. This includes the ability to work with people to understand their individual circumstances and needs, and to co-develop care and discharge plans, which consider a range of therapeutic activities, interventions and treatments.
- Able to deliver activities and interventions that can support people’s recovery (with appropriate training), for example, brief physical health interventions and techniques from psychological approaches.
- Understanding of trauma and the impact it can have on people’s lives, and the ability to apply trauma-informed approaches to care.
- Able to talk to people about how their cultural needs can be best met while in hospital, and the cultural competency to work with people to deliver care in a way that meets these needs.
- Skilled at engaging and working with people with specific needs, including young adults, older adults, people with dementia, people with alcohol and drug problems, people with a learning disability and autistic people , and an awareness of when and how to access additional support from specialist services, when required. Please note, staff working in services registered with the CQC need to attend mandatory training on learning disability and autism, in line with the Health and Care Act (2022).
- Awareness of a variety of local NHS and non-NHS services (including VCSE sector organisations), what these services offer, and how to work in partnership with them to carry out assessments, develop care and discharge plans, and deliver support in a coordinated way.
- Understanding of local discharge pathways, what the challenges can be to timely and effective discharge and how these can be proactively addressed.
- Able to reflect on own emotional responses and use supervision to continuously learn and develop own practice.

- Able to respond appropriately where concerns or complaints are raised by people on the ward, their carers, the public or other members of staff, and to take action to address these concerns or complaints. This may include escalating issues to more senior managers.
- Able to work with people who have used services or cared for people who have used services to improve the delivery of acute mental health care.
- Able to understand and interpret data that is routinely collected in acute services and use this to guide service improvement.
- Understanding of quality improvement methodology and how to use this to improve acute inpatient services.
- Understanding of data protection legislation and the common law duty of confidentiality, and in particular their application to situations involving the use and disclosure of information about adults and older adults in acute inpatient mental health settings.
- Understanding of when hospital-based acute care is most appropriate for an individual and when community-based acute care would be the most suitable option (including to facilitate discharge).
- Able to write clear purpose of admission statements and use these to inform care and discharge planning.
- Able to work in partnership with people and their chosen carer/s to ensure that they receive personalised support. This includes the ability to work with people to understand their individual circumstances and needs, and to co-develop care and discharge plans, which consider a range of therapeutic activities, interventions and treatments.
- Able to deliver activities and interventions that can support people's recovery (with appropriate training), for example, brief physical health interventions and techniques from psychological approaches.
- Understanding of trauma and the impact it can have on people's lives, and the ability to apply trauma-informed approaches to care.
- Able to talk to people about how their cultural needs can be best met while in hospital, and the cultural competency to work with people to deliver care in a way that meets these needs.
- Skilled at engaging and working with people with specific needs, including young adults, older adults, people with dementia, people with alcohol and drug problems, people with a learning disability and autistic people , and an awareness of when and how to access additional support from specialist services, when required. Please note, staff working in services registered with the CQC need to attend mandatory training on learning disability and autism, in line with the Health and Care Act (2022).
- Awareness of a variety of local NHS and non-NHS services (including VCSE sector organisations), what these services offer, and how to work in partnership with them to carry out assessments, develop care and discharge plans, and deliver support in a coordinated way.
- Understanding of local discharge pathways, what the challenges can be to timely and effective discharge and how these can be proactively addressed.
- Able to reflect on own emotional responses and use supervision to continuously learn and develop own practice.

- Able to respond appropriately where concerns or complaints are raised by people on the ward, their carers, the public or other members of staff, and to take action to address these concerns or complaints. This may include escalating issues to more senior managers.
- Able to work with people who have used services or cared for people who have used services to improve the delivery of acute mental health care.
- Able to understand and interpret data that is routinely collected in acute services and use this to guide service improvement.
- Understanding of quality improvement methodology and how to use this to improve acute inpatient services.

List of abbreviations

- ADASS: Association of Directors of Adult Social Services
- AMHP: Approved Mental Health Professional
- CCG: Clinical Commissioning Group
- CQC: Care Quality Commission
- C(E)TR: Care (Education) and Treatment Review
- CIWA-Ar: Clinical Institute Withdrawal Assessment Alcohol Scale Revised
- COWS: Clinical Opiate Withdrawal Scale
- CRFD: Clinically Ready for Discharge
- CRHTT: Crisis Resolution Home Treatment Team
- CTO: Community Treatment Order

- EDD: Estimated Discharge Date
- EHC: Education Health and Care plan
- EPR: Electronic Patient Record
- FTE: Full-Time Equivalent
- GDPR: General Data Protection Regulation
- GIRFT: Getting It Right First Time programme
- ICB: Integrated care board
- ICS: Integrated care system
- IMCA: Independent Mental Capacity Advocate
- IMHA: Independent Mental Health Advocate
- LGBT+: Lesbian, Gay, Bisexual and Transgender. The plus indicates that this term is inclusive of a wide range of sexual orientations and gender identities.
- LED: Light emitting diode
- MCA: Mental Capacity Act
- MDT: Multi-Disciplinary Team
- MHA: Mental Health Act
- NCISH: National Confidential Inquiry into Suicide and Safety In Mental Health
- NDTi: National Development Team for Inclusion
- NICE: National Institute for Clinical Excellence
- PCREF: Patient And Carer Race Equality Framework
- PDSA: Plan-Do-Study-Act cycle
- PICU: Psychiatric Intensive Care Unit
- UCL: University College London
- VCSE: Voluntary, Community and Social Enterprise organisations

Contributors to this guidance

In addition to the people named here, the guidance has built on broader engagement and learning through local, regional and national networks over the NHS Long Term Plan delivery period.

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13. WORKFORCE RACE EQUALITY STANDARD AND WORKFORCE DISABILITY EQUALITY STANDARD

Lynne Shaw, Executive Director of Workforce and OD

REFERENCES

Only PDFs are attached

13. WRES WDES Annual Report 2023 - Final.pdf

Name of meeting	Board of Directors
Date of Meeting	Wednesday 6 September 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 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			Management meetings where this item has been considered	
Quality and Performance			Executive Team	
Audit			Executive Management Group	X
Mental Health Legislation			Business Delivery Group	
Remuneration Committee			Trust Safety Group	
Resource and Business Assurance			Locality Operational Management Group	
Charitable Funds Committee				
People Committee	X			
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	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 6 September 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

14. CONSTITUTION AMENDMENT

Debbie Henderson, Director of Communications and Corporate Affairs

REFERENCES

Only PDFs are attached

14. Constitutional change report Aug 23.pdf

Name of meeting	Board of Directors
Date of Meeting	Wednesday 6th September 2023
Title of report	Amendment to the Trust Constitution
Lead	Debbie Henderson, Director of Communications and Corporate Affairs/ Trust Secretary
Report author	N/A

Purpose of the report	
To note	
For assurance	
For discussion	
For decision	X

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		Management meetings where this item has been considered	
Quality and Performance		Executive Management Group	
Audit		Business Delivery Group	
Mental Health Legislation		Trust Safety Group	
Remuneration Committee		Locality Operational Management Group	
Resource and Business Assurance			
Charitable Funds Committee			
Provider Collaborative/Lead Provider			
People			
CEDAR Programme Board			
Other/external (please specify) **Board of Directors – August** **Council of Governors' Nomination Committee - August**			

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	x
Quality, safety and experience		Service user, carer and stakeholder involvement	

Board Assurance Framework/Corporate Risk Register risks this paper relates to
Compliance with statutory and regulatory requirements

Board of Directors Meeting

Wednesday 6th September 2023

Amendment to the Trust Constitution

1. Executive Summary

Following the appointment of Darren Best (current Vice-Chair and Non-Executive Director), as of Chair of the Council of Governors and Board of Directors, discussions have taken place regarding the appointment process for a replacement Non-Executive Director (NED) to the Board. This paper formalises the proposal to appoint two Non-Executive Directors (one additional NED post to the current Board composition), the rationale of which is outlined below.

2. Board composition – proposed increase in Non-Executive Directors

Darren Best was successfully appointed as Chair of CNTW on 13th July following unanimous decision by the Council of Governors. Darren will commence in the role on 1st October 2023 for an initial term of office of three years. It is therefore important that the Trust commence the process to appoint into the vacant NED role as soon as possible to ensure continued balance on the Board of Directors.

Following confirmation of the Chair appointment, Darren Best as Chair designate, has undertaken discussions with the following:

- Ken Jarrold, Chair of the Council of Governors and Board of Directors
- David Arthur, Senior Independent Director/Non-Executive Director
- James Duncan, Chief Executive
- Debbie Henderson, Director of Communications and Corporate Affairs
- Anne Carlile, Lead Governor and Tom Rebair, Deputy Lead Governor
- The Council of Governors' Nomination Committee
- The Board of Directors

Darren has reflected on the Trust's future journey in the context of the implementation of the Trust's new Strategy, 'With you in mind', the challenges facing the NHS and wider health and care sector nationally, regionally and locally, the current challenges facing the Trust and mental health and disability services particularly in terms of the Trust's financial position, continual demand, workforce challenges and the need to reframe our care and support model as an organisation.

As well as the need to appoint a replacement NED for the vacancy left by Darren, it is proposed that the Council of Governors and Board of Directors approve the proposal to appoint an additional NED to the Board to represent the voice of service users and carers.

It is recognised that the Trust is perceived as a leader in terms of its approach to involvement, however, it is important that involvement is reflected within the Trust systems of governance, decision-making and setting the strategic direction, particularly within such a challenging internal and external environment.

The proposal has been supported in principle by the Board of Directors at its meeting held 2 August and the Governors' Nomination Committee at its meeting held 16 August.

As a result, this report outlines the required amendment to the Trust Constitution regarding the change to the Board composition in light of the proposals to increase the number of Non-Executive Directors.

3. Trust Constitution – Board composition

It is proposed that the section relating to the Board composition outlined in the Trust Constitution be revised to state:

23. Board of Directors- composition

> *23.1 The Trust is to have a Board of Directors, which shall comprise both executive and non-executive directors'*
>
> *23.2 The Board of Directors is to comprise:*
>
> > *23.2.1 A non-executive Chair*
> >
> > *23.2.2 A minimum of 7 other non-executive directors*
> >
> > *23.2.3 A maximum of 7 executive directors*
>
> *23.3 One of the executive directors shall be The Chief Executive*
>
> *23.4 The Chief Executive shall be The Accounting Officer*
>
> *23.5 One of the executive directors shall be The Finance Director*
>
> *23.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of The Dentists Act 1984)*
>
> *23.7 One of the executive directors is to be a registered nurse or a registered midwife*
>
> *23.8 The Board of Directors shall at all times be constituted so that at least half of the board excluding the chair, shall be independent non-executive directors*

4. Recommendation

The Board of Directors is asked to approve the amendment to the Trust Constitution regarding the composition of the Board. The amendment, if approved by the Board, will also be submitted for approval to the Council of Governors meeting on 14th September.

Debbie Henderson
Director of Communications and Corporate Affairs

August 2023

15. INTEGRATED CARE SYSTEM / INTEGRATED CARE BOARD UPDATE

James Duncan, Chief Executive

verbal update

16. FINANCE REPORT

Kevin Scollay, Executive Director of Finance

REFERENCES

Only PDFs are attached

16. Mth 4 Finance Report Board.pdf

Name of meeting	Board of Directors Closed Meeting
Date of Meeting	Wednesday 6th September 2023
Title of report	Month 4 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		Management meetings where this item has been considered	
Quality and Performance		Executive Team	x
Audit		Business Delivery Group	x
Mental Health Legislation		Trust Safety Group	
Remuneration Committee		Locality Operational Management Group	
Resource and Business Assurance		Executive Management Group	x
Charitable Funds Committee			
Provider Collaborative/Lead Provider			
People			
Provider Collaborative			
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	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 an £8.6m 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 **£1.2m better than the financial plan submitted to NHSE at Month 4**. This plan is phased to deliver deficits in the first 6 months of the year and surpluses for the second half of the year. Monthly financial targets have become more challenging in Month 4. This tightening of targets is the key reason for the worsening of the financial position – the monthly run rate shows a slight improvement. Internal budgets are phased more ambitiously and assumes delivery more evenly through the year.

1.3 **Agency costs are higher than both the agency ceiling and planned levels**. At the end of Month 4 the Trust has spent £6.2m on agency staff against a plan £5.6m and the against the Trusts nationally applied agency ceiling of £4.8m.

1.4 **Expenditure on the Trust capital programme is £2.0m lower than planned** at Month 4 but is forecasting to deliver against plan for the year. This position remains under review.

1.5 **The Trust has a cash balance of £38.8m** at the end of Month 4 which is ahead of plan, but a deterioration since last month due to changes in working capital and the current month deficit.

2. Key Financial Targets

2.1 Table 1 highlights the key financial metrics for Month 3.

Table 1

	Month 4		
Key Financial Targets	**Trust Plan**	**Actual**	**Variance/ Rating**
I&E – Surplus /(Deficit) (Internal)	(£9.8m)	(£8.6m)	£1.2m
Agency Spend	£5.6m	£6.2m	£0.6m
Cash	£17.7m	£38.8m	£21.1m
Capital Spend	£4.7m	£2.7m	£2.0m

3. Financial Performance

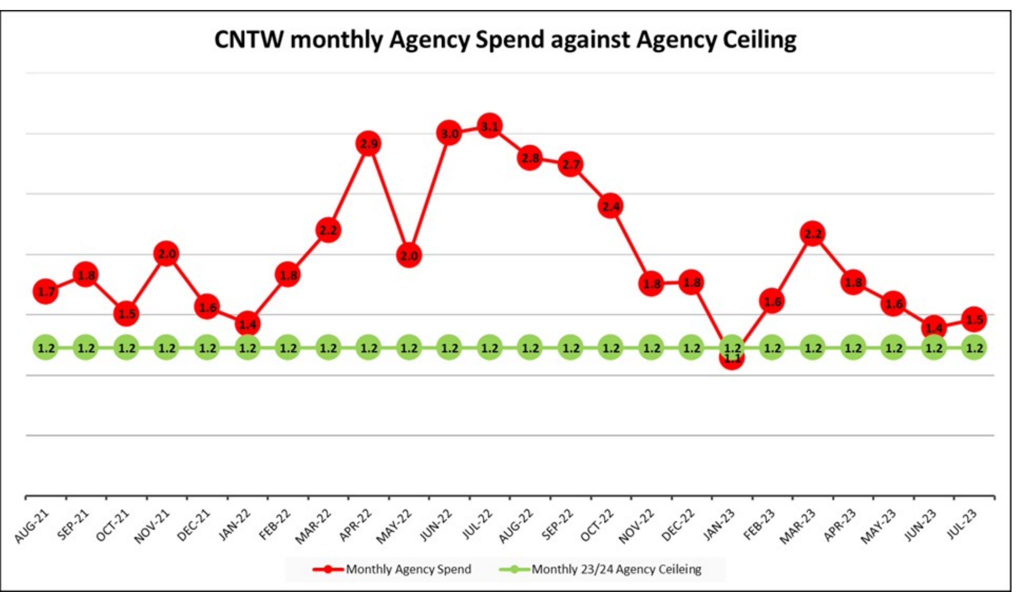
Income and Expenditure

3.1 At the end of Month 4 the Trust has reported an £8.6m deficit on Income and Expenditure, which is ahead of the plan submitted to NHSE by £1.2m. 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 August 2021. Costs in July stand at £1.5m, which is slightly higher than thise reported in June. Costs remain above the Trust budget year to date. 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



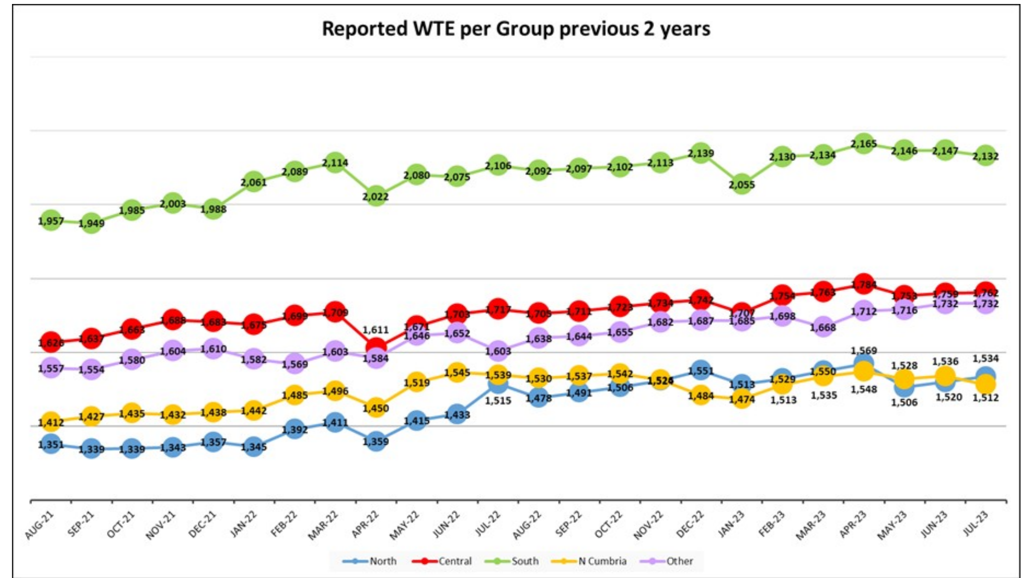
3.4 Agency costs have been a focus for the Trust in managing it's overall financial position for a number of reasons. These inlcude;

- 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. Usage of WTEs has decreased slightly since last month by 21 WTEs.

Table 3

	WTE Aug 21	WTE Jun 23	WTE Jul 23	Change since last month	Change over last 24 mths
North	1,351	1,520	1,534	14	183
Central	1,626	1,759	1,762	3	135
South	1,957	2,147	2,132	-15	175
N Cumbria	1,412	1,536	1,512	-24	101
	6,346	**6,962**	**6,940**	**-21**	**594**
Corporate & Other	1,557	1,732	1,732	0	175
	7,903	**8,693**	**8,673**	**-21**	**769**

3.8 The Trusts IM&T has been supporting the ICB in discussions with the national team regarding fuding flows associated with Miscrosoft licences, which have previously been identified as a pressure in the forecast (£0.5m). Guidance has now been reissued and this is no longer expected to increase in year efficiciency requirements for the Trust.

4. Cash

Table 4

	Year To Date		
	Plan (£m)	**Actual (£m)**	**Variance/ Rating (£m)**
Cash	17.7	38.8	(21.1)

4.1 Cash balances at the end of June were £21.2 m higher than plan, but have reduced in Month 4.

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	4.7	2.7	(2.0)	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 4 is £2.7m which is £2.0m less than the plan. The Trust is forecasting to deliver the capital programme at the end of the financial year, but has this position under review.

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.

17. MEDICAL ASSISTANT PROGRAMME

Bruce Owen, Consultant Psychiatrist / Director of Medical Education

presentation

18. QUALITY AND PERFORMANCE COMMITTEE

Darren Best, Chair

No meeting held during the period

19. AUDIT COMMITTEE

David Arthur, Chair

No meeting held during the period

20. RESOURCE AND BUSINESS ASSURANCE COMMITTEE

Paula Breen, Chair

No meeting held during the period

21. MENTAL HEALTH LEGISLATION COMMITTEE

Michael Robinson, Chair

No meeting held during the period

22. PROVIDER COLLABORATIVE COMMITTEE

Michael Robinson, Chair

No meeting has been held during the period

23. PEOPLE COMMITTEE

Brendan Hill, Chair

No meeting held during the period

24. CHARITABLE FUNDS COMMITTEE

Louise Nelson, Chair

No meeting held during the period

25. COUNCIL OF GOVERNORS' ISSUES

Ken Jarrold, Chairman

26. QUESTIONS FROM THE PUBLIC

Ken Jarrold, Chairman

27. ANY OTHER BUSINESS

Ken Jarrold, Chairman

28. DATE AND TIME OF NEXT MEETING

Wednesday 4th October 2023
1:30 - 3:30pm
Trust Board Room, St Nicholas Hospital and Microsoft Teams