Board of Directors Meeting (PUBLIC)

05 August 2020, 13:30 to 15:30
Via Microsoft Teams

Agenda

1. **Staff Story**

2. **Welcome and Apologies for absence**

Ken Jarrold, Chairman

3. **Declarations of Interest**

Ken Jarrold, Chairman

4. **Minutes of the previous meeting held Wednesday, 23 June 2020**

Ken Jarrold, Chairman

03. 23 June 2020 DRAFT PUBLIC Board minutes WIP.pdf (13 pages)

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

Ken Jarrold, Chairman

05. BoD Action Log PUBLIC as at 23.06.20.pdf (3 pages)

6. **Chairman's Remarks**

Ken Jarrold, Chairman

7. **Chief Executive's Report**

John Lawlor, Chief Executive

07. CEO Report 5 August 2020.pdf (6 pages)

Quality, Clinical and Patient Issues

8. **COVID-19 Update**

Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

08. COVID-19 Update.pdf (12 pages)

8.1. **Mental Health Legislation update in view of COVID-19**

Rajesh Nadkarni, Executive Medical Director

08.1 Mental Health Legislation Update in View of the Coronavirus Pandemic Board Paper August 2020.pdf (5 pages)

9. **IPC Board Assurance Framework**

Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

09. IPC - Board Assurance Framework -JULY 20 AM.pdf (18 pages)

10. **Annual Flu Plan**

Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

10. Annual Flu Plan 2020-21.pdf (30 pages)

DRAFT

11. Commissioning and Quality Assurance Report (Month 3)

Lisa Quinn, Executive Director of Commissioning and Quality Assurance and James Duncan, Deputy Chief Executive / Executive Director of Finance

- 11. Monthly Commissioning Quality Assurance Report - Month 3.pdf (8 pages)

12. Safer Care Annual Report 2019-20 (including Q1 update)

Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

- 12. Safer Care Annual Report July 20 - FINAL.pdf (26 pages)

13. Service User and Carer Experience Report (Quarter 1)

Lisa Quinn, Executive Director of Commissioning and Quality Assurance

- 13. Service User and Carer Experience Report Q1 202021.pdf (20 pages)

14. Safer staffing levels (Quarter 1 including 6 monthly skill mix review)

Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

- 14. Safer Staffing Report Inc Six Month Skill Mix - May 2020 data.pdf (7 pages)

15. Guardian of safe working hours (Quarter 1)

Rajesh Nadkarni, Executive Medical Director

- 15. GoSW Q1 Board Report April - June 2020 Final.pdf (6 pages)

16. Local Clinical Excellence Awards 2019

note: CEA 2019 report is required to be submitted to Board prior to being published on the Trust website

Rajesh Nadkarni, Executive Medical Director

- 16. CEA Report July 20.pdf (6 pages)

Strategy and Partnerships - no issues for this month

Regulatory

17. CQC Must Do Action Plans Update

Lisa Quinn, Executive Director of Commissioning and Quality Assurance

- 17. BoD - CQC Must Do Action Plans Q1 Update.pdf (60 pages)

17.1. Focused inspection - Learning Disability and Autism

17.2. North Cumbria - closure of Must Do actions

17.3. CQC Must Do actions update

18. Board Assurance Framework and Corporate Risk Register (Quarter 1)

Lisa Quinn, Executive Director of Commissioning and Quality Assurance

- 18a. BAF and Corporate Risk Register Report July 2020.pdf (9 pages)
- 18b. BoD - BAF Risk Register - Appendix 1.pdf (1 pages)

DRAFT

18c. BoD - BAF Risk Register - Appendix 2.pdf (22 pages)

18d. BoD - BAF Risk Register - Appendix 3.pdf (27 pages)

19. Quarterly Report to NHS England and Improvement including submissions

Lisa Quinn, Executive Director of Commissioning and Quality Assurance

20. Annual Security Management Report

Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

20. Security Management Annual Report - Board of Directors Final 20 July 202...pdf (10 pages)

21. Annual Infection Prevention and Control Report

Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

21. IPC Annual Report 2019-20 - FINAL.pdf (26 pages)

22. Annual Safeguarding Report

Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

22. Safeguarding Annual Report 2019-20 - Final.pdf (15 pages)

Minutes/Papers for Information

23. Committee Updates

Verbal/Information

Non-Executive Directors

24. Council of Governors' Issues

Verbal/Information

Ken Jarrold, Chairman

25. Any other Business

Ken Jarrold, Chairman

26. Questions from the Public

Ken Jarrold, Chairman

Date, time and place of next meeting:

27. Wednesday, 2 September 2020, 1.30 pm Venue TBC

DRAFT

Minutes of the meeting of the Board of Directors held in public on 23 June 2020, 1.30pm – 3.00pm Microsoft Teams Meeting

Present:
Ken Jarrold, Chairman
David Arthur, Non-executive Director
Darren Best, Non-Executive Director
Dr Leslie Boobis, Non-Executive Director
Paula Breen, Non-Executive Director
Alexis Cleveland, Non-Executive Director
Michael Robinson, Non-Executive Director
Peter Studd, Non-Executive Director
John Lawlor, Chief Executive
James Duncan, Deputy Chief Executive/Executive Finance Director
Rajesh Nadkarni, Executive Medical Director
Gary O'Hare, Executive Director of Nursing and Chief Operating Officer
Lisa Quinn, Executive Director of Commissioning and Quality Assurance
Lynne Shaw, Acting Executive Director of Workforce and Organisational Development

Governors in attendance:
Margaret Adams, Public Governor
Tom Bentley, Public Governor
Fiona Regan, Carer Governor
Revell Cornell, Staff Governor
Bob Waddell, Staff Governor
Evelyn Bitcon, Shadow Governor

In attendance:
Debbie Henderson, Deputy Director of Communications and Corporate Affairs
Jennifer Cribbes, Corporate Affairs Manager
Keith Reid,
Ron Weddle
Christine Ntanda
Edith Russell,

1. BAME Staff Network

Ken Jarrold extended a warm welcome to Edith Russell, and Christine Ntanda, Co-Chairs of the BAME Staff Network who were in attendance to provide the Board with an update in relation to the recent work of the BAME Staff Network.

Edith Russell commenced by thanking the Board, for the Trust's support, as the staff who had attended the last BAME network meeting had felt supported by the Trust during the recent pandemic. Edith continued by sharing a personal experience when working as a bank member of staff on one of the Trust's wards.

DRAFT

Christine Ntanda spoke to a PowerPoint presentation to update the Board on recent work of the BAME Staff Network including the network's development plan, education and representation.

Rajesh Nadkarni thanked both Edith and Christine for their excellent leadership.

Lynne Shaw thanked Edith and Christine for their honest and powerful presentation and referred to the section of the presentation on development opportunities and recruitment. She advised that the Trust's statistics show that over the last 12 months, a white person would be more likely to be appointed to a position in a recruitment process following shortlisting than a BAME person. Furthermore, statistics in relation to disciplinary processes, show that BAME staff are more likely to be subjected to a disciplinary process than a white member of staff. Therefore, the Trust is required to make improvements. Lynne further advised that the BAME Staff Network would have the full support of the Workforce and OD Directorate to take forward the work in this area.

Lynne Shaw referred to cultural ambassadors and advised that she was meeting with the Royal College of Nursing later that day. Lynne explained that she would be encouraging them to arrange some training to increase the number of cultural ambassadors within the Trust and across the region.

James Duncan thanked Edith and Christine for an excellent presentation and asked how the Board could provide support and help to increase the profile of the BAME Staff Network. Edith Russell advised that there had been a significant increase in BAME colleagues attending the last meeting of the Staff Network and that one of the benefits of the COVID-19 Pandemic had been the introduction of Microsoft Teams as it has made the meeting more accessible. Edith also explained that they would like middle managers to support BAME staff to attend the Staff Network meeting, as they are aware that some individuals working on wards are not able to take the time away from their duties to attend.

Christine Ntanda further asked that leaders within the Trust make time to listen, without judgement, to BAME staff when expressing their views and sharing their lived experience. Furthermore, when making change, ensure that the BAME member of staff is included and part of the solution.

Evelyn Bitcon, Shadow Governor, congratulated Edith and Christine for delivering a very powerful presentation and advised that although Cumbria has a slow growing BAME community, good work had been completed relating to inclusion and equality. Evelyn expressed her sadness for the experiences that BAME staff have had whilst working within the NHS and raised the need for providing BAME staff with the opportunities that they deserve.

David Arthur asked Edith and Christine if the Non-Executive Directors could attend one of the BAME Staff Network meetings to enable them to gain an understanding of the issues raised and identify ways in which the Board can positively support BAME staff. David referred to the presentation in which it was stated that representation was needed from individuals higher in the organisation and advised that the representation from Non-Executive Directors and Governors may help to achieve that aim.

DRAFT

Edith Russell invited the Board to attend the BAME Staff Network and agreed to send a diary invite with further details. Edith advised that Ken Jarrold had attended the meeting and explained the valuable advice that he had provided in relation to not needing a lot of people in attendance at a meeting in order for it to be successful, as sometimes fewer people can make a difference.

Margaret Adams, Governor, explained that the Service User and Carer Reference Group was actively looking to ensure that the Trust's Together Strategy is embedded in a way that is inclusive. Margaret further questioned how BAME colleagues could be included to support the implementation of the next phase. Edith recommended including colleagues from the BAME Staff Network and also the Trust's Cultural Ambassadors from the beginning.

John Lawlor thanked Edith and Christine for an excellent presentation and advised that over previous years the Trust had focused on the Workforce Race Equality Standard metrics. However, it was important to understand the Trust's role in its capacity of an organisation, provider of services and employer of over 7000 staff. John referred to the increased number of attendees at the staff network meeting as a result of the introduction of Microsoft Teams and explained that the Trust maybe held to account more as a result.

Les Boobis explained that his daughter is a Director of a Community Arts Programme in London and had recognised that black artists were under-represented and have difficulty accessing programmes that white people can easily access. As a result she will be advertising to specifically encourage black people to apply. Edith explained that the media displays black people negatively. Therefore, people have an unrealistic view of black people, their culture and intelligence. Christine advised that she had read some research that demonstrated that biases are embedded in an individual from childhood. Therefore, there is a generation that has grown up knowing that black is inferior and white is superior which has resulted in some people bleaching their skin to try and become accepted. Furthermore, the biases have resulted in black people being viewed as threatening, uncultured, not talented and not capable of doing a job at a certain level. Christine provided an example of how stereotypes had impacted on the quality of care of patients.

Fiona Regan advised that one of her friends, living in America, is black and had said to her that "you don't understand the problems that black people face until you have worn the skin". Edith agreed and explained that black people have to work three times harder than everyone else to prove themselves.

Ken Jarrold thanked Edith and Christine for the presentation stating that it was one of the most defining moments of his time with CNTW and appropriately challenging. Ken advised that the Trust was very grateful to both Edith and Christine for delivering the presentation and explained that the Trust will do it's very best to respond to the issues raised. Ken advised that Jennifer Cribbes would help to circulate the BAME meeting dates and some papers that had been helpful to him.

Resolved:

- **The Board received the BAME update**

DRAFT

Action:

- **BAME meeting dates and papers for information to be circulated**

2. Welcome and Introduction

Ken Jarrold opened the meeting and welcomed those in attendance.

3. Apologies for absence:

There were no apologies for absence.

4. Declarations of Interest

There were no additional conflicts of interest declared for the meeting.

5. Minutes of the meeting held 29 May 2020

The minutes of the meeting held on 29 May 2020 were considered and agreed as an accurate record of the meeting.

Approved:

- **The minutes of the meeting held 29 May 2020 were agreed as an accurate record**

6. Action list and matters arising not included on the agenda

29.05.20 (9) IPC Board Assurance Framework
Gary O'Hare confirmed that there had been no change to the framework since the last Board of Directors meeting.

Alexis Cleveland referred to the large number of actions included in the action list and noted that many had been delayed as a consequence of the COVID-19 pandemic. Alexis suggested developing a plan for recovery, whereby a review of actions could be conducted and where appropriate, some actions could be delegated to the Board Sub-Committees. It was agreed that Debbie Henderson would lead the review of Board actions.

Resolved:

- **The Board received and updated the Action List.**

Action:

- **Review of actions to be conducted and delegated to Board Sub-Committees where appropriate.**

Matters Arising

There were no matters arising.

DRAFT

7. Chairman's remarks

Ken Jarrold commenced the meeting and apologised to Fiona Regan, Governor, for omitting to include the 'CQC Report – Focused Inspection of wards for people with a learning disability or autism' as a separate item on this agenda. Ken explained that the report had been included as an item within the Chief Executive's report and that it had not been excluded as a separate item to limit coverage of the report.

Resolved: • **The Board received and noted the Chairman's report**

8. Chief Executive's report

John Lawlor provided a verbal update to keep the Board informed on current issues.

John commenced by providing an update on the Trust's response to the COVID-19 Pandemic and advised that the Trust had responded to the pandemic well. It was explained that further information would be provided under agenda item 10 'Response to COVID-19 Pandemic.

John referred to the CQC Focused Inspection of wards for people with a learning disability or autism report and reminded the Board that it had been published on 28 May 2020, the day prior to the last Board of Directors meeting. It was explained that as a result of the timescales involved, the draft report had been considered at the Closed Board of Directors meeting held on the 29 May 2020. It was further explained that a number of areas of non-compliance had been found which had been very disappointing. John further advised that the first draft of the action plan had been discussed at the Closed Board of Directors meeting held earlier that morning and would subsequently be published as part of the papers of the Board of Directors meeting held in Public in August.

John provided an update in relation to the CEDAR project and advised that with the exception of the land sale value being less than expected as a result of the COVID-19 pandemic and subsequent impact on the economy, the project had been progressing well. James Duncan explained that the full business case had been submitted and subsequently the Department of Health has made the Trust aware that they are intending to fast-track the business case. Therefore, it will be presented at the national Investment Committee in August. Peter Studd made the Board aware that planning permission for the Ferndene site had been approved. Therefore, all planning permission associated with the CEDAR project had been approved.

John provided an update in relation to the Newcastle Collaborative and advised that the development of a Memorandum of Understanding/Collaborative Agreement is planned which will be presented at a future Board of Directors meeting. John explained that it is an example where Place based planning could be achieved. It was further explained that CNTW would be required to understand what could be offered from the organisation, such as how the Trust can support local care homes.

DRAFT

Finally, John advised that the national planning guidance due to be issued had been delayed which makes it difficult to plan financially.

In response to a question raised by Michael Robinson, John Lawlor described the structure of Localities, Place/Local Authority, Integrated Care Partnerships and Integrated Care Systems.

Fiona Regan, Governor referred to the CQC Report and advised that it had been the last item on the Council of Governors meeting agenda. Therefore, a number of Governors had not been able to participate in an in-depth discussion. Fiona explained that this was the reason she had requested the CQC report to be added as an agenda item to the Board of Directors meeting. Fiona explained that the report highlighted areas that the Board are required to prioritise their focus on and explained that to obtain first-hand knowledge, visits must be arranged that are unannounced. Fiona commented that she felt what had been reported within the Board papers had not been implemented in practice. Fiona further raised that at the Board meeting in November 2019, she had suggested that the Board convene a special meeting to review and plan the Trust's response to the current crisis in mental health, particularly relating to Learning Disability and Autism. Fiona explained that it had been agreed by John Lawlor, Chief Executive and it had been suggested that other interested parties should be involved including Local Authorities and CCGs. However, the meeting had not been organised. Fiona asked the Board to respond to her comments.

Ken Jarrold advised that the COVID-19 pandemic had postponed a lot of work that the Trust had planned to complete. John Lawlor explained that he visits the Learning Disability Services frequently and had visited them soon after the closure of Whorton Hall. John explained that in his view, talking to service users and staff was better than receiving a performance report.

Gary further advised that he would consider Fiona's comments alongside the overall CQC report and clear actions will be developed. Gary explained that people with Learning Disabilities and Autism had been subject of high profile media attention over recent months and advised that the CQC report is an important reminder that we must focus on those services. Gary further advised that senior people within the Trust will be involved in the review of services and highlighted that the Trust will endeavour to improve the services beyond the CQC Must Do actions.

Ken Jarrold thanked Fiona for her comments and reminded those in attendance at the meeting that the Board had spent a significant amount of time in the Closed Board meeting reviewing the action plans that will be presented at the next Board of Directors meeting held in public.

Evelyn Bitcon advised that there are issues in North Cumbria in relation to Learning Disability Services, Autism and Mental Health and asked if Governors are able to visit services. Ken Jarrold advised that Debbie Henderson had been working on a Governors visit programme which will be implemented in the near future.

Resolved:

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

DRAFT

Annual Reports

9. Positive and Safe Annual Report

Gary O'Hare introduced the agenda item stating that a phenomenal amount of work had been completed during the year. Gary referred to recently published 'CQC Focused Inspection of wards for people with a learning disability or autism report' and advised that the Positive and Safe Annual Report demonstrates the challenges in existence across the health system for people with Learning Disabilities and Autism.

Ron Weddle commenced by introducing the report and providing detail in relation to service user and carer involvement in quality improvement days, new initiative, changes to policy and draft strategy in development.

Keith Reid commenced by providing background information on work completed over the previous year, including contributing to national policy documents, national work to reduce restraint, the challenges faced as a result of individuals transferring from private sector facilities that had been closed, mechanical restraint, primary, secondary and tertiary interventions, and Seni's law.

Keith provided detailed information and statistics in relation to the use of restraint, rapid tranquilisation injections, prone restraint, mechanical restraint equipment, seclusion, rapid tranquilisation oral, assaults on staff, violence and aggression and self-harm.

Darren Best referred to the graph that showed the mechanical restraint figures on one ward and commented on the usefulness of the graph to demonstrate the impact that one person can have on restraint figures.

Darren congratulated the team for the innovation used, particularly in relation to body worn cameras and use of staff who are good at restraint reduction.

Darren referred to the information and statistics within the report and highlighted that there was currently no equality comparison within the figures. Darren explained that equality data would be useful to understand how staff respond to different ethnic minorities. Keith advised that they would look to introduce equality data into the report and explained that neuro developmental services had the most incidences of restraint. Keith further advised that the figures within the neuro-development service relating to the restraint of BAME individuals are very small.

In response to a question raised by Darren Best in relation to the North Locality figures for use of rapid tranquilisation, assaults on staff and self-harm, Keith Reid explained that the Autism service which takes care of people who have required restraint elsewhere, is with the North Locality and this contributes to the higher figures.

Finally Darren questioned the Full Monty Award. Keith Reid explained that the award is given to wards who have done the full number of social inclusion and activity interventions within the Star Wards programme. It was explained that Star Wards is

DRAFT

an evidence based restraint reduction suite of activities such as having comedy and pizza nights.

Fiona Regan referred to the section of the Positive and Safe Annual Report on Prone Restraint and stated that she had a problem with the statement on page 4 "Prone restraint, while a focus of discussion for some, is not universally seen as worse than alternatives by all service users, and there is no evidence that prone is more physically dangerous". Fiona advised that she felt this was in direct contrast and contradicted the Department of Health's paper 'Positive and Proactive Care: reducing the needs for restrictive interventions'. Fiona read out a section of the report and advised that when she attended the Restraint Reduction Conference in November 2019, a mother shared her story in which her non-verbal son with autism had died due to prone restraint. Fiona further referred to the George Floyd case whereby he could not breathe as a consequence of prone restraint and had also sadly died. Therefore, people who had autism and are non-verbal are unable to say they cannot breathe.

Fiona read further a section of the Department of Health paper in relation to leadership assurance and stated that the Board must approve positive behaviour support planning and restrictive intervention reduction training to staff. Furthermore, Audits must provide and include reviews of positive behaviour support. Fiona further stated that she could not see reference within the bar charts within the Positive and Safe Annual Report to any positive behaviour support.

Fiona stated that her first question, which she believes is very misleading as the wording in relation to prone restraint. Keith Reid stated that all restraint is bad and people had died in different positions due to airway occlusion, compression of the chest, cardiac exhaustion and crush injuries. Keith advised that he agrees that for some people, prone restraint can be psychologically damaging. However, he believed prone restraint is not more dangerous than other types of restrain positions and to generalise restraint position is less important than having individualised care and asking individual people what type of restraint they would prefer to have.

John Lawlor, referred to the ongoing national review into children and young people's inpatient services and advised that the points and discussions raised were currently live issues. John referred to the Oversight Board, Chaired by the Children's Commissioner and advised that they have a view that a young person should never be restrained.

John further highlighted the increased focus on human rights and explained that Keith and Ron will consider the issues regarding human rights going forward. John explained that one of the first services he had visited as Chief Executive of the Trust was Alnwood the Children and Young People's service and explained that a young lady explained that in her care plan she wished to be prone restrained because she felt safer in that position.

Ken Jarrold thanked Keith Reid and Ron Weddle for sharing their very important report.

Ken further thanked everyone in attendance for their comments and contribution to the difficult discussions.

DRAFT

Resolved:

- **The Board received the Positive and Safe Annual Report**

Quality, Clinical and Patient Issues

10. Response to COVID-19

Gary O'Hare spoke to the enclosed report, 'Response to COVID-19' and advised that it was an update to the detailed report received the previous month.

Gary referred to the section of the report, Non-Executive Director visit to Gold Command and advised that since the last Board of Directors meeting, Darren Best had visited Gold Command, joined the Incident Management Group meeting and had spent time with Gold Command members in a round table discussion. Gary explained that his visit had been very well received by the team and his reflections had been very useful.

Gary explained that in terms of quality and performance, 74 patients had been screened. It was explained that the vast majority of these patients had been screened due to their admission or prior to being discharged. Gary made the Board aware that a very small number had been confirmed as positive for COVID-19.

Gary referred to the section of the report on PPE and explained that the Trust continues to have sufficient stores. However, there is a national shortage particularly in relation to FFP3 Masks. Furthermore, some of the FFP3 masks had been recalled.

Gary brought the Board's attention to the section of the report on national testing and government's five pillar testing strategy. Gary advised that the Trust covers four of the strategies as listed within the report. Gary explained that all patients are tested on admission, prior to discharge and if they are symptomatic. Gary confirmed that three patients had currently tested positive for COVID-19 and advised that all three had recently visited acute inpatient services. In relation to staff testing, it was explained that all staff who have symptoms of COVID-19 are swab tested at pace which helps manage the sickness levels across the organisation. It was confirmed that over 5500 staff had been tested for antibodies in 2 ½ weeks and approximately 15% had tested positive for antibodies which is consistent with the figures for the North East. Gary reminded Board members that there is still no clear evidence that proves that someone with antibodies will not be re-infected.

Gary advised that staff sickness has continued to be managed by the centralised staff absence line and explained that the service had been enhanced to include 'test and trace' as internal organisations are required to complete their own test and trace. It was explained that an internal test and trace had led to a positive patient and staff result.

DRAFT

Gary referred to next phase work and re-introduction of services that had been stood down as a result of the covid-19 pandemic. It was explained that the Trust would be looking to maintain the good working practices that had resulted from the pandemic, including 7 day working with extended hours where appropriate.

Gary referred to the impact on the workforce and advised that there were low numbers of staff off sick with the vast majority being staff who are shielding.

Gary advised that in relation to risk assessments of staff in high risk groups including BAME staff, 86% has been completed. It was explained that the managers who had not yet had a completed risk assessments on staff in high risk groups were being chased to ensure that the remaining staff have been risk assessed.

In relation to communications, Gary advised that a daily bulletin continues to be shared across the organisation alongside a weekly Executive Director Question and Answer session which has been well received by staff.

Darren Best referred to his visit to Gold Command and thanked Gary and the Gold Command members. Darren explained that despite knowing a lot about command from his previous role in Northumbria Police, he had learned a lot. Darren advised that he had gained assurance from the visit and highlighted that the staff had been amazing particularly the action loggist, call handlers and Gold Command members. Darren explained that during the Incident Management Meeting, decisions had been made at pace by appropriate senior managers in attendance which provided assurance.

Darren explained that there were two suggestions for improvement that he had made during his visit. These were, to consider developing a high level strategy to focus agendas and next phase work and also to consider a structure for capturing relating to lessons learned to ensure they are visible.

In response to a question raised by Peter Studd in relation to the risk associated with test and trace and potentially a high number of staff being required to self-isolate, Gary O'Hare explained that the guidance advises that if staff are wearing PPE i.e. a mask, and a colleague tests positive, staff will not be required to self-isolate for two weeks as they have been protected. Gary advised that the Trust had taken all possible measure to protect staff. Furthermore, the staff would be quickly swab tested. Gary advised that as a result of a patient testing positive on a ward, all members of staff who had been in contact with the patient quickly received a swab test.

In response to a question raised by Les Boobis in relation to staff testing for those who have been exposed to someone infected with the COVID-19 virus, Gary explained that if the first test is negative, staff can be retested. However, it is now known that someone can receive a negative virology test and when receiving an antibody test, can have a positive result for antibodies.

Resolved: • **The Board received the Response to COVID-19**

DRAFT

11. Commissioning and Quality Assurance Report (Month 2)

Lisa Quinn spoke to the Integrated Commissioning and Quality Assurance Report for May 2020 (month 2) to update the Board on issues arising and progress made against the quality standards.

Lisa brought the Board's attention to the section of the report on Mental Health Act Reviewer visits and confirmed that there had been six visits during the period. Lisa advised that the issues raised during the visits would be considered within the CQC Compliance and Steering Groups.

Lisa further highlighted the position in relation to the Trust's waiting times and advised that there had been an increase in waiting times for adult services, in particular, for the Memory Protection Services for older people. Lisa advised that a paper had been taken to the Incident Management Group to introduce measures for access to Memory Protection Services. Lisa further highlighted that waiting times for access to Children and Young People's Services had improved.

Lisa further explained that there had been a negative impact on staff training and appraisal as a consequence of the COVID-19 pandemic. However, all of the Trust localities were now concentrating on completing appraisal and training as the vast majority can be completed online.

Finally, Lisa advised that the Accountability Framework Meetings had been re-introduced and would be held in July.

In response to a question raised by Darren Best in relation to the Mental Health Act review visits and the issues that had arose, Lisa Quinn explained the changing position in relation to visiting and leave as a result of the COVID-19 Pandemic and national guidance. Lisa explained that reviews of leave management and visiting had been conducted to ensure that an individual approach has been taken. Gary advised that all the reviewer visits were now being reviewed and considered at the Business Development Group on a weekly basis to ensure significant progress is made.

Darren Best further highlighted improvement as a consequence of the COVID-19 pandemic. Such as, the reduction in out of areas placements which may increase again in the future. Lisa Quinn advised that there had already been a small increase in the number of out of areas placements in month 3. Lisa explained that the reduction in out of area placements had been helpful as it has allowed the Trust to accommodate people locality who have required to be admitted. Lisa advised that the Trust is expecting an increase in out of area placements and highlighted that pressure on inpatients services had been increasing during month 3.

Michael Robinson referred to Darren's question in relation to section 17 leave and advised that information in relation to the Trust's approach will be included in the Mental Health Act report paper that will be presented at a future Board meeting.

Resolved: • **The Board received the Commissioning and Quality Assurance Reports for month 2.**

DRAFT

Regulatory

12. Board Self Certification to NHS Improvement (Condition FT4 (8)) G6(8) and CoS7(3)

Lisa Quinn spoke to the enclosed reports Board Self-Certification to NHS Improvement (Condition FT4(8)), G6(8) and CoS7(3).

Lisa explained that NHS Foundation Trusts are required by NHS Improvement to self-certify the declarations annually to maintain their Provider Licence. Lisa referred to the evidence provided within the report that demonstrates the Trust's compliance.

The Board was asked to confirm compliance in relation to Condition FT4(8), G6(8) and CoS7(3) of the Provider Licence which confirms that the Trust has complied with required governance standards and objectives.

Approved: • **The Board approved that the Trust is compliant with Provider Licence Condition FT4(8) G6(8) and CoS7(3)**

13. Provider Licence Self-Certification Annual Board Statement Training of Governors

Lisa Quinn spoke to the enclosed Board Self-Certification to NHS Improvement report and explained that NHS Foundation Trusts are required by NHS Improvement to annually self-certify the Trust's compliance.

Lisa advised that the Council of Governors, at their meeting on the 18 June 2020, confirmed that they recommend that the Board of Directors approve the Board Statement confirming that the Trust has provided the necessary training to the Council of Governors during 2019/20.

Approved: • **The Board approved that the Trust is compliant with Provider Licence Self-Certification Annual Board Statement Training of Governors**

Minutes/papers for information:

14. Committee updates

David Arthur, Chair of the Audit Committee, made the Board aware that the Audit Committee had reviewed the Trust's Annual Accounts in detail and following the External Audit, the Trust is on track to receive a clean Audit report.

There were no further updates from Committees that required escalation to the Board.

DRAFT

Resolved:

- **The Board received the update from Committees**

15. Council of Governor issues

Ken Jarrold provided an update on Governor Issues and advised that the Council of Governors meeting was held in public on 18 June 2020 via Microsoft Teams. It was explained that the meeting had been very good with presentations having been delivered in relation to the Cumbria Locality, COVID-19 and CQC Report – Focused Inspection of wards for people with a learning disability or autism.

Ken advised that positive feedback had been received following the meeting.

There were no further Council of Governor issues.

Resolved:

- **The Board received the update on Council of Governor Issues**

16. Any Other business

Fiona Regan referred to the section of the Positive and Safe Annual Report on Body Worn Cameras and advised that she had raised the issue with Body Worn Cameras at two Governor Meetings and it had been agreed that the finding should be presented to the Governors following the pilot. Fiona explained that the report indicated that the use of Body Worn Cameras had been agreed and accepted. However, the Governors had not agreed. Fiona advised that she was asking for the use of Body Worn Cameras to be reviewed. Debbie advised that she would follow up the comments made by Fiona and will organise a meeting with Fiona to discuss the issues raised.

Les Boobis made the Board aware that the NHS Charities Together Fund had greatly benefited from money raised by Sir Captain Tom and advised that the Trust had been awarded two payments of £50k and a grant application had been submitted for a further £35k to use on improving the environment for patients and staff and also managing the challenges associated with COVID-19. Les advised that the Trust had been very lucky to gain the additional funds.

Ken Jarrold thanked Sir Captain Tom and the British public for their generosity.

There being no further business to discuss, Ken Jarrold closed the meeting and thanked everyone for their contribution.

17. Questions from the public

There were no questions from members of the public in attendance.

Date and time of next meeting: Wednesday, 5 August 2020, 1:30pm to 3:30pm, Microsoft Teams.

DRAFT

Board of Directors Meeting held in public

Action Log as at 5 August 2020

Item No.	Subject	Action	By Whom	By When	Update/Comments
		Actions outstanding			
06.11.19 (12)	Staff Friends and Family Test	Explore possible actions to address potential impact of automated messages on people who contact services by telephone	Gary O'Hare	~~May 2020~~ August 2020	Verbal update to be provided at the August meeting under action log update
07.08.19 (19)	Safer Staffing Levels incl 6 monthly skill mix review	A revised paper to include an MDT approach to safer staffing including agency medical locums to be presented to a future Board meeting	Gary O'Hare/Rajesh Nadkarni	~~May 2020~~ August 2020	Verbal assurance to be provided at the August meeting under action log update
04.03.20 (11)	Commissioning and Quality Assurance Report	Board to receive a briefing on waiting times for Children and Young People's Services in Sunderland.	Lisa Quinn	~~May 2020~~ September 2020	On track. Propose to bring a paper on waiting times across the trust to September meeting
29.05.20 (24)	Safer Care Report	The Trust to explore including data in relation to Positive Behaviour Support within future Safer Care reports	Gary O'Hare	September 2020	On track
29.05.20 (17)	Freedom to Speak Up	Board to receive a report detailing the process for managing complaints, concerns and compliments from service users	Gary O'Hare	September 2020	On track
06.11.19 (11)	Safer Care Report	Provide an analysis of the forecasted data relating to restraint and seclusion to a future Board meeting	Gary O'Hare/ Damian Robinson	~~April 2020~~ September 2020	On track

DRAFT

Item No.	Subject	Action	By Whom	By When	Update/Comments
01.04.20 (8)	Transfer between Children and Young Peoples services	Improve the transition between Children and Young Peoples services and Adult services	John Lawlor/ Gary O'Hare	October 2020	On track
06.11.19 (7)	Chief Executive's Report	Recommendations/actions following the IIP assessment to be submitted to a future Board meeting	Lynne Shaw	November 2020	To be included as part of a Board development session in November
04.03.20 (7)	Chief Executives Report / Marmot Report	Board to hold a Development Session to review the findings in the Marmot Report	John Lawlor	November 2020	On track
29.05.20 (17)	Freedom to Speak Up	Future FTSU Reports to detail which concerns had been raised as whistle blowing and which had been raised as concerns	Lynne Shaw	December 2020	On track

DRAFT

Completed Actions					
23.06.20 (1)	BAME Staff Network	BAME Staff Network dates and papers for information to be circulated to the Board	Jennifer Cribbes	August 2020	Complete
23.06.20 (6)	Action list	Review of actions to be conducted and delegated to Board Sub-Committees where appropriate	Debbie Henderson Sub-committee Chairs	August 2020	Complete
29.05.20 (7)	Planning Arrangements and Strategy	The Board to receive a report on planning arrangements and future strategy.	John Lawlor / James Duncan	June 2020	Complete – agenda item August meeting
29.05.20 (8)	Response to COVID-19	Letter of thanks to be included in the staff bulletin	Debbie Henderson	June 2020	Complete

29.05.20 (9)	IPC Board Assurance Framework	The Board to receive a further paper on IPC Board Assurance Framework in June.	Gary O'Hare	June 2020	Complete – August agenda item
04.03.20 (14)	Staff Survey Results	Board to receive further analysis of the staff survey results at a future meeting	Lynne Shaw	May 2020 Deferred re COVID	Included on Board development session cycle
04.03.20 (11)	Commissioning and Quality Assurance Report	Board to receive feedback to provide assurance that actions arising from Mental Health Review visits have been resolved	Lisa Quinn	May 2020 August 2020	Complete. Update in the CQC Q1 report this month. Assurances going through MHL too.

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 5 August 2020

Title and Author of Paper: Chief Executive's Report
John Lawlor, Chief Executive

Paper for Debate, Decision or Information: Information

Key Points to Note:

Trust updates

1. Staff Survey
2. Climate Health
3. Ministerial Visit
4. CAMHS
5. CEDAR scheme

Regional updates

6. Newcastle Collaborative Agreement
7. Home Treatment Accreditation Scheme
8. CQC Provider Collaboration Reviews

National updates

9. NHS Planning Update 20/21
10. Summer Economic Statement
11. Recovery Position: What next for the NHS?
12. A Paradigm Shift in Mental Health in the COVID era
13. Contribution to a Roundtable Conference with Baroness Lawrence.

Outcome required: For information

DRAFT

Chief Executive's Report

5 August 2020

Trust updates

1. Staff Survey

This years' Staff Survey will take place in the Autumn. This announcement was made last week following several months of uncertainty and national discussion about the viability of undertaking a survey this year due to the current Covid-19 situation. The questionnaire will remain virtually the same as in previous years to support comparable data measurement from previous surveys. However, questions have been added which are specific to Covid-19 and which will enable an understanding of the experience of staff during the pandemic.

As in previous years all staff will be surveyed and it been agreed that all surveys will be completed online to mitigate the logistical issues associated with distributing surveys across localities during the current pandemic.

Preparations are underway and a communications plan has also been developed. The exact date of distribution has not yet been agreed, but it is likely that this will be end September/Early October.

2. Climate Health

After the Trust Board declared a Climate and Ecological Emergency in March 2020, work has continued on developing the Trust's Green plan 2020-2025, setting out proposed milestones to progress towards our aim of being carbon neutral by 2040. The plan will also cover non-carbon related initiatives such as reduction in single use plastics, green spaces and bio-diversity, and sustainable models of care, and is expected to be presented to the Trust Board in October 2020.

During three months of lockdown, it is estimated that the reduction in mileage claims across the Trust amounted to 1.5 million miles (excluding commutes to work), which in time saved is equivalent to an additional 115 WTE staff for the same period. The estimated carbon saved equates to planning 118 trees.

3. Ministerial Visit

The Trust contributed to a virtual visit requested by Minister of State for Social Care, Helen Whately on 9th July 2020 to learn about the innovative initiatives taken by CNTW to support staff and the wider health and care system, during the Covid-19 pandemic. The Minister and her department staff heard from trust staff including Executive Medical Director, Chair of the Trust's BAME Network, Trust Psychological Well Being Leads and students and trainees (nursing, medical and psychology). She was particularly impressed with the well-being work, including establishment of the 'wobble rooms' by CNTW, and initiatives developed around supporting BAME staff.

4. Children's and Adolescent Mental Health Services Programme

CNTW Academy is making great progress in its journey to become an Accredited Learning Centre able to create, deliver and accredit its own bespoke modules at

DRAFT

various levels of academic accreditation. We are confident this will become reality by September 2020.

On 29 July 2020 the first bespoke CYPS module will commence. We have an agreement that when we are successfully accredited by September 2020, our CYPS module can be accredited retrospectively, acknowledging the contribution of this module as part of the evidence portfolio submitted.

Aimed at registrants new to the area of CYPS practice, it is an 18 week, degree level programme. The teaching is based on existing and current developments in contemporary practice, realigned to meet academic standards and governed by a quality framework to achieve academic excellence. Most importantly, unique to CNTW, this is a competence-based module, available at levels 4, 5 and 6, allowing access not only for registrants but for healthcare support work staff too, at the expected role competency and academic level appropriate to the individual.

By September 2020, we will have module start dates for all levels, across both community and in-patient areas to allow CBUs to plan their workforce development and meet service developments.

A presentation at Trust Board about overall Academy progress is scheduled for September 2020.

5. CEDAR scheme

The Trust has submitted its draft Final Business Case for consideration by Regional and National Teams, with a Guaranteed Maximum Price (GMP) of £72.6m. We have received letters of support from all commissioners, and from the two New Models of Care Partnership Boards involved. We have received and responded to questions from the national teams. We have been set a date for the National Joint Investment Committee of 27th August when we are expecting to present our Final Business Case for final approval. A Final Business Case will then be presented to the Board in September or October.

Regional updates

6. Newcastle Collaborative Agreement

The Trust is working with partners across Newcastle in developing a collaborative agreement to support the development of integrated services across the city. This is intended to be a legally binding agreement, but it will work alongside existing contractual agreements rather than replacing them. The intention is to bind partners in working together in the interests of the people of Newcastle. It's envisages three domains of services: those that are in view to all partners; those that are aligned; and those where resources are pooled. It builds on the successful collaborative work to date and is focused around four priority areas for co-production these are:

- Integrated Children's Service
- Supporting Care Homes
- Complex Care for Adults
- Positive Mental Health

Work on developing this is ongoing with an expectation that this will be brought to the Board as a substantive item in September or October

DRAFT

7. Home Treatment Accreditation Scheme

Newcastle and Gateshead Crisis Resolution and Home Treatment Team, which has recently come together through a reorganisation of services has just received accreditation from the Royal College of Psychiatrists for the period from 2nd June 2020 to 18th May 2023. Both predecessor teams had accreditation, but have moved quickly to secure this as a new team. There are three types of standards that are covered by accreditation: Type 1 – requiring 100% adherence; Type 2 – requiring 80% adherence; and Type 3 – requiring 60%. The team achieved scores of 100%, 99% and 100% respectively, which is a great reflection on their efforts. Even more rewarding are all of the positive comments from service users and carers involved with the service. Thanks and congratulations go to all of the team.

8. CQC Provider Collaboration Reviews

The CQC are carrying out a series of rapid reviews of how providers are working collaboratively in local areas to help health and social care services learn from the experiences of responding to coronavirus. These Provider Collaboration Reviews (PCRs) will identify themes and learning that can be used to inform planning for the coming winter and any subsequent spikes of Covid-19 and help providers and leaders of local health and care systems plan and work more effectively together.

North East and North Cumbria has been selected as one of 11 Integrated Care System / Sustainability and Transformation Plan areas to participate in these reviews during the first phase between July and August. Specifically, the aim of the PCRs will be to:

- Support providers across systems by sharing learning around the key attributes of partnership efforts, resulting in improved experiences and outcomes for those who have used services during the pandemic.
- Share the learning of approaches underway to support preparation for re-establishing services.
- Share learning locally and nationally in advance of any subsequent spikes and winter 2020/21, to help drive improvement.

The programme is starting with a focus on health and social care services for the over-65 population, because the population group has been particularly impacted by COVID-19. The programme will include looking at their access to and experiences of urgent and emergency care services.

Themes from the 11 initial reviews will be reported in the September edition of CQC's COVID Insight report and in State of Care in October. There is the potential for future reviews focused on different population groups.

National updates

9. NHS Planning Update 20/21

Planning guidance for the rest of the current year has been further delayed as negotiations continue nationally on both the ask from the NHS and the funding available. We are clearly living in unprecedented times and the scale of investment across the UK economy has been significant and is ongoing.

DRAFT

Within the NHS we have responded to the Covid-19 crisis and avoided some of the predicted worst case scenarios, but this has been combined with a significant level of emergency funding. This has been represented by all Trusts moving to a nationally determined block contract with a monthly top up to support each organisation to break even on a monthly basis. Across the North East and North Cumbria this top up process has resulted in nearly £100m of additional funding in the first 3 months. In the absence of a clearer position for the rest of the year, this top up process has been extended from 31st July, when it was initially due to be replaced, to the end of August, with an expectation that it will be further extended to the end of September.

While we await planning guidance for the latter part of the year, a letter is expected to be issued on 30th July from Simon Stevens, CE of NHS and Amanda Pritchard Chief Executive NHS Improvement setting out the key asks for the NHS. These will include the stepping up of services, particularly elective surgery, supporting the mental health of the population and supporting the wellbeing of staff. This will be supported by an interim People Plan for the rest of the year. Further details, if received, will be provided at the meeting.

10. Summer Economic Statement

The Chancellor delivered his summer economic update on 8th July. In it, he announced a range of measures to support the economy, including support for those organisations who retain previously furloughed staff, a kick-start scheme for youth employment, additional support for apprenticeships, a green jobs plan and decarbonisation scheme, an increase in the stamp duty threshold and a cut in VAT in the hospitality sector.

In addition he announced £1.5bn of additional capital spend across the NHS in 2020/21 including: further investment of £1.05bn in critical infrastructure; £250m to eliminate dormitory wards in the NHS, and a further £200m for the Health Infrastructure plan, to accelerate a number of the 40 new building projects across England. The Trust has received £1.4m in critical infrastructure funding, and expects to receive a further £2m to eliminate dormitory accommodation (the Trust has no dormitory wards, but has four wards in use which have a multi-occupancy bay).

The Trust's CEDAR development is also one of the 40 new hospitals to be announced.

11. Recovery Position: What next for the NHS?

NHS Providers have published the results of their first survey of member chairs and chief executives since the Covid-19 pandemic began. It highlights the significant achievements of Trusts and their partners during the pandemic but also reinforces the need for realism and prioritisation as the NHS recovers. The survey has four key sets of findings under the following headings:

- Trusts are facing significantly increased demand
- Trusts are facing major capacity constraints and uncertainties in trying to re-start services
- Trusts are doing all they can to re-start services as quickly as possible
- Given the demand and constraints, services will take a significant time to resume, particularly in acute hospitals.

DRAFT

The report available to read here

12. A Paradigm Shift in Mental Health in the Covid-19 era

Representatives for the World Health Organisation led by Roberto Mezzina, formerly Director of Mental Health Services in Trieste, are holding a national symposium online on 29th July to provide an opportunity to share experience, develop a consensus around the need to implement change and then work on how to develop the practical responses at a local national and global level.

A Charter for Discovery and Recovery is proposed with a set off commonly accepted principles that set out a radical ambition for the future of mental health support. A number of Trust representatives will be attending and will feed back to the Board.

13. Contribution to a Roundtable Conference with Baroness Lawrence.

Dr Rajesh Nadkarni, Executive Medical Director represented the Trust in contributing to a Roundtable Conference with Baroness Lawrence (Race Advisor for the Labour Party) organised on behalf of NHS Providers on 10th July 2020.

Baroness Lawrence was keen to hear from the attendees who represented Executive and Non-Executive Board members from across the Provider Trusts on their experiences in supporting BAME staff during the pandemic. Dr Nadkarni had the opportunity to inform the Baroness about the range of actions undertaken including empowerment and support of the Trust's BAME Staff Network. Similar themes were contributed by other organisations. It was concluded that diversity and inclusion still remains an area to work upon within the health service, and there needed to be appropriate BAME representation at all levels of decision making, including NHS Trust Boards.

DRAFT

Report to the Board of Directors
July 2020

Title of report	COVID-19 update
Report author(s)	Anne Moore, Group Nurse Director Safer Care, Director of Infection Prevention and Control
Executive Lead (if different from above)	Gary O'Hare, Executive Director of Nursing and Chief Operating Officer/Emergency Planning Executive Lead

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	x
To achieve "no health without mental health" and "joined up" services		Sustainable mental health and disability services delivering real value	
To be a centre of excellence for mental health and disability		The Trust to be regarded as a great place to work	

Board Sub-committee meetings where this item has been considered (specify date)		**Management Group meetings where this item has been considered (specify date)**	
Quality and Performance	N/A	Executive Team	N/A
Audit	N/A	Corporate Decisions Team (CDT)	N/A
Mental Health Legislation	N/A	CDT – Quality	N/A
Remuneration Committee	N/A	CDT – Business	N/A
Resource and Business Assurance	N/A	CDT – Workforce	N/A
Charitable Funds Committee	N/A	CDT – Climate	N/A
CEDAR Programme Board	N/A	CDT – Risk	N/A
Other/external (please specify)	N/A	Business Delivery Group (BDG)	N/A

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

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

DRAFT

Coronavirus (COVID-19)
Report for the Board of Directors meeting
July 2020

1. Executive Summary

This report provides an overview of actions and activity in response to the COVID-19 pandemic since the last Trust Board. The Trust is managing these circumstances under Surge Emergency Planning and Emergency Infection Prevention Control measures through the Gold Command structure. This process has ensured that we have been able to provide continuous daily updates to our workforce on the key issues and decisions relating to COVID-19.

Our priority has been to ensure we continue to provide safe, effective care and treatment to our patients, and to ensure any control measures protect patients and staff during the response. As an organisation we have also supported the Integrated NE&C System in response to pressures in other sectors. The Pandemic system approach has also highlighted the opportunity to deliver services differently, work differently and speed up collaborative responses.

It is important to note that the response and assurances have continued to be delivered at pace, not only in response to the multiple changes in guidance and its relevance for CNTW, but to ensure a prompt system response.

This report provides assurance to the Board of Directors on the actions taken by the Trust to ensure business continuity and the delivery of safe care and support for our service users, carers, local communities and staff.

2. National and Regional update

Since the beginning of the pandemic, government and scientific advice has changed, often daily, with the specific objective of combatting the virus with a focus on minimising transmission. Since the last Board meeting overall there continues to be a reduction in new positive cases of Covid19 both nationally and regionally as the lockdown measures have been released to reinvigorate the economy. However local outbreaks have emerged in some parts of the country necessitating lockdown i.e. Leicester and Blackburn.

2.1 Outbreak management- North Cumbria

At the time of reporting, North Cumbria Locality is experiencing a Covid19 outbreak involving Staff and patients in North Cumbria Integrated NHS Foundation Trust and in addition members of the public who have accessed several pubs and house/garden parties during July. The Local Authority and Public Health England have established a Covid19 Outbreak Incident Management Group which is co-ordinating actions required for test and trace and reinforcing requirements for COVID19 Secure environments i.e. promoting social distancing, the use of face coverings and face masks and effective hand hygiene. CNTW DIPC and Operational services are represented on the IMG and actions in place. Board members will be kept informed of any further escalations out with the board meeting.

DRAFT

3 Quality and Performance

Overall the rate of transmission rate for Covid19 continues to drop. As a trust we continue to see a very small number of cases with patients testing positive on admission screening. A small number of staff testing positive have been linked to the North Cumbria Outbreak. These cases have been subject to Test and Trace

4. Gold Command Assurance processes

As part of the emergency planning arrangements, we have continued with a 'Gold Command' based in St Nicholas Hospital led by Gary O'Hare, Executive Director of Nursing and Chief Operating Officer and lead for Emergency Planning. Gold Command is supported by:

COVID-19 Incident Management Group (comprised of Group Directors, Director leads from corporate and support services) –meetings twice weekly;

- COVID-19 Operational Teams – daily calls
- COVID-19 ICS-wide weekly calls service specific (i.e., communications, workforce, CEO, Executives) to ensure we're sharing practice and approaches across the wider system where appropriate to do so

This process has ensured business continuity and a rapid response to the dynamic changing national picture.

It has been agreed that Gold Command will continue to operate over the next few months alongside the Central Absence Line and IPC team to manage the step up of services, Test and Trace activity, local outbreak management, prepare and respond to a second wave/local outbreak and the preparation and delivery of the national Flu Plan, which will Go Live in September.

4. Guidance response to Covid19- impact assessment and response to guidance issued from Public Health England and Government departments

Within Gold Command and as part of the Emergency Planning Response (EPRR) the dedicated Manager role is responsible for triaging all guidance within two hours of receipt. This includes guidance received at weekends. In total the number of pieces of guidance that we have been received during June is 1649. This total can be broken down as follows.

- 122 have been received through the emergency planning route (EPRR) from NHSE/I in the North East region, whilst the total received was 122 not all were relevant to the NHS, but will have an impact on businesses, schools, Local Authorities, Transport, Aviation and therefore the general population. This figure includes an NHS Daily Brief of any guidance that might be relevant to the covid 19 response and Daily Trends which outline the PHE position across the region regarding the spread of infection, the sickness absence and hospital activity data. This is shared at CNTW Incident Management Group and summarised to ensure all IMG members are fully informed.

DRAFT

- 5 have been received via HSEI directly as an email, and this relates primarily to information requests e.g. assurance on 2 metre distancing between beds in inpatient settings and the use of PPE. All have been submitted on time following sign off from the Gold Commander.

- 1 update from the ICC in the form of a newsletter.

- 1521 Gov.uk guidance of which 85 were applicable. It should be noted that this guidance covers a broad range of documents applicable to the general public but help with the NHS response. An example is the guidance in relation to working safely which has been fully incorporated into the working safely guidance produced by the trust.

All guidance is allocated to a subject matter expert within the Trust and evidence collected to inform specific actions and recommendations which are taken into task and finish working groups and where necessary through to IMG. The responses are monitored through a specific guidance review group which meets weekly to provide assurance of the actions taken for further scrutiny. During June and July, we invited senior representation from the Groups to ensure involvement in the meeting and include a locality perspective. Key items for communication are included in the daily Covid19 bulletin.

Key actions taken from the guidance includes:

- Test and Trace processes at national and regional level.
- Risk assessment, BAME and extremely clinical vulnerable group.
- Updates to IPC guidance including a product recall for a mask which was managed as a CAS alert.
- Change in operating hours of EPRR regional team.
- Recommendations for children's services around SEND and educational settings
- Guidance for prisons which is applicable to services which operate into prisons.
- Changes to GP Commissioning which is being presented to IMG.

5. Infection Prevention and Control measures and Personal Protective Equipment (PPE)

In May, the Board received the first Nosocomial Infections (health care acquired infection) IPC Board Assurance for Covid19. Since then each locality has been assessing against the standards to provide continuous assurance the baseline standards are at the required level and escalation of any non-compliance. An update report will be provided separately for July board. There have been no reported instances of Nosocomial Infection within the Trust during July. A recent meeting with the CQC to review the IPC BAF was positively received.

As the understanding of COVID-19 has developed, guidance on essential infection prevention and control measures has been published, updated and refined by Public Health England.

The DIPC has continued to provide assurance via scheduled briefings at the IMG, including implementation of any changes in guidance

DRAFT

IPC Assurance Meetings are now held twice per week led by the DIPC, and include IPC team, Safer Care lead for PPE, Communications lead and Group Nurse Directors from each locality. This approach has enabled and supported rapid responses to:

- changing National or MHLDA specific IPC guidance,
- targeted support / to clinical teams such as cohorting, isolation, management of V&A and restraint, complex cases and review of environmental concerns
- distribution, supply and use of PPE including the use of face masks in all inpatient areas ahead of the Government guidance on facemask use in all hospital settings
- implementation of Patient and Staff virology and Antibody testing programme for COVID-19
- Fit testing of staff for FFP3 masks for AGPs and BAME staff following risk assessments

All updated PHE guidance on IPC and PPE for all health and care settings has been made available via the Trust's COVID-19 Daily Communications bulletin as well as direct engagement using Teams.

5.1 Personal Protective Equipment

The Trust has been working closely with NHSE/I regarding the supply and safe use of NHS PPE. Since the last board, there has been a significant improvement in the availability of PPE, in some instances exceeding 17 days supply some items.

As a result, requests for mutual aid have been reduced and daily escalations e.g. for gloves, aprons and masks continue have been less frequent. This has resulted in a reduction in the escalation required via daily and organisational sitreps.

It has been necessary to provide additional dedicated Senior Nurse and Administration capacity to work in partnership with NTW Solutions and tightly manage the daily ward and team stocktake and PPE distribution. This arrangement will continue for at least the next 6 months until the situation regarding PPE becomes clearer

There have been no instances where staff have not had the required PPE or been in a position where re-use has been required. The IPC Team works daily with multi professional clinical leads to ensure PPE is worn correctly to ensure safe practice for both staff and patients.

6. Patient and Staff Testing

CNTW continues to provide testing in line with the government's testing strategy. This covers:

- Virology swabbing of Patients on admission, discharge and transfer
- Virology swabbing of symptomatic staff and household members
- Virology swabbing for Key workers outside CNTW via NECs

DRAFT

- Virology swabbing Pilot with NUTH for screening pre-elective admission patients
- Antibody/Serology testing for all staff and patients
- Test and Trace processes for our staff and In-patient contacts

6.1 Patients Admission and discharge screening

The Trust commenced patient admission and discharge screening on the 28th April. Screening on admission continues to enable wards to manage the patient as a presumptive positive case, putting isolation measures in place utilising effective PPE pending result. Patient results are usually received back within 24 hrs and depending on the results manage the care and treatment of the patient within the ward effectively

Discharge screening has supported transfers into Care Homes and other hospital and home situations where other vulnerable or shielding individuals may reside. This is supporting the proactive public health approach to potential transmission

6.2 Staff Testing

We continue to run a dedicated Testing Team for virology swabbing to symptomatic staff and household index cases supported by the Regional Testing Cell in collaboration with Queen Elizabeth Hospital.

Working in conjunction with the Central Absence Line the testing of symptomatic staff and household members (index case) has been taking place across all our localities. The number of symptomatic individuals is much lower than when the services were set up and is delivered primarily as a mobile service currently. However, we have a flexible model which allows the standing up of testing sites at Carleton Clinic, St Nicholas Hospital and Hopewood Park if required. To date we have tested over 1,200 staff and household members since March.

CNTW Staff / Household Member Testing			
Staff / Household member	Total Tested	Positive	
	1213	204	16.8%

6.3 Support to the ICS Testing capacity

To support patient pathways and system testing capacity CNTW have also offered this service to our partner organisations and more recently offered some capacity to support the testing of symptomatic key workers including care home staff and a 6 week pilot commencing this month with NuTH to test pre-elective hospital admissions for tertiary services, who live in rural settings and are too unwell to travel 72 hrs prior to surgery. This pilot has been extended for another 4 weeks after very positive responses from NuTH and 120 patients who were able to access diagnostic endoscopy and surgery. A business case is being considered by the Regional Testing Cell to take this forward as an option for other acute providers

DRAFT

6.4 Test and Trace

Since the last Board meeting the National Test and Trace processes have begun to emerge, led locally by the Regional Health Protection Teams (HPT) PHE North East and Cumbria. Processes are still evolving at the time of reporting, however in summary

- Lab Confirmed cases in Health, Care Homes and Prisons will be traced via HPT CNTW will be notified of positive cases of staff
- Will include patients who are tested during CNTW hospital stay i.e. any positive admission/discharge/transfer screening samples
- Individual staff members will be contacted by CNTW and if had contact in the 48 hrs prior to the positive case becoming symptomatic and no use of face mask and other PPE, will be instructed to self-isolate for 14 days.
- CNTW will then identify contacts both staff and patients due to interface with health care along the pathway. HPT will follow up community contacts
- recall of contacts looking for clusters/outbreaks

Test and Trace has been discussed fully in IMG and systems are in place to respond to a potential patient safety risk and risk to business continuity of the workforce if significant numbers of staff are instructed to leave work at any time.

6.5 Antibody Testing

The intention of testing is to improve the understanding and data on COVID-19 as part of a national surveillance programme. It is important to note that a positive test result for antibodies does not currently mean that the person being tested is immune to COVID-19.

There is also no firm evidence that the presence of antibodies means someone cannot be re-infected with the virus or will not pass it on to someone else. If someone tests positive, they still need to follow social distancing measures and appropriate use of PPE.

CNTW launched Antibody Testing at the beginning of June with a plan to offer to all staff and test as many within 6 weeks. There has been a phenomenal response from our clinical teams to release staff to perform the phlebotomy tests across each locality prioritising inpatients and community frontline staff, BAME staff and domestics, porters and facilities staff and corporate staff

- 6,428 have been tested
- 862 positive for antibodies

=**13.41%**

Patients who are already having blood taken as part of other tests will be asked whether they would like an antibody test. This will be based on clinical judgement and with patients who have capacity. Data on the number of positive and negative cases will be reported to PHE.

7. Managing staff absence during COVID-19

DRAFT

Since the start of the pandemic, the Trust experienced significant staff absence (including those staff who are shielding) with a peak in April and a decreasing trend since then, with current absence due to COVID-19 at 21% of total staff absences, which is lower than the average for similar Trusts in the region.

To support the proactive management of COVID-19 related staff absence, the Central Absence Reporting line was established in March to manage the reporting of **all** staff absence across the Trust. It is continuing to be resourced using senior workforce leads and senior clinical managers from across the Trust providing a consistent approach to managing sickness whilst also supporting staff providing clinical advice and regular welfare calls. From 11th June it now includes support to the Contact Tracing function required following Test and Trace

The absence line is operating seven days per week, between the hours of 7am – 8pm

8. COVID-19 Secure Risk assessment and Service Change Process

As the pandemic began to unfold it was evident that services would need to change quickly in order to comply with the new government guidelines and restrictions. It was essential that a clear governance process was embedded to ensure that any changes to services were reviewed, agreed and communicated to service users, carers, staff, partners and regulators so there was clear understanding of the impact not only for patient safety and experience but for access to Mental Health and Learning Disability services within CNTW.

As we move into the second phase of the pandemic there is a need to begin to review clinical services to consider if face to face consultations need to be reinstated, particularly for those patients where remote consultations have been challenging. The agreed governance process for service change requests has continued to be utilised to reinstate and re-establish services that had to change their delivery during the first phase of the pandemic. A significant part of the service change process includes a CNTW Covid-19 Secure Workplace risk assessment to ensure clinical services can resume face to face contact with service users in a safe way adhering to government guidance. In order to support the decision-making process, the Working safely at CNTW – being Covid-19 Secure guidance has been developed. Over the last 4 weeks we have seen a significant increase in the number of Covid-19 Secure Workplace Risk Assessments submitted for clinical services and corporate teams that are co- located on sites across the trust. In order to gain an understanding of the impact services returning, to not only trust sites, but to premises and property previously used elsewhere in the community we have set up Locality Working Safely groups so each locality can monitor and review the risk assessments and services changes being undertaken and then being considered by the Service Change panel. It is essential for business continuity to have a detailed understanding of the impact this may have on managing Covid-19 secure workplaces across the whole organisation.

The government has provided guidance and identified five steps to help demonstrate that that we have complied in implementing their guidance. These are: -

DRAFT

- We have carried out a Covid-19 risk assessment and shared the results with the people who work here
- We have cleaning, handwashing and hygiene procedures in line with guidance
- We have taken all reasonable steps to help people work from home
- We have taken all reasonable steps to maintain a 2m distance in the workplace
- Where people cannot be 2m apart, we have done everything practical to manage transmission risk

To date we have received over 100 Covid-19 Secure Workplace risk assessments and we are now undertaking the assurance processes to issue their compliance certificates

We are supporting our workforce to ensure a balance between sustaining our services and supporting those members of staff who may be living with someone who may be symptomatic, or indeed may be symptomatic themselves.

10. COVID actions in relation to BAME and Vulnerable staff

Following the report to the Board in May we have continued to focus on the needs of our staff and patients who are in the BAME population, where there is evidence and growing concerns about the disproportionate impact of Covid-19

The Trust wrote to our BAME colleagues advising them of several initiatives we are putting in place to support their health, wellbeing and safety and to ensure that they are safe and supported during this difficult time.

At the time of reporting 98% of BAME staff risk assessments have been completed and prioritisation for Antibody testing, Fit Testing for FFP3 masks and required PPE is took place

IMG has since the last board meeting focused on the Vulnerable staff and those who have been shielding. This has resulted in risk assessments being planned for all staff who have been identified or believe themselves to be vulnerable. An update will be provided at the next meeting from the Clinical Risk Assessment Group (CRAG) which has combined all staff risk assessments.

11 Learning & Reflection

As an organisation we have a strong focus on learning and reflection and while specific learning from the pandemic was a challenge during the initial months, due to the pace of events, there is now more opportunity to reflect on the events of the last few months. We are taking any learning into the next phase of stepping up services, living with COVID19 and remaining responsive to any future national or local outbreaks. Different elements of learning include:

- Gold Command whiteboard maintained of ideas and suggestions as they arise, and these are regularly discussed in team meetings. The daily COVID19 communication to all staff is often used to share learning across the

DRAFT

organisation, along with the Executive Directors live-streamed Question and Answer sessions.

- Following helpful feedback from the Non-Executive Director, Darren Best, learning and reflection was introduced as a standing agenda item on the twice-weekly Incident Management Group (IMG) meetings.
- Ensuring attendance at relevant national and local webinars.
- Ensuring that horizon-scanning of forums such as the NHS Futures Collaboration platform to share ideas and best practice.
- Liaising with peers.

A key source of learning is the feedback we receive from our staff, service users and carers. A series of four COVID19 online surveys have been implemented as follows:

Survey:	Progress:
1. Staff survey	Complete & results shared with staff. Key points include positive feedback from staff about teamwork, support and information sharing, the use of technology to facilitate home-working and virtual consultations, and reductions in travelling and meetings. Areas for improvement include work/life balance when working from home and using Teams, internet connectivity, and keeping up with large volumes of rapidly changing guidance.
2. Adult mental health service users survey	Complete and analysed – see summary in separate Service User & Carers Experience report. Key points include the negative impact of the pandemic on wellbeing, particularly on those with poor mental wellbeing before the pandemic. Service users reported feeling isolated and more anxious. Many service users were grateful for the efforts that CNTW staff have made to keep in touch, often by telephone and for some, by video-consultations, however, many expressed a desire to return to face to face contacts. The survey also highlighted differences where people with protected characteristics have a different experience of the services we provide.
3. Carers survey	Complete and undergoing analysis.
4. Young People's survey	Ongoing – closes 31 July 2020.

A learning survey was completed in early June 2020, to gather IMG views on what worked well and not so well in the trust's initial response to the pandemic. As a result of this exercise, several changes to processes were implements, for example, the streamlining of internal exception reporting to escalate key issues to Gold Command. A series of reflection sessions for IMG are due to take place in the last week of July, organised as a series of three sessions to challenge ourselves in readiness for moving into the next phase and explore:

- a safe space for members of IMG to reflect on the emotional impact of the pandemic, both personally and professionally.
- To have frank discussions about our appetite for change and what we need to do to face the challenges ahead, and how we inspire others to change.

DRAFT

- To agree some broad expectations to be set out for the organisation re ways of working/principles.
- To have honest conversations about any cultural changes that are needed and the barriers to change.
- To put ourselves on the best footing to boldly move forward into next steps while also retaining the flexibility to respond to future COVID19 outbreaks/peaks.

The agreement to the investment of time in these sessions demonstrates the commitment of the Trust to ensuring that we take any learning from the last four months into our preparations for the coming months, planning for known factors such as:

- Working within social-distancing guidelines and stepping up services.
- Managing future local and/or national lockdowns or restrictions, including test and trace, PPE, IPC processes etc.
- Increase in referrals from pent-up existing demand.
- Increase in referrals due to the impact of the pandemic on mental health.
- Increase in referrals due to the mental health impact of the economic downturn.
- Seasonal winter pressures and flu.

The Trust's Learning and Improvement Group has restarted virtually, allowing all Trust staff to receive an invite to the group. There were over 130 attendees at the July meeting, where a number of presentations reflected on the impact and learning from COVID across a number of clinical and corporate services.

Lastly the Covid19 Clinical Ethical Forum has also supported discussion and learning on a range of topics in support of practice.

12. Communications

From week commencing 16th March the Covid-19 Gold Command Team have been issuing daily email updates to all staff across the Trust (with additional measures in place to ensure that messages are disseminated by Line Managers and team to those staff who do not frequently access emails). Communications have included NTW Solutions Limited. Live events have also been screened weekly enabling the Executive Team to engage with staff across the organisation on issues of concern as well as share good practice.

A Covid-19 staff survey has also been undertaken and results demonstrate that the Trust has provided a good level of support to staff during the Covid-19 pandemic. An animation has been developed providing a quick, easy read medium for all staff to consider the outcome of the results. It is hoped that the animation can used as a vehicle for teams across the Trust to talk about their experiences during the pandemic and enable the Trust to use such feedback in future planning.

Advice, information and guidance relating to the pandemic, the impact of the pandemic on services and information to support well-being continues to be provided to services users, carers, stakeholders and the public. This includes the use of written information, social media platforms, website, animations and videos.

DRAFT

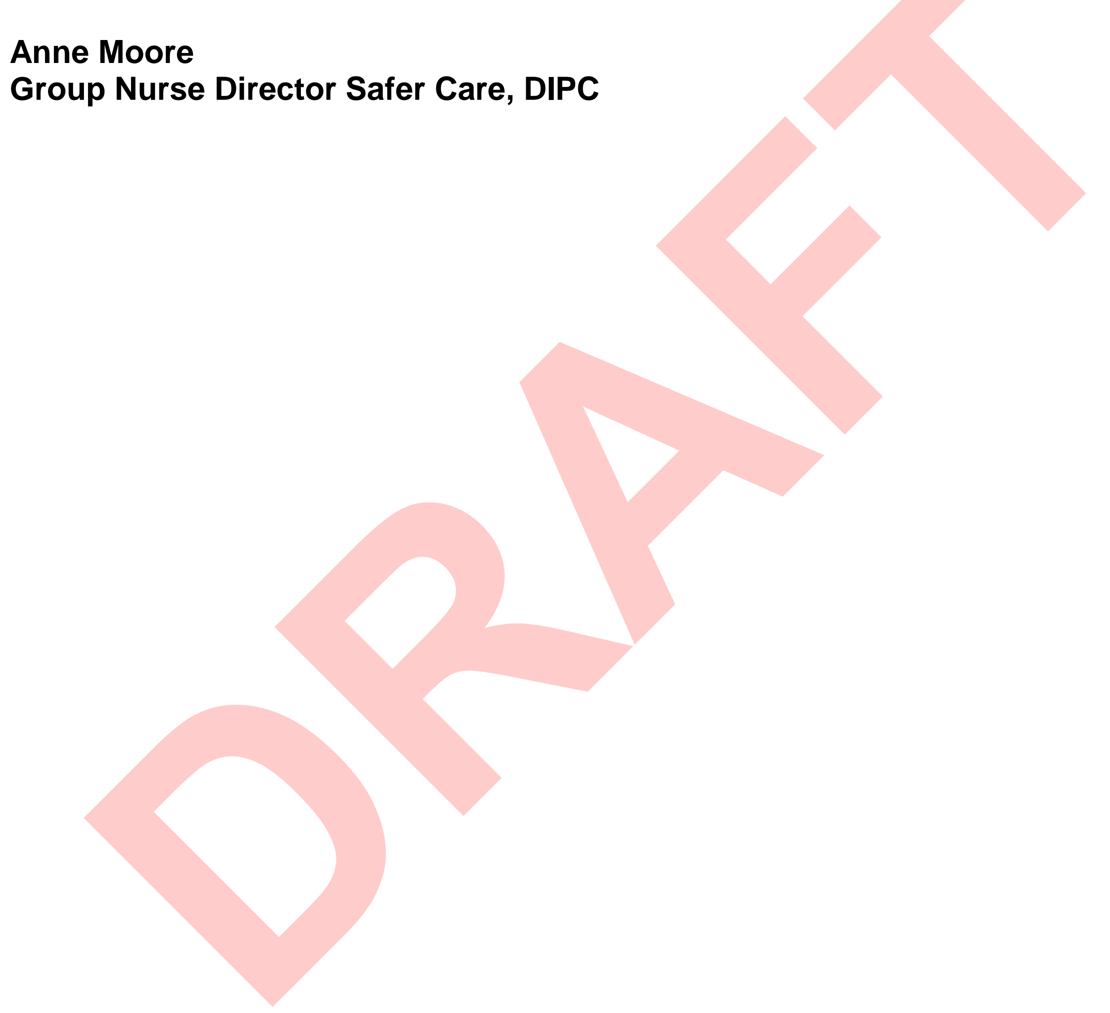
13. The Next Phase

Whilst this paper covers the Trust response to the COVID-19 pandemic, the organisation continues to move into the “next phase” of living with Covid19, ensuring safe services and environments are available for our patients their families and our staff

Recommendation

The Board are asked to receive this report for assurance on the measures taken to date

Anne Moore
Group Nurse Director Safer Care, DIPC



Report to the Board of Directors
Wednesday 5th August 2020

Title of report	Mental Health Legislation Update in View of the Coronavirus Pandemic.
Report author(s)	Andrew Hope, Head of Mental Health Legislation
Executive Lead (if different from above)	Dr Rajesh Nadkarni, Executive Medical Director

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	
To achieve “no health without mental health” and “joined up” services	X	Sustainable mental health and disability services delivering real value	X
To be a centre of excellence for mental health and disability	X	The Trust to be regarded as a great place to work	

Board Sub-committee meetings where this item has been considered (specify date)		**Management Group meetings where this item has been considered (specify date)**	
Quality and Performance		Executive Team	
Audit		Corporate Decisions Team (CDT)	
Mental Health Legislation	29/07/20	CDT – Quality	
Remuneration Committee		CDT – Business	
Resource and Business Assurance		CDT – Workforce	
Charitable Funds Committee		CDT – Climate	
CEDAR Programme Board		CDT – Risk	
Other/external (please specify)		Business Delivery Group (BDG)	

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

Board Assurance Framework/Corporate Risk Register risks this paper relates to
SA5.2 That we do not meet statutory and legal requirements in relation to Mental Health Legislation

DRAFT

Mental Health Legislation Update in View of the Coronavirus Pandemic

This paper is to update CNTW Board of Directors on actions taken to ensure compliance with Government *Instructions* and Guidance in relation to the operation of the Mental Health Act 1983, Mental Health Tribunals and the CQC role in relation to SOAD visits during the current Covid-19 pandemic.

Coronavirus Act: Enshrined into English Law on March 25th 2020. The Act contains emergency powers to amend the Mental Health Act if it becomes necessary. These powers include amending the second opinion safeguards, periods of detention and medical assessments. To date no changes to the MHA have been made and organisations "***should continue"*** to operate in line with existing MHA Law.

On the 30th March 2020, NHS England and NHS Improvement issued "Legal guidance for mental health learning disability and autism and specialised commissioning services supporting people of all ages during the coronavirus pandemic". The guidance concerns the impact of the pandemic on the use of the Mental Health Act and the safeguarding systems that support the legal rights of people receiving mental health, learning disability…… Services. The guidance provides advice and support to help providers etc.: implement changes to policies, code of practices, rules, regulations and so on during the pandemic period. This guidance was updated on the 19th May 2020 and version 2 was published.
It should be noted that the guidance is one of a suite of documents issued to assist during the pandemic period. It should not be used in isolation and the local and national picture needs to be considered at each stage of the pandemic.

Important information the guidance is offered to assist if there is a need to temporarily depart from the Code of Practice which may be justified in the interests of minimising risks to patients, staff and the public. The implementation of the guidance should be seen as "***a last resort***" with the primary aim to operate in line with current MH Act Legislation.

The author of this paper wishes to draw attention to the following changes that have been made internally to support the safe operation of the MHA and to comply with Parliamentary instruction. The guidance provided in the attached documents tries to go some way to bridge the gap and tensions brought about by conflicting laws, instructions and guidance.

The following changes made by CNTW aim to comply with both the law and the spirit of the Code of Practice. For ease of reference, this paper covers the nine main themes in annex D covering the implementation of the Code of Practice and the challenges complying with it during the pandemic.

Section 136 assessments: No change to practice or policy. The Trust have excellent links with the regional police forces and this ensures any issues can be quickly addressed. Cumbria currently do not have a street triage team so the use of Section 136 in the North Cumbria is still high compared to the rest of CNTW.

AMHPs and responsibilities: Applies to Local Social Services only and they feed in via Locality Care Groups and the MH Legislation Team. Work is currently ongoing within some authorities in relation to digital assessments. The MH Legislation Team is monitoring changes in regards to how MH Act assessments are being undertaken and the number of digital assessments received will be monitored by MHLSG (Mental Health Legislation Steering Group). Regular meetings are being established with the seven local authority leads to ensure good communication between all parties.

The role of the Hospital Managers' panel: Code deviation, Hospital Managers Hearings have changed to ensure social distancing and reduce the risks to patients, staff and others. In an attempt to achieve the best possible compliance with the Code of Practice and ensure a measure of safeguarding the following process is now carried out.

Hospital Managers review process changed to a paper-based review process of Forms.

DRAFT

The introduction of this process on March 23rd 2020 has not only allowed the facilitation of social distancing but has removed the demand on clinical time. Responsible Clinicians (RC) are no longer required to complete their medical report or attend a Hospital Managers hearing. This also applies to the inpatient nurse and the author of the social circumstances report. For renewal hearings, the RC is still required to examine the patient within 2 months prior to the expiry date and complete either the H5 (renewal of detention) statutory form or the CT07 (extension of CTO) statutory form.

M3 form (request by nearest relative for discharge) is only used in exceptional circumstances and the completion of this form along with requests for reviews are dealt with on a case by case base so a fuller hearing can be facilitated.

The Mental Health Legislation Team are working closely with IT to engineer remote digital hearings. It is hoped that this will progress quickly, with Microsoft Teams taking a leading role in facilitating it. Pilot digital hearings have taken place and were in the whole successful. Work will continue to support this with patients being at the centre of this work and their views leading, how each hearing will take place going forward.

MHLSG has asked a working group to review the reintroduction of full participation at hearings as and when requested. Updates will be provided to the MHLSG monthly.

Mental Health Tribunal: The Mental Health Tribunal issued an emergency practice direction starting 23rd March 2020.

Tribunals have taken place albeit on a limited number of occasions with Section 2 hearings their main priority. Tribunals up to the 1st June 2020 were conducted on the whole as a one-person hearing. One judge sitting alone conducted a telephone conference and made the decision.

As of the 1st June, three member Tribunals will be convening digitally, and all participants will be visible to the patient and other attendees.
The MH Legislation Team have worked with IT to identify all areas where hearings may take place and these venues now have the electronic means to carry out live digital hearings, so in this respect the Trust is Tribunal and Code compliant.

This has been a major piece of work for the Trust and its staff as the changes are not as straightforward as one would imagine.

Connectivity problems aside it is a major challenge presenting to a legal body and managing the hearing digitally.
Extra safeguards are being explored for services users and cares as there could be financial problems for people connecting to a hearing on a mobile device with limited data packages etc.

The MH Legislation Team and IT along with clinical colleagues are exploring how best to facilitate hearings and protect and safeguard patients and carers rights in this area. Monitoring will continue through the MHLSG.

Medical reviews when a patient is placed in seclusion: No change to policy or code.
The introduction of Microsoft Teams has allowed some of the below reviews to be undertaken remotely via the use of records and Microsoft Teams, *Note this was originally planned as a response to Covid19 but has helped reduce the need for staff moving around site(s)*.

First medical review will be completed by the doctor (medical) within 60 minutes of the initiation of seclusion unless the seclusion was initiated by the Psychiatrist.

Medical reviews should continue every 4 hours from the point of seclusion by a doctor (medical) alongside the registered nurse.

Reviews should continue until the first Internal Multi-Disciplinary Team (MDT) review has taken place, following which further medical reviews should be completed at least twice in every 24-hour period (Code of Practice 26.132).

DRAFT

Section 17 Leave and Visitors: Change to policy and Code deviation, The Trust issued guidance on 26th March 2020 to comply with the parliamentary instruction to stay home, protect the NHS and save lives. This guidance severely affected the ability of Responsible Clinicians to authorise leave. The guidance to comply with these instructions meant a departure from the Code of Practice with leave across the board limited to once a day, for no more than 30 minutes and to facilitate exercise only.

The Prime Minister issued an update with regards to fighting the pandemic on Sunday 10th May 2020. This led to new Trust guidance on leave being produced and came into effect from 13th May 2020.

A return to compliance with the Code of Practice has been achieved with a relaxation in the lockdown rules by the Government and the ability to reapply Trust policy. Lockdown restrictions were again relaxed on the 1st June 2020 with the ability to meet with more than one person allowed.

With regards to **patients' visits,** this has been more complex to facilitate due to the initial instruction by Government and "hospital visits not being a reason to leave home".

A decision was taken via Gold Command to protect the health and safety of our patients and staff to temporarily suspend visiting in all but exceptional circumstances. This position was relaxed in relation to specific groups of patients and on a case by case basis. Further guidance on visiting was issued by the Government to take effect on **Monday 15th June** reviewing to enable further relaxation of current restrictions an updated visiting guidance which is person centred whilst considering safety requirements has now been devised and approved by the IMG of the Covid command centre. Visiting will stay under constant review at Gold Command and a small working group from the MHLSG will review Leave and visiting as each set of new instructions and guidance is issued. MHLSG to monitor as a standing agenda item.

Access to Independent Mental Health Advocates (IMHAs) The Trust has provided digital solutions to all wards so that patients can contact IMHAs, legal reps and so on in line with the current government restrictions and in line with the Code of Practice. It is hoped this will ensure the safeguards of access to the IMHA services.

Second opinion appointed doctors: The CQC introduced interim changes to the CQC SOAD service implemented 20 March 2020. These changes allow compliance with the Treatment provisions of the MH Act. It should be noted that this services is all provided digitally and the movement of all forms is electronic.

Electronic forms and electronic delivery: To support remote working arrangements during the pandemic a number of initiatives are either in testing or agreed. The use of electronic forms and digital signatures is now accepted, and the MH Legislation Team are working to develop a Trust standard pack of Section forms, as these have not been designed nationally along with a protocol/audit process for digital signatures.

Attention should also be drawn to the complex problem of digital clinical assessments. This will need detailed consideration and work is on-going in this area.

Digital working is crucial to facilitating work in the "*Covid world*" we currently live, work and operate in. Social distancing and the need for shielding etc. will sometimes mean that some Mental Health Act assessments may need to be undertaken digitally.

Guidance offered is clear that remote assessments for detention should be conducted as a last resort and we subject to appropriate safe guards and oversight A helpful "annex E" of the guidance is available to assist and allow Trusts and clinicians to review and monitor why a digital assessment was necessary. The MH Legislation Team have built this onto RiO and some manual collection of data has been carried out.

Due to the complexities and the ethical and moral issues raised around this area, a working group led by the Associate Clinical Director for Digital and CRIS will move this forward within CNTW. Work is ongoing in this area both locally and nationally, it is hoped further guidance will be issued in late August 2020.

DRAFT

Other Areas contained within the guidance but not necessarily COP relevant.
General principles within the legal guidance for specific services or infection prevention control are all being monitored and in the process of being compliant if not already. The will again report to the MHLSG on a regular basis.

Report to the Board of Directors
August 2020

Title of report	IPC Board Assurance Framework
Report author(s)	Anne Moore, Group Nurse Director Safer Care, Director of Infection Prevention and Control
Executive Lead (if different from above)	Gary O'Hare, Executive Director of Nursing and Chief Operating Officer/Emergency Planning Executive Lead

Strategic ambitions this paper supports (please check the appropriate box)

Work with service users and carers to provide excellent care and health and wellbeing	x	Work together to promote prevention, early intervention and resilience	X
To achieve "no health without mental health" and "joined up" services		Sustainable mental health and disability services delivering real value	
To be a centre of excellence for mental health and disability		The Trust to be regarded as a great place to work	

Board Sub-committee meetings where this item has been considered (specify date)		**Management Group meetings where this item has been considered (specify date)**	
Quality and Performance		Executive Team	
Audit		Corporate Decisions Team (CDT)	
Mental Health Legislation		CDT – Quality	
Remuneration Committee		CDT – Business	
Resource and Business Assurance		CDT – Workforce	
Charitable Funds Committee		CDT – Climate	
CEDAR Programme Board		CDT – Risk	
Other/external (please specify)		Business Delivery Group (BDG)	31,7,20

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*

Equality, diversity and or disability		Reputational	X
Workforce	x	Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	X
Quality, safety, experience and effectiveness	x	Service user, carer and stakeholder involvement	X

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

N/A

DRAFT

Infection Prevention and Control (IPC)
Board Assurance Framework
Board of Directors Meeting

1. Executive Summary

The IPC Board Assurance Framework is designed to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It is also intended to identify any areas of risk and show the corrective actions taken in response. The tool also provides assurance to trust boards that organisational compliance has been systematically reviewed for other potential Nosocomial or Hospital Acquired Infections (HAI's.)

2 Compliance

Board Members received a paper in May that confirmed that the self-assessment for Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust is compliant with all standards, except for the items summarised in sections 5 and 7. This related to:

- limited isolation facilities at Hadrian clinic for presumptive positive patients awaiting admission screening test results- mitigation includes the decision to admit directly to Bede ward pending COVID-19 Screening results.
- At the time of the first report the lack of current PHE guidance in relation to Contact Tracing was a risk- the PHE North East and North west have since confirmed their standing operating procedures and CNTW Absence line and senior nurse team alongside IPC have developed local protocols to respond in a timely way to ensure patient and staff safety
- wearing of Face masks for the potential use by patients in Covid19 positive areas continue to be risk assessed on a case by case basis considering communication challenges, ability to comply with social distancing and ligature risk from mask types

All clinical areas have completed the Infection prevention and control COVID-19 management checklist, version 1.2 (22 May 2020). These checklists are being led by Locality Group Nurse Directors and reviewed on a monthly basis through Locality Quality & Standards meetings

It was agreed to provide the Trust Board with a bimonthly updated paper to provide further assurance. This paper specifically highlights the Locality Care Groups initial risk assessments and any associated actions.

.2 Assurance mechanisms for the initial and new standards

In addition, actions to support assurance of the self-assessment during the COVID19 Pandemic also include:

- Covid19-Gold Command, which is led by the Executive Director of Nursing and Chief Operating Officer and has continued to operate as a hub for rapid decision making in response to guidance impacting on safe clinical practices,

DRAFT

Covid19 secure workplaces and relaxation of lockdown. The Command team manage the he escalation of daily sitreps, distribution and demands on PPE as well as emergency response.

- The plan is to continue to operate Gold Command to respond to the new Test and Trace processes, staff absence management, as well as planning and preparation for the roll out of the Seasonal Flu Vaccination Plan
- Reports to Covid19 IMG by Group Nurse Director Safer Care/DIPC on national and emerging IPC guidance and implications, PPE position, staff and index case testing. These meetings have moved from daily to twice weekly over the period
- IPC Assurance meetings 3 times per week. Membership includes Director for Infection Prevention and Control (DIPC)/Group Nurse Director for Safer Care, Group Medical Director Safer Care, IPC Team, Locality Group Nurse Directors and Deputy Director of Communications;
- Daily IPC Assurance Agenda has continued to be action focused with the purpose to ensure rapid assessment required to implement national clinical guidance e.g. Patient cohorting, implementing staff testing, process for daily stocktake of and guidance on the use of PPE, Aerosol Generating Procedures, admission and discharge screening, cleaning regimes and waste management;
- Group Nurse Directors provide assurance at locality level via daily SITREP meetings to ensure actions are being implemented. Any issues identified are escalated to national level;
- Daily IPC/PPE Communications brief has been distributed – separate to the Daily COVID-19 communications aimed at exclusive route and reference for IPC/PEE messages- backed up with guidance on the intranet;
- IPC team have continued throughout the Pandemic to undertake scheduled and adhoc 'Teams' Meetings with Clinical Nurse Managers, Ward Managers and clinical care groups to discuss complex cases, practical application of 7- and 14-day isolation, restraint and management of violence and aggression;
- IPC Team have continued where possible and to minimise transmission, to make 'visit/walkabouts' to hospital and some community service sites enabling switch over of recalled eyewear, spot check hand washing, social distancing, advise on inappropriate use of PPE then reinforced in daily communications brief;
- IPC Team have repeated sessions with NTW Solutions Domestic Supervisors and domestic/facilities staff at ward and service level in addition to ward-based sessions; led by ward managers; regarding cleaning regimes for covid and non covid areas
- Following BAME Risk assessment the comprehensive roll out of Fit Testing of FFP3 masks has been led by IPC Team and Academy Physical Health Leads to staff and has also enabled clarification of understanding on safe IPC practices and updated IPC guidance98% of risk assessments have been completed
- Staff Testing Training has been delivered by a combination of DIPC/CNTW Academy Physical Health Trainers, and this has also been developed into a package for Domiciliary Providers and care homes across the ICS since the last meeting;
- The Public Health Team members including DIPC/ IPC/Tissue Viability have led the daily co-ordination of the Staff and Index Case Testing Teams with

DRAFT

responsibility to observe IPC practice and induct new trainees during testing sessions; and

- LNC/Staff Side weekly meetings- IPC items have been used to support actions required to support practice

3. Conclusion

The IPC standards for preventing the spread of Nosocomial have been met. Self-assessment and triangulation will continue. There have been no instances of Hospital acquired infection or outbreaks of COVID19 or other infections in the period since the last report.

Anne Moore
Group Nurse Director Safer Care, Director of Infection Prevention and Control.
August 2020

DRAFT

Infection Prevention and Control board assurance framework – completed May 2020 (updated July 2020)

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• infection risk is assessed at the front door and this is documented in patient notes	All admissions into the Trust are screened and managed appropriately. Appropriate care plan re isolation until result known. Documented in Rio progress notes and alerts.	None	
• patients with possible or confirmed COVID-19 are not moved unless this is appropriate for their care or reduces the risk of transmission	Community teams contact patients prior to visit to establish any COVID-19 infection risks.	"	
• compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients	Transfer of COVID-19 positive patients is limited as much as possible.		
• patients and staff are protected with PPE, as per the PHE national guidance	Trust PPE guidance reflects the guidance issued nationally by PHE.		

DRAFT

• national IPC PHE guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way • changes to PHE guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the Board Assurance Framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	Daily communications released to update staff around any changes to national IPC guidance. Weekly meeting with clinical teams via 'Teams' to provide an update in guidance and application at clinical level. Spot check visits by IPC team members in addition to individual case discussions Daily contact with DIPC/Gold Command to discuss any changes in guidance. Discussed with Executive Team at daily Incident Management Team. Board members receive daily communications updates Risks added to Trust risk register as appropriate. Staff continue to report infections via the web-based incident reporting system. IPC policies and advice provided.		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			

DRAFT

• designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas • designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas. • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance • increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance • Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas • Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum	All ward staff appropriately trained and upskilled to manage COVID-19 patients Where clinically/IPC required, cohort areas/wards introduced across the Trust All domestic staff have thorough Trust IPC induction and targeted training sessions in relation to the management of COVID-19. Domestic supervisors and support staff link in and meet with IPC team on a regular basis. Decontamination and terminal decontamination included in Trust guidance in line with PHE advice. Specific poster produced for domestic staff and Q&A via NTW solutions All areas throughout the Trust utilising Chlor-Clean as a precautionary measure. All isolation areas decontaminated at least once daily. Domestic staff are instructed in the required standards and pay particular attention to cleaning of toilets/ bathrooms All areas throughout the Trust utilise neutral purpose detergent and chlor-clean (a chlorine	North Cumbria locality using Tristel-Fuse as per NCIC products	

DRAFT

strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses • Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products as per national guidance: • 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids • electronic equipment, egg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily • rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	based disinfectant) Staff have training and guidance on using this Domestic staff have been made aware of the importance of following manufacturers guidance in use of all cleaning / disinfect products Cleaning and decontamination will increase to the twice daily standard Staff working with keyboards, desk tops etc are aware of increased frequency of cleaning for these areas. Ward managers advise domestic teams when top enter rooms for cleaning following patient movement or clinical interventions		

DRAFT

• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken • single use items are used where possible and according to Single Use Policy • reusable equipment is appropriately decontaminated in line with local and PHE and other national policy • review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	All linen from possible/confirmed COVID-19 patients managed as infectious linen and disposed of/laundered appropriately. Single use items used throughout the Trust in accordance with Single Use Policy Reusable equipment is decontaminated appropriately and effectively after use in line with Trust policy This standard is Rooms in CNTW are not typically mechanically ventilated and openable windows is the only method.		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	Incident reports submitted where antibiotics are prescribed Antibiotic surveillance is reported into the IPCC on a quarterly basis		

DRAFT

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• implementation of national guidance on visiting patients in a care setting	In line with national guidance, visiting was suspended across the Trust except for patients requiring End of Life Care and Children.		However, this has now been relaxed all requests are considered on a case by case basis
• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas marked with appropriate signage and where appropriate with restricted access	Access is restricted to core team members where COVID-19 positive patients is suspected/ confirmed		
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	COVID-19 resource pages available on the intranet including easy read and specifically designed resources for patients with a Learning disability		
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Documented on Patient Electronic Record i.e. RiO - evidenced that this is communicated on patient transfer		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			

DRAFT

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure: • Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection as per national guidance • mask usage is emphasized for suspected individuals • ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff • for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible • patients with suspected COVID-19 are tested promptly	Patients with possible or confirmed COVID-19 are isolated from non-COVID-19 patients Some patients do not wish to comply with social isolation or alternative mask use Perspex screens are being placed insitu in reception areas Contact tracing now in place PHE guidance for local implementation is in early days. Outbreak control Boards are being formed All patients who develop symptoms are tested and isolated promptly with continued monitoring of the patient's physical health	There are occasions when patients do not wish to comply with social isolation pending results This can be due to communication difficulties of sensory impairment or risks of ligature use of masks	Triage via Bed Management Clinical Team. Asymptomatic Patients are also routinely tested on admission Staff wear full PPE at all times.

DRAFT

• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Patients who are symptomatic are isolated, if continue to display symptoms following negative result they will be retested Reduced face-to-face appointments and increased use of technology. Staff check with the patient that they are well and symptom-free before appointment where possible to reduce risk of spread		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • all staff (clinical and non- clinical) have appropriate training, in line with latest PHE guidance, to ensure their personal safety and working environment is safe • all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it • a record of staff training is maintained	All staff receive in-depth IPC training on induction into the Trust. Targeted training sessions across all sites in the Trust in relation to PPE (appropriate use/donning and doffing). As above Training records are maintained by training facilitators		

DRAFT

• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	Trust not currently advocating re-use of PPE however fully aware of the CAS Alert describing potential options if supply interrupted		
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	Incident reporting system is in place to report any PPE related concerns		
• adherence to PHE national guidance on the use of PPE is regularly audited	Adherence to PHE National Guidance is undertaken via Routine checks by Clinical Nurse Managers, and IPC Team		
• staff regularly undertake hand hygiene and observe standard infection control precautions	All inpatient staff across the Trust undertake hand hygiene competency assessments/IPC on an annual basis. Hand washing is promoted as a core message via Daily communications and posters in every ward/department across the Trust		
• Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	Hand towel dispensers are available in all areas and are regularly maintained.		

DRAFT

• Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas • staff understand the requirements for uniform laundering where this is not provided for on site • all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE national guidance if they or a member of their household display any of the symptoms	Hand hygiene posters are readily available and clearly displayed in all prominent areas. Communications on personal Uniform laundering has been issued via Daily Communications briefings All staff displaying symptoms of COVID-19 are contacting the Central Absence Reporting Centre within the Trust for advice and to access Trust based Testing Team for themselves and family members.		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	As above, all areas compliant facilities to support isolation/cohorting with the exception of Hadrian Clinic Compliance in line with PHE guidance	Hadrian Clinic difficult to isolate due to layout (no en-suite facilities).	Designation of Bede Ward for admission screening and if negative transfer. If positive the patient will remain and be cared for via isolation on Bede Ward

DRAFT

• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	No change in usual management of these infections		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE [national guidance] • screening for other potential infections takes place	All Trust staff undertaking testing are appropriately trained Testing of both staff and patients is undertaken promptly (usually same day that symptoms are first noticed). Screening takes place to rule out other infections/symptoms being displayed		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that:			

DRAFT

• staff are supported in adhering to all IPC policies, including those for other alert organisms • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff • all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current PHE national guidance • PPE stock is appropriately stored and accessible to staff who require it	IPC Team are in daily contact with clinical areas regarding IPC processes and advising wards/teams where other infections are reported Any changes to PHE guidance communicated to staff as soon as possible via the daily communications and Team meetings All waste related to suspected or confirmed COVID-19 cases is disposed of appropriately as infectious clinical waste into orange bags Central management of PPE has been introduced to ensure adequate stock for all areas based on usage		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	Staff in 'at risk' groups identified and supported appropriately, including the completion of individual risk assessments		

DRAFT

• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	All staff that are required to wear FFP masks undergo fit-testing by an appropriately trained individual. Training is recorded		
• Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	Staff teams remain on their allocated areas with minimal movement. This includes Domestic Teams.		
• All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	Staff are aware of the need for social distancing. Work is underway to ensure there are 2m floor spacers to prompt and remind staff re need for 2m distancing. Posters are on display in all wards/departments across the Trust.		
• Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	The Trust Covid19 Environmental working group has undertaken environmental risk assessments and recommended modifications required trust wide		
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Staff absence and well-being monitored via individual team managers and centrally through the Central Absence Line. Well-being checks undertaken		

DRAFT

• staff that test positive have adequate information and support to aid their recovery and return to work	Information is provided to staff at point of test explaining outcome of results i.e. negative and positive including ongoing support should symptoms worsen or re-occur. Welfare calls support staff to either return or onward referral to Occupational Health		

Report to the Board of Directors
5th August 2020

Title of report	**Seasonal Flu Vaccination Plan 2020/21**
Report author(s)	**Kay Gwynn, Modern Matron, Infection Prevention and Control** **Anne Moore Group Nurse Director Safer Care, DIPC**
Executive Lead (if different from above)	**Gary O'Hare, Executive Director of Nursing and Chief Operating Officer**

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	X
To achieve "no health without mental health" and "joined up" services		Sustainable mental health and disability services delivering real value	
To be a centre of excellence for mental health and disability		The Trust to be regarded as a great place to work	X

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

Management Group meetings where this item has been considered (specify date)	
Executive Team	
Corporate Decisions Team (CDT)	
CDT – Quality	
CDT – Business	
CDT – Workforce	
CDT – Climate	
CDT – Risk	
Business Delivery Group (BDG)	31.7.20

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, experience and effectiveness	x	Service user, carer and stakeholder involvement	X

Board Assurance Framework/Corporate Risk Register risks this paper relates to
CQUIN Flu target 90% 2020/21

DRAFT

DRAFT

Contents

1. Purpose 4
2. Seasonal Influenza (Flu) 4
3. Seasonal Influenza Vaccination Programme 5
   3.1 Seasonal Flu Vaccination 2018/19 Lessons Learnt 5
   3.2 Seasonal Flu group 7
   3.3 Influenza Vaccine 2019/20 8
   3.4 Vaccine Delivery 9
   3.5 Patient Vaccination 10
   3.6 Children and Young Peoples Services (CYPS) 10
   3.7 Flu Vaccination of Health Care Workers 11
   3.8 Peer Vaccinators 11
   3.9 Patient Group Direction 12
   3.10 Flu Vaccination Clinics 12
4. Data Collection 13
   4.1 External reporting 13
   4.2 Internal reporting 13
5. Communication 13
6. Reviewing and monitoring 14
References 15
Appendices 16
   Appendix 1 17
   Appendix 2 24
   Appendix 3 25
   Appendix 4 27
   Appendix 5 29

DRAFT

1. Purpose

This plan sets out the Cumbria, Northumberland Tyne and Wear (CNTW) strategic approach to the delivery of seasonal influenza vaccination to both patients and staff.

The plan should be read in conjunction with the Pandemic Influenza Plan as a framework for vaccination in the event of a pandemic.

The plan is not intended to provide clinical guidance on seasonal flu vaccine. Guidance for the management of patients with an influenza like illness or confirmed influenza is set out in IPC- PGN- 26, (part of CNTW (C) 23 Infection Prevention and Control Policy).

2. Seasonal Influenza (Flu)

Influenza is a highly infectious respiratory illness which can affect all population groups with severe morbidity and mortality common amongst elderly and specific high risk groups. Symptoms include sudden onset of headache, fever, sore throat, lethargy aching muscles and joints.

There are three influenza types; Influenza A and influenza B responsible for most acute respiratory illness with the third Influenza C less typical. Influenza A is the cause of large outbreaks and epidemics.

Influenza viruses are transmitted from person to person by inhalation of large and small droplets from the secretions of an infected person. Environmental contamination with secretions also plays a role in transmission.

The incubation period for influenza ranges from 1-5 days, typically 2-3 days. The infectious period lasts from the onset of symptoms until 3-5 days afterwards, although virus can be detected prior to the onset of symptoms
Infants and children may continue to shed the virus up to 2 weeks after the onset of illness
Common complications from influenza include bronchitis, ear infections, sinusitis and more seriously pneumonia and meningitis. Most people will recover from the virus within a few days however people from high risk groups frequently develop secondary bacterial infections.

Influenza viruses undergo frequent changes in their surface antigen therefore new influenza vaccines must be developed annually to match those influenza viruses expected to circulate in the next season. Antigenic drift, occurring more in Influenza A than B signals minor changes in the virus envelope. Antigenic shift signifies major changes in the virus envelope, different from those of previously circulating viruses and are responsible for major epidemics and pandemics where populations have no immunity to the new strain.

DRAFT

3. Seasonal Influenza Vaccination Programme

The epidemiology of circulating flu viruses are monitored continually by the World Health Organisation (WHO). Virus strains selected for seasonal flu vaccines are announced by WHO in the first quarter of the New Year. These strains are those expected to be in wide circulation in the Northern hemisphere in the following winter months.

Influenza vaccines for the 2020/21 season for staff and patients under 65 years is a quadrivalent inactivated vaccine containing two subtypes of both influenza A and B. The adjuvanted trivalent inactivated vaccine for age group 65 years and over contains two subtypes of Influenza A and one type B. Vaccines previously and currently used are inactivated and therefore unable to cause influenza.

In the event of an emerging pandemic influenza strain, the seasonal flu vaccination will probably be ineffective. The development of a monovalent vaccine will be undertaken and implemented although there may be a considerable delay before the vaccine is freely available for mass vaccination.

Due to the current COVID-19 Pandemic there is concerns relating to the effects that this may have during flu season.

3.1 Seasonal Flu Vaccination 2019/20 Lessons Learnt

The 2019/20 seasonal flu vaccination campaign was the most successful to date with 82% of frontline clinical staff choosing to be vaccinated, this represented a 5.5% increase from the previous year.

2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
62.4%	63.6%	64.4%	73.5%	76.5%	82%

Employing initiatives that have proven to be successful in previous years, the flu team working closely with the vaccinators held a range of drop in clinics and, continued to offer a flexible approach to vaccination across the Trust

In 2019/20 we:

1. Achieved above the CQUIN target of 80% frontline staff vaccination uptake
2. We continue to achieve a year on year increase in vaccination uptake rates in front line staff.
3. We vaccinated 4614 frontline staff, 675 non CNTW staff who had front line contact with our patients.
4. We trained 175 clinical staff to be vaccinators across the Trust.
5. Patients who were 65 years and over were offered the adjuvanted trivalent vaccine.

DRAFT

Due to COVID-19 pandemic the lessons learnt event was stood down. As an alternative to achieve feedback all of the peer vaccinators received an electronic questionnaire to complete. 54 vaccinators completed the questionnaire.

Due to the addition of North Cumbria Locality in October 2019 the questionnaire provided useful feedback from the vaccinators within this locality. This was the first time for the majority of vaccinators to have undertaken this role.
Appendix 1

Proposals:

- To continue to identify those patients in clinical risk groups and offer vaccination.
- To provide vaccination training to established vaccinators and to recruit vaccinators into areas across all services with particular focus upon community teams
- Clinical Business Units (CBU) to take ownership of the vaccination uptake rates including co-ordination of the vaccinators within their teams.
- Each CBU to develop their own flu plan to achieve 90% vaccination uptake
- Focus upon engagement with medical staff to be vaccinated and encourage vaccination across clinical teams.
- Ensure that positive messages and true facts about the vaccine are available to all staff.
- Continue to provide education around the impact of flu and the consequences of flu on health.
- Continue with a flexible easy to access vaccination plan.

3.2 Seasonal Flu group

The purpose of the Seasonal flu group is to:

- Act as a sub-group of the Infection Prevention and Control Committee (IPCC) to promote and protect the health and wellbeing of service users, carers, staff and visitors from seasonal flu.
- Provide the Trust Board via the IPCC with assurance that appropriate systems are in place to achieve herd immunity in staff groups and provide external assurances on flu vaccination uptake levels.
- Produce an effective flu vaccination delivery programme to protect patients, staff and visitors
- Ensure that all patients in clinical risk groups are identified and offered flu vaccine
- Produce weekly reports of front line healthcare worker vaccination uptake rates to Group Directors.
- Provide monthly reports to the Department of Health through the ImmForm web site.
- Provide the Emergency preparedness group with assurance that measures to prevent and protect against flu support the Trust overall winter preparedness plan.

The group has Nurse Director leadership, with a multi-disciplinary team of clinical and non-clinical staff delivering the campaign at local level. The terms of reference of the group are included in Appendix 2 and are reviewed regularly.

Meeting dates for the group reflect the activity required as the flu season approaches, although additional meetings may be required to suit the needs of the programme.

The group will report into the Infection Prevention and Control Committee, the Physical Health and Wellbeing Group and the Emergency Preparedness Resilience and

DRAFT

Response group to give assurance to the Clinical Commissioning Groups (CCGS) in respect of winter planning.

Flu Group Meeting Dates

Date	Time	Venue
11/06/2020	2.00pm -3.30pm	Via Teams
25/06/2020	12.30pm – 2.00pm	Via Teams
30/07/2020	2.00pm – 3.30pm	Via Teams
20/08/2020	2.00pm – 3.30pm	Via Teams
17/09/2020	2.00pm – 3.30pm	Via Teams
22/10/2020	2.00pm – 3.30pm	Via Teams
12/11/2020	2.00pm – 3.30pm	Via Teams
17/12/2020	2.00pm – 3.30pm	Via Teams
21/01/2021	2.00pm – 3.30pm	Via Teams
33/03/2021	9.30am - 11.30am	Lesson's learnt event

3.3 Influenza Vaccine 2020/21

As with the 2019/20 campaign, the Trust has placed orders with Sanofi for the quadrivalent vaccine to be offered to both inpatients and staff. This is in accordance with the recommendations from NHS England.

Patients who are 65 years old and over will receive the adjuvanted trivalent vaccine as recommended by the NHS England. The vaccine has a higher immunogenicity and effectiveness than the non-adjuvanted vaccine and is regarded as the best option for this age group. This season a new vaccine, cell –grown quadrivalent vaccine is available suitable for those patients and staff who are unable to have the standard egg based vaccine due to allergy. This vaccine will be ordered in small numbers and available through pharmacy only.

Influenza strains included in the 2020/21 quadrivalent inactivated vaccine (QIV) are:

- an A/Guangdong-Maonan/SWL1536/2019 (H1N1)pdm09-like virus;
- an A/Hong Kong/2671/2019 (H3N2)-like virus;
- a B/Washington/02/2019 (B/Victoria lineage)-like virus; and
- a B/Phuket/3073/2013 (B/Yamagata lineage)-like virus

Influenza strains in the 2020/21 adjuvanted trivalent inactivated vaccine (aTIV) are

- an A/Guangdong-Maonan/SWL1536/2019 (H1N1)pdm09-like virus;
- an A/Hong Kong/2671/2019 (H3N2)-like virus; and
- a B/Washington/02/2019 (B/Victoria lineage)-like virus.

DRAFT

Vaccine Type	Age	Dose
Inactivated intramuscular vaccine (number of different brands)	Children aged 6 months and less than 2 years old and adults, although some of the vaccines are not authorised for young children.	Single injection of 0.5ml
Adjuvanted inactivated vaccine	65 years and over	Single injection of 0.5 ml
Live attenuated influenza vaccine LAIV Fluenz Tetra®	Childhood vaccination programmes	Both nostrils total dose 0.2ml.

The national flu immunisation programme 2020/21 available at:
https://www.england.nhs.uk/wp-content/uploads/2020/05/national-flu-immunisation-programme-2020-2021.pdf

Contraindications

There are very few individuals who cannot receive influenza vaccine. None of the influenza vaccines should be given to those who have had:

- a confirmed anaphylactic reaction to a previous dose of the vaccine
- a confirmed anaphylactic reaction to any component of the vaccine (other than ovalbumin).
- Are presenting with a febrile illness or who are systemically unwell.

More common allergic reactions include rashes but are not contraindications to further vaccination. The clinical risk groups are included in Appendix 3.

3.4 Vaccine Delivery

Vaccine delivery schedule into the Trust is as follows, although the dates are subject to change according to the supplier.

QIV

Date Expected	SNH	SGP	HWP	Yewdale	Carleton Clinic
W/C 14th September 2020	1050	380	200	TBC	TBC
W/C 5th October 2020	840	300	160	TBC	TBC
W/C 19th October 2020	1050	380	200	TBC	TBC
W/C 2nd November 2020	1260	440	240	TBC	TBC

aTIV

Pharmacy Site	Date expected	Doses to be delivered
St. Nicholas Hospital	w/c 28th September 2020	300

DRAFT

Distribution of the vaccine reflects the activity across the Trust and can be transported to community areas adhering to the maintenance of the cold chain in discussion with the pharmacy department.
It is anticipated that the seasonal flu vaccination campaign for patients and staff will commence on 21st September 2020. This is subject to delivery dates as stated above.

3.5 Patient Vaccination

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

Wards are reminded to review all patients who are in the clinical risk groups and offer flu vaccination to both current inpatients and new admissions throughout the flu season. It is also an opportunity to ensure that patients are also protected against pneumococcal infection where indicated. A sample letter sent to clinicians prior to commencing the campaign can be found in Appendix 4.

Consent must always be obtained prior to vaccination. For further information staff are advised to refer to CNTW (C) (05) - Consent to Examination or Treatment Policy. Community teams and day units across the Trust are encouraged to promote influenza vaccination to patients who they have contact with and are in the clinical risk groups, vaccination is provided by GP services.

In some instances, where patients have no access to GP services, e.g. drug and alcohol services, flu vaccine is offered and prescribed by the clinician responsible for the care of the individual. Patients are prescribed seasonal influenza vaccine as a once only medication on their drug kardex by the ward Doctor.

NHS England following recommendations by the Joint Committee on Vaccination and Immunisation (JCVI) have advised the use of an adjuvanted trivalent influenza vaccine (aTIV) for all those aged 65 years and over, whilst adults aged under 65 years in clinical at risk groups should be offered the quadrivalent vaccine (QIV). Orders for the vaccine have been through the usual procurement process and are expected to be received by the Trust in time for the commencement of the campaign.

DRAFT

3.6 Children and Young Peoples Services (CYPS)

GP services are contracted to provide physical health care to children and young people within CNTW in patient services. Children and young people who are admitted into the service as inpatients are assessed on admission. Those who are identified to be in the clinical risk groups are referred to the GP who will offer vaccination in discussion with parents and child/young person. Community teams working within CYPS have a duty and responsibility to ensure that the patients under their care have information and access to relevant immunisations. In this instance the patient and family are directed to the GP clinic

3.7 Flu Vaccination of Health Care Workers

The Health and Social Care Act 2008 states that all health organisations should; ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care. (Department of Health [DH] 2008).
Transmission of the flu virus from health care workers to patients has been well documented. (Public Health England [PHE] 2016)
The purpose of vaccination of health care workers is

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

The table below shows the uptake rates of the front line clinical workers in CNTW in 2019/20

Category	% flu vaccination uptake
Doctors	74.2%
Qualified nurses	81.6%
All other professionally qualified clinical staff	87.9%
Support to clinical staff	82%

All front line groups have seen an increase in uptake in the 2019/20 season contributing to an overall increase of 5.5% from the 2018/19 campaign. For the purpose of identifying front line health care workers in CNTW, appendix 5 outlines the front line staff groups. This list is not exhaustive and each post should be assessed in accordance with ESR and clinical activity.

3.8 Peer Vaccinators

In 2019/20, 175 registered staff from community teams, pharmacy, nurse directors and medical staff undertook training to be able to vaccinate all CNTW staff. The effectiveness of this approach has seen a year on year increase in vaccines delivered. We will continue to use and build on this approach offering a mixture of flu vaccination update training and new vaccinator training sessions. Vaccinators who were trained in last year's campaign are automatically enrolled onto a course the following year, this facilitates staff competency and helps to embed practice.

Vaccinators across hospital sites work well when they are co-ordinated, supported and given autonomy to deliver vaccinations in a variety of delivery methods, e.g. clinics, drop in sessions, team meetings. Clinical business units (CBUs) will be informed of trained vaccinators within the groups with the expectation that they will direct and oversee their performance. This will assist with the identification of areas of poor vaccination uptake and aid in a targeted approach to a specific group or area. Vaccinator training is competency based and vaccinators are required to have

DRAFT

completed basic/intermediate life support and anaphylaxis training. This now available via E-Learning.

Peer vaccinators continue to play a pivotal role in providing clinical information to frontline health care workers and acting as role models. This is a key priority in all seasonal flu campaigns. All vaccinators will have access to PowerPoint presentations and the latest vaccine information through an e-book available through the internal intranet share point site. This will facilitate the delivery of key messages at team brief and other meetings.

Training of vaccinators is being delivered using a different model due to COVID-19. All vaccinators will be able to access the training via a specific e-learning package.

New vaccinators will complete a further 1-1 practical session/sign off arranged on an individual basis with either the IPC team or an experienced vaccinator.

The IPC team in conjunction with the Training Academy are in the process of designing a suitable e-learning training package which should be available to access from August 2020.

3.9 Patient Group Direction

All trained vaccinators will administer seasonal influenza vaccine to all CNTW staff under a Patient Group Direction (PGD) reviewed and ratified by the Medicines Optimisation Committee.
The PGD sets out the required characteristics of staff who will undertake seasonal flu vaccination:

- Qualified Nurses or Pharmacist with current professional registration
- Abide by the CNTW standards for record keeping and guidelines for the administration of medicines
- Must attend an annual CPR update
- Inpatient areas Immediate Life support (ILS)
- Community areas Basic Life support (BLS)
- Complete annual infection prevention and control training
- Complete annual anaphylaxis training
- Complete annual influenza vaccination training

3.10 Flu Vaccination Clinics

Trained vaccinators across the Trust are expected to provide a flexible approach to vaccination and are encouraged to hold vaccination sessions that best suits the environments that they work in.

COVID-19 will impact on how the vaccination clinics are run and held this year. Previously, *drop in* clinics were held with as many as 120 staff to vaccinate within a single clinic. All control measures are required to be in place in line with national guidance and therefore flu clinics will be via a booked appointment time slot for staff.

DRAFT

Each CBU has produced a locality flu plan to identify vaccinator coverage outlining how and when clinics will be held to ensure all IPC measures are in place to reduce any increased risk of COVID-19 transmission occurring.

Flu vaccine will be offered to all staff by occupational health who attend health screening clinics throughout the flu season. The new occupational health provider have allocated time on a weekly basis to help support this campaign.

In recognising the importance of accessibility to vaccination to all frontline healthcare workers in both the NHS and other organisations, CNTW will be offering flu vaccination to all staff working within, or into CNTW. This includes North East Ambulance staff, social workers, teachers and others who provide front line care /services to our patients.

Many staff are currently working from home and will need to access sites to obtain their vaccine on a booked appointment basis.

4. Data Collection

4.1 External reporting

As in previous years, vaccination of front line health care workers will be reported through the ImmForm website. Uptake data information for healthcare workers will be collected on immunisations given from September 2020 to the end of February 2021 (final data collected in March 2021).
It is anticipated that further reporting through the Clinical Commissioning Groups and NHS England Area Team will be required

4.2 Internal reporting

CNTW Informatics Department have created a system that accommodates information governance and data protection issues, and allows the collection of data to be used in the reporting to ImmForm and any other relevant organisation.

The production of a weekly statistical report to trust senior managers across all services will assist with identifying areas of poor vaccination uptake in front line health care workers. This will enable the CBU and vaccinators to focus upon these wards/areas to ensure staff have access to vaccination.

5. Communication

The Communications Team are key members to the success of the seasonal flu campaign and the communication plan informs the delivery of information delivered Trust wide.
We continue to recognise the importance of effective communication throughout the campaign in dispelling myths and in delivering important messages.

DRAFT

Key messages will start with a phased approach in the Trust Bulletin, followed by more frequent key messages as the flu season approaches. The dedicated flu page on the Trust intranet is instrumental in relaying key messages, clinic dates and myth busters. All CNTW staff have access to Twitter and internal messaging through Chatterbox. The dedicated flu fighter e-mail address (flufighter@cntw.nhs.uk) is used as a point of contact for all vaccination queries and is promoted through the vaccination training, staff bulletin and e-mails. This is monitored by the Infection Prevention and Control Team. Following the positive reviews from staff of the "real life" personal stories posters, these will continue into the 2020/21 campaign to raise awareness of the importance of vaccination to protect people in clinical risk groups.
Engagement with patients and carers in the flu campaign remains a key priority to both encourage and support patients to make an informed choice about the importance of vaccination. Community teams have the responsibility to facilitate patients attending the GP for vaccination where appropriate highlighting to carers the availability of a free flu vaccine by the GP surgery.
Inpatient staff are encouraged to use carer/patient meetings as an opportunity to discuss the importance of flu vaccination especially in clinical risk groups.

6. Reviewing and monitoring

Whilst the Trust achieved the CQUIN target in 2019/20, there is an expectation that all Trusts will achieve 90% vaccination uptake in front line staff in the 2020/21 campaign. Our commitment is to continue to increase vaccination uptake rates year on year across the Trust.

Whilst this will continue to be challenging we will continue to

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

Infection Prevention and Control Team

DRAFT

References

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, (2018). Influenza Guidance, Guidance for Management of Patients/Clients with an Influenza like Illness or confirmed influenza (IPC-PGN -26).

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, (2016). CNTW (C) 05 – Consent to Examination or Treatment Policy.

Department of Health (DH), (2008) Health and Social Care Act. Code of Practice on the prevention and control of infections and related guidance. Updated 2010. London.

Department of Health (DH), (2006) Immunisation against infectious diseases 2006.. Chapter 19 Influenza, Chapter 25 Pneumococcal [Online], Available: https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Public Health England (PHE) (2019) Seasonal flu vaccine uptake in healthcare workers in England: winter season 2019 to 2020 [Online] https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-healthcare-workers-monthly-data-2019-to-2020

Public Health England (PHE), (2020) the national flu immunisation programme 2020/21[Online] https://www.england.nhs.uk/wp-content/uploads/2020/05/national-flu-immunisation-programme-2020-2021.pdf

DRAFT

Appendices

Appendix 1 Vaccinator Questionnaire

Appendix 2 Terms of Reference for Seasonal Flu Group

Appendix 3 Clinical Risk Groups

Appendix 4 Letter to Clinical Staff. The Seasonal Influenza Immunisation and Pneumococcal Vaccination Programme 2020/21.

Appendix 5 CNTW Front Line Staff Definitions

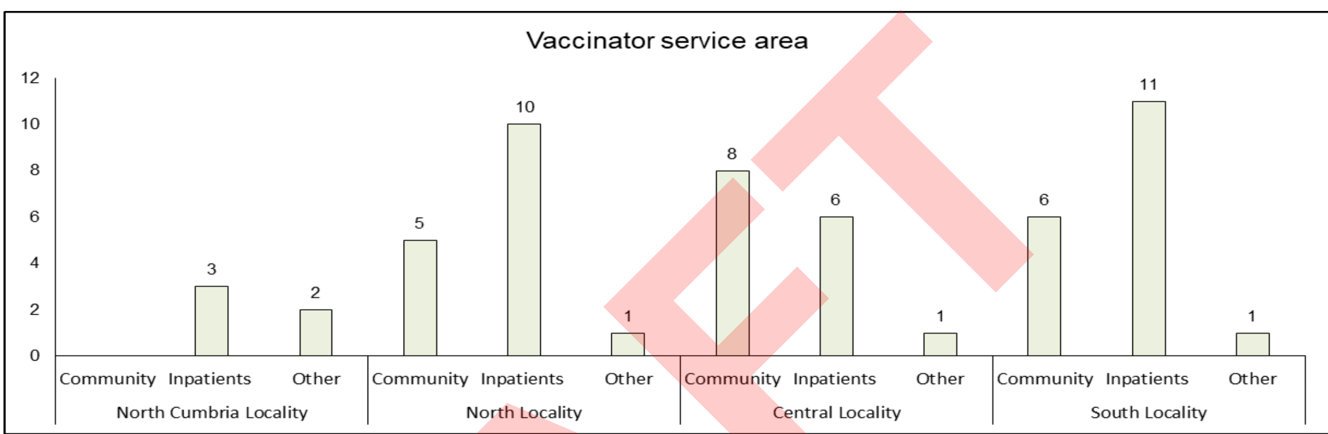
Appendix 1

FLU CAMPAIGN 2019 / 2020 EVALUATION

Updated 23rd June 2020

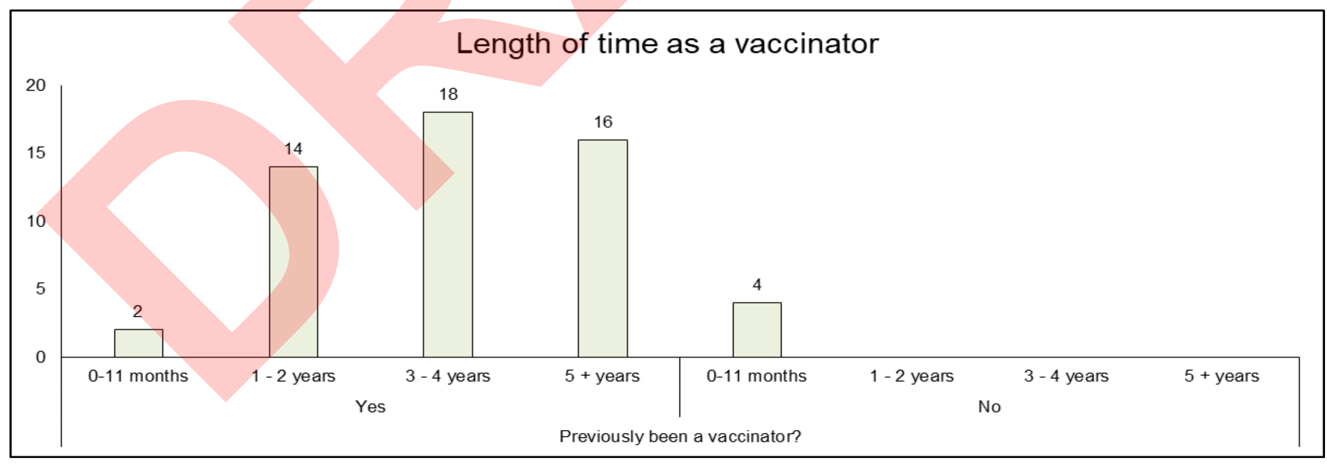
Overall a total of 54 responses were received to the on-line questionnaire to evaluate the 2019 to 2020 CNTW Flu Campaign.

1. Which Locality / Service area do you work in?



- 18 (33.3%) of vaccinators are based in the South Locality
- 30 (56%) of vaccinators are based in Inpatient Services.

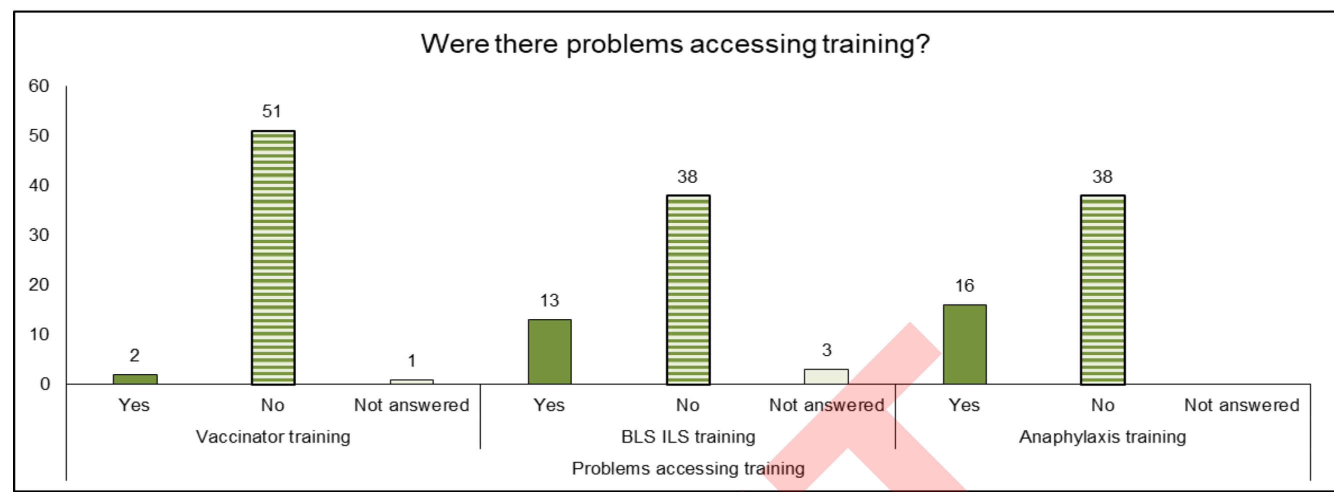
2. Have you previously been a vaccinator and length of time?



- 50 (93%) of vaccinators have previously been in the role of vaccinator.
- 34 (63%) have vaccinated for 3 years and longer.

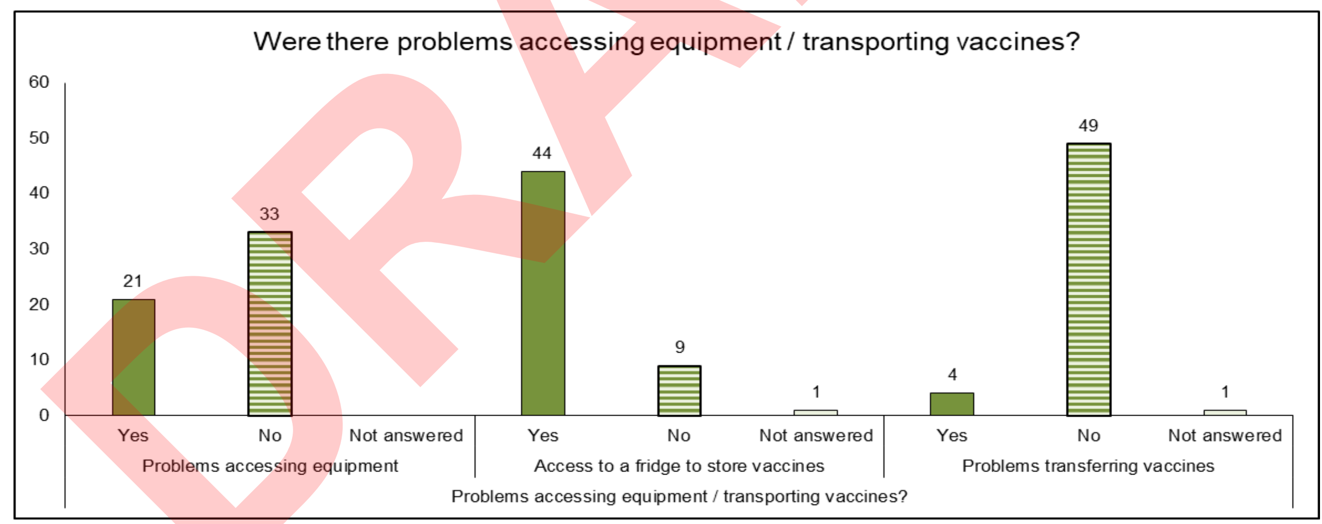
DRAFT

3. **Did you have any problems booking / accessing the required training?**



- 2 (4%) staff had problems booking onto vaccinator training.
- 13 (24%) staff had problems accessing BLS ILS training.
- 16 (30%) staff had problems accessing anaphylaxis training.

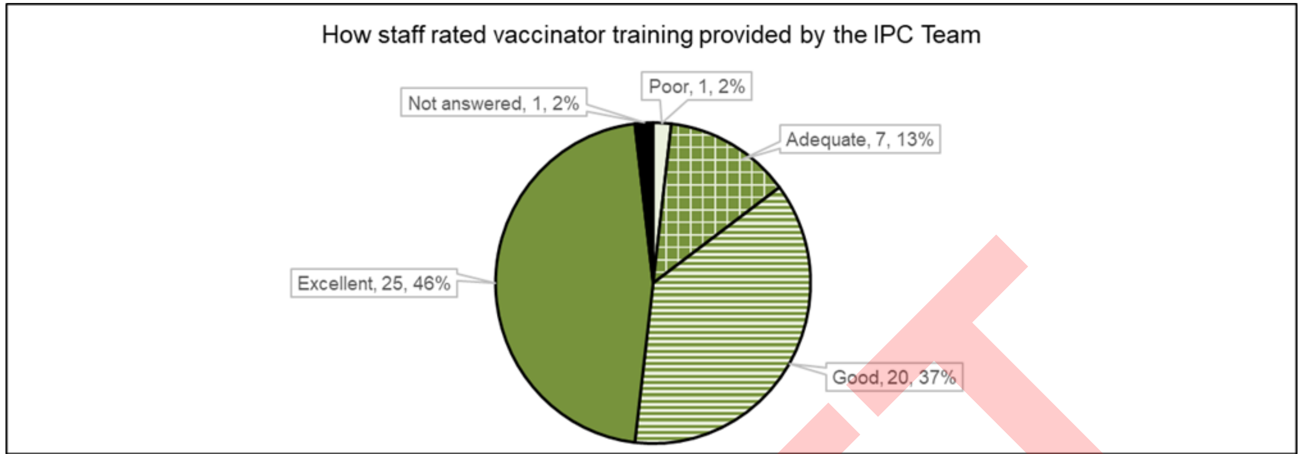
4. **Did you have any problems accessing any equipment needed to vaccinate or problems transporting vaccines?**



- 21 (39%) staff had problems accessing equipment needed to vaccinate.
    - 16 of the 21 (76%) related to shortage in supplies of the vaccine and adrenaline.
- 9 (17%) staff did not have access to a fridge to store vaccines.
- 4 (7%) staff had problems transferring vaccines.

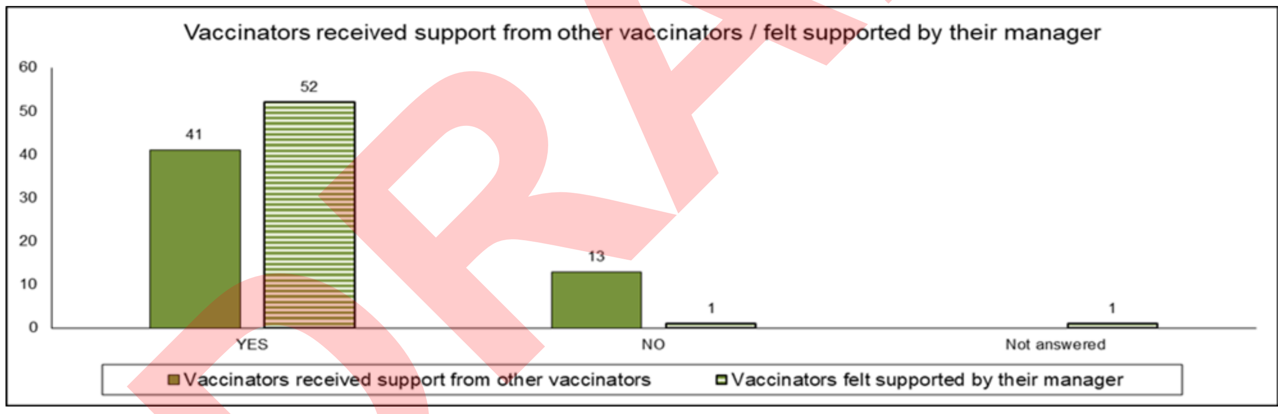
DRAFT

5. **Staff were asked to rate the vaccinator training that they received from the IPC Team.**



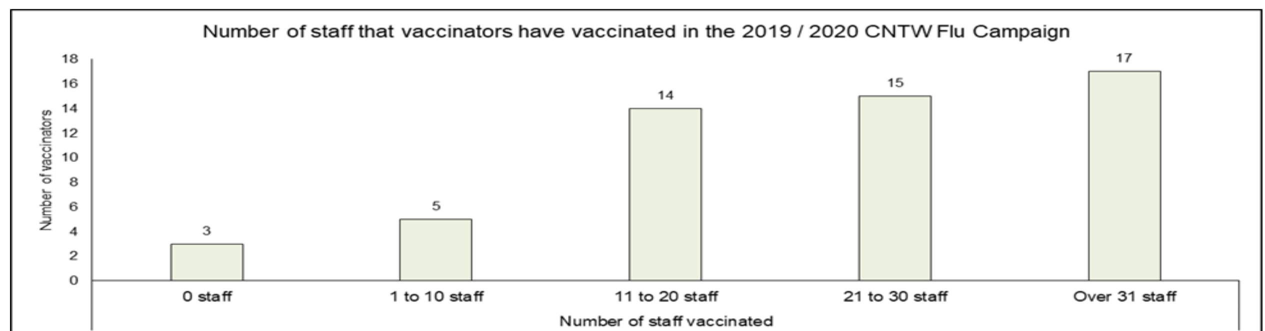
- 45 (83%) of 54 staff responding to the questionnaire indicated that the training delivered by the IPC Team was good or excellent.

6. **Vaccinators were asked if they were supported in their role as a vaccinator.**



- 41 (76%) of 54 staff indicated they had support from other vaccinators.
- 52 (96%) of 54 staff indicated that they were supported in their role as a flu vaccinator by their manager.

7. **Approximately how many members of staff have you vaccinated in the 2019 2020 CNTW Flu Campaign?**



- 46 (85%) of vaccinators have vaccinated 11 or more members of staff during the 2019/2020 CNTW Flu Campaign.
- **NB.** 52 (96%) of the 54 vaccinators who responded to the questionnaire indicated that they would like to be a vaccinator within the forthcoming 2020/2021 flu campaign.

Any further comments / ideas which would benefit / improve the 2020/2021 Flu Campaign?

The majority of comments to improve the 2020/2021 flu campaign concerned provision of all training on the same day as vaccinator training. There was also comment on portable flu stations for each site and the lack of regular communication updates. All comments below:

- Keen to be involved with the flu committee and undertake work to support the programme.
- Maybe if we could arrange a time to be observed giving the vaccine as I had some difficulties getting started due to this. However.... in IPC was extremely helpful.
- Please take notice of comments above. We need all training in 1 day.
- Provide BLS as part of influenza training as used to happen.
- It would be easier to have the BSL and anaphylaxis training at same time (BSL currently only 2 yearly with breakaway).
- The anaphylaxis training should be face to face on the same day as your flu update.
- Believe that the anaphylaxis training should be part of the flu training. A lot of time was wasted due to people not being able to access training for this and BLS ILS.
- The use of a portable work flu station would be useful when in non-clinical areas to provide timely vaccinations for clinical-non clinical staff who are not ward based. Could consist of trolley portable (plug in) fridge sharps box plasters cotton balls paperwork and adrenaline pens - one on each main site stored in pharmacy :).
- I think that the communication was poor as normally ….. would send out regular communication however this year it was non-existent. Our modern matron was unaware that we were not getting sent the figures in order to target specific areas. I felt very isolated in this year campaign in getting up messages

DRAFT

that I could pass on i.e. there is flu outbreak it is important to get the flu jab. If anyone was to ask if flu was circulating I could not tell them.

- Due to LT sickness I was unable to access the vaccinator training until late in the campaign therefore I did not vaccinate as many staff as in previous years as they were vaccinated by another vaccinator within my area of work.

- **Additional Comments**

Did you have any problems booking onto your vaccinator training?

Two staff indicated that they had problems booking onto vaccinator training:

- As now PT 2.5 days a week.
- This year training did not go as smoothly as previous year.

One member of staff did not have problems booking onto vaccinator training however commented that they worked on the nurse bank and as they were retired there was an issue on who would pay for the training time. The training went ahead as it was beneficial to the clinical setting.

Did you have any problems accessing BLS ILS training?

13 staff indicated that they had problems accessing BLS ILS training. All comments below:

- Due to the Trusts merging and equipment not being compatible.
- Wasn't clear how to access or where it was being held.
- Insufficient dates for training in the Northumberland area.
- None available had to wait.
- Had no courses available but eventually a course was made available.
- This was difficult to access in a timely manner due to the lateness of the flu vaccinator training and difficulty in sourcing sessions.
- Updates not readily available in the classroom and unsure if e-learning was appropriate
- Classroom updates not readily available and unsure if e-learning suitable but accessible.
- No sessions available to access for community staff. Ward staff usually complete theirs within the PMVA so are covered but the BLS is less common.
- I am not required to complete the full PMVA training and there were no dates available at the time I required it. I was given names of ILS tutors but our availabilities did not match so there was a delay in completion.
- Yes as BLS is not included in flu training and pharmacy staff do not routinely receive this. Originally told I could not access BLS via PMVA training but went along anyway as I had no other way of accessing BLS.
- As I am a previous vaccinator I just book for breakaway course - even although this is only needed to be completed every 2 years. Thus taking out several hours for training that I don't need to complete.
- No comment provided.

Did you have any problems accessing Anaphylaxis training?

DRAFT

16 staff indicated that they had problems accessing Anaphylaxis training. All comments below:

- Anaphylaxis training is usually combined with the vaccinator update training however this year that was not case. Anaphylaxis needed to be completed via E-learning which caused delay and was very challenging to take time out to do on top of attending vaccinator update training given clinical demands.
- Absolutely diabolical only e learning took ages to complete timed out did not save previous work. I was very late vaccinating ppl not till January 2020!!!!!!!!!! Resources wasted every other year all completed in 1 day.
- As with above comment re accessing BLS training: Yes as BLS is not included in flu training + pharmacy staff do not routinely receive this. Originally told I could not access BLS via PMVA training but went along anyway as I had no other way of accessing BLS.
- Was unsure where to find this and just did the one on e-learning. Requested feedback to check if this was correct but received none.
- I couldn't find it on the Intranet. IPCC Matron assisted me.
- Was able to use on-line training PowerPoint.
- Yes the e-learning did not initially work and the usual scenario played out it IT issue and when you speak with IT it becomes a trailing problem. As there was a delay in getting the course on line there was additional pressure to complete this within a very short time scale and including the issues I had getting on to the eLearning. I had to complete this course in my own time.
- Usually this has previously been done in the class room but this year had to be done on e-learning this did take a bit to work out it was not clear cut.
- Anaphylaxis training was not made available until 1 month after completing my vaccinator update.
- Updates not readily available in the classroom and unsure if e-learning was appropriate.
- Classroom updates not readily available and unsure if e-learning suitable it was but accessible.
- I eventually got on the training face to face in October 2020 as that is what I prefer. Also problem with on line training at the time.
- Initially but once set up and e-learning had no issues just took a while with being separate from the classroom.
- However I did do this on line.
- No comment provided (2).

Additionally

Two members of staff did not have any problem accessing the training but commented:

- Two colleagues did which meant that they were the sole vaccinator for the majority of the programme.
- Still not showing as complete on Dashboard.

Did you have problems accessing any equipment needed to vaccinate?

21 staff indicated that they had problems accessing the equipment they required to vaccinate. All comments below:

DRAFT

- The flu vaccinations initially.
- Shortage of vaccines on site.
- Delay on influenza vaccine.
- Delay in getting vaccines.
- Long delay in receiving a supply of vaccinations.
- There was an initial shortage on the flu vaccines.
- Shortage of vaccinations nearer the end of the campaign.
- Flu vaccines were late. I think this was a supply problem so we had to start slightly later than planned.
- Not able to get a cool bag to keep the cold chain and unclear about accessing the vaccinations and adrenalin.
- Delay in getting the vaccines due to supply issue. I could not start for around 4 week from initially ordering the stock. As you are aware there was adrenaline supply issues.
- Both the vaccine and adrenaline was difficult to obtain.
- Both the vaccine and adrenaline was initially difficult to obtain.
- Initially ordering of vaccines was slow and how many we could have then the issue of the adrenalin shortage and how long it took to be ordered but once on the wards was okay afterwards.
- Unable to get adrenaline or cool bag. Overcame this by only vaccinating on the ward and support another vaccinator who has the equipment.
- Adrenaline unavailable for some time.
- Adrenaline arrival prevented commencement of vaccine due to delay although ordered in advance however shortage throughout the UK.
- Accessing vaccines for patients in a timely manner due to changes in pharmacy policy.
- I am not able to order from pharmacy as I work in liaison psychiatry and we no longer have a mental health ward on site. This has been problematic for a number of years.
- Not sure how to order vaccinations etc. from pharmacy at the Carleton Clinic.
- Anaphylaxis pens.
- As not ward based I had to purchase my own cotton wool, hand, sanitiser plasters etc.

Did you have access to a fridge to store vaccines in?
9 staff indicated that they did not have access to a fridge in which to store the vaccines. All comments below:

- I am not ward based so accessed vaccinations on the day of clinics from the pharmacy. A portable fridge based on site would have been useful.
- We didn't have access to a fridge prior to the flu campaign however once the campaign started the fridge was ordered and delivered within days. Very good service.
- Our office is next door to the Pharmacy at SNH so I only order small amounts of the vaccine in line with the number of staff who are expected to receive the injection to avoid any wastage.

DRAFT

- There is a fridge on the ward however to give vaccinations for other staff the room used does not have a fridge.
- We are situated next door to SNH Pharmacy so an agreement was made to order enough supply on the day of the clinics only for the expected amount of clients to minimise wastage.
- No comment provided (4).

Did you have any problems transferring vaccines?
4 staff indicated that they had problems transferring vaccines. Comments include:
- Between community bases for our team.
- Had to access the school nurses fridge and community supplies.
- No cool bag to transfer.
- Unable to access.

How would you rate the vaccinator training received from the IPC Team?
Poor
- This score is due to not receiving all of the training on 1 day.

Adequate
- Trainer was new to delivering the course appeared to lack confidence slightly.
- Not as good as previous years.

Good
- I know it was unavoidable as the flu vaccine was late this year but it would have been good to do the training once they had arrived so that we could administer and get signed off for our first vaccine as this is also an issue for me.

Excellent
- That was probably the best part of this year campaign.
- The IPC Team were excellent in every respect as usual both during the training and with follow-up advice.
- The IPC Team was as always excellent both in training and with queries and advice afterwards.
- Really good training and supported me to give injections when I hadn't given for a very long time.
- Considering was first time in post and first time delivering training I think they dealt with it well and any issues.

12. Did you feel supported by your manager in your role as flu vaccinator?
- My manager is also a vaccinator so we worked together to ensure that the patients and staff were vaccinated.
- I supported my manager to become a flu vaccinator.
- Pharmacy managers were very supportive of this role.
- I did not do any vaccinations this year. I could not get the ILS training and I also changed jobs.
- Did most of the clinics as extra time due to staff availability   shortage when on shift (time owing given).

DRAFT

Appendix 2

Group Name: Trust Wide Flu Group
Committee Type: Standing subgroup of Infection Prevention & Control Committee
Timing & Frequency: Monthly July to November. 90 minutes. Additional meetings may be held as necessary.
Personal Assistant to Committee: Public Health Admin Support Officer
Reporting Arrangements: Minutes and Report from Chair to Quality and Performance Committee

Membership:	
Chair:	Anne Moore: Group Nurse Director, Safer Care/Director of Infection Prevention and Control
Deputy Chair:	Kay Gwynn Infection Prevention & Control Modern Matron
Members:	Clinical Nurse Managers from each CBU Service User/Carer Representative: Medical Representative: Dr Andrea Tocca Workforce Representative: Julie White Team Prevent Representative: Helen Hough Informatics, Systems Development Manager: Jo Latimer Informatics, Systems Support Officer: Katie Johnson Pharmacy Technician: Antony Coleman AHP Representative: CNTW Solutions Representative: Martin Laing/Susan Scroggins Resilience Lead: Training Representative: Tess Walker Communications Adviser: Fiona Kettle Staff Side Representative: Mark Goodall Staffing Solutions Manager: Joanna Kennedy Medical Devices Administrator, Public Health: Debra Bedir Public Health Admin Support Officer: Katharine Grant
In Attendance:	Others to be invited for specific items as agreed by the Chair/Deputy Chair
Quorum:	Six, including the chair or deputy chair
Deputies:	A nominated deputy should attend if the member is unavailable

Purpose:

- To act as a subgroup of the Infection Prevention and Control Committee (IPCC) to promote and protect the health and wellbeing of service users, carers, staff and visitors from seasonal flu.
- To provide the IPCC with assurance that appropriate systems are in place to achieve herd immunity in staff groups and provide external assurances on flu vaccine uptake levels.
- Provide the Emergency Preparedness Group with assurance that measures to prevent and protect against flu support the Trust's overall winter preparedness plan.

DRAFT

Appendix 3

Clinical Risk Groups

Those eligible for vaccination are:

All patients aged 65 years and over	Defined as people aged 65years or over (including those becoming age 65 years by 31st March 2020).
Chronic respiratory disease (6 months or older)	Asthma that requires continuous or repeated use or inhaled or systemic steroids or exacerbations requiring hospital admission. COPD including chronic bronchitis Emphysema Bronchiectasis Cystic fibrosis Interstitial lung fibrosis Pneumoconiosis Bronchopulmonary dysplasia Children who have previously been admitted to hospital for lower respiratory tract infection.
Chronic heart disease aged 6 months or older	Congenital heart disease Hypertension with cardiac complications Chronic heart failure Individuals requiring regular medication and/or follow up for ischaemic heart disease
Chronic kidney disease aged 6 months or older	Chronic kidney disease at stage 3,4 or 5 , Chronic kidney failure Nephritic syndrome, kidney transplantation.
Chronic Liver disease aged 6 months or older	Cirrhosis, biliary atresia, chronic hepatitis
Chronic neurological disease aged 6 months or older	Stroke transient ischaemic attack (TIA). Conditions in which respiratory function might be compromised due to neurological disease (e.g. polio) Clinicians should consider on an individual basis the clinical needs of the patient s including individual with cerebral palsy, multiple sclerosis and related similar conditions; or hereditary and degenerative disease of the nervous system or muscles; or severe neurological disability.
Diabetes aged 6 months or older	Type 1 diabetes, type2 diabetes requiring insulin or oral hypoglycaemic medicines, diet controlled diabetes
Immunosuppression aged 6 months or older	Due to disease or treatment. Patients undergoing chemotherapy. Asplenic or splenic dysfunction HIV infection at all stages.

DRAFT

	Individuals treated with or likely to be treated with systemic steroids for more than a month as a dose equivalent to prednisolone at 20mg or more per day (any age) or for children under 20kg a dose of 1mg or more per kg per day. It is difficult to define at what level of immuno- suppression a patient could be considered to be at greater risk of the serious consequences of flu and should be offered flu vaccination. This decision is best made on an individual basis and left to the patients clinician. Some immunocompromised patients have suboptimal immunological response to vaccine. Consideration should also be given to the vaccine of household contacts of immunocompromised individuals i.e. individuals who expect to share living accommodation on most days over the winter and therefore for whom continuing close contact is unavoidable. This may include carers (see below.)
Pregnant women	Pregnant women at any stage of pregnancy (first, second and third trimester)
People in long stay residential or homes	Vaccination is recommended for people living in long stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality. This does not include, for instance prisons, young offender institutions or university halls of residence.
Carers	Those who are in receipt of carer's allowance, or those who are the main carer, or the carer of the elderly or disabled person whose welfare may be at risk if the carer falls ill.
Health and Social Care Staff	Professional health and social care workers who are in direct contact with patients/clients should be vaccinated by their employer as part of an occupational health programme.
Morbid obesity(class III obesity)	Adults with a Body Mass Index ≥ 40kg/m²

DRAFT

Appendix 4

Public Health
1st floor St. Nicholas House
St. Nicholas Hospital
Gosforth
Newcastle upon Tyne
Tel: 0191 2456650
E-mail: flufighter@CNTW.nhs.uk

PH/IPC/20/01
To:
Medical Staff, CNTW
Chief Pharmacist, CNTW
Clinical Directors
Nurse Directors/Associate Nurse Directors/ Associate Directors
Associate Allied Health Professional Directors
Clinical Nurse Managers

Dear Colleagues

THE SEASONAL INFLUENZA IMMUNISATION AND PNEUMOCOCCAL VACCINATION PROGRAMME 2020/21

We are fast approaching the annual influenza vaccination programme and I am writing to request inpatient wards and units to commence identifying to the pharmacy department those patients who are eligible to receive the seasonal flu vaccine and or pneumococcal vaccination.

It is crucial to the health and wellbeing of our patients that they have access to vaccination to protect them against this year's circulating flu strains. This applies to all new and recurrent admissions who are assessed for eligibility to receive the vaccines. Please note that pneumococcal vaccine should be offered to those patients who are in the clinical risk groups and where there is no evidence to support previous vaccination.

Following recommendations from the Joint Committee on Vaccination and Immunisation, NHS England have recommended the use of an adjuvanted Trivalent Inactivated Vaccine (aTIV) for all people who are 65years and over.
Those patients who are in clinical risk groups and under 65 years will continue to receive the Quadrivalent Inactivated Vaccine (QIV).

Enclose is a copy of Chapter 19, Influenza and Chapter 25 Pneumococcal from the Green Book for your reference; these chapters identify the clinical risk groups. Also enclosed is a copy of the annual national flu immunisation programme 2020/21 to assist you with informing patients of the importance of vaccination

As in previous years we will continue to audit the uptake of both seasonal flu vaccine and pneumococcal across all groups.

DRAFT

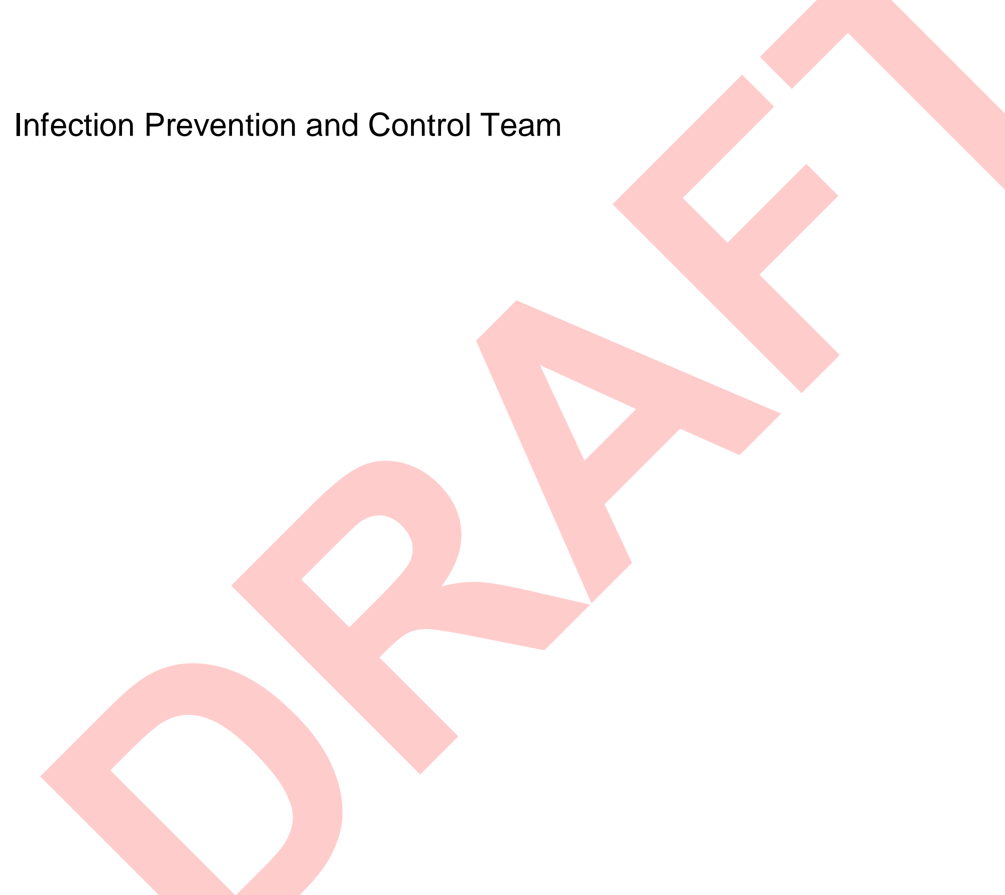
There is continuing evidence that people with enduring mental illness and learning disability in the community, often fail to get access to preventative health services. Once again can we ask you to publicise the criteria for eligibility for vaccination amongst community staff so they facilitate their clients seeking vaccination from the registered GP.

Due to the current COVID19 Pandemic there will be

Can the flu team thank you in advance for your help this year as in previous years.

Yours sincerely

Infection Prevention and Control Team



Appendix 5

Seasonal Flu Campaign – Frontline Staff Definitions for CNTW

Staff Group	Description
Doctor	All grades of hospital, community and public health doctor.
Qualified Nurse	Qualified nursing staff, working on hospital sites and community services. Includes nurse consultants, nurse managers and bank nurses but not student nurses.
Other Professionally Qualified This comprises : • Qualified scientific and therapeutic &technical staff • Qualified allied health professionals • Other qualified ST&T	Qualified allied health professionals (AHPs): • Chiropodists/podiatrists • Dieticians • Occupational therapists • Physiotherapists • Art/music/drama therapists • Speech & language therapists. Other qualified health professionals: • Pharmacists • Psychologists Qualified ambulance staff • Ambulance paramedics, technicians, emergency care practitioners.
Support to Clinical Staff This comprises : • Support to doctors and nurses • Support to ST &T • Support to ambulance staff	Nursing assistants/auxiliaries, nursery nurses, health care assistants and support staff in nursing areas. Also includes clerical & administrative staff and maintenance & works staff working specifically in clinical areas, for example medical secretaries and medical records officers. Also includes porters and similar roles provides support to inpatient areas.

DRAFT

Report to the Board of Directors
5th August 2020

Title of report	CNTW Integrated Commissioning & Quality Assurance Report
Report author(s)	**Allan Fairlamb, Head of Commissioning & Quality Assurance**
Executive Lead (if different from above)	**Lisa Quinn, Executive Director of Commissioning & Quality Assurance**

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	
To achieve "no health without mental health" and "joined up" services		Sustainable mental health and disability services delivering real value	
To be a centre of excellence for mental health and disability	X	The Trust to be regarded as a great place to work	X

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	29.07.20
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered (specify date)	
Executive Team	27.07.20
Corporate Decisions Team (CDT)	
CDT – Quality	27.07.20
CDT – Business	
CDT – Workforce	
CDT – Climate	
CDT – Risk	
Business Delivery Group (BDG)	

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, experience and effectiveness	X	Service user, carer and stakeholder involvement	X

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

DRAFT

CNTW Integrated Commissioning & Quality Assurance Report

2020-21 Month 3 (June 2020)

Executive Summary

1. The Trust remains assigned to segment 1 by NHS Improvement as assessed against the Single Oversight Framework (SOF).

2. There have been three Mental Health Act reviewer visit reports received this month highlighting a number of issues:

   Shoredrift, Hopewood Park (Acute ward for adults of working age)

   - Patients said there were activities available on the ward. However, there was no pool cue and the pool room was locked and opened by staff on request. The ward manager said the laundry room was locked due to a self-closing door. This is a concern that has been raised previously.
   - Patients were satisfied with the ward environment but said that they did not have bedroom door keys. The ward manager initially said that patients did have bedroom door keys, however after checking this confirmed this was an issue.
   - Visitors were not allowed. The ward manager said this was linked to COVID-19 and ensuring all patients safety. At the time of visit arrangements were not in place for patients to see visitors in the outdoors while socially distancing.

   Longview, Hopewood Park (Acute ward for adults of working age)
   - Patients said they did not always feel safe on the ward. One patient said they had been physically assaulted by another patient and another patient reported seeing others assaulted. A different patient said they had been racially abused.
   - While patients said that most staff treated them with dignity and respect, patients said this was not always the case.
   - Patients said there was not always adequate choice if they were vegetarian or vegan. Staff said there were no difficulties accessing meals for those with a special diet.
   - Patients said they did not have information regarding their care plan or their medication. Some patients felt they had been told they had to accept medication but did not feel fully informed about the purpose, alternatives and side-effects.

   Lamesley, Campus for Ageing and Vitality (Acute ward for adults of working age)
   - The patients and family members spoken with said that there were some issues regarding communication:
   - There was a low Wi-Fi signal on the ward.
   - The phone patients used to contact family was based in a room used by staff for meetings making it unavailable for long periods during the day.
   - The ward provided limited or no video conferencing facilities for patients to speak with family and friends.
   - Patients did not all understand their treatment plan and what needed to change in order to facilitate discharge.
   - One family member said they did not get the planned weekly communication update.

DRAFT

- Both family members felt they needed more contact with their relative and for staff to encourage and promote this

3. The Trust met all local CCG's contract requirements for month 3 and Quarter 1 with the exception of:
   - CPA metrics within Newcastle Gateshead, Durham & Tees and North Cumbria CCG's.
   - Numbers entering treatment within Sunderland IAPT service (477 patients entered treatment against a target of 779)
   - Referral to Treatment incomplete referrals waiting less than 18 weeks within Northumberland and Newcastle Gateshead CCG's
   - Delayed Transfers of Care North Tyneside and Durham and Tees CCG's
   - EIP patients seen within 14 days in North Cumbria CCG

4. The Trust met all the requirements for month 3 and in the Quarter within the NHS England contract with the exception of the percentage of patients with a completed outcome plan (98.4%), Referral to Treatment incomplete referrals waiting less than 18 weeks (87.5% in the month against an 95% standard) and CPA metrics.

5 All of the CQUIN schemes are currently suspended until further notice due to the COVID-19 pandemic. Further detailed guidance is expected in August.

6 There are 196 people waiting more than 18 weeks to access services this month in non-specialised adult services (78 reported last month). Within children's community services there are currently 437 children and young people waiting more than 18 weeks to treatment (370 reported last month).

7 Training topics below the required trust standard as at month 3 are listed below, a number of these are anticipated to improve in line with the North Cumbria data quality improvement plan:

Fire (76.2%)	Medicines Management (83.6%)
Information Governance (83.4%)	PMVA basic training (42.5%)
PMVA breakaway training (60.7%)	Mental Health Act combined (62.6%)
MHCT Clustering (61.6%)	Clinical Risk (69.3%)
Clinical Supervision (69.5%)	Seclusion training (75.3%)
Safeguarding Adults (85.2%)	Moving and Handling training (84.2%)

8 Appraisal rates currently stand at 68.5% Trust wide against an 85% standard which is an increase from last month (67.0%).

9 Clinical supervision training is reported at 69.5% for June (was 69.9% last month) against an 85% standard

10 The confirmed May 2020 sickness figure is 5.2%. This was provisionally reported as 5.52% in last month's report. The provisional June 2020 sickness figure is 4.90% which is below the 5% standard. The 12 month rolling average sickness rate has decreased to 5.87% in the month.

DRAFT

11 At Month 3 the Trust has a breakeven position which reflects the financial arrangements that have been put in place in response to COVID-19. Additional costs due to COVID-19 in April, May and June were £2.2m. Agency spend at Month 3 is £3.7m

Other issues to note:

- There are currently 21 notifications showing within the NHS Model Hospital site for the Trust.
- The number of follow up contacts conducted within 72 hours of discharge has increased in the month and is reported trust wide above standard at 96.1%.
- There were a total of 24 inappropriate out of area bed days reported in June 2020 relating to three patients who were placed out of area. This compares with 9 inappropriate bed days in May.
- There is no reported service user and carer FFT recommend score following the suspension of the Points of You mailshot.

Regulatory

Single Oversight Framework

Segment	Description		Score
1	The Trust's assigned shadow segment under the Single Oversight Framework remains assigned as segment "1" (maximum autonomy).	Use of Resources Score:	2

CQC

Overall Rating	Number of "Must Dos"	
Outstanding	45	There have been three Mental Health Act reviewer visit reports received since the last report. The visits have now commenced virtually with the process including interviews with Ward Managers/Clinical Leads, service users and carers and IMHA representatives

Contract

Contract Summary: Percentage of Quality Standards achieved in the month:

	NHS England	Northumberland CCG	North Tyneside CCG	Newcastle / Gateshead CCG	South Tyneside CCG	Sunderland CCG	Durham, Darlington & Tees CCGs	North Cumbria CCG
Month	75%	90%	100%	80%	100%	93%	62%	50%
Contract Summary: Percentage of Quality Standards achieved in the Quarter:	75%	90%	100%	80%	100%	93%	50%	50%

CQUIN - Suspended

Cirrhosis & fibrosis tests for alcohol dependant patients	Staff Flu Vaccinations	Use of specific Anxiety Disorder measures within IAPT	Routine outcome monitoring in CYPS & Perinatal MH Services	Routine outcome monitoring in Community Mental Health Services	Biopsychosocial assessment by Mental Health Liaison Services	Healthy Weight in Adult Secure Services	Achieving high quality 'formulations' for CAMHS inpatients	Mental Health for Deaf	Routine outcome monitoring in perinatal inpatient services

All of the CQUIN schemes are currently suspended until further notice due to the COVID-19 pandemic

Internal

Accountability Framework

North Locality Care Group Score: June 2020		Central Locality Care Group Score: June 2020		South Locality Care Group Score: June 2020		North Cumbria Locality Care Group Score: June 2020	
4	The group is below standard in relation to CPP metrics and training requirements	4	The group is below standard in relation to a number of internal requirements	4	The group is below standard in relation to a number of internal requirements	4	The group is below standard in relation to a number of internal requirements

Quality Priorities: Quarter 1 internal assessment RAG rating

Improving the inpatient experience	Improve Waiting times for referrals to multidisciplinary teams	Equality, Diversity & Inclusion and Human Rights

DRAFT

Waiting Times

The number of people waiting more than 18 weeks to access services has increased in the month for non-specialised adult services. The number of young people waiting to access children's community services has increased in month 3. There are continuing pressures on waiting times across the organisation, particularly within community services for children and young people. Each locality group have developed action plans which continue to be monitored via the Business Delivery Group and the Executive Management Team.

Workforce

Statistical & Essential Training:

Number of courses Standard Achieved Trustwide:	Number of courses <5% below standard Trustwide:	Number of courses Standard not achieved (>5% below standard):
6	2	9

Moving and Handling training (84.2%) and Medicines Management training (83.6%), are within 5% of the required standard. Information Governance (83.4%), PMVA basic training (42.5%), PMVA Breakaway training (60.7%), MHA combined training (62.6%), MHCT Clustering Training (61.6%), Clinical Risk training (69.3%), Fire training (76.2%), Seclusion training (75.3%) and Clinical Supervision training (69.5%) are reported at more than 5% below the standard.

Appraisals:

Appraisal rates have increased to 68.5% in June 20 (was 67.0% last month).

Sickness Absence:

CNTW Sickness (Rolling 12 months) April 2017 to date

The provisional "in month" sickness absence rate is below the 5% target at 4.90% for June 2020

The rolling 12 month sickness average has decreased to 5.87% in the month

CNTW Sickness (in month) 2017/18 to 2020/21

Finance

At Month 3, the Trust has a breakeven position which reflects the financial arrangements that have been put in place in response to COVID-19. Additional costs due to COVID-19 in April, May and June were £2.2m. Agency spend at Month 3 is £3.7m.

DRAFT

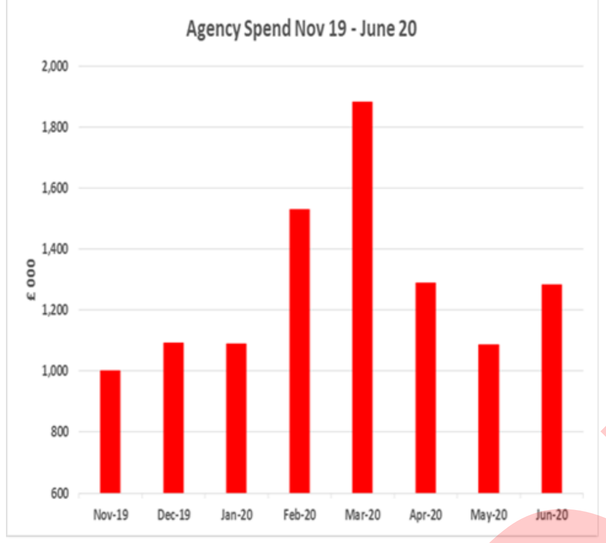
Financial Performance Dashboard

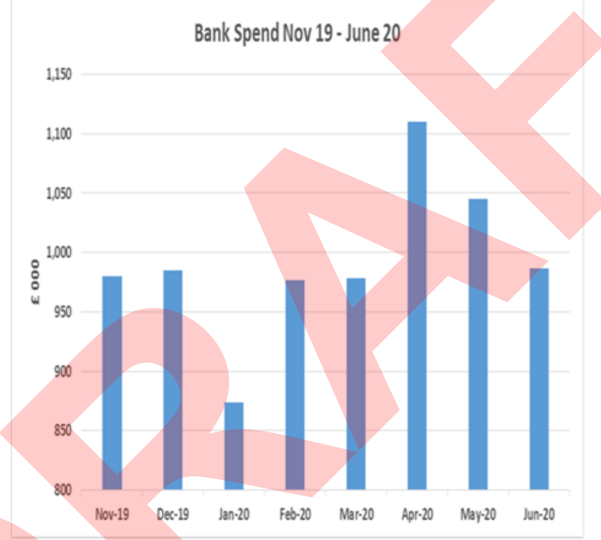
CNTW Income & Expenditure

	YTD Plan £m	YTD Actual £m	YTD Variance £m
Income	100.5	102.5	2.1
Pay	(80.4)	(82.0)	(1.6)
Non Pay	(20.1)	(20.5)	(0.5)
Surplus / (Deficit)	**0.0**	**0.0**	**0.0**

CNTW Key Indicators

Key Indicators	Year-End
Surplus	£0.0m
Agency Spend	£3.7m
Cash	£55.8m
Capital Spend	£2.2m





Key Issues/Risks

- In line the with NHS response to the COVID-19 pandemic the Trust is delivering a break-even financial position at month 3.
- Pay costs have reduced from month 2, but remain high. Month 2 included bank holidays payments. Pay costs in month 2 included student nurses supporting services through the pandemic. Month 3 includes more student nurses and student therapists.
- Overtime and bank costs have returned to the levels experienced before March.
- The Trust has incurred £0.8m additional costs due to COVID-19 in month 3 which is covered by a top-up payment. Reductions in spend on both Travel and Drugs have helped offset the size of the top-up payment. The Trust has identified £2.2m of COVID-19 cost up to month 3.
- Cash – £55.8m at month 3 which is higher than normal due to early payment of month 4 income.
- Capital Spend - £2.2m at month 3 which is £0.4m less than plan.

DRAFT

Reporting to NHSI – Number of Agency shifts and number of shifts that breach the agency cap

	01/06/2020		08/06/2020		15/06/2020		22/06/2020		28/06/2020	
Medical	117	59	117	59	117	59	122	59	122	59
Qual Nursing	184	73	189	43	199	46	199	67	204	70
Unq Nursing	799	52	747	40	752	55	931	49	983	46
A&C	44		64		56		62		64	
	1,144	**184**	**1,117**	**142**	**1,124**	**160**	**1,314**	**175**	**1,373**	**175**

In June the Trust reported an average of 167 price cap breaches (59 medical, 60 qualified nursing and 48 unqualified). At the end of June 13 medics were paid over the price cap.

Risks and Mitigations associated with the report

- There is a risk of non-compliance with CQC essential standards and the NHS Improvement Oversight Framework.
- The Trust did not meet all the commissioning standards across all local CCG's and NHS England during Quarter 1, therefore not meeting the contract requirements.
- There continues to be over 18 week waiters across services. Work continues to monitor and improve access to services across all localities
- The Trust continues to see a number of out of area bed days
- Please note the change in requirement and reporting due to COVID-19 are not reflected in this report.
- Quality and training standards have been impacted as a consequence of responding to COVID-19.

Recommendations

The Board of Directors are asked to note the information included within this report.

Anna Foster	Lisa Quinn
Deputy Director of Commissioning & Quality Assurance	Executive Director of Commissioning & Quality Assurance

16th July 2020

DRAFT

Report to the Board of Directors
5th August 2020

Title of report	**Safer Care Annual Report 2019 - 2020**
Report author(s)	**Anne Moore - Group Nurse Director Safer Care**
Executive Lead (if different from above)	**Gary O'Hare, Executive Director of Nursing / Chief Operating Officer**

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	X
To achieve "no health without mental health" and "joined up" services	X	Sustainable mental health and disability services delivering real value	
To be a centre of excellence for mental health and disability		The Trust to be regarded as a great place to work	

Board Sub-committee meetings where this item has been considered (specify date)		**Management Group meetings where this item has been considered (specify date)**	
Quality and Performance	X	Executive Team	
Audit		Corporate Decisions Team (CDT)	
Mental Health Legislation		CDT – Quality	X
Remuneration Committee		CDT – Business	
Resource and Business Assurance		CDT – Workforce	
Charitable Funds Committee		CDT – Climate	
CEDAR Programme Board	X	CDT – Risk	
Other/external (please specify)		Business Delivery Group (BDG)	

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

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

DRAFT

Safer Care Directorate

Annual Report

2019/2020

DRAFT

Introduction *4*

Safer Care Directorate Ambitions *4*

Section 1 *Serious Incident, Investigations and Inquest Management Team.* *6*

Section 2 *Health, Safety, Security and Resilience* *9*

Section 3 *Public Health Team* *11*

Section 4 *Safeguarding and Public Protection Team* *17*

Section 5 *Nursing Development, Education and Clinical Quality Improvement Team* *19*

Section 6 *Staffing Solutions Team* *25*

Section 7 *Treatment Effectiveness and Governance* ***Error! Bookmark not defined.***

DRAFT

INTRODUCTION

This is the fourth directorate annual report that reflects the high level of activity across all Safer Care teams. Over the year we have significantly improved processes and built on existing systems and procedures whilst at the same time undergoing a review of team structures and transitional plan to new ways of working. We are proud to assist in the provision of a comprehensive effective and sustainable culture of learning and improvement to underpin the delivery of good clinical governance.

This Trustwide learning and improvement culture enables the Safer Care directorate to use all sources of insight available to us to improve services and quality of care, particularly for the most vulnerable. In so doing, the Safer Care Directorate continues to strengthen its role in supporting the Locality Care Groups, trust committees and groups as well as providing Board assurance about quality care and safety. It has successfully integrated services in the North Cumbria locality which joined the Trust in October 2019.

Safer Care Directorate Ambitions

At the heart of our ambition is the view that greater integrated working is the primary vehicle to improve the quality of the service we provide to patients and carers. Our ambitions are linked to the Trust's overarching strategy '**Caring, Discovering, Growing'**, and are

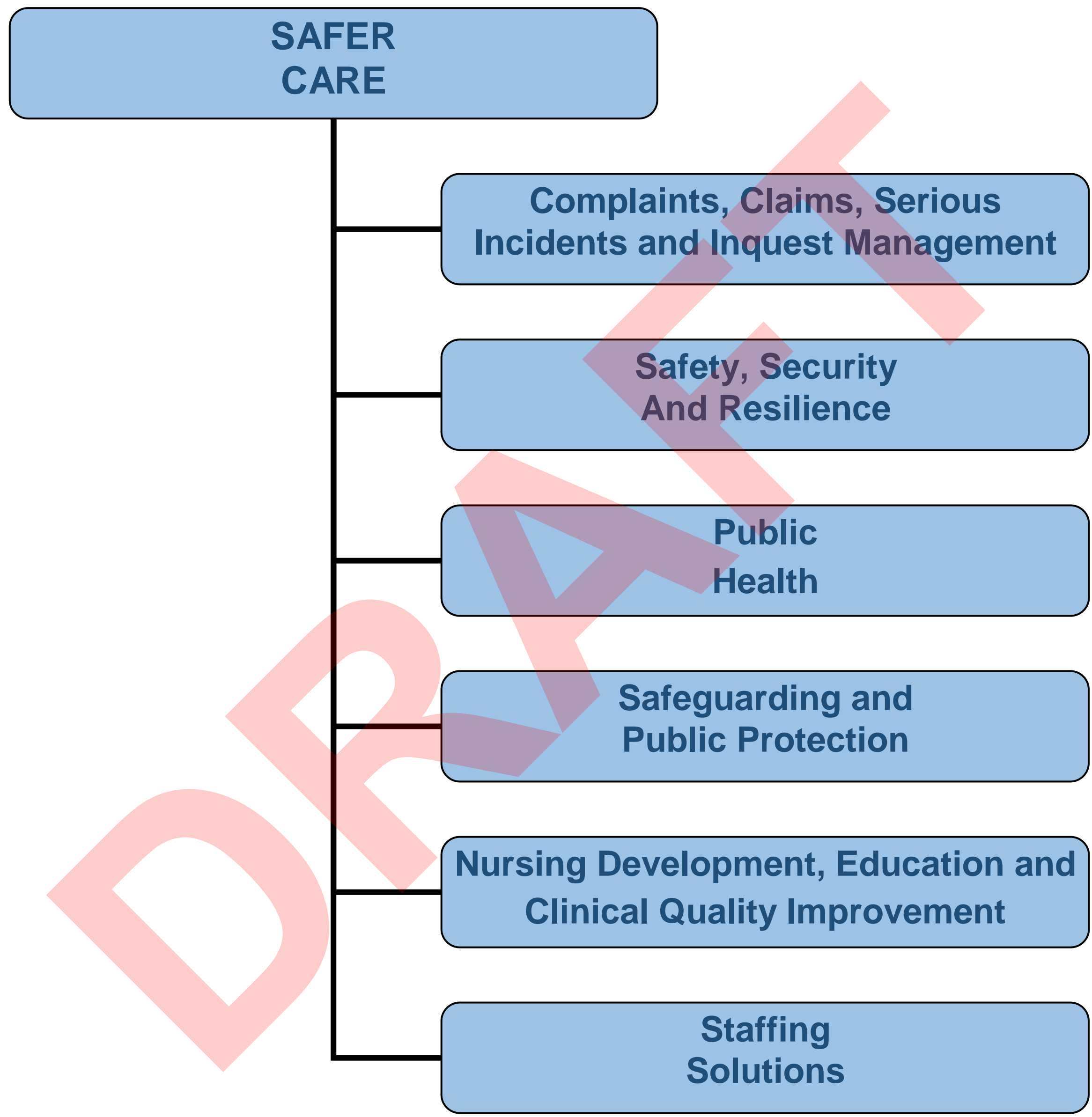
- ✓ **To maintain a relentless focus on quality, based on understanding the drivers and human factors involved in delivering high quality care and reducing avoidable harm.**
- ✓ **To work together**
- ✓ **To be committed to continuous Trustwide learning and improvement**
- ✓ **To be highly flexible and respond to any changes in the delivery of care**

This annual report provides an overview of the achievements of each individual team within the Directorate over the last year. It details how we have worked together across Trust services over the last year to fulfil our ambitions. The report also highlights individual team developments for the coming year.

DRAFT

Safer Care Directorate functions:

The Safer Care Directorate delivers several functions which work together to deliver the overall Directorate ambition



DRAFT

Sections 1 to 6 provides an overview of each function, the work undertaken and key achievements over the last 12 months. There is a hyperlink to a full annual report for those teams who provide a statutory function for the Trust.

Section 1
CLINICAL RISK AND INVESTIGATIONS TEAM

This team is overseen by the Head of Clinical Risk and Investigations. It manages five major functions of the Directorate: the investigation of serious incidents and Inquest management, complaints managements and claims management

Investigation of serious incidents and Inquest management

The team of Serious Incident investigators and administration support over the last year have managed the review process and procedure to help ensure serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again.

The team have ensured all serious incidents over the year have been investigated, identified lessons learned and disseminated this learning to improve practice. Of those serious incidents that required a Coroner's Inquest, the team also support clinical staff through the process.

From 1 October 2019, this has included all of the above for the North Cumbria locality following the dissolution of Cumbria Partnership NHS Foundation Trust and re-organisation of North Cumbria Mental Health Services under the management of Cumbria Northumberland Tyne and Wear NHS Foundation Trust (CNTW).

Key achievements in 2019/20

- ✓ Formal meetings have taken place with the North Cumbria Coroners in relation to how the coronial process is managed within CNTW.
- ✓ Ongoing training with the local Coroners for trust senior clinical staff in relation to the Coronial process.
- ✓ Training for North Cumbria staff in relation to serious incident management and Inquest management and provision of support for staff attending Inquests.
- ✓ Programme developed to deliver training via Medical Education for junior doctors around the serious incident process and Inquests.
- ✓ A review of the serious incident chairing process has taken place to standardise the serious incident review / panel process.
- ✓ Commencement of a review of the serious incident policy and its associated practice guidance in line with the anticipated production of the NHS England Patient Safety Incident Response Framework (PSIRF).
- ✓ To maintain the Complex Case Panel process to support the Clinical Business Units with difficult and challenging cases.
- ✓ Delivery of a pilot training session in Human Factors based investigation to key staff within the Safer Care Directorate and serious incident Investigation review process.

DRAFT

Ambitions for 2020/21

- Continuation of a review of the serious incident policy and its associated practice guidance in line with the anticipated introduction of the NHS England Patient Safety Incident Response Framework (PSIRF).
- To support learning from incidents related to the COVID-19 Pandemic emergency.
- To promote the development of a family liaison post to support bereaved families.
- Further thematic review of Mortality Reviews presented at serious incident panel to be taken to BDG Safety and Trust-wide Learning and Improving Group.
- To work with IT and Safer Care Business Support Officer to develop the incident dashboard.
- To support any work in relation to FACE risk assessment which comes out of Serious Incident Reviews.
- To continue further joint working with the nine Northern mental health trusts in relation to mortality reviews.
- To establish and roll out Human Factors based training to CNTW staff involved in incident review and management.

Complaint and Claim Management

The Incident, Complaints and Claims Manager manages the day to day function of the complaints and claims teams. The team process all complaints received into the Trust and all claims made against the Trust for clinical negligence, employer liability, and public liability and property expenses in conjunction with NHS Resolution, panel solicitors DAC Beachcroft and NTW Solutions commercial insurers, Royal Sun Alliance.

They deal with ex gratia claims for easily quantifiable damage that does not fit into the other categories; usually missing or damaged property of patients, staff and visitors.

They also manage the process for dealing with third party claims where a member of staff has claimed against another party in relation to an accident and their sick pay can be reclaimed back into the Trust.

Key achievements in 2019/20

- ✓ A programme of awareness training of the complaint process to staff has been delivered across the Trust, updated as any changes are made with any National guidance or local learning, including six dedicated sessions with North Cumbria staff.

DRAFT

- ✓ Review and updating of the complaints policy, covering consent in relation to access of patient records in line with the new GDPR regulations, strengthening the persistent and unreasonable complaints process. This has included a new process for managing complaints received from MPs in conjunction with the Deputy Director of Corporate Affairs and Communication.

- ✓ Attendance at several Incident Management Groups with regard to the effective management of persistent and unreasonable complainers.

- ✓ Strengthened links with other NHS complaints departments by attendance at the Regional Complaints Manager's forum.

- ✓ Continued support to the Service User and Carer Involvement Forum with regular attendance and production of complaint information.

- ✓ Provision of regular information for the Locality Care Group Complaint Leads in relation to complaint investigation and action plans. Resulting in a targeted approach to the timely completion of action plans. Provision of training materials made available to support this.

- ✓ Continued development of closer working relationships with independent Complaint Advocates and PALS officers to enhance the complaint process for the complainants.

- ✓ Regular thematic reviews of complaint information across Locality Care Groups, Clinical Business Units and individual service areas and teams.

Ambitions for 2020/21

- Continue with the embedding of a newly integrated team of complaints, incidents, claims and inquest staff to administer the core functions supporting and strengthening the processes.

- To review the Standard Operating Procedures for the department specific to Complaint Management.

- Attendance/participation at the newly formed Northern Regional Complaints Forum to share learning and good practice.

- To continue to deliver training across the Trust with regard to complaint awareness.

- To work with IT and Safer Care Business Support Officer to develop the complaints dashboard.

DRAFT

Section 2
SAFETY, SECURITY AND RESILIENCE

The following functions form part of the operational responsibilities for the Head of Safety, Security and Resilience.

- Incident Management - overseeing the reporting, recording, quality checking and transfer to national systems of 50,000 incidents per year.
- Health & Safety – The Trust has 2 competent safety professionals in the Head and Deputy Head of Safety , Security and Resilience, they support teams to comply with Health and Safety legislation, ensure compliance with Reporting Injuries, Diseases and Dangerous Occurrences Legislation 2013 (RIDDOR), and oversee policy support and improvements.
- Central Alert System, co-ordinate the system to ensure compliance with all Department of Health & Social Care, NHS Improvement and Medicines and Healthcare Products Regulatory Agency alerts. To ensure timely response and distribution of all safety related alerts.
- Security Management including lone working – The Trust still maintains 2 accredited security management professionals in the Head and Deputy Head of Safety, Security and Resilience, and they support the Trust to comply with all internal security standards and response to any external requests. Close alignment with the Positive and Safe Team to ensure support for the reduction of aggression and violence across the Trust. It is acknowledged that a separate annual report is produced for the Board of Directors which has more information on the work of Security Management, acknowledging that there is no longer a legal requirement to produce this report, but Board of Directors asked for it to be maintained.
- Policy Management System – The central team co-ordinates over 400 policies and PGNS and 1000 supporting documents within the Trust, supporting authors to review, update, consult and approve their corporate documents.
- Management of the Safer Care intranet site, and dissemination of the Safer Care Bulletin.
- Emergency Preparedness, Resilience and Response – The responsibilities for EPRR have been embedded into the central safety function to further integrate the systems of the Trust. It is acknowledged that a separate annual report is produced for the Board of Directors which has more information on compliance with NHS Improvement EPRR standards.

Key achievements in 2019/20

✓ Full compliance with external incident reporting for patient safety incidents for NHS Improvement, with no concerns identified. Published information shows us no significant change from the previous period, and no under – reporting as a

DRAFT

Trust. We are currently showing green across the board for the quality standards of information for our provisional data.

- ✓ Continued support for the NHS Improvement - Development of Patient Safety Incident Management System throughout 2019 / 20, becoming the first NHS organisation to submit data into the system in April 2019 and in July 2019, the first NHS organisation to submit incident data through a Local Risk Management System, establishing a proof of concept for a national incident reporting system the first time, a change of this nature has been completed in the last 16 years.

- ✓ Review of all Health, Safety, Security and Emergency Preparedness Policies and Practice Guidance notes in line with required dates to ensure guidance available for staff is up to date, including a review of all policies in line with North Cumbria Transition plan.

- ✓ Full compliance of the Central Alert System (CAS), formal review of policy and distribution lists to maintain safety following clinical transition, expansion of CAS system to North Cumbria services.

- ✓ Expansion of lone working system to protect front line clinical teams in North Cumbria services. This was expedited from May 2019, in advance of the transition date of October 1st, with contracts signed to deploy 500+ devices to lone workers who had already been identified as at risk in previous CQC reports and assessments.

- ✓ Go live of Lone working portal, as a management tool and self-service portal for training and update of escalation contacts for individual lone workers.

- ✓ Completed the re-build of Trust Local Risk Management System to align with North Cumbria Services and National Pilot go live.

- ✓ Completion of the 2019/20 Security Management Annual Report for submission to Board of Directors in August 2020.

- ✓ Maintenance and update of Safer Care Intranet page and population with over 24 months' worth of learning, including embedding of Learning and Improvement Group presentations.

- ✓ Embedding of the Trust's Safer Care Bulletin, as a learning and dissemination tool for all clinical and operational services, with over 24 months of learning available.

- ✓ Management of Emergency Preparedness, Resilience and Response processes, including updates to the Heatwave Plan for 2019 / 20 in line with requirements from NHS Improvement and in recognition of COVID-19 related activity. All completed in readiness of receipt of annual Core Standards and production of Annual Report for 2019 / 20 for Emergency Preparedness Resilience and Response. Ensuring needs of North Cumbria services are aligned into established systems.

- ✓ Continual review of Trust approach to CCTV systems for in-patient and community services, including schemes delivered for Rose Lodge, and Hadrian

DRAFT

Clinic, to re-provide systems that were obsolete, or in Hadrian Clinic, not previously installed.

✓ Review of internal structures for Safety, Security and Resilience, following new structures as part of North Cumbria Transition Plan.

Ambitions for 2020/21

- Continued support and development of NHS Improvement – Development Patient Safety Incident Management System as key pilot area, including further beta and public testing before go live in April 2021.

- Pilot project with NHS Improvement in relation national violence against staff and security reporting, aligning principles of previous Security Incident Reporting System (SIRS) with new DPSIMS above.

- Creation of specific Health, Safety, Security and Resilience Intranet pages, tailored to clinical and operational need.

- Update of the Health, Safety, Security and Resilience Policies as refresh to new structures.

- Update of who's who and how to contact staff information document in relation to transition of function from Safer Care to Deputy Chief Operating Officer Portfolio.

- Recruitment of 2nd dog handler and new search dog team , with Service Level Agreement in partnership with Tees, Esk and Wear Valleys, NHS Foundation Trust, including taking receipt of 2 new accredited search dogs from Northumbria Police, and planning retirement of the existing search dog (Coco) after 8 years loyal service.

- Review of a number of in-patient environmental standard initiatives that were put on hold due to North Cumbria transition, to ensure all wards considered evenly, these include Closed Circuit Television systems, Metal Detection, Nurse Call Systems in line with CQC requirements, as well as supporting other safety projects such as lone working, body worn cameras, and the Oxe Health – digital care assistant and other Falls detection systems.

DRAFT

Section 3
PUBLIC HEALTH TEAM

The Public Health Team provides Infection, Prevention Control, Tissue Viability, Medical devices, Physical Health and Public Health and Lifestyle functions to support staff and patients across the trust.

INFECTION PREVENTION AND CONTROL.

There have been changes within the structure of the IPC team since the previous report. The IPC team consists of 1 IPC Matron and 2 IPC nurses. The IPC service across the trust ensures the trust meets its statutory requirements and the Health and Social Care Act.

The IPC Matron also has the responsibility of managing medical devices across the Trust with the exception of North Cumbria Locality which is managed through an SLA with North Cumbria Integrated Care NHS Foundation Trust /NTW Solutions.

As a statutory requirement, the Director of Infection Prevention and Control (DIPC) is required to provide an annual report IPC Annual Report (Link Below) that includes a summary of activity, provides assurance and developments that took place during 2019/20 relating to Infection Prevention and Control. This IPC report includes lessons learned from the flu campaign. The Infection Prevention and Control team is responsible for the outline delivery of the 2019/20 Infection Prevention and Control Annual Plan. This is available via the IPC Annual Report.

Key achievements in 2019/20

- ✓ There was a New Trust standard for profiling beds for use at Walkergate Park Hospital. There were 5 Arjo Enterprise beds purchased which will result in a cost saving in the longer term compared to hiring.
- ✓ The flu CQUIN target was set at 80%.We achieved a flu vaccination uptake of 82% in front line staff, this is our greatest achievement to date.
- ✓ We continue to ensure our patients in clinical risk groups are offered flu and pneumococcal vaccination where appropriate.
- ✓ Re audit practice around UTI practice and compliance in line with NICE guidance and the UTI PGN. This demonstrated minor areas of concern which have all been actioned.
- ✓ Re audit practice around the sepsis tool in line with NICE guidance and the Sepsis PGN. This demonstrated excellent practice
- ✓ Smooth transition of IPC service provision to the staff and patients within the North Cumbria Locality
- ✓ The responsive approach of IPC team with the emerging COVID 19 pandemic

Ambitions for 2019/20

- ∗ Achieve flu vaccination CQUIN which is set at 90%
- ∗ IPC risk assessment tool has been developed into an electronic format and will be on a rolling programme throughout the year. This format will allow for more detailed analysis and developing themes.

DRAFT

* The frequency of these audits can be increased due to the time saved by changing into an electronic format.
* Ongoing locality assessments to provide COVID 19 assurance as part of the Board assurance framework in conjunction with the CBUs
* Newly recruited IPC nurses to commence open university courses to achieve formal IPC qualification
* Undertake a review and lessons learnt following COVID 19 pandemic.

TISSUE VIABILITY.

The trust provides specialist Tissue Viability services in a range of clinical settings.

The Tissue Viability Service is currently provided by a Modern Matron / Team lead and two Clinical Nurse Specialists.

Key achievements in 2019/20

	Total visits	**Individual clients seen**
April 2019 – March 2020	**980**	**305**

- ✓ May 2019 TVN lead presented to the National TVS conference in Southampton to 200 people from across the NHS.
- ✓ Continued the roll-out of the new NHSI / NPUAP guidance introduced in late 2018. The TVN's continued to support the Trusts continued efforts to meet or exceed national pressure ulcer risk assessment time frames and reduce incidents. (We are proud to identify no avoidable Category 3 or 4 pressure ulcers within the trust for the 8th year running).
- ✓ The team have either as individual practitioners or as a service been nominated for several local, regional or national awards. Although not successful it has helped raise awareness of the specialist nature of our work and their unique challenges. (Patient Safety Awards, Kate Grainger Award, Nursing Times, Journal of Wound care and our own Staff excellence awards)
- ✓ The team have continued to offer both bespoke and topic specific wound care training across the Trust linking in with training and also physical health agendas.
- ✓ The team continue to support the local universities by providing specialist tissue viability training to their student nurses.
- ✓ The team have continued to develop the innovative ideas commenced in 2018 with the further development and launch of a 'modular self-harm analogue' to assist with training staff in self-harm injury management.
- ✓ The team are continuing the work to develop the AI / Augmented reality educational APP to support the identification, management of pressure ulcers. A working prototype is now available and the trust is now working with the manufacturer and local ICS teams to identify 'next steps'.

DRAFT

- ✓ The team along with colleagues in Informatics completed the roll-out of the 'remote solution' (Microsoft Teams) to support and provide timely advice remotely around wound management. (The next stage / roll out will incorporate the North Cumbria wards which joined the Trust in late 2019)
- ✓ With the integration of the North Cumbrian wards into CNTW in October 2019, the Tissue Viability team expanded to include a new Clinical Specialist to support the new wards and ensure seamless integration of wound care into the new areas.
- ✓ The team piloted and has now begun to roll-out a Skin Bundle (ASSKING) which will further augment the work to reduce and eliminate all 'avoidable pressure ulcers' from the Trust.
- ✓ The team continue to support the wider 'safer care' team with local projects / health promotion projects and national campaigns such as the seasonal flu campaign.

PHYSICAL HEALTH, PUBLIC HEALTH AND LIFESTYLE.

The Public Health Team centrally coordinate aspects of physical health, public health and lifestyle in respect of health promotion and prevention. The trust wide Physical Health and Wellbeing group is chaired by the Director of Nursing Safer Care that sets the strategic direction for the trust.
Within the team there is a Public health and wellbeing lead and 2 Health Improvement Specialist. The team provide guidance and support on public health supporting the clinical teams to embed preventative methods and lead on the implementation of public health interventions. The team also support the physical health agenda as agreed via the Trust physical health and wellbeing group.

Key achievements in 2019/20

- ✓ Completed review of the CNTW 'Strategy for Improving the Physical Health and Wellbeing of People Receiving CNTW Services' implementation plan to ensure clinical teams are compliant with strategy.
- ✓ Completed review of the CQUIN monitoring weekly report and how this is used in teams to inform clinical practice/decisions.
- ✓ Successful development and Implementation of the CNTW local AWOYM plan to support service users to maintain/achieve a healthy weight and be physically active. Significantly raised the profile of AWOYM and staff engagement via presentations and communication plan. Developed AWOYM website, logo and resources. Worked with Teesside University to submit NIHR funding bid for formal evaluation of plan. Liaised with local authority physical activity commissioners to develop partnership working and establish pathways for CNTW service users.
- ✓ Public Health and Wellbeing lead has supported the regional implementation of AWOYM, chaired regional steering group meetings and raised awareness by presenting at regional and national conferences. Highlighted by PHE as example of good practice.
- ✓ Developed and successfully implemented bespoke MECC Train the trainer programme within CNTW to support staff to initiate lifestyle conversations and support the physical health moto of 'Don't just screen intervene' and support staff to implement preventative measures. Physical health and wellbeing

DRAFT

lead represents CNTW on regional MECC steering group. Worked with Newcastle University to submit ARC funding bid for formal evaluation.

- ✓ Physical health and wellbeing lead has led on the 'Improving the physical health of those with an SMI/LD' ICS work stream. Successful implementation of 2019/20 action plan. PHWB Lead part of leadership team on ICS work stream and arranged successful workshop in Jan 20 to agree priorities for 20/21 and reflect on previous ambitions.
- ✓ Successful implementation of the updated Smoke Free policy in Oct 19, prohibiting all smoking materials and introducing e-cigarettes. Implemented training for staff.
- ✓ Partnership working with Stop Smoking Services commissioners to agree piloting new ways of working for 20/21 with SSS providing in reach support to CMHT's and training for staff.
- ✓ Partnership with NHSE and national screening providers to review reasonable adjustments and engagement with SMI/LD service users. Agreed as an ICS priority for 20/21.
- ✓ PHWB Lead represented CNTW at CVD Prevention Network. CVD Prevention strategy developed and includes section for mental health.
- ✓ Successful completion of diabetes pilot at HWP.
- ✓ Partnership working with the Macmillan Mental Health Cancer Care Research Lead to develop pilot proposal for the physical health passport to be piloted in 2 older persons community teams.
- ✓ Partnership working with Newcastle hospitals Trust to develop a pilot proposal for Hep C screening. Pilot to be agreed at BDG then rolled out at HWP.
- ✓ Developed AWOYM and MECC training package for the COMET training programme.
- ✓ Supported the Trust wide Covid 19 testing rollout, providing leadership and redeployed of PHW lead and health improvement specialist to testing team.

Ambitions for 2020/21

- Lead AWOYM steering group to the next phase, implementation complete – Embed within clinical practice, move to business as usual.
- Progress the AWOYM physical activity pathways workshops which were delayed due to Covid 19.
- Cancer screening:
  - Progress the work with NHSE and national screening programme leads to increase engagement with CNTW service users. Lead this via the ICS.
  - Progress the Physical Health Passport pilot to roll out across the Trust.
  - Implement the Hep C pilot HWP and if successful roll out across the Trust.
- Deliver on the ICS ambitions for 20/21 as agreed in the Jan 20 workshop.
- Implement Smoke Free Trusts in Cumbria in Sept 20 (delayed due to Covid 19)
- Support the implementation of the Smoke Cessation pilots within Northumberland, Newcastle, and Sunderland. Move towards this model being standard practice.

DRAFT

- Support work to ensure the physical health monitoring form and foundation skills training are aligned with CQUIN and contracting arrangements for 20/21.
- Review and slim line the physical health strategy implementation plan to focus on key priorities.
- Roll out of cascade MECC awareness training within clinical teams.

Section 4

SAFEGUARDING AND PUBLIC PROTECTION TEAM

The Safeguarding and Public Protection (SAPP) Team aims to support all trust staff to keep children, young people and adults at risk safe, and to meet its statutory obligations. We promote collective accountability in all that we do, working together to prevent and stop all forms of abuse or neglect happening wherever possible. The SAPP team continually work with partner agencies on a day to day basis to ensure robust safety plans and risk management are in place to safeguard and protect. The Safeguarding and Public Protection service consists of a Team Manager/ Named Nurse, six Senior Nurse Practitioners, Case Review Report Writer, Safeguarding and Public Protection Development Officer and the Clinical Police Liaison Nurse who bring a variety of safeguarding and public protection expertise, skills and experience. They are supported by the Administration Team Manager and two administration support officers. The SAPP team produce an annual report that is requested and shared with the Clinical Commissioning Group's and Local Safeguarding Children and Adult Boards to provide assurance of the trusts safeguarding arrangements. This is available via the full Safeguarding Annual Report.

Key achievements in 2019/20

- ✓ The development and introduction of the Case Review Report Writer
- ✓ With the inception of North Cumbria locality in October, positive working relationships were fostered over the year to ensure the safeguarding and public protection arrangements were transitioned in line with national standards.
- ✓ A significant piece of work has been undertaken with Cumbria multi agency partners in respect of MAPPA standardisation and change of practice with support provided to Cumbria Locality Care Group services.
- ✓ The Associate Director and SAPP Prevent Lead were invited to a review session with Lord Carlile of the national review for Prevent.
- ✓ Developed with multi agency colleagues two Multi Agency Safeguarding Hub (MASH) posts in Sunderland and Northumberland of mental health practitioners.
- ✓ Maintained a fully operational SAPP service with a multitude of platforms to ensure wherever possible all are safeguarded in respect of Covid 19.

Ambitions for 2020/2021

- ∗ Further development and evaluation of the newly appointed CNTW MASH Practitioners and potential development of these posts if successful within other localities if funding were available.
- ∗ Further development of the Prevent post in line with local and national demands.

DRAFT

* The monitoring of the Case Review Report writer post including volume of potential reports/supervision and psychological support.

* The Clinical Police Lead will continue to work closely with Cumbria Police to further enhance close working relationships with support of any new developments in conjunction with the Safeguarding Development Officer.

* The Clinical Police Liaison lead is continuing to look at data and doing more around Police activity data, to evidence what we do and how we do it, as well as look at demand and ensure the capturing lessons learnt. Working with the Safer Care Business Manager a police activity dashboard is being developed.

Section 5
NURSING DEVELOPMENT, EDUCATION AND CLINICAL QUALITY IMPROVEMENT TEAM

The Professional Nursing and Nurse Education Team have played a significant role in the development of our nursing strategy Delivering Compassion in Practice 2019-2024.

The nursing strategy provides us with a sound and flexible framework to enable the nursing workforce to grow and develop to meet the needs of patients within a changing culture of care provision and economic climate.

Working in collaboration with CNTW Academy and partner HEI's, the team leads on a number of initiatives covering;

- professional development
- nurse education and workforce development
- development and delivery of clinical placements
- recruitment and retention initiatives
- international recruitment
- annual nursing conference

Key achievements in 2019/20

✓ During the Covid 19 pandemic we established a core team of senior nurses and have supported our front line colleagues in a number of ways ;

- Working with our partner HEI's we have placed 166 students who responded so positively to our call for assistance and joined our teams to support them in delivering care to our service users
- This process has proved to be extremely successful and we have had very positive responses from services, students and HEI partners.
- We have seen a 36% fall in requests for bank and agency shifts which we believe is attributable to the deployment of these students who stepped up and have lived through the ever changing landscape as valued members of our teams.

✓ Through this initiative we have enabled;

- 3rd year final six month students to complete their undergraduate programmes on time ensuring recruitment remains unaffected and allowing

DRAFT

them to transition from a Band 4 position to a Band 5 Registered Nurse, increasing their experience and building confidence

- 2nd/3rd (first six months) students to continue to meet their clinical placement hours and assessment requirements, preventing a significant back log in terms of placements and enabling them to gain experience as members of multi-disciplinary teams working in a non-supernumerary capacity

- 1st year students to gain valuable extended clinical experience which we believe will increase their confidence as they continue to undertake their undergraduate programme

- As we move into planning for winter pressures, potential COVID 19 spikes, ensuring annual leave is covered and the onset of the flu season we will capitalise on our investment in supporting this important initiative and the significant gains we have achieved and importantly recognize the contribution made by the student nurses and provide them with an offer to join our nursing bank

In addition

- We have answered the call to support COVID 19 testing with members of our Practice Education team supporting swab testing

- Senior Nurses provide test result feedback, test and trace providing support and guidance to colleagues

- Our Senior Nurse: International Recruitment and Relocation has continued to maintain virtual contact with recruited medical and nursing staff providing reassurance and updates; continuing to monitor the situation for potential dates for arrival. There are

✓ We are supporting the Trusts recruitment and retention strategy and the development of skills based nursing workforce plans, with the implementation of the post of Recruitment and Retention Senior Nurse to our team. A key initiative is the introduction of “itchy feet” and “stay” interviews aligned to appraisal processes and review process for exit interviews

✓ Working with the Head of Workforce Development, the Retention and Recruitment Senior Nurse has developed a pilot internal transfer and rotational programme aligned to service and individual development needs

✓ We supported our celebration of 100 years of Learning Disability Nursing promoting the many different roles our Learning Disability nurses undertake across our services and continue to champion both locally and nationally, the recruitment and retention of a sustainable Learning Disability nursing workforce; promoting and strengthening career pathways

✓ We continue to co-ordinate the production of the Multi-Professional Self-Assessment Report for the Annual Deans Quality Meeting providing assurance

DRAFT

that the Trust meets the standards for training required by HEE and Regulatory Bodies both at organisational and across training placements.

- ✓ Working in partnership with the Trust Academy we are supporting the delivery of our Grown our Own strategy strengthening clinical career pathways and develop new roles essential in protecting future service delivery

- ✓ Strengthening our partnerships with local education providers by co-producing curricula, we are delivering increasing numbers of undergraduate programmes and developing innovative programmes across our geographical spread. Northumbria University has acknowledged our support in moving them 6 places in the Complete University League to11th in the UK and 8th in England. This is vital in attracting applications.

- ✓ We have continued to expand access to innovative clinical placements building greater capacity by aligning NMC requirements with internal reporting systems; evaluating the effectiveness of teaching and quality of clinical placements through audit of practice and student evaluation; identifying areas of good practice and professional development needs; supporting the development of service wide strategies to promote the implementation of the new NMC standards for education and training.

- ✓ To support the expansion of clinical placements and the introduction of new programmes we have embedded the roles of Practice Educator Support Nurse's and Practice Placement Support Co-ordinator providing support to individual learners and promoting understanding of curriculum to ensure students (nursing, return to practice, trainee nursing associates and apprentices) are empowered, supported and inspired to become resilient, caring and reflective lifelong learners who are capable of working in inter professional and interagency teams.

- ✓ Our Nurse Education Forum continues to provide the framework for professional governance and assurance and delivery of the strategic direction for nurse education and training ensuring it reflects changing clinical priorities and models of care in line with the Transformation agenda

- ✓ We have seen the Nurse Leadership Forum continue to develop; ensuring nurses voices are heard enabling them to lead on initiatives and create robust networks

- ✓ We have organised our annual Nursing Conference for the past six years. The conference continues to be well attended attracting national key note speakers and providing opportunity for the sharing of practice and a platform for innovation

Ambitions for 2020/21

- ∗ We will support the delivery of our nursing Strategy 2019-2024 through the Nurse Education and Nurse Leadership Forums and by leading on initiatives which supports its delivery

- ∗ Work regionally with acute trusts / primary care to consider how we collectively develop opportunities for Learning Disability nurses by increasing regional capacity through the creation of innovative alternative placements

DRAFT

* Create opportunities to raise profile of Learning Disability nurses and importance of maintaining this essential branch of nursing building on work to date with national team creating and building networks

* Support HEI partners in the marketing and recruitment to undergraduate programmes

* Work in partnership with clinical services to continue to expand innovative placement capacity ensuring quality of learning experience, building supportive networks and sourcing innovative placements

* Evaluate the effectiveness of our student evaluation tool building in service user feedback and ensuring an inter professional focus

* Develop an accredited practice assessor and supervisor programme building and strengthening the capacity and capability to deliver the ever increasing numbers of students

* Work in partnership with clinicians and preceptees to evaluate the preceptorship programme and explore the potential to develop an accredited programme

* Evaluate the effectiveness of teaching and quality of placements through audit of practice and student evaluation; identifying areas of good practice and professional development needs.

* Promote a dynamic learning environment which focuses on developing an evidence based culture enabling staff to take an enquiring approach to practice

* Work to provide a three year programme of student allocations for each team, to support clinical groups in discharging their responsibilities in relation to the sourcing and provision of clinical placements

* Support implementation of new roles and evaluate both effectiveness and impact on skill mix

* Ensure we have effective governance systems that ensure compliance with all legal regulatory professional and educational requirements.

* Work in partnership with our education partners to evaluate impact student on learning experience during COVID 19 deployment

* Work with the Academy Apprenticeship and Career Development Team in the Academy to support Ambassador Programme in schools to make NHS careers across the Trust attractive to young people

DRAFT

INTERNATIONAL RECRUITMENT

The international recruiment team has now been established for over three years. It is a partnership with Nursing, Medical staffing,International Agency, NTW Solutions, Clinical Services,Sunderland University and Safer Care Directorate and this is underpinned by a Project Steering Group. As part of our plan to support the medical and nursing workforce strategy we can report that visits to India to develop liasions and recruit Nurses and Doctors have successfully led to a number of offers of employment using values based recruitment. The recruitment of the staff is having a having a positive impact upon patient care and wellbeing. Ensuring a seamless and safe transition into a new role is a primary objective for the team and this is led by the Senior Nurse, International Recruitment and relocation support with support from the team. Relocating to another country is a daunting experience let alone taking up a new role with new systems, processes and a new team. We never underestimate these things and will work with each member of staff on an individual bases and assess their individual needs. Induction to the service is completed in a safe and considered manner. There will be a dedicated mentor / supervisor to support each individual member of staff and regular supervision meetings.

Developments for 2020/21

Our international recruitment programme has continued to grow strengthened by our values based recruitment process and the support provided by our Senior Nurses: International Recruitment and Relocation Support including;

- Recruitment in December 2019 in India of Nurses and Doctors.
- Develop relationships with existing teams to develop the physical health agenda and enhance staff skills in meeting the needs of patients.
- Working in partnership with CBU on the success of the recruitment programme
- Reflect with existing fellowship Drs and hear first-hand of their experiences that will inform the next fellowship cohort arriving in 2020.
- Sourcing accommodation aligned to individual need, management of all of the practical elements to make the transition as seamless and stress free as possible
- Use the strength of Teams and have face to face meetings with the staff who are planning to relocate as this will develop working relationships and alleviate worries and anxieties.
- Recruitment of Associate directors for the Fellowship programme which will have a cohort of 21 Fellows joining the Trust across all CBU
- Workforce development of introducing Adult Nurses into Mental Health services across the Trust.

DRAFT

- Appointment of Dr Neeraj Berry, Deputy Medical Director (DMD) for International Recruitment

- Appointment of 2nd Senior Nurse: International Recruitment and Relocation support

- Continue to develop relationships with local communities and all of the support services i.e. GP practices, banks and schools

- Creating networks of internal and community support

- Orientation to local area and amenities

- Working with practice education team colleagues, clinical services and local HEI enabling preparation for meeting the requirements of professional body registration and post registration preceptorship programmes

- The Senior Nurse: International Recruitment and Relocation support was shortlisted for the National BAME Health and Care Awards in the Compassionate and Inclusive Leader category

- The International recruitment team were also shortlisted by the Nursing Times for the Best International Recruitment experience

Feedback

Support began even before I arrived to Newcastle. Our Relocation Support Officer is the most charming person I have ever met. The Trust has ensures our safety and comfort and Ms. Sheryle Cleave has dazzled me with all the arrangements from housing to transport to orientations to the new city. I have received corporate induction and orientations as necessary. The support continues to date! We received overwhelming support for the OSCE's as much as possible including practise sessions at the University of Sunderland and support to travel to Northampton University for our OSCE's.

I feel privileged to have been selected to be a part of NTW Trust. I had never imagined I could be able to be a registered Mental Health Nurse in the UK but NTW Trust helped my dream come true. Working at the NTW Trust means that I have potential to progress and exhibit my nursing skills at the same time. Potential for professional growth and experience is immense. Thank you NTW Trust for all the support!!!

DRAFT

- ✓ We will support the development of Medical staff in completing Section 12 Approved Training at an appropriate point of Induction to service.
- ✓ We will review the effectiveness of induction particularly with Medical Staff.
- ✓ We will ensure there is a robust plan for each Nurse engaging in OSCE preparation.
- ✓ We will evaluate the effectiveness of our achievements by receiving feedback from individual staff who have relocated to the UK.
- ✓ We will ensure that each member of staff has a seamless transition to the UK by continuing to refine our approach to relocation.
- ✓ We will ensure that a dedicated point of contact (from clinical services) begin to communicate prior to relocating.
- ✓ We will learn from others experiences and feed this back to the Project Steering Group to help inform changes in practice.

Section 6
STAFFING SOLUTIONS TEAM

Staffing Solutions is a one point service that supports operational services with temporary and flexible staffing needs. It incorporates Nursing, AHP, Psychology and Admin banks and offers a timely solution to short term staffing issues. In addition to the banks the Staffing Solutions team also support the flexi pools that operate within each of the three localities

Staffing solutions role is to effectively manage the deployment of temporary staff so that they can help to create clinical capacity by taking on the administrative burden from ward and team managers

The SMART system is used to request, allocate and approve assignments and bank members are notified of vacant shifts and can express their availability via an SMS system.

Average shift request fill rates remain at approximately 70% - 80%+.

One of the key roles of the professional nursing lead within the Staffing Solutions team is to ensure our temporary staff are competent, have access to all relevant training and can deliver safe and effective care to our patients. Any bank workers who do not have up to date training compliance are contacted by email or telephone to remind them of the need to keep training up to date before being allowed to take up any future work assignment.

Key achievements

- ✓ Standard Operating Procedures continue to be updated to ensure a consistent process is operating across the service and to improve on previous practice.

DRAFT

- ✓ Information hub for internal and external workers developed and is available vi the intranet and internet web page
- ✓ Staffing solutions team involved in resource planning meetings across localities and developing more interactive networks with clinical services and bank workers alike
- ✓ "one point" service developed for all banks
- ✓ Flexi pools have successfully been reintegrated into locality groups.
- ✓ The introduction of a complaints and performance escalation report has seen a decrease in the numbers of outstanding cases and has enabled more robust management of them.
- ✓ The team have demonstrated their ability to adapt to immediate pressures such as covid 19 without impacting on service delivery and performance

Developments for 20/21

Developing discussion forums for bank workers in collaboration with staff side

Summary

The report demonstrates significant achievements by the Safer Care Directorate during 20219/20 in support of the Board Assurance on Patient Safety priorities. The focus for 2021/22 will be to continue to strengthen and embed learning trust wide from the various thematic reviews, Learning and Improvement group and the current Covid19 Pandemic. This will be a key focus of next year's Annual Report.

Report to Board of Directors
5th August 2020

Title of report	**Service User, Carer and Staff Feedback Report**
Report author(s)	**Allan Fairlamb, Head of Commissioning & Quality Assurance**
Executive Lead (if different from above)	**Lisa Quinn, Executive Director of Commissioning & Quality Assurance**

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	
To achieve “no health without mental health” and “joined up” services		Sustainable mental health and disability services delivering real value	
To be a centre of excellence for mental health and disability	X	The Trust to be regarded as a great place to work	

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	29/07/20
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered (specify date)	
Executive Team	
Corporate Decisions Team (CDT)	
CDT – Quality	27/07/20
CDT – Business	
CDT – Workforce	
CDT – Climate	
CDT – Risk	
Business Delivery Group (BDG)	

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

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

DRAFT

Service User, Carer and Staff Feedback

Quarter 1 2020/21 Update

Executive Summary:

The results of an online survey of service users undertaken in relation to COVID-19 responses are included in section 3. The survey was designed by the Trust's Involvement Facilitators to capture and respond to patient experience during the pandemic.

Section 4 contains the results of a staff survey into the trust response to COVID-19. The theme with the most responses in the survey was flexible working, with the impact of the trust's response being very positive. Many staff also felt that meetings were affected positively in the trust's response to COVID-19. The area most negatively affected was face-to-face contact with service users. Communication and technology were important themes in the reactions in which the trust's response had more balance between positive and negative impacts.

The Trust restarted the Points of You survey in the last week of June 2020 to seek feedback on the experience of service users and carers. In the quarter we received over 300 survey returns, of which 73% were from service users and 27% from carers. The COVID-19 related pause to the Points of You survey meant that the volume of responses was reduced by 81% compared to the previous quarter.

Analysis of the responses is provided, but comparison between services and to the previous quarter is difficult and less meaningful given the small number of responses in quarter 1.

An analysis of FFT recommend scores by demographic factors has been undertaken (see pages 12-13). This shows higher satisfaction in older age groups.

Full details of the small number of published comments made about trust services and responses provided on social media has been included within this report at Appendix 2.

DRAFT

1. Purpose and Background

This report provides a summary of the Quarter 1 2020/21 service user and carer experience feedback received across the Trust.

The Trust is committed to improving the quality of services by using experience feedback to understand what matters the most to service users and carers. The information included in this paper outlines the Quarter 1 position on the following:

- Friends and Family Test
- Points of You (Service User & Carer) (& Gender Dysphoria Survey)
- The NHS website/ Care Opinion / Healthwatch
- Compliments

2. Recent local and national developments

Friends and Family Test response to COVID-19
NHS England and Improvement has provided high-level advice about reducing burden and releasing capacity to manage the COVID-19 pandemic, and after a decision made by Gold Command, the Trust ceased sending out Points of You at the end of March. The measures are intended to allow for staff resources to be diverted towards more immediate priorities during the COVID-19 pandemic. Service users and carers can still complete the online Points of You survey, contact PALS to raise concerns, and they can be directed to NHS.uk or Care Opinion (where feedback reviews can be posted online); they can also leave feedback with the CQC or contact their local Healthwatch.

NHS England and Improvement are currently exploring when will be the optimum time to restart FFT data submissions and will advise providers when to restart submitting FFT data in the weeks ahead. Any feedback collected may be useful locally, but there will be no national submission until further advice is published later in the year.

NHS England is carrying out a project[1] to improve some areas of the way the Friends and Family Test operates, and has undertaken interviews with providers, commissioners and other stakeholders.

The requirement to implement the changes to the Friends and Family Test question by 1st April has been postponed and NHS England and Improvement will provide more advice about adopting the new question and timing requirements in due course. The planned changes to the FFT are about helping services and commissioners to use this as more than a quantative measure of collection and move towards more active use of feedback, alongside other patient experience data, to drive quality improvements.

CNTW are already prepared for the FFT changes to be implemented after a review of the full Points of You survey. The new version of the survey was developed and approved in March 2020.
The new version of Points of You is in appendix 3.

[1] https://www.england.nhs.uk/fft/friends-and-family-test-development-project-2018-19/

DRAFT

Using patient experience data to support improvements in inpatient mental health care: the EURIPIDES multimethod study

This report has been published in Health Services and Delivery Research in May 2020[2]. It found that:

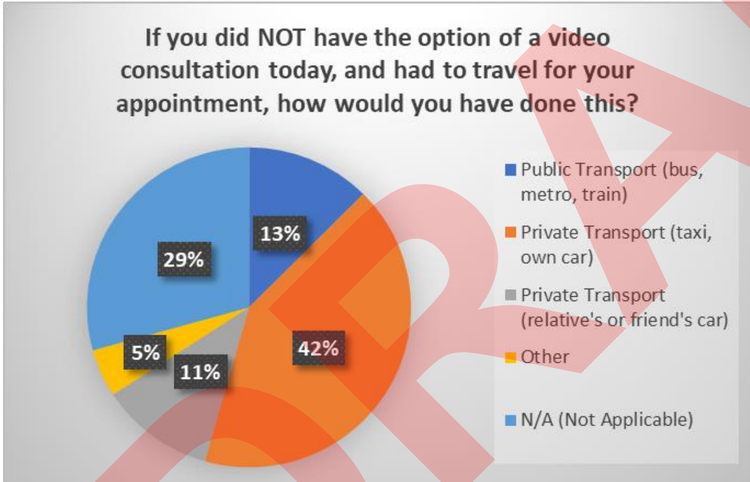
> The patient experience feedback cycle was rarely completed and, even when improvements were implemented, these tended to be environmental rather than cultural. There were few examples of triangulation with patient safety or outcomes data.

3. Service User COVID-19 Response Survey Results

In May 2020 the Trust launched an online survey of service users to gather service user experience of the rapid changes we made to the way we work. 682 responses were received.

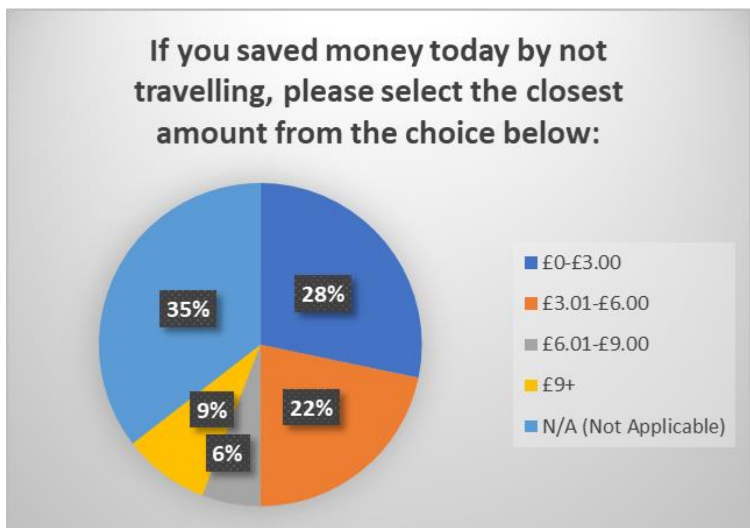
The results of the survey are shown below in three sections, travel, technology and appointment types.

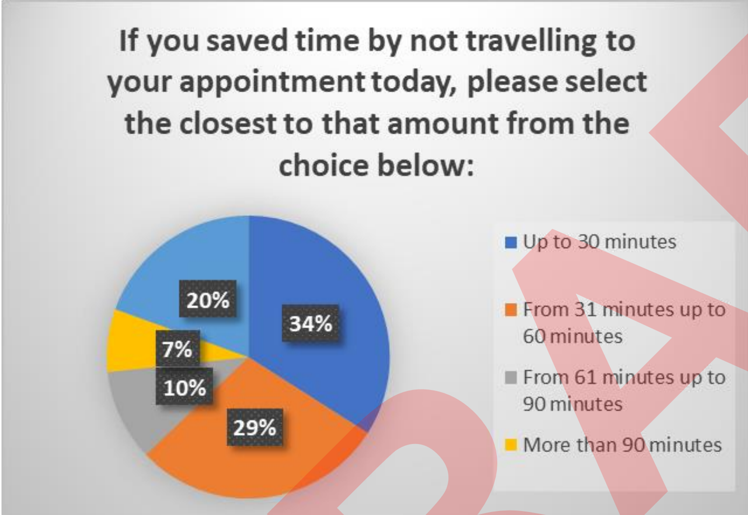
Figure 1: Reponses to transport questions



DRAFT

[2] Weich S, Fenton S-J, Staniszewska S, Canaway A, Crepaz-Keay D, Larkin M, *et al*. Using patient experience data to support improvements in inpatient mental health care: the EURIPIDES multimethod study. *Health Serv Deliv Res* 2020;8(21)



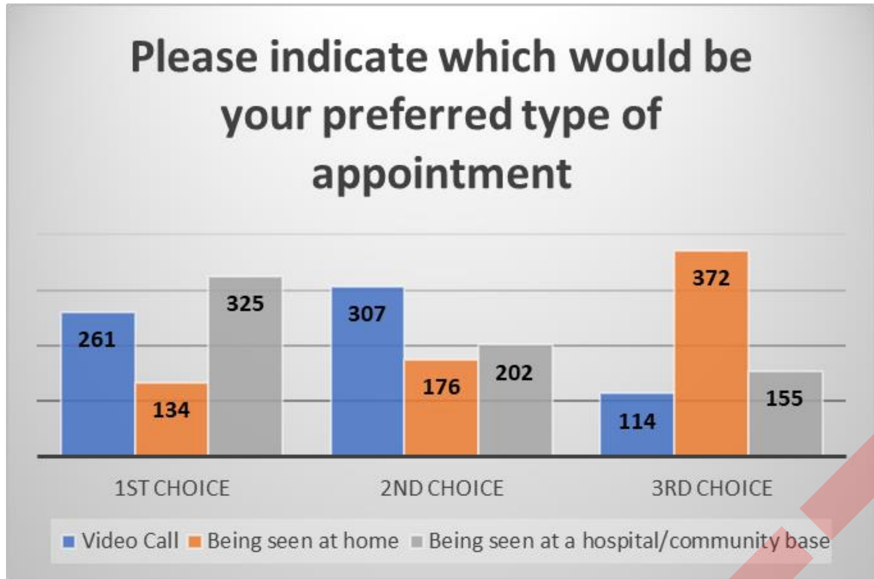


DRAFT

Table 1: responses to technology table

	Strongly Agree	Agree	Disagree	Strongly disagree	Unsure /NA	Total
I was satisfied with the overall experience of today's video call	425	225	17	5	10	682
I would be willing to receive future mental health care via a video call	358	265	13	11	35	682
The technology was easy to use	370	269	22	10	11	682
The sound quality was good	275	318	57	19	13	682
The picture quality was good	275	329	52	15	11	682
I felt able to share information the same as is if the clinician was in the room with me	346	259	43	12	22	682

Figure 2: preferred type of appointment



DRAFT

4. Staff COVID-19 Response Survey Results

In a trustwide survey, 658 members of staff gave their experiences, reflections, suggestions and ideas on how to learn from the trust's response to the COVID-19 pandemic.

Feedback was received from across staff groups and localities, and the most common responses are summarised in table 2. Overall, the theme with the most responses in the survey was flexible working, with the impact of the trust's response being very positive. Many staff also felt that meetings were affected positively in response to COVID-19. The area most negatively affected was face-to-face contact with service users. Communication and technology were important themes in the replies where the impact of the trust's response had more of a balance between positive and negative.

Table 2: most common themes in responses to Staff COVID-19 Response Survey

Question	Most common themes
What is working or has worked well?	Working flexibly (31% of responses to this question) Technology (28%) Connections with others service users, colleagues and carers (20%)
What is not working or has not worked well?	Technology (18% of responses to this question) Communication & Consistent messages (18%) Working from home (13%)
What do you think we should keep doing differently	Home working / Flexible Working (39%) Using a variety of methods to engage/communicate with people (36%)
What were we doing before COVID-19 that we need to return to?	Face to face contact and choice (49%)
What were we doing before COVID-19 that we should not return to?	Travelling to meetings (24%) Non-essential face to face meetings (22%) Being rigid in our thinking and fixed in our ways of working (16%)

Question	Most common themes
What more could have been done to support you during this challenging time?	Communication (21%) We got everything we needed (18%) Support from line managers (10%)
Do you have one top tip or one thing you have learned during COVID-19 that you will take with you into your future working practice?	Communication / Team working (26%) Ways of working (21%) Home working / Flexible Working (14%) Wellbeing (13%)

Staff were also asked whether they were supported during COVID-19 by a range of groups within the trust, with the percentage who agreed or strongly agreed ranging from 57% for other services, 78% for the Trust, 82% for their manager and 91% for their colleagues.

81% of respondents agree (or strongly agreed) that “The Trust has communicated the information you need in relation to COVID-19, when you need it and in a format you need”, with 80% agreeing or strongly agreeing in relation to communication from their manager.

5. Points of You Responses and Uptake (including Friends and Family Test)

Around 300 service users and carers provided feedback on their experience with the Trust during the period. Experience feedback is shared with clinical and operational teams via locality Group Quality Standards meetings and via an online dashboard updated daily.

Figure 3: Total number of service users and carer experience responses since April 2018

Number of Feedback Responses (April 2018- June 2020)

	2018-19 Qtr 1	2018-19 Qtr 2	2018-19 Qtr 3	2018-19 Qtr 4	2019-20 Qtr 1	2019-20 Qtr 2	2019-20 Qtr 3	2019-20 Qtr 4	2020-21 Qtr 1
Service User Responses	1346	1277	1156	1139	1267	1174	1111	1086	201
Carer/ Relative/ Friend Responses	467	409	304	379	419	421	391	367	75
"Both" Responses	40	31	47	22	24	31	20	19	6
Not answered	139	105	120	122	125	117	86	126	28
Total	1992	1822	1627	1662	1835	1743	1608	1598	310

DRAFT

The volume of Points of You responses received (incorporating the Friends and Family Test) decreased in the quarter by 81% to 310, with no responses received between the first week in April and the last week in June. Figures also do not take into account any new PoY surveys that may have been completed after the distribution to teams took place.
Noting that the small number of responses received in the quarter may make the results less representative than usual, the following themes are suggested by the data

- 40% of the responses were from the North Cumbria Locality, with more than a third of all responses coming from the localities Older Adult Community Mental Health Teams

- 92% of responses were by the mailshot method.

Figure 4 Points of You responses by locality and method April 2018 to June 2020

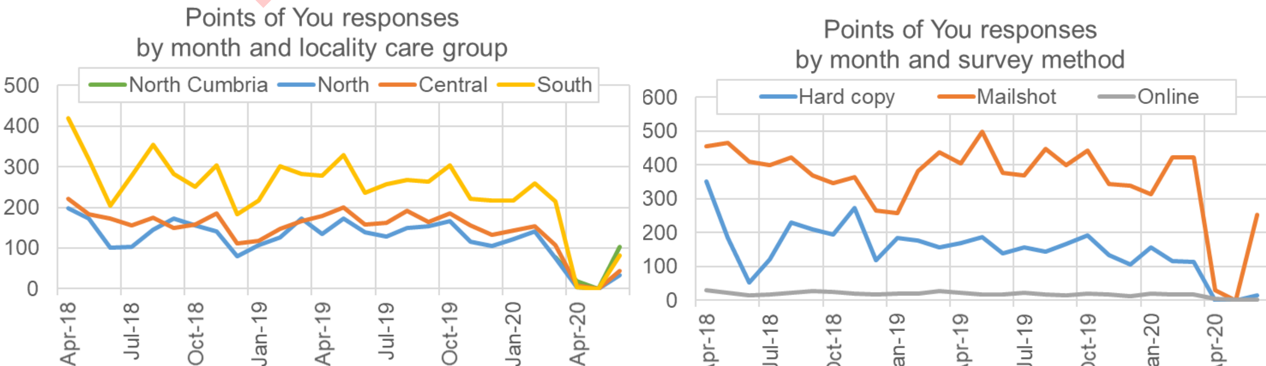
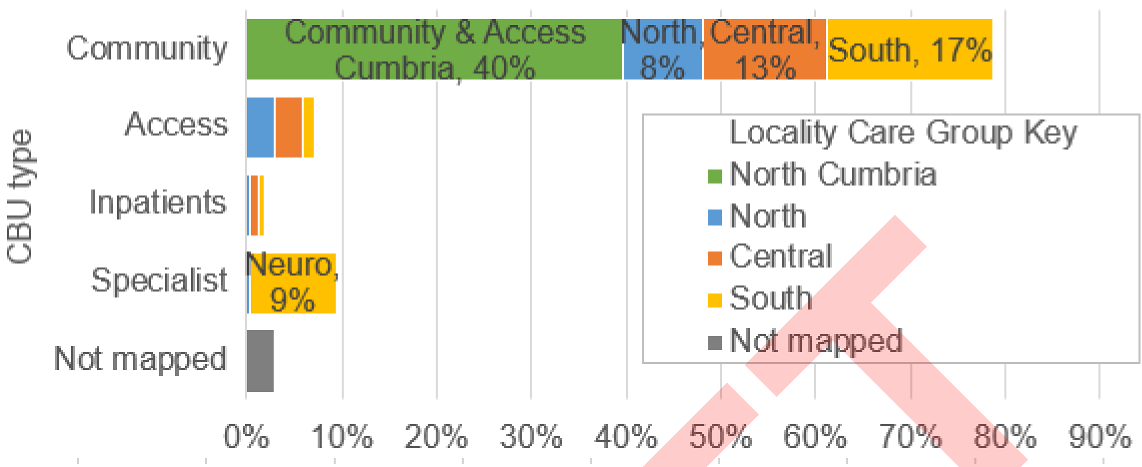


Figure 5 Points of You responses by service type April to June 2020



The ten services with the highest response volumes in the quarter (representing 56% of feedback received) were

Table 3 Top 10 Points of You responses by service January to March 2020

Team	CBU	Responses
Older Adult Community Mental Health Team (Allerdale)	Community & Access Cumbria CBU	49
Memory Protection Service	Community South CBU	25
Older Adult Community Mental Health Team (Eden)	Community & Access Cumbria CBU	24
Older Adult Community Mental Health Team (Carlisle)	Community & Access Cumbria CBU	19
Older Adult Community Mental Health Team (Copeland)	Community & Access Cumbria CBU	18
Outpatient and Community Rehabilitation Clinic	Neurological & Specialist Services CBU	10
South Tyneside Community Treatment Team (Psychosis)	Community South CBU	8
Newcastle and Gateshead Children and Young Peoples Service	Community Central CBU	7
Newcastle Older Peoples Community Treatment Teams	Community Central CBU	7
Northumberland Children and Young Peoples Service	Community North CBU	7

4. NHS Friends & Family Test Quarter 1 2020/21

Data submission and publication for the Friends and Family Test has been paused during the response to COVID-19, with February 2020 being the latest month with data available. We are currently awaiting guidance on when submission of data will resume.

DRAFT

Data for the “old” Friends and Family Test question “How likely are you to recommend our team or ward to friends and family if they needed similar care or treatment?” are shown below

Table 4 FFT responses and results by locality group

	Number of FFT Responses* Quarter 1 2020/21	Quarter 1 % would recommend	Number of FFT Responses * Quarter 4 19/20	Quarter 4 % would recommend	Number of FFT Responses * Quarter 3 19/20	Quarter 3 % would recommend	Number of FFT Responses * Quarter 2 19/20	Quarter 2 % would recommend
Trust	302	91%	1,555	87%	1,569	88%	1,707	89%
North Cumbria Locality Group	119	92%	75	83%				
North Locality Group	35	86%	330	85%	378	88%	420	85%
Central Locality Group	53	94%	396	84%	458	86%	512	88%
South Locality Group	86	91%	673	90%	730	90%	772	92%
Responses not mapped to locality	9		81		14		36	

(excluding not answered)

**The FFT question is incorporated into the Points of You survey. Not all respondents to the survey complete the FFT question, therefore the total FFT responses is lower than the total Points of You responses for the quarter.*

6. Points of You Experience Analysis Quarter 1 2020/21

The Points of You survey is used across all Trust services* for both service users and carers and the questions included within the survey are shown at Appendix 1.

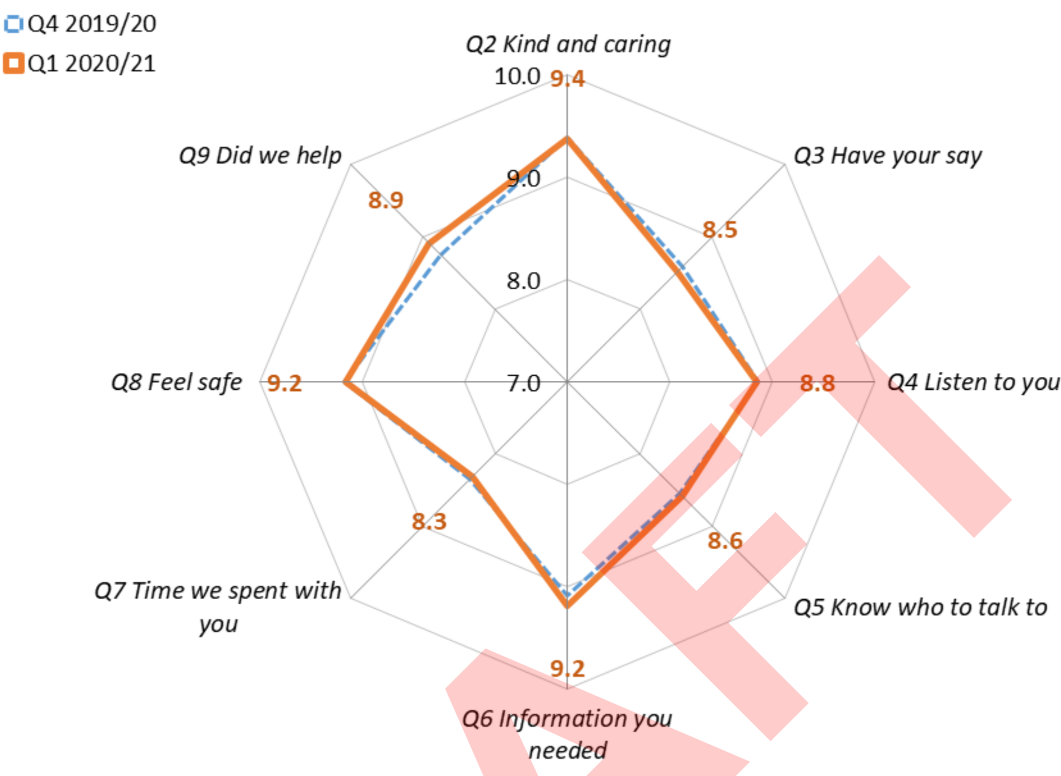
**The Gender Dysphoria Service is the only exemption to the Trust-wide Points of You service users and carer experience programme, using a nationally agreed survey format in line with English Gender Dysphoria service providers. See section 8.*

Each of the 8 questions (excluding the Friends and Family Test question) in the Points of You survey results in a score out of ten and Figure 6 below illustrates the average score received for each question trustwide during Quarter 1. The trustwide results were very similar to the previous quarter.

- The highest scoring question remains question 2 “How kind and caring were staff to you?”
- The lowest scored question remains question 7 – “were you happy with how much time we spent with you?”
- The largest changes on quarter 4 were the decreases in scores for question 3 “Have your say” and the increases for question 9 “Overall did we help?” and question 6 “Information you needed”

DRAFT

Figure 6: Average score for questions 2-9 for all Trust services for quarter 1 2020/21 compared with quarter 4 2019/20 (10 being the best, 0 being the worst)



The following analysis in Table 5 below shows a breakdown of the average score per question by locality group. This shows:

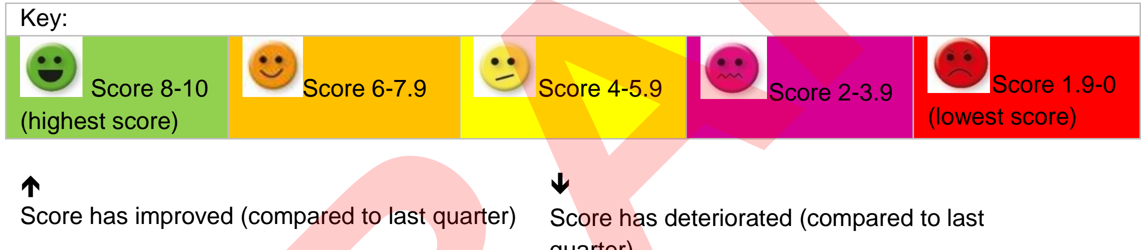
- The North Cumbria and South localities received a higher volume of responses than the other localities
- Variation between localities and the changes on the previous quarter may relate to differences in the type of services provided.

DRAFT

Table 5 Analysis of Quarter 1 2020/21 Points of You scores by locality across all questions

	Number of Responses for latest quarter (previous quarter)	Q2 - Kind and caring	Q3 - Have your say	Q4 - Listen to you	Q5 - Know who to talk to	Q6 - Information you needed	Q7 - Time we spent with you	Q8 - Feel safe	Q9 - Did we help
Trust	**310** (1,598)	**9.4** ↔	**8.5** ↓0.1	**8.8** ↓0.1	**8.6** ↑0.1	**9.2** ↑0.1	**8.3** ↔	**9.2** ↔	**8.9** ↑0.1
North Cumbria Locality Care Group	123 (78)	9.6 ↑0.4	8.6 ↑0.4	8.9 ↑0.3	8.7 ↑0.9	9.4 ↑0.3	8.5 ↑0.4	9.4 ↑0.5	9.3 ↑1
North Locality Care Group	37 (339)	8.4 ↓0.8	7.7 ↓0.6	8.1 ↓0.5	8.3 ↔	8.6 ↓0.3	7.6 ↓0.3	8.5 ↓0.5	8.2 ↓0.3
Central Locality Care Group	53 (406)	9.1 ↓0.1	8.1 ↓0.4	8.4 ↓0.3	8.1 ↓0.4	8.8 ↔	7.8 ↓0.3	8.8 ↓0.2	8.5 ↔
South Locality Care Group	88 (693)	9.8 ↑0.2	9.1 ↑0.3	9.4 ↑0.3	8.8 ↔	9.5 ↑0.1	8.8 ↑0.1	9.5 ↑0.1	9.0 ↓0.1

Note. 82 responses were unable to be assigned to a locality care group



DRAFT

Figure 8 below shows responses over time, broken down by locality, to the question 9 “Overall did we help?”. Responses for April to June 2020 are not shown

Figure 7: Responses by month and locality care group to question 9.

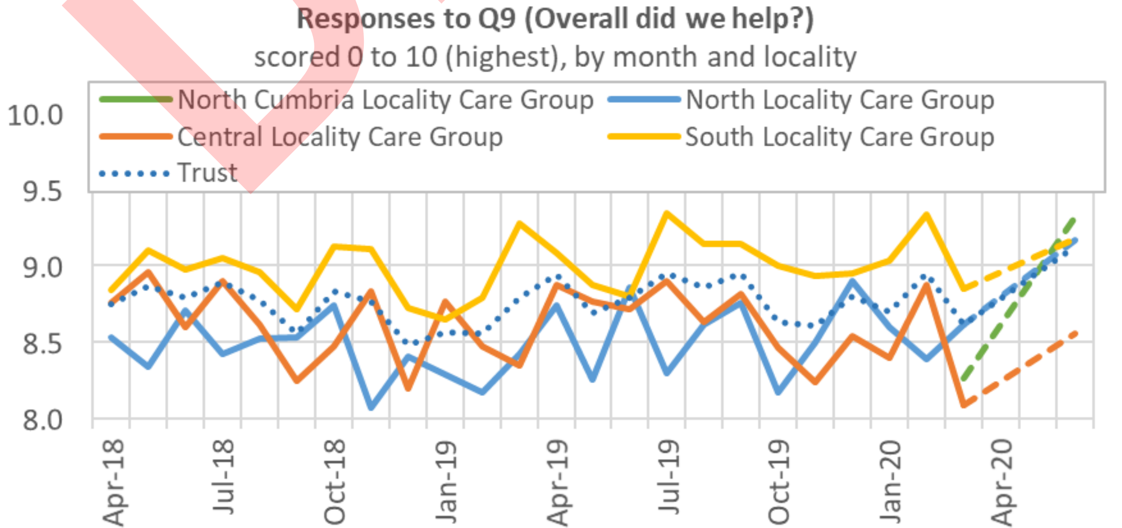


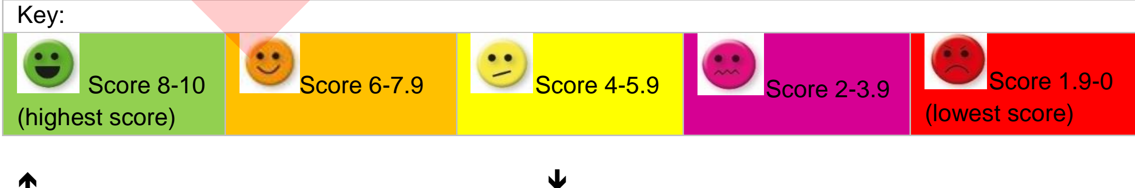
Table 6 below shows a breakdown of responses at question level, displayed by CQC core service groupings.

Table 6: Average score per question by core service

	Number of Responses for latest quarter (previous quarter)	Q2 - Kind and caring	Q3 - Have your say	Q4 - Listen to you	Q5 - Know who to talk to	Q6 - Information you needed	Q7 - Time we spent with you	Q8 - Feel safe	Q9 - Did we help
Trust	**310** (1,598)	**9.4** ↔	**8.5** ↓0.1	**8.8** ↓0.1	**8.6** ↑0.1	**9.2** ↑0.1	**8.3** ↔	**9.2** ↔	**8.9** ↑0.1
Neuro Rehab Outpatients (Acute Outpatients)	12 (115)	9.6 ↓0.3	9.6 ↑0.2	9.4 ↓0.1	10.0 ↑0.8	10.0 ↑0.3	9.2 ↑0.1	9.8 ↑0.1	9.6 ↔
Community mental health services for people with learning disabilities or autism	12 (38)	9.2 ↑0.6	9.1 ↑1.7	9.0 ↑1.2	9.2 ↑1.9	9.2 ↑0.8	8.5 ↑1.3	9.6 ↑0.7	10.0 ↑1.8
Community-based mental health services for adults of working age	53 (281)	9.0 ↑0.1	7.7 ↓0.2	8.3 ↑0.1	8.3 ↑0.6	8.5 ↓0.2	7.4 ↓0.2	8.7 ↑0.1	8.0 ↑0.1
Community-based mental health services for older peple	164 (465)	9.6 ↓0.1	8.7 ↓0.2	9.0 ↓0.2	8.5 ↓0.1	9.6 ↑0.2	8.6 ↔	9.4 ↓0.2	9.3 ↑0.1
Mental health crisis services and health-based places of safety	9 (77)	7.2 ↓1.3	5.0 ↓2.9	6.3 ↓1.9	5.6 ↓2.4	5.6 ↓2.7	6.4 ↓1.5	6.6 ↓1.6	5.6 ↓2.2
Specialist community mental health services for children and young people	23 (153)	9.8 ↑0.8	9.3 ↑0.5	9.5 ↑0.6	9.1 ↑0.8	9.5 ↑1	8.4 ↑0.3	9.5 ↑0.3	9.6 ↑1.5
Substance Misuse Services	9 (112)	10.0 ↑0.2	9.2 ↑0.3	9.4 ↑0.2	10.0 ↑0.8	10.0 ↑0.4	9.1 ↑0.7	9.7 ↑0.3	9.4 ↑0.3
Other	9 (193)	9.4 ↓0.3	10.0 ↑1.1	10.0 ↑0.8	10.0 ↑0.9	10.0 ↑0.7	9.7 ↑0.8	9.7 ↑0.2	9.4 ↑0.2

DRAFT

Note. Responses that were assigned to a core service are included in 'Other'. Core services with less than 5 responses not shown (Child and adolescent mental health wards, Gender Identity services, Personality disorder services, Secure mental health wards/Forensic inpatients)



↑ Score has improved (compared to last quarter)

↓ Score has deteriorated (compared to last quarter)

A Trust-wide thematic analysis has not been undertaken for the responses received in quarter 1 2020/21.

7. Points of You Response Demographics

For the following categories below, the percentage of Points of You respondents who selected and identified the following options is shown, including the percentage who didn't answer. Also shown for each option in each characteristic is the percentage who would recommend the service to their friends and family, as recorded in question 1 of the survey. As shown in table 4, the trust's recommend score for the quarter was **91%**.
It should be noted that other factors will affect these results such as differences in the type of service being reviewed. Respondents who didn't complete the monitoring information generally give less positive feedback.

Table 7: Points of You reponses by respondent category – Quarter 1 2020/21

Respondent	% of responses	FFT recommend score (question 1)
Service User/Patient	65%	92%
Carer/Relative/Friend	24%	90%
Both	2%	83%
Not Answered	9%	80%

Table 8: Points of You reponses by gender – Quarter 1 2020/21

Gender	% of responses	FFT recommend score (question 1)
Male	37%	92%
Female	60%	91%
Other	0%	0%
Not Answered	3%	75%

Table 9: Points of You responses by ethnic group – Quarter 1 2020/21

Ethnic group	% of responses	FFT recommend score (question 1)
Asian/Asian British	1%	100%
Black/African/Caribbean/Black British		
Mixed/Multiple ethnic groups	1%	33%
Other ethnic group	0%	0%
White	95%	92%
Not Answered	3%	71%

DRAFT

Table 10: Points of You responses by age group – Quarter 1 2020/21

Age group	% of responses	FFT recommend score (question 1)
0-18	4%	100%
19-24	4%	73%
25-34	5%	93%
35-44	6%	80%
45-54	12%	91%
55-64	15%	98%
65-74	17%	88%
75-84	23%	89%
85+	11%	97%
Not Answered	2%	80%

8. Gender Dysphoria Survey - Responses and Analysis

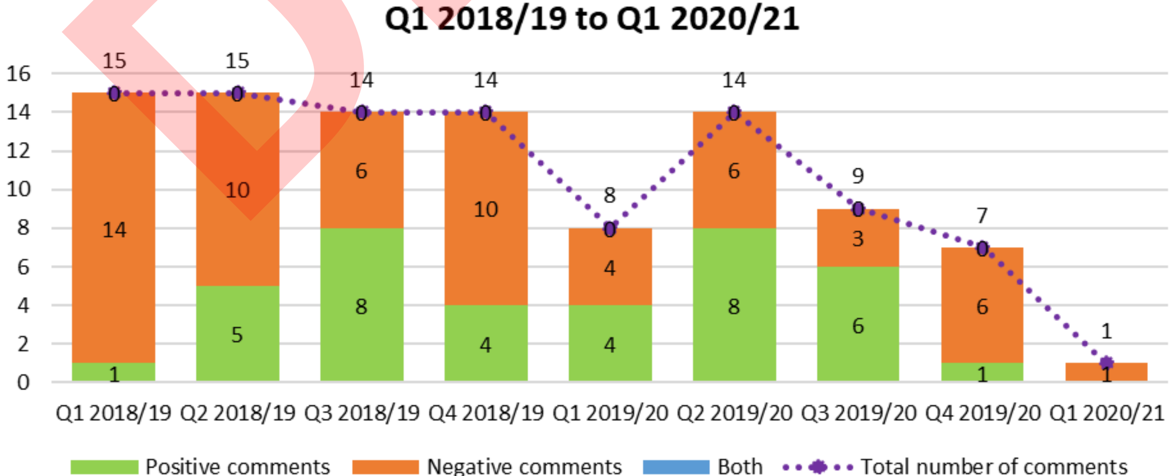
No surveys have been received for quarter 1 2020/21.

9. NHS website, Care Opinion & Healthwatch reviews for quarter 1 2020/21

The three main websites for service users and carers to leave feedback are the NHS website (previously known as NHS Choices), Care Opinion and Healthwatch (Newcastle/ Gateshead/ North Tyneside and South Tyneside). One comment was received during quarter 1, which is given in appendix 2.

Figure 8 below shows the number of comments posted on feedback sites from April to June 2020.

Figure 8 – Number of comments published on the NHS website, Care Opinion & Healthwatch sites each quarter (Quarter 1 2018/19 to Quarter 1 2020/21)



DRAFT

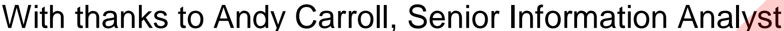
10. Compliments and Thank-yous – Quarter 1 2020/21

During Quarter 1, 153 thank-yous and compliments were received via Points of You and from other routes (including Chatterbox). There were 198 compliments received during Quarter 4 2019/20.

11. Recommendations

The Corporate Decisions Team Quality Sub Group are asked to note the information included within this report.

Allan Fairlamb
Head of Commissioning & Quality Assurance



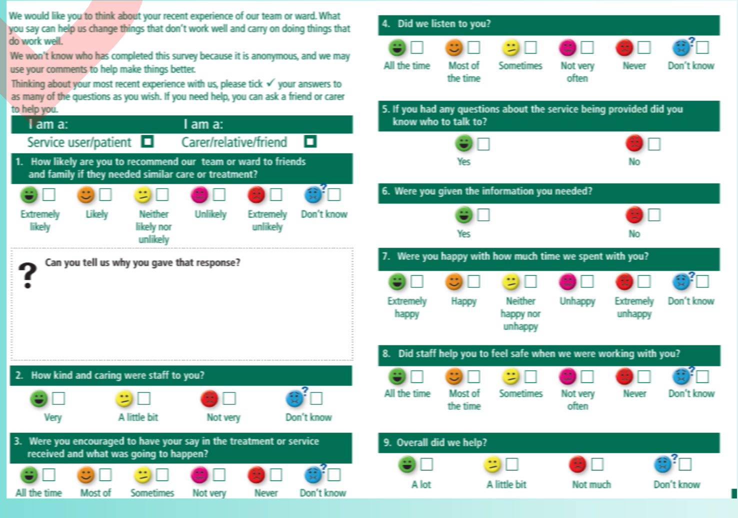
With thanks to Andy Carroll, Senior Information Analyst

Appendix 1

Points of You Format

Points of You Survey format:

1. How likely are you to recommend our team or ward to friends and family if they needed similar care or treatment? **(This is known and the "Friends and Family Test")**
2. How kind and caring were staff to you?
3. Were you encouraged to have your say in the treatment or service received and what was going to happen?
4. Did we listen to you?
5. If you had any questions about the service being provided did you know who to talk to?
6. Were you given the information you needed?
7. Were you happy with how much time we spent with you?
8. Did staff help you to feel safe when we were working with you?
9. Overall did we help?
10. Is there anything else you would like to tell us about the team or ward?



We would like you to think about your recent experience of our team or ward. What you say can help us change things that don't work well and carry on doing things that do work well.

We won't know who has completed this survey because it is anonymous, and we may use your comments to help make things better.

Thinking about your most recent experience with us, please tick ✓ your answers to as many of the questions as you wish. If you need help, you can ask a friend or carer to help you.

I am a: Service user/patient ☐ I am a: Carer/relative/friend ☐

1. How likely are you to recommend our team or ward to friends and family if they needed similar care or treatment?
☐ Extremely likely ☐ Likely ☐ Neither likely nor unlikely ☐ Unlikely ☐ Extremely unlikely ☐ Don't know

? Can you tell us why you gave that response?

2. How kind and caring were staff to you?
☐ Very ☐ A little bit ☐ Not very ☐ Don't know

3. Were you encouraged to have your say in the treatment or service received and what was going to happen?
☐ All the time ☐ Most of ☐ Sometimes ☐ Not very ☐ Never ☐ Don't know

4. Did we listen to you?
☐ All the time ☐ Most of the time ☐ Sometimes ☐ Not very often ☐ Never ☐ Don't know

5. If you had any questions about the service being provided did you know who to talk to?
☐ Yes ☐ No

6. Were you given the information you needed?
☐ Yes ☐ No

7. Were you happy with how much time we spent with you?
☐ Extremely happy ☐ Happy ☐ Neither happy nor unhappy ☐ Unhappy ☐ Extremely unhappy ☐ Don't know

8. Did staff help you to feel safe when we were working with you?
☐ All the time ☐ Most of the time ☐ Sometimes ☐ Not very often ☐ Never ☐ Don't know

9. Overall did we help?
☐ A lot ☐ A little bit ☐ Not much ☐ Don't know

DRAFT

Appendix 2

Reviews made on the NHS website, Care Opinion & Healthwatch in quarter 1 2020/21

Reviewed on 11 June 2020 (Rating: Terrible, Adult ADHD Service, Keegan Court, Gateshead)

Terribly long wait for assessment

Service seems underfunded. Send in evidence wait months then ring up get told that ‘by coincidence’ letter is being read that day even though it arrived five months ago. They then start waiting list time from date letter read not date assessment sent. Attempt to massage excessive waiting list times.

If you prefer not to answer the following questions please tick this box ☐

What is your gender?

Male ☐ Female ☐ Other ____________________

Prefer not to say ☐

What age are you?

0-18 ☐ 19-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐

65-74 ☐ 75-84 ☐ 85+ ☐

Prefer not to say ☐

What is your ethnic group?

White ☐ Mixed/Multiple ethnic groups ☐ Asian/Asian British ☐

Black/African/Caribbean/Black British ☐

Other ethnic group ____________________

Prefer not to say ☐

What is your sexual orientation? ____________________

What is your faith? ____________________

Disability: Do you have a disability or are you affected by a long term health condition which has an effect on your day to day activities?

Yes ☐ No ☐

If you need any help, advice or support about your care or treatment please contact the Patient Advice and Liaison Service (PALS)
North of Tyne – Tel: 0800 032 02 02; Email: northoftynepals@nhct.nhs.uk
South of Tyne – Tel: 0800 328 4397; Email: pals@cntw.nhs.uk

This survey can be made available in a range of formats on request (e.g. Braille, audio, larger print, BSL or other languages). Please contact poy@cntw.nhs.uk to make a request or if you have any questions about the survey.

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Tell us what you think about our services

Your life | Points of you | Your experience

Please use this survey to tell us about your recent experience of the team or ward named above.
If what you write on this survey is about a different team or ward, please write the name below:

____

You can fill this survey in online at www.cntw.nhs.uk/poy

Caring | Discovering | Growing | **Together**

2

FAO Commissioning and Quality Assurance

Freepost RTLK-SHCY-SHGC
Cumbria, Northumberland, Tyne & Wear NHS FT
Jubilee Road
Gosforth
NEWCASTLE UPON TYNE
NE3 3XT

DRAFT

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) gather feedback from people who use our services in a variety of ways. This helps us to know what we are doing well and what we could do better.

You can complete the survey online at www.cntw.nhs.uk/poy or use the NHS website www.nhs.uk to feedback your views.

We also ask for some information about you so we know what we need to improve for some people.

You can post it back using the freepost address on the card. You do not need a stamp.

If you need help, you can ask a friend or carer to help you.

We don't know who fills in the form because we don't ask for your name or contact details. If you would like to provide further information, or know how the service has responded to your feedback, then please let us know your name and contact details below.

If you do not want your comments sharing with the ward/team, please tick here ☐

I am a:

Service user/patient ☐ Family/carer/friend ☐ or completing on behalf of a service user/patient ☐

1. Overall, how was your experience of our service?

☐ Very good ☐ Good ☐ Neither good nor poor ☐ Poor ☐ Very poor ☐ Don't know

Please tell us why you gave that answer

2. What things could be better about the service?

Add your comments/thoughts here

3. What did you find good/helpful about the service?

Add your comments/thoughts here

4. Did we listen to you when making decisions about care and treatment?

☐ Yes ☐ No ☐ Sometimes

Please tell us why you gave that answer

5. Were staff kind and caring?

☐ Yes ☐ No ☐ Sometimes

Please tell us why you gave that answer

6. Did you feel safe with our service?

☐ Yes ☐ No ☐ Sometimes

Please tell us why you gave that answer

7. Were you given information that was helpful?

☐ Yes ☐ No ☐ Don't know

Please tell us why you gave that answer

Please turn over

DRAFT

Board of Directors
05 August 2020

Title of report	Safer Staffing Report including Six Month Skill Mix – May 2020
Report author(s)	Anne Moore, Group Nurse Director, Safer Care Directorate
Executive Lead (if different from above)	Gary O'Hare, Executive Director of Nursing and Operations

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	x	Work together to promote prevention, early intervention and resilience	
To achieve "no health without mental health" and "joined up" services		Sustainable mental health and disability services delivering real value	x
To be a centre of excellence for mental health and disability		The Trust to be regarded as a great place to work	x

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	29/07/2020
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	Covid19 Gold Command and IMG

Management Group meetings where this item has been considered (specify date)	
Executive Team	
Corporate Decisions Team (CDT)	
CDT – Quality	27/07/2020
CDT – Business	
CDT – Workforce	
CDT – Climate	
CDT – Risk	
Business Delivery Group (BDG)	

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

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

DRAFT

Safer Staffing Report including Six Month Skill Mix
Trust Board
05 August 2020

Executive Summary

The following report includes the exception data of all wards against Trust agreed Safer Staffing levels for the period May 2020. However, the Board should note that analysis and detailed variations are not covered here in the usual way. The period covered includes the response to the Covid19 Pandemic. As a result, the impact on staffing levels was significantly altered and not able to be reflected accurately by TAER.

The variation was due to several factors including:

- Staff absence as a consequence of Covid19 or related Infection
- Staff absence (working from home) due to extremely vulnerable group and shielding
- Staff absence (working from home) due to shielding others
- Temporary redeployment of corporate clinical staff
- Movement of final year Student Nurses and Medical Students onto substantive contracts ahead of qualifying in partnership with HEE/NMC/GMC

- Services were also subject to modification and change as a result of patient confirmed Covid19 cases whereby necessitating changes in bed occupancy to create options for cohorting to prevent the transmission of infection and to support patients who required self-isolation/Social Distancing.

- All service changes have been subject to scrutiny via the Incident Management Group established under the auspices of Covid19 Gold Command. The IMG membership includes Gold Command, Executive Directors and nominated Group Director.

During this period staffing levels, risks and mitigation have been monitored at service, CBU and Group level via Daily Sitrep meetings. This results in the generation of a daily Sitrep submitted into Gold Command. The risks, mitigations and escalations are discussed and reflected in daily returns to NHSE/I

Despite the challenges of Covid19 it was agreed that the plan for recruitment to the Trust should continue where safe to do so using alternative assessment methods underpinned by values-based recruitment. This has been led in parallel by the Central Recruitment Team.

Risks and mitigations associated with the report

The Board should note that the attached locality Safer Staffing returns do not accurately reflect the situation during the Covid19 Pandemic as described above and the limitations of TAER. However, the group should be assured that the daily scrutiny at CBU, Group and Executive level has ensured the safe provision of services to patients.

Recommendation/summary

The Board is asked to receive the executive summary and locality data attached for information and assurance.

DRAFT

1. Purpose of this report

The purpose of the report is to provide assurance on the current position across all inpatient wards within CNTW in accordance with the National Quality Board (NQB) Safer Staffing requirements. In addition the NHSI publication of 2018 builds on the NQB guidance and recommended that the Workforce Standards are continually reviewed in the context of the Safer Staffing returns.

The following report includes the exception data of all wards against Trust agreed Safer Staffing levels for the period May 2020. However, the group should note that the usual narrative to support the analysis and detailed variations are not covered here in the usual way. The period covered includes the response to the Covid19 Pandemic. As a result, the impact on staffing levels was significantly altered and not able to be reflected accurately by TAER system

The variation was due to several factors including:

- Staff absence as a consequence of Covid19 or related Infection
- Staff absence (working from home) due to extremely vulnerable group and shielding
- Staff absence (working from home) due to shielding others
- Temporary redeployment of corporate clinical staff
- Movement of final year Student Nurses and Medical Students onto substantive contracts ahead of qualifying in partnership with HEE/NMC/GMC

- Services were also subject to modification and change as a result of patient confirmed Covid19 cases whereby necessitating changes in bed occupancy to create options for cohorting to prevent the transmission of infection and to support patients who required self-isolation/Social Distancing.

- All service changes have been subject to scrutiny via the Incident Management Group established under the auspices of Covid19 Gold Command. The IMG membership includes Gold Command, Executive Directors and nominated Group Director.

Staffing levels, risks and mitigation have been monitored at service, CBU and Group level via Daily Sitrep meetings. This has resulted in the generation of a daily Sitrep submitted into Covid19 Gold Command. The risks, mitigations and escalations are discussed and agreed for inclusion in daily returns to NHSE/I. There have been no incidents of harm reported during the period relating to safe staffing levels during the Covid19 period to date

This report is an exception report that highlights wards that are either 10% + under or 20% + over planned staffing levels. The exception reporting is via a RAG rating that identifies the following categories:

- **Red** for any ward under 90%
- White for within range
- **Green** for wards over 120%
- Blue maximum safe staffing levels

NB. Trust Board should note this is not an accurate reflection of Safe Staffing recording due to the significant manual adjustments which would have been required to TAER to reflect the position described above. However for completeness the raw data is included.

DRAFT

North Cumbria Locality

North Cumbria CBU has 6 wards

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Overall Day Coverage	Overall Night Coverage
Edenwood Unit	162.65%	514.34%	136.62%	454.75%	100.00%	100.00%
Hadrian Ward	83.17%	143.75%	152.86%	133.97%	100.00%	100.00%
Oakwood Ward	80.00%	166.88%	106.49%	128.81%	100.00%	100.00%
Rowanwood	84.24%	193.55%	102.39%	303.81%	100.00%	100.00%
Ruskin Unit	93.94%	154.84%	187.37%	113.46%	100.00%	100.00%
Yewdale Ward	79.39%	131.44%	100.01%	198.50%	100.00%	100.00%

North Locality

The North CBU has 13 inpatient wards

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Overall Day Coverage	Overall Night Coverage
Alnmouth	86.79%	340.97%	146.71%	212.61%	100.00%	100.00%
Ashby	84.86%	241.64%	117.25%	241.34%	100.00%	100.00%
Embleton	96.89%	301.57%	104.83%	185.60%	100.00%	100.00%
Fraser	95.11%	180.39%	111.48%	169.24%	100.00%	100.00%
Hauxley	62.91%	102.46%	108.86%	102.74%	82.69%	100.00%
Kinnersley	145.53%	361.67%	242.69%	186.03%	100.00%	100.00%
Lennox	122.27%	248.84%	113.63%	292.07%	100.00%	100.00%
Newton	94.72%	154.18%	104.85%	203.33%	100.00%	100.00%
Redburn YPU	88.76%	192.65%	141.41%	178.35%	100.00%	100.00%
Stephenson House	119.56%	168.41%	173.09%	180.05%	100.00%	100.00%
Warkworth	107.46%	292.87%	90.45%	240.50%	100.00%	100.00%
Woodhorn	67.15%	220.98%	37.41%	109.30%	100.00%	73.36%
Mitford	140.95%	167.08%	99.17%	137.30%	100.00%	100.00%

DRAFT

Central Locality
Central Locality has 16 wards

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Overall Day Coverage	Overall Night Coverage
Aidan	88.30%	179.21%	111.00%	169.47%	100.00%	100.00%
Akenside	96.07%	116.31%	104.33%	104.55%	100.00%	100.00%
Collingwood Court	107.76%	312.78%	102.12%	321.38%	100.00%	100.00%
Castleside	118.65%	96.78%	96.84%	131.15%	100.00%	100.00%
Cuthbert	88.75%	139.27%	140.71%	118.28%	100.00%	100.00%
Elm House	99.17%	86.54%	102.08%	210.95%	92.85%	100.00%
Fellside	94.32%	299.13%	109.62%	204.62%	100.00%	100.00%
Lamesley	109.64%	148.39%	128.87%	161.82%	100.00%	100.00%
Lowry	129.69%	215.57%	75.20%	159.48%	100.00%	100.00%
Oswin	95.01%	223.51%	106.55%	108.99%	100.00%	100.00%
Willow View	97.71%	163.37%	102.68%	51.21%	100.00%	76.95%
KDU Cheviot	90.21%	194.55%	112.63%	203.17%	100.00%	100.00%
KDU Lindisfarne	90.58%	169.82%	105.43%	220.69%	100.00%	100.00%
KDU Wansbeck	78.67%	190.68%	116.11%	168.31%	100.00%	100.00%
Tweed Unit	86.93%	146.58%	110.81%	240.53%	100.00%	100.00%
Tyne Unit	67.60%	47.51%	218.34%	139.73%	57.55%	100.00%

South Locality
The South Locality has 20 wards

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Overall Day Coverage	Overall Night Coverage
Aldervale	93.07%	295.91%	119.83%	161.54%	100.00%	100.00%
Beadnell	128.32%	73.95%	104.16%	174.18%	100.00%	100.00%
Beckfield	83.27%	199.94%	115.63%	174.18%	100.00%	100.00%
Bridgewell	132.09%	171.61%	118.98%	130.88%	100.00%	100.00%
Brooke House	108.42%	97.57%	104.54%	102.69%	100.00%	100.00%
Cleadon	138.15%	104.52%	82.83%	157.43%	100.00%	100.00%
Clearbrook	99.64%	263.27%	99.58%	218.38%	100.00%	100.00%
Longview	89.37%	244.28%	105.33%	190.45%	100.00%	100.00%
Marsden	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Mowbray	94.06%	147.16%	90.20%	169.80%	100.00%	100.00%
Gibside	43.73%	209.81%	105.98%	103.95%	100.00%	100.00%
Roker	102.88%	161.58%	99.98%	173.14%	100.00%	100.00%
Rose Lodge	97.77%	312.94%	159.91%	355.28%	100.00%	100.00%
Shoredrift	71.89%	313.40%	122.43%	238.42%	100.00%	100.00%
Springrise	90.77%	345.38%	64.57%	246.56%	100.00%	100.00%
Walkergate Ward 1	80.54%	77.79%	104.48%	106.32%	79.16%	100.00%
Walkergate Ward 2	68.47%	98.71%	111.91%	171.42%	83.59%	100.00%
Walkergate Ward 3	76.63%	77.36%	105.44%	158.77%	77.00%	100.00%
Walkergate Ward 4	91.02%	76.14%	105.29%	150.08%	83.58%	100.00%
Ward 31A	105.36%	97.48%	93.77%	104.24%	100.00%	99.01%

DRAFT

Trust wide value based recruitment and retention

2. Recruitment update

Despite the challenges of Covid19 it was agreed that the plan for recruitment to the Trust should continue to be priortitised, where safe to do so using alternative assessment methods underpinned by values-based recruitment. This has been led in parallel to managing the major incident by the Central Recruitment Team and we can report all vacant Band 3 posts in the previously reported hotspot in the North locality have been filled. Across the Trust the progress to recruiting to both Qualified and Unqualified posts has continued. In addition, student nurse recruitment is looking extremely positive for September 2020 qualifiers following the proactive engagement of third year students into paid posts at Band 4 during the pandemic. From an assurance perspective even though much recruitment has been done through virtual means, fidelity to the values based recruitment process has been maintained.

3. Retention Strategy

It is important given the challenges that staff have overcome in augmenting delivery of care to patients at home and in hospital that we take time to recognise the positive response. During the Pandemic the pilot projects i.e. Stay Interviews have been put on hold but will resume as the Trust moves into restoration. The focus during the pandemic period has been on staff health and wellbeing and many self-help resources have been disseminated through the 'A Wish' initiatives. The importance of staff health and wellbeing, and safe working practices will continue to be a priority as we maintain to engage staff in preparation for a potential second surge of Covid19, increase in Mental Health referrals and prepare our plans for winter and Flu season.

4. Six monthly skill mix review & analysis of current staffing matters

This current six monthly update focusses specifically on how the workforce numbers have been maintained during a period of National unprecedented emergency as follows:

Covid-19 Pandemic & Enhancing the Workforce
During the Pandemic many of the courses within the higher education establishments were suspended. This created an exciting opportunity to reinforce our Nursing workforce through the employment of 1st, 2nd and 3rd year students whilst training was suspended.

The Senior Student Nursing Assistants, Band 4, are the students in their final six months, due to qualify in September 2020. These students have now been interviewed and allocated posts; many of the students selected the areas they had been working in as a Band 4 for their Band 5 posts upon qualifying. They are also automatically given an opportunity to continue on the Nurse Bank.

The first year students were employed on fixed term contracts, 7.5 hours, for three months and were allocated to the flexi pools. These students are also being offered the opportunity to stay on the nurse bank given their recent experience as Support Workers.

The second year students have worked as Student Nursing Assistants with fixed term contracts. These will be offered the opportunity of continuing on the nurse bank whilst completing their training.

Utilising the student nurses during the height of the pandemic allowed us to compliment the nursing workforce through an additional circa 160 staff. Although the higher education

DRAFT

institutions will be reinstating courses from September 2020, these clinical skills and experience would be retained via the nurse bank as above.

Covid-19 Staff Shielding
Although many nurses came into the protected groups who were required to shield in accordance with government guidance. A large percentage of these staff, although shielding, have continued to work from home. This has enabled service continuity as they have been able to provide patient contact via virtual means.

Covid-19 Staff Support Health & Wellbeing
Throughout the pandemic it has been critical to ensure staff have been well supported through:

- Continued access to clinical supervision and support, often through virtual means
- Clear communication and interpretation of emerging National Guidance to provide safe frameworks to underpin their practice
- Availability of Personal Protective Equipment (PPE) and changes to the environment to allow social distancing
- Wherever possible staff have continued to work from home, with an ongoing review and staff risk assessments continuing to take place
- Dissemination of information to support health and wellbeing
- Psychological wellbeing support and helpline
- Central staff absence line which has given staff immediate support and guidance
- Timely and responsive staff testing to allow staff to return to work as soon as possible

There has been no significant Skill Mix change undertaken in the last 6 months during the Covid-19 pandemic. However Locality Care Groups are reviewing all structures as vacancies and potential retirements emerge to ensure these are filled to ensure safe staffing levels but also enabling career progression and acting up opportunities with exposure into new areas of responsibility. This will feature significantly in the next report to Trust Board.

5. Conclusion

Daily risk assessment takes place according to changing clinical need and levels of acuity. Adjustments have been made as necessary to ensure that patient safety is not compromised. The report highlights the significant collaborative work undertaken during the Covid19 pandemic to ensure staffing levels remain safe and that staff continue to feel well supported in the face of this adversity.

DRAFT

Anne Moore, Group Nurse Director
July 2020

Report to Board of Directors
5th August 2020

Title of report	**Quarterly Report on Safe Working Hours: Doctors in Training – April to June 2020**
Report author(s)	**Dr Clare McLeod – Guardian of Safe Working Hours**
Executive Lead	**Dr Rajesh Nadkarni – Executive Medical Director**

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing		Work together to promote prevention, early intervention and resilience	
To achieve "no health without mental health" and "joined up" services		Sustainable mental health and disability services delivering real value	
To be a centre of excellence for mental health and disability		The Trust to be regarded as a great place to work	X

Board Sub-committee meetings where this item has been considered (specify date)		**Management Group meetings where this item has been considered (specify date)**	
Quality and Performance	29/07/2020	Executive Team	
Audit		Corporate Decisions Team (CDT)	
Mental Health Legislation		CDT – Quality	
Remuneration Committee		CDT – Business	
Resource and Business Assurance		CDT – Workforce	
Charitable Funds Committee		CDT – Climate	
CEDAR Programme Board		CDT – Risk	
Other/external (please specify)		Business Delivery Group (BDG)	

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, experience and effectiveness	X	Service user, carer and stakeholder involvement	

Board Assurance Framework/Corporate Risk Register risks this paper relates to
No

DRAFT

Quarterly Report on Safe Working Hours: Doctors in Training – April to June 2020

1. Executive summary

This is the Quarterly Board report for April to June 2020 on Safe Working Hours which focuses on Junior Doctors. The process of reporting has been built into the new junior doctor contract and aims to allow trusts to have an overview of working practices of junior doctors as well as training delivered.

The new contract is being offered to new trainees' as they take up training posts, in effect this will mean for a number of years we will have trainees employed on two different contracts. It is also of note that although we host over 160 trainee posts, we do not directly employ the majority of these trainees, also due to current recruitment challenges a number of the senior posts are vacant.

All new Psychiatry Trainees and GP Trainees rotating into a Psychiatry placement from 2nd August 2017 are on the New 2016 Terms and Conditions of Service. There are currently 126 trainees working into CNTW with 122 on the new Terms and Conditions of Service via the accredited training scheme via Health Education England. There are an additional 12 trainees employed directly by NTW working as Trust Grade Doctors or Teaching Fellows. WEF 1st October 2019 North Cumbria Trainees have been added to the Report.

High level data

Number of doctors in training (total): 138 Trainees (as at July 2020)

Number of doctors in training on 2016 TCS (total): 122 Trainees (as at July 2020)

Amount of time available in job plan for guardian to do the role: This is being remunerated through payment of 1 Additional Programmed Activity

Admin support provided to the guardian (if any): Ad Hoc by MedW Team

Amount of job-planned time for educational supervisors: 0.5 PAs per trainee

Trust Guardian of Safeworking Hours: Dr Clare McLeod

2. Risks and mitigations associated with the report

- 14 Exception Reports raised during the period April to June with TOIL being granted for all 14 due to hours and rest.
- No Agency Locums booked during the period covering vacant posts
- 194 shifts lasting between 4hrs and 12hrs were covered by internal doctors
- On 7 occasions during the period the Emergency Rotas were implemented
- 15 IR1s submitted due to insufficient handover of patient information
- No Fines received during the quarter due to minimum rest requirements between shifts not being met

DRAFT

Exception reports (with regard to working hours)

		Exception Reports Received April to June 2020				
Grade	Rota	April	May	June	Total Hours & Rest	Total Education
CT1-3	St Nicholas	1	0	0	1	0
CT1-3	Hopewood Park	1	0	0	1	0
CT1-3	RVI/CAMHS	1	0	0	1	0
CT1-3	NGH/CAV	0	0	0	0	0
CT 1-3	St George's Park	0	0	0	0	0
CT 1-3	GHD/MWM	0	0	0	0	0
CT 1-3	Cumbria	2	8	0	10	0
ST4+	North of Tyne	0	0	0	0	0
ST4+	South of Tyne	0	1	0	1	0
Total		5	9	0	14	0

Work schedule reviews

During the period April to June 2020 there have been 14 Exception Reports submitted from Trainees all for hours and rest; the outcome of which was that TOIL was granted for all 14 cases.

Emergency Rota cover is arranged when no cover can be found from either Agency or current Trainees. The Rota's are covered by 2 trainees rather than 3 and payment is made to the 2 trainees providing cover at half rate.

a) Locum bookings - Agency

Locum bookings (agency) by department				
Specialty	April	May	June	
Hopewood Park	1*	0	0	
Gateshead	0	0	0	
NGH	0	0	0	
RVI	0	0	0	
SNH	0	0	0	
CAMHS	0	0	0	
LD	0	0	0	
SGP	0	0	0	
Cumbria	0	0	0	
South of Tyne	0	0	0	
North of Tyne	0	0	0	
Total	1	0	0	

DRAFT

Locum bookings (agency) by grade				
	April	May	June	
F2	1	0	0	
CT1-3	0	0	0	
ST4+	0	0	0	
Total	1	0	0	
Locum bookings (agency) by reason				
	April	May	June	
Vacancy	1	0	0	
Sickness/other	0	0	0	
Total	1	0	0	

*Pre – April booking

b) Locum work carried out by trainees

Area	Number of shifts worked	Number of hours worked	Number of hours to cover sickness	Number of hours to cover OH Adjustments	Number of hours to cover special leave	Number of hours to cover a vacant post
SNH	30	279.5	266.75	12.75	0	0
SGP	24	238	172	66	0	0
Gateshead	56	524.5	114.5	249.25	33	127.75
Hopewood Park	12	115	57.5	8.5	0	49
RVI	6	33.5	0	33.5	0	0
NGH	9	94.25	94.25	0	0	0
Cumbria	18	145	48	0	0	97
North of Tyne	26	238.5	0	238.5	0	0
South of Tyne	12	123	4.25	4.25	114.5	0
CAMHS	0	0	0	0	0	0
Total	193	1791.3	757.25	612.75	147.5	273.75

c) Vacancies

Vacancies by month					
Area	Grade	April	May	June	
NGH/CAV	CT GP	0 0	0 0	0 0	
SNH	CT GP	1 0	1 0	1 0	
SGP	CT GP	7 0	7 0	7 0	
RVI	CT GP	1 0	1 0	1 0	
Cumbria	CT GP	2 0	2 0	2 0	
Hopewood Park	CT GP	4 1	4 1	4 1	
TOTAL	CT GP	15 1	15 1	15 1	

DRAFT

To note the majority of these training gaps have been filled by Teaching/Research Fellows & LAS appointments. There are currently 5 posts unfilled.

d) Emergency Rota Cover

Emergency Rota Cover by Trainees				
	Rota	April	May	June
Vacancy	HWP	1	1	0
Sickness/Other	NOT	0	0	0
	SOT	0	0	0
	SGP	0	0	0
	SNH	0	0	0
	RVI	0	0	0
	GHD/MWM	0	0	1
	Cumbria	0	0	0
	HWP	0	0	0
	NGH	3	0	1
Total	7	4	1	2

e) Fines

There were no fines issued during this quarter.

Issues Arising

The intensity of work over weekends and bank holiday days had increased particularly March- May on the inpatient wards due to COVID-19. To manage this increase in intensity, an additional rota was introduced to cover 10am until 4 pm on weekend days and bank holidays. Trainees volunteered to cover this rota at CAV, HWP, SGP and Cumbria and were re-numerated at locum rates. With the COVID situation easing, this is gradually being phased out across the Trust with the exception of SGP where it will continue until the end of the year due to the ongoing intensity of work.

There have been 14 exception reports submitted in the three months April to June 2020. This is a reduction from the same period in 2019 when 31 exception reports were submitted. All 14 are closed with Time off In Lieu.

There have been 15 IR1s submitted for inadequate medical handover this quarter, a slight increase from last quarter, but lower than the average number per quarter last year. This continues to be collated by Medical Education staff and the DME and reviewed through the GoSW forum.

The Trust was awarded £84,166.33 (£60,833.33 from 'old NTW' and £23,333 from North Cumbria) following the adoption of the BMAs Fatigue and Facilities charter, to be spent to improve the working lives of junior doctors. This money has largely been spent with the new equipment initially stored but now being distributed with the easing of COVID restrictions. In the Carlton clinic, Cumbria, it seems likely that there will be temporary move of on-call facility where the equipment could be delivered to and used until the permanent facility is ready. The new equipment is to improve all the on-call facilities in the Trust so that they are all of the same standard and similarly equipped. The equipment purchased includes chair-beds, televisions, lap-tops, docking stations, game-machines, gym equipment (for sites where there is not already a gym), pool

DRAFT

tables, coffee machines, fridges, kettles as well as supplies of coffee, tea and hot chocolate. In Cumbria, we have purchased a table and a set of chairs for meetings in the new mess facility. The surplus money will be used to purchase sleep pods once the other equipment is in place and the right size of sleep pod can be ascertained.

The GoSW forum on 7th May and 10th July 2020 took place via Microsoft Teams with good attendance.

The GoSW with staff from medical staffing has been visiting trainees at times to coincide with training opportunities to review issues arising, raise the profile of ERs and medical handover. Due to COVID-19 meetings over this quarter have taken place via Microsoft Teams.

Summary

An additional temporary rota is in place to support trainees and manage the increased workload over weekend and bank holiday days. This is now gradually being phased out but will continue at SGP.

The GoSW forum took place virtually via Teams on the 7th May and 10th July 2020 with trainees across Trust sites.

Work continues to increase the completeness of Exception Reporting and change the culture of under-reporting.

We will continue to encourage trainees to report episodes of Insufficient Medical Handover and promote good practice and feedback progress to clinicians throughout the Trust.

The process of allocating the funds from the BMA Fatigue and Facilities charter is almost complete, with most of the new equipment purchased and delivery now possible. The on-call room at the Carlton clinic is to move to a temporary facility until the permanent room is available.

3. Recommendation

Receive the paper for information only.

Author: Dr Clare McLeod - Guardian of Safe Working for CNTW
Executive Lead: Dr Rajesh Nadkarni – Executive Medical Director

15th July 2020

DRAFT

Report to Board of Directors
5th August 2020

Title of report	Local Clinical Excellence Awards 2019 Round Report
Report author(s)	Dr Rajesh Nadkarni – Executive Medical Director Lynne Shaw – Acting Executive Director of Workforce and OD
Executive Lead (if different from above)	Dr Rajesh Nadkarni, Executive Medical Director

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing		Work together to promote prevention, early intervention and resilience	
To achieve “no health without mental health” and “joined up” services		Sustainable mental health and disability services delivering real value	
To be a centre of excellence for mental health and disability		The Trust to be regarded as a great place to work	x

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	29/07/2020
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered (specify date)	
Executive Team	
Corporate Decisions Team (CDT)	
CDT – Quality	
CDT – Business	
CDT – Workforce	
CDT – Climate	
CDT – Risk	
Business Delivery Group (BDG)	

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

Board Assurance Framework/Corporate Risk Register risks this paper relates to
None

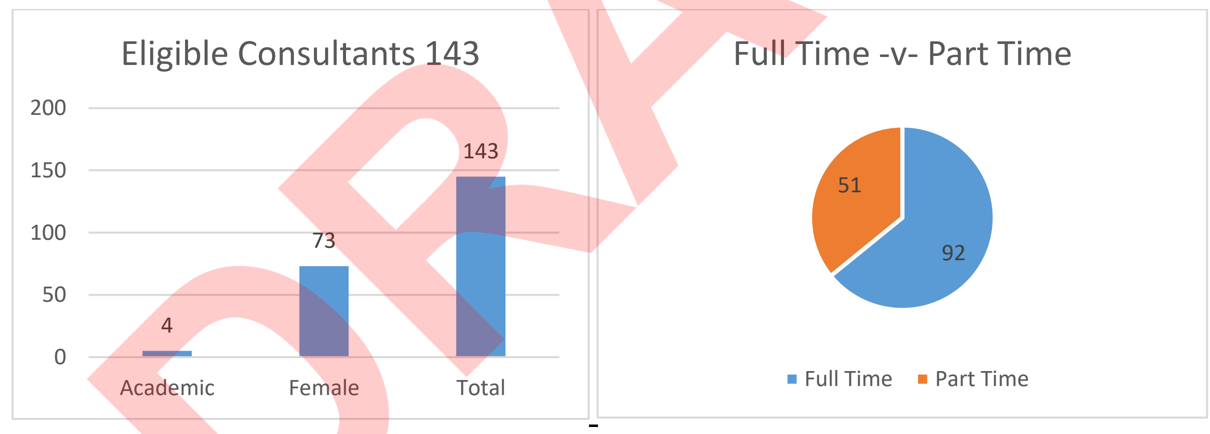
DRAFT

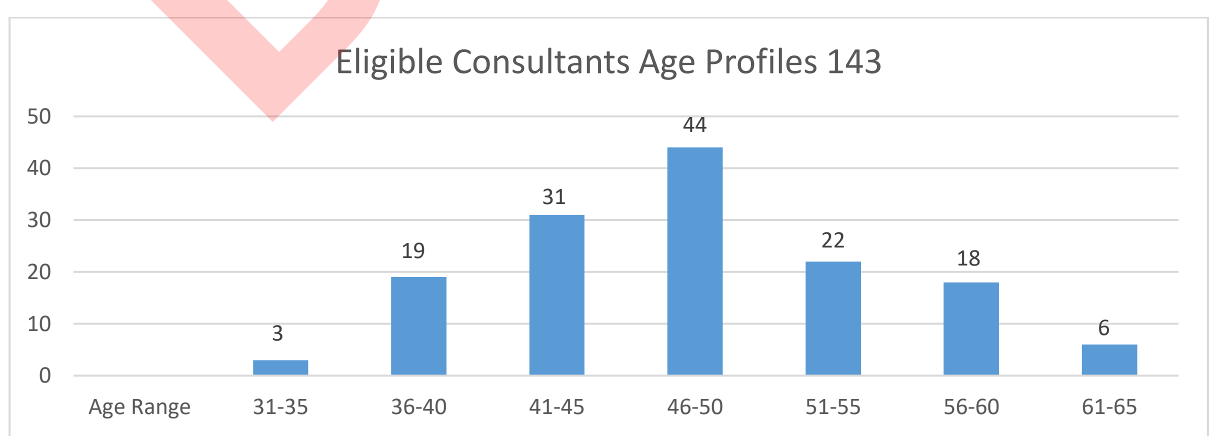
Local Clinical Excellence Awards 2019 Round Report

1. **Introduction**
New guidance was issued by NHS Employers/BMA on the Local Clinical Excellence Awards Process for the period 2018-2021 in July 2018, Part 5 of the guidance states that an Annual Report must be produced for consideration by the Board and LNC before being published on the Trust Intranet. This is the second year of awards within the new guidance.

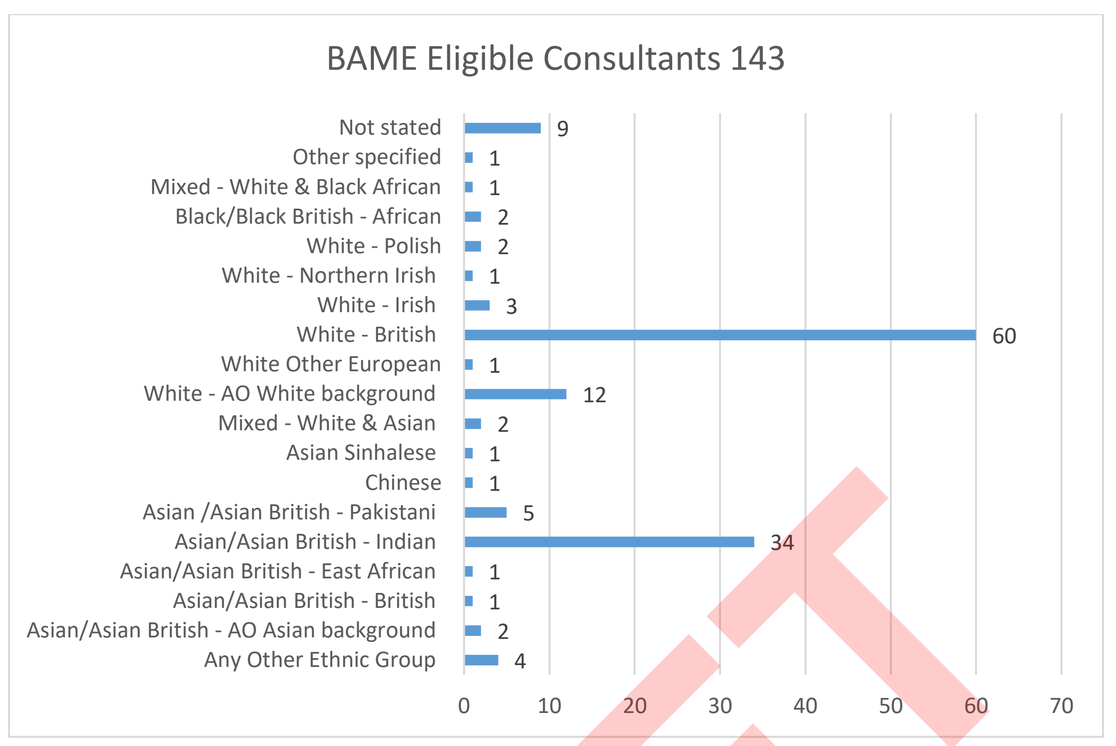
2. **Background**
Following review of the 2018 Round guidance was refreshed and a number of training sessions for Consultants were arranged to update on relevant changes within the process. Following this the Awards Round was then opened for eligible Consultants to apply from within NTW only as CPFT had held their awards prior to 1st October 2019. The Panel met on 13th February 2020 and considered 33 applications (including 1 Level 9 Renewal). This is a decrease in applications from 44 the year prior.

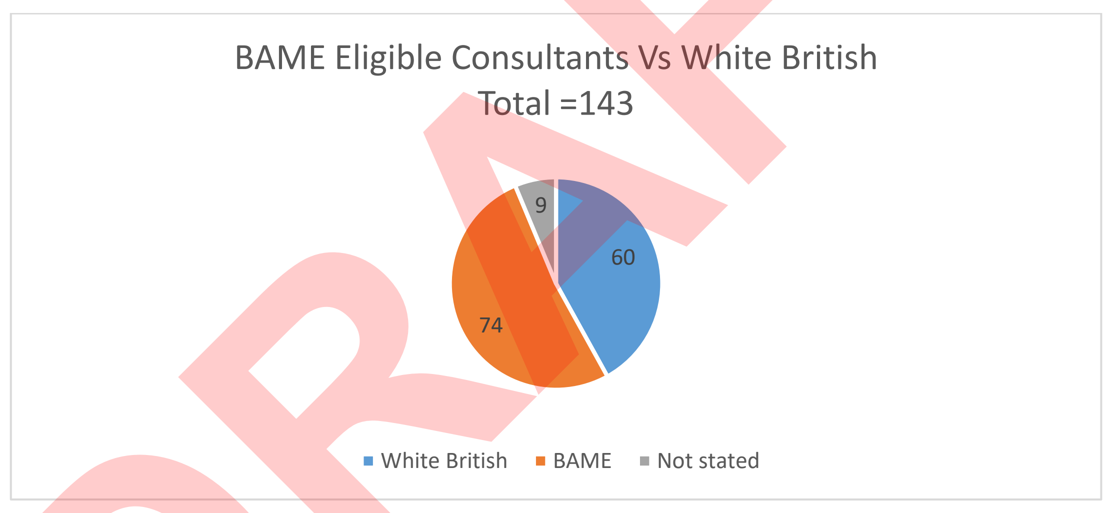
3. **Report Demographics for 2019**
a) The number of Consultants eligible for Consideration from a total workforce of 195 is 143.



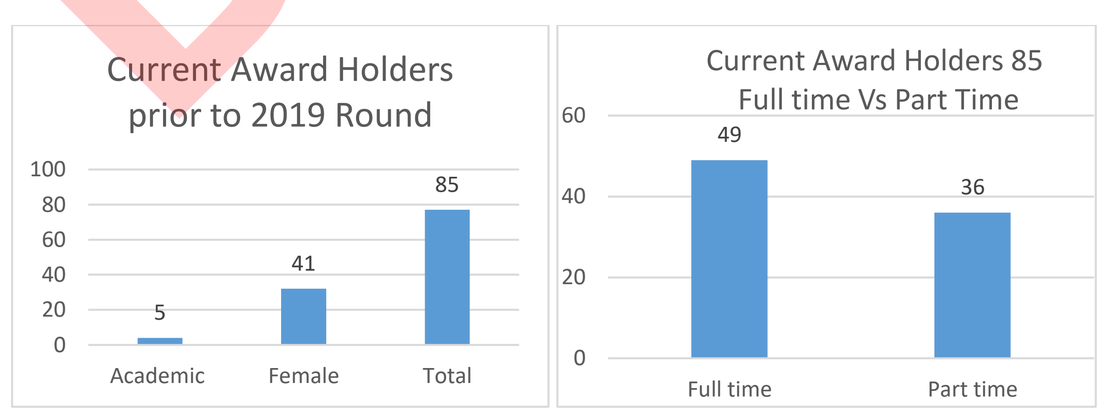


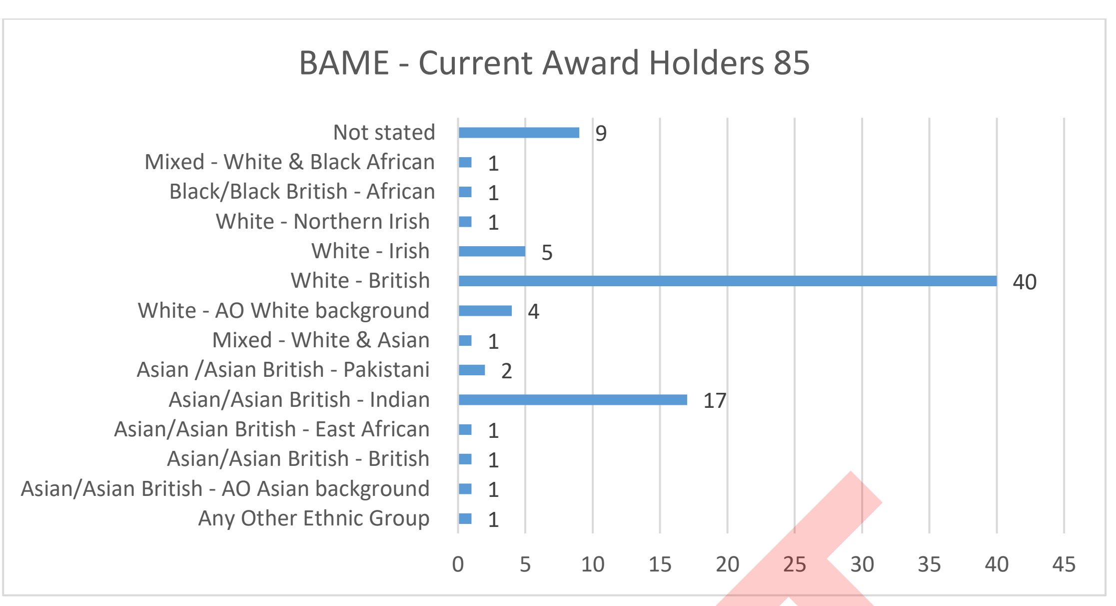
DRAFT



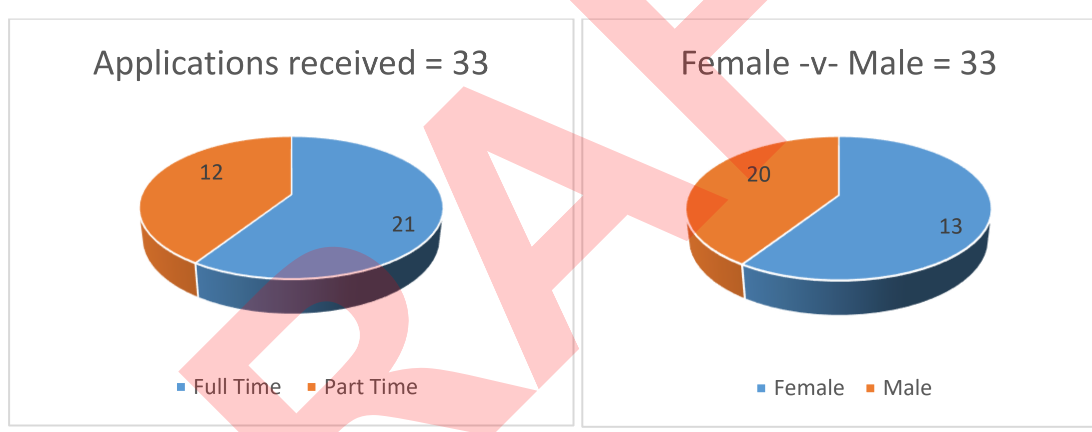


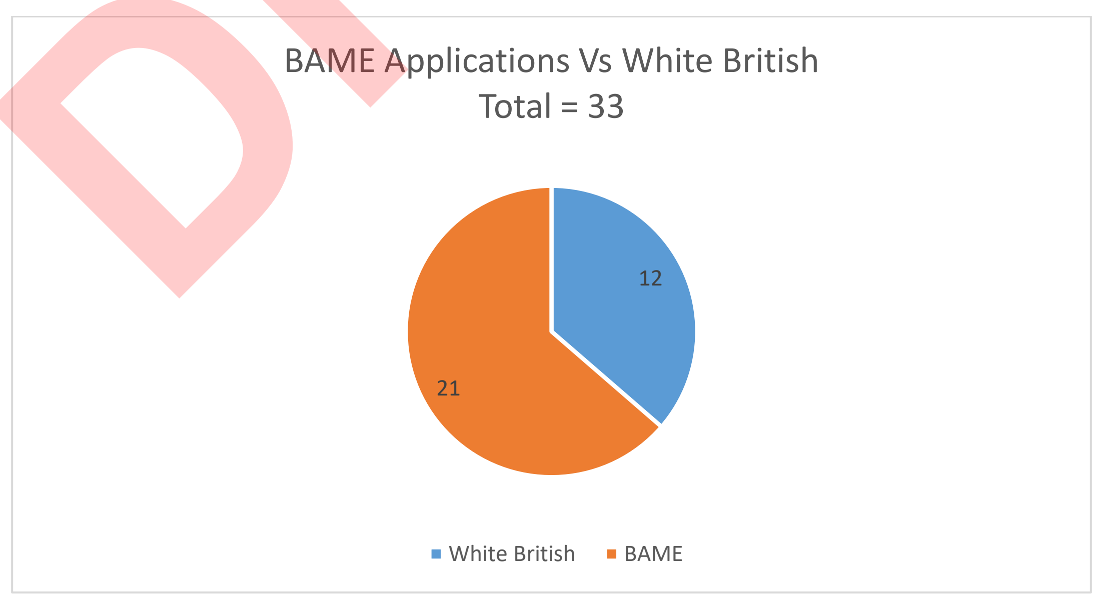
b) Current Award Holders = 85 (increase from 78 the year prior)





c) The number of applications submitted for an award in 2019

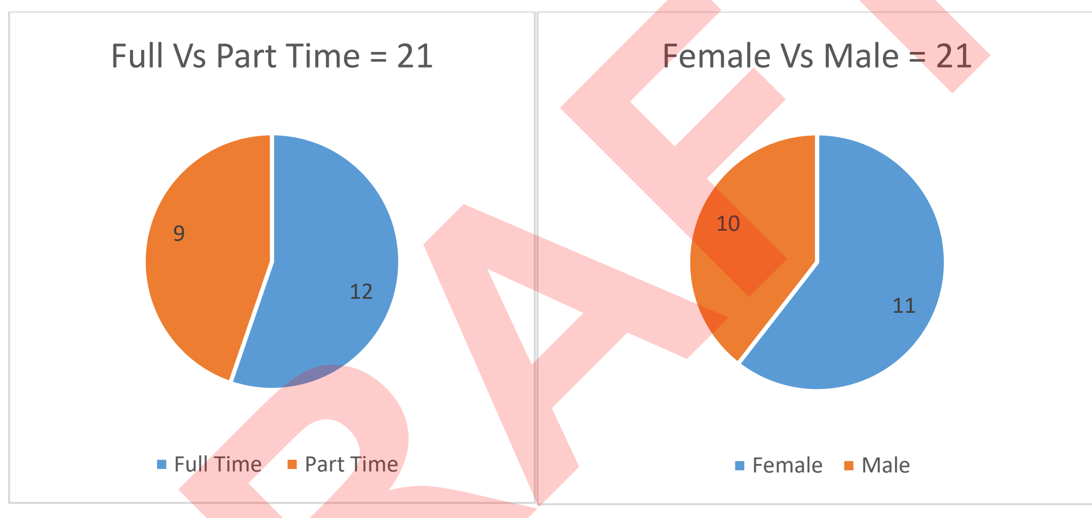


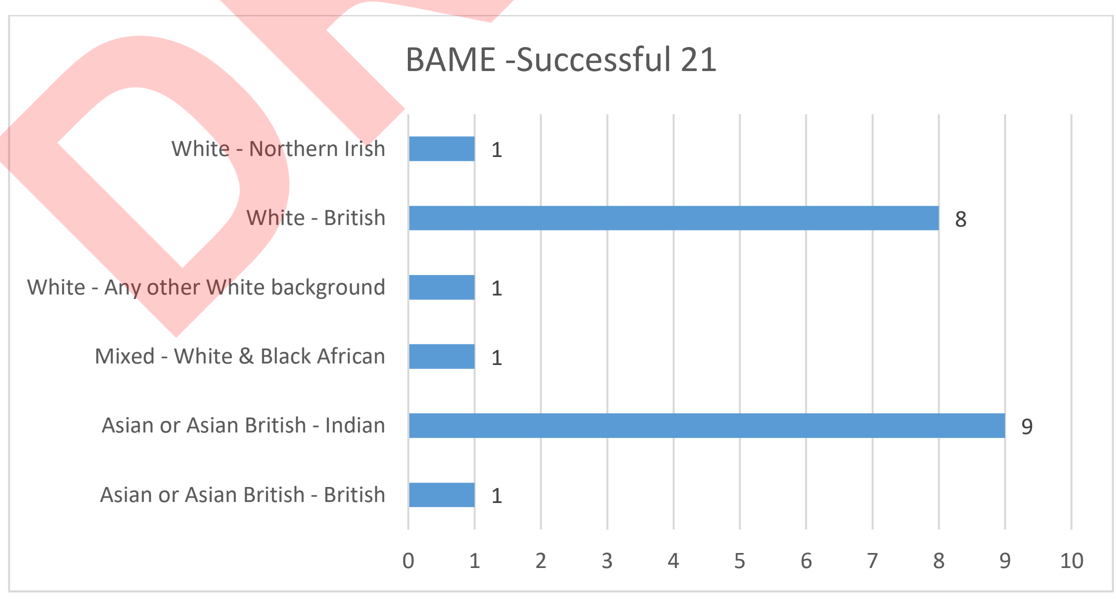


DRAFT

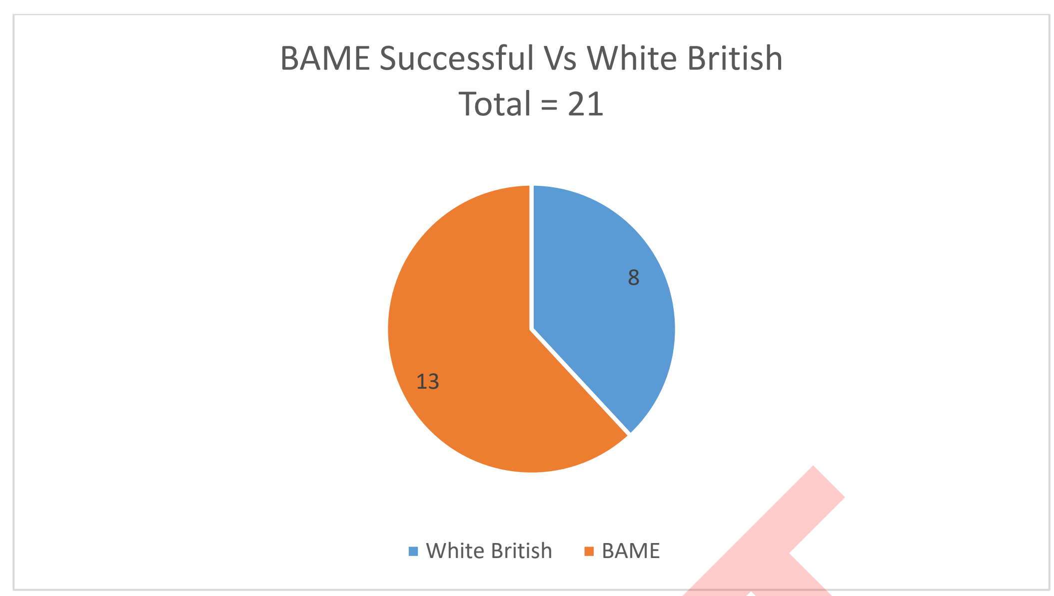
d) The Consultants recommended for an Award in 2019 Round = 21

Aditya Sharma	Neeti Sud
Alan Currie	Prathibha Rao
Andrew Cairns	Priya Khanna
Ann Ryman	Rachel Gore
Frauke Boddy	Rajesh Nair
Hermarette Van den Bergh	Richard Duggins
Jane Carlile	Stuart McKirdy
John-Paul Taylor	Sunil Nodiyal
Jonathan Richardson	Uma Geethanath
Kalayani Kodimela	Uri Torres
Kedar Kale	





DRAFT



e) There were 4 Consultants successful in the 2019 Round in receiving their first Award.

f) The Amount available for investment was:
£132,956 based on 43 points for 2019 Round

g) Formal feedback was requested by 5 out of 12 Consultants who were unsuccessful with their application. Feedback was given by Dr Rajesh Nadkarni, Executive Medical Director which resulted in no appeals being submitted. 3 Consultants requested scores only.

4. Compliance Statement

As Chair of the local Clinical Excellence Awards Committee, I can confirm that due process and the appropriate mechanisms for advising and supporting consultants were in place throughout the application, assessment and awarding of our CEA's in the year 2019. The information listed above is discussed within a management group, including LNC Representatives, and remedial actions put in place as necessary.

Print Name: Date:

Signed:

DRAFT

Report to Board of Directors
5 August 2020

Title of report	**Update on CQC Must Do Action Plans (Quarter 1)**
Report author(s)	**Vicky Grieves, CQC Compliance Officer**
Executive Lead (if different from above)	**Lisa Quinn, Executive Director of Commissioning and Quality Assurance**

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	X
To achieve "no health without mental health" and "joined up" services	X	Sustainable mental health and disability services delivering real value	X
To be a centre of excellence for mental health and disability	X	The Trust to be regarded as a great place to work	X

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	29/07/2020
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered (specify date)	
Executive Team	27/07/2020
Corporate Decisions Team (CDT)	
CDT – Quality	27/07/2020
CDT – Business	
CDT – Workforce	
CDT – Climate	
CDT – Risk	
Business Delivery Group (BDG)	

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, experience and effectiveness	X	Service user, carer and stakeholder involvement	X

Board Assurance Framework/Corporate Risk Register risks this paper relates to
SA5.2, SA1.4, SA5.1, SA5.5, SA1.2, SA4.2

DRAFT

Update on CQC Must Do Action Plans

Board of Directors

5 August 2020

1. Executive Summary

This report provides an update on all 46 areas of improvement (Must Do action plans) which were received following inspections undertaken during 2015, 2017, 2018 and 2019.

At the closed Board of Directors meeting in June the Board received 5 draft formal action plans following the focused inspection of wards for people with a learning disability or autism. These action plans have been included as appendix 1.

In April the Board of Directors received details of the 38 action plans specific to the North Cumbria Locality. These action plans have been monitored through the North Cumbria Locality Care Group and Trust governance structures and seeks approval from the Board of Directors that there is sufficient evidence and assurance to close 7 action plans listed as appendix 2.

Work continues to address each of the remaining action plans and the key pieces of work identified in the Quarter 1 update (appendix 3) will help to mitigate against the risks which have been raised. It is the first time that the Board has received this style of report for the must do action plans, they have been grouped by theme and highlights to the Board work done and work proposed as well as impact. Comments from the Board of Directors in terms of its presentation and content would be welcomed.

Quarterly updates on all action plans will continue to be reported to the Executive Directors, Corporate Decisions Team – Quality Sub Group, Quality and Performance Committee and Board of Directors.

2. Risks and mitigations associated with the report

The Care Quality Commission has raised all of 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 are 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

DRAFT

Board to have oversight of progress and be assured that these concerns are being addressed.

The Board are asked to:

- Note the final submission of the 5 action plans related to the focused inspection – appendix 1.
- Approve the closure of 7 action plans listed in appendix 2 recognising the Trust will continue to monitor the impact of previous actions through appendix 3.
- Note the Quarter 1 updates on all 46 CQC must do action plans listed within appendix 3.
- Provide any comments on format and content of appendix 3.

Author:
Vicky Grieves, CQC Compliance Officer

Executive Lead:
Lisa Quinn, Executive Director of Commissioning and Quality Assurance

21 July 2020

Report on actions you plan to take to meet Health and Social Care Act 2008, its associated regulations, or any other relevant legislation.

Please see the covering letter for the date by when you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RX4
Our reference	INS2-8477811271
Location name	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

DRAFT

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 13 Safeguarding service users from abuse and improper treatment** **How the regulation was not being met:** The trust must ensure that the patients in long term segregation and seclusion have the appropriate safeguards in place in accordance with the Mental Health Act Code of Practice and these are documented clearly in patients' records. Regulation 13.1
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	

Core Service Actions
All staff to adhere to the CNTW (C) 10 Seclusion Policy and SP-PGN-02 Long Term Segregation. Within the Policy and the Practice Guidance Note the Trust outlines the safeguards that must be adhered to in accordance with the Mental Health Act Code of Practice and these are clearly documented in patient's records.

Any area identified in the weekly trust audit that does not meet the standards will be discussed with individual staff member. The Clinical Lead Nurse will discuss specific actions required to improve the long term segregation and seclusion standards with the Named Nurse. The Clinical Lead Nurse and Clinical Team Leads will offer individual 1-1 coaching with the Named Nurse to improve competence in line with the Trust standards.

The Ward Manager will be responsible to ensure that the areas that require improvement are communicated to the qualified staff on the ward and the wider team.

Trust-wide Actions
Independent review of CNTW practice.
Review of policy to take into account independent review recommendations.
The weekly audit for Long Term Segregation now incorporates additional flag to ensure the

review of independent and 3 monthly external reviews, as stipulated by Trust Policy and MHA Code of Practice Electronic recording is now in use within CNTW for: Long Term Segregation (initiation / review / end of LTS) Seclusion (initiation / review / end of seclusion) Electronic recording gives the opportunity to identify at an earlier stage any breaches and to initiate remedial actions, through dashboard monitoring. Electronic segregation allows for daily reviews on an individual client basis. The Trust will review the pilot of the seclusion room wall / floor covering to understand if this is rolled out across all areas. Oxy Health pilot in CNTW to enable the monitoring of physical observations (external to the seclusion room through digital means) without the need to disturb patients in a distressed state.	
Who is responsible for the action?	Vida Morris, Group Nurse Director – North Locality Group Karen Worton, Group Nurse Director – Central Locality Group Anthony Deery, Group Nurse Director – South Locality Group Jose Robe, Group Nurse Director – North Cumbria Locality Group
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Core Service Actions A weekly CQC action plan review meeting will take place on Rose Lodge and Mitford. These meetings will review the position of actions outlined and progress on improvements. They will also be used to test compliance that the actions are improving the standards. Use existing established Trust audits to review compliance against standards and also to strengthen local governance by discussing the weekly audits at the individual service weekly meetings. The feedback mechanism facilitated by the Ward Manager (or delegated other senior nurse) to support improvement; will be facilitated during clinical supervision and leadership team meetings. Minutes can be provided from the team meetings to evidence feedback from audit to support practice improvement. In Rose Lodge the Long-Term Segregation and Seclusion focus group will be arranged monthly to facilitate discussion about standards, areas to improve from audit, reflection on how we can improve as a team, invite colleagues from other Learning Disability services within the Trust to share practice. Mitford will use the established monthly core governance Positive & Safe meeting to review the above. Clinical Managers at Rose Lodge and Mitford will have an overview of quality and adherence to standards as outlined in CNTW (C) 10 Seclusion Policy and SP-PGN-02 Long Term	

DRAFT

Segregation.

Clinical Managers should escalate by exception through CBU governance meetings.

Trust-wide Actions
CBU governance meetings will have a specific agenda items relating to standards for LTS and Seclusion including review of clinical dashboards.

The Trust keeps a record of all environments measured against an agreed set of Trust standards. The safety team, Seclusion Standards Group chair and NTW Solutions will re-audit of all environments.

Who is responsible?	Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

What resources (if any) are needed to implement the change(s) and are these resources available?

All identified environmental improvements will need supported via Trust finances.

Date actions will be completed:	30th September 2020

DRAFT

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 **Diagnostic and screening procedures** **Treatment of disease, disorder or injury**	**Regulation 13** **Safeguarding service users from abuse and improper treatment** **How the regulation was not being met:** The trust must ensure that the environment at Edenwood is improved including the provision of specialist furniture which meet the needs of the patient using this service. Regulation 13.1

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Review of the accommodation in relation to remedial works required related to damage of internal space sustained to floor and walls in bedroom, hall and lounge areas.

Remedial works to make good floor and wall areas in the above spaces.

Review of external space in relation to remedial works required to ground and fencing improve the environment.

Remedial works to make ground and fencing good.

Review of furniture required including POD, seating and bed in line with ongoing MDT assessment.

Staff will be trained in the use of the POD by a PMVA instructor.

Who is responsible for the action?	David Muir, Group Director – North Cumbria Locality Group

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Progress against actions identified will be monitored on a fortnightly basis via the MDT sit rep meeting. Any issues identified will be escalated to Group Director level to ensure swift remedy.

Once actions are completed the same meeting will also serve to review the ongoing quality of the internal and external environments so that any ongoing repairs required can be identified and attended to quickly.

Once obtained furniture etc will be introduced as part of wider MDT assessment and care planning.

DRAFT

Use of the POD will be recorded via MDT meetings and also through IR1 incident report system, and our 'Talk First' approach.	
Who is responsible?	Gary O'Hare, Executive Director of Nursing and Chief Operating Officer
What resources (if any) are needed to implement the change(s) and are these resources available?	
Estates – Support and materials. Work has been completed. Furniture – Ordered and obtained. MDT discussions on going about different bed. Training for POD – Booked. Needed clearance in relation to COVID 19 as the training if face to face and has infection control implications. Was booked previously and was suspended due to COVID 19.	
Date actions will be completed:	30th September 2020

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 **Diagnostic and screening procedures** **Treatment of disease, disorder or injury**	**Regulation 17** **Good governance** **How the regulation was not being met:** The trust must review and reduce the use of mechanical restraint within their learning disability services and ensure that its use is in line with best practice guidance and the appropriate authorisation and recording is in place. Regulation 17.2 (a)

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve
Core Service Actions The Ward Managers will be responsible to ensure all staff on Rose Lodge and Mitford adhere to the Trust's Positive and Safe approach. This expects the staff to use least restrictive interventions when caring for patients who exhibit behaviours that are challenging to manage. This is underpinned in the Trust's Prevention and Management of Violence and Aggression policy CNTW (C) 16 (PMVA) and Practice Guidance note PMVA-PGN-01 which explicitly set out the responsibility and accountability expectations for staff and the primary safeguards they must apply when considering the use of Mechanical Restraint Equipment (MRE). Staff at Rose Lodge and Mitford have received Positive and Safe training and we are continuing to increase the number of staff trained in the use of MRE. The completion of this training will enhance the safe care of patients and further support our staff's knowledge and responsibilities. Duty rota's are managed to support a minimum safe number of MRE staff trained on duty per shift. **Trust-wide Actions** The Trust has undertaken a review of the use of MRE. The current MRE PGN will be reviewed to reflect the findings from the report and recent national documents related to restraint reduction.

Who is responsible for the action?	Vida Morris, Group Nurse Director – North Locality Group Karen Worton, Group Nurse Director – Central Locality Group Anthony Deery, Group Nurse Director – South Locality

DRAFT

	Group Jose Robe, Group Nurse Director – North Cumbria Locality Group
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Core Service Actions The CQC action plans will be reviewed weekly at Rose Lodge and Mitford. These meeting will review progress; test the impact the actions are having and identify any additional actions to support continuous improvement. Following each episode of MRE use the Clinical Manager will complete a review of the process to ensure the safeguards have been adhered to. Clinical Manager will work with CNTW Academy to ensure the training is achieved and trajectories monitored. CBU to be made aware of any exceptions. **Trust-wide Actions** All locality services have been directed to review the use of restrictive interventions annually within their services and produce a rationale for its use including an indication of compliance with relevant policy. This will be incorporated within the Positive and Safe care annual report. All wards using MRE will meet the Trust training standard. The Trust wide Positive and Safe Group will keep under review the Positive and Safe Dashboards and review all episodes of the use of MRE. Locality Groups will include a MRE section in their reports to the Trust's Quality and Performance Committee.	
Who is responsible?	Gary O'Hare, Executive Director of Nursing and Chief Operating Officer
What resources (if any) are needed to implement the change(s) and are these resources available?	
MRE Training - the training is physically interactive and therefore has been suspended due to the COVID19 pandemic. As part of the next phase the Trust is looking at how training of this nature can be re-established using PPE. The Pilot is due to commence in late June and we expect to have results by September at which point the Training trajectories will be revised.	
Date actions will be completed:	30th September 2020

DRAFT

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 **Diagnostic and screening procedures** **Treatment of disease, disorder or injury**	**Regulation 12** **Safe care and treatment** **How the regulation was not being met:** The trust must ensure that risk assessments are regularly updated to reflect current risk and needs of patients Regulation 12.2 (a)

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Core Service Actions
The clinical leadership teams on Rose Lodge and Mitford will ensure that all staff undertaking risk assessments comply with CNTW (C) 20 Care Programme Approach Policy. This policy outlines the responsibility of professionals completing risk assessment and the expected standards.

Following the CQC inspection on Rose lodge a review of all risk assessments has taken place. This was completed by the Clinical Lead Nurse to ensure that the risk assessments were up to date, reflected current need and triangulated with other aspects of the patients assessments/care plans.

The Health Care Record review which is completed monthly will be used to ensure that risk assessments explicitly reflects the current risk and need of the patients. The clinical Lead that completes the audit will be tasked to ensure that the quality of the risk assessment meets the patient's current need and risk.

Any areas of the risk assessment that does not reflect the current risk, need and presentation of the patient will be discussed with the Named Nurse by the Clinical Team Lead in case load/clinical supervision. The Clinical Lead will identify specific areas in relation to risk assessments for improvement, they will use 1-1 coaching to support compliance with standards.

Trust-wide Actions
The clinical leadership teams will ensure that all staff undertaking risk assessments comply with CNTW (C) 20 Care Programme Approach Policy. This policy outlines the responsibility of professionals completing risk assessment and the expected standards.

Who is responsible for the action?	Dr Kedar Kale, Group Medical Director – North Locality Group Dr Jurgita Soriene, Group Medical Director – Central Locality Group

DRAFT

	Dr Patrick Keown, Group Medical Director – South Locality Group Dr Stuart Beatson, Group Medical Director – North Cumbria Locality Group

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Core Service Actions
Monthly audit tool in place to also support with ensuring current and historic risk factors are differentiated.
Risk assessments are reviewed as an integral part of the monthly health care records audit.
Health care records audit to be reported by exception through CBU QSO meeting on monthly basis.

Trust-wide Actions
Compliance will be monitored within the CBU Quality structures and reported through Locality governance processes.

Within these structures there would be an expectation for compliance to any national or local quality standards for example AIMS accreditation, My Shared Pathway and Recovery Star.
The expectation would be that, at a local level, issues would be addressed immediately and any good practice and lessons learned through the above structure.

The Trust expectation is that Risk Assessment forms part of all MDT case discussions and clinical supervision meetings which will enable issues to be raised around compliance with reviews of risk and the sharing of information pertaining to changes in risk presentation. Adherence is achieved through CPA Policy as reviews are recorded within the patients Rio documents.

The Trust undertakes a regular Quarterly Monitoring Tool (QMT) audit where nominated senior clinicians review a random set of health records where compliance with risk recording and its relationship to identified need is compared. The findings of this audit are shared Trust wide and specific to clinical teams. Issues in relation to poor compliance are addressed via an action plan and reported on via the Group Quality Standards Meetings.

Examples of good practice around risk assessment and management are also promoted through the Trust wide Learning and Improvement Group and via the Strategic Clinical Reference Group for Autism & Learning Disability.

Staff compliance with clinical risk training and care coordination are monitored at CBU level and via the Group Quality Standards Meetings.

Work has commenced in North Cumbria to ensure that the Trust has a consistent use of the FACE risk assessment tool across all 4 Locality Groups.

Who is responsible?	Dr Rajesh Nadkarni, Executive Medical Director

What resources (if any) are needed to implement the change(s) and are these resources available?

DRAFT

Trust-wide Development capacity will need to be identified from the Trust Informatics team to migrate North Cumbria across from GRIST to the FACE risk tool. Training capacity will also be required to train staff in its use.	
Date actions will be completed:	30th September 2020

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 **Diagnostic and screening procedures** **Treatment of disease, disorder or injury**	**Regulation 9** **Person-centred care** **How the regulation was not being met:** The trust must ensure that care plans contain the relevant supporting information, reflective of current need, regularly updated and that staff are aware of these and follow plans accordingly Regulation 9.3 (b)

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Core Service Actions
Existing care plans are being reviewed to ensure they have been developed in a co-produced way with the service user, reflect multi-disciplinary team input and support the principles of Person-Centred Care.

Where this care planning standard has not been met this will be discussed with the Named Nurse or author of the care plan. The Clinical Lead will discuss specific actions required to improve the care plan and where necessary will offer individual coaching with the Named Nurse and/or author to both improve the quality of the plan and outcomes for the service user.

In addition, the ward manager will ensure the Trust internal review document is completed by the named nurse and all actions updated as required and as a minimum on a monthly basis and at CPA meetings in collaboration with the service user and carer. Care plans will reflect the changing need of the individual and will be reviewed in line with any change or request and linked to risk, formulation and other interventions to meet holistic need.

Copies of a service user's care plan will continue to be available in patient's bedrooms in their wellbeing folder where they are accessible to the patient, family/carer, staff, and available at the point of care delivery so reference to the detail can be easily accessed.

The Ward Manger will ensure that all qualified staff have received Person Centred Care Plan Training.

The Clinical Leadership Teams at Rose Lodge and Mitford will ensure Care Planning is a standing agenda item at their weekly Team meetings.

Trust-wide Actions
The CNTW C20 CPA Policy outlines the requirements for care planning and promotes continuity, treatment and support through the patient's pathway and outline the review

DRAFT

process.

This will be achieved by ensuring training, staff awareness in relation to the above policy, process and collaborative working between the MDT, patient and / or carer to achieve needs led patient centred care planning. Care plans will be written in a format that is accessible and meets the individuals need, adhering to the principles of coproduction and collaboration, taking into account the individual's ability and capacity to engage in the process and ensure their needs and preferences are addressed and met.

Care plans will follow the principles of SMART to ensure that a consistent standard is achieved and maintained. Care will be evidence based and subject to review in a timely manner.

Ward managers will ensure the Trust internal review document is completed by the named nurse and all actions updated as required and as a minimum on a monthly basis and at CPA meetings in collaboration with the patient and carer. Care plans will reflect the changing need of the individual and will be reviewed in line with any change or request and linked to risk, formulation and other interventions to meet holistic need.

Compliance will be monitored within the CBU Quality structures and reported through Trusts Quality Committee.

Within these structures there would be an expectation for compliance to any national or local quality standards for example AIMS accreditation, My Shared Pathway and Recovery Star.

Who is responsible for the action?	Vida Morris, Group Nurse Director – North Locality Group Karen Worton, Group Nurse Director – Central Locality Group Anthony Deery, Group Nurse Director – South Locality Group Jose Robe, Group Nurse Director – North Cumbria Locality Group

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Core Service Actions
The Clinical Business Unit will have overview of progress via the Person-Centred Care Planning results.
The CQC action plan will be reviewed on a weekly basis at Rose Lodge and Mitford. This will include a review our progress against the actions and identify any additional considerations to assist our continuous improvement.
The review of care plans using the 'Person Centred Care Planning Audit' tool will be established, the monthly and external three-monthly audit, to include feedback from service users, families and carers. The feedback cycle using coaching with the named nurse will produce an increase in engagement and improve confidence and competence in care planning.

Trust-wide Actions
Compliance will be monitored within the CBU Quality structures and reported through Locality governance processes.
Within these structures there would be an expectation for compliance to any national or local

DRAFT

quality standards for example AIMS accreditation, My Shared Pathway and Recovery Star. The expectation would be that, at a local level, issues would be addressed immediately, and any good practice and lessons learned through the above structure. Care plans form part of our Clinical Supervision Policy and will be reviewed by the Supervisor to ensure quality standards are met, coproduction is evident and reviews have taken place in a timely manner. Adherence is achieved through CPA Policy as reviews are recorded within the patients RiO documents.	
Who is responsible?	Gary O'Hare, Executive Director of Nursing and Chief Operating Officer
What resources (if any) are needed to implement the change(s) and are these resources available?	
Date actions will be completed:	30th September 2020

How will people who use the service(s) be affected by you not meeting this regulation until this date?
A care plan audit was completed following CQC inspection, to provide assurance that relevant care plans are in place to support current need. The implementation of the described actions will improve the quality and show a robust system to evidence, review and embed quality standards going forward.

DRAFT

1.1 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.

Regulated activity(ies)	Regulation
Assessment or medical treatment for persons detained **under the Mental Health Act 1983** **Treatment of disease, disorder or injury**	**Regulation 17 HSCA (RA) Regulations 2014 Good governance** **How the regulation was not being met:** 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.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
Following the CQC inspection there were identified weakness in the approach to governance within the CPFT model. Following the transfer of services, the North Cumbria Locality adopts and implements fully the governance structures within CNTW.	
Who is responsible for the action?	David Muir, Group Director
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Root and branch restructure of the entire care group. Embedded new governance structures, collective leadership, terms of references, reporting and job roles.	
Who is responsible?	Gary O'Hare, Executive Director of Nursing and Chief Operating Officer
What resources (if any) are needed to implement the change(s) and are these resources available?	
Date actions will be completed:	30th September 2020

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Avoidable harm

DRAFT

Comments including good practice:
The locality has completed a root and branch restructure and transition into CNTW. It is clearer to understand where concerns are escalated, addressed and then communicated back to the team within the governance and management structure. The locality has provided evidence of adopting CNTW governance structures, evidence of actions, reports completed and sharing of information and cycle of meetings. The CNTW board reports provides evidence of communication processes from Ward to Board. There are standardised agendas in use in team meetings at Group level and these are replicated at CBU level. The locality has undergone a rigorous process of values and behaviour management development over a 6-month period, culminating in the delivery of team based 'collective leadership' presentations. An outcome of which has been collective team working to address priority areas that then feeds into personal development plans across each of the CBUs. Evidenced has been provided of interactive workshops aimed at developing individual CBU level plans that now detail clear mission statements, visions, priorities and baseline quality metrics that are owned by each CBU. Crosscutting themes are human rights, patient and carer involvement and quality improvement, there is evidence of displayed in staff accessible areas.
Evidence Submitted
North Cumbria Evidence Storeroom 1.05 North Cumbria Organisational Diagram. 1.40 Community and Access CBU Governance Diagram. 1.46 Inpatient Quality Agenda. 1.65 BDG Papers 2020-01-24 FINAL 1.66 2020-01-28 Resource committee papers 1.67 20200211 North Cumbria Ops Agenda. 1.69 Business Plan - Access and Community CBU Plan. 1.70 Business Plan - Inpatient CBU Plan. 1.71 CDT-B meeting 20.01.2020 1.72 Monthly Commissioning Quality Assurance Report - Month 9. 1.73 Service User and Carer Experience Report Q3 201920. 1.74 CQC Service User Survey November 2019. 1.75 CDT-Q Outcomes Report Q3 201920. 1.76 Quality Priorities Update Q3 201920- Trustwide. 1.77 CNTW - Safer Care Report - January 2020. 1.78 Collective Leadership Programme Session 5 January 2020. 1.79 Comms PoY review engagement sessions. 1.80 North Cumbria Locality TOR for Risk Management sub-group. 1.81 Safer Care Q3 Report (Jan 2020).

DRAFT

1.82 Safer Care Report - Month 9 December 2019. 1.83 Safer Staffing Report Inc Six Month Skill Mix - November 2019 data (January meeting). 1.84 TOR Operational Management Group. 1.85 Values and Behaviours Workshop PowerPoint January 2020. 1.93 Quality Metrics Weekly Summary week 6 07 05 2020 V2.
Recommendation:
Complete. Evidence that practice has been mainstreamed within the North Cumbria Locality.

1.2 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.

Regulated activity(ies)	Regulation
Assessment or medical treatment for persons detained **under the Mental Health Act 1983** **Treatment of disease, disorder or injury**	**Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** **How the regulation was not being met:** 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

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
Following the CQC inspection there were identified weakness in the approach to risk escalation, risk management and assurance within CPFT. Following the transfer of services, the North Cumbria Locality adopts and implements fully the Risk Management Policy. Evidence that risk register is effectively reviewed and managed in line with the Trust Policy and that there is evidence of a clear link between the register and the Board Assurance Framework.	
Who is responsible for the action?	Lisa Quinn, Executive Director of Commissioning and Quality Assurance
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Risk Master class attendance Individual Team leader training Risk Log updated and reviewed in the locality, agenda Risks managed as per policy Mock Inspection Staff survey feedback New risk log for North Cumbria Job Plans WebRisk rollout	
Who is responsible?	Jose Robe, Group Nurse Director
What resources (if any) are needed to implement the change(s) and are these resources available?	
Date actions will be completed:	30th September 2020

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Avoidable harm

DRAFT

Comments including good practice:
The locality management has completed a Risk Management Masterclass introduction. Following the transfer of services, the residual risks have been reviewed and added to the Webrisk system as appropriate. The locality has implemented a monthly Risk Management subgroup of the Locality Operations Meeting to provide oversight of locality risks. There is evidence of ward/team reporting to board via the Resources Committee.
Evidence Submitted
North Cumbria Evidence Storeroom 1.34 Risk Management Masterclass. 1.66 2020-01-28 Resource committee papers 1.80 North Cumbria Locality TOR for Risk Management sub-group.
Recommendation:
Complete. Evidence that practice has been mainstreamed within the North Cumbria Locality.

2.4 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.

Regulated activity(ies)	Regulation
Assessment or medical treatment for persons detained **under the Mental Health Act 1983** **Treatment of disease, disorder or injury**	**Regulation 17 HSCA (RA) Regulations 2014 Good Governance** **How the regulation was not being met:** 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.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
New North Cumbria bed management systems implemented from Monday 1st July 2019. 7 days per week from 7.30am – 8.30pm. Receive requests for all inpatient admissions Triage these requests, challenge the requests where necessary and appropriate and potentially agree a plan as an alternative to inpatient admission e.g. home based treatment or direct admission to either Lowther Street in West Cumbria or the Crisis Beds in South Cumbria ran by Northern Healthcare. Admit to a Cumbria inpatient bed if required, admit to an Out of Area bed if no beds are available within Cumbria, where Out of Area admissions are made, ensure frequent contact with the placement to ensure repatriation at the earliest and safest opportunity. Discharge Facilitator posts are being recruited to at present and will form an essential part of the overall patient flow.	
Who is responsible for the action?	Lisa Quinn, Executive Director of Commissioning and Quality Assurance
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Review of the acute pathway has commenced across CNTW Monitoring of core trust reporting metric	
Who is responsible?	Jose Robe, Group Nurse Director
What resources (if any) are needed to implement the change(s) and are these resources available?	
None	
Date actions will be completed:	30th September 2020

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Bed management in place, OOA reduced. If this increases again risk of patients being admitted away from their homes and families.

DRAFT

Comments including good practice:
Positive feedback from North Cumbria CCG regarding the reduction in out of area placements as a result of the introduction of a new bed management function and policy. Oversight of out of area activity is reported to BDG. The locality has adopted the Bed Management Policy and engage in national learning opportunities.
Evidence Submitted
North Cumbria Evidence Storeroom 1.65 BDG Papers 2020-01-24 10-57-47 FINAL 1.88 Bed Management Policy 1.39 FW IR000262 Inpatient Care Daily Ward Statistics 1.91 OAPs slides national webinar 1.76 Quality Priorities Update Q3 201920- Trust-wide

Recommendation:
Complete. Evidence that practice has been mainstreamed within the North Cumbria Locality.

DRAFT

4.4 The provider must ensure that all patients have regular access to therapeutic activities to meet their needs and preferences.

<table>
<tr><th>Regulated activity(ies)</th><th colspan="2">Regulation</th></tr>
<tr><td rowspan="3">Assessment or medical treatment for persons detained

under the Mental Health Act 1983

Treatment of disease, disorder or injury</td><td colspan="2">Regulation 9 HSCA (RA) Regulations 2014 Person-centred Care</td></tr>
<tr><td colspan="2">How the regulation was not being met:</td></tr>
<tr><td colspan="2">The provider must ensure that all patients have regular access to therapeutic activities to meet their needs and preferences.</td></tr>
<tr><th colspan="3">Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve</th></tr>
<tr><td colspan="3">The North Cumbria Locality will ensure there are a range of meaningful day activities in place for service users within inpatient settings.</td></tr>
<tr><td colspan="2">Who is responsible for the action?</td><td>Jose Robe, Group Nurse Director</td></tr>
<tr><th colspan="3">How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?</th></tr>
<tr><td colspan="3">Monitored through the ward MDT.</td></tr>
<tr><td colspan="2">Who is responsible?</td><td>Jose Robe, Group Nurse Director</td></tr>
<tr><th colspan="3">What resources (if any) are needed to implement the change(s) and are these resources available?</th></tr>
<tr><td colspan="3"></td></tr>
<tr><th colspan="2">Date actions will be completed:</th><td>30th September 2020</td></tr>
</table>

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Plans in place and monitored, risk to patients care if not implemented.

DRAFT

Comments including good practice:

The locality has provided multiple sources of evidence regarding activities across all inpatient wards. There is evidence of events and timetables that are appropriate for the ward type/environment. There is evidence of patient facing information and displays of the events. There is evidence of continuous improvements at a team level via action planning.

Evidence Submitted

North Cumbria Evidence Storeroom

1.04 OT while in Seclusion.
1.06 Photos of VE Day, Patient Buffets, Joe Wicks exercises, Star Awards
1.07 Photos of Arts and Crafts, Gardening and activities
1.10 Rowanwood Activity Planner - COVID 19
1.10 Rowanwood Activity Planner.
1.16 Talk 1st Hadrian action plan April 2020.
1.16 Talk 1st Oakwood action plan May 2020.
1.16 Talk 1st Rowanwood action plan April 2020.
1.16 Talk 1st Ruskin action plan May 2020.
1.16 Talk 1st Yewdale action plan April 2020.

1.22
A3 Chill out room update
Activity Coordinator Catch up May 2020
Activity Pack March 2020
Activity timetable Rowanwood
Edenwood action plan April 2020
Hadrian action plan April 2020
Mutual Help Meeting 25.03.20
Newsletter Yewdale
Oakwood action plan May 2020
REIS CNTW Presentation
Remotivation process
Rowanwood action plan April 2020
Ruskin action plan May 2020
Talk 1st catch up meeting 01.05.20
Yewdale action plan April 2020

Recommendation:

Complete. Evidence that practice has been mainstreamed within the North Cumbria Locality.

DRAFT

5.2 The trust must ensure there is always a dedicated member of staff to observe patients in the health-based places of safety.

Regulated activity(ies)	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 **Treatment of disease, disorder or injury**	**Regulation 18 HSCA (RA) Regulations 2014 Staffing** **How the regulation was not being met:** The trust must ensure there is always a dedicated member of staff to observe patients in the health-based places of safety.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
A standard operating procedure will be developed for Carlton Clinic and Yewdale ward.	
Who is responsible for the action?	Jose Robe, Group Nurse Director
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Standard Operating Procedure will be in place with night co-ordinator. Safer care review of any untoward incidents.	
Who is responsible?	Jose Robe, Group Nurse Director
What resources (if any) are needed to implement the change(s) and are these resources available?	
Increase in staff numbers at times of high demand.	
Date actions will be completed:	30th September 2020

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Risk to patients if not observed

Comments including good practice:
The locality has provided evidence of the completion and implementation of a standard operating process of the staffing of the place of safety at Carlton Clinic and Yewdale. In addition, the night coordinator role has been implemented. There is evidence that the SOP has been agreed at CBU and Group level.

DRAFT

Evidence Submitted
North Cumbria Evidence Storeroom
1.87 HBPOS Standard Operation Practice.

Recommendation:
Complete. Evidence that practice has been mainstreamed within the North Cumbria Locality.

5.3 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.

Regulated activity(ies)	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 **Treatment of disease, disorder or injury**	**Regulation 17 HSCA (RA) Regulations 2014 Good Governance** **How the regulation was not being met:** 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.
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
Review of urgent care pathway across CNTW.	
Who is responsible for the action?	Clare Tom, Clinical Manager
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Audit presented to the quality standards meeting to demonstrate completion	
Who is responsible?	Jose Robe, Group Nurse Director
What resources (if any) are needed to implement the change(s) and are these resources available?	
Date actions will be completed:	30th September 2020

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Risk to staff and patient care

DRAFT

Comments including good practice:
The locality has provided evidence of adopting CNTW governance structures, evidence of actions, reports completed and sharing of information and cycle of meetings. The CNTW board reported provides evidence of communication processes from Ward to Board. There are standardised agendas in use in team meetings at Group level and these are replicated at CBU level.
Evidence Submitted
North Cumbria Evidence Storeroom 1.72 Monthly Commissioning Quality Assurance Report - Month 9. 1.73 Service User and Carer Experience Report Q3 201920. 1.75 CDT-Q Outcomes Report Q3 201920. 1.76 Quality Priorities Update Q3 201920- Trustwide. 1.77 CNTW - Safer Care Report - January 2020. 1.79 Comms PoY review engagement sessions. 1.81 Safer Care Q3 Report (Jan 2020). 1.82 Safer Care Report - Month 9 December 2019. 1.83 Safer Staffing Report Inc Six Month Skill Mix - November 2019 data (January meeting).

Recommendation:
Complete. Evidence that practice has been mainstreamed within the North Cumbria Locality.

DRAFT

8.2 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.

Regulated activity(ies)	Regulation
Assessment or medical treatment for persons detained **under the Mental Health Act 1983** **Treatment of disease, disorder or injury**	**Regulation 17 HSCA (RA) Regulations 2014 - Good Governance** **How the regulation was not being met:** 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.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
Adopt CNTW approach to gaining feedback from service users and carers.	
Who is responsible for the action?	Anna Foster, Deputy Director of Commissioning and Quality Assurance
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Through patient experience reporting within Locality and through to Board.	
Who is responsible?	Anna Foster, Deputy Director of Commissioning and Quality Assurance
What resources (if any) are needed to implement the change(s) and are these resources available?	
Date actions will be completed:	30th September 2020

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Risk to staff and patients

DRAFT

Comments including good practice:
The Access and Community CBU has provided evidence patient and carer involvement via a locality 'Together' meeting. The locality is undertaking work to understand the involvement of carers 'Getting to Know You' process. Further evidence is required that this has become embedded and has made an impact on service provision.
Evidence Submitted
North Cumbria Evidence Storeroom 1.33 North Cumbria Together Locality meeting agenda. 1.69 Business Plan Access and Community CBU Plan.

Recommendation:
Complete. Evidence that practice has been mainstreamed within the North Cumbria Locality.

DRAFT

Appendix 3

<table>
<tr><td colspan="2">Must Do Theme: (1) Personalisation of care plans</td><td>Lead: Vida Morris, Group Nurse Director</td></tr>
<tr><td>Community LD
Year: 2015
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></tr>
<tr><td>Community OP
Year: 2017
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: 2017
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>LD & Autism wards
Year: 2020
Org: CNTW</td><td colspan="2">The trust must ensure that care plans contain the relevant supporting information, reflective of current need, regularly updated and that staff are aware of these and follow plans accordingly.</td></tr>
<tr><td colspan="3">Actions taken Trust wide in the last 3 Months:</td></tr>
<tr><td colspan="3">Individual pieces of work have been undertaken across the localities in relation to care planning to address concerns raised at ward level. However this work had been paused by the COVID-19 response.</td></tr>
<tr><td colspan="3">Actions taken at core Service in the last 3 Months:</td></tr>
<tr><td>Community LD
Community OP
Community CYPS</td><td colspan="2">The North Cumbria locality has embedded the monitoring of the patient care metric related to care planning, these are now supported by actions plans and trajectories.</td></tr>
<tr><td>LD & Autism wards</td><td colspan="2">• Monthly Care Plan Audit is completed by designated Clinical Lead.
• All Qualified Staff have received the Care Planning training and are aware of the expectations relating to the standards.
• Care planning added to team meetings and supervision meetings as a standard meeting agenda.</td></tr>
<tr><td colspan="3">Planned future Actions:</td></tr>
<tr><td colspan="3">A Trust-wide Group has been established, meetings are scheduled fortnightly and specific areas of improvement have been identified and will be benchmarked against the must dos. There are essential Trust-wide standards being agreed across all localities and sitting below these service specific / pathways specific standards will be agreed by Task and Finish Groups.</td></tr>
<tr><td colspan="3">Evidence of Impact:</td></tr>
<tr><td colspan="3">Since the last inspection (2018) care plan issues were identified across 29 of the 55 wards visited by MHA reviewers. From May 2020 physical inspections of wards were stood down and undertaken remotely therefore clinical records are not reviewed at present.</td></tr>
<tr><td colspan="3">Status:</td></tr>
<tr><td colspan="3">Ongoing further action required to make improvements.</td></tr>
</table>

DRAFT

<table>
<tr><td colspan="2">Must Do Theme: (2) Blanket restrictions</td><td>Lead: Karen Worton, Group Nurse Director</td></tr>
<tr><td>Adult Acute wards
Year: 2018
Org: NTW</td><td colspan="2">The trust must ensure that blanket restrictions are reviewed and ensure that all restrictions are individually risk assessed.</td></tr>
<tr><td>Adult Acute wards
Year: 2019
Org: CPFT</td><td colspan="2">The trust must ensure that blanket restrictions are all reviewed and individually risk assessed.</td></tr>
<tr><td colspan="3">Actions taken Trust wide in the last 3 Months:</td></tr>
<tr><td colspan="3">Each ward maintains a blanket restriction register on identification or implementation of restrictions. An audit tool for all wards to complete on a quarterly basis forms part of the policy. All individualised blanket restrictions are risk assessed and reviewed through ward processes and documented accordingly in RiO.</td></tr>
<tr><td colspan="3">Actions taken at core Service in the last 3 Months:</td></tr>
<tr><td colspan="3">As per Trust-wide response.</td></tr>
<tr><td colspan="3">Planned future Actions:</td></tr>
<tr><td colspan="3">Policy reviewed and to go to BDG on 17/07/20 for 2 week consultation. Comments received by Identified Lead prior to BDG ratification.
A task and finish group to be established to review:
1) Locality restricted practice/blanket restrictions registers and Peer Review process.
2) The blanket restrictions identified by MHA reviews and compliance with the Blanket Restriction Policy.</td></tr>
<tr><td colspan="3">Evidence of Impact:</td></tr>
<tr><td colspan="3">Since the last inspection (2018) blanket restrictions were identified 34 times across 29 wards visited by MHA reviewers. 55 wards were visited and for some wards more than one restriction was identified. Examples of the type of blanket restrictions were:
• patients were unable to enter all rooms on the ward
• patients were unable to access their own drink
• patients did not have their own key to bedroom
• smoking policy
• visiting times not being individualised</td></tr>
<tr><td colspan="3">Status:</td></tr>
<tr><td colspan="3">Ongoing further action required to make improvements.</td></tr>
</table>

DRAFT

<table>
<tr><th colspan="2">Must Do Theme: (3) Restrictive practices, seclusion and long term segregation</th><th>Lead: Ron Weddle, Deputy Director – Positive and Safe</th></tr>
<tr><td>LD & Autism wards
Year: 2019
Org: CPFT</td><td colspan="2">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.</td></tr>
<tr><td>LD & Autism wards
Year: 2020
Org: CNTW</td><td colspan="2">The trust must ensure that the patients in long term segregation and seclusion have the appropriate safeguards in place in accordance with the Mental Health Act Code of Practice and these are documented clearly in patients’ records</td></tr>
<tr><td>LD & Autism wards
Year: 2020
Org: CNTW</td><td colspan="2">The trust must review and reduce the use of mechanical restraint within their learning disability services and ensure that its use is in line with best practice guidance and the appropriate authorisation and recording is in place</td></tr>
<tr><td colspan="3">Actions taken Trust wide in the last 3 Months:</td></tr>
<tr><td colspan="3">Incident reports require all physical interventions by staff to be recorded, showing what staff member controlled what part of the patient's body during episodes of restraint. Any physical harm is also recorded on a body map when appropriate. Incident reports are a 'must do' in any tertiary response situation. Notes on RiO also capture these incidents, as well as incidents that did not require a tertiary response. Audit of physical observation during and after any restraint situation is carried out as well as situations that include rapid tranquilisation. The Positive and Safe team have updated the previous PMVA Policy with the Restraint Reduction Policy - a policy to meet the requirements of Seni's Law.</td></tr>
<tr><td colspan="3">• There is a Trust-wide Seclusion Steering Group that supports adherence to national and local policies, identifying any issues and rectifying quickly.
• The weekly audit for Long Term Segregation now incorporates additional flag to ensure the review of independent and 3 monthly external reviews, as stipulated by Trust Policy and MHA Code of Practice.
• Trust wide electronic recording implemented March/April 2020.
• The pilot of the wall/floor covering continues with a suite on Mitford ward. The covering is proving to be robust however small cracks have appeared within distinct areas of the suite. The wall coverings integrity remains intact and the room operational however the Trust is exploring fully the cause of the identified issue before agreeing a roll out.
• Seclusion suite within Rose Lodge is intact.
• The Trust has encountered difficulties with regards to the installation of the Oxy Health system, which has resulted in delay.</td></tr>
<tr><td colspan="3">The Trust has undertaken a review of the use of MRE. The current MRE PGN has been updated to reflect the findings from the report and recent national documents related to restraint reduction.</td></tr>
<tr><td colspan="3">Actions taken at core Service in the last 3 Months:</td></tr>
<tr><td colspan="3">Autism and Learning Disability services are required to follow Trust guidance set out in the Trust-wide position. There is an audit system that requires incidents to be monitored by Ward Managers, Clinical Managers and Associate Directors at core service level. Audit of physical observation during and after any restraint situation is carried out as well as situations that include rapid tranquilisation. This is a requirement at ward and locality level as well as a Trust-wide expectation.</td></tr>
<tr><td colspan="3">• Discussions in core and ward team meetings for patients in Long Term Segregation and seclusion implemented.
• Audits for seclusion have taken place regularly and show no outstanding actions or areas for improvement.
• Individualised care plans reviewed and in place evidencing patient and carer involvement.</td></tr>
</table>

DRAFT

• Attention in care plan drawn to safeguards around use of Long Term Segregation. Outlining its rationale for use, environment, daily occupation, staff support and aims. • Training update: MHA/Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLS) training: 77.1%, Seclusion training: 87%. • Clinical Lead Nurse providing scrutiny and case load supervision to improve compliance with safeguards and embed review process.
Actions are applicable to Rose Lodge and Mitford wards but learning is shared across the core service. • Positive and Safe approach to all restrictive interventions in place. • MRE audit tool developed to support delivery of standards against guidance. MRE reduction reviewed in MDT. • Positive and Safe approach is active and in use staff work with patients, carers/relatives and IMHA to tailor talk first interventions for the individual. • Debrief following each occasion of MRE evidences areas that went well and alternatives that could be implemented to prevent escalation of need and reduce recurrence. • Positive and Safe face to face training was paused due to COVID-19. This has now recommenced, and staff training level are expected to improve through the next quarter. • Clear evidence within duty sheets established, MRE trained staff on duty are clearly highlighted with a minimum number of staff per shift. • As a further safeguard Kenneth Day Unit control room has a daily plan of all MRE trained staff on the Northgate site. • To support staff being on shift with MRE training, the ward rotas have been reviewed.
Planned future Actions:
Live dashboard development is currently ongoing to support overview of this and other parameters, and will be shared locally through insight reports on a quarterly basis which will provide assurance. There is a Clinical Incident Lead who has an overview of all incidents in the Trust.
• Independent review of CNTW practice. • Review of policy to take into account independent review recommendations. • Issues have been identified in seclusion data handling between two otherwise optimised data systems. The systems are RiO's 'green book' audit of seclusion, run by Ruth Jordan, and the other is the Incident Reporting (IR)/dashboard/Safeguard. The latter over counts due to lack of cancelled seclusions. We have a solution which is that IRs will trigger Clinical Nurse Managers to clean up impossible "two seclusions at once" type errors. This has support at the highest level, and the issues seem to pertain partly to over-reporting due to incidents not being stopped. That in turn may create unticked boxes for governance per incident. A Use of Force leaflet to support adherance to the Use of Force act is in the final stages of production, it will support patients and their families with up to date information soon.
Continue to support the reduction in use of MRE by supporting individual teams and localities to look at alternative methods, these include the introduction of safety pods Trust-wide (except older people's services currently).
Evidence of Impact:
Since the focused inspection in March 2020 there have been similar issues flagged from the Integrated Care Treatment Review (ICTR) process.
Status:
Ongoing further action required to make improvements.

DRAFT

<table>
<tr><td>Must Do Theme: (4) Appraisal and training</td><td>Lead: Marc House, Head of CNTW Academy</td></tr>
<tr><td>Community LD
Year: 2015
Org: CPFT</td><td>The trust must ensure that all staff have an annual appraisal.</td></tr>
<tr><td>Community CYPS
Year: 2017
Org: CPFT</td><td>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.</td></tr>
<tr><td>LD & Autism wards
Year: 2019
Org: CPFT</td><td>The provider must ensure that staff complete their mandatory and statutory training.</td></tr>
<tr><td colspan="2">Actions taken Trust wide in the last 3 Months:</td></tr>
<tr><td>Community LD</td><td>The requirement to complete appraisals was paused as part of the response to COVID-19. In the last 4 weeks the message has gone out to all staff that they should be recommence appraisals and clinical supervision.</td></tr>
<tr><td>Community CYPS</td><td rowspan="2">The requirement to complete essential training was paused as part of the response to COVID-19. In the last 4 weeks the message has gone out to all staff that they should be recommence training where available. Training that is available via e-learning has been advertised widely. PMVA training has recommenced for staff who have joined the trust in the last 3 months and who have previously not received any training. Teams has been utilised to deliver MH Legislation training.</td></tr>
<tr><td>LD & Autism wards</td></tr>
<tr><td colspan="2">Actions taken at core Service in the last 3 Months:</td></tr>
<tr><td colspan="2">As per Trust-wide response.</td></tr>
<tr><td colspan="2">Planned future Actions:</td></tr>
<tr><td>Community LD</td><td>New appraisal training is being developed with workforce colleagues in line with new appraisal documentation and process.</td></tr>
<tr><td>Community CYPS</td><td>Review how the Academy can support specific services to meet their specialist training needs.</td></tr>
<tr><td>LD & Autism wards</td><td>Training is planned via Teams in July and August to support staff to be able to access e-learning successfully and the portfolio of training available via Teams will be increased to include clinical supervision and clinical risk.</td></tr>
<tr><td colspan="2">Evidence of Impact:</td></tr>
<tr><td colspan="2">The following training courses are below standard for June 2020 across all localities:
• Clinical Risk
• Clinical Supervision
• MCA/MHA/DOLS
• PMVA Basic and Breakaway
• Information Governance

The following training courses are below standard for June in the North Cumbria locality:
• Fire
• Safeguarding Adults
• Medicines Management
• MHCT Clustering

• Fire training is below the standard in the Central and South localities
• MHCT Clustering training is below the standard in the South locality
• Seclusion training is below the standard in the North locality</td></tr>
</table>

DRAFT

Appraisals is reported at 68.5% for June against 85% standard • North Cumbria Locality - 53.5% • North Locality - 75.9% • Central Locality - 75.4% • South Locality - 77.9% • Support and Corporate - 49.2%
Status:
Ongoing further action required to make improvements.

DRAFT

Must Do Theme: (5) Clinical supervision	Lead: Esther Cohen-Tovee, Director of AHPs & Psychological Services
Community OP Year: 2017 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.
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.
LD & Autism wards Year: 2019 Org: CPFT	The provider must ensure that all staff receive regular supervision.
Actions taken Trust wide in the last 3 Months:	
Community OP	For Clinical Supervision this is a Trust policy requirement, and is monitored by managers via dashboard reports in North, Central and South. The dashboard reports are accessible to senior managers. Preparations made to roll out on-line recording system in North Cumbria locality.
Trust-wide	The policy was revised in 2019-20 to address findings from previous audit, to reduce scope to exclude medical staff and to harmonise with North Cumbria policy.
LD & Autism wards	This is a Trust policy requirement, and is monitored by managers via dashboard reports in North, Central and South. Preparations made to roll out on-line recording system in North Cumbria locality.
Actions taken at core Service in the last 3 Months:	
As per Trust-wide response.	
Planned future Actions:	
Community OP	IT to address system improvements requested. Bespoke training to be delivered in North Cumbria. Refresher training to be made available on Teams and recorded to be accessible at any time. On-line recording system to be rolled out in North Cumbria. Dashboard reports to be checked for adherence to Trust standards in Older Peoples' community services. Further consideration needed re management supervision.
Trust-wide	Trust-wide clinical supervision audit to be initiated in September 2020, analysis in October 2020 and report in November 2020. Timescales may need adjustment for North Cumbria roll out of online recording system.
LD & Autism wards	IT to address system improvements requested. Bespoke training to be delivered in North Cumbria. Refresher training to be made available on Teams and recorded to be accessible at any time. On-line recording system to be rolled out in North Cumbria. Dashboard reports to be checked for adherence to Trust standards in LD and autism wards.
Evidence of Impact:	
Clinical supervision figures per group are as follows and are subject to data quality issues • North Cumbria Locality – 47.4% • North Locality – 45% • Central Locality – 44% • South Locality – 46%	
Status:	
Ongoing further action required to make improvements.	

DRAFT

<table>
<tr><th colspan="2">Must Do Theme: (6) Risk registers</th><th>Lead: Lisa Quinn, Executive Director of Commissioning and Quality Assurance</th></tr>
<tr><td>Trust-wide
Year: 2019
Org: CPFT</td><td colspan="2">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.</td></tr>
<tr><td>Crisis MH teams
Year: 2019
Org: CPFT</td><td colspan="2">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.</td></tr>
<tr><td colspan="3">Actions taken Trust wide in the last 3 Months:</td></tr>
<tr><td>Trust-wide</td><td colspan="2">Following the CQC inspection there were identified weakness in the approach to risk escalation, risk management and assurance within CPFT. Following the transfer of services, the North Cumbria Locality adopts and implements fully the Risk Management Policy. Evidence that risk register is effectively reviewed and managed in line with the Trust Policy and that there is evidence of a clear link between the register and the Board Assurance Framework.</td></tr>
<tr><td>MH crisis teams</td><td colspan="2">The North Cumbria Locality has provided evidence of adopting CNTW governance structures, evidence of actions, reports completed and sharing of information and cycle of meetings. The CNTW board reported provides evidence of communication processes from Ward to Board. There are standardised agendas in use in team meetings at Group level and these are replicated at CBU level.</td></tr>
<tr><td colspan="3">Actions taken at core Service in the last 3 Months:</td></tr>
<tr><td colspan="3">As per Trust-wide response.</td></tr>
<tr><td colspan="3">Planned future Actions:</td></tr>
<tr><td colspan="3">No further action required.</td></tr>
<tr><td colspan="3">Evidence of Impact:</td></tr>
<tr><td colspan="3">Continue to monitor impact.</td></tr>
<tr><td colspan="3">Status:</td></tr>
<tr><td colspan="3">Submitted to board under Appendix 2 for closure.</td></tr>
</table>

DRAFT

Must Do Theme: (7) Documentation of consent to medical treatment		**Lead: Jose Robe, Group Nurse Director**
Community OP Year: 2017 Org: CPFT	The trust must ensure that consent to treatment and capacity to consent is clearly documented in patient's records.	
Actions taken Trust wide in the last 3 Months:		
Work had been paused due to COVID-19 response.		
Actions taken at core Service in the last 3 Months:		
The North Cumbria locality has embedded the monitoring of the patient care metric related to capacity recording, these are now supported by actions plans and trajectories.		
Planned future Actions:		
The North Cumbria locality will evidence and overall improvement in compliance in the memory and later life pathway.		
Evidence of Impact:		
Since the last inspection (2018) consent to medical treatment issues were identified 49 times across 30 wards visited by MHA reviewers. 55 wards were visited and for some wards more than one action was identified in relation to consent to medical treatment. Current service users who had a discussion recorded at the point of their detention during June is as follows: Trust-wide - 65.2% North Locality - 52.6% Central Locality - 70.8% South Locality - 73.5% North Cumbria Locality - 58.3%		
Status:		
Ongoing further action required to make improvements.		

DRAFT

Must Do Theme: (8) Collecting and acting on feedback from service users and carers		**Lead: Allan Fairlamb, Head of Commissioning & Quality Assurance**
Community CYPS Year: 2017 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.	
Actions taken Trust wide in the last 3 Months:		
The Access and Community CBU has provided evidence patient and carer involvement via a locality 'Together' meeting. The North Cumbria Locality is undertaking work to understand the involvement of carers 'Getting to Know You' process. There is evidence that practice has been mainstreamed within the North Cumbria Locality.		
Actions taken at core Service in the last 3 Months:		
As per Trust-wide response.		
Planned future Actions:		
No further action required.		
Evidence of Impact:		
Continue to monitor evidence of impact.		
Status:		
Submitted to board under Appendix 2 for closure.		

Must Do Theme: (9) Environmental issues	Lead: Paul McCabe, Director of Estates and Facilities
Long stay / rehab wards Year: 2015 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.
Community OP Year: 2017 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.
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.
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.
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.
LD & Autism wards Year: 2020 Org: CNTW	The trust must ensure that the environment at Edenwood is improved including the provision of specialist furniture which meet the needs of the patient using this service
Actions taken Trust wide in the last 3 Months:	
Long stay / rehab wards	Plans are being drawn up to look the feasibility of installing nurse call alarms systems across wards in the Trust that do not currently have them.
Community OP	Investigation into available options to improve the accommodation has been carried out. This has resulted in additional space been identified at Lilleyhall, this will relieve overcrowding at Whitehaven. A longer term solution to move Community services off the Whitehaven site will be explored.
Adult acute wards	The premises are maintained under contract with NCIC and the performance of this contract is monitored by NTW Solutions on behalf of the Trust. There are areas of improvement that are required and these include some must do's and once completed this will be satisfied.
MH crisis teams	
OP wards	Robust assessment and mitigation of risk recorded on Risk log re dormitory provision. Currently (during COVID-19) the dormitory rooms are being used for single accommodation.
LD & Autism wards	• Approval of £200k investment into the improvement of the facilities on Edenwood has been granted. • All areas that required refurbishment have been completed, flooring has been replaced and walls repainted in one colour in all main areas and bedroom. External garden completed. See attached pictures. • Gradual introduction of furniture includes sofa, chairs, table and new bed on order. • Safety pod in place. • Appropriate seating, mattress and bean bags in place. • Table top in place for activities.

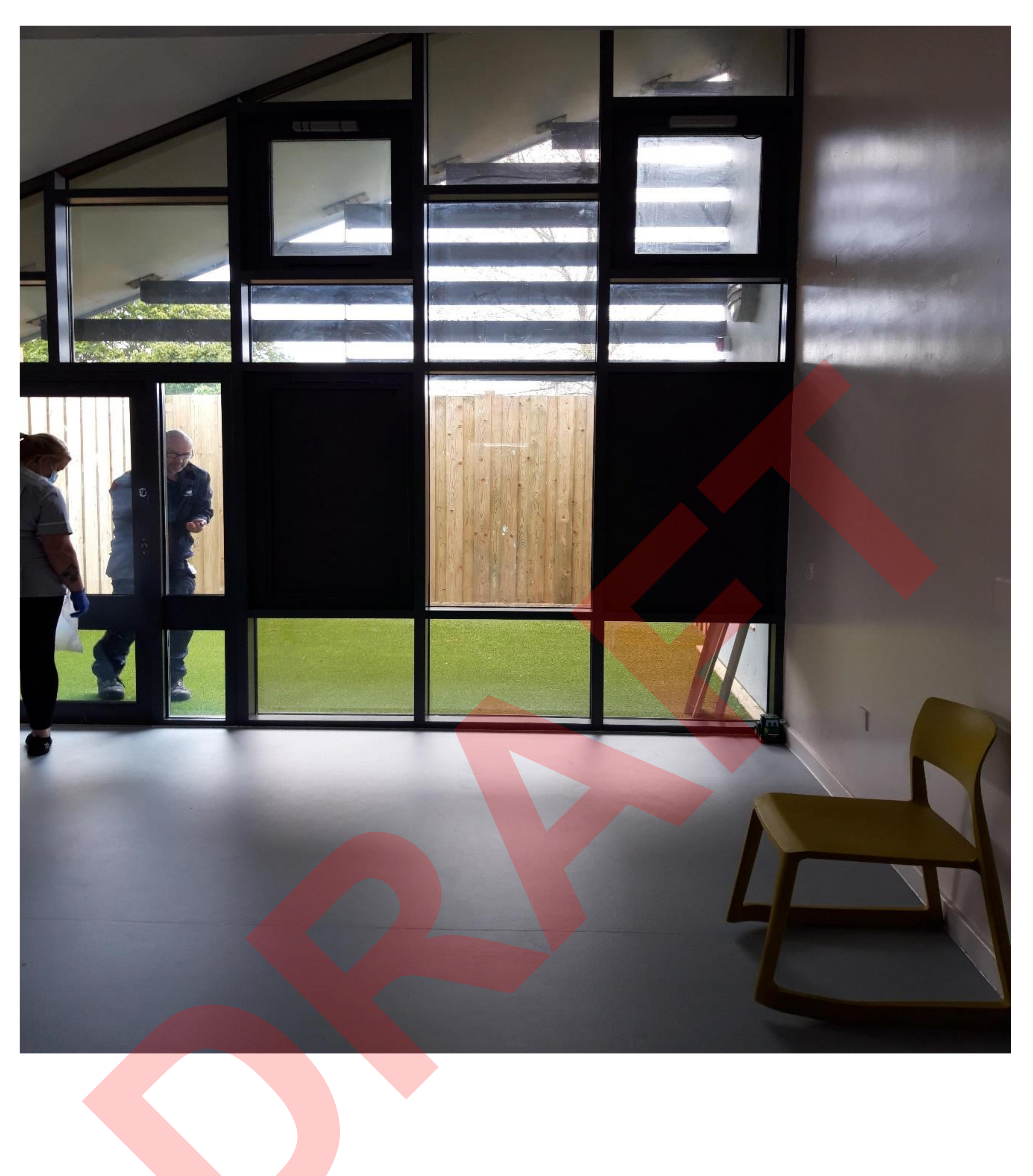
DRAFT

Actions taken at core Service in the last 3 Months:	
As per Trust-wide response.	
Planned future Actions:	
Long stay / rehab wards	The work in the next 3 months will identify gaps to address shortfalls.
Community OP	Move Community services off West Cumberland Hospital site
Adult acute wards	Ongoing monitoring of contracts.
MH crisis teams	A detailed assessment will be made of the Places of Safety in Carlisle and Whitehaven with a view to submitting a business case to rectify any deficiencies. A trial is also underway (at St Georges Park) to trial replacement en-suite doors with a saloon style doors that are anti-ligature in design - following the short trial a roll out program to include Cumbria will be undertaken.
OP wards	Receive the outcome of bid submitted for funds that will address the provision of dormitory beds and will convert them into single room accommodation.
LD & Autism wards	Training on the use of Safety pod has commenced and will be completed by July.
Evidence of Impact:	
To further develop the evidence of impact.	
Status:	
Ongoing further action required to make improvements.	

DRAFT

DRAFT

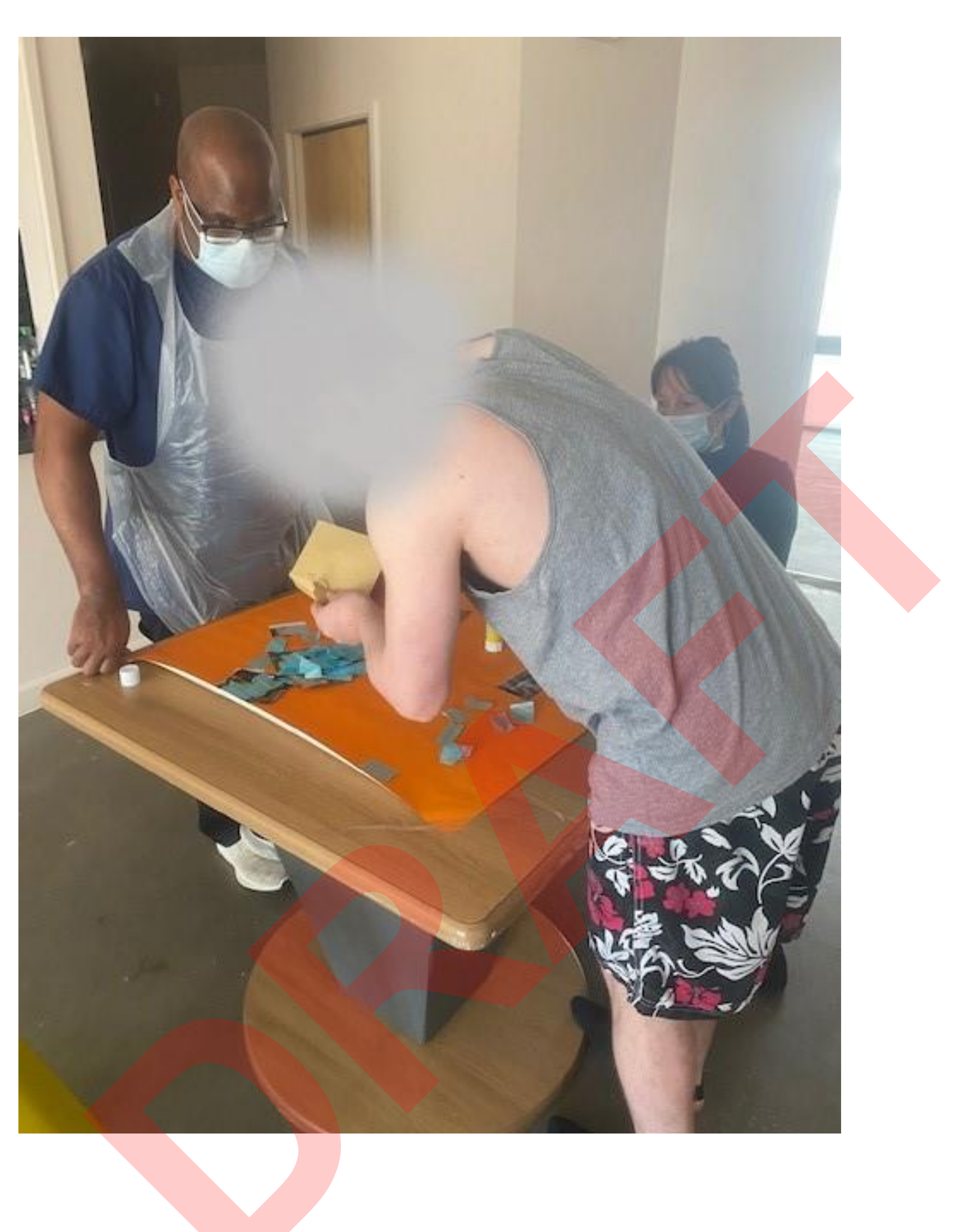
DRAFT



DRAFT

DRAFT

DRAFT



DRAFT

Must Do Theme: (10) Risk assessment and record management	**Lead: Andy Airey, Group Director**
Community LD Year: 2015 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.
Community CYPS Year: 2017 Org: CPFT	The service must ensure that all young people receive a thorough risk assessment which is recorded appropriately in accordance with the trusts policies and procedures to ensure safe care and treatment.
MH crisis teams Year: 2019 Org: CPFT	The trust must ensure systems and processes are established to maintain the records of each patient accurately, completely and contemporaneously.
LD & Autism wards Year: 2020 Org: CNTW	The trust must ensure that risk assessments are regularly updated to reflect current risk and needs of patients
Actions taken Trust wide in the last 3 Months:	
A baseline assessment has been undertaken across all CBU's within the 4 localities. Audits and records checks are undertaken routinely across all localities. For Specialist services commissioned by NHSE completion of a risk assessment within the last six months is a performance metric and monitored via the dashboards.	
Actions taken at core Service in the last 3 Months:	
Community LD MH crisis teams	As per Trust-wide response.
Community CYPS	A Waiting Times protocol has been agreed across CYPS (Trust-wide) which includes a first letter following Triage, a 12 week wait letter and phone call follow up contact at 18 weeks, 25 and 35 weeks. Each CBU will arrange an Audit process to ensure this protocol is embedded.
LD & Autism wards	• Risk assessments are updated within MDT meetings on a minimum of a weekly basis. In addition, these are updated after significant risk incidents. • Risks are clearly defined in historic and current risks. • Individual Supervision addressing areas from the Health Care Record Audit that do not meet the standard has been implemented. Monthly Health Care Record audits have been carried out during April, May and June.
Planned future Actions:	
To consider the establishment of a task and finish group to look at all of the issues raised in relation to risk assessment and the particular issues raised with regards to record keeping (must do and should do actions raised within inspection reports).	
Evidence of Impact:	
To further develop evidence of impact.	
Status:	
Ongoing further action required to make improvements.	

DRAFT

Must Do Theme: (11) Staffing levels		**Lead: Anne Moore, Group Nurse Director**
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.	
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.	
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.	
LD & Autism wards Year: 2019 Org: CPFT	The provider must ensure that all patients have regular access to therapeutic activities to meet their needs and preferences.	
Actions taken Trust wide in the last 3 Months:		
Community CYPS	The North Cumbria Locality has medical vacancies within the CAMHS team, the locality has embedded new roles such as nurse prescribers to support the functioning of the team. The service can demonstrate minimal waits to treatment.	
Adult acute wards	The North Cumbria Locality can demonstrate a robust approach to ward shift staffing and reporting of breaches. It is acknowledged there is a shortage of substantive staff for all shift, however the ward can evidence how these shifts are covered by a mix of overtime, bank and agency. The ward is able to clearly articulate how many breaches against it set staffing and can demonstrate ward to board reporting.	
MH crisis teams	The North Cumbria Locality has provided evidence of the completion and implementation of a standard operating process of the staffing of the place of safety at Carlton Clinic and Yewdale. In addition, the night co-ordinator role has been implemented. There is evidence that the SOP has been agreed at CBU and Group level.	
LD & Autism wards	The North Cumbria Locality has provided multiple sources of evidence regarding activities across all inpatient wards. There is evidence of events and timetables that are appropriate for the ward type/environment. There is evidence of patient facing information and displays of the events. There is evidence of continuous improvements at a team level via action planning.	
Actions taken at core Service in the last 3 Months:		
As per Trust-wide response.		
Planned future Actions:		
Community CYPS	The North Cumbria Locality will demonstrate a consistent responsive service over Quarter 2.	
Adult acute wards	The North Cumbria Locality will undertake further work in relation to Values Based Recruitment to attract staff. PICUs in other locality are to provide assurance of having mechanisms in place to ensure staffing levels are sustained.	
MH crisis teams	No further action required.	
LD & Autism wards	No further action required.	
Evidence of Impact:		
To further develop evidence of impact.		
Status:		
MH crisis teams	Submitted to board under Appendix 2 for closure.	
LD & Autism wards	Submitted to board under Appendix 2 for closure.	

DRAFT

Must Do Theme: (12) Physical health and Rapid tranquilisation		Lead: Anne Moore, Group Nurse Director and David Muir, Group Director
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.	
LD & Autism wards Year: 2019 Org: CPFT	The provider must ensure that all staff review patients' observations following the use of rapid tranquilisation to comply with the provider's rapid tranquilisation policy and National Institute of Health and Care Excellence guidance.	
Actions taken Trust wide in the last 3 Months:		
Results of completed audits in July 2019, November 2019 and July 2020 to be taken to Trust-wide Physical Health and Wellbeing Group for approval.		
Actions taken at core Service in the last 3 Months:		
As per Trust-wide response.		
Planned future Actions:		
Anne Moore supported by David Muir to commission a multi-disciplinary task and finish group to undertake the review of practice and the implications for multi-disciplinary practice, risk management and implications for training. Bruce Owen has proposed Senior Registrar capacity to support the review.		
Evidence of Impact:		
Results of the latest audits will be included for Quarter 2.		
Status:		
Ongoing further action required to make improvements.		

DRAFT

Must Do Theme: (13) Governance	Lead: Lisa Quinn, Executive Director of Commissioning and Quality Assurance
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.
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.
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.
Actions taken Trust wide in the last 3 Months:	
Trust-wide	Following the CQC inspection there were identified weakness in the approach to governance within the CPFT model. Following the transfer of services, the North Cumbria Locality adopts and implements fully the governance structures within CNTW.
MH crisis teams	North Cumbria Locality adopted the governance arrangements of CNTW from 1 October 2019.
Actions taken at core Service in the last 3 Months:	
Trust-wide	As per Trust-wide response.
Planned future Actions:	
Trust-wide	No further action required.
MH crisis teams	Review of group level governance arrangements to confirm they are embedded within North Cumbria to take place over the next 3 months.
Evidence of Impact:	
Trust-wide governance structures. Agreed terms of reference and policies in place.	
Status:	
Trust-wide	Submitted to board under Appendix 2 for closure.
MH crisis teams	Ongoing further action required to make improvements.

DRAFT

Must Do Theme: (14) Staff engagement	**Lead: Michelle Evans, Acting Deputy Director of Workforce and Organisational Development**
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.
Actions taken Trust wide in the last 3 Months:	
The Rowanwood ward is required to undertake staff development regarding culture, values and behaviours. The CBU can demonstrate this work through its approached to business planning, however direct evidence related to Rowanwood is required.	
Actions taken at core Service in the last 3 Months:	
As per Trust-wide response.	
Planned future Actions:	
Baseline survey to be completed, and retaken once the work has completed.	
Evidence of Impact:	
To further develop the evidence of impact.	
Status:	
Ongoing further action required to make improvements.	

<table>
<tr><td colspan="2">Must Do Theme: (15) Medicines Management</td><td>Lead: Tim Donaldson, Chief Pharmacist/Controlled Drugs Accountable Officer</td></tr>
<tr><td>LD & Autism wards
Year: 2019
Org: CPFT</td><td colspan="2">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.</td></tr>
<tr><td colspan="3">Actions taken Trust wide in the last 3 Months:</td></tr>
<tr><td colspan="3">1. Labelling of medicines:
A Pharmacy-led series of CQC assessments is underway across inpatient units to identify any unlabelled medicines (e.g. creams, inhalers). Lloyds Pharmacy SOPs have been obtained to ensure that national pharmacy professional standards for labelling dispensed have been incorporated

2. Valproate:
• Trust valproate prescribing guideline (PPT-PGN-25, Safe Prescribing of Valproate) was reviewed and approved by the MOC in July 2020 (currently undergoing a 2-week Trustwide consultation)
• Data collection for a POMH-UK national benchmarking audit of valproate prescribing (topic 20a) will commence in September 2020 (delayed from March, due to COVID-19). The audit has been registered with Clinical Audit department and a medical lead will be assigned by BDG. Patients will be identified via a combination of RiO searches (using CRIS & SNOMED-CT) and requests to community teams (including forensic services) irrespective of age and sex
• Following the appointment of an R&D Informatics Project Co-ordinator, a CRIS search of RiO care records was re-run to include the North Cumbria locality (July 2020); data cleansing is currently underway
• The Clinical Audit team will analyse the CRIS search results to identify women and girls of childbearing age who are currently prescribed valproate. RiO records will be flagged (via SNOMED-CT coding) to support patient identification during the forthcoming POMH-UK valproate prescribing Trust-wide audit
• An updated list of RiO patient identity numbers will be sent to clinical leads for the four localities with a request to ensure that all relevant patients have received an annual clinical review in the past 12 months, have the appropriate risk assessment paperwork in place (with copies having been sent to GPs) and are being actively recalled for annual review.
• Localities are being asked to nominate leads for the POMH-UK valproate audit.</td></tr>
<tr><td colspan="3">Actions taken at core Service in the last 3 Months:</td></tr>
<tr><td colspan="3">As per Trust-wide response.</td></tr>
<tr><td colspan="3">Planned future Actions:</td></tr>
<tr><td colspan="3">• Further CRIS data interrogation by Clinical Audit colleagues and ensure SNOMED-CT valproate entry. Localities to review all cases against PPT-PGN-25 Safe Prescribing of Valproate standards. Lead for North Cumbria locality to be identified. Medic lead for POMH-UK QIP Topic 20a Valproate to be assigned by BDG. Localities to identify interested parties to assist with data collection for POMH-UK QIP Topic 20a.
• Pharmacy colleagues to undertake CQC self-assessment on all inpatient units to address labelled medications.
• Lloyds Pharmacy SOPs obtained to ensure labelling of medicines is appropriately addressed.
• This issue will be considered as a deep dive at Quality and Performance Committee in September.</td></tr>
<tr><td colspan="3">Evidence of Impact:</td></tr>
<tr><td colspan="3">To further develop the evidence of impact.</td></tr>
<tr><td colspan="3">Status:</td></tr>
<tr><td colspan="3">Ongoing further action required to make improvements.</td></tr>
</table>

DRAFT

<table>
<tr><th colspan="2">Must Do Theme: (16) Nurse Call Systems</th><th>Lead: Russell Patton, Deputy Chief Operating Officer</th></tr>
<tr><td>Adult acute wards
Year: 2018
Org: NTW</td><td colspan="2">The trust must ensure patients have access to a nurse call system in the event of an emergency.</td></tr>
<tr><td colspan="3">Actions taken Trust wide in the last 3 Months:</td></tr>
<tr><td colspan="3">Following the introduction of Nurse Call Systems into the former NTW Urgent Care Inpatient facilities work has commenced on developing a current state analysis for the remaining Inpatient facilities.</td></tr>
<tr><td colspan="3">Actions taken at core Service in the last 3 Months:</td></tr>
<tr><td colspan="3">As per Trust-wide response.</td></tr>
<tr><td colspan="3">Planned future Actions:</td></tr>
<tr><td colspan="3">The work in the next 3 months will identify gaps to address shortfalls.</td></tr>
<tr><td colspan="3">Evidence of Impact:</td></tr>
<tr><td colspan="3">To further develop the evidence of impact.</td></tr>
<tr><td colspan="3">Status:</td></tr>
<tr><td colspan="3">Ongoing further action required to make improvements.</td></tr>
</table>

Must Do Theme: (17) Bed Management	Lead: Andy Airey, Group Director
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.
Actions taken Trust wide in the last 3 Months:	
Implemented new process and policy which has led to positive feedback from North Cumbria CCG regarding the reduction in out of area placements as a result of the introduction of a new bed management function and policy.	
Actions taken at core Service in the last 3 Months:	
As per Trust-wide response.	
Planned future Actions:	
No further action required.	
Evidence of Impact:	
There has been a total of 68 OAP days during the last quarter: • Newcastle Gateshead - 24 • North Tyneside - 6 • Northumberland - 2 • North Cumbria - 19 • South Tyneside - 0 • Sunderland - 17	
Status:	
Submitted to board under Appendix 2 for closure.	

Must Do Theme: (18) Section 17 Leave	**Lead: Dr Patrick Keown, Group Medical Director**
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.
Actions taken Trust wide in the last 3 Months:	
The MHL team have reviewed records in the North Cumbria older adult wards. A review of records of detained patients in Central, North and South localities has been undertaken and all had individualised Section 17 leave forms which accurately reflected leave. Risks are not routinely identified on the Section 17 form itself but this is identified in leave care plans and FACE risk assessments.	
Actions taken at core Service in the last 3 Months:	
As per Trust-wide response.	
Planned future Actions:	
• Task and Finish Group to be set up to continue with work to ensure Section 17 leave forms link with individualised care plans and risk assessments, focusing on personalisation and evidencing that patient and/or families received a copy of the Section 17 leave forms. • Issues around risks and care planning will be addressed with the named nurses and MDTs.	
Evidence of Impact:	
Since the last inspection (2018) issues relating to Section 17 leave were identified across 19 of the 55 wards visited by MHA reviewers.	
Status:	
Ongoing further action required to make improvements.	

Must Do Theme: (19) Clinical audits	**Lead: Dr Kedar Kale, Group Medical Director**
LD & Autism wards Year: 2019 Org: CPFT	The provider must ensure that clinical audits are effective in identifying and addressing areas of improvement within the service.
Actions taken Trust wide in the last 3 Months:	
The North Cumbria locality can demonstrate it has embedded the Trust-wide approach to clinical audit and re-audit. The trust overall has a significant amount of evidence regarding a robust approach to clinical audit.	
Actions taken at core Service in the last 3 Months:	
As per Trust-wide response.	
Planned future Actions:	
The North Cumbria locality will demonstrate over the next 3 months that audit recommendation(s) are tracked and logged, and actioned using a consistent process in the locality.	
Evidence of Impact:	
To further develop the evidence of impact.	
Status:	
Ongoing further action required to make improvements.	

Must Do Theme: (20) Management supervision	**Lead: Lisa Quinn, Executive Director of Commissioning and Quality Assurance**
Community OP Year: 2017 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.
Actions taken Trust wide in the last 3 Months:	
Limited work has been done to progress this action however a snapshot of the position was captured through the weekly question mechanism.	
Actions taken at core Service in the last 3 Months:	
As per Trust-wide response.	
Planned future Actions:	
Process for collecting records in relation to management supervision will be developed in the next 3 months.	
Evidence of Impact:	
To further develop the evidence of impact.	
Status:	
Ongoing further action required to make improvements.	

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
Board of Directors Meeting on 5 August 2020

Title of report	Board Assurance Framework (BAF) Corporate Risk Register (CRR) Exception Report
Report author(s)	Lindsay Hamberg, Risk Management Lead.
Executive Lead (if different from above)	Lisa Quinn, Executive Director of Commissioning and Quality Assurance

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	X
To achieve “no health without mental health” and “joined up” services	X	Sustainable mental health and disability services delivering real value	X
To be a centre of excellence for mental health and disability	X	The Trust to be regarded as a great place to work	X

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	
Audit	29 July 2020
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered (specify date)	
Executive Team	
Corporate Decisions Team (CDT)	
CDT – Quality	
CDT – Business	
CDT – Workforce	
CDT – Climate	
CDT – Risk	
Business Delivery Group (BDG)	

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

DRAFT

Board Assurance Framework and Corporate Risk Register

Purpose

The Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust Board Assurance Framework/Corporate Risk Register identifies the strategic ambitions and key risks facing the organisation in achieving the strategic ambitions.

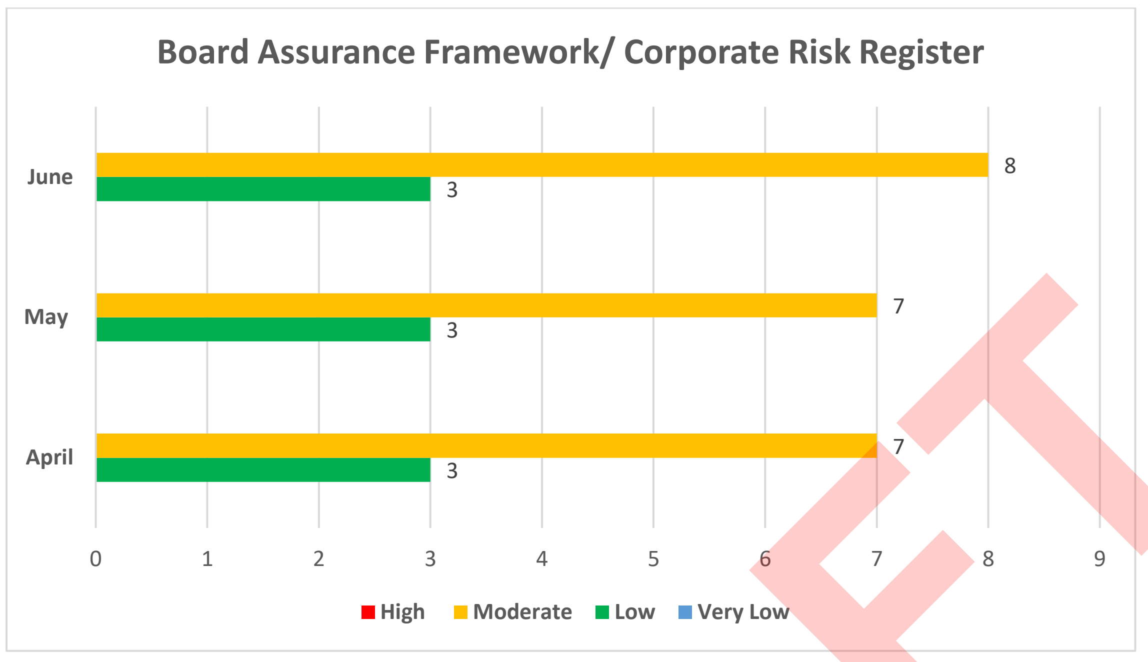
This paper provides:

- A summary of both the overall number and grade of risks contained in the Board Assurance Framework (BAF) and Corporate Risk Register (CRR).
- A detailed description of the risks which have exceeded a Risk Appetite included on the BAF/CRR.
- A detailed description of any changes made to the BAF and CRR.
- A detailed description of any BAF/CRR reviewed and agreed risks to close.
- A copy of the Trusts Risk Appetite table is attached as **appendix 1.**
- A copy of the BAF/CRR is included as **appendix 2**.
- **Appendix 3** gives a summary of both the overall number and grade of risks held by each Locality Group, Corporate Directorate Risk Registers, Clinical Groups, Corporate Business Units and Executive Corporate Risk Registers on the Safeguard system as at October 2019 there have been no risks escalated within the quarter, action plans are in place to ensure these risks are managed effectively and all risk are held at the appropriate level..

DRAFT

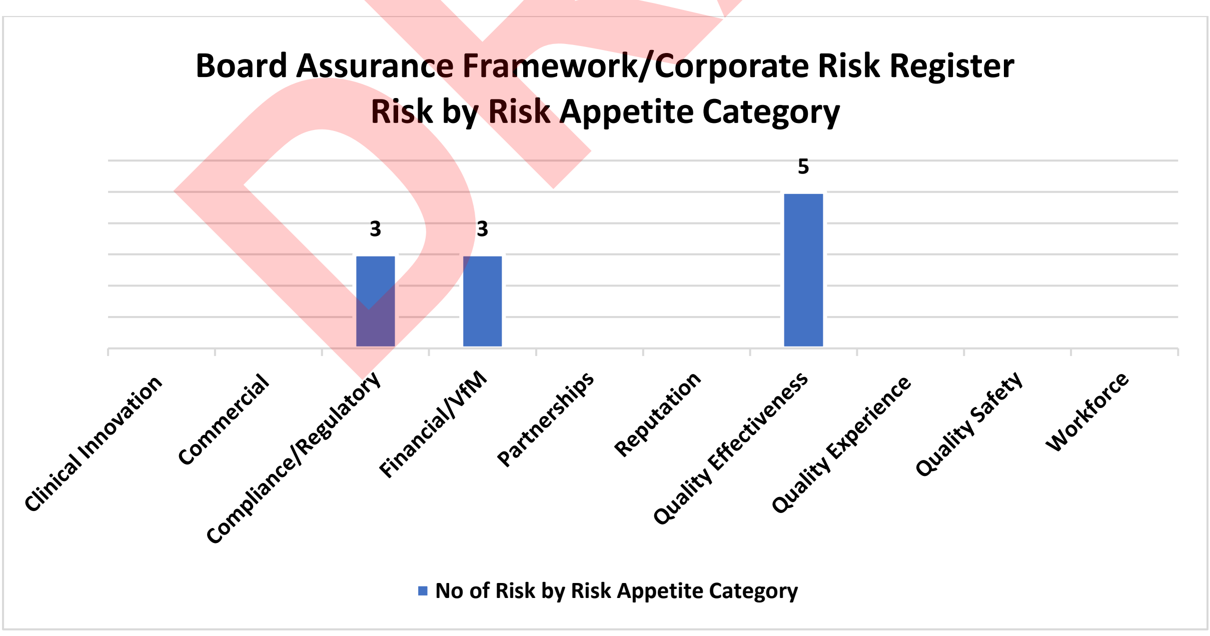
1.0 Board Assurance Framework and Corporate Risk Register

The below graph shows a summary of both the overall number and grade of risks held on the Board Assurance Framework/Corporate Risk Registers as at end of June 2020. In quarter 1 there are 11 risks on the BAF/CRR.



1.1. Risk Appetite

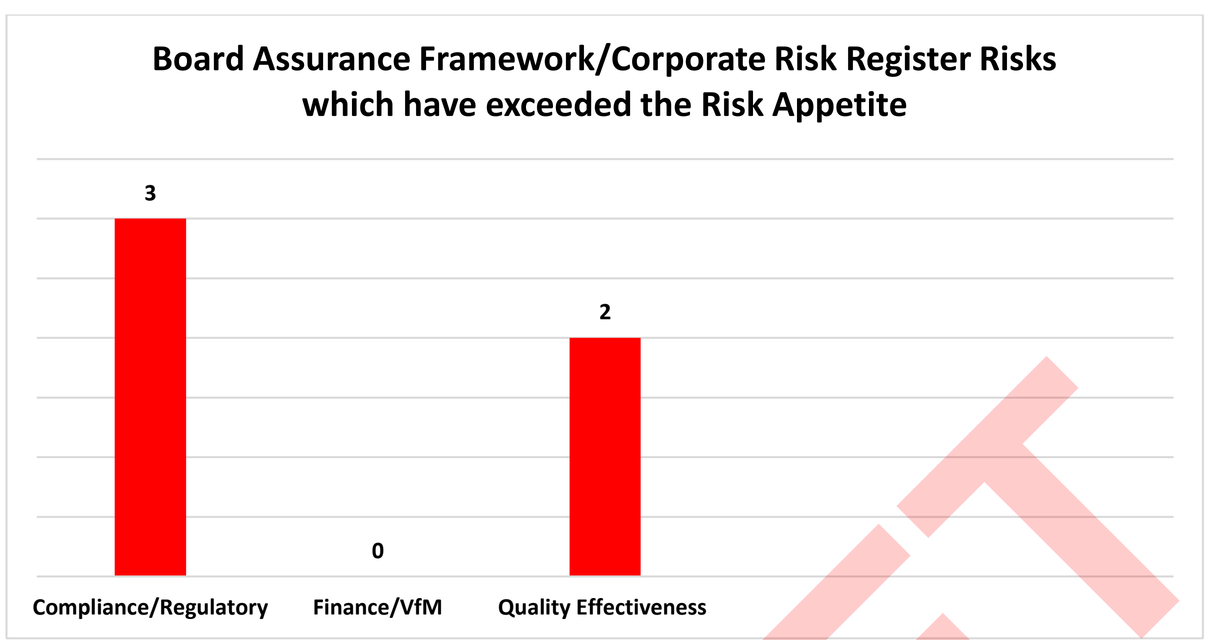
Risk appetite was implemented throughout the Board Assurance Framework/Corporate Risk Register in April 2017. The below table shows risks by risk appetite category. The highest risk appetite category is Quality Effectiveness (5) which is defined as risks that may compromise the delivery of outcomes.



Each risk category has an assigned risk tolerance score. The risk tolerance score highlights when a risk is below, within or has exceeded a risk appetite tolerance. There are currently 11 risks on the BAF/CRR and 5 risks which have exceeded a risk appetite tolerance.

DRAFT

The table below shows all BAF/CRR risks which have exceeded a risk appetite tolerance.



A detailed description of each BAF/CRR risk which has exceeded a risk appetite can be found below. Action plans are in place to ensure these risks are managed effectively:

Risk Reference	Risk Description	Risk Appetite	Risk Score	Executive Lead
1680v.21 SA1	If the Trust were to acquire additional geographical areas this could have a detrimental impact on CNTW as an organisation.	Compliance/ Regulatory (6-10)	3x4 = 12	Lisa Quinn
1683v.11 SA1	There is a risk that high quality, evidence based safe services will not be provided if there are difficulties accessing services in a timely manner due to waiting times and bed pressures resulting in the inability to sufficiently respond to demands.	Quality Effectiveness (6-10)	4x4 = 16	Gary O'Hare
1688v.28 SA5	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	Compliance/ Regulator (6-10)	3x5 = 15	Lisa Quinn

DRAFT

	statutory duties and regulatory requirements.			
1691v.20 SA5	As a result of not meeting statutory and legal requirements regarding Mental Health Legislation this may compromise the Trust's compliance with statutory duties and regulatory requirements.	Compliance/ Regulator (6-10)	3x4 = 12	Rajesh Nadkarni
1694v.12 SA5	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	Quality Effectiveness (6-10)	3x4 = 12	Gary O'Hare
1836v.1	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.	Quality Effectiveness	3x4 = 12	Gary O'Hare

DRAFT

1.2. Amendments to BAF

Following review of the BAF/CRR with each lead Executive Director/Directors, the following amendments have been made:

Risk Ref	Risk description	Amendment	Executive Lead
1680 SA1	If the Trust were to acquire additional geographical areas this could have a detrimental impact on NTW as an organisation.	Action complete re ongoing dialogue with Trust Board monthly.	Lisa Quinn
1681 SA1 Closed	Restrictions of Capital Funding nationally and lack of flexibility on PFI leading to failure to meet our aim to achieve first class environments to support care and increasing risk of harm to patients through continuing to use sub optimal environments.	Risk 1681 has been merged with 1692. New BAF risk 1819, Risk Owner James Duncan and is held on the RBAC Board Committee.	James Duncan
1682 SA1	That there are adverse impacts on clinical care due to potential future changes in clinical pathways through changes in the commissioning of Services.	Action complete re agree governance arrangements for lead provider models.	Lisa Quinn
1683 SA1	There is a risk that high quality, evidence based safe services will not be provided if there are difficulties accessing services in a timely manner due to waiting times and bed pressures resulting in the inability to sufficiently respond to demands.	No change.	Gary O'Hare
1685 SA3	Inability to control regional issues including the development of integrated new care models and alliance working could affect the sustainability of MH and disability services.	No change.	John Lawlor
1687 SA4	Inability to control regional issues including the development of integrated new care models and alliance working could affect the sustainability of MH and disability service.	Action complete re internal audit NTW1819 37 procurement. Risk description has been updated to include more detail.	James Duncan
1688 SA5	Due to the compliance standards set from NHSI,	1 action update regarding the employee information – meeting	Lisa Quinn

DRAFT

	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.	arranged. Risk description updated with more detail.	
1691 SA5	As a result of not meeting statutory and legal requirements regarding Mental Health Legislation this may compromise the Trust's compliance with statutory duties and regulatory requirements.	Risk description has been updated to define risk. There are 2 new actions that have been added 1. Ongoing MHL Steering Group Extra-ordinary meeting and 2. Working Sub-Group to monitor remote assessments. 1 Action updated re: training figures. 2 x Controls with assurances added.	Rajesh Nadkarni
1692 SA5 Closed	That there are risks to the safety of service users and others if we do not have safe and supportive clinical environments.	Risk 1692 has been merged with 1681. New BAF risk 1819, Risk Owner James Duncan and is held on the RBAC Board Committee.	Gary O'Hare
1694 SA5	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.	There are several updates to actions stated below in actions progressed.	Gary O'Hare
1762 SA1	Due to restrictions in capital funding there is a risk of significant reduction in cash reserves which could lead to a limited funding source.	No change.	James Duncan
1819 SA1	Due to restrictions of capital funding nationally and lack of flexibility on PFI, failure to meet our aim to achieve first class environments in all areas of the Trust. Particular risk in North Cumbria and at Rose Lodge, which could result in risk of harm to patients	**New BAF risk** added due to merging risk 1681 and 1692.	James Duncan
1831 SA4	Due to the failure of third-party providers there is a risk that this may place pressure on CNTW which could result in the Trust not being able to manage effectively impacting on the quality of care to existing services users	**New BAF risk.**	Lisa Quinn

DRAFT

1836 SA4	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.	**New BAF risk.**	Gary O'Hare

Risk 1681 'Restrictions of Capital Funding nationally and lack of flexibility on PFI leading to failure to meet our aim to achieve first class environments to support care and increasing risk of harm to patients through continuing to use sub optimal environments' and **risk 1692** 'That there are risks to the safety of service users and others if we do not have safe and supportive clinical environments' merged to **new BAF risk 1819**, 'Due to restrictions of capital funding nationally and lack of flexibility on PFI, failure to meet our aim to achieve first class environments in all areas of the Trust. Particular risk in North Cumbria and at Rose Lodge, which could result in risk of harm to patients' Risk Owner is James Duncan and the risk is held on the RBAC Board Committee.

1.3. Risk Escalations to the BAF/CRR

There have been no risks escalated to the BAF/CRR in the quarter.

1.4. Risks to be de-escalated.

There have been no risks de-escalated to the BAF/CRR in the quarter.

1.5. Emerging Risks.

We are awaiting an update in relation to the new BAF risk mentioned below:

- Due to a major incident involving a virus outbreak there is an immediate risk to human health as well as seeing disruption-related impacts to the Trust. The risk could result in disruption of services and potentially serious harm or death to service users, carers and staff due to the outbreak.

1.6. Recommendation

The Trust Board are asked to:

- Note the changes and approve the BAF/CRR.
- Note the risks which have exceeded a risk appetite.
- Note the summary of risks in the Locality Care Groups/Corporate Directorate risk registers.
- Provide any comments of feedback.

Lindsay Hamberg
Risk Management Lead
13 July 2020

DRAFT

Internal Audit Plan					
Review Area	2019/2020				
	Q1	Q2	Q3	Q4	BAF/CRR Ref
GOVERNANCE					
Head of Audit Opinion				*	
Third Party Assurance				*	
Openness and Honesty/Duty of Candour		*			
Business Continuity Planning/ Integrated Emergency Management				*	SA5.5
RISK MANAGEMENT					
Risk Management				*	SA5.5
FINANCIAL					
Key Financial Systems (including Pay Expenditure, Financial Reporting & Budgetary Control, Financial Accounting & General Ledger, Accounts Payable, Accounts Receivable and Bank & Treasury Management)	*	*	*	*	SA4.2
Lease Cars	*				
KEY BUSINESS SYSTEMS					
Data Quality and Performance					
Performance Management and Reporting (rolling programme)		*	*		SA5.3
Contractual & Legal					
Contract Management (PFI, Subsidiary, Other)		*			SA4.1
Tendering for Services				*	SA4.1
Insurance Arrangements					
Capital and Asset Management					
Development, Procurement and Implementation of Capital Funded Projects				*	SA1.2
Workforce					
Recruitment & Selection (incl. pre-employment & DBS checks)		*			
Absence Management		*			
Employee Appraisal		*			
Education and Learning			*		
Equality and Diversity				*	
Disciplinary & Grievance		*			
Time Attendance and eRostering			*		SA5.3
NTW Academy Governance Arrangements				*	
KEY CLINICAL SYSTEMS					
Records Management		*			
Central Alert System	*				SA5.5
Safeguarding Arrangements	*	*			
Medical Devices Management	*				SA5.5
Mental Health Act (Rolling Programme) - Previous coverage includes: Tribunal Reports, CTO, Patients' Rights, DoLs, S17 Leave & S136 Place of Safety		*			SA5.2
Health & Safety	*				SA5.5
TECHNOLOGY RISK ASSURANCE					
IM&T					
Data Security & Protection Toolkit (formerly IGT)				*	SA1.7
IM&T Risk Management			*		SA1.7
Cyber Security and Network Infrastructure (specific areas to be included in operational plans each year)					
Network Continuous Testing: Server Operational Management	*		*		SA1.7
Penetration Test			*		SA1.7
Active Directory Privileged User Management	*				SA1.7
Network Perimeter Security: Firewall Configuration & Management		*			SA1.7
VMWare Security & Configuration Controls			*		SA1.7
Web Filtering and Monitoring (IT Security)				*	SA1.7
Clinical and Operational System Reviews – Trust's key systems list (provide assurance over the confidentiality, integrity and availability of information processed by clinical and operational systems) – system audited determined in each year in agreement with organisation management					
Ascribe Pharmacy System IT General Controls		*			SA1.7
Backtraq FM System IT General Controls				*	SA1.7
Digital Dictation System IT General Controls				*	SA1.7

DRAFT

Appendix 1

Select a risk appetite category based on the impact of your identified risk

Risk Appetite Statement Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust recognises that its long-term sustainability depends upon the delivery of its strategic ambitions and its relationships with its service users, carers, staff, public and partners. As such, Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust will not accept risks that materially provide a negative impact on quality. However, CNTW has a greater appetite to take considered risks in terms of their impact on organisational issues. CNTW has a greatest appetite to pursue Commercial gain, partnerships, clinical innovation, Financial/ Value for Money and Reputational risks in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.		
Category	**Risk Appetite**	**Risk Appetite Score**
Clinical Innovation	CNTW has a **MODERATE** risk appetite for Clinical Innovation that does not compromise quality of care.	**12-16**
Commercial	CNTW has a **HIGH** risk appetite for Commercial gain whilst ensuring quality and sustainability for our service users.	**20-25**
Compliance/Regulatory	CNTW has a **LOW** risk appetite for Compliance/Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements.	**6-10**
Financial/Value for money	CNTW has a **MODERATE** risk appetite for financial/VfM which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements.	**12-16**
Partnerships, including new system working (ICS, ICP and PLACE)	CNTW has a **HIGH** risk appetite for partnerships which may support and benefit the people we serve.	**20-25**
Reputation	CNTW has a **MODERATE** risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation.	**12-16**
Quality Effectiveness	CNTW has a **LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users.	**6-10**
Quality Experience	CNTW has a **LOW** risk appetite for risks that may affect the experience of our service users.	**6-10**
Quality Safety	CNTW has a **LOW** risk appetite for risks that may compromise safety.	**6-10**
Workforce	CNTW has a **MODERATE** risk appetite for actions and decisions taken in relation to workforce.	**12-16**
Climate and Ecological Sustainability	CNTW has a **LOW** risk appetite for risks that may result in the harming of the environment which could lead to harm to the health and safety of the service users, carers and staff and the population we serve	**6-10**

DRAFT

Appendix 1

BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER 2020-2021

DRAFT

Risk Report

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
If the Trust were to acquire additional geographical areas this could have a detrimental impact on CNTW as an organisation. SA1.10	Risk on identification (09/10/2018):	4	4	16	Moderate
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Compliance/Regulatory			Breach

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Joint Programme Board	1 Minutes of meetings	Agree communication strategy for additional CAMHS Inpatient provision - Board to consider
2 Due Diligence	2 Due Diligence report	to develop proposal for Board to consider the impact of additional CAMHS Inpatient provision
3 Exec Leadership	3 Identified Exec Lead	Review CQC improvement requirements through Board on a Quarterly basis
4 Specific Capacity Identified	4 Identified CNTW Team	
5 Clear Oversight by Trust Board	5 Board Development sessions and Papers	
6 Secured workforce to deliver services	6 Identified staff	
7 Implementation plan developed	7 Implementation planning paper	
8 Contract agreed and completed	8 Contract report	
9 Report mechanism set up to segregate data quality areas re North Cumbria	9 Data Quality Reporting	
Review of first 6 months - North Cumbria	North Cumbria Group reporting	

DRAFT

Risk Report

Ref: 1680v.21

Risk Owner: Lisa Quinn

Next Review Date: 06/08/2020

Review/Comments:

07/07/2020 - Lisa Quinn
Risk has been reviewed today - Actions updated

DRAFT

Risk Report

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
That there are adverse impacts on clinical care due to potential future changes in clinical pathways through changes in the commissioning of Services. SA1.3	Risk on identification (15/03/2018):	3	4	12	Moderate
	Residual Risk (with current controls in place):	2	4	8	Low (Yellow)
	Target Risk (after improved controls):	1	4	4	Very Low
	Risk Appetite (the amount of Risk NTW will accept)	Quality Effectiveness			Within Risk Appetite

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Integrated Governance Framework	1 Independent review of governance- amber/green rating.	Implement new sub-committee of Board for new provider collaborative
2 Agreed contracts signed and framework in place for managing change	2 Contract monitoring and contract change	Agree Business Plan for provider collaborative
3 Locality Partnership arrangements	3 Updates from Locality Partnership meetings	
4 Well Led Action Plan Complete	4 Well Led Action Plan document	
5 All CCG Contracts Agreed	5 Contract documentation	
6 Lead/ prime provider models and alliance contracts	6 Provider models and alliance contract documentation	

DRAFT

Risk Report

Ref: 1682v.11

Risk Owner: Lisa Quinn

Next Review Date: 31/08/2020

Review/Comments:

02/06/2020 - Lisa Quinn
Risk reviewed today and updated actions - LQ to look further consider details of risk (new version set)

DRAFT

Risk Report

DRAFT

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
There is a risk that high quality, evidence based safe services will not be provided if there are difficulties accessing services in a timely manner due to waiting times and bed pressures resulting in the inability to sufficiently respond to demands. SA1.4	Risk on identification (15/03/2018):	4	4	16	Moderate
	Residual Risk (with current controls in place):	4	4	16	Moderate
	Target Risk (after improved controls):	1	4	4	Very Low
	Risk Appetite (the amount of Risk NTW will accept)	Quality Effectiveness			Breach

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Integrated Governance Framework	1 Operational plan reviewed by NHSI Independent review of governance - amber/green rating External audit of quality account	Complete Access and Waiting Times Standard Group work plan - This is ongoing
2 Performance review monitoring and reporting incl compliance with standards, indicators and CQUIN.	2 Reports to CDTQ, Q&P and QRG's External audit of quality account	
3 Operational and clinical policies and procedures	3 Compliance with policies and procedures	
4 Annual quality account	4 External audit of quality account	
5 CQC compliance group	5 Minutes of meeting CQC rated outstanding	
6 Trust-wide access and waiting times standard group established	6 Minutes of access and waiting times meeting	
7 Waiting times dashboard developed	7 Monitoring of the waiting times dashboard	
8 Creating capacity to care workstreams are established	8 Monthly updates to BDG	

Risk Report

1 Monitoring and delivery of operational plan 18/19	1 Operational Plan Report 18/19	
2 Delivery of 5-year Trust strategy 17/22 and supporting strategies	2 Trust Strategy report 17/22	
3 Regular Reviews & Discussions at BDG and Q&P	3 Minutes of meetings	

Ref: 1683v.11

Risk Owner: Gary O'Hare

Next Review Date: 05/08/2020

Review/Comments:

05/05/2020 - Paul Stevens
Risk Reviewed today - Remains the same

DRAFT

Risk Report

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Inability to control regional issues including the development of integrated new care models and alliance working could affect the sustainability of MH and disability services. SA3.2	Risk on identification (15/03/2018):	4	5	20	High (Red)
	Residual Risk (with current controls in place):	2	4	8	Low (Yellow)
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Quality Effectiveness			Within Risk Appetite

Controls & Mitigation (what are we currently doing about the risk)	**Assurances/ Evidence (how do we know we are making an impact)**	**Gaps in Controls (Further actions to achieve target risk)**
1 Executive and Group leadership embedded in each CCG/LA area to ensure MH and disability services are sustainable	1 Successfully influenced service models across a number of localities	Finalise the implementation plan for ICS MH workstream
2 Leadership of ICS MH workstream	2 Established close relationships with senior clinicians, managerial leaders across acute trusts and some GP practices. Regular updates/monitoring of ICS via Exec/CDT/Board. Papers from MH ICS workstream	Delivery of NCM business Strategy (this has now been replaced by Provider Collaborative Model
3 Involvement in DTDT programme for OP and acute MH services	3 Regular updates via Execs/CDT/Board	
4 Member of Gateshead care partnership	4 Regular updates via Execs/CDT/Board	
5 Member of Exec group for MCP in Sunderland	5 regular updates via Execs/CDT/Board	
6 Member of the ICS Health Strategy Group	6 Regular updates via Execs/CDT/Board	
7 Member of North and Central ICP's	7 Regular updates via Execs/CDT/Board	
8 Member of Northumberland Transformation Board	8 Regular updates via Execs/CDT/Board	

DRAFT

Risk Report

1 Member of the Newcastle Joint Exec Group	1 Regular updates via Execs/CDT/Board	

Ref: 1685v.13

Risk Owner: John Lawlor

Next Review Date: 17/08/2020

Review/Comments:

19/05/2020 - John Lawlor
Risk has been reviewed today and there is no change

DRAFT

Risk Report

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Failure to deliver strategic financial and ongoing productivity improvements at a group and corporate trust level, leading to long term financial instability, reporting of losses and potential external intervention. SA4.2	Risk on identification (15/03/2018):	3	5	15	Moderate
	Residual Risk (with current controls in place):	3	5	15	Moderate
	Target Risk (after improved controls):	2	5	10	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Financial/Value For Money			Within Risk Appetite

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Integrated governance framework	1 Annual Governance Statement, Quality Account ,Annual plans	5 year plan to be approved by the Board March 2021
2 Financial Strategy/FDP	2 Operational Plan 19/20 submitted	Routine reporting against delivery of operational plan to be incorporated into CDT-B from June 2020 and to Board from July 2020. Ongoing January 2020
3 Financial and Operating procedures	3 Policy/PGN NTW1718 26 Payroll expenditure ,NTW 1718 39 Cashier	
4 Quality Goals and Quality Account	4 External audit of Quality Account	Trust working in interim financial regime through COVID-long term implications to be assessed within long term strategy
5 Accountability Framework	5 Accountability Framework Reports	
6 Quarterly review of financial delivery	6 Quarterly review delivered at RBAC	
7 Programme agreed for capacity to care and Trust Innovations capacity expanded	7 Capacity to care programme, report to BDG and CDT-B	
8 Going Concern Report	8 Going Concern Report - Audit Committee April 2019	

DRAFT

Risk Report

1 NTW 18/19 Internal Audit	1 NTW 1819 25 Single Oversight Framework, Substantial, April 2019 NTW 1819 37 Procurement: Good, July 2019 NTW 1819 38 Compliance Review of Key Financial Systems: Good, May 2019 NTW 18/19 43 Risk based audit of charitable funds - Substantial, August 2018 NTW18/19 41 Risk based audit payroll - Substantial, November 2018 NTW18/19 40 Central arrangements managing patient monies - Substantial, February 2019	

Ref: 1687v.19

Risk Owner: James Duncan

Next Review Date: 05/08/2020

Review/Comments:

03/07/2020 - James Duncan
Risk has been reviewed today. Actions updated

DRAFT

Risk Report

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Due to the compliance standards set from NHSI, CQC and for Legislation there is a risk that we do not meet and maintain standards which could compromise the Trust's statutory duties and regulatory requirements. SA 5	Risk on identification (15/03/2018):	3	5	15	Moderate
	Residual Risk (with current controls in place):	3	5	15	Moderate
	Target Risk (after improved controls):	1	5	5	Very Low
	Risk Appetite (the amount of Risk NTW will accept)	Compliance/Regulatory			Breach

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Integrated Governance Framework	1 Independent review of Governance - amber/green rating	NTW17/1843 action - Employee information. Once pilot is completed to be rolled out for Trust employee records
2 Trust policies and procedures	2 Compliance with policy and procedures	Quarterly Review of compliance against standards through accountability framework
3 Compliance with NICE	3 CQC MHA Visits and completed action plans NTW 1718 09 CQC Process - Substantial Assurance NTW 17/18 13 NICE Good - August 2018	
4 CQC Compliance Group and Compliance Steering Group - re-started fortnightly	4 Reports and updates to board sub committees	
5 Performance reviewed/integrated commissioning and assurance reports	5 Reports/updates to board sub committees	
6 Accountability Framework - Quarterly meetings	6 Accountability Framework document	
7 Regulatory framework of CQC NHSI	7 NTW18-19 - 19/05 CQC Internal Audit (well-led) - Process Substantial Assurance	
8 Agreement of Quality Priorities	8 Monitored via reports/updates	

DRAFT

Risk Report

1	NTW Internal Audit 17/18	1	NTW17/1813 NICE - Good, August 18 - Actions complete NTW17/18 11 Data Quality - Good, August 18 - Actions complete NTW17/1843 Records Management - Reasonable
2	NTW Internal Audit 18/19	2	NTW 18/1955 Risk Based Audit - Mortality - Good, February 19

Ref: 1688v.28

Risk Owner: Lisa Quinn

Next Review Date: 06/08/2020

Review/Comments:

07/07/2020 - Lisa Quinn
Risk has been reviewed today - updated actions and controls

DRAFT

Risk Report

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
As a result of not meeting statutory and legal requirements regarding Mental Health Legislation this may compromise the Trust's compliance with statutory duties and regulatory requirements. SA5	Risk on identification (29/10/2018):	3	4	12	Moderate
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Compliance/Regulatory			Breach

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Integrated Governance Framework	1 Independent review of governance	Review the monitoring of CQC themes raised with Groups at the Mental Health Steering Group
2 Trust Policies and Procedures relating to relevant acts and practice	2 Compliance with policy/training requirements NTW1617 33 MHA section 17 - good level of assurance NTW1718 42 MHA Statutory Function - Good Level of Assurance NTW181957 Compliance review of MHA Rights - Good Level - Feb 19	To respond effectively to any proposed new Mental Health Legislation
		Prompts for consent to treatment to be included on the to do list on RiO - NTW 1819 58
		Improvement review of MHA Training: (77.8%) (June 2019 80%) (Oct 2019 83.3%) (Jan 2020 83.4%) (March 2020 66.5%) (Jun 2020 62.6%)
3 Decision making framework	3 Decision making framework document	Ongoing MHL Steering Group Extra-ordinary meeting
4 Performance review/integrated performance reports	4 Reports to Board and sub committees	Working Sub Group to monitor remote assessments
5 Mental health legislation committee	5 Minutes of mental health legislation committee	
6 Process for 135/136 legislation with external stakeholders	6 135/136 action plan complete	
7 New process in place for monitoring themes from MHA Reviewer visits through MHL Steering Group	7 MHL Group papers and updates	

DRAFT

Risk Report

1	CQC MHA Reviewer session delivered at learning and development group in November 2018	1	Minutes and papers from Learning and Development Group	
2	Internal Audit 18/19	2	NTW 2018/19/57 Compliance Review of MHA - Patient Rights. Good. NTW 2018-19/58 Compliance Review of Mental Health Act - Rolling Programme - CTO - Substantial	
3	Effectiveness of reporting on themes from MHA Reviewer visits	3	Mental Health Steering Group	
4	Legal Guidance for MH & LD during the Corona Pandemic	4	Regular updates to the Board - Board Minutes	
5	CNTW Internal Audit 19 20	5	CNTW 19 20-29 MHA - Holding Powers - Good Assurance	

Ref: 1691v.20

Risk Owner: Rajesh Nadkarni

Next Review Date: 24/07/2020

Review/Comments:

17/06/2020 - Rajesh Nadkarni
Risk reviewed today - actions and controls with assurances added. Risk description has been updated

DRAFT

Risk Report

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Inability to recruit the required number of medical staff or provide alternative ways of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high class services. (SA5.9)	Risk on identification (06/11/2018):	4	4	16	Moderate
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Quality Effectiveness			Breach

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Workforce strategy	1 Delivery of workforce strategy	Executive Awareness of International recruitment through Medical Director, Trust aware for medical recruitment as a whole through medical managers
2 RPIW Medical Recruitment	2 RPIW Medical Recruitment outcomes papers	
3 NTW International recruitment competency process	3 NTW International recruitment competency documents	Monitor 7 fellowship recruits still on placement - updated that they are enjoying their placements, gaining education and training experience
4 OPEL Framework	4 OPEL Framework Documents	
5 MDT Collegiate Leadership Team in place	5 MDT Leadership advice and support available	Ongoing central recruitment and apprenticeships scheme for nursing
6 All seven fellowship international recruits arrived into the Trust in December 2018	6 All still in post and deployed across the Trust	Complete International Recruitment Campaign - Quarterly updates.
7 The medical recruitment functions have been moved to the medical staffing team	7 The medical staffing team manage the medical recruitment function	
8 Medical Induction Programme	8 Delivery of medical induction programme	

DRAFT

Risk Report
NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust
Ref: 1694v.12
Risk Owner: Gary O'Hare
Next Review Date: 14/09/2020
Review/Comments:
16/06/2020 - Paul Stevens
Update provided by CT
DRAFT

Risk Report

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Due to restrictions in capital funding there is increasing reliance on Trust cash to deliver capital programmes, which over the medium term could lead to a risk of significant reduction in cash reserves, and reliance on short term borrowing (SA1)	Risk on identification (07/11/2019):	3	5	15	Moderate
	Residual Risk (with current controls in place):	3	5	15	Moderate
	Target Risk (after improved controls):	1	5	5	Very Low
	Risk Appetite (the amount of Risk NTW will accept)	Financial/Value For Money			Within Risk Appetite

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)
1 Financial planning budgets	1 Reported and in minutes of CDT-B and RBAC
2 Working capital management	2 Reported through and in minutes of CDT-B and RBAC
3 Going Concerns Reporting	3 Discussed and in minutes of Audit Committee
4 OBC approved nationally - CEDAR business case including inherent improvement to revenue position	4 Agreement of long term plan as part of CEDAR OBC - Approved by the Board (minutes)

Gaps in Controls (Further actions to achieve target risk)
Capital and estates strategy to be updated during 2020/21 alongside financial strategy. Nationals guidance expected July 2020 and December 2020. Updated strategy to be presented to Board March 2021
CEDAR FBC submitted without requirement for bridging loan due to improvement in underlying cash position

Ref: 1762v.7

Risk Owner: James Duncan

Next Review Date: 04/10/2020

Review/Comments:

03/07/2020 - James Duncan
Risk has been reviewed today. Actions updated

DRAFT

Risk Report

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Due to restrictions of capital funding nationally and lack of flexibility on PFI, failure to meet our aim to achieve first class environments in all areas of the Trust. Particular risk in North Cumbria and at Rose Lodge, which could result in risk of harm to patients	Risk on identification (26/05/2020):	5	3	15	Moderate
	Residual Risk (with current controls in place):	4	4	16	Moderate
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Financial/Value For Money			Within Risk Appetite

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 CEDAR Programme Board established with key partners	1 Minutes of the CEDAR Programme Board	Updated Estate Strategy as part of 5 year Trust Strategy to be presented to Board March 2021
2 CEDAR Programme Board Delivery	2 CEDAR Documents	Capital Strategy for Cumbria to be developed by Autumn 2020, bid to be submitted for national funding
3 CERA Programmes	3 CERA Documents	Lack of national capital allocation and process to access capital funding leading to significant parts of developing capital programme having no funding source. National clarification now expected in long term capital settlement - Autumn 2020
4 Business Care approved for interim solutions for WAA and Newcastle/ Gateshead Building Programme in place	4 Business Case Document	
5 ICS - support nationally and funding identified	5 ICS bid document	
6 CEDAR Business Care Process in place	6 Business case cycle for Board meetings	
7 Asset sales now identified	7 Standard reporting CDT-B and RBAC	

DRAFT

Risk Report

Ref: 1819v.2

Risk Owner: James Duncan

Next Review Date: 05/08/2020

Review/Comments:

03/07/2020 - James Duncan
Risk reviewed today - Actions updated. Risk Appetite updated to (L)4 x (I)4 = 16

DRAFT

Risk Report

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Due to the failure of third-party providers there is a risk that this may place pressure on CNTW which could result in the Trust not being able to manage effectively impacting on the quality of care to existing services users SA4	Risk on identification (01/06/2020):	3	3	9	Low (Yellow)
	Residual Risk (with current controls in place):	3	3	9	Low (Yellow)
	Target Risk (after improved controls):	1	3	3	Very Low
	Risk Appetite (the amount of Risk NTW will accept)	Quality Effectiveness			Within Risk Appetite

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Sign Subcontracts	1 To complete	Agree NED Chair of sub-committee
2 Clear Service Specifications	2 To complete	Review all contracts for 2021-22
3 Contract monitoring meetings	3 Minutes of Contract monitoring meetings	Review all specifications for 2021-22
4 Governance Arrangements through to Board	4 Board approved Governance arrangements	Establish approved sub-committee of the Board

Ref: 1831v.1

Risk Owner: Lisa Quinn

Next Review Date: 12/08/2020

Review/Comments:

DRAFT

Risk Report

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
A failure to develop flexible robust Community Mental Health Services may well lead to quality and service failures which could impact on the people we serve and cause reputational harm.	Risk on identification (01/06/2020):	3	4	12	Moderate
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	1	4	4	Very Low
	Risk Appetite (the amount of Risk NTW will accept)	Quality Effectiveness			Breach

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Access and Waiting Times Group	1 Monitor and manage waiting times - recommend what can change - minutes of meetings	
2 Weekly and Quarterly reporting - Accountability meetings	2 Minutes of meetings	
3 Complaints and Incidents reporting	3 Safeguarding system - reporting	
4 Working together with partner organisations	4 New Community Framework/ New approaches documents	
5 Next phase and Long Term Plan	5 Next phase and Long Term Plan reports	

Ref: 1836v.1

Risk Owner: Gary O'Hare

Next Review Date: 20/08/2020

Review/Comments:

21/07/2020 - Russell Patton
New risk - awaiting update on actions to be added

DRAFT

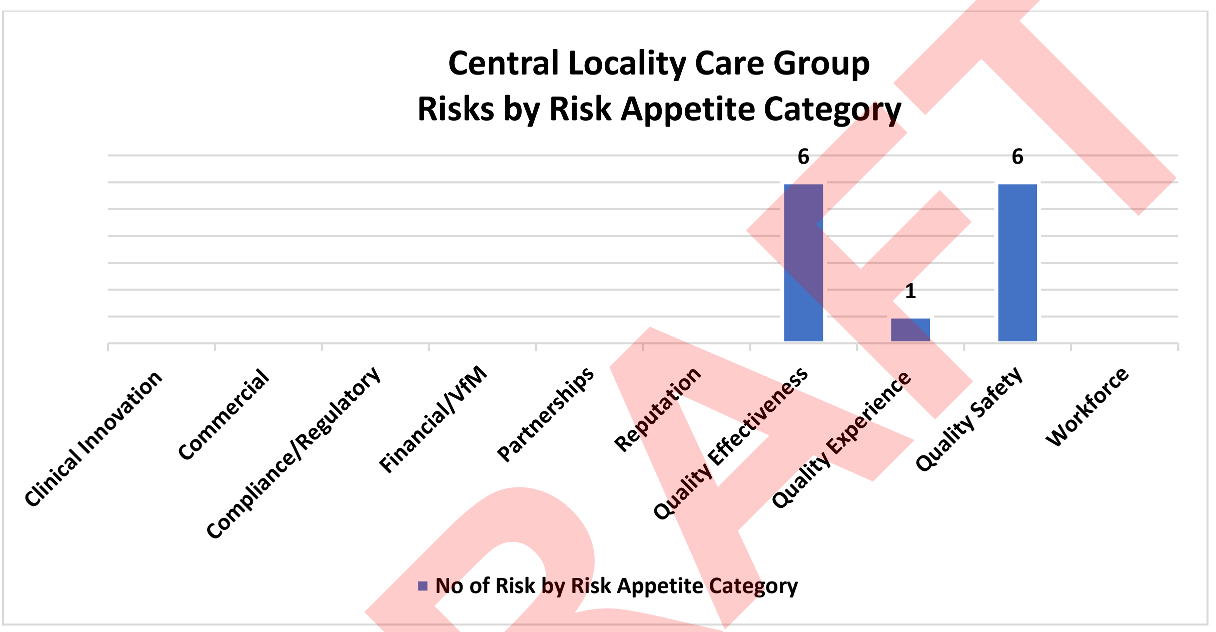
Appendix 3

Clinical Locality Care Groups and Executive Corporate Trust Risk Registers.

The below charts show a summary of the number of risks by risk appetite category held by each Locality Care Group (Group Locality Risk Register) and Executive Corporate risk registers. Safeguard Web Risk Management and Risk appetite has been fully implemented throughout the group risk registers/executive corporate risk registers and risk continue to be monitored at the CDT Risk Management Sub-Group monthly.

Clinical Groups

1.0 Central Locality Care Group



DRAFT

In total as at end of June 2020 Central Locality Care Group hold 13 risks, 13 risks which have exceeded the risk appetite. All risks are being managed within the Central Locality Care Group and no requests to escalate to BAF/CRR have been received.

There are 8 risks on the Central Corporate Group risk register. Below are the risks which have exceeded a risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1038v.17	Medication information not accurately recorded at discharge and discharge summaries not issued in a timely manner. There is a potential risk of harm to service users if medication information is incorrectly communicated to GPs or the receipt of that information is delayed.	Quality Safety (6-10)	16	4	4	Sarah Rushbrooke

1513v.16	Access and Waiting times within the ADHD and ASD Service. The service is commissioned as an Adult Neuro-disability service and provides an autism diagnosis service and ADHD diagnosis and treatment monitoring service across the six trust localities. Agreed service specification is not available and the baseline for expected demand at the time of commissioning is therefore unclear. Weekly activity reports are provided for both ADHD and ASD services. The weekly activity reports indicate that there has been no significant improvement in flow and the waiting lists are not reducing. Discussions regarding capacity and demand have taken place with commissioners, however, no further investment has been confirmed to date. This poses a potential impact on service delivery and the effectiveness of treatment.	Quality Effectiveness (6-10)	15	3	5	Sarah Rushbrooke
1545v.18	Potential ligature risks identified within Central Locality Care Group wards during the CERA process during 2017-18. See Attached Potential risk of harm to service users	Quality Safety (6-10)	15	5	3	Sarah Rushbrooke
1665v.11	Staffing pressures due to vacancies and difficulties recruiting and retaining medical staff within the Central Locality Care Group. This poses a potential impact on service delivery and the effectiveness of treatment.	Quality Effectiveness (6-10)	16	4	4	Sarah Rushbrooke
1736.v4	Sickness absence within the Group has risen in July to 5.3%, with overall Group and three Clinical Business Units above the Trust target of 5%. There is a risk to service delivery and the effectiveness of treatment delivered to our service users.	Quality Effectiveness (6-10)	12	4	3	Sarah Rushbrooke
1737v.6	Access and Waiting Times within CYPS Community Services - Significant work has been undertaken with regard to waiting times within this service however there remains a significant issue in	Quality Effectiveness (6-10)	12	4	3	Sarah Rushbrooke

DRAFT

	regards to waiting times. There is a risk to service delivery and the effectiveness of treatment delivered to our service users.					
1763v.8	Current staffing pressures within the Secure Care service currently being experienced due to each of the secure care learning disability wards having at least 1 complex patient who requires the support of additional staff resource. This poses a potential impact in the effectiveness of treatment and the safety of patients, staff and visitors	Quality Safety (6-10)	15	5	3	Sarah Rushbrooke
1830v.1	Numerous incidents of environmental damage have occurred within the seclusion suites in the Secure Care CBU. The environmental damage impacts on the locking mechanism as well as the fabric of the seclusion room. There is a potential risk to patient safety if staff cannot enter the seclusion room and also a potential risk of escape and injury if staff cannot safely exit seclusion and lock the door behind them.	Quality Safety (6-10)	12	4	3	Sarah Rushbrooke

DRAFT

1.2 Central Locality Corporate Business Units

The four CBU's within the central locality currently hold a total of 5 risks.

1.3 Community Central CBU

Community Central CBU has 4 risks which have exceeded risk appetite and are listed below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1284v.18	Following an internal audit there is a risk around the monitoring arrangements for lone working which could result in reduced compliance and staff safety issues	Quality Safety (6-10)	15	5	3	Anna Williams
1457v.24	Increased demand has seen an increase in waiting times, leading to a significant delay in assessment and treatment across the CBU. An increase demand for secondary care mental health has seen an increase in waiting times and	Quality Effectiveness (6-10)	12	4	3	Anna Williams

	assessment in treatment across Central Community CBU. The impact is we're not as responsive to our client group as we would like to be					
1673v.11	There is a safety and security risk due to the current CAV environment and as such we to ensure Community staff have processes in place to support their safety	Quality Safety (6-10)	12	4	3	Anna Williams
1761v.6	Access and waiting times within Learning Disability Psychology services. The service continues to report a number of over 18 week waits for clients. There is a risk to service delivery and the effectiveness of treatment delivered to our service users. Risk to be reviewed quarterly	Quality Effectiveness (6-10)	12	4	3	Anna Williams

1.4 Inpatient Central CBU

Inpatient Central CBU has 0 risks.

1.5 Secure Care Services CBU

Secure Care Services CBU has 0 risks.

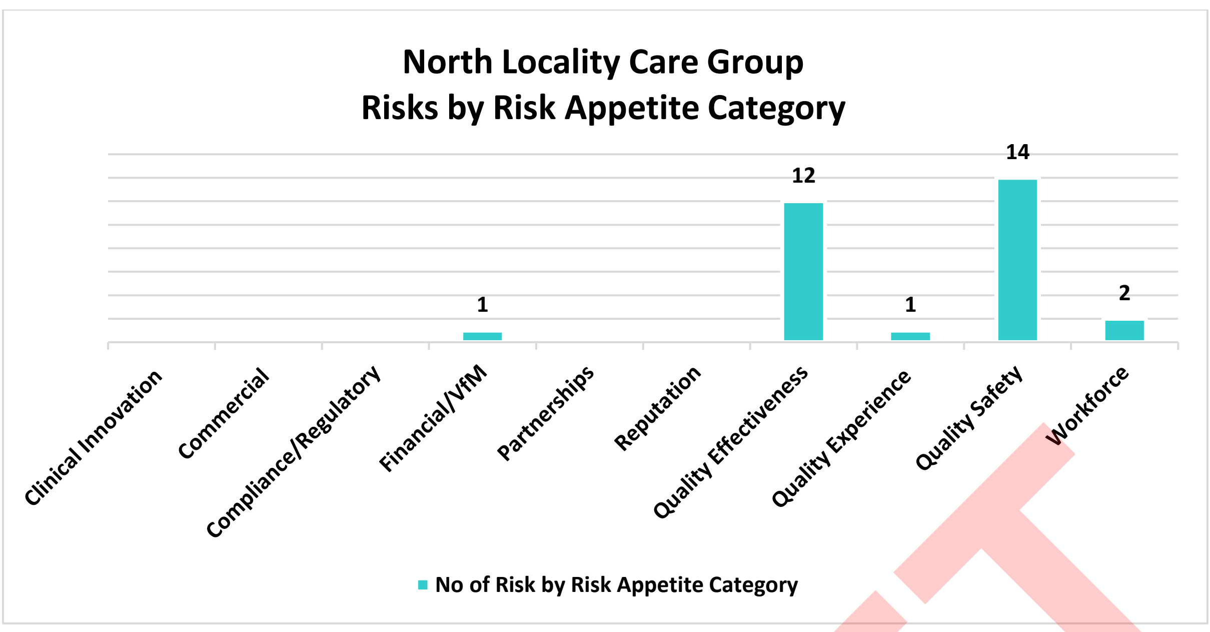
1.6 Access Central CBU

Access Central CBU currently holds 1 risk which has exceeded risk appetite and is below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1308v.7	Environmental issues identified for S136 suites SNH via CQC inspection and Royal College that are not able to be met within the current footprint and would require significant investment to meet standards. No private room for assessment, no shower facility, private space for physical examinations and no sleeping facilities. Risk impact: to patient experience whilst in the suite. Additional risk impact linked to compliance which was previously held on Executive operational risk register	Quality Experience (6-10)	12	4	3	Rachael Winter

DRAFT

2.0 North Locality Care Group



North Locality Care Group as at end of June 2020 hold 30 risks, 10 risks within the risk appetite and 20 risks which have exceeded the risk appetite. All risks are being managed within the North Locality Care Group and no requests to escalate to BAF/CRR have been received.

There are 6 risks on the North Corporate Group risk register. 2 risks within the risk appetite and 4 risks exceeding the risk appetite. Below are the risks which have exceeded a risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1176v.43	Significant staffing pressures due to vacancies and difficulties recruiting and retaining permanent medical, nursing, SALT staff within the North Locality. Operational Risk - significant impact on the continuity of care.	Quality Effectiveness (6-10)	16	4	5	Kedar Kale
1198v.37	Sickness absence levels have risen in the last month however continue to be lower than the previous year currently at 6.1%. We continue to monitor monthly via Workforce Meeting.	Quality Effectiveness (6-10)	12	4	3	Vida Morris
1287v.27	Medication pages on RiO are not being kept up to date as per NTW Policy. Information transferred to the MHDS may not be accurate	Quality Safety (6-10)	16	4	4	Kedar Kale

DRAFT

1809v.6	CCTV coverage within St Georges Park site is extremely limited, the system is over 15years old and of poor quality. The wards only have coverage at the door entry system and does not cover reception and admin areas. The lack of/poor provision makes SGP an outlier within the Trust in terms of security and compromised patient safety.	Quality Safety (6-10)	16	4	4	Pam Travers

2.1 North Locality Corporate Business Units

The four CBU's within the North locality currently hold a total of 24 risks.

2.2 Community North CBU

Community North CBU is currently holding 3 risks – 3 risks are exceeding risk appetite. Risks which have exceeded risk appetite are documented below:-

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1336v.10	The WAA and LD services have experienced significant pressures as a result of difficulties in recruiting substantive Consultant Psychiatrists over the last 12 months. The WAA teams have 1 of 4 substantive medics and no substantive medic in Berwick. In LD we have no substantive consultants. The gaps have been covered where possible with locum capacity, but this adds to the financial pressure and impacts on waiting times, psychiatric outpatient diagnosis and reviews resulting in increased complaints from service users and GP referrers	Quality Effectiveness (6-10)	12	4	3	Rebecca Campbell
1347v.10	Increased burden of physical health investigations for those service users who are prescribed antipsychotic medication alongside general physical health awareness monitoring across all conditions. This is required despite the lack of additional resources to deliver this. In addition, some team areas have	Quality Effectiveness (6-10)	12	3	4	Rebecca Campbell

DRAFT

	lack of skilled practitioners to deliver the wide range of health interventions or have access to fit for purpose treatment rooms. This has a wider impact on clinical capacity in the west and north of the county. This is also an issue in North Tyneside					
1369v.11	Whitley Bay, North Shields, Long Benton CMHTs merged into North Tyneside east CMHT in October 2012. However, the service continues to operate across 2 sites. Until finalisation of estates plan contingency is required to prevent risk to service continuity and equity across both sites	Quality Effectiveness (6-10)	15	3	5	Rebecca Campbell

2.3 Inpatient North CBU

Inpatient North CBU is currently holding 7 risks. 4 risks are within risk appetite and 3 risks are exceeding risk appetite. Risks which have exceeded risk appetite are documented below:-

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1392v.22	Patients smoking on wards and on site	Quality Safety (6-10)	12	4	3	William Kay
1642v.17	At times, there is a delay in response, or the alarm system across the St George's Park site does not show exact location where alarm was activated, leading to potential delay in response team attending	Quality Safety (6-10)	15	3	5	William Kay
1730v.7	Bed Pressures. Allocation of red and amber leave beds when admitting onto. Acute wards has resulted in increasing numbers of patients being accommodated on Rehab wards for varying periods of time. No opportunity to plan appropriately when moving patients from controlled environments to less secure ones. Issues with AC responsibilities, care, staff, environment and risk management and effective communication to patients	Quality Safety (6-10)	12	3	4	William Kay

DRAFT

2.4 Specialist Children and Young People's CBU

Specialist Children and Young Peoples CBU is currently holding 9 risks – 2 risks are within the risk appetite and 7 risks are exceeding risk appetite. Risks which have exceeded risk appetite are documented below:-

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1612v.16	The clinical environment of Alnwood (CAMHS MSU) has been identified as being inappropriate to provide safe, effective, responsive, caring and well led services to the young people who are patients there. In 2016 the CQC assessment of NTW identified that in the long term CAMHS MSU Services needed to be re-provided in a more appropriate clinical environment. The limitations of the building at Alnwood have been identified by staff and young people as leading to boredom, frustration and increased levels of stress and aggression by young people towards others and themselves. Issues relating to the environment at Alnwood continue to be highlighted through MHA CQC Visits and Place Assessments.	Quality Safety (6-10)	12	4	3	Lisa Long
1613v.19	Young people with autism (with or without an LD) who require bespoke environments when admitted to Hospital. Providing these bespoke environments has an impact on the environmental and staffing resources of teams that can negatively impact on the patient experience and the ability of the ward to facilitate future admissions. Environmental issues may also lead to increased levels of violence and aggression, and deliberate self harm.	Quality Safety (6-10)	12	4	3	Lisa Long

DRAFT

1704v.12	Clinical services within CAMHS at Cumbria are increasingly being reported as being under-resourced due to ongoing staff recruitment issues. These have been noted on an individual case basis, particularly in regards to planning robust discharge arrangements for children and young people from Cumbria. There is a risk that due to these service issues, young people from Cumbria have / are:- 1) admitted inappropriately 2) inappropriate discharge arrangements / delayed discharge 3) increased risk of readmission	Quality Safety (6-10)	16	4	4	Lisa Long
1725v.6	Environment at PICU (Ferndene) is limited in terms of accessibility to therapeutic space for young people, access to seclusion facilities and appropriate staff meeting areas / clinical rooms. These limitations present a risk in our ability to admit patients, impacts on existing patient care and raises a potential risk of having to send patients out of area due to the environment.	Quality Safety (6-10)	6	4	3	Jane Robb
1734v.6	Reduced capacity within the NTW and TEWV footprint due to the closure of Newberry and suspension of admissions to TEWV SEDU and LSU Units. This has resulted in increased pressure to admit to the Ferndene site from NHSE. This could result in NTW young people being admitted out of the NTW area which potentially could impact on their experience, mental health and also their length of hospital stay	Quality Safety (6-10)	16	3	4	Lisa Long
1735v.4	No dedicated Consultant Psychiatrist time in to ICTS in Newcastle and Gateshead. The team were receiving 2 PAs from CYPS consultants but this has been withdrawn due to long term sickness within the CYPS service. As a result	Quality Effectiveness (6-10)	12	4	3	Lisa Rippon

DRAFT

	Newcastle and Gateshead ICTS are unable to provide consultant psychiatry input in to care and treatment other than from the on call/duty psychiatry rota. The impact of this may be that a young person may not get a full MDT approach to care and treatment. This could impact on patient experience and effectiveness.					
1798v5	Based upon reported incidents from Aycliffe Secure Centre it has transpired that there are cultural differences and opinions of LADO (Local Authority Designated Officer) referral thresholds. There is also a lack of clarity as to how Local Authority management within Aycliffe have been addressing the concerns which have been reported.	Quality Safety (6-10)	12	4	3	Lisa Long

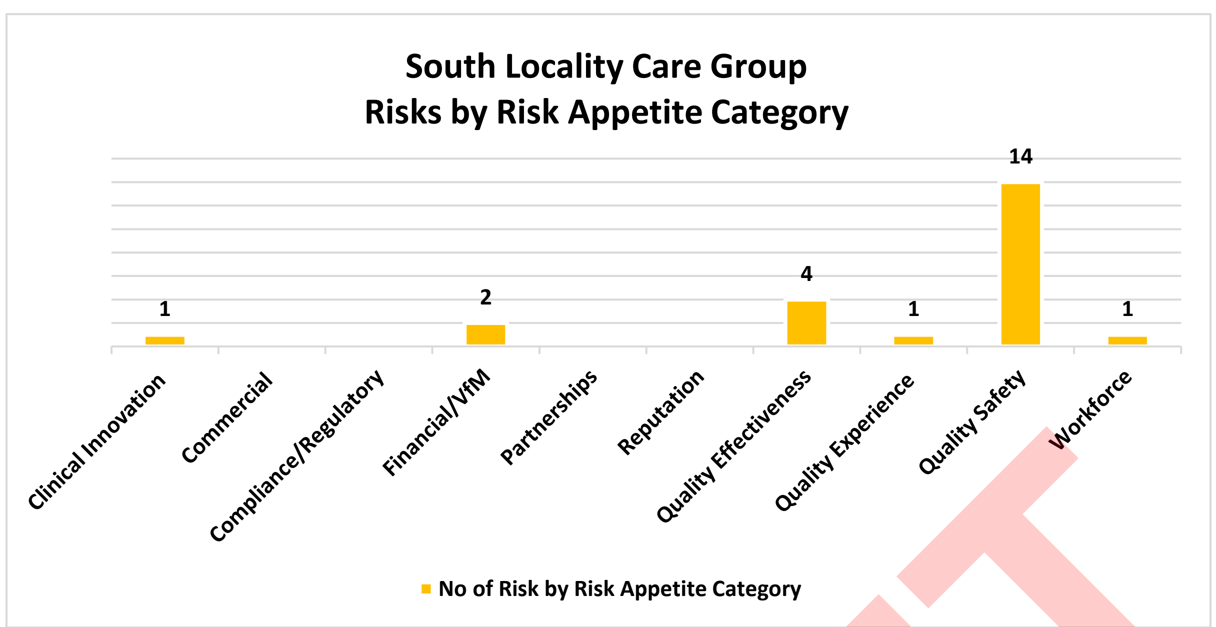
2.5 Access North CBU

Access North CBU is currently holding 5 risks – 2 risks are within risk appetite and 3 risks are exceeding risk appetite. Risks which have exceeded risk appetite are documented below:-

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1701v.18	Environments in both Greenacres and Sextant House are not fit for purpose and pose a number of safety for both Service Users and staff. No high risk rooms or anti barricade doors. Inadequate staff attack system and CCTV. Greenacres require controlled access point to Interview rooms. Windows require strengthening.	Quality Safety (6-10)	16	4	3	Elaine Fletcher
1795v.2	There was a significant fire at the Wallsend NTRP. The fire has rendered the building uninhabitable for staff and service users.	Quality Safety (6-10)	16	5	4	Elaine Fletcher
1816v.2	Due to no clinical base unable to undertake our usual screening including BBV testing due to risk of contamination/no clinical setting	Quality Effectiveness (6-10)	16	4	4	Elaine Fletcher

DRAFT

3.0 South Locality Care Group



In total as at end of June 2020 the South Locality Care Group hold 23 risks, 3 risks lower than the risk appetite, 8 risks within the risk appetite and 12 risks which have exceeded the risk appetite and one below the risk appetite. All risks are being managed within the South Locality Care Group and no requests to escalate to BAF/CRR have been received.

There are 10 risks on the South Corporate Group risk register – 1 risk is below the risk appetite, 5 risks are within the risk appetite and 4 risks that that have exceeded the risk appetite. Below are the risks which have exceeded a risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1084v.25	The Personality Disorder Hub team are based at Benfield House at Walkergate Park and have been allocated desk space for up to 8 people. At present the room is being used by up to 23 members of the team. Stress risk assessment carried out by the team demonstrate that the accommodation is not a conducive environment (cramped space and lack of privacy) which could result in high levels of staff sickness.	Quality Safety (6-10)	15	5	3	Andy Airey
1160v.11	There are pressures on staffing due to vacancies particularly within CYPS MH, RGN's WGP which may impact on the quality of service, patient safety and experience.	Quality Effectiveness (6-10)	12	4	3	Andy Airey
1497.v15	Staffing pressures due to vacancies and difficulties	Quality Experience	16	4	4	Andy Airey

DRAFT

	recruiting and retaining medical staff within the South Locality Group	(6-10)				
1670.v6	Year on Year increasing demand has led to significant numbers of children and young people waiting for treatment.	Quality Safety (6-10)	12	4	3	Andy Airey

3.1 South Locality Corporate Business Units

The four CBU's within the South locality currently hold a total of 13 risks.

3.2 Community South CBU

Community South CBU is currently holding 4 risks which are exceeding the risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1716v.6	High level of Vacancies is impacting on current service delivery and patient safety and quality of care. This is increasing waiting times for Assessment & Treatment. Recruitment of nursing staff is a national challenge.	Quality Safety (6-10)	12	3	4	Janet Thomson
1820v.2	MPS - unable to undertake assessments due to COVID situation. Sunderland Royal not accepting Scans. Increase in Wait Times inevitable.	Quality Safety (6-10)	15	3	5	Janet Thomson
1832v.1	Increase in Wait Times Older Adults CTT as a result of COVID. patients unable to attend face to face assessments and shielding.	Quality Safety (6-10)	20	4	5	Janet Thomson
1833v.1	Blood results not recorded in Physical Health Form from Emis. This would lead to Patient information not being updated on RiO	Quality Safety (6-10)	15	3	5	Janet Thomson

3.3 Inpatient South CBU

Inpatient South CBU is currently holding 4 risks, 1 is below the risk appetite, 1 risk is within the risk appetite and 2 risks are exceeding the risk appetite. Information in relation to the breach risks are given below:-

DRAFT

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1388v.18	Trust sites smoke free; risks with service users secreting cigarettes and lighters, smoking in bedrooms and on site. Increase of fire risks on some wards. Related incidents of aggression when service users are asked not to smoke Service users leaving the ward more regularly to have cigarettes; at times staff encountering difficulty adhering to access, egress and engagement policy - potential risk to service users	Quality Safety (6-10)	12	3	4	Denise Pickersgill
1720v.6	Risk of increased bed pressures within the South adult pathway. (Acute and Rehabilitation) as a result of bed reductions in the Northumberland and Central Localities. Risk of an increase in admissions from other localities and over spill in to other pathways such as PICU and Older Persons.	Quality Effectiveness (6-10)	12	4	3	Denise Pickersgill

3.4 Neurological and Specialist Services CBU

Neurological and Specialist Services CBU is currently holding 5 risks, 1 risk is below the risk appetite, 2 risks are within the risk appetite and 2 risks are exceeding the risk appetite. Information in relation to breached risks are given below:-

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1660v.25	Benfield House houses several services with varying needs and at times insufficient space to provide quality experience for patients. This can impact the therapeutic alliance between patients and clinicians where there is a lack of space and privacy to engage and concentrate during therapeutic conversations. This can increase the likelihood of mistakes being made it can also change the risk signature of some patients which can directly impact on their safety.	Quality Safety (6-10)	12	4	3	Andrew McMinn

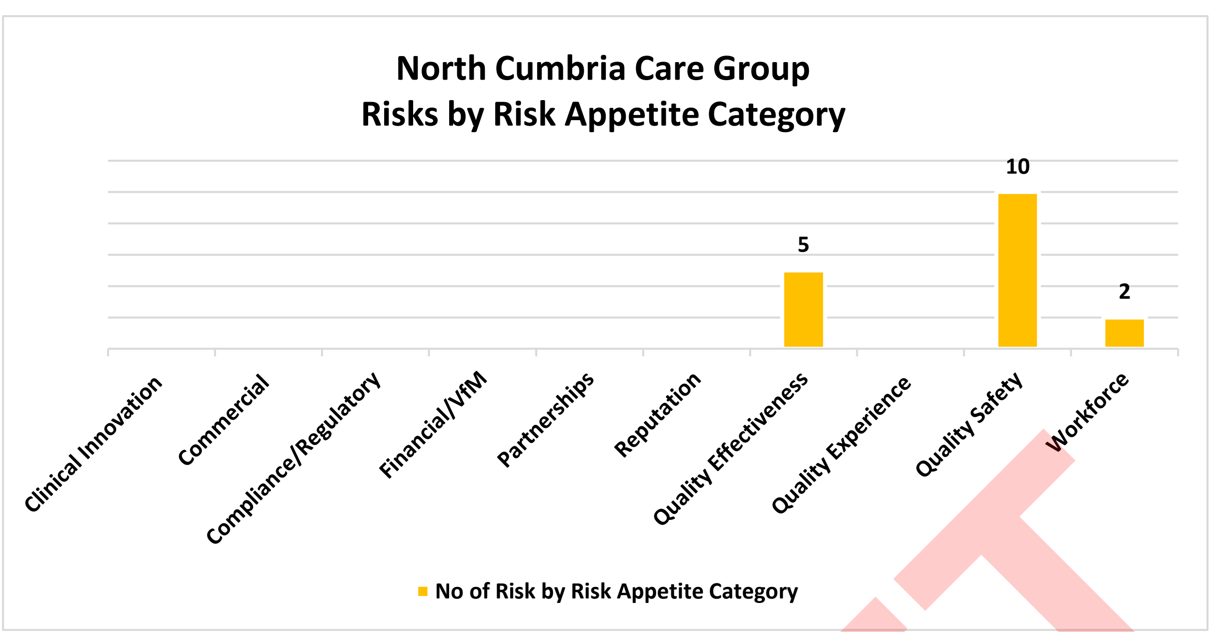
DRAFT

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1822v.1	Lengthy waits increase the distress caused by Gender Dysphoria leading to potential deterioration and impacting on the patients wellbeing.	Quality Safety (6-10)	12	4	3	Andrew McMinn

3.5 Access South CBU

Access South CBU has no risks.

4.0 North Cumbria Locality Care Group



In total as at end of June 2020 the North Cumbria Locality Care Group hold 17 risks, 1 risk below the risk appetite, 6 risks within the risk appetite and 10 risks which have exceeded the risk appetite and one below the risk appetite. All risks are being managed within the South Locality Care Group and no requests to escalate to BAF/CRR have been received.

There are 9 risks on the North Cumbria Corporate Group risk register – 1 risk below the risk appetite, 3 risks are within the risk appetite and 5 risks that that have exceeded the risk appetite. Below are the risks which have exceeded a risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1793v.2	Because there is a shortage of clinical capacity (within the CAMHS service) there is a risk that this will lead to delays in routine reviews, emergency assessments and MHA work. This could lead to inability of the service to meet the health needs of our patients.	Quality Safety (6-10)	15	5	3	David Muir
1794v.3	Because staff have historically been unable to complete mandatory training such as PMVA, safeguarding, fire, ILS, this creates a risk that staff will not have the most up to date skills and knowledge to deal with certain situations. This could lead to a patient and/or staff safety incident should staff not have appropriate skills to deal with an incident such as PMVA, fire etc.	Quality Safety (6-10)	12	4	3	David Muir

DRAFT

1799v.6	Due to upcoming retirement and departure of several medical staff, there is a risk that there will not be a sufficient level of consultant cover across many services in North Cumbria. If not addressed services will struggle to operate at a level which is safe and/or timely in order to meet patient need.	Quality Safety (6-10)	16	4	4	Stuart Beatson
1800v.5	Because there are staff identified as lone workers who have not yet received lone worker device training, there is a risk that staff involved in a potentially harmful incident cannot contact their colleagues for help quickly. Risk of personal harm, delayed response to an emergency.	Quality Safety (6-10)	12	4	3	David Muir
1815v.6	Because the Care Group Management currently has insufficient visibility in relation to drug safety procedures around the prescribing of sodium valproate, there is a risk that women of childbearing potential could be being prescribed sodium valproate without the pregnancy prevention programme being met. The impact of this risk materialising could lead to neurodevelopmental disorders (approx. 30-40% risk) and congenital malformations (approx. 10% risk).	Quality Safety (6-10)	15	5	3	Stuart Beatson

DRAFT

4.1 North Cumbria Locality Corporate Business Units

The 2 CBU's within the North Cumbria locality currently hold a total of 8 risks.

4.2 Community/ Access North Cumbria CBU

Community/ Access North Cumbria CBU currently hold 6 risks, 2 which are within the risk appetite and 4 risks are exceeding risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1803v.1	136 suites: serious injury to staff; physical damage to 136 suite and Trust property; can restrict use of other areas of hospital; risk of harm to other patients and members of public; damage to 136 suite may result in it being unusable for a period of time; risk to other patients due to depleted staffing whilst assisting incidences in the 136 suites; Risk to Trust of possible claims and litigation also cost of repairing damaged property	Quality Safety (6-10)	15	5	3	David Storm
1804v.1	Service delivery will cease as there will be no staff to deliver. Patient care will be impacted on	Quality Effectiveness (6-10)	12	3	4	David Storm
1805v.1	Risk of increased wait for patients, wait for diagnosis in reasonable time, delay in seeking appropriate support and intervention; reputational risk to trust	Quality Effectiveness (6-10)	12	4	3	David Storm
1806v.1	Use of medication for children and young people due to lack of Tier 2 services within North Cumbria for moderate ADHD. Widespread practice of over prescribing and continue to prescribe longer duration than needed. Not enough consideration being given on alternative explanations other than ADHD; potential harm to children due to non compliance with NICE guidelines.	Quality Effectiveness (6-10)	12	4	3	David Storm

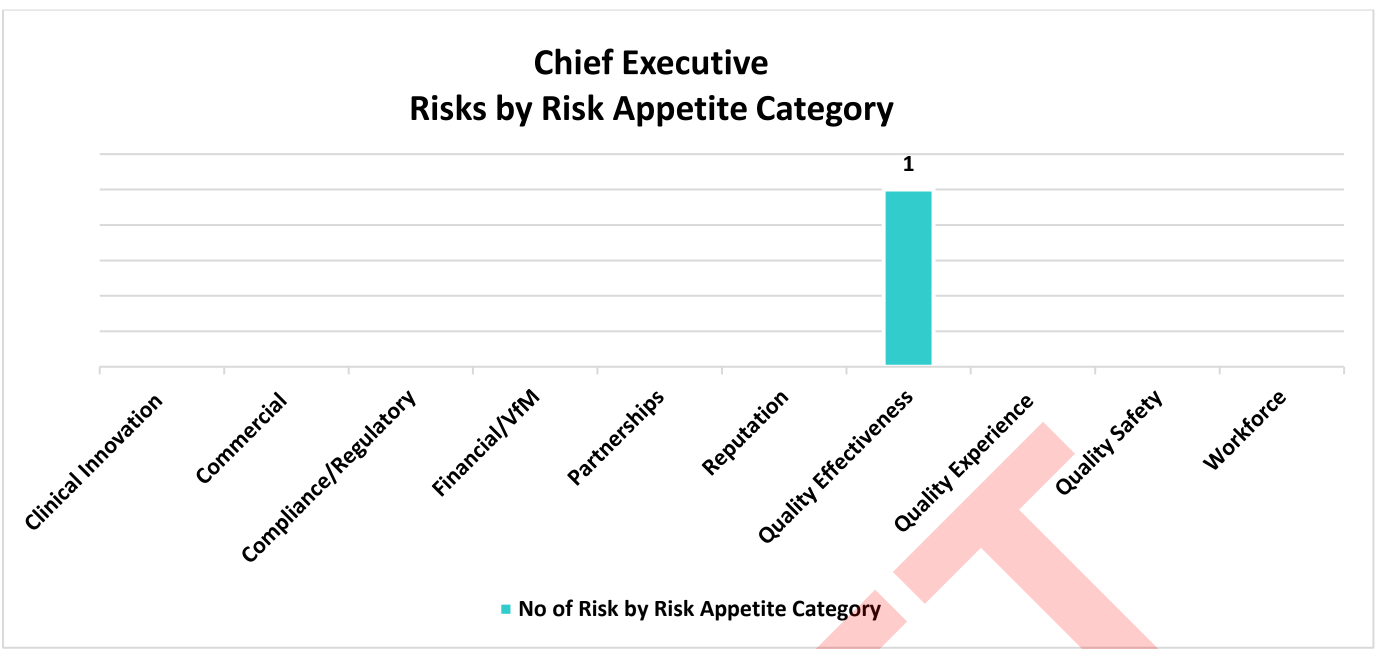
DRAFT

4.3 Inpatient North Cumbria CBU

Inpatient North Cumbria CBU is currently holding 2 risks, 1 risk is within the risk appetite and 1 risk is exceeding the risk appetite. Information in relation to the breach risks are given below:-

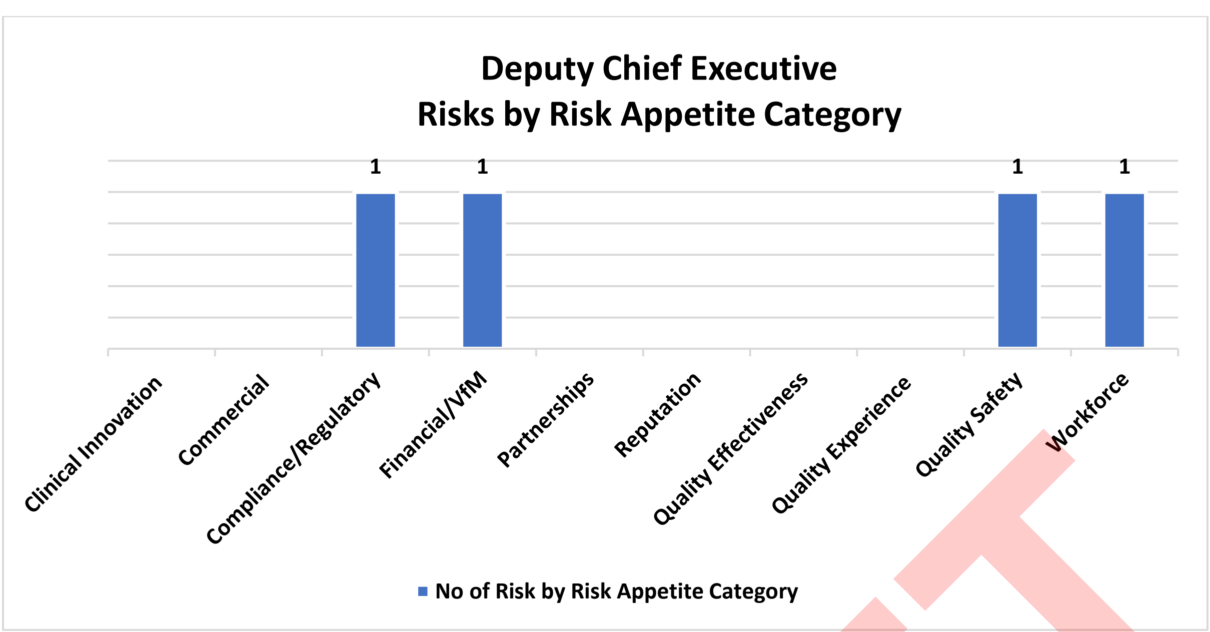
Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1786v.5	Due to North Cumbria inpatient service not being tobacco free there is a potential accidental purposeful fire setting risk which could result in patient and environmental harm.	Quality Safety (6-10)	15	5	3	Andrea Cox

5.0 Executive Corporate



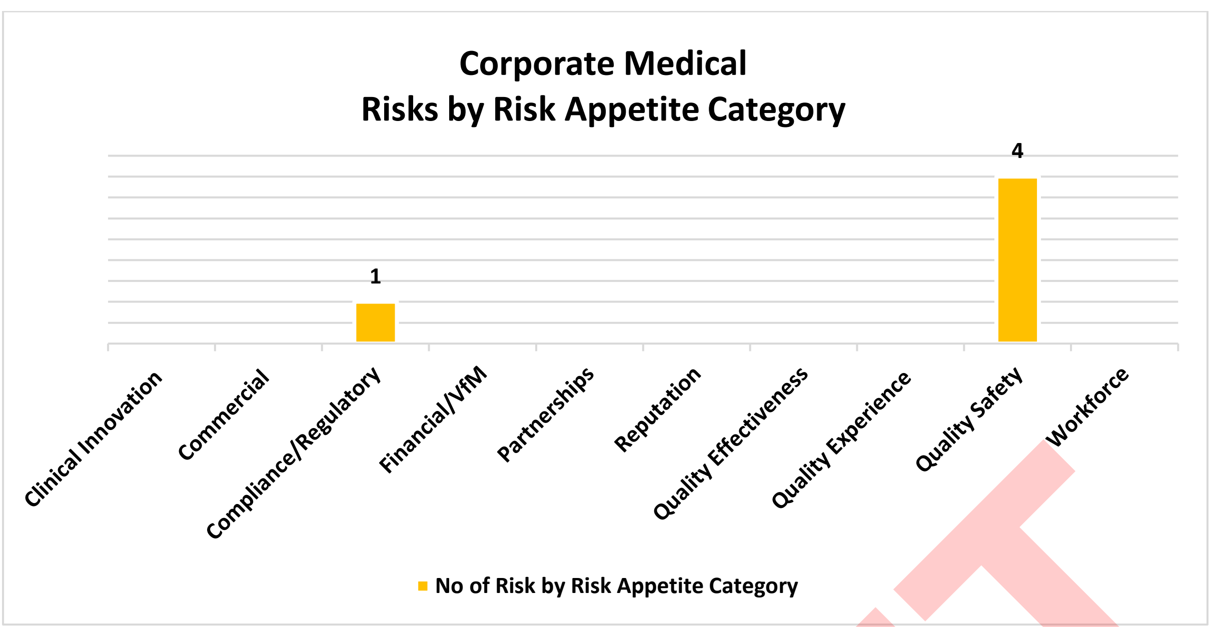
The Chief Executive as at end of June 2020 holds 1 risk. 1 risk is within the risk appetite All risks are being managed within the Chief Executive's Office and no requests to escalate to BAF/CRR have been received.

6.0 Deputy Chief Executive



The Deputy Chief Executive as at end of June 2020 holds 4 risks, 1 risk lower than the risk appetite, 3 risks within the risk appetite. All risks are being managed within the Deputy Chief Executive Directorate and no requests to escalate to BAF/CRR have been received.

7.0 Corporate Medical

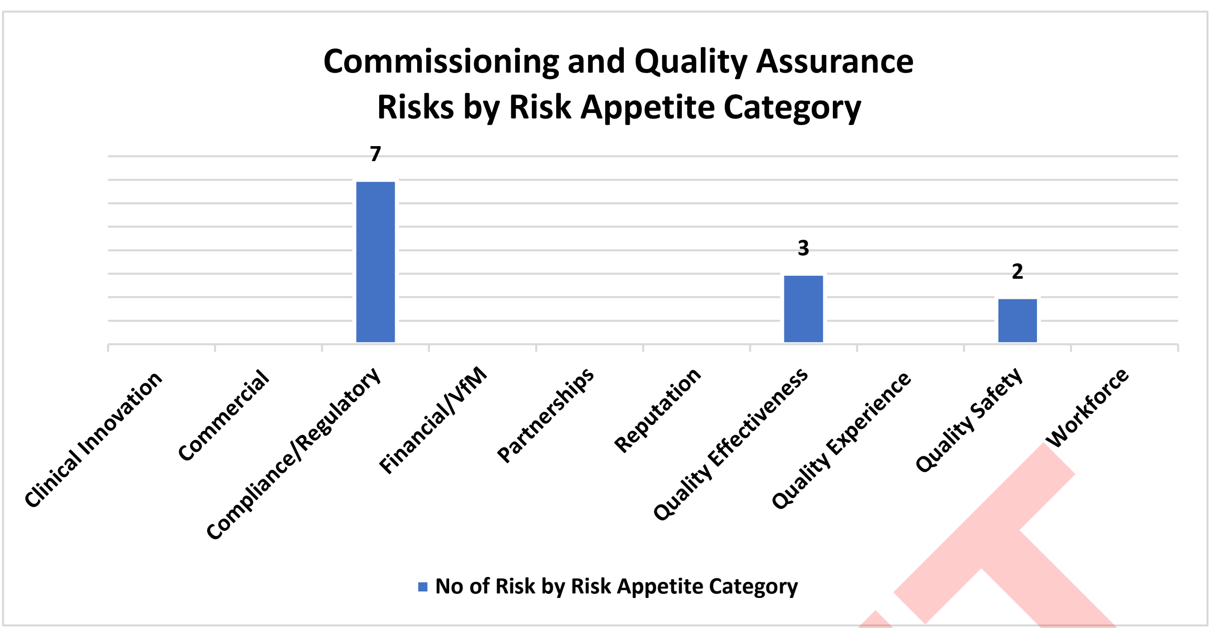


The Executive Medical Director as at end of June 2020 holds 5 risks, 3 risk within the risk appetite and 2 risks which have exceeded a risk appetite. All risks are being managed within the Medical Directorate and no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1808v.4	Variation in clinical and operational practice during harmonisation of CPFT and CNTW Medicines Optimisation and Pharmacological Therapies policies. Potential litigation and reduced quality service delivery for safety and experience	Quality Safety (6-10)	12	4	3	Timothy Donaldson
1814v.3	The Falsified Medicines Directive came into effect 9 February 2019. The Trust are not be able to meet these requirements since Lloyds Pharmacy (current North Cumbria pharmacy service provider) are not currently decommissioning stock issued medicine	Compliance/ Regulatory (6-10)	15	3	5	Timothy Donaldson

DRAFT

8.0 Commissioning and Quality Assurance



The Executive Director of Commissioning and Quality Assurance as at end of June 2020 holds 12 risks, 1 risk below the risk appetite, 5 risks within the risk appetite and 6 risks which have exceeded a risk appetite. All risks are being managed within Commissioning and Quality Assurance Directorate and no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1172 v.19	Increased risk of security threats coupled with increasing type and range of device access to the network linked to technology developments increasing attack vectors and increased sophistication of exploits.	Compliance/ Regulatory (6-10)	12	4	3	Jon Gair
1576 v.10	Data leakage risk of Trust Users transferring sensitive information via insecure methods or to untrusted destinations. This is likely to be via data sharing methods such as unencrypted USB drives, e-mail or personal cloud storage facilities (such as dropbox, google drive, personal onedrive etc)	Compliance/ Regulatory (6-10)	15	5	3	Jon Gair
1637 v.16	That we misreport compliance and quality standards through data quality errors.	Compliance/ Regulatory	12	4	3	Lisa Quinn

DRAFT

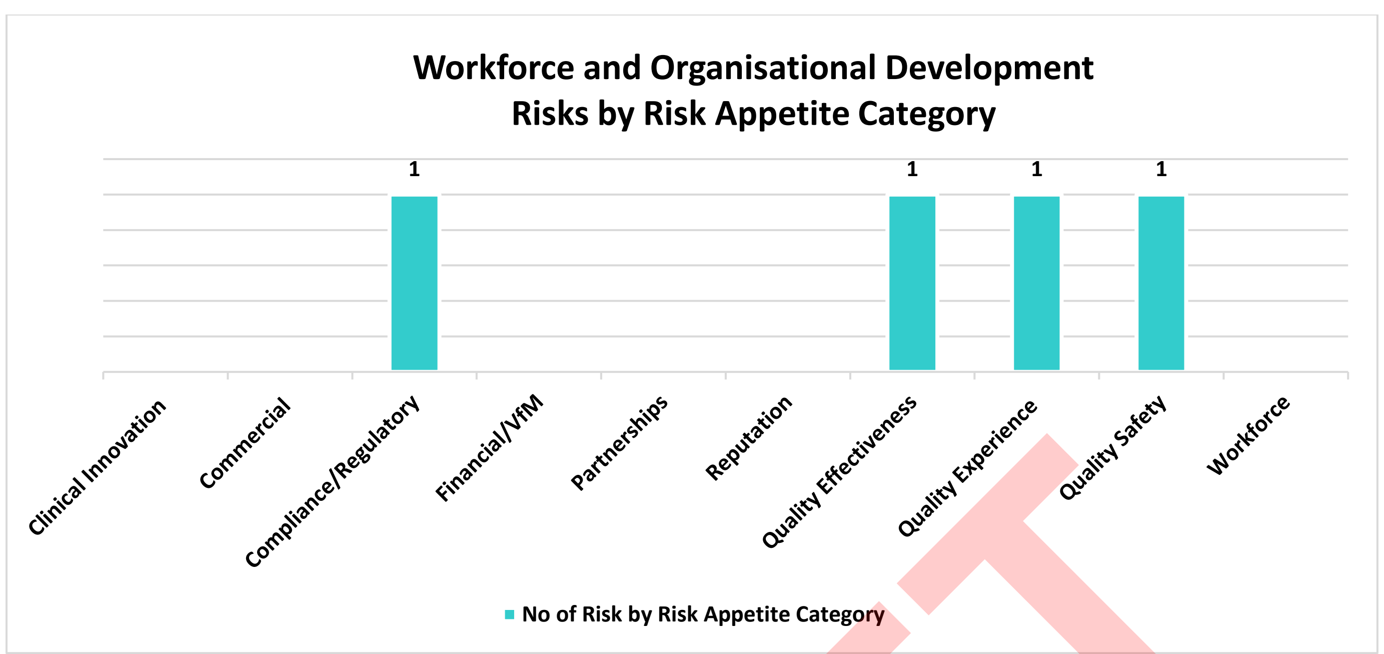
Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1655 v.18	Subject Access Requests: There is a risk of non-compliance with the reduced time frame (1 month). In the absence of electronic systems, the task is labour intensive and wholly reliant on human resource. Therefore, increasing the risk of not meeting the legislation timeframe and error during the process which in turn breaches confidentiality or serious harm.	Compliance/ Regulatory (6-10)	12	3	4	Angela Faill
1719v.8	A number of systems that are relied upon by the Trust are running on unsupported software that is no longer receiving security updates or patches. There is a risk that unknown exploits take over this machine, bypassing any security controls in place. The systems this includes are the following NTW-SP which is running an old version of Windows server and SQL database, currently running Sharepoint service for Informatics staff.	Compliance/ Regulatory (6-10)	12	4	3	Jon Gair
1755v.5	The Trust has agreed to continue using the Galatean Risk and Safety Technology (GRIST) clinical risk assessment tool across the North Cumbria services as part of the RiO and IAPTus clinical record. This system was originally procured via Cumbria Partnerships a number of years ago and the following risks have been identified on assessment by CNTW informatics staff :-- No formal contractual arrangement is in place with the supplier so no service level agreement availability which could impact on accessibility to the system.	Compliance/ Regulatory (6-10)	16	4	4	Jon Gair

DRAFT

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
	- System and data is hosted on Aston University servers with no formal contracted levels of security in place to secure access to data.- Free text fields exist within the system which may contain sensitive or personally identifiable information. - No audit trail exists to identify who is making changes to GRIST data, increasing the risk of unexpected changes that are not accountable to individuals. - All changes to the data are made via parameter-based URL calls so with knowledge of the API and session ID, records could be manipulated or deleted by end users.					

DRAFT

9.0 Workforce and Organisational Development

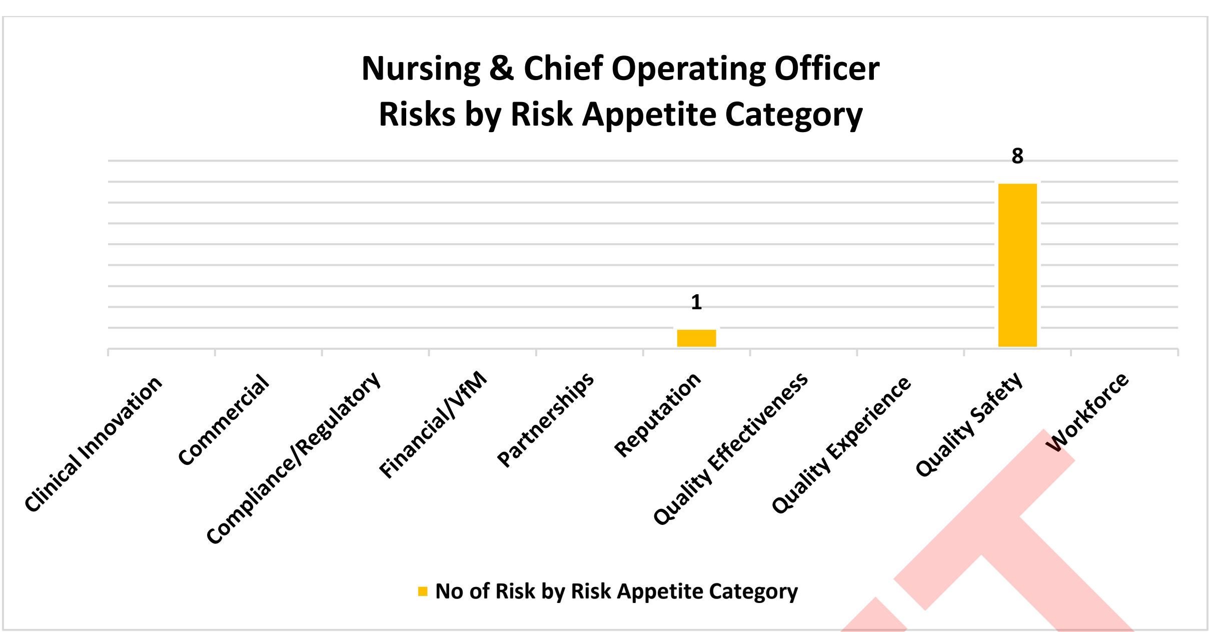


The Executive Director of Workforce and Organisational Development as at end of June 2020 holds 4 risks. There are 2 risks that are within the risk appetite and 2 risks which breach the risk appetite. No risks to escalate to the BAF/CRR have been received.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1715v.5	Sickness absence continues to remain above trust target of 5%. Reduced staff available resulting in increased use of temporary staff having both impact on quality of consistency in care and financial impact	Quality Experience (6-10)	12	3	4	Michelle Evans
1760v.10	Due to significant data gaps within workforce information transferred from Cumbria Partnerships NHS Foundation Trust there is a risk the data is not accurate, and the trust do not meet legislative and regulatory requirements	Compliance/ Regulatory (6-10)	16	4	3	Lynne Shaw

DRAFT

10.0 Nursing & Chief Operating Officer



The Nursing & Chief Operating Officer as at end of June 2020 holds 9 risks. 3 risks lower than risk appetite, 2 risks are within the risk appetite and 4 risk which exceed the risk appetite. All risks are being managed within Nursing & Chief Operating Officer Directorate and there have been no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1220v.21	Women of childbearing age are prescribed valproate without appropriate awareness of the risks involved. Risk identified in POMH-UK 15a Bipolar Disorder audit results, baseline assessment of NICE CG192 and MHRA Patient Safety Alert NHS/PSA/RE/2017/002	Quality Safety (6-10)	15	5	3	Gary O'Hare
1611v.18	It is important to identify patients who have a swallowing difficulty and the risk it poses. Patients who have a swallowing risk require appropriate assessment and for staff to recognise the potential risk off dysphagia therefore accessing and referring to the SALT team. The impact of this risk is on patient safety.	Quality Safety (6-10)	15	5	3	Gary O'Hare

DRAFT

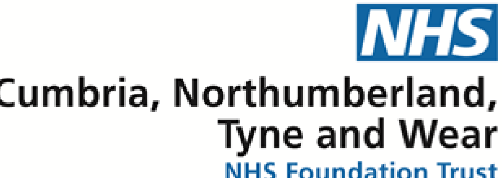
Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1758v.6	Due to several incidents occurring whereby, patients have been able to remove light fittings and gain access to a wire in the seclusion room and in a number of ward areas a ligature risk has been identified. The potential risk could result in serious harm to the patient	Quality Safety (6-10)	15	5	3	Gary O'Hare
1821 v.2	Due to several incidents occurring whereby, patients have been able to insert knotted items into plug holes in sinks, fill with water causing the knot to swell and anchor into position, a ligature risk has been identified. The potential risk could result in serious harm to the patient	Quality Safety (6-10)	15	5	3	Gary O'Hare

12. Emerging Risks

There are no new emerging risks in the Locality Care Groups and Executive Corporate risk registers that are not mentioned in the report.

Lindsay Hamberg
Risk Management Lead
15 July 2020

DRAFT



Report to the Board of Directors
5th August 2020

Title of report	**Annual Security Management Report - 2019 / 2020**
Report author(s)	**Tony Gray – Head of Safety, Security and Resilience** **Phil Storey – Patient Safety Manager**
Executive Lead (if different from above)	**Gary O'Hare – Executive Director of Nursing and Chief Operating Officer**

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing		Work together to promote prevention, early intervention and resilience	
To achieve "no health without mental health" and "joined up" services		Sustainable mental health and disability services delivering real value	
To be a centre of excellence for mental health and disability		The Trust to be regarded as a great place to work	x

Board Sub-committee meetings where this item has been considered (specify date)		**Management Group meetings where this item has been considered (specify date)**	
Quality and Performance	x	Executive Team	
Audit		Corporate Decisions Team (CDT)	
Mental Health Legislation		CDT – Quality	x
Remuneration Committee		CDT – Business	
Resource and Business Assurance		CDT – Workforce	
Charitable Funds Committee		CDT – Climate	
CEDAR Programme Board		CDT – Risk	
Other/external (please specify)		Business Delivery Group (BDG)	

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability		Reputational	
Workforce		Environmental	x
Financial/value for money		Estates and facilities	x
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

DRAFT

Annual Security Management Report - 2019 / 2020

Board of Directors Meeting
5th August 2020

1. Executive Summary

Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust is committed to the delivery of an environment for those who use or work in the Trust that is properly secure so that the highest possible standard of clinical care can be made available to patients. Security affects everyone who works for or uses the NHS. The security of staff, patients, carers and assets is a priority of the Board within the development and delivery of health services.

All of those working within the Trust also have a responsibility to be aware of these issues and to assist in preventing security related incidents or losses. Reductions in losses and incidents relating to violence, theft or damage will lead to more resources being freed up for the delivery of patient care and contribute to creating and maintaining an environment where all staff, patients and visitors feel safe and secure.

The purpose of this report is to provide information and assurance of the controls currently in place to create a pro-security culture across the Trust, as well as informing of the work currently being carried out across the organisation to improve security arrangements.

This is the 12th Security Management Annual Report for Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust

Background

Security Management in the NHS has been the sole responsibility of each NHS organisation, with the demise of NHS Protect in April 2017, arrangements for Security Management have been overseen by Boards of Directors and the resources available are with the agreement of the Board lead for Security. Within Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust, this responsibility is discharged to the Executive Director of Nursing and Chief Operating Officer (within Trust policy the term Security Management Director is still used to describe the responsibilities of this role).

There is also still a requirement to comply with the National Security Management Standards in line with the NHS Standard Contract, acknowledging that there is no national oversight of this.

There is an on-going conversation in relation to aspects of the standards being re-aligned to the National Violence Reduction Strategy which is currently overseen by NHS England / Improvement.

There are still external organisations such as the Health & Safety Executive that still have a legal responsibility to oversee and enforce any staff safety issues that are passed to them in relation to the Trust, and the Care Quality Commission would have a view of our safe staffing information as a regulated activity as well as any security concerns that impacted on patient care.

DRAFT

Security Management Director (SMD) and Local Security Management Specialist (LSMS)

The roles of the SMD and LSMS were previously defined in law to carry out the following functions:-

The Executive Director of Nursing and Chief Operating Officer in their capacity as the Trust's Security Management Director shall assume responsibility on behalf of the Board of Directors for all aspects of Security Management within the Trust. They will ensure that all management arrangements are in place to ensure compliance with the Trust's policy arrangements and supporting Practice Guidance Notes which covers the following areas:-

- Closed Circuit Television
- Lone Working
- Counter Terrorism Response (including bomb threats)
- Working in Partnership with the Police (including prosecutions where appropriate)
- Trust Search Dog
- Hospital Lockdown
- Nuisance and Malicious Calls

In order to maintain and improve the safety and security systems within the Trust, the Security Management Director has deemed it appropriate to maintain the Trust's Local Security Management Specialists, as part of the central Safer Care Team.

The two individuals provide cover across the organisation in relation to security management but have a greater portfolio than security management which covers the following areas:-

- Emergency Preparedness, Resilience and Response
- Security Management (Including Lone Working System)
- Health & Safety Management
- Incident System Management
- Policy Administration and Management
- Central Alert System
- Safer Care Website / Bulletin / Information and Management

Current Position and Review of the Year

The LSMS function regularly undertake security based risk assessments on behalf of the organisation. These assessments cover a range of subjects including:

- Targeted risks to Trust staff and support for lone working situations
- Security of premises
- Protecting property and assets
- Security preparedness and resilience
- Use of weapons / Use of illicit substances

The results of security risk assessments and associated recommendations are shared with key stakeholders. Security risk assessments are carried out both reactively, pro-actively and Clinical Environmental Risk Assessments also include aspects of security management when they are carried out on in-patient wards.

DRAFT

The Clinical Environmental Risk Assessment process is completed annually for each in-patient ward, acknowledging this is where 3 out of every 4 incidents occur.

There were over 29 assessments carried out in the last 12 months, including assessments for the North Cumbria Wards as part of Transition in October 19.

The assessment process also considers safety and security of the following areas:-

- CCTV
- Staff Attack Systems
- Door Access
- Asset Security
- Building Security
- Abscond Risk
- Substance Misuse / concealment / supply etc.
- Nurse Call Systems
- Falls Detection

Lone Working

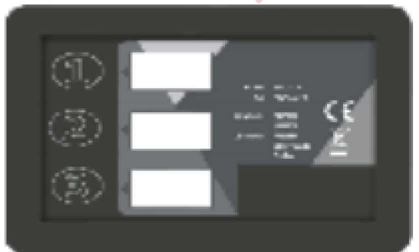
Health care workers have long been identified as a high risk group when considering lone working. Issues identified in high profile incidents emphasise the scale of the risk faced by mental health care staff on a daily basis.

Lone workers face environmental risks and are increasingly exposed to incidents with regards to assaults, aggression, abuse and harassment. Most often, these incidents occur one to one situations with no other evidence available to support taking action against alleged offenders. This can result in a reluctance by lone workers to report incidents that occur, leading to a feeling that nothing can be done to protect them or deal with the problems they face. Lone workers, by the nature of their work, can feel isolated or unsupported, simply by the very fact that they do not work in an environment surrounded by their colleagues or others.

As per previous years, we have had number of genuine red alerts, which continue to be dealt with in an effective and safe manner. In some of these cases police assistance has been required and rapid response was provided.

The Trust, has a robust contract and system provision in place to protect its lone working staff.

DRAFT



The provision predominantly comes in the form of an ID badge holder, however, the Trust have also recently implemented the provision of Pulse devices which is provided for staff who

have physical difficulties in operating the ID badge. The Pulse device is also currently being utilised in some reception areas that have been identified as being at risk. All identified staff receive comprehensive training on the purpose and correct use of the device.

The system was originally commissioned as part of a centrally funded Department of Health initiative in 2009, and the Trust has continued to use and develop the system since its inception. In 2009, the Trust rolled out over 400 devices to its community staff, and as community services have developed at the end of 2019 / 2020 we have 2,977 active devices. We continue to forge a strong relationship with our provider Reliance Protect.

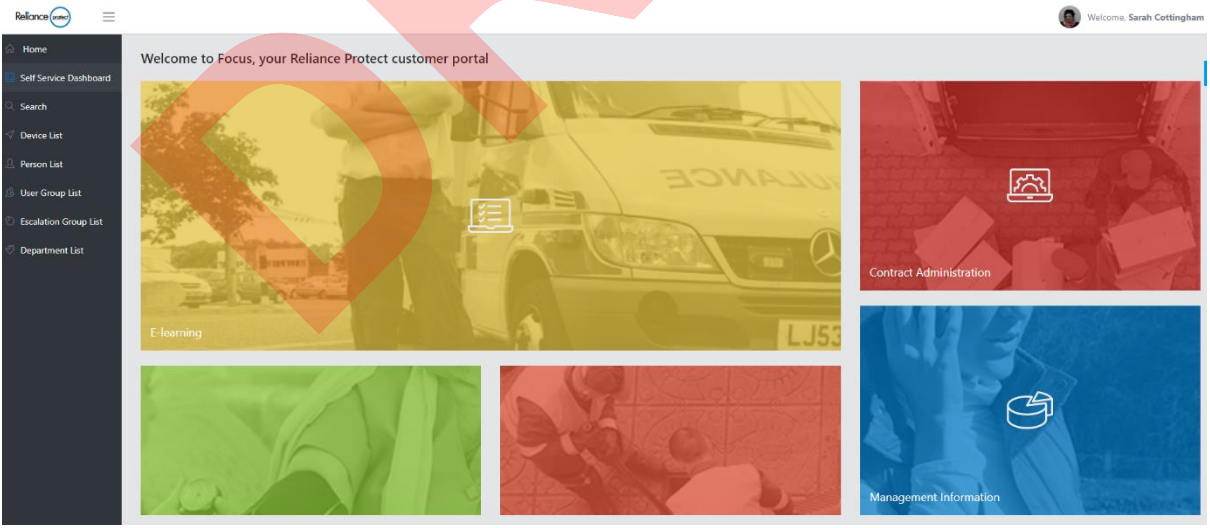
From June 2019 to October 2019, the Lone Working Team successfully implemented the roll out of lone worker devices to community teams in what we now know as the North Cumbria Locality. More than 500 devices were issued and training was provided to all identified staff ahead of the transition date.

Device usage continues to be measured by the activation of amber alerts. Updates and improvements to technology now allow the Trust access to and the use of a live portal so that device usage can be seen through a live integrated web based system.

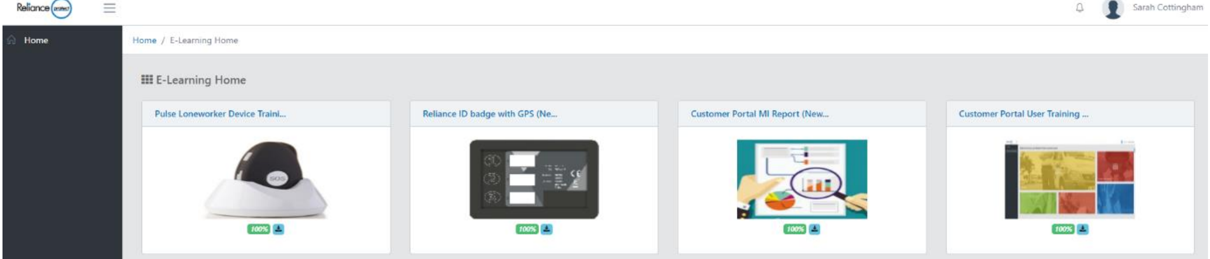
It is acknowledged that as the biggest users of this system nationally, there will always be opportunities for improvement of usage. Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust was the first NHS organisation in the country to adopt the Management Information (MI) system, which has been in place since January 2020, live monitoring of device usage is now accessible by Managers at all levels and displays data in a variety of formats including tables, graphs and charts.

DRAFT

Screenshots of the customer portal and the new MI aspect are below. As of March 2020, all staff in possession of a device have been assigned individual access to the portal where they can update their personal information. Within the web system, Managers at all levels can view all activity by individuals and teams for updates on device usage and setting usage benchmarks.



The portal also allows individuals to utilise e-learning refresher training as and when required.



Ongoing improvements are currently underway to provide a Trust specific lone working dashboard. The additional provision will allow lone working data to be integrated into Trust dashboards for comparison and analysis to improve quality and safety of care. It is hoped the new dashboard will be operational by October 2020.

From March 2020, developments due to the Covid-19 Pandemic have seen the implementation of virtual classroom training hosted by a Reliance Protect Trainer. This is proving to be a successful venture and staff are now able to access a lone working device and training earlier than previous provisions. The typical turn over from receipt of an application form to training delivery has accelerated the process from historically taking one month to now taking approximately one week. As a result of this we have seen a higher uptake of training invitations and training attendance. Training will continue to be predominantly provided in this ways for the future.

Clinical Police Liaison Lead (CPLL)

The Clinical Police Liaison Lead is an established role within the trust having been operational for 6 years. It has developed and changed throughout this time, adapting to national changes and trust need. The post is now embedded working within the Safeguarding and Public Protection (SAPP) Team after a move around 18 months ago from the Safety Team, but there are still close working relationships in respect of staff safety.

During 2019 and so far in 2020 it has continued to be busy and active role in all matters Police Liaison, Multi Agency working and Risk management. This year has included strengthening of the relationship and understanding at all levels, supporting Northumbria Police Chief Constable spending time in clinical services, and our own Chief Executive and Executive Director of Nursing and Operations, gaining an insight into the Police control room and Firearms Unit. The role has also continued to attract attention from other areas of the country and been shared to neighbouring trusts of Tees, Esk & Wear Valley NHS Foundation Trust and Lancashire and South Cumbria NHS Foundation Trust. The latter has used the agreed trust job description and the post is being recruited into for 12 months. CNTW lead will work closely with the new lead and offered a chance of shadowing.

Work has continued with Northumbria Police and British Transport Police (BTP) within the trust area, supporting clinical teams around risk management and multi-agency working, but also educating services around new ways of working in Northumbria. With the introduction of new model of working and arrival of harm reduction units and ensuring risk management and reducing harm. As well as providing essential training and education and for the first time an input to senior tactical firearms advisors training to support and guide their decision making around serious incidents and educate on increased activity with weapon use on our wards.

More recently the role has had a further focus with the addition of North Cumbria locality. The lead has quickly established links/ relationships and partnerships with Cumbria Constabulary,

DRAFT

BTP Carlisle and Civil Nuclear Police. Work began early identifying and improving ways of working, understanding of each other and looking at ensuing CPLL as a point of contact.

There is still much work to be done and it will take many years as it has with Northumbria Police to embed the role and influence change. But it's began - there is Police contact from the locality, and clinical teams contact although promotion of role in locality is needed. There is regular meetings and contact with force lead. There is an additional support in Cumbria locality around Police Liaison. A SAPP Development Officer who is an retired officer is supporting with the development work needed, due to their extensive knowledge of the locality and practices.

The lead is continuing to look at data and doing more around Police activity data, to evidence what we do and how we do it, as well as look at demand and ensure capturing lessons learnt. Working with the new business manager a police activity dashboard is being developed to give us clearer and better understanding.

Respond Multi Agency Training has also gone from strength to strength with a London area and Lancashire and South Cumbria purchasing the package. It has also won a National award from the positive practice collaborative late last year.

Tackling Illicit Drug Use

The use of illicit drugs and new psychoactive substances (NPS formerly known as legal highs) continues to be a problem in some inpatient setting. A number of serious incidents have occurred relating directly to consumption of illicit substances both on the ward and following an episode of leave, media reports and national research have continued to highlight the problem the North East is facing. The Trust isn't an outlier in this, and the Trust is currently working in partnership with Tees, Esk and Wear Valley NHS Foundation Trust the Trust to share learning. We have continued to jointly sharing our Search Dog and Handler across both organisations and working closely with respective Police Forces that cover the geographical locations, to identify trends and report activity , sharing intelligence of vehicles that come onto Hospital sites and known sellers of illicit substances. We will be supporting a full business case for a further Dog Handler and Search dog in 2019, once we have conducted an assessment of need for North Cumbria Mental Health Services. This position has now been filled with the candidate starting in July 2020, a service level agreement will be agreed between the 2 organisations.

Understanding the impact of Aggression and Violence on Staff

This report has previously contained historical information in relation to Reported Physical Assaults on Staff, however this has been removed from this report, due to the Annual Positive and Safe report containing much more detailed information , and also due to the fact that there is currently no nationally comparative data available.

There is a national task and finish group currently project led by the NHS England / Improvement Violence Prevention and Reduction Lead, reviewing the creation of a national reporting system for assaults, aggression and other security related activity, acknowledging no national position on violence incidents and impact on the NHS since the demise of NHS Protect's Security Incident Reporting System in 2017. The Trust has been approached to support this as a pilot, due to our previous successful testing of the National Development of a Patient Safety Incident Management System, which is due to go live in April 2021.

DRAFT

Future Work

The Safety Team has recently moved from the Safer Care Directorate to the Portfolio of the Deputy Chief Operating Officer to further align the support to the Operational Care Groups, where most of the activity is driven across the organisation.

There are a number of projects which will be progressed / business cased in 2020 / 2021 as follows:-

Metal Detection

Following the completion of North Cumbria services in October 2019, the plan was to revisit the business case that had been submitted to progress with implementation across the identified high risk wards. Unfortunately due to operational issues and COVID-19 this work has been delayed but is now back on track, and consideration will be given to this within the organisation. A senior clinician will be supporting this work, as there are major implications around search procedures and potential blanket restrictions that will need to be considered as part of the project work.

Closed Circuit Television

The Safety Team in partnership with NTW Solutions are currently reviewing the specifications of CCTV across the Trust, due to a range of issues, of technology, age, and variability. A single specification is currently being drafted, to think about the latest technology, exploring cloud based systems, and protected access, for evidential purposes. A number of schemes have been progressed over the last year, but there are still a number of locations that do not benefit from CCTV, and these areas will be business cased throughout the year.

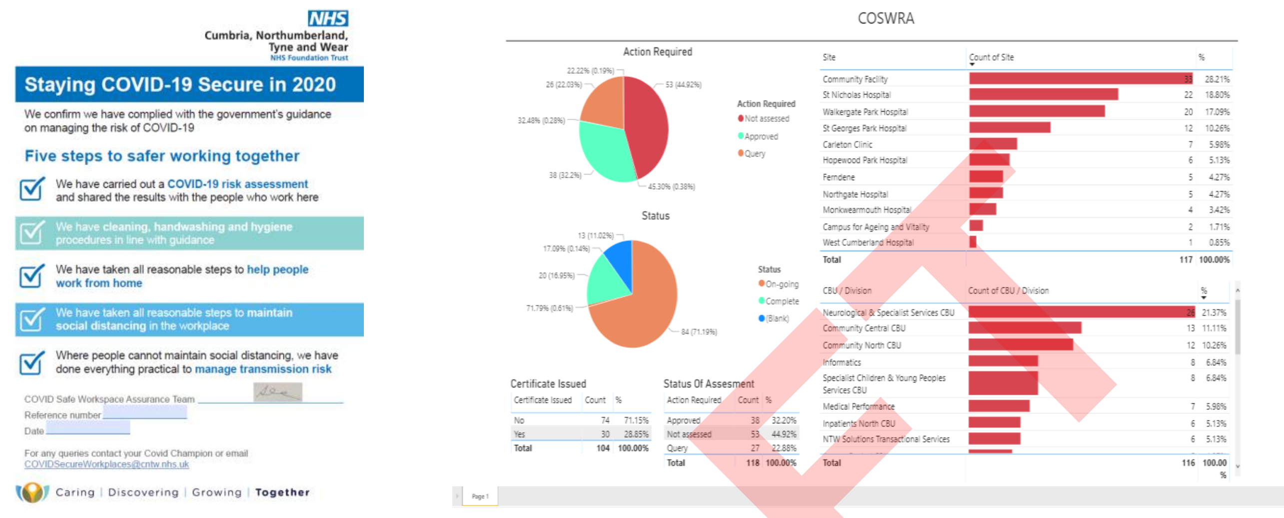
DRAFT

Service Level Agreement for Trust Search Dog Handler

The Safety Team will progress an agreement by the Trust and Tees, Esk and Wear Valleys NHS Foundation Trust in respect of provision of a search dog handler, and as part of this the Trust has secured 2 accredited search dogs from Northumbria Police. This is also to provide a replacement service as Coco , is nearing retirement in December 2020, after 8 years loyal service.

COVID Secure Workplace Risk Assessments (CoSWRA)

The Trust has developed guidance and a risk assessment process, to ensure that any workplace that staff are returning to is COVID secure. As always the principle remains if staff can work from home they should continue to do so. The Safety Team are over-seeing the assessment process and where assurance has been gained and COVID certificates are being issue. As part of monitoring an internal dashboard has been created to oversee the activity. It is expected that some 600+ risk assessments are required across the Trust, so this is at an early stage of implementation.



2. Risks and mitigations associated with the report

The Safety Team strives to complete the tasks asked of it, and as a small team of 8 staff we deliver the following agenda:-

Health and Safety

- Workplace Safety (including COVID Secure Workplace Risk Assessment)
- Clinical Environmental Risk Assessment
- Work with clinical teams to find safety solutions to reduce harm
- Safe Work Equipment
- Control of Substances Hazardous to Health (COSHH)
- Display Screen Equipment Guidance
- Health and Safety Inspections in partnership with staff-side
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
- Maintaining and updating policies to ensure they comply with national guidance and legislation

Security Management

- Overseeing the Security Strategy of the Trust
- Monitoring Security Contracts
- Setting standards of CCTV and ensuring compliance
- Working in partnership with the Police
- Supporting the lone working agenda within the Trust

Emergency Preparedness, Resilience and Response

- Planning, reviewing and implementing Emergency Planning arrangements
- Reviewing and updating guidance in respect of Heatwave Planning
- Reviewing and updating guidance in respect of The Cold Weather Plan

DRAFT

- Working in partnership with NHS Improvement regional and national EPRR Teams

In respect of this, the challenge of capacity and demand is significant, and this is a risk to delivery of all of the tasks above. However in law we believe that the team achieves a reasonably practicable outcome for the resources at it's disposal, acknowledging there is always a new ask, based on the incidents and activity it is exposed to.

The Safety Team actively escalate risks as appropriate through the Trust's Risk Management processes, none of which have required escalation to the Board of Directors for concern.

It is also expected that through 2020/ 2021 there will be further alignment of the Health & Safety , Security and Resilience functions , which would mean the alignment of the 2 separate Board reports being assimilated by next year.

3. Recommendation/summary

The Trust's Safety Team continues to work to mitigate the security risks faced both internal / external to the organisation. As the organisation continues its journey of development, and the NHS as a whole goes through major transformational change, it is acknowledged that safety and security remains paramount and on the highest level of all agendas throughout the Trust.

In short, security needs to be considered by all levels of staff from the Board to the ward and the understanding at each level of the organisation for the parts to play to continue to improve the quality and safety of care that is delivered within the resources we have available. COVID 19 has brought a new dimension to the risk assessments that are being conducted for both people and place and the Safety Team is well placed to support this.

COVID-19 has changed the risk dynamic over the last period, with lone working risk diminishing in relation to reduce home visits, and the utilisation of technology, but with an increased risk of staff safety on in-patient wards , as the system was on lockdown. As the Trust prepares for a potential 2nd wave, the Safety, Security and Resilience function is well prepared to support Gold Command in relation to any requirements, as we continue to provide improvements to the quality and safety of care in these strange and uncertain times.

This paper should be received for information.

DRAFT

Tony Gray
Head of Safety, Security and Resilience

Gary O'Hare
Executive Director of Nursing and Chief Operating Officer (Security Management Director)

20th July 2020

Report to the Board of Directors

Title of report	Annual Report for Infection Prevention and Control 2019 – 2020
Report author(s)	Anne Moore, Director of Infection Prevention & Control Kay Gwynn IPC Matron
Executive Lead (if different from above)	Gary O'Hare, Executive Director of Nursing/Chief Operating Officer

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	X
To achieve "no health without mental health" and "joined up" services	X	Sustainable mental health and disability services delivering real value	
To be a centre of excellence for mental health and disability		The Trust to be regarded as a great place to work	

Board Sub-committee meetings where this item has been considered (specify date)		**Management Group meetings where this item has been considered (specify date)**	
Quality and Performance	X	Executive Team	
Audit		Corporate Decisions Team (CDT)	
Mental Health Legislation		CDT – Quality	X
Remuneration Committee		CDT – Business	
Resource and Business Assurance		CDT – Workforce	
Charitable Funds Committee		CDT – Climate	
CEDAR Programme Board	X	CDT – Risk	
Other/external (please specify)		Business Delivery Group (BDG)	

Does the report impact on any of the following areas			
Equality, diversity and or disability	X	Reputational	
Workforce		Environmental	X
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	X
Quality, safety, experience and effectiveness	X	Service user, carer and stakeholder involvement	

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

DRAFT

2019/20 Annual IPC Report for the Northumberland, Tyne and Wear NHS Trust

Anne Moore, Director of Infection Prevention & Control
Kay Gwynn IPC Matron

DRAFT

Contents

Contents

NORTHUMBERLAND TYNE AND WEAR NHS FOUNDATION TRUST .... Error! Bookmark not defined.

Board .... Error! Bookmark not defined.

Introduction and Context 2

Infection Prevention and Control Team Structure 2

Service Level Agreements 2

IPC Committee meetings held in 2019/20 3

External Accreditation Bodies 3

Infections from Incidents 3

Root Cause Analysis of Clostridium Difficile Infection 4

There were no cases of clinical clostridium difficile infections that were acquired within CNTW 4

Seasonal Flu Vaccination Campaign 5

Key achievements identified in 2019/20 Flu Campaign 6

Training in Infection Prevention and Control 6

Audit 7

Decontamination Report/Medical Devices 8

Water Safety Group Report 8

Annual Cleaning Services Report 9

Staffing 10

Summary 11

Appendix 1 12

Appendix 2 13

Appendix 3 Cleanliness Audit Results 14

Appendix 4 PLACE Results 15

Appendix 5 16

DRAFT

Introduction and Context

The Annual Report of the Director of Infection Prevention and Control (DIPC) provides the Infection Prevention Control Committee, Quality and Performance Committee and the Trust Board with a summary of activity relating to assurance and developments which took place during 2019/20 relating to Infection Prevention and Control across the Trust. The IPC function carried out across the Trust meets statutory requirements and the Health and Social Care Act 2008. The Infection Prevention and Control team is responsible for the outline delivery of the 2019/20 Infection Prevention and Control Annual Plan.

Covid-19

This Annual Report focusses largely on the activity prior to the emergence of the Covid19 global pandemic at the end of February 2010, which has necessitated a significant IPC Team response to the implementation of national guidance to ensure patient and staff safety, via Gold Command Emergency Response. Out with this Annual Report, the Board has been receiving a separate Covid19 update as well as an IPC Nosocomial Infection Board Assurance Report, therefore detail has not been included at this point as it will feature highly in next years annual report

Infection Prevention and Control team structure

The Public Health and Infection Prevention and Control team consists of:

- Group Nurse Director, Safer Care Directorate and Director of Infection Prevention and Control (DIPC)
- Associate Director Safer Care
- Infection Prevention and Control Modern Matron
- x2 wte Infection Prevention Control Nurse
-
- Tissue Viability Modern Matron
- 1.5wte Tissue Viability Nurse Specialist
- Consultant Microbiologist/Infectious Disease Consultant support is obtained by a Service Level Agreement with Northumbria Healthcare Foundation Trust.

Following consultation on the Directorate structure in 2018/2019 in line with a review of corporate and operational services to deliver a Cost Improvement Target, the excellent work on systems and monitoring as well as historical IPC Trust trend activity indicated the structure could be safely modified. The IPC team was reduced by 1 wte IPC Matron. This is under constant review.

The IPC team have good working relationships with Clinical Care Groups, CBUs, wards and clinical teams which is vital to the success of both preventative and responsive and effective IPC measures. These working relationships have been strengthened further during the Covid 19 pandemic with the combined objective of reducing/minimising this infection whilst also providing advice and support for patient management.

DRAFT

The DIPC attends the Trust Board annually to present this report. Key Performance Indicators data is received by the Board on a quarterly basis in the Safer Care report or by exception.

The IPC Committee meets quarterly and is chaired by the DIPC. The IPC committee reports to Trust wide Quality and Performance group. IPC Committee meetings were held in 2019/20 on:

- 6th June 2019
- 5th September 2019
- 5th December 2019
- 16th January 2020

Microbiology Support

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

External Accreditation Bodies

Registration with the Care Quality Commission (CQC)

The Trust received unconditional registration to the Health and Social Care Act and Associated Code of Practice in 2008 (2015)

Infection Incident reporting and monitoring

The data on infections is reviewed at each IPC Committee meeting and sent to the Locality Care Group Safe meetings. Incident data is shared on a monthly basis within the Safer Care monthly report to CDT-Q and quarterly report to Q & P and the Trust Board.

Infection and IPC Surveillance

MRSA and Clostridium difficile

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

As required, mechanisms exist to formally report data on Clostridium difficile and MRSA bacteraemia in the six monthly performance report reviewed by the Trust Board. This is supplemented by six monthly attendances at the Board by the DIPC

DRAFT

IPC Dataset 2019/20

The following tables form the Infection Prevention and Control data set for Northumberland, Tyne and Wear NHS Foundation Trust for the year 2019/20

KPI	Detail	2016/17	2017/18	2018/19	2019/20
IPC-KPI 01	Cases of MRSA bacteraemia	0	0	0	0
IPC-KPI 02	Cases of clinical clostridium difficile infections	0	1	2	0

Source: Trust records

MRSA bacteraemia

There were no cases of MRSA bacteraemia in the period 2019/20

Root Cause Analysis of Clostridium Difficile Infection

There were no cases of hospital acquired clinical clostridium difficile infections within CNTW

Reported diarrhoea and and/or vomiting outbreaks

There were 17 outbreaks of diarrhoea and vomiting. Learning from these incidents highlighted that each incident was managed in a timely manner with outbreak control measures implemented effectively and resolved in the expected timescales. Infection prevention control measures such as cohorting, isolation, environmental cleaning and handwashing were effective

Key achievements

There was a smooth transition of IPC service provision for staff and patients within the North Cumbria Locality

The responsive approach of IPC team with the emerging COVID 19 pandemic

Infection Prevention and Control Link Workers

Infection Prevention and Control Link Workers are an important conduit to share good practice across the clinical services from the IPC team and equally from the clinical services to the IPC team. Their contribution is valuable, however due to frequent staff changes within clinical teams it has become more difficult and very labour intensive to ensure that each clinical area has an identified link work who has undertaken an IPC induction day. An approach was piloted to combine the Physical Health Link Workers with the IPC workers as they were often the same member of staff and also to reduce the amount of time staff were off the wards in order to optimise their clinical time and

DRAFT

capacity to care. Due to the emerging COVID 19 pandemic this combined role and specific training development has been postponed until August 2020.

Infection Prevention and Control Practice Guidance notes (PGNs)

The IPC Policy and PGNS were harmonised with North Cumbria Integrated Care NHS Foundation Trust. A number of PGNs have been updated this financial year in line with the three yearly Trust requirement update. See appendix 1.

Seasonal Flu Vaccination Campaign

The seasonal flu vaccination campaign was launched on the 1st October 2019, with a series of clinics, drop in sessions, and attendance at staff events and meetings. By the end of February 2020, 82% of all front line staff had received their flu vaccine. CNTW staff continue to show year on year commitment to ensuring our patients are protected against flu.

Frontline Staff Group	2018/19	2019/2020
Doctors	72%	74.2%
Qualified Nurses	77%	81.6%
All other professionally qualified	77%	87.9%
Support to clinical staff	76%	82%

Vaccination uptake over the last two years amongst frontline staff

As in previous years we have offered vaccination to staff who deliver frontline care to our patients, but who are not employed by CNTW. This season we vaccinated 4614 of frontline staff. There were 675 staff vaccinated that were not employed by CNTW but who work into our services. This included teachers, agency staff, social workers, medical students, student nurses, police officers and ambulance staff.

As recommended by the Joint Committee on Vaccinations and Immunisations, the Trust offered patients who were 65 years and over the adjuvanted trivalent vaccine in the 2019 campaign. All staff were offered the quadrivalent vaccine. Staff aged 65 years and over who want to access the adjuvanted trivalent vaccine were signposted to access this vaccine via their GP.

In preparation for the flu campaign we trained 175 staff from both nursing and pharmacy in flu vaccination administration. This enabled all CNTW staff to have easy access to vaccination at a time and place that was convenient to themselves with minimal impact. The flu trailer was not used as a venue for flu vaccination this year's as it has been recognised staff in previous years were waiting in inclement weather and there was a greater number of local vaccinators across hospital and community sites available for all staff.

A Lessons Learnt event was due to be held in March 2020 to review the programme and inform the 2019/20 campaign. However due to the COVID 19 pandemic this event could not take place, as an alternative to achieve feedback all of the peer vaccinators were emailed a link to a questionnaire. 54 members of staff from across the Trust completed this questionnaire.

Key areas included with questionnaire

DRAFT

1. Vaccinator experience and length of time having undertaken the role
2. Identifying any problems or issues accessing the different training required to vaccinate including anaphylaxis, BLS/ILS
3. Accessing the necessary equipment and vaccines
4. Level of support provided
5. Number of vaccinations administered per individual

Due to the addition of North Cumbria Locality in October 2019 the questionnaire provided useful feedback from the vaccinators. This was the first time for the majority of vaccinators from this locality to undertake this role with positive feedback of their experience.

Key achievements identified in 2019/20 Flu Campaign

1. Achieved the CQUIN target of 80% front line staff vaccination uptake.
2. Following the addition of North Cumbria Locality the number of staff working within the Trust increased.
3. We continue to achieve a year on year increase in vaccination uptake rates in front line staff.
4. There were 175 staff trained as peer vaccinators trust wide
5. Patients who were 65 years and over were offered the adjuvanted trivalent vaccine.

Key challenges identified for the 2020/21 Flu campaign

1. The CQUIN target has been raised to 90%.
2. Due to the ongoing Covid 19 pandemic there is concern that there may be a second wave and how this will impact on flu, respiratory activity and the demand on the NHS services.
3. Due to COVID 19 the delivery of the training will be reviewed to ensure social distancing/safety measures.
4. Attendance at flu vaccination clinics will change from previous years where usually they were held as drop in clinics. Social distancing in clinics will need to be adhered to.
5. Staff working from home maybe more reluctant to come into work to receive their vaccination.

Training in Infection Prevention and Control

Staff employed by CNTW must access IPC training via eLearning. The E-Learning programme is a national programme that fulfils statutory requirements. Infection Prevention and Control training is currently a requirement on induction and every three years thereafter for all staff

Bespoke sessions continue to be delivered face to face by the IPC team when required to groups of staff who require specialist knowledge specifically in relation to the roles that they undertake.

DRAFT

Training performance reports have been monitored by each locality care group via their Quality and Performance meetings, IPCC and are also monitored through the CQC Compliance meetings and during "mock" visits to wards and departments by service managers.

Hand Hygiene competencies have been completed for all clinical staff every three years by the link workers on the wards and department. This is a practical session assessing knowledge of technique for hand washing and staff knowledge.

Audit

The IPC team audit areas to systematically measure the effectiveness of healthcare and service delivery against agreed standards to implement, where necessary, improvements and changes at individual, team or service level.

This is implemented in conjunction with the CNTW Clinical Effectiveness Strategy, in particular Objective 2, which aims to ensure the culture of the organisation is to deliver clinically effective care. This ensures clinical teams and clinicians are actively involved with auditing practice and improving care.

A re audit of compliance to Trust and NICE Guidance of Lower urinary tract infections was undertaken in May 2019 this identified minor areas of concern that have all been actioned. There was also a Sepsis re-audit which demonstrated excellent practice.

Risk Assessments

It is a requirement that we as a Trust comply with the Health and Social Care Act for reducing Healthcare-Associated Infections 2008. Criterion 1 states that providers should demonstrate systems to manage and monitor the prevention and control of infection using risk assessments to consider the susceptibility of service users and any risks that their environment and other users may pose to them. Inpatient areas and community services in CNTW which conduct physical health screening will have a risk assessment by a member of the Infection Prevention Control Team accompanied by a senior member of the nursing team. This is an opportunity for the IPC tem to observe practice and the environment to ensure practices comply with IPC PGNs and recognised national guidance.

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

Each section has a percentage score, this indicates the level of compliance. IPC risk assessment tool has been developed into an electronic format and will be on a rolling programme throughout the year. This format will allow for more detailed analysis and developing themes as well as decreasing the time taken to complete.

Following the risk assessment an action plan is compiled ensuring that any comments raised in the assessment are also included. The formulation of this action plan is the responsibility of the service. The completed risk assessment is sent to the Ward Manager, Clinical Nurse Manager and Associate Director.

Due to COVID19 pandemic this has prevented the completion of all areas having a risk assessment completed by the IPC will be completed as soon as possible

DRAFT

Decontamination and Medical Devices

Decontamination

The IPC team have led on Decontamination in 2019/20

Contaminated equipment can lead to the spread of infection. Decontamination of equipment is reinforced during IPC training. This reminds staff the relevance and importance that this process occurs.

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

As part of control measures for COVID 19 all national guidance relating to cleaning frequencies have been implemented.

Staff across disciplines clean equipment and the environment in line with this guidance.

Medical Devices

The IPC Team have led on Medical Device maintenance and procurement during 2019/20

Following a review of the current processes and procedures for the ordering, receiving of medical devices and how the current medical device policy is implemented.

Due to staff sickness, a structural change in the IPC team and the time required for the flu vaccination campaign there was a reduction in available time to spend specifically within this area of the service between the months of August-November.

An internal audit has been undertaken with recommendations made for improvement.

This will involve further review of some of the PGNS. Initial meetings have taken place to review the current SLA provision within the North East of the Trust. .

North Cumbria Integrated Care NHS Foundation Trust Estates Department currently provide the SLA for maintenance and repair of medical devices within the North Cumbria Locality. This SLA is monitored through NTW Solutions.

All new medical devices purchased are taken from CNTW medical devices catalogue and are monitored via the trust CAFM system. There has been one incident where a member of staff has received an injury from a hired piece of equipment (bed) this has been investigated and resulted in a staff claim.

Water Safety Group Report

The Director of Infection and Prevention Control has ensured that water safety standards have been met in 2019/2020.

The Water Safety Group (WSG) has met on a regular basis throughout the year, although due to COVID -19 the March 2020 meeting was stood down. The group has since met in July 2020. The aim of the Trust wide group is to identify, analyse and propose remedies for risks relating to water safety including Legionella. The group is chaired by the Director of Infection and Prevention Control with the Head of Estates

DRAFT

acting as the deputy chair. The group comprises of technical estates staff including the Responsible Person and Deputy Responsible Persons, together with the Infection Control nurses, Facilities staff and representation from nursing teams and additional technical support from an external Legionella/water safety consultancy. The focus of the group remains that multi-disciplinary management of infrastructure and services to ensure prevention of contamination, swift eradication, or control and minimisation of water borne bacteria including legionella.

Management Policies

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

Training

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

Risk Assessments and Audits

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

In the coming 12 months, the group will look to implement the revised Management procedures and ensure new/upgrade schemes incorporate designs and systems designed to reduce risk as far as reasonably possible.

Annual Cleaning Services Report

The domestic services are provided by NTW Solutions Limited which is a wholly owned subsidiary of the Trust. The cleanliness standards throughout the Trust have continued to remain consistently high as evidenced by the monthly inspections and the PLACE inspection scores which reflect the inspections carried out at the beginning of the period.

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

Within the North Locality the domestic service staff are employed by CNTW however they are managed by North Cumbria Integrated Care NHS Foundation Trust through an SLA, NTW Solutions manage and monitor this agreement.

Cleanliness Audits

DRAFT

The organisation continues to carry out detailed periodic cleanliness audits in line with the requirements of the national standards. The scores consistently meet the 95% pass target indicating a high standard of cleanliness is maintained across Trust premises.

The cleanliness standards throughout the Trust have continued to remain consistently high as evidenced by the monthly inspections and the PLACE inspection scores which reflect the inspections carried out at the beginning of the period.

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

However, a decision was taken in March to halt the Cleanliness Audits due to the Pandemic. This was to prevent unnecessary visits to the wards and also to use the Domestic Supervisory resources on duties related to Covid-19.

Cleanliness Audits will recommence in August 2020.

Staffing

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

PLACE (Patient Led Assessments of the Care Environment)

Between September and November 2019 a total of 74 CNTW locations were visited at 14 sites and the results are summarised in the table below. The table illustrates the final results for CNTW overall organisation score set against the national average for each of the six domains.

It can be seen that the overall scores for the Trust are above the national average across all of the individual assessment criteria apart from Overall Food and Disability.

	Cleanliness	Food & Hydration	Privacy and Dignity	Condition, Appearance and Maintenance	Dementia	Disability
CNTW Average	98.9%	91.59%	89.5%	97.92%	85.58%	79.97%
National Average	98.6%	92.2%	86.12%	96.44%	80.7%	82.5%
Variation	**+ 0.3%**	**- 0.6%**	**+ 3.9%**	**+ 1.5%**	**+ 6%**	**- 3.1%**

DRAFT

The assessment process ran well and it should be noted that this was due to the input of the patient assessors, CNTW assessors, admin support and the co-operation of ward staff during the visits. A number of new assessors representing both the patient and CNTW were utilised for the first time on this assessment. Where site have dropped scores when compared with the previous year or in general, the reasons for this are explored to see where improvements can be made.

Summary

The IPC Team alongside NTW Solutions Limited which provides the Estates and Facilities services to the Trust, have worked with clinical care groups to ensure the safe and effective implementation of IPC measures across the Trust during the 2019/20 period in line with the statutory requirements of the Health and Social Care Act 2008.

Appendix 1

Infection Prevention and Control Practice Guidance Notes (PGNs) updated in 2019/20

Document No.	Document Name	Author	Responsible Person	Version/Issue	Ratification Date
IPC- Policy CNTW(C)23	Infection Prevention and Control Policy	Kay Gwynn	Anne Moore	Governance changes	October 19
IPC PGN 01	Infection Prevention and Control Practice Guidance Note Access to Infection, Prevention and Control Advice	Kay Gwynn	Anne Moore	V05	October 2019
IPC-PGN 05	Reporting and Notification of Infectious Diseases	Kay Gwynn	Anne Moore	V05	March 20
AMPH-PGN-09 Part of CNTW(C)29 -	Trust Standard for Assessment and Management of Physical Health Practice Guidance Note Lower Urinary Tract Infection –	Kay Gwynn	Anne Moore	V02	March 20

Infection Prevention and Control Practice Guidance Note Access to Infection, Prevention and Control Advice -

DRAFT

Appendix 2

IPC Training 2019/20

Executive Directorate > Business Unit > Service > Cost Centre	Total Staff	Training Complete	Due to Expire by 20/9/20	Percent Complete @ 25/6/20
North Cumbria Locality Care Group	818	745	1	91.1%
North Locality Care Group	1741	1613	118	92.6%
Central Locality Care Group	1563	1436	95	91.9%
South Locality Care Group	1879	1719	93	91.5%
Nursing & Chief Operating Officer	472	303	16	64.2%
Chief Executive	31	28	1	90.3%
Deputy Chief Executive	190	168	22	88.4%
Medical	391	272	23	69.6%
Commissioning & Quality Assurance	150	148	12	98.7%
Workforce & Organisational Development	48	44	1	91.7%
NTW Solutions	734	647	15	88.1%
NON-CURRENT ASSETS	4	4	0	100.0%
SUSPENSE	584	404	31	69.2%
Total	**8605**	**7531**	**428**	**87.5%**

DRAFT

Appendix 3 Cleanliness Audit Results

Cleaning Audit Results							
Hospital Site	**Average Score (%)**						
	2013-2014	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**
St Nicholas Hospital	96	97	98	98	97	97	97
Campus for Ageing & Vitality	96	97	98	98	97	97	98
Walkergate Park	96	98	99	99	98	98	99
Ferndene	98	98	98	99	99	98	99
St George's Park	98	98	98	98	98	98	98
Northgate Hospital	99	99	98	99	99	99	99
Monkwearmouth Hospital	98	98	99	99	99	99	99
Hopewood Park	97	98	99	99	99	99	99
Tranwell Unit	98	97	98	98	98	97	98
Elm House	n/a	98	98	98	98	97	98
Rose Lodge	n/a	97	98	98	98	98	99
Carleton Clinic							88
Yewdale							97

DRAFT

Appendix 4 PLACE Results

PLACE Cleanliness Results 2019						
Hospital Site	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
St Nicholas Hospital, Gosforth	99.87	100	100	99.92	100	99.93
Campus for Ageing & Vitality	98.58	97.13	96.35	99.05	99.05	99.68
Walkergate Park	100	100	99.86	99.94	100	100
Ferndene	100	99.9	100	98.41	99.3	99.85
St George's Park	99.63	99.82	98.71	98.24	98.69	99.39
Northgate Hospital	99.41	99.95	99.87	99.96	99.71	99.67
Monkwearmouth Hospital	99.80	99.43	99.33	99.56	100	99.91
Hopewood Park	98.80	98.58	99.94	100	99.52	100
Tranwell Unit	99.08	98.18	97.58	97.89	99.24	n/a
Elm House	99.81	100	100	100	95.45	99.06

DRAFT

Rose Lodge	100	99.83	100	100	93.72	100
Brooke House	100	Not inspected	100	96.2	100	99.35
Royal Victoria Infirmary (31A)	100	99.15	100	98.73	98.72	100
Carleton Clinic	n/a	n/a	n/a	n/a	n/a	91
Yewdale	n/a	n/a	n/a	n/a	n/a	100

Appendix 5

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

This document details how the Northumberland, Tyne and Wear NHS Foundation Trust will protect service users, staff and visitors from Healthcare-Acquired Infections, and comply with the Health and Social Care Act 2008 Code of Practice, for the year 2019/20.

Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them
Statement • The Trust IPC policy incorporates the Trust statement reflecting its commitment to prevention and control of infection amongst service users, staff and visitors. This document also outlines the collective and individual responsibility for minimising the risks of infection and provides detail of the structures and processes in place to achieve this. • The Trust has appointed a Director of Infection Prevention and Control accountable directly to the Chief Executive and Board (see below).

DRAFT

- Effective prevention and control of infection is secured through an IPC team, assurance framework, annual work and audit programme, and surveillance and reporting system (see below)
- Training, information and supervision is delivered to all staff through either face-to-face or e-learning.
- There is an annual audit programme in place, approved by the Board, to ensure implementation of key policies and guidance.
- We have a named decontamination lead.

Risk Assessment

- The Trust has developed an IPC specification for clinical areas, which details all the standards for IPC. Following a risk assessment, action plans for achieving compliance with the specification are developed where necessary. Ownership of the action plans lies within the clinical Groups, and is monitored in each Governance meeting a sub Group of Quality and Performance groups. Groups decide if identified risks are sufficient to enter on the Group's risk register or escalate to the Trust risk register. IPC nurses are members of the Groups meetings and are available to advise.
- The risk assessment tool is used annually to monitor improvements achieved through action plans. In addition, the risk assessment is triangulated against other assessments through the year (including, but not limited to, PLACE assessments, CERA assessments, root cause analyses, serious untoward incidents, quality-monitoring tool) to ensure that any new risks are identified and recorded. Risks are reported through the quality and performance meetings of the Groups.
- The Trust has implemented an electronic patient record system (RiO) which has electronic admission and discharge criteria which include infection control issues.

Director of Infection Prevention and Control

- The Trust has designated the Director of Infection Prevention and Control, referred to as the DIPC. This post is held by Anne Moore, Group Nurse Director, Safer Care Directorate.
- The DIPC is directly accountable to the Chief Executive and Trust Board. The roles and responsibilities of the DIPC are detailed in the Trust Infection Prevention and Control policy
- The DIPC chairs the Trust wide Infection Prevention and Control Committee, which meets at least every three months and is a member of the Trust wide Quality and Performance Committee (a subgroup of the Trust Board),
- The DIPC produces an annual report for the Trust Board on the state of public health in the Trust. This also constitutes the annual report of the

DRAFT

DIPC. This report is made publicly available on the Trust internet, and is available in print to any service user, staff member, or member of the public who requests it.

Assurance Framework

- The DIPC reports to the Trust Board on an annual basis to report on developments on public health services, including infection prevention and control. Data is provided on C difficile and MRSA bacteraemia, and modern matrons concerns regarding cleanliness and infection control are reported on each occasion. The annual work and audit plan and the annual report are presented to the Board each year for approval.
- All infection related incidents are reported to the Trust through the Trust wide incident reporting system, SAFEGUARD areas are provided with appropriate advice, by the IPC team relating to the reported incident. Statistics on incidents are produced monthly and reported at the quality standards meeting, for analysis and discussion. Full datasets are reviewed by the IPC Committee at each meeting for analysis of trends. This data includes, but is not limited to, MRSA infections and screening compliance, Clostridium difficile infections and outbreaks of gastrointestinal infections. The low level of infections in the Trust render year on year analysis of trends difficult.
- Serious untoward incidents related to infections are reported through the Trusts SUI reporting system and investigated accordingly. The results of SUI investigations, and action plans arising from them, are monitored through the Safe sub groups Quality and Performance meetings and the IPC Committee.
- The IPC team undertakes Route Cause Analyses for each case of MRSA bacteraemia and Clostridium Difficile infection identified. The results of root cause analyses, and action plans arising from them, are monitored through the quality standards meetings and the IPC Committee. They are also reported through the North of Tyne Health Care Acquired Infection (HCAI) reduction partnership meetings.
- Data on MRSA bacteraemia and Clostridium difficile infections are Trust wide key performance indicators (KPIs) which are reported to the Board each quarter.
- All inoculation incidents are reported through to the IPC committee and the Governance sub Group Q and P meetings and are subject to an after action review at local level if appropriate.

Infection Control Programme

- Each year the DIPC and IPC team produces an infection prevention and control programme which set objectives for ensuring the safety of service users, staff and visitors, and identifies priorities for action over the year. The programme also includes audits to be undertaken to assure the Trust of compliance with key IPC policies.
- This programme is presented to, and approved by, the Trust Board at the start of each year. Progress against the programme is reported to the Board in the annual report of the DIPC.

DRAFT

- All staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient information on and training and supervision in Infection Prevention & Control.

Infection Prevention and Control Infrastructure

- Cumbria Northumberland, Tyne and Wear NHS Trust provides an Infection Prevention and Control service in house. The IPC team comprises, the IPC team comprises of 1 WTE Modern Matron/clinical Lead for medical devices 2 WTE Infection Prevention Control Nurses B7.
- They work closely with other senior nurses in the Trust to support them in delivering the infection control and cleanliness agenda.
- The IPC team and IPC Committee obtain expert microbiology advice through a service level agreement with Northumbria Healthcare NHS Trust to provide attendance of a microbiologist at the IPC committee meetings and support on the development of policies and guidance.
- The Trust has 24-hour access to infectious diseases advice through SLAs with microbiology services.
- The Trust receives information from the multi-agency North of Tyne Healthcare Associated Infections Reduction Group.

Movement of Service Users

- IPC team provide advice and support to the bed management team relating to the admission and or movement of patients with known or suspected infections.
- All wards have access via the intranet to the outbreak management pgn which provides information on restricting admissions, discharges and transfers during an outbreak. Also identifies need for good communication between services.

Criterion 2: The Trust provides and maintains a clean and appropriate environment in managed premises which facilitates the prevention and control of infection

Statement

- The Trust lead for the provision of cleaning services is the Head NTW Solutions.
- Ward Managers are accountable for the cleanliness standards on all in-patient areas
- The Trust has a range of buildings ranging from new, purpose built facilities to old or adapted facilities.
- The CNTW solutions strategy envisages all clinical areas achieving category B standard for buildings.
- Cleaning schedules detail the standard of cleanliness required and the frequency of cleaning. Cleaning schedules comply with the National Standards of Cleanliness. All schedules have been reviewed and will be

DRAFT

signed off by IPC modern matron and ward managers. These schedules are displayed publicly in all clinical areas.

- The cleanliness of the environment is assessed through, weekly ward checks, monthly standardised cleaning audits (SYNBIOTIX audits) and annual PLACE assessments. The results of these assessments are made available to the Groups, the IPC committee and are available on the Trust intranet.
- The Trust has issued guidance on staff dress reflecting infection prevention and control and health and safety standards and requirements, including promoting good hand hygiene practice. The guidance includes advice on the correct laundering of uniforms and clothes worn at work.

Cleaning Services

- Clear definitions of specific roles and responsibilities are identified in job descriptions and the cleaning strategy.
- Service level agreements with each ward identify the cleaning specification including standards, cleaning frequency and responsibility for cleaning all equipment. These have recently been reviewed by IPC Modern matron, facilities and ward managers.
- Sufficient resources have been identified to maintain clean environments. Where potential gaps are identified due, for example, to holidays or sickness, additional resources are identified including the use of overtime and agency staff. Any concerns that cannot be addressed are individually assessed and escalated where appropriate.
- Routinely requests for additional cleaning are directed through the facilities department and all areas have appropriate contact numbers. Domestic supervisors visit areas weekly and any concerns are escalated to the appropriate level. Urgent and out of hours cleaning requests are escalated via the on call manager/director to CNTW solutions manager.

Policies on the Environment

- IPC staff are members of the Trust water safety group.
- The Trust has policies on Legionella control, potable water management, waste, laundry and food & nutrition.

Decontamination

- The Trust does not undertake sterilisation procedures for any reusable medical devices. A practice guidance note outlines disinfection and decontamination procedures. Wherever possible all medical devices are single use or single named patient use only.
- The Trust PGN on decontamination was amended in 2019 to include some new guidance specifically relating to portable electric fans.
- The Trust lead for decontamination for 2019/20 is Kay Gwynn, IPC Matron.

Linen, Laundry and Dress

DRAFT

- All staff are required to adhere to “bare below the elbow” practice guidance note which was reviewed in 2019/20.
- This review included guidance specifically relating to the IPS mental health guidance.

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

Statement.

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

Criterion 4: Provide suitable accurate information on infections to any person concerned with

providing further support or nursing/medical care in a timely fashion

Statement

- Arrangements are in place to prevent and control HCAI and demonstrate that responsibility for IPC is effectively devolved. This is detailed in the IPC policy and associated practice guidance notes. Staff have access to electronic versions of the IPC manual and core plans and advice on infection prevention and control is available from IPC services from 0900 to 1700 each day. Advice on the specific treatment of infected patients is available from local microbiology departments or the regional infectious diseases unit.
- An IPC/Physical Health link worker network has been developed with the aim of ensuring that all areas having a link worker. There is an active training and support programme in place for IPC link workers.
- The Trust has access to the electronic reporting systems of most pathology departments (ICE)

DRAFT

- We have robust reporting systems with other trusts.
- Outbreak communication demonstrates accurate, timely communication with other departments e.g. Facilities, Estates and other healthcare providers

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

Statement

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

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

Statement

- Responsibility for infection prevention and control is detailed in the Trust IPC policy and is included in the job description of all staff
- Mandatory training is provided via e-learning every three years for all staff, both clinical and non-clinical. All new staff receive IPC training in their induction programme.
- The IPC team has robust relationships with CBU Senior nurses and NTW Solutions.
- Regular updates on the Hygiene Code are given at appropriate meetings.
- All staff have the opportunity to have a flu vaccination each year. Service users in risk groups who are inpatients are offered flu vaccination

Criterion 7: Provide or secure adequate isolation facilities.

Statement

- IPC Practice Guidance Note (IPC-PGN 08) details the procedures to be followed to isolate a patient with a known or suspected infectious disease.
- The availability of a suitable isolation area in each in-patient area is part of the IPC specification.
- Most in-patient areas in the Trust have single rooms suitable for the isolation of patients with infectious diseases. In the event of a service user requiring isolation, and that not being available on their own inpatient unit, arrangements would be made to transfer the service user to a clinical area where adequate isolation facilities are available.

DRAFT

- In the event of a large scale outbreak of infection then affected service users would be cohort nursed in an identified area of an in-patient ward, or the entire in-patient ward would be regarded as an isolation area.

Criterion 8: Secure adequate access to laboratory support as appropriate

Statement

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

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

Statement

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

DRAFT

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

Report to the Board of Directors
5th August 2020

DRAFT

Title of report	Annual Report for Safeguarding and Public Protection 2019 – 2020
Report author(s)	Safeguarding and Public Protection Annual Report Joanne Sharp Named Nurse
Executive Lead (if different from above)	Gary O'Hare, Executive Director of Nursing/Chief Operating Officer

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	X
To achieve "no health without mental health" and "joined up" services	X	Sustainable mental health and disability services delivering real value	
To be a centre of excellence for mental health and disability		The Trust to be regarded as a great place to work	

Board Sub-committee meetings where this item has been considered (specify date)		**Management Group meetings where this item has been considered (specify date)**	
Quality and Performance	X	Executive Team	
Audit		Corporate Decisions Team (CDT)	
Mental Health Legislation		CDT – Quality	X
Remuneration Committee		CDT – Business	
Resource and Business Assurance		CDT – Workforce	
Charitable Funds Committee		CDT – Climate	
CEDAR Programme Board	X	CDT – Risk	
Other/external (please specify)		Business Delivery Group (BDG)	

Does the report impact on any of the following areas			
Equality, diversity and or disability	X	Reputational	
Workforce		Environmental	X
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	X
Quality, safety, experience and effectiveness	X	Service user, carer and stakeholder involvement	

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

Key Points to Note:

The Trust Safeguarding and Public Protection annual report covers the period from April 2019 to March 2020.

Safeguarding is fundamental to all work of the trust. This report provides assurance that the trust is fulfilling its statutory safeguarding responsibilities and demonstrates a strong commitment to working together within all aspects of safeguarding and public protection.

We have been working hard in relation to the revised Working Together statutory guidance, which new child protection and safeguarding partnership arrangements have been in place since autumn 2019.

The trust has exceeded its training target percentage set by NHS England of all staff trained in Prevent.

The team have also seen developments in contextual safeguarding, an approach to child protection that recognises that children and young people are often vulnerable to abuse outside of the family environment, such as child sexual exploitation (CSE), drug dealing and criminal exploitation.

Safeguarding and public protection activity remains constant with a high level of vulnerability and complexities of cases identified. This is across all four Locality Care Groups.

The team have continued to provide a responsive level of service but demand has increased. Towards the end of this period i.e. February /March 20120 CNTW began to work with national COVID restrictions, where each safeguarding board and CCG were seeking bespoke data to provide assurance that the Trust was, maintaining and providing a full safeguarding and public protection service The Trust has remained compliant with its statutory duty during this period

The report outlines the progress that has been made in safeguarding the health and wellbeing of patients and carers. It highlights areas where the safeguarding and public protection team are continuing to develop and offers an insight into the safeguarding priorities for the organisation.

DRAFT

Safeguarding and Public Protection

Annual Report

2019/2020

Contents

Introduction 5

Safeguarding and Public Protection Team 5

Key Achievements 2020/2021 6

Operational Management Developments 7

Safeguarding Assurance 7

External Assurance Audits 10

Safeguarding and Public Protection Statistical Data 11

Policies and Procedures 12

Case Reviews 12

Children Serious Practice Reviews (SPR) 13

Domestic Homicide Reviews 13

Annual Work Plan 2020/21 14

Conclusion 15

DRAFT

Introduction

This annual report gives an account of the safeguarding activity across Cumbria, Northumberland Tyne and Wear NHS Foundation Trust. The report covers the period April 2019 – March 2020. The report demonstrates the organisations commitment to protecting children, young people and adults at risk of harm across all service areas. Safeguarding activity across the Trust continues to increase in volume and complexity. Safeguarding concerns are positively being recognised more frequently across clinical areas. All health providers are required to have effective arrangements in place to safeguard vulnerable children and adults at risk and to assure themselves, regulators and their commissioners that these are working. These arrangements include safe recruitment, effective training of all staff, effective supervision arrangements, working in partnership with other agencies and identification of a Named Doctor and a Named Nurse. Ultimately the Trust Board requires assurance that the organisation is fulfilling its obligations to make arrangements to safeguard and promote the welfare of children and vulnerable adults. Prevention and early intervention are key areas that the SAPP wish to take forward into 20/21

"Safeguarding is everybody's business"

Safeguarding and Public Protection Team

The Safeguarding and Public Protection service consists of a Team Manager/ Named Nurse, six Senior Nurse Practitioners, Case Review Report Writer, Safeguarding and Public Protection Development Officer and the Police Liaison Nurse who bring a variety of safeguarding and public protection expertise, skills and experience.

The core functions of the team are:

- To provide clinical leadership in respect of safeguarding to support high quality safeguarding and public protection practice for children and adults
- To provide a "triage" service for all safeguarding and public protection concerns raised within the organisation to ensure the individual is safeguarded and effective safety plans are in place.
- Sharing learning from internal and external reviews of cases and best practice
- To provide support and advice on complex cases
- To attend MARAC (Domestic Abuse meetings), MAPPA and Prevent (public protection) multi-agency meetings on behalf of the trust.
- Provide strategic advice and leadership through the involvement in Safeguarding Practice Reviews, Safeguarding Adult Reviews and Learning Lesson Reviews.

DRAFT

- To provide challenge and scrutiny of safeguarding and public protection practice including the interface with statutory agencies.
- To provide oversight and development of policy and procedures.
- To provide strategic vision in respect of safeguarding and public protection.
- To provide high quality supervision and check that supervision delivered across the organisation is in line with evidenced based practice
- To support individuals working with adults at risk to practice in adherence to the six safeguarding principles.

They are supported by the Safer Care administration team. The Safeguarding and Public Protection Team aims to support all trust staff to keep children, young people and adults at risk, safe and to meet statutory obligations. We promote collective accountability in all that we do, working together to prevent all forms of abuse or neglect occurring.

A commitment to safeguarding children and adults is evident at all levels within the organisation. The Trust has a clear and consistent structure in place to ensure scrutiny and challenge of safeguarding arrangements and consideration of the impact on the people who use services.

Key achievements 2020/2021

- ✓ The development and introduction of the Case Review Report Writer
- ✓ With the inception of North Cumbria locality in October, positive working relationships were fostered over the year to ensure the safeguarding and public protection arrangements were transitioned in line with national standards.
- ✓ A significant piece of work has been undertaken with Cumbria multi agency partners in respect of MAPPA standardisation and change of practice with support provided to Cumbria Locality Care Group services.
- ✓ The Associate Director and SAPP Prevent Lead were invited to advise at a Prevent Review session with Lord Carlile of the national review for Prevent.
- ✓ Developed with multi agency colleagues two Multi Agency Safeguarding Hub (MASH) posts in Sunderland and Northumberland of mental health practitioners.
- ✓ Maintained a fully operational SAPP service with a multitude of platforms to ensure wherever possible all are safeguarded in respect of Covid 19.

DRAFT

Operational Management Developments

- ❖ SAPP triage “front door” continues to be operational. The team have seen a positive reporting culture across services with appropriate concerns raised as well as complex cases being raised for support from the team. Need to add into 2020/21

- ❖ MASH in two localities has been strengthened by the development of two dedicated posts to sit within the MASH. These posts will ensure that vulnerable people with mental health and learning disabilities will get the correct service at the right time from the right professional.

- ❖ A successful full transition for North Cumbria of all safeguarding and public protection arrangements including new team members within SAPP.

- ❖ On an operational level, we have maintained strong multi-agency cooperation to Counter terrorism Policing (Special branch) and local authority Channel panel chairs within Cumbria and Northumbria Police area and the 7 CCG’s that CNTW covers.

Safeguarding Assurance

The leadership and governance structures are well established and systems are in place to ensure that any required changes to the structure are effectively managed to maintain consistency and stability across the Trust.

The Safeguarding and Public Protection Group is a quarterly Trust Sub Group of Q&P that enables Safeguarding and Public Protection Professionals and senior Trust managers to support learning and practice development specifically to meet the safeguarding agenda. The Safeguarding Group is chaired by Group Nurse Director Safer Care who brings challenge and scrutiny into the work of the group. Internal Trust assurance is led by this group with a number of reviewing and reporting mechanisms including:

- BDG Safety weekly meetings for significant/complex safeguarding concerns.
- CDTQ Monthly Safer Care reports.
- Bi-monthly Trust Board reports for Case reviews.
- Quality and Performance Committee four monthly report.
- Locality Care Groups individual Quality and Performance SAPP activity report.
- CCG quarterly Safeguarding Dashboard reports.

DRAFT

Our Commitment to Partnership Working

The safeguarding and public protection team continue work with partner agencies and will contribute to multi agency safeguarding arrangements on a day to day basis to ensure robust safety plans, risk management are in place and will share responsibility for the effective discharge of its functions in safeguarding and promoting the welfare of children and adults by ensuring there is appropriate representation at Safeguarding Partnership meetings, boards and sub groups. Currently, the Trust Medical Directors, Nursing Directors and the SAPP Team have played an integral part in relation to this crucial partnership working. This has been achieved by assisting in Ofsted and peer inspections, representation on Local Safeguarding Boards and sub-groups, as well as attendance at the Police and Probation statutory meetings for Public Protection. Trust Clinical staff and the Locality Care Groups, Heads of Commissioning and Quality Assurance are actively involved in sub groups that sit underneath the safeguarding Boards.

Clinical Police Liaison Lead (CPLL)

The Clinical Police Liaison Lead is an established role within the trust for 6 years this year. It has developed and changed throughout this time, adapting to national changes and trust need. The post is now embedded working within the Safeguarding and Public Protection (SAPP) Team after a move around 18 months ago from patient safety team.

During 2019 and so far in 2020 it has continued to be busy and active role in all matters Police Liaison, Multi Agency working and Risk management. This year has included strengthening of the relationship and understanding at all levels, supporting Northumbria Police Chief Constable spending time in clinical services, and our own Chief Executive and Executive Director of Nursing and Operations, gaining an insight into the Police control room and Firearms Unit. The role has also continued to attract attention from other areas of the country and been shared to neighbouring trusts of Tees Esk Wear Valley Trust and Lancashire and South Cumbria Trust.

Work has continued with Northumbria Police and British Transport Police (BTP) within the trust area, supporting clinical teams around risk management and multi-agency working, but also educating services around new ways of working in Northumbria. With the introduction of new model of working and arrival of harm reduction units and ensuring risk management and reducing harm. As well as providing essential training and education and for the first time an input to senior tactical firearms advisors training to support and guide their decision making around serious incidents and educate on increased activity with makeshift weapon use on our wards.

Recently the role has had further focus with the addition of North Cumbria locality. The lead has quickly established links/ relationships and partnerships

DRAFT

with Cumbria Constabulary, BTP Carlisle and Civil Nuclear Police. Work began early identifying and improving ways of working, understanding of each other and looking at ensuing CPLL as a point of contact.

There is still much work to be done - there is Police contact from the locality, and clinical teams contact although promotion of role in locality is needed. There is regular meetings and contact with force lead. There is an additional support in Cumbria locality around Police Liaison. The SAPP Development Officer) who is a retired officer is supporting with the development work needed, due to his extensive knowledge of the locality and practices.

Respond Multi Agency Training has also gone from strength to strength with a London area and Lancashire and South Cumbria purchasing the package. It has also won a National award from the positive practice collaborative late last year.

Prevent

The CNTW Prevent role has been an instrumental aspect of the management of both the mental health and vulnerability factors with individuals who have been referred to Prevent.
Nationally and as a region, concerns have been raised in relation to the low number of referrals from mental health workers, associates and partners. There is a concern that there is a lack of trust and therefore an inability to comply with the statutory responsibility as a partner health has, to have "due regard" as set out in the Counter Terrorism Security Act 2015. Through the CNTW role this is not the case within the Northumbria Police Area. In 2019 apart from CT police, CNTW had the highest number of referrals. Through the support afforded by the Prevent lead role it clear that members of CNTW understand the safeguarding key role in prevent and the requirement for early intervention, ensuring those vulnerable do not enter the criminal space and they are safeguarded.
During a recent Home Office Prevent Peer Review of Newcastle (January 2020) the work that CNTW SAPP Prevent lead has conducted and the role was highlighted as good practice. CNTW SAPP Prevent lead has attended the Northumbria Strategic Contest Board to enable partners to consider a similar role in their areas of business.

DRAFT

External Assurance Audits

The SAPP team have participated in 3 multi-agency audits for safeguarding children. The topics of the audits were: referrals to the local authority, missing sexual exploitation and trafficked, making safeguarding personal x 2. Assurance was given that abuse is recognised, recorded and responded.

Section 11 audits

The Trust completes annual Section 11 Self-Assessment Assurance Audits in relation to their duties under Section 11 Children Act 2004. This tool aims to assess the effectiveness of the arrangements for safeguarding children at a strategic level. The safeguarding team have completed several Section 11 audits in respect of the trust arrangements for safeguarding.

Quality Assurance Framework (QAF) audits

The Trust also completes annual Quality Assurance Framework Audits in relation to their duties under the Care Act 2014 for safeguarding adults. This tool aims to assess the effectiveness of the arrangements for safeguarding adults at a strategic level. Assurance has been provided to the LSAB's that the trust is meeting its safeguarding adult responsibilities. A trust Director attended a challenge event in one locality. This promoted constructive challenge to trust safeguarding arrangements and provided assurance that the trust is meeting its safeguarding responsibilities.

External Inspections

A number of OFSTED and CQC inspections have taken place within Local Authorities/health that the trust have assisted with case information and attendance at focus groups and case scrutiny for the inspections. Any action plans post inspection that have been developed and where necessary the trust have assisted within the allocated time frame.

Raising Awareness

Throughout the year the trust communication team have supported Safeguarding and Public Protection through a range of information to staff this has included:

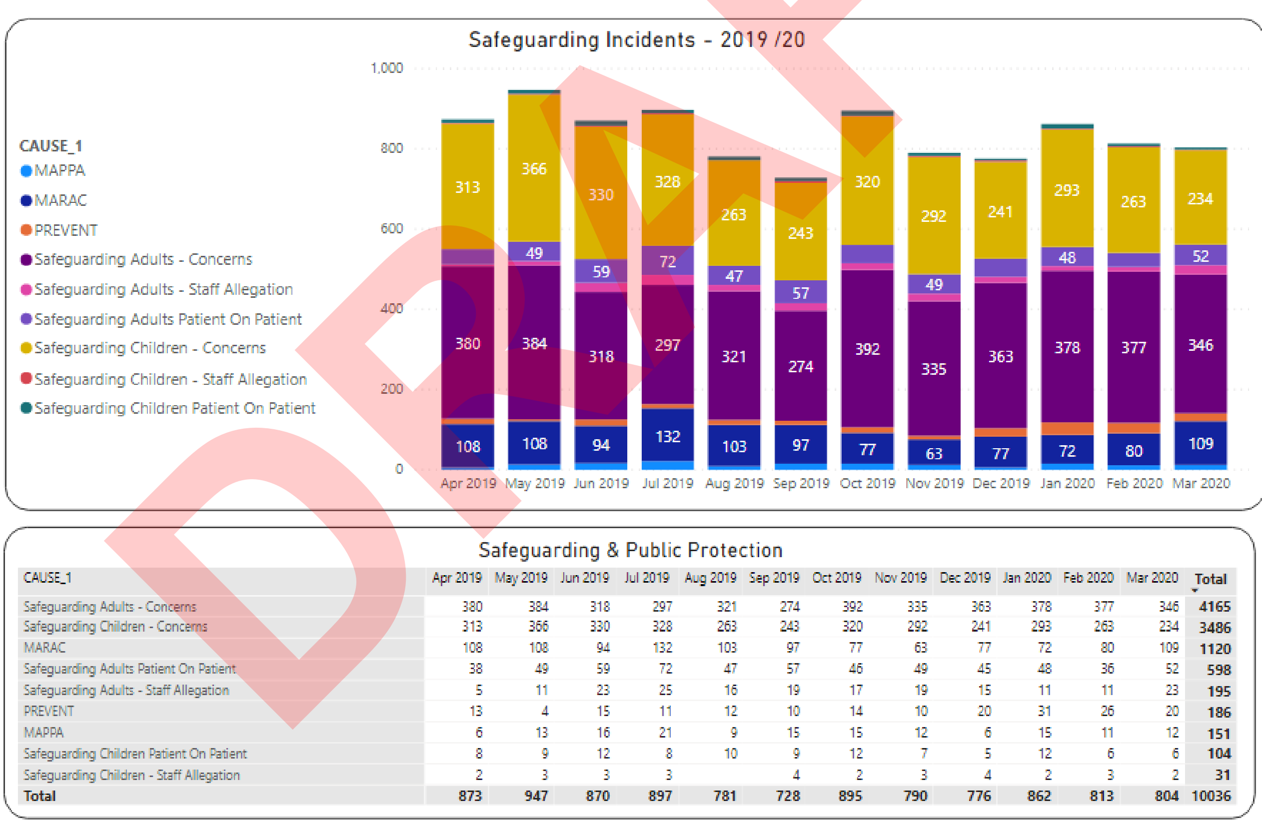
- Seven minute briefings
- Safe Sleeping
- Domestic Violence for patients and staff (covid related)
- Learning from Case Reviews
- Prevent in line with national intelligence
- Presentations at Trust Learning and Improvement Group of good practice cases.

DRAFT

The team also ensure any learning identified and any safeguarding campaigns/awareness raising information are available to all staff trustwide via the Safer Care Intranet page.

Safeguarding and Public Protection Statistical Data

The SAPP team uses data generated from the web based incident forms used across the organisation. The incident forms track appropriate actions at the point of the concern being raised. They categorise the cause of concern, threshold of concern, where the concern was raised and the outcome. This information is collected into quarterly dashboards, scrutinised and is used to identify themes/trends and provide complex supervision by the SAPP team. The safeguarding performance information are shared with the Locality Care Groups, CCGS and Trust Quality and Performance Committee.



Safeguarding & Public Protection

CAUSE_1	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Total
Safeguarding Adults - Concerns	380	384	318	297	321	274	392	335	363	378	377	346	**4165**
Safeguarding Children - Concerns	313	366	330	328	263	243	320	292	241	293	263	234	**3486**
MARAC	108	108	94	132	103	97	77	63	77	72	80	109	**1120**
Safeguarding Adults Patient On Patient	38	49	59	72	47	57	46	49	45	48	36	52	**598**
Safeguarding Adults - Staff Allegation	5	11	23	25	16	19	17	19	15	11	11	23	**195**
PREVENT	13	4	15	11	12	10	14	10	20	31	26	20	**186**
MAPPA	6	13	16	21	9	15	15	12	6	15	11	12	**151**
Safeguarding Children Patient On Patient	8	9	12	8	10	9	12	7	5	12	6	6	**104**
Safeguarding Children - Staff Allegation	2	3	3	3		4	2	3	4	2	3	2	**31**
Total	**873**	**947**	**870**	**897**	**781**	**728**	**895**	**790**	**776**	**862**	**813**	**804**	**10036**

Over the last 12 months there were 8,814 Safeguarding and Public Protection concerns reported into the SAPP team. This is an increase from last year of 6,652.The SAPP Practitioners on average are reviewing 734 reported safeguarding and public protection concerns via Web Based Reports per month,

DRAFT

liaising with services and recording on every service user health records to safeguard.
MARAC meeting requirements across 7 localities being increased from fortnightly for many years to weekly meetings.
This increase in safeguarding and public protection concerns is multi-faceted. Reasons includes a greater awareness of staff in recognising vulnerabilities through training; societal changes and increased deprivation; changes to early help and available support leading to a greater unmet needs of children and families and an increase in prevalence of children and young people's mental health. A high level of domestic abuse incidents are evident in cases that are seen across the localities we serve.

There has been a significant increase in the amount of referrals across the seven local authority areas. This increase equates to 40% over the last twelve months. It should be noted that every referral require information from CNTW in order for a thorough assessment to be carried out and to enable appropriate support and safeguarding for individuals who are often extremely vulnerable.

Training

The Trust has maintained its position in demonstrating compliance above the 85% set training target for the year for Safeguarding and Public Protection. Prevent training has exceeded the 90% target set by NHS England. Training requirements have been updated in line with the intercollegiate document and level 3 face to face training for all professionally registered staff is in place.

Policies and Procedures

Safeguarding policies are in place and are accessible to staff via the Trust intranet. The seven Local Authority areas safeguarding and public protection policies and procedures are also available via links on the staff intranet site. During the reporting period, SAPP policies are continually monitored and updated in line with local and national changes.

Case Reviews

From October 2019 the SAPP team were fortunate to have a dedicated post for Case Reviews, a Case Review Report Writer to support al safeguarding and public protection multi agency reviews.

- Children Safeguarding Practice Reviews- (CSPR)
- Serious Adult Reviews – Adults
- Domestic Homicide Reviews (adults)
- MAPPA Serious Case Reviews (adults)
- Appreciative Inquiries (adults and children multi agency reviews)

DRAFT

Children Serious Practice Reviews (SPR)

Serious Practice Reviews are undertaken by local safeguarding children partnerships CSP's) for every case where abuse or neglect is known or suspected and either: a child dies, or a child is seriously harmed and there are concerns about how organisations or professionals worked together to protect the child.

Over the last twelve months there has been 3 SCR where CNTW have been involved with the family.

Safeguarding Adult Reviews

A Safeguarding Adults Review (SAR) is a process for all partner agencies to identify the lessons that can be learned from particularly complex or serious safeguarding adults cases, where an adult in vulnerable circumstances has died or been seriously injured and abuse or neglect has been suspected. The purpose of a SAR is to learn lessons, review effectiveness of procedures, improve practice.

Over the last twelve months there has been 2 SAR's commissioned.

Domestic Homicide Reviews

The Statutory requirement related to domestic homicide reviews came into force in April 2011. The focus is a multiagency approach with the purpose of identifying learning. NTW have been involved in 5 Domestic homicide Reviews over this 12 months period.

MAPPA Serious Case Reviews

It is mandatory for a MAPPA Serious Case Review to be carried out by the local MAPPA Strategic Management Board where a MAPPA offender managed at either Level 2 or 3 is charged with committing or attempting to commit an offence of murder, manslaughter or rape. A MAPPA Serious Case Review may also be conducted on a discretionary basis in other circumstances.

Over the last 12 months there has been no MAPPA SCR commissioned.

All reviews are reported to the Trust Board on a bi-monthly basis and lessons learnt are cascaded throughout the organisation and/or built into future training. Bespoke training has also been provided for those service areas involved to ensure all staff have received the lessons learned.

DRAFT

Annual Work Plan 2020/21

All of the actions in relation to the 19/20 Annual Work plan have been achieved.

Further development and evaluation of the newly appointed CNTW MASH Practitioners and potential development of these posts if successful within other localities if funding were available.

Further development of the Prevent post in line with local and national demands.

The monitoring of the Case Review Report writer post including volume of potential reports/supervision and psychological support.

The Clinical Police Lead will continue to work closely with Cumbria Police to further enhance close working relationships with support of any new developments in conjunction with the Safeguarding Development Officer.

The Clinical Police Liaison lead is continuing to look at data and doing more around Police activity data, to evidence what we do and how we do it, as well as look at demand and ensure capturing lessons learnt. Working with the Safer Care Business Manager a police activity dashboard is being developed to give us clearer and better understanding.

Lessons Learnt

The key areas of focus are outlined below. The areas of focussed learning have been shared via the Trustwide SAPP meeting for Operational Training and Workforce leads to note actions and cascade. The expectation is that the themes and case reviews are discussed in Safeguarding Supervision. Findings have also been presented via LIG events during 2019/20:

- Safeguarding Children - The importance of the quality of child and family assessments as inadequate assessments are more likely to be associated with worse outcomes. Child and family assessments should be informed by evidence and reflection.

- Domestic Abuse- Referrals without consent - Depending upon the level of risk it may be that a referral can be made without the consent of the victim. We can also still work with victims to link with Domestic abuse support services and to look at safety planning measures.

- Public Protection - Every member of staff has a responsibility to protect the public from serious harm arising from the mental health of their service users. Concern expressed from carers should be taken very seriously.

DRAFT

- Safeguarding adults- all multi agencies will have a clear understanding of their role and responsibilities, and the services available for the management of bariatric clients

Conclusion

This annual Report provides the Trust Board, partners and stakeholders with an overview and assurance of the activity for Safeguarding and Public Protection during the periods 2019/20, including the learning from Case Reviews and investigations. The Safeguarding and Public Protection Team will be working with locality teams to ensure the learning is embedded in practice.

The Team are looking forward to the year ahead in ensuring safeguarding is maintained as a high priority for the Trust and continues to be seen as everyone's business.

Joanne Sharp 2020