Board of Directors Meeting (PUBLIC)

Wed 07 April 2021, 13:30 - 15:30

Microsoft Teams

Agenda

1. Service User/Carer Experience

2. Apologies for Absence

Ken Jarrold, Chairman

3. Declarations of Interest

Ken Jarrold, Chairman

4. Minutes of the previous meeting held Wednesday, 3 March 2021

Ken Jarrold, Chairman

4. mins Board PUBLIC meeting 03.03.20 DRAFT DH KJ.pdf (11 pages)

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

Ken Jarrold, Chairman

5. BoD Action Log PUBLIC as at 07.04.21.pdf (1 pages)

6. Chairman's Remarks

Ken Jarrold, Chairman

7. Chief Executive's Report

John Lawlor, Chief Executive

Quality, Clinical and Patient Issues

8. COVID-19 Response update

Anne Moore, Group Nurse Director Safer Care

8. Covid Update - March report for April 2021 Board.pdf (4 pages)

9. Commissioning and Quality Assurance Report

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

9. Monthly Commissioning Quality Assurance Report - Month 11.pdf (9 pages)

10. Guardian of Safe Working Reports (Q2 and Q3)

Rajesh Nadkarni, Executive Medical Director

10. Guardian of Safe Working - BD 31.03.21..pdf (8 pages)

Workforce

11. NHS Staff Survey 2020 Results

Lynne Shaw, Executive Director of Workforce and Organisational Development

11. Staff Survey 2020 for April 2021 Trust Board Meeting.pdf (12 pages)

Strategy and Policy

12. Children, Adolescent Mental Health Service update

David Muir, Group Director

12. West Lane Board Update April 2021 V1.pdf (6 pages)

13. Budget Planning 2021/22

For approval *James Duncan, Deputy Chief Executive and Executive Director of Finance*

13. Resource Plan Budgeting 21-22.pdf (6 pages)

Regulatory

14. NHS Improvement Code of Governance

Debbie Henderson, Director of Communications and Corporate Affairs/Company Secretary

14. CNTW Code of Governance Compliance 20 - 21.pdf (18 pages)

Minutes/Papers for Information

15. Committee Updates

Verbal/Information *Non-Executive Directors*

15.1. Quality and Performance Committee

Alexis Cleveland, Chair

15.2. Audit Committee

David Arthur, Chair

15.3. Resource Business and Assurance Committee

Peter Studd, Chair

15.4. Mental Health Legislation Committee

Michael Robinson, Chair

15.5. Provider Collaborative Committee

Michael Robinson, Chair

15.6. CEDAR Programme Board

Peter Studd, Chair

15.7. Charitable Funds Committee

Les Boobis, Chair

16. Council of Governors' Issues

Verbal/Information *Ken Jarrold, Chairman*

17. Any Other Business

Ken Jarrold, Chairman

18. Questions from the Public

Ken Jarrold, Chairman

Date, time and place of next meeting:

19. Friday, 5 May 2020, 1:30 pm to 3:30 pm via Microsoft Teams

20. PCLP Committee Terms of Reference

Lisa Quinn, Executive Director of Commissioning and Quality Assurance

20. PC Committee ToR - Final April 2021.pdf (3 pages)

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Minutes of the Board of Directors meeting held in Public
Held on 3 March 2020 1.30pm – 3.30pm
Via Microsoft Teams

Present:
Ken Jarrold, Chairman
David Arthur, Non-Executive Director
Darren Best, Non-Executive Director
Les 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, Executive Director of Workforce and Organisational Development

In attendance:
Debbie Henderson, Director of Communications and Corporate Affairs / Company Secretary
Kirsty Allan, Acting Corporate Affairs Manager (Minute Taker)
Jayne Simpson, Corporate Affairs Officer
Fiona Grant, Lead Governor/Service User Governor for Adult Services
Anne Carlile, Carer Governor for Adult Services
Fiona Regan, Carer Governor for Learning Disabilities
Margaret Adams, Deputy Lead Governor/Public Governor for South Tyneside
Tom Bentley, Public Governor for Gateshead
Bob Waddell, Staff Governor – Non-clinical
Stephen Blair, Public Governor for Newcastle
Revell Cornell, Staff Governor – Non-clinical
Uma Geethanath, Staff Governor - Medical
Kim Holt, University of Northumbria Governor
Paul Richardson, Local Authority Governor, North Tyneside
Evelyn Bitcon, Public Governor, Cumbria
Bill Scott, Public Governor, Northumberland
Allan Brownrigg, Staff Governor – Clinical
Colin Browne, Carer Governor for Older Peoples Services
Kelly Chequer, Local Authority Governor, Sunderland City Council
Wilf Flynn, Local Authority Governor, South Tyneside Council
Tom Rebair, Service User Governor, Adult Services
Felicity Mendelson, Local Authority Governor, Newcastle City Council
Damian Robinson, Group Medical Director, Safer Care *(Item 10)*

1. **Service User story**

Ken Jarrold extended a warm welcome and thanks to Aimee Wilson who attended the Board to share her story including experiences, achievements and challenges on her journey to recovery.

2. **Welcome and apologies for absence**

Ken Jarrold welcomed Sharon Baines, CQC who joined the meeting as an observer and Ramona Duguid joining the meeting as on observer. Ramona would be commencing in post as the Chief Operating Officer from 5th April 2021.

Ken also warmly welcomed Tom Rebair, Grace Wood, Allan Brownrigg, Evelyn Bitcon and Raza Rahman as recently elected members of the Council of Governors.

3. **Declarations of interest**

There were no conflicts of interest declared for the meeting.

4. **Minutes of the meeting held 3 February 2021**

The minutes of the meeting held 3 February 2021 were considered.

Peter Studd referred to page 10 of February minutes referencing the CEDAR Programme Gateway Stage 4 review is now complete with the Trust achieving the highest assurance level of 'Green'. Ken Jarrold thanked everyone involved in the CEDAR programme for the excellent outcome.

Approved:

- **The minutes of the meeting held 2 December 2020 were approved as an accurate record**

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

With regards to action 06.11.2019 (12) and 02.09.20 (5) Gary O'Hare referred to the Staff Friends and Family Test which will be aligned with the Reset and Redesign work and an update would be provided at May Board meeting.

With regards to action 05.08.20 (07) John Lawlor advised an update on Trieste will be provided at a future Board meeting.

6. **Chairman's Remarks**

Ken Jarrold referred to a very valuable Board Development Session which took place to discuss service and financial planning as well as governance models proposed as part of the changes to the NHS and the Integrated Care Systems (ICS).

Resolved:

- **The Board noted the Chairman's verbal update.**

7. **Chief Executive's Report**

John Lawlor provided an update on Community Transformation work and confirmed that resources for 2021/22 had now been secured in relation to mental health. The Trust would be seeking to undertake work associated with community transformation

in a coproduced way with the help of service users, carers and stakeholders including third sector colleagues.

A Staff Network event will be held on 11 March 2021 attended by Staff Network Chairs, executive lead sponsors and other key individuals to continue the work to ensure the Trust provides a safe space to reflect on the contribution of the Networks.

James Duncan referred to the work of the LGBT+ Network and the LGBT+ history month event held which was attended by over 150 people.

On 24 February 2021 both the Trust and NTW Solutions Limited signed the Armed Forces Covenant and pledged support to the Armed Forces Community and supporting the employment of veterans.

John referred to the work of Provider Collaboratives as the successors to the New Care Models and confirmed the Trusts intention to move into a Provider Collaborative with Tees, Esk and Wear Valley (TEWV). John advised that the team were envisaging a go-live date of 1st April 2021 with the three Provider Collaboratives covering the North East and North Cumbria Integrated Care System population.

Lisa Quinn highlighted an outstanding action relating to the finalisation of the financial budget and advised discussions were ongoing with regional colleagues.

John referred to the Mental Health Act White Paper consultation on changes to the Mental Health Act. The consultation aims to put patients at the centre of decisions about their own care. The Trust was in the process of seeking the views of staff, Governors, service users and board members through a series of sessions to inform the Trust's response to the consultation by the closing date of 21st April 2021.

Resolved:

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

Quality, Clinical and Patient Issues

8. Covid-19 Response update

Gary O'Hare provided an update to the Trust response to the pandemic. The Trust currently has one covid-positive patient. Staff Covid-19 Swab Testing (PCR) continues for symptomatic staff and household members. Following the roll-out of Lateral Flow Device (LFD) testing kits there has been 156 positive results and 18 returned as a negative following a PCR test.

Staff absence has improved with a total number of 511 staff currently absent with 138 Covid-related either shielding or self-isolating and 32 staff members having a positive PCR test.

There has been a significant reduction in Covid-19 outbreaks across the Trust with the Trust currently managing four outbreaks.

The Trust has continued with its vaccination programme, successfully vaccinating over 8000 people including staff, patients and clinical partners (873). Vaccination clinics continue with one clinic per week and work is ongoing to encourage uptake of vaccinations with those who have yet to receive a vaccination.

Gary referred to the Government announcement of the new group of people added to the 'Clinically Extremely Vulnerable' (CEV) list. All recommendations from the recently published CEV guidance was now included in the Trust Covid-19 risk assessment.

Gary confirmed the Trust had noted a very stabilised and improvement position both nationally and regionally. Public Health England has suggested there may be a 'spike' rather than a 'wave' in cases of Covid-19 as children return to school during March. Gary confirmed the Trust was currently preparing should there be a need to step up the Trusts response further.

Bill Scott queried if there have been reports of any adverse effects from the Covid-19 vaccination. Gary confirmed there has been a small number of staff who had experienced side effects and confirmed there had been no Trust reports of severe reactions to the vaccine.

Resolved:

- **The Board received the COVID-19 Response update report.**

9. Commissioning and Quality Assurance Report (Month 10)

Lisa Quinn spoke to the enclosed report and referred to three Mental Health Act review visits. Key points from those visits were included in the report as well as action plans and submissions to the CQC.

Lisa provided an update on access and waits explaining the current position in relation to adults and older people there are 40 people waiting more than 18 weeks to access services this month in non-specialised adult's services. In terms of young people the Trust reported an increase in both Newcastle/Gateshead and South Tyneside as well as the autism pathway with a number of young people transferred into the Trust from another organisation.

Lisa referred to a recent Health Service Journal (HSJ) article around children services included in the report. The article referenced the demand and availability of inpatient child and adolescent mental health beds across the country, particularly for eating disorders as demand had increased during the pandemic.

A rise in the number of referrals has been highlighted with the latest NHS Digital figures showing, as at end of November 2020, a 28% increase nationally in the number of children and young people in contact with services compared to November 2019. Within CNTW the number of referrals made to Children and Young People services remained the same for this period.

Lisa provided detail regarding bed occupancy levels for Redburn for November 2020 and November 2019. Lisa noted that the Trust had implemented new community based models for positive behavioural support for eating disorder services working

closely with paediatric services and eating disorder services. This had led to a reduction in inpatient demand.

Lisa referred to training and appraisal compliance and reminded Board members of the agreement made that performance management would be stood down due to Covid-19 pressures within wave 3 of the pandemic. The Trust was now in a position to incrementally step-up performance management and Lisa suggested providing a further update at a future Board meeting on the areas below standard.

James Duncan provided an update on the Month 10 financial position noting a £0.7m surplus due to increased income levels. The Trust had received over £1m of income from Health Education England (HEE) that was not included in the Month 7 – Month 12 planning. The Trust has incurred £0.3m additional costs due to pandemic in Month 10 and had incurred £6.0m of operational Covid-19 costs up to Month 10.

Peter Studd commented on the outcome of the Yewdale mental health reviewer visit and the issues raised in relation to the quality of facilities and asked that this be considered as part of the prioritisation of capital funding, particularly regards to investment within the North Cumbria locality.

Peter Studd referred to the Hopewood Park mental health reviewer visit and queried the issues raised relating to the accommodating patients despite bed availability. Lisa confirmed that due to capacity issues, beds associated with service users on leave were used to accommodate admissions. It was acknowledged that these were rare circumstances and decisions were taken while considering the impact of alternative options including sending service users out of area to receive their care.

Resolved:

- **The Board received the Commissioning and Quality Assurance Report**

10. Safer Care Report

Damian Robinson spoke to the enclosed report and in terms of incidents, deaths and serious incidents from October – December 2020 was comparable with previous quarters. Damian referred to a Regulation 28 involving issues relating to collaboration between the Trust and Police. It was noted that the Trust responded appropriately and within timescale.

Damian referred to a Never Event which concerned a collapsible shower rail and a serious incident review had been completed, taking learning forward within the Trust and at a national level.

Damian highlighted the national concern about safeguarding reports increasing because of the Covid-19 pandemic.

Damian mentioned two Clostridium Difficile infections recorded, both of which were identified on routine screening.

At the time of the report 76% of all staff had received the flu vaccination.

Complaints had decreased by 9% in comparison to Quarter 2 and during Quarter 3 period October – December 2020. 13 complaints had been received relating to Covid-19, a decrease of 38% from Quarter 2, the majority of which related to increased anxiety around changes to practices and processes during lockdown.

Resolved:

- **The Board received the Safer Care Report**

11. Outcome of Board Assurance Framework/Corporate Risk Register Annual Review

Lisa Quinn referred to a Board Development Session held in February to review the Board Assurance Framework and Corporate Risk Register and referred to the report which summarised the decisions made.

The thematic risk review also highlighted that the Workforce category holds five risks Trust-wide and that Workforce staffing risks were captured in other Risk Appetite Categories. It was proposed that the Workforce risk appetite category be removed once the five identified risks have been transferred to a more relevant category.

The thematic risk review identified two current financial risks that are below the risk appetite and the Board members proposed that the risks be closed.

The Board approved all the recommendations set out in the paper and considered the proposal to review operational partnership and reputational categories at a later stage when reviewing the full Board Assurance Framework in line with the new service strategy.

David Arthur referred to the digital and IT risks and noted that these had been recognised as part of the Internal Audit on risk assurance relating to digital risks.

Michael Robinson referred to risk categories relating to partnership working and the link to collaboration, provider collaboratives, and new care models and suggested reallocating these risks to partnership category. Lisa advised that discussions were taking place with the risk lead with a view to reviewing the risks.

Resolved:

- **The Board received the report on the outcome of BAF/CRR Annual Review**

Approved

- **The Board approved recommendations set out under section 5 of the report subject to additional suggestion that the Partnership risk to be further reviewed and discussed**
- **The Board approved the closure of the two financial risks that are below the risk appetite**

Workforce

12. Workforce Quarterly update

Lynne Shaw presented the report highlighting the Recruitment Improvement Event as part of the Trust's commitment to progressing the Equality, Diversity and Inclusion agenda. In January, a group of representatives from the Trust Staff Networks met to review the recruitment process to discuss ideas to improve recruitment processes and develop recommendations to reduce those barriers. The three day session generated a number of ideas on how to make improvements with the Group presenting final recommendations to the Executive Directors meeting on 31 March 2021.

Lynne referred to the Health and Wellbeing Strategy which aligns to the objectives of the wider Workforce Strategy and NHS People Plan.

Lynne made reference to the Talent Management plan with a formal launch planned to take place in the Spring.

Les Boobis asked if the new appraisal policy would address the current low appraisal compliance rates by providing a more comprehensive policy for all staff. Lynne agreed also noting the plans to train managers on the new policy with a more streamlined process.

Paula Breen queried the transition phase to the new policy. Lynne advised that appraisals were undertaken as a rolling programme therefore, individuals would be required to comply with the new policy when their current appraisal is due for renewal.

Ken Jarrold noted that a lot of important work was underway, clearly reflecting the need to support staff and offer development opportunities as well as the importance of health and wellbeing.

Resolved:

- **The Board received the Workforce Quarterly Report.**

13. Gender Pay Gap Annual Report – CNTW & NTW Solutions

Lynne Shaw referred to the report and highlighted there had been a requirement since April 2018 for organisations with 250 employees or more to report their gender pay gap on an annual basis.

Lynne noted that in terms of the Trust there has been a slight deterioration from mean and median gender pay gap on the basis of hourly pay and a slight improvement for mean and median gender pay gap using bonus pay.

Lynne Shaw referred to NTW Solutions report which had been submitted to the NTW Solutions Board. NTW Solutions have had a slight improvement in both their mean and median gender pay gaps using hourly pay and the actions for NTW Solutions are similar to the Trust and the plan to work together to undertake some of the actions noted.

Resolved:

- **The Board received the Gender Pay Gap Annual Report – CNTW & NTW Solutions Limited**

Strategy and Partnerships

14. Update on CAMHS Services, Tees Valley

Gary O'Hare referred to the report and advised that all posts had now been recruited to with the exception of some vacancies at Band 7 level and the Ward Manager post. A ward manger would be moved into the service from Ferndene as an interim measure.

Challenges remain in terms of medical recruitment. Re-advertisements have taken place working with the Royal College and in the interim period, Lisa Rippon, Consultant and Associate Director, will provide consultant cover to the unit. A Consultant on-call service will also be provided from all CAMHS consultants from CNTW, with junior doctor provision from TEWV.

Gary also referred to the initial scoping exercise for the installation of the Oxehealth patient safety system onto the ward to detect movement in the rooms.

Debbie Henderson provided an update on the process of choosing the ward name whereby service users from Ferndene and Alwood reviewed a range of options. Service users chose 'Lotus Ward' meaning 'regeneration'.

Gary advised that TEWV had commenced the engagement process to rename West Lane Hospital. Acklam Road Hospital had been proposed as the new name.

Gary advised that a CQC visit and NHSE/I visit would take place as part of the registration process.

Resolved:

- **The Board received the update on CAMHS Services, Tees Valley**

15. ICS Join our Journey website

John Lawlor referred to a website www.joinourjourney.org.uk containing all North East and North Cumbria ICS material.

Resolved:

- **The Board noted the ICS Join our Journey website**

16. Gateshead Carers Alliance Agreement

James Duncan presented the agreement noting the Gateshead Health and Care System Group had been operating under a framework provided by a Memorandum of Understanding (MoU) since 2019.

The Gateshead Carers Alliance Agreement further strengthens the MoU by providing a framework to move forward on the ambitions for the Gateshead system, reflecting national policy for strong place-based partnerships. Partners are already working together to develop Gateshead System arrangements in order to establish an improved governance, financial and contractual framework for delivering integrated health support and care to the people of Gateshead.

The benefits of entering into a formal arrangement were acknowledged. James requested approval from the Board to enter into the Alliance Agreement for the Gateshead Health and Care System with effect from the 1st April 2021. The Board also agreed delegated authority to James as Deputy Chief Executive and Executive Director of Finance to approve any final amendments to the Agreement.

Michael Robinson welcomed the idea of entering into a more formal arrangement and queried how the alliance would go forward within the wider ICS. James Duncan confirmed the Alliance formed part of the ICS working in terms of partnerships at place level which are part of that wider ICS system.

Resolved:

- **The Board received the Gateshead Carers Alliance Agreement Report.**

Approved:

- **The Board approved the Gateshead Alliance agreement and delegated authority to Deputy Chief Executive/Executive Director of Finance to approve final additions and/or amendments.**

Regulatory / Compliance

17. CQC Action Plan – Focused Inspection of Child and Adolescent Mental Health Wards

Lisa Quinn presented the report and advised that some further amendments were required to clarify: details of responsible officers; timescales for HOPE training; and use of MRE in children services. All comments would be included prior to submission to the CQC.

John Lawlor mentioned a number of staff meetings were taking place to discuss both the findings of the report as well as the action plan.

Alexis Cleveland noted that the report was also discussed at Quality and Performance Committee as well as a deep dive exercise into the Empower Programme.

Resolved:

- **The Board received and noted CQC Action Plan – Focused Inspection of Child and Adolescent Mental Health Wards**

Approved

- **The Board approved the action plan**

18. Fit and Proper Person Report

Debbie Henderson spoke to the enclosed report which outlines the annual review process undertaken of the Directors Fit and Proper Persons test which is in-line with the CQC requirements. The annual review includes completion of an annual declaration undertaken by individual Directors and checks undertaken for all individuals against the range of registers outlined in the report.

Resolved:

- **The Board received the Fit and Proper Persons Report**

Minutes/papers for information

19. Committee updates

19.1 Quality and Performance Committee

Alexis Cleveland confirmed there has been a further Quality and Performance Committee with an update from North Cumbria Locality Group. The update provided strong assurance, particularly in terms of the feedback received from staff following the transfer of services.

Alexis also referred to an updates provided on the Medicines Optimisation Report and a report on Clinical Audit.

19.2 Audit Committee

Nothing to report.

19.3 Resource and Business Assurance Committee

Nothing to report.

19.4 CEDAR Programme Board

Nothing to report.

19.5 Mental Health Legislation Committee

Nothing to report.

19.6 Charitable Fund Committee

Nothing to report.

20 Council of Governors issues

Ken Jarrold referred to the recent Governor Elections and warmly welcomed new Governors to the meeting expressing thanks for their time already shared via one to one meetings. A Governors Induction will be arranged in the coming weeks.

The Steering Group has been reviewing the business of the Council as well as the Trusts approach to membership engagement.

Ken Jarrold confirmed the Nominations Committee has been meeting to discuss preparations to address a number of Non-Executive Directors coming to the end of their Term of Office during 2021.

Evelyn Bitcon, Public Governor for Cumbria requested an update on Cumbria. Ken Jarrold advised that an update on the North Cumbria locality would be provided at the May meeting of the Council of Governors.

Alexis extended an invitation to Evelyn Bitcon to attend Quality and Performance Committee when a deep dive will take place for Cumbria.

21 Any Other Business

Ken Jarrold noted that the meeting was the last meeting for Gary O'Hare in his current role as Executive Director of Nursing and Chief Operating Officer, with Gary returning as part-time Executive Director of Nursing from 12th April.

Ken thanked Gary on behalf of the Board for his immense and outstanding contribution to the Trust over 39 years, a remarkable achievement.

22 Questions from the public

None to note.

Date and time of next meeting

Wednesday, 7 April 2021, 1.30pm via Microsoft Teams

Board of Directors Meeting held in public

Action Log as at 7 April 2021

Item No.	Subject	Action	By Whom	By When	Update/Comments
Actions outstanding					
06.11.19 (12) 02.09.20 (5)	Staff Friends and Family Test	Agreed that actions to address potential impact of automated messages on people who contact services by telephone to be included in the Reset and Redesign of services work.	Gary O'Hare	~~May 2020~~ ~~August 2020~~ ~~December 2020~~ ~~February 2021~~ ~~March 2021~~ May 2021	Update to be provided in line with the Reset and Redesign work and staff friends and family test
05.08.20 (07)	Chief Executive's Report	Update on Trieste to be provided to a future Board development session	James Duncan	June 2021	Complete – Board development topic for June meeting
Completed Actions					
02.09.20 (13)	Quarterly Workforce Report	Details of the allocation and placement of overseas staff to be circulated to the Board	Rajesh Nadkarni	~~October~~ ~~November~~ ~~December 2020~~ February 2021	Complete
02.12.20 (10)	Commissioning and Quality Assurance Report	After Action Review associated with the Mental Health Act visits to be circulated to Board members for information	Lisa Quinn	~~February 2021~~ March 2021	Complete – included in March Board report
03.02.21 (18)	CQC Strategy for 2021 and beyond	Questions to be considered through the Quality and Performance Committee	Lisa Quinn	~~March 2021~~	Complete – included on February Q&P meeting for discussion

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
7th April 2021

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

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

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

Coronavirus (COVID-19)
Report for the Board of Directors meeting
7th April 2021

1. Executive Summary

This report provides an exception report in response to the COVID-19 pandemic since the last Trust Board. For this month the report includes three areas:

- Outbreak management and Patient Testing
- Patient and Staff Testing & Vaccinations
- Clinically Extremely Vulnerable (CEV) and staff risk assessment

2. Trust COVID-19 Outbreak management

Since the last report there has been a significant reduction in community prevalence of circulating Covid19 across the CNTW footprint which has resulted in both a reduction in staff and patient transmission. There have been two actively managed outbreaks since the last report i.e. Plummer Court and Universal Crisis Team South. Neither outbreak involved patients. Staff transmission was linked to environmental office practices and inconsistent Personal Protective Equipment (PPE) usage. These issues were resolved with immediate effect and additional Infection Prevention Control (IPC) training and awareness for managers and staff has taken place reminding everyone of the practice. **(see Appendix 1 for outbreak breakdown)**

All outbreaks are managed and have a robust action plan in place, overseen by the Director of Infection Prevention Control (DIPC), Gold Command and Locality leadership team. Learning is shared through the outbreak de-brief meetings and the Trustwide IPC meetings.

3. Patient and Staff Testing & Vaccinations

The last report highlighted our testing strategy i.e. patient swabbing on days 1,3, 5 to 7 for new admissions, and every seven days thereafter.

The learning from outbreaks had identified the risk of nosocomial transmission post the 1st and 3rd day test. This had occurred where the index case had been identified as a new admission or transfer to the ward with an asymptomatic presentation and negative test results on day 1 and 3 but then becoming symptomatic on days 4/5, when they have been out of isolation. This resulted in hospital acquired transmission to other patients.

Since the last meeting the Trust has reviewed the arrangements for cohorting patients and isolation periods to reduce the risk of nosocomial transmission across inpatient wards. To further reduce transmission, it has been agreed to step down the Bede admission model and admit directly to all wards with isolation until the first negative swab. This will be reviewed again in May.

3.1 Asymptomatic Staff Testing and Visiting Professional to Care Homes

The roll out of Asymptomatic Lateral Flow Device (LFD) testing kits to those staff that have signed up to the twice weekly testing arrangements continues. However, we have seen a noticeable drop in collection of the second kits and reporting of results suggests staff are not using LFDs routinely. Initial feedback suggests over reliance on vaccination providing

protection. LFD Testing has been reinforced this week following guidance from the Department of Health & Social Care (DHSC) and the Care Quality Commission (CQC) requiring all Visiting Professionals to a care home to demonstrate a negative lateral flow in the previous 72 hours prior to the visit. This will be closely monitored.

3.2 COVID-19 Vaccination Staff, Patients and Clinical Partners

The Trust has continued with its vaccination programme. This has been a successful programme to date via both developments including the joint arrangement with North Cumbria Integrated Care (NCIC) for the administration of the Pfizer vaccine for the North Cumbria Locality and the CNTW run East model using the 3-site arrangement from St Nicholas Hospital, St George's Park and Hopewood Park to administer the Oxford / AstraZeneca vaccine. The roll out of Second Dose Vaccine clinics following a 12 week gap, commenced on 22nd March. This will continue over the next four weeks.

In terms of patient vaccination roll out, the Trust continues to administer the vaccine for patients within the priority groups as per the Joint Committee on Vaccinations and Immunisations (JCVI) guidance. Since the last meeting the processes are in place to support patients i.e. community mental health and learning disability teams to access their vaccine either via Primary Care Networks (PCN's) or in some circumstances, via the community mental health teams. Targeted vaccination clinics for Addictions services patients are operating in each locality, with the exception of South locality which is under review due to change in service provider.

Appendix 1 provides a breakdown of the vaccination numbers per group.

4.0 Clinically Extremely Vulnerable Criteria and Staff Risk Assessments

Since the last meeting the Clinical Risk Assessment Group (CRAG) have reviewed on behalf of the Trust the guidance to support those CEV staff who have been shielding to return to work at the end of March following risk assessment.

5.0 Recommendation

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

Anne Moore
Group Nurse Director, DIPC

CNTW COVID-19 Trust Summary

COVID Positive

Current positive patients: 1
1 Mowbray

Staff PCR+ result: **339 (339)** since 1st Dec

LFT – **164 (164)** positive results
23 (21) returned a negative PCR result (14.0%)

Staff Absence

Total staff absent: **534 (540)**
161 (160) COVID related – **16 (16)** due to COVID+ test (9.9%)

Outbreaks

Outbreaks by Locality	Open	Closed	Total
North Cumbria	0	8	8
North	0	8	8
Central	0	7	7
South	1	14	15
Total	1	37	38

Figures below relate to the whole of each outbreak and are not current positive staff/patients

Live Outbreaks	Day	Staff	Patients
South ICTS / Crisis	22	2	0

COVID Vaccinations

Total Current Patients: **696**
Fully vaccinated (2 doses): **0 (0.0%)**
Partially Vaccinated (1 dose): **448 (64.4%)**
Patients refused: **85 (12.2%)**

Total Staff: **8814**
Fully vaccinated (2 doses): **2887 (32.8%)**
Partially Vaccinated (1 dose): **7776 (88.2%)**
Unable to receive – **169 (1.9%)**

Clinical Partners :
Fully vaccinated (2 doses): **49 (5.2% of 940)**
Partially Vaccinated (1 dose): **940**

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
7th April 2021

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	24.03.21
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	22.03.21
Corporate Decisions Team (CDT)	
CDT – Quality	22.03.21
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

CNTW Integrated Commissioning & Quality Assurance Report

2020-21 Month 11 (February 2021)

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 two remote Mental Health Act reviewer visit report received this month.

Beckfield PICU, Hopewood Park (Acute ward for adults of working age and psychiatric intensive care units) – 9 February 2021

The following issues were identified from this visit:

- The environment for a patient being nursed in Long Term Segregation did not meet the MHA Code of Practice guidance.
- Overall feedback from IMHA's regarding the ward was positive. However, the IMHA for the patient being nursed in Long Term Segregation reported they had never been invited to any meetings regarding the patient. The ward manager explained that the IMHA had only recently been appointed and that IMHA contact had been closed and reopened on several occasions.
- One patient thought that their period of seclusion could have ended earlier and that ending seclusion appeared to wait for certain staff to be present.
- Two patients had remained on PICU for very lengthy periods. It was unclear why this was seen as the right environment for them. The ward manager also explained that at times transferring patients from the PICU was delayed due to acute bed availability.

Lindisfarne, Northgate Hospital (Forensic secure service) – 24 February 2021

The following issues were identified from this visit:

- One family member and one patient was unclear about how discharge would occur.
- One patient had regular periods in seclusion and these often lasted months. Staff recognised that the ward environment and patient mix was a trigger for this patient. The patient had an autism diagnosis and was waiting for transfer to a more appropriate environment. The patient was using seclusion to regulate his emotions and often wanted to be in seclusion. The seclusion room was small and not suitable for lengthy periods.
- The acting ward manager explained that they were not considering a community placement for the autistic patient despite the number of referrals to other in-patient services being rejected.
- During this review staff were present with patients during the interviews by CQC.

The action plans relating to these visits are owned by the relevant service and the Associate Director is responsible for following up on actions until the action plan is complete through their CMT/CBU. The CQC Compliance Officer routinely receives updates on all outstanding action plans and these are collated and shared with the Mental Health Legislation Steering Group and Mental Health Legislation Committee on

a quarterly basis. The Associate Director/CBU must provide evidence to the CQC Compliance Officer to support the closure of any action contained in the action plan.

The CQC Reviewer Group considers all action plans and adds in any additional overarching information where relevant prior to sign off by the Group Director/Group Nurse Director for the relevant locality group.

The themes from these visits are taken to BDG on a monthly basis and Mental Health Legislation Steering Group and Mental Health Legislation Committee on a quarterly basis.

3 The Trust met all local CCG's contract requirements for month 11 with the exception of:

- CPA metrics for all CCG's.
- Numbers entering treatment within Sunderland IAPT service (526 patients entered treatment against a target of 810) and North Cumbria (352 patients entered treatment against a target of 605).
- Delayed Transfers of Care within Durham, Darlington and Tees and North Cumbria.

5 The Trust met all the requirements for month 11 within the NHS England contract with the exception of the percentage of patients with a completed outcome plan (94.5%).

6 All CQUIN schemes for 2020/21 have been suspended due to the COVID-19 pandemic.

7 There are 70 people waiting more than 18 weeks to access services this month in non-specialised adult services (40 reported last month). Within children's community services there are currently 545 children and young people waiting more than 18 weeks to treatment (434 reported last month).

8 Training topics below the required trust standard as at month 11 are listed below:

Fire (82.4%)	Medicines Management (83.7%)
Information Governance (80.6%)	PMVA basic training (20.1%)
PMVA breakaway training (67.3%)	Mental Health Act combined (64.6%)
MHCT Clustering (62.9%)	Clinical Risk (80.0%)
Clinical Supervision (76.8%)	Seclusion training (67.6%)
Rapid Tranquilisation (77.2%)	Clinical Supervision recorded (49.3%)
Management Supervision recorded (43.2%)	

9 Appraisal rates currently stand at 75.4% Trust wide against an 85% standard which is a decrease from last month (76.5%).

10 Clinical supervision training is reported at 76.8% for February (was 77.4% last month) against an 85% standard. The percentage of staff with a completed clinical supervision record is reported at 49.3% as at 10th March 2021. At 28th February 2021 the proportion of staff with a management supervision recorded in the last 3 months is reported at 43.2% against an 85%.

11 The confirmed January 2021 sickness figure is 6.6%. This was provisionally reported as 6.75% in last month's report. The provisional February 2021 sickness figure is 5.44% which is above the 5% standard. The 12 month rolling average sickness rate has decreased to 5.65% in the month.

12 At Month 11, the Trust has a £1.2m surplus which is £2.1m ahead of the Trust's revised plan for the year. The forecast deficit is currently £1.5m which is £0.7m below the planned deficit. However, additional funding is expected to be confirmed shortly which will move the forecast back to breakeven. In line with the financial arrangements put in place in response to COVID-19 the Trust was breakeven at the end of September. Additional costs due to COVID-19 from April – February were £6.6m. Agency spend at Month 11 is £14.0m of which £6.6m (47%) relates to nursing support staff and forecast agency spend is £16.0m.

Other issues to note:

- There are currently 18 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 at 95.5% which is above the 80% standard. (was 94.2% last month).
- There were 15 inappropriate out of area bed days reported in February relating to the unavailability of older persons beds for two patients. This compares with 24 inappropriate bed days in January.
- During February 2021 the Trust received 307 Points of You survey returns, of which 66% were from service users, 29% from carers and 5% did not state the person type. Of the 307 responses 294 answered the FFT question with 87% of service users and carers stating their overall experience with CNTW services was either good or very good.

Current reporting of Training & Appraisals during pandemic

The Trust is experience continuing pressure maintaining services through the extended wave 3 Covid 19 period. The Executive Team and Operational Directors have stood down non-essential meetings and the centre have ceased several reporting requirements. We have explored the continuation of the training and appraisal standards. In wave 1 we paused the standard and gradually reintroduced them during the summer. At its February meeting the Board of Directors agreed the following:

The Operational Groups will to continue to make best endeavours to achieve the standards for training and appraisals however recognise this is not always possible in managing safe care with fluctuating staffing levels, managing patient co-horting to ensure we continue to remain open to admissions and managing varying restrictions. We will continue to monitor training and appraisals through the Board and the Accountability Framework meetings but not performance manage the expected standards. This will be reviewed each quarter with the Board.

Regulatory

Single Oversight Framework

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 two Mental Health Act reviewer visit reports received since the last report. The visits continue 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
94%	90%	90%	80%	90%	86%	75%	58%

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 CQUIN schemes are currently suspended for 2020/21

Internal

Accountability Framework

North Locality Care Group Score: February 2021		Central Locality Care Group Score: February 2021		South Locality Care Group Score: February 2021		North Cumbria Locality Care Group Score: February 2021	
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 4 internal assessment RAG rating

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

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 11. 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

Statutory & Essential Training:

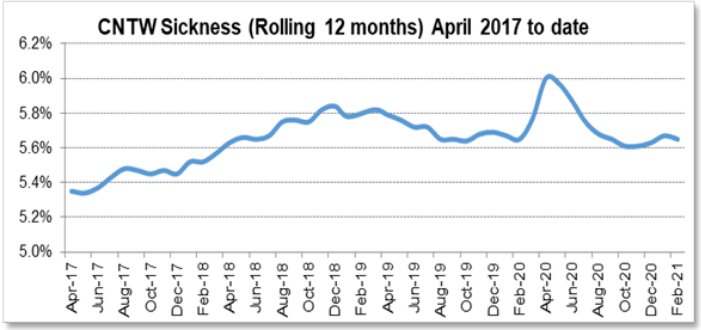
Number of courses Standard Achieved Trustwide:	Number of courses <5% below standard Trustwide:	Number of courses Standard not achieved (>5% below standard):
6	3	10

Fire training (82.4%), Clinical Risk training (80.0%) and Medicines Management training (83.7%), are within 5% of the required standard. Rapid Tranquilisation training (77.2%) Information Governance (80.6%), PMVA basic training (20.1%), PMVA Breakaway training (67.3%), MHA combined training (64.6%), MHCT Clustering Training (62.9%), Seclusion training (67.6%), Clinical Supervision training (76.8%), Record of Management Supervision recorded (43.2%) and Record of Clinical Supervision recorded (49.3%) are reported at more than 5% below the standard.

Appraisals:

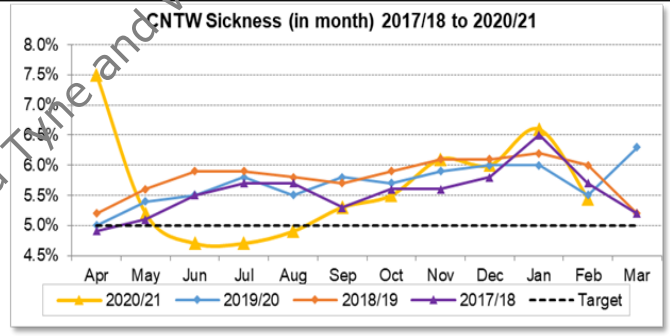
Appraisal rates have decreased to 75.4% in February 2021 (was 76.5% last month).

Sickness Absence:



The provisional "in month" sickness absence rate is above the 5% target at 5.44% for February 2021

The rolling 12 month sickness average has decreased to 5.65% in the month



Finance

At Month 11, the Trust has a £1.2m surplus which is £2.1m ahead of the Trust's revised plan for the year. The forecast deficit is currently £1.5m which is £0.7m below the planned deficit. However, additional funding is expected to be confirmed shortly which will move the forecast back to breakeven. In line with the financial arrangements put in place in response to COVID-19 the Trust was breakeven at the end of September. Additional costs due to COVID-19 from April – February were £6.6m. Agency spend at Month 11 is £14.0m of which £6.6m (47%) relates to nursing support staff and forecast agency spend is £16.0m.

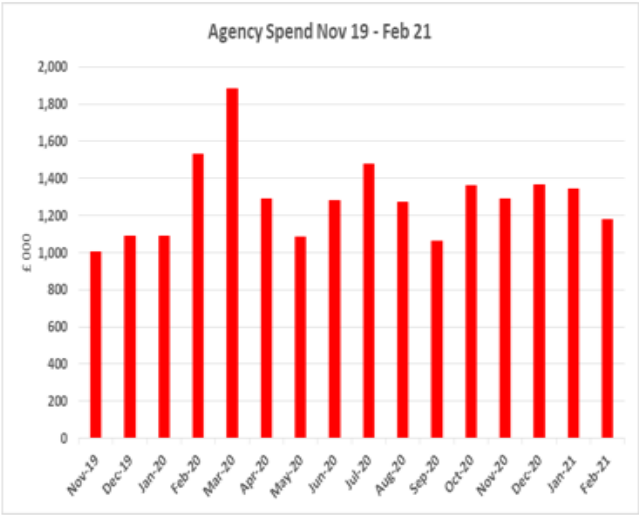
Financial Performance Dashboard

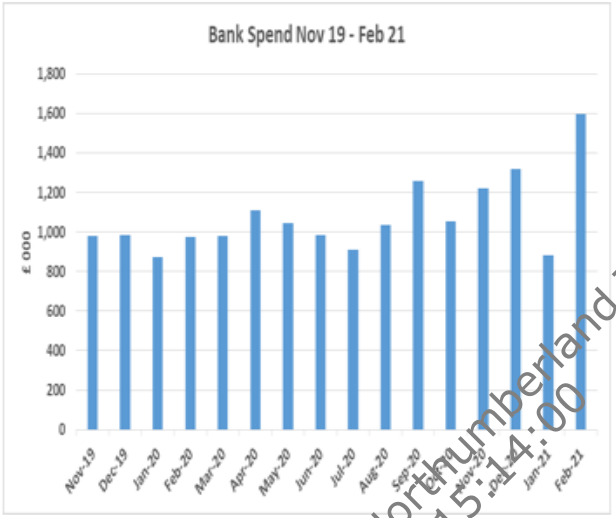
Income & Expenditure

	Year to Date			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	380.0	386.5	(6.5)	414.7	428.1	(13.4)
Pay	(304.1)	(306.9)	2.8	(332.9)	(338.2)	5.3
Non Pay	(76.8)	(78.4)	1.6	(84.0)	(91.4)	7.4
	(0.9)	**1.2**	**(2.1)**	**(2.2)**	**(1.5)**	**(0.7)**

Key Indicators

Key Indicators	Year to Date	Forecast
Surplus/ (Deficit)	£1.2m	(£1.5m)
Agency Spend	£14.0m	£16.0m
Cash	£89.0m	£51.3m
Capital Spend	£13.9m	£19.6m





Key Issues/Risks.

- At month 11 the Trust has a £1.2m surplus which is £2.1m better than the M7-12 plan.
- The Trust planned £2.2m deficit was as a result of a shortfall in income (£1.4m) and an increase in the annual leave provision (£0.8m). The Trust has received funding to cover the income shortfall and the forecast now shows a £1.5m deficit which relates to a higher annual leave figure. Central funding is to be provided for this as well to get to a breakeven position.
- Trust pay costs have increased in month 11 as a result of sickness levels from wave 3 and delivering vaccines to staff. This has been offset by additional income.
- The Trust has incurred £0.6m additional costs due to COVID-19 in month 11. and has incurred £6.6m of Operational COVID costs up to month 11. The Trust is also incurring the costs of additional services developed to support the pandemic.
- Cash – £89.0m at month 11 which is higher than normal due to early payment of income.
- Capital Spend - £13.9m at month 11 which is £7.2m less than plan.

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

	01/02/2021		08/02/2021		15/02/2021		22/02/2021	
Medical	102	38	102	38	102	38	103	38
Qual Nursing	199	120	196	115	203	119	222	141
Unq Nursing	1,508	70	1,530	59	1,493	66	1,401	65
A&C	76		67		66		65	
	1,885	**228**	**1,895**	**212**	**1,864**	**223**	**1,790**	**244**

In February the Trust reported an average of 227 price cap breaches (38 medical, 124 qualified nursing and 65 nursing support). At the end of February 8 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 at month 11.
- There continues to be over 18 week waiters across services. Work continues to monitor and improve access to services across all localities.
- 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.

Allan Fairlamb	Lisa Quinn
Head of Commissioning & Quality Assurance	Executive Director of Commissioning & Quality Assurance

15th March 2021

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Report to the Board of Directors
7th April 2021

Title of report	**Annual Report on Safe Working Hours: Doctors in Training – January to December 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)	
Quality and Performance	13/5/20
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	
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	

Board Assurance Framework/Corporate Risk Register risks this paper relates to
No

Annual Report on Safe Working Hours:
Doctors in Training – January to December 2020

1. Executive Summary

This is the Annual Board report 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 are on the New 2016 Terms and Conditions of Service. There are currently 150 trainees working into CNTW with 150 on the new Terms and Conditions of Service via the accredited training scheme via Health Education England. There are an additional 23 trainees employed directly by CNTW working as Trust Grade Doctors or Teaching/Clinical/Research Fellows.

High level data

- Number of doctors in training (total): 150 Trainees (at December 2020)
- Number of doctors in training on 2016 TCS (total): 150 Trainees (December 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: Dr Clare McLeod

2. Risks and mitigations associated with the report

- 69 exception reports raised during the year
- 15 agency locums booked during the period covering vacant posts and sickness
- 642 shifts lasting between 4hrs and 12hrs were covered by internal doctors
- On 47 occasions during the period the emergency rotas were implemented
- 83 IR1s submitted due to insufficient handover of patient information

Exception reports (with regard to working hours)

Exception Reports Received						
Grade	Rota	Q1	Q2	Q3	Q4	Total Hours & Rest
CT1-3	Gateshead/MWH	5	10			15
CT1-3	St George's Park	4	6	6	1	17
CT1-3	NGH	1	8	1	4	14
CT1-3	RVI	2	4			6
CT1-3	St Nicholas		1		1	2
CT1-3	Hopewood Park			2	10	12
CT1-3	Cumbria					
ST4+	North of Tyne		2		1	3
ST4+	South of Tyne					
ST4+	CAMHS					
Total		12	31	9	17	69

Work schedule reviews

During the year there have been 69 exception reports submitted from trainees all for hours and rest throughout 2020; the outcome of which was that TOIL (time off in lieu) was granted for 53 cases, 1 no action required and payment was made on 15 occasions. Emergency rota cover is arranged when no cover can be found from either agency or current trainees. The rotas are covered by 2 trainees rather than 3 and payment is made to the 2 trainees providing cover at half rate.

i) Locum bookings
Agency

Locum bookings (agency) by department				
Specialty	Q1	Q2	Q3	Q4
Hopewood Park	5	1		
SGP			3	3
Total	5	1	3	3
Locum bookings (agency) by grade				
	Q1	Q2	Q3	Q4
F2	3	1		
CT1-3	2		3	3
ST4+				
Total	5	1	3	3
Locum bookings (agency) by reason				
	Q1	Q2	Q3	Q4
Vacancy	5	1	3	3
Sickness/other				
Total	5	1	3	3

a) Locum work carried out by trainees

Area	Number of shifts worked Q1	Number of shifts worked Q2	Number of shifts worked Q3	Number of shifts worked Q4	Total for Year 2020
SNH	31	30	31	31	123
SGP	18	24	22	34	98
Gateshead/MWH	14	56	36	23	129
Hopewood Park	9	12	28	15	64
RVI	5	6	6	28	45
CAV	19	9	3	8	39
Cumbria	2	18	10	4	34
North of Tyne	9	26	12	10	57
South of Tyne	16	12	21	4	53
Total	123	193	169	157	642

b) Vacancies

Vacancies by month					
Area	Grade	Q1	Q2	Q3	Q4
NGH/CAV	CT GP FY2	6		 2	 1
SNH	CT GP	6	3		
SGP	CT GP	30	21	9	9
RVI	CT GP	3	3	1	
Hopewood Park	CT GP FY2	12	12 3	4 1	4
Gateshead/MWH	CT GP FY2	6			
Cumbria	CT GP FY2	4	6	 3 2	
Total		67	48	22	14

To note these training gaps have been filled by Teaching/Research/Clinical Fellows & LAS appointments

c) Emergency Rota Cover

Emergency Rota Cover by Trainees					
		Q1	Q2	Q3	Q4
Vacancy		2	2	1	1
Sickness/Other		16	5	11	9
Total		18	7	12	10

d) Fines

There were 3 fines during the last year due to minimum rest requirements between shifts not being met due to finishing twilight/weekend shifts late.

Issues Arising:

The numbers of exception reports has remained the same from 2019, with 69 submitted in 2020.

The majority of exception reports continue to be closed mainly with TOIL (53) and payment made to 15 trainees.

There have been 83 IR1s submitted for insufficient medical handover in 2020. In 2019, there were 88 IR1s; so this represents a small decrease.

There was a decrease in the number of times emergency rota cover was necessary, from 70 in 2019 to 47 in 2020. This may be due to the fact that a training rota was implemented from August 2020. This rota is an additional trust wide rota where the first on-call doctors contribute on weekends and nights. The trainee's shadow the higher trainee on shift and gain exposure to emergency psychiatry such as Mental Health Act assessments. If there is a gap on the site rotas the trainee on the training rota would move to cover this.

Due to the increasing demand on the inpatient wards due to the pandemic there was additional cover offered between the hours of 10am to 4pm on weekends and bank holidays on the Hopewood Park, St Georges Park and North Cumbria junior rotas. The trainees volunteered for this work and were paid locum rates.

To assist with the COVID Vaccine Clinics, junior doctors also volunteered to assist and those who worked additional hours were paid the appropriate locum rates.

The number of shifts undertaken by internal doctors to cover rota gaps due to sickness, adjustments or gaps has increased considerably from 493 in 2019 to 642 in 2020. From August to December just over half of these were shifts covered due to COVID (trainees testing positive, isolating or reactions to vaccine).

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 which has now been spent to improve the working lives of junior doctors.

Actions Taken to Resolve These Issues:

<u>Exception Reporting</u>

The number of exception reports has remained stable in comparison to 2019, following the numbers almost doubling from 2018 to 2019. The numbers of exception reports submitted by higher trainees remains small and likely to be significantly lower than would be expected, as in other Trusts. Two of the three fines were due to Mental Health Act assessments which were started during twilight or weekend shifts and resulted in late finishes for higher trainees. Whilst there is guidance in place about when during a twilight shift to commence a Mental Health Act assessment to allow it to be completed without an impact on finish time and therefore rest and when to hand this over. However, it is acknowledged that this can be difficult as the duration of the organisation and completion of these assessments is variable and this has been discussed at the GoSW forum.

The majority of exception reports in CNTW continue to be closed with TOIL (53 out of 69 in 2020) which is encouraging. A proportion of the exception reports which had to be closed by payment was due to trainees having to use the exception reporting for travel time from West Cumbria to the Carlton Clinic where there is an agreement with the LET (Lead Employer Trust) for remuneration rather than TOIL. It is in discussion with the LET for adjustment of the work schedules to resolve this issue.

The profile of Exception Reporting continues to be raised and encouraged at induction, the GoSW forum and in meetings with trainees. Screen shots of the documentation are shared at induction and via email.

Medical Handover

The number of IR1s submitted for insufficient medical handover at admission has fallen very slightly from the numbers in 2019 which is encouraging. This follows the increase in numbers from 2018 to 2019 and relative stability month on month following this. Since October 2019, some of the increase would be explained by the addition of reports from Cumbria with the increase in size of the Trust. These reports continue to be reviewed and followed up by the Director of Medical Education and collated to share with staff throughout the Trust and are discussed at every GoSW forum, in addition to being shared specifically with clinical staff most involved in admissions to hospital. The importance of medical handover will remain a priority to be discussed at induction and in the forums mentioned and continue to be monitored accordingly; we hope that this slight fall in numbers represents the beginning of a sustained change.

Emergency Rota

The substantial reduction in the need for the Emergency Cover Rota in 2020 is encouraging after the increase from 2018 to 2019. This arrangement is necessary if there is a rota gap that, despite the efforts of Medical Staffing, is not filled by lunchtime. There are monitoring procedures in place on each occasion that the emergency rota is necessary to ensure no compromise to patient care. The number of times that this provision is necessary is discussed and monitored through the GoSW forum; it is a source of stress to trainees with the need to work in less familiar sites and the increase in workload.

The new training rota that was introduced in August 2020 is primarily to provide experience for Core and GP trainees in emergency psychiatry, shadowing the Higher Trainees. This, however, also provides a means of covering any vacant shift by moving this trainee from the training rota to cover the gap. If a trainee misses their slot on the training rota due to having to cover a rota gap, they are offered additional slots on the training rota on a voluntary and paid basis.

COVID-19

There has been an increase in the number of shifts covered by internal locums due to absences, sickness, adjustments or rota gaps in comparison to 2019, when prior to this the numbers had been fairly stable. We have information relating to the period August- December 2020 when just over half of these gaps were due to COVID related absences. It would seem likely that the earlier part of the year is similar.

We are grateful to the trainees who have volunteered to assist with the Trust COVID vaccination programme, working additional hours to cover these clinics. These

additional hours were remunerated at locum rates.

The intensity of work, especially over weekends and bank holidays, increased due to the physical healthcare needs of inpatients due to COVID. This was especially in the period March- June 2020. This was managed with an additional rota to cover 10am-4pm on weekend days and bank holidays which trainees volunteered to cover at Cumbria, HWP and SGP and were remunerated at locum rates. This was gradually phased out from June 2020, but due to the ongoing increased work intensity at SGP it has been integrated into the routine working arrangements from Feb 2021.

The GoSW forum continued to take place throughout the COVID restrictions, but as with other meetings took place via TEAMS. Attendance has been maintained and in some instances increased with this and this is something we need to consider through the forum continuing in some format once restrictions are eased.

BMA, Fatigue and Facilities Charter, Monies and Spend

The Trust was awarded a total of £84,166.33 to be spent to improve the working lives of junior doctors following the adoption of the Fatigue and Facilities Charter. The new equipment was purchased to bring all the on-call accommodation within CNTW to the same standard whilst improving on-call facilities across the Trust. The equipment includes chair-beds, televisions, lap-tops, game machines, gym equipment (where there is no gym on site), pool tables, coffee machines fridges, kettles. Unfortunately, due to COVID, there were some delays in the ability to distribute this equipment but it was distributed as soon as restrictions allowed.

Summary

The number of exception reports have remained stable with the majority closed through TOIL. Work will continue to increase the level of completeness of reporting.

It is encouraging to see a slight fall in the number of reports of insufficient medical handover which will continue to be encouraged and the completeness of handover promoted in a variety of forums.

There has been a fall in the number of occasions where the emergency cover rota was necessary which is encouraging. This will continue to be monitored and reviewed to include the impact of the new training rota.

COVID has been an exceptional challenge to us all. It is encouraging how the trainees supported each other to volunteer to provide locum cover for the additional rota, to manage the increase in work intensity and to cover shifts which were vacant due to COVID related absence. Additionally, we are grateful to our trainees who have volunteered to work extra locum shifts to staff the Trust vaccination programme.

The equipment purchased with the monies from the BMA Fatigue and Facilities Charter has now been distributed.

3. Recommendation

Receive the paper for information only.

Dr Clare McLeod, Guardian of Safe Working for CNTW
Dr Rajesh Nadkarni, Executive Medical Director

7th April 2021

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Report to the Board of Directors
7th April 2021

Title of report	**Staff Survey 2020**
Report author(s)	**Christopher Rowlands**
Executive Lead (if different from above)	**Lynne Shaw, Executive Director of Workforce & OD**

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	✓

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	15.03.21
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	
Workforce	✓	Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness		Service user, carer and stakeholder involvement	

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

Staff Survey 2020
Trust Board of Directors
7th April 2020

1. Executive Summary

In line with previous years all staff were offered the opportunity to complete the survey. 50% (3,405) staff completed the survey between the last week in September and 27 November 2020. For the first time, prompted by concerns around potential delayed delivery due to the pandemic, we opted to conduct the survey entirely online. The results in this paper are benchmarked nationally against the 52 Trusts in the Mental Health and Learning Disability and Mental Health, Learning Disability and Community Trusts grouping. Across these Trusts there were 109,280 responses in all and a median response rate of 49%.

Our results across the ten themes showed

- 8 Themes in 2020 Survey above benchmark average
- Quality of Care equal to benchmark average
- Safe Environment – Violence result below benchmark average
- 8 Themes have improved in 2020 compared to Trust's 2019 results
- Equality Diversity and Inclusion and Quality of Care results have remained the same as 2019
- 6 Themes have seen statistically significant improvements this year
- WRES and WDES figures continue to show a gap in experience between BAME and White Staff and for WDES Disabled and Non-Disabled Staff.

2. Risks and mitigations associated with the report

The key risks are centred on the WRES and WDES performance. Work has been identified to address these concerns and has commenced with Speakeasy style conversations with BAME staff. To address concerns around disability a session for the staff network has been arranged with managers, with a view to extending further to a Trust-wide Q&A session to address issues raised by the network, that are reflected in the survey findings.

3. Recommendation/summary

It is proposed we should:

- Have a Big Conversation around each of the themes to better understand the issues and seek suggestions for action with a focus on those issues identified with the scope for the greatest improvement. This will take place at the end of April and members of The Improvement Collaborative have been invited to be part of this.
- During May that we have a similar conversation with the localities to establish joint and local actions.
- Map staff survey findings into existing related action plans to help inform work and that we monitor the actions that result from the conversations at Trust and locality levels.
- Interrogate the national data to establish the best performing organisation for each theme and in turn the best performing organisation for the questions identified in each theme with the greatest scope for improvement. Links should be established with these organisations to establish if there is anything that we can learn and implement from their experiences.
- We consider the Covid-19 variation in scores as part the proposed wider thematic Staff Survey conversation.

- Organisational development initiatives for all staff with a sharp focus on equality, diversity and inclusion need to be prioritised, to ensure the maximum impact of the work that has already started.

Christopher Rowlands Equality, Diversity & Inclusion Lead	Lynne Shaw Executive Director Workforce and Organisational Development

March 2021

Staff Survey 2020

In line with previous years all staff were offered the opportunity to complete the survey. 50% (3,405) staff completed the survey between the last week in September and 27 November 2020. For the first time, prompted by concerns around potential delayed delivery due to the pandemic, we opted to conduct the survey entirely online. The results in this paper are benchmarked nationally against the 52 Trusts in the Mental Health and Learning Disability and Mental Health, Learning Disability and Community Trusts grouping. Across these Trusts there were 109,280 responses in all and a median response rate of 49%.

Results for staff survey questions are grouped into ten themes, with each of those themes given a score out of ten, where 10 is the best score possible. The ten themes are as follows:

- Equality, Diversity & Inclusion
- Health & Wellbeing
- Immediate Managers
- Morale
- Quality of Care
- Safe Environment Bullying & Harassment
- Safe Environment – Violence
- Safety Culture
- Staff Engagement
- Team Working

The following table collates the results across the ten themes

Theme	Trust Score	Above or Below Benchmark Average (Benchmark Score)	Trust Performance compared to (2019 Survey Score)
Equality, Diversity & Inclusion	9.3	↑ (9.1)	=
Health & Wellbeing	6.6	↑ (6.4)	↑ (6.4)
Immediate Managers	7.5	↑ (7.3)	↑ (7.4)
Morale	6.7	↑ (6.4)	↑ (6.5)
Quality of Care	7.5	=	=
Safe Environment - B&H	8.4	↑ (8.3)	↑ (8.3)
Safe Environment - Violence	9.3	↓ (9.5)	↑ (9.1)
Safety Culture	7.2	↑ (6.9)	↑ (7.1)
Staff Engagement	7.3	↑ (7.2)	↑ (7.1)
Team Working	7.2	↑ (7.0)	↑ (7.1)

- 8 Themes in 2020 Survey above benchmark average
- Quality of Care equal to benchmark average
- Safe Environment – Violence result below benchmark average
- 8 Themes have improved in 2020 compared to Trust's 2019 results
- Equality Diversity and Inclusion and Quality of Care results have remained the same as 2019

Theme trends between 2016 and 2020 compared to benchmark results

Theme	2016	2017	2018	2019	2020
Equality, Diversity & Inclusion	9.4	9.4	9.3	9.3	9.3
Health & Wellbeing	6.6	6.6	6.5	6.4	6.6
Immediate Managers	7.3	7.5	7.5	7.4	7.5
Morale *			6.6	6.5	6.7
Quality of Care	7.7	7.6	7.4	7.5	7.5
Safe Environment - B&H	8.3	8.3	8.2	8.3	8.4
Safe Environment - Violence	9.0	8.9	9.1	9.1	9.3
Safety Culture	7.1	7.0	7.0	7.1	7.2
Staff Engagement	7.2	7.1	7.1	7.1	7.3
Team Working	7.1	7.1	7.2	7.1	7.2

*Questions on morale only added to the survey in 2018

Key
Best
Better than Average
Average
Below Average
Worst

- Except for Safe Environment – Violence, broadly above average results over the five-year period
- Best in benchmark scores during the five-year period for Health and Wellbeing, Immediate Managers and Safety Culture, but no best in benchmark results since 2018
- Safe Environment – Violence has slightly improved in 2020 whilst still being below average

Significant results for themes 2019 - 2020

Theme	2019	2020	Significance
Equality, Diversity & Inclusion	9.3	9.3	Not significant
Health & Wellbeing	6.4	6.6	↑
Immediate Managers	7.4	7.5	Not significant
Morale	6.5	6.7	↑
Quality of Care	7.5	7.5	Not significant
Safe Environment - B&H	8.3	8.4	Not significant
Safe Environment - Violence	9.1	9.3	↑
Safety Culture	7.1	7.2	↑
Staff Engagement	7.1	7.3	↑
Team Working	7.1	7.2	↑

- 6 Themes have seen statistically significant improvements this year.
- This is the first time since 2018 that we have seen statistically significant improvements compared to the previous year's results.

Issues by theme with the greatest scope for improvement

From the analysis detailed in Appendix A, the following issues in each theme show the most scope for improvement.

Theme	Question	2020 Result %	% Point Gap to Close on Best
Equality Diversity Inclusion	26b Has your employer made adequate adjustment(s) to enable you to carry out your work	84.2	5.0
Health & Wellbeing Immediate Managers Morale Quality of Care	11a.Does your organisation take positive action on health and well-being?	43.3	9.8
	8c....gives me clear feedback on my work.	71.0	5.8
	6b.I feel I have a choice in deciding how to do my work	65.1	9.6
	7c.I am able to deliver the care I aspire to	71.4	6.4
Safe Environment B&H	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? 13a. Patients / service users, their relatives or other members of the public	28.0	8.0
Safe Environment Violence	In the last 12 months how many times have you personally experienced physical violence at work from…? 12a. Patients / service users, their relatives or other members of the public	19.1	12.9
Safety Culture	16a. My organisation treats staff who are involved in an error, near miss or incident fairly.	62.0	12.1
Staff Engagement	18d. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	73.3	10.9
Team Working	4h. The team I work in has a set of shared objectives.	78.6	3.3
	4i. The team I work in often meets to discuss the team's effectiveness	72.5	3.3

Some of the above issues have previously been identified and work has commenced to address them – reasonable adjustments for the Equality theme is one such issue.

It is suggested that we adopt the following approach:

- Map staff survey findings into existing related action plans to help inform work
- Have a series of conversations around each of the themes to better understand the issues and seek suggestions for action with a focus on those issues identified with the scope for the greatest improvement.
- Interrogate the national data to establish the best performing organisation for each theme and in turn the best performing organisation for the questions identified in each theme with the greatest scope for improvement. Links should be established with these organisations to establish if there is anything that we can learn and implement from their experiences.

Covid-19 specific questions

The National Staff Survey group devised the following questions related to the pandemic.

- Have you worked on a Covid-19 specific ward or area at any time?
- Have you been redeployed due to the Covid-19 pandemic at any time?
- Have you been required to work remotely/from home due to the Covid-19 pandemic?
- Have you been shielding?

The Trust's result for working in a specific ward were slightly lower than the benchmark average with 18.5% compared to 18.9%. We had a lower than average redeployment rate with 8.7% of staff being redeployed compared to the benchmark average of 10.9%. Only 57.9% of respondents stated that they had worked remotely/from home, compared to the benchmark average of 65.7%.

The shielding question had 3 possible answers.

- 6.3% of Trust respondents were shielding for themselves, compared to the benchmark average of 8.3%.
- 3.1% of Trust respondents were shielding for a member of their household, compared to the benchmark average of 4.9%
- 91% of Trust respondents were not shielding, compared to the benchmark average of 87.7%

Results for each theme broken down by the answers for the Covid-19 questions and compared to the all staff answers are detailed below.

Theme	All Staff	Worked on CV-19 Ward	Redeployed	Working Remotely	Shielding for Self	Shielding for Household Member
Equality Diversity Inclusion	9.3	9.0	9.0	9.3	9.2	9.2
Health & Wellbeing	6.6	6.3	6.5	6.7	6.4	6.5
Immediate Managers	7.5	7.4	7.5	7.6	7.7	7.8
Morale	6.7	6.6	6.5	6.8	6.7	6.9
Quality of Care	7.5	7.7	7.7	7.5	7.7	7.8
Safe Environment B&H	8.4	7.9	8.4	8.7	8.2	8.1
Safe Environment Violence	9.3	8.5	9.3	9.7	9.4	9.4
Safety Culture	7.2	7.1	7.2	7.3	7.2	7.4
Staff Engagement	7.3	7.3	7.3	7.4	7.3	7.4
Team Working	7.2	7.1	7.4	7.3	7.2	7.6

- Staff who worked on CV-19 wards scored less than all staff across all themes, apart from Quality of Care, where the score was higher.
- Staff who were redeployed scored the same for Immediate Managers, Safe Environment B&H and Violence, Safety Culture and Staff Engagement. Scores were higher for Quality of Care and Team Working. Score were lower for Equality, Health and Wellbeing, Morale.
- For staff working remotely, scores were the same for Equality, Quality of Care, they were better for all other themes.
- For staff shielding for self, results were the same for Morale, Safety Culture, Staff Engagement and Team Working. Results were better for Immediate Managers, Quality of Care, Safe Environment – Violence, Safety Culture, Staff Engagement and Team Working. Results were worse for Equality, Health and Wellbeing, Safe Environment B&H.
- For staff shielding for a household member, no scores were the same as all staff. Scores that were higher were Immediate Managers, Morale, Quality of Care, Safe Environment Violence, Safety Culture, Staff Engagement, and Team Working. Scores that were lower, Equality, Health and Wellbeing and Safe Environment B&H,

No statistical significance testing was undertaken on these scores. It is recommended that we consider the Covid-19 variation in scores as part the proposed wider thematic Staff Survey conversation.

Workforce Race Equality Standard

Results will be discussed in greater detail as part of the submission of our full range of metrics for the Standard later in the year. The overall trend of results for BAME staff demonstrating a worse experience than that of White staff continues. Corresponding results for White staff are depicted in blue below. All figures are expressed as percentages.

Question	2017	2018	2019	2020
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? 13a. Patients / service users, their relatives or other members of the public	44.6/36.4	43.6/37.7	39.2/34.2	35.3/30.4
Experience of bullying, harassment or abuse in the last 12 months from staff	24.3/15.4	22.6/15.5	24.0/16.2	25.0/15.9
Equal opportunities for career progression or promotion	81.1/92.7	84.1/92.5	83.5/90.6	83.2/89.9
Experience of discrimination from manager in the last 12 months	8.8/4.6	12.1/4.8	8.9/4.8	13.1/5.0

Over the four-year period a:

- Small narrowing of the gap for harassment, bullying and abuse from patients, service users or other members of the public.
- Small increase for bullying, harassment and abuse from staff.
- Narrowing of the gap for equal opportunities for career progression or promotion.

- 49% increase in the experience of discrimination for BAME staff between 2017-2020, compared with a 9% increase for White staff.

Speak Easy style conversations have been taking place with BAME staff in the Central Locality. It is recommended that this approach is taken across all localities. Outcomes of these discussions will lead to additional actions for the WRES action plan which will be monitored on a monthly basis at the Trust-wide Equality, Diversity and Inclusion Steering Group.

Workforce Disability Equality Standard

Results will be discussed in greater detail as part of the submission of our full range of metrics for the Standard later in the year. The overall trend of results for disabled staff demonstrating a worse experience than that of non-disabled staff continues. Corresponding results for non-disabled staff are depicted in blue below. All figures are expressed as percentages.

Question	2018	2019	2020
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? 13a. Patients / service users, their relatives or other members of the public	39.8/37.3	39.7/32.3	35.0/28.8
Experience of bullying, harassment or abuse from a manager in the last 12 months	9.6/5.6	11.8/5.5	13.2/5.8
Experience of bullying, harassment or abuse from other colleagues in the last 12 months	16.6/10.6	18.2/9.7	17.2/9.5
Percentage of staff saying that they had reported an experience of bullying, harassment or abuse.	70.6/74.4	65.5/74.3	66.2/73.0
Equal opportunities for career progression or promotion	89.1/93.1	85.9/91.6	85.2/91.3
Percentage of staff who feel pressure to come to work despite not feeling well enough to do their duties.	21.8/12.7	23.0/12.5	19.4/13.2
Percentage of staff satisfied that the organisation values their work	43.2/54.0	43.4/55.3	46.1/57.4
Percentage of disabled staff saying that the organisation has made adequate reasonable adjustments	83.0	83.1	84.3
Staff engagement score	6.8/7.2	6.8/7.2	7.0/7.4

- A small improvement has been made in the percentage of staff saying that the organisation has made adequate reasonable adjustments.
- The gap between disabled and non-disabled staff has widened for
    - All measures of bullying, harassment and abuse
    - Equal opportunities

    - Feeling valued
- A small narrowing of the gap for pressure to come to work despite not feeling well enough.

Both the WRES and WDES figures point towards cultural issues in the Trust that should be addressed as a matter of importance. A number of measures are being progressed including training on race issues and meetings are taking place that will lead to disability awareness and equality training sessions being provided by Difference North East, the start of Inclusive Mentoring, and the extension of the E&D offer on the Collective Leadership Programme. The work taking place on recruitment and that taking place with the Speak Easy style conversations with BAME staff will all help towards addressing these issues, but the figures triangulated against the qualitative information that we have from the Staff Networks and the outputs of the Speak Easy conversations suggests that even more needs to be done. One of the comments from a recent Speak Easy event was that the Trust has an issue with difference of all types. Organisational development initiatives for all staff with a sharp focus on equality, diversity and inclusion need to be prioritised, to ensure the maximum impact of the work that has already started.

Recommendations

It is proposed we should:

- Have a Big Conversation around each of the themes to better understand the issues and seek suggestions for action with a focus on those issues identified with the scope for the greatest improvement. This will take place at the end of April and involve members of The Improvement Collaborative have been invited to be part of this.
- During May have a similar conversation with the localities to establish joint and local actions.
- Map staff survey findings into existing related action plans to help inform work and that we monitor the actions that result from the conversations at Trust and locality levels.
- Interrogate the national data to establish the best performing organisation for each theme and in turn the best performing organisation for the questions identified in each theme with the greatest scope for improvement. Links should be established with these organisations to establish if there is anything that we can learn and implement from their experiences.
- We consider the Covid-19 variation in scores as part the proposed wider thematic Staff Survey conversation.
- Organisational development initiatives for all staff with a sharp focus on equality, diversity and inclusion need to be prioritised, to ensure the maximum impact of the work that has already started.

Christopher Rowlands

March 2021

Appendix A Theme by theme detailed analysis

Theme	Question	2020 Result %	% Point Gap to Close on Best
Equality	14. Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	89.2	2.2
	15a In the last 12 months have you personally experienced discrimination at work from Patients / service users, their relatives or other members of the public	5.3	2.1
	15b. Manager / team leader or other colleagues	5.5	1.5
	26b Has your employer made adequate adjustment(s) to enable you to carry out your work	84.2	5.0
Health & Wellbeing	5h.The opportunities for flexible working patterns.	68.1	8.0
	11a.Does your organisation take positive action on health and well-being?	43.3	9.8
	11b. In the last 12 months have you experienced musculoskeletal (MSK) problems as a result of work activities	24.2	3.2
	11c.During the last 12 months have you felt unwell as a result of work- related stress?	39.4	2.3
	11d.In the last three months have you ever come to work despite not feeling well enough to perform your duties?	43.4	3.8
Immediate Managers	5b. The support I get from my immediate manager.	79.9	1.9
	8c....gives me clear feedback on my work.	71.0	5.8
	8d....asks for my opinion before making decisions that affect my work.	65.3	5.0
	8f.…takes a positive interest in my health and well-being.	79.0	4.2
	8g....values my work.	80.7	1.9
Morale	4c.I am involved in deciding on changes introduced that affect my work area / team / department.	58.5	4.9
	4j.I receive the respect I deserve from my colleagues at work	78.3	2.3
	6a. I have unrealistic time pressures	30.9	4.1
	6b.I feel I have a choice in deciding how to do my work	65.1	9.6
	6c.Relationships at work are strained	55.5	4.4
	8a....encourages me at work	79.9	1.7
	19a. I often think of leaving this organisation	22.1	4.3
	19b. I will probably look for a job at a new organisation in the next 12 months	14.6	1.5
	19c. As soon as I can find another job, I will leave this organisation	9.2	1.5
Quality of Care	7a. I am satisfied with the quality of care I give to patients / service users	85.3	2.8
	7b. I feel that my role makes a difference to patients/service users	89.0	2.8
	7c.I am able to deliver the care I aspire to	71.4	6.4

Theme by theme detailed analysis

Theme	Question	2020 Result %	% Point Gap to Close on Best
Safe Environment B&H	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? 13a. Patients / service users, their relatives or other members of the public	28.0	8.0
	13b. Managers	8.0	2.1
	13c. Other colleagues	11.6	2.0
Safe Environment Violence	In the last 12 months how many times have you personally experienced physical violence at work from…? 12a. Patients / service users, their relatives or other members of the public	19.1	12.9
	12b. Managers	0.1	0.1
	12c. Other colleagues	0.8	0.8
Safety Culture	16a. My organisation treats staff who are involved in an error, near miss or incident fairly.	62.0	12.1
	16c. When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	81.5	3.7
	16d.We are given feedback about changes made in response to reported errors, near misses and incidents.	68.9	6.8
	17b. I would feel secure raising concerns about unsafe clinical practice.	78.9	2.8
	17c. I am confident that my organisation would address my concern.	69.6	6.9
	18b. My organisation acts on concerns raised by patients /service users.	84.4	0.8
Staff Engagement	2a. I look forward to going to work.	62.1	4.8
	2b. I am enthusiastic about my job.	76.1	4.3
	2c. Time passes quickly when I am working.	76.7	7.8
	4a.There are frequent opportunities for me to show initiative in my role.	77.5	2.9
	4b. I am able to make suggestions to improve the work of my team / department.	80.4	1.7
	4d. I am able to make improvements happen in my area of work.	63.3	5.6
	18a. Care of patients / service users is my organisation's top priority.	84.1	3.8
	18c. I would recommend my organisation as a place to work.	70.3	7.5
	18d. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	73.3	10.9
Team Working	4h. The team I work in has a set of shared objectives.	78.6	3.3
	4i.The team I work in often meets to discuss the team's effectiveness	72.5	3.3

Report to the Board of Directors
7th April 2021

Title of report	Children and Young Peoples Inpatient Services, West Lane Hospital: Board Briefing Paper
Report author(s)	Elaine Fletcher – Group Nurse Director, North Cumbria Locality
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	✓	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	✓

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

Management Group meetings where this item has been considered (specify date)	
Executive Team	N/A
Corporate Decisions Team (CDT)	N/A
CDT – Quality	N/A
CDT – Business	N/A
CDT – Workforce	N/A
CDT – Climate	N/A
CDT – Risk	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	✓
Workforce	✓	Environmental	✓
Financial/value for money	✓	Estates and facilities	✓
Commercial	✓	Compliance/Regulatory	✓
Quality, safety, experience and effectiveness	✓	Service user, carer and stakeholder involvement	✓

Board Assurance Framework/Corporate Risk Register risks this paper relates to
BAF - Risk Number 1680 - Compliance and Regulatory

Children and Young Peoples Inpatient Services, West Lane Hospital:
Board Briefing paper
7th April 2021

Introduction

This brief paper follows on from last month's Board update paper and outlines continued progress in relation to establishing services at West Lane Hospital.

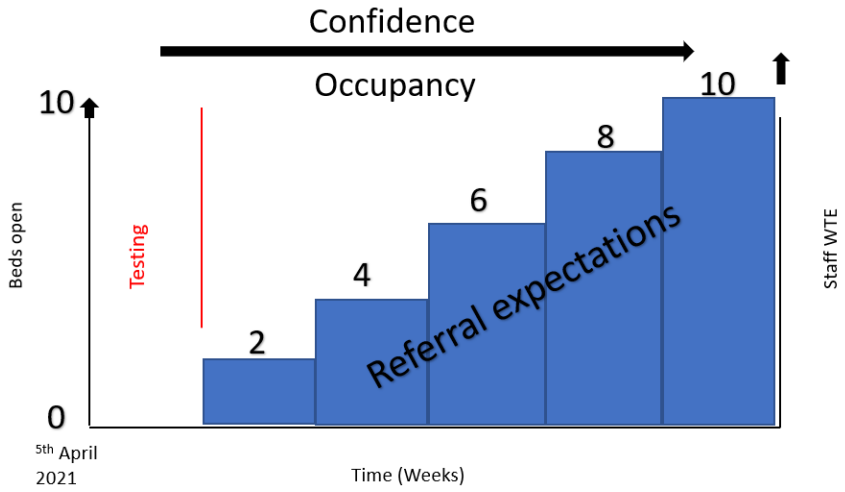
West Lane closed following regulatory action in 2019 and a formal request to take over the running of inpatient services at West Lane was made to CNTW. In the first instance, this comprises a General Adolescent Unit of 10 beds.

Progress to Date

Opening

We continue to work towards opening in April 2021 with incremental patient occupation thereafter determined by staffing numbers, demand and confidence in the Ward team. This is graphically represented in Figure 1. It is anticipated that the Ward will receive its first patients later in April providing Registered Nurse staffing numbers allow. The mostly like route for these first patients will be repatriation from out of area placements.

Figure 1.



Communications and Service User / Carer Involvement

Stakeholder meetings have continued and have gone well. In recent weeks socially distanced visits been undertaken on site. Visitors have included, John Lawlor Chief Executive Officer (CEO), NHSE & I and the Care Quality Commission (CQC). In addition, several ranks from Sergeant to Assistant Chief Constable from Cleveland Police visited the Ward to see first-hand the environment. A brief presentation has also been delivered to the Directors of Childrens Service in the Teesside areas and to the New Care Model (NCM) Implementation Group.

As we pointed out in last month's report, Lotus has been selected as the name of the ward[1]. Tees, Esk & Wear Valley's (TEWV) consultation with regards to the renaming of West Lane Hospital has been concluded and as expected the Hospital is to be renamed Acklam Road Hospital.

On the 29th March 2021 a virtual launch was conducted via Teams with a wide range of participants, including impacted families, staff from both TEWV and CNTW, Local Authorities as well as local politicians and councillors to name but a few. The session involved a presentation followed by a questions and answers session. Feedback to date has been favourable. A ward walkthrough video has been created and this was used to conclude the presentation[2]. It should be noted that this was filmed prior to redecoration. A new video will be filmed, and it is hoped going forward that young people will be involved in the production of this.

Operational Management and Safety

This workstream, as per previous updates, continues to influence the direction of all the other workstreams and is currently engaged in several areas of work, particularly estates and workforce.

Over the last month, there has been a significant on-site presence from clinical and senior managers at both Associate and Group Director level on site. This has enabled direct engagement with the estate team who have been working there as well as providing ongoing familiarisation with the environment.

Progress continues to be made across multiple areas related to operational management and safety. Processes are very much aligning. The following areas give an example of work to date; Policy, procedures and risk assessments (clinical, environmental, operational and Covid-19), full plug-in to all CNTW safer-care, governance, health and safety structures, safeguarding links with local teams, Tissue viability / Infection Control link up, education provider in place[3], Omnicell cabinet installed, body worn cameras available, Oxehealth[4] patient safety system agreed and installed.

We continue to affirm that Mechanical Restraint Equipment (MRE) will not be used on this site, as we progress work linked to the reduction and eventual eradication of it in our other inpatient Child & Adolescent Mental Health (CAMHs) wards.

[1] Symbol of regeneration
[2] https://www.youtube.com/watch?app=desktop&v=_jWP43UK3vk&feature=youtu.be
[3] River Tees Multi Academy Trust
[4] www.oxehealth.com – allows the remote monitoring of vital signs to enable less intrusive monitoring of patients on observation. Currently installed in Hopewood Park and many other mental health facilities across the country.

Workforce

In short recruitment continues. We have at times experienced high number of withdrawals and DNAs (for registered nurses) and so not all posts have been appointed to in previous recruitment campaigns. Adverts remain open and further interviews are scheduled for April. Contingency arrangements are now being explored. The ability to recruit enough staff numbers has been flagged from the outset on the programme risk register.

Medical recruitment remains a challenge with a lack of suitable applicants received for all posts. Consequently, a consultant from Ferndene has agreed to cover with additional input from one of the Clinical Business Units (CBU), a specialist community service consultant. Backfill arrangements are being explored.

Agreements have been reached with regards the wholetime equivalency and skill mix needed to build the wider Multidisciplinary Team (MDT) and these have been advertised with some posts being appointed to. Economies of scale continue to be sought across the service especially in leadership and managerial posts.

Specific weekly meetings are ongoing to focus on recruitment, induction, and training. This work has progressed well with wider induction training commenced. Scenarios are being developed to use in the testing period. These will include several clinical and environmental scenarios designed to explore with staff “actions on” in the event of issues arising such as a clinical incident e.g. self-harm or an environmental issue e.g. failure of telephony

Estates (Facilities) / Informatics

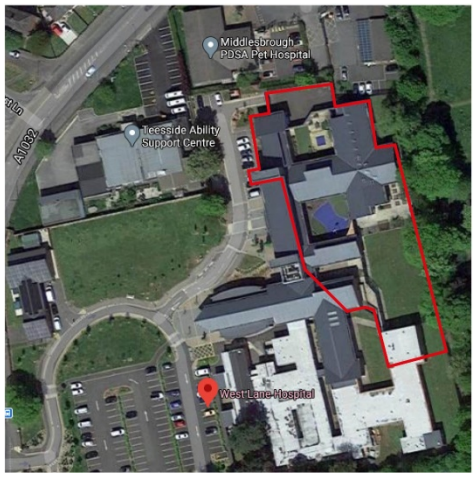
Estates and Informatics groups continue to have links with colleagues in TEWV. Overall, the main elements of necessary building and decorative work have been completed. This has included installation of anti-barricade safety doors, anti-ligature en-suite doors bathroom and a nurse-call, the replacement of sanitary ware, a seclusion upgrade, as well as internal decoration of the ward and several administrative areas. Contracts for estates and facilities support are being finalised.

Informatics have worked closely with estates and operational managers to ensure that the installation of computer hardware on site is completed. This has included the installation of an ‘at a glance patient status’ board in the Nurse Station, computers, and photocopier / printers. In addition, several Amazon Fire Tablets have been purchased for use on the Ward.

Cross-checks are also being carried out on what equipment and furniture is already in situ and what is additionally required. Various items have been ordered and items are now being delivered. This has included curtains, furniture and bedding etc. The photograph in Figure 2 by way of the red outline gives an approximation of the size of the Ward and the space accessible.

Arrangements are being finalised as part of the wider testing period, before any patients are admitted, to have a staff “live-in” for a 48 hour period to check out the environment and systems installed.

Figure 2.

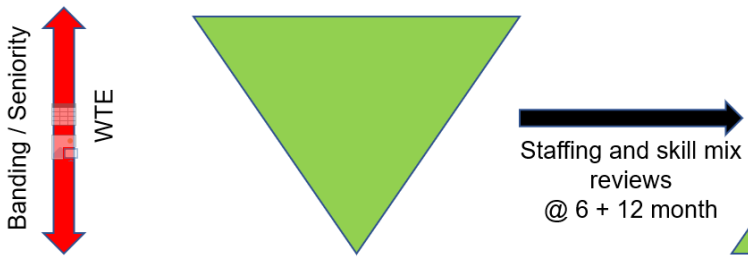


Commissioning and Regulation

As part of the application process a range of documents have been submitted to the CQC e.g. Business Continuity Plan, Clinical Environmental Risk Assessment (CERA), Risk Register. In addition, the CQC have also both physically visited the site to review it and conducted a Key Lines of Enquiry (KLOE) discussion. Both went well and the CQC have indicated that there should be no issue with the site being registered. NHS E & I have also visited the site as part of their service validation assessment process. As part of this process the Trust conducted a self-assessment against the General Adolescent Service specification. NSHE & I have indicated that they are satisfied with work to date, therefore the Ward can be designated for the purpose of the care and treatment of children and young people.

Agreement has also been reached with our Commissioning and Quality Assurance colleagues with regards the income level for the Ward as well. The figure of £3.5m has been agreed pending final sign off at both the Corporate Decisions Team – Business Group (CDT-B) and the NCM / provider Collaborative Board. This gives an occupied bed day price in the region of £1200. As part of this agreement, there will be reviews of staffing and skill mix at the 6- and 12-month points after opening. Figure 3 is illustrative.

Figure 3.



A business case has for CDT B and the NCM / Provider Collaborative board has also been prepared and this is with Executive Directors for agreement before final submission.

Programme Approach, Governance and Risk

The frequency of Multi Agency Joint Steering Group continues to meet monthly. At the last meeting the Group was joined be a representative from the Teesside Directors of Childrens Services. Based on the crossover between the workstreams, IT, estates, workforce, and operational work meetings have previously merged to facilitate a more programme-based approach. We have however, reduced the frequency of these meetings to afford members more time to focus on tasks.

Recommendation

1. Note the contents of this paper.
2. Advise on further detail or supplementary information required at this stage.

David Muir
Group Director – North Cumbria Locality Care Group

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
7th April 2021

Title of report	Operational and Financial Planning Update 2021/22
Report author(s)	James Duncan, Deputy Chief Executive and Executive Director of Finance
Executive Lead (if different from above)	

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	/

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	6/4/21
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		Reputational	/
Workforce	/	Environmental	/
Financial/value for money	/	Estates and facilities	/
Commercial		Compliance/Regulatory	/
Quality, safety, experience and effectiveness	/	Service user, carer and stakeholder involvement	/

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

Financial Planning & Budgets 2021/22

1. Executive Summary

Purpose of the Report

- The NHS National Planning Guidance for 2021/22 was issued on 25th March
- Guidance identifies the priorities for 2021/22 and the financial and contracting arrangements for April 21 – September 21 (H1).
- There is a requirement for an ICS Mental Health finance submission for the full year to be submitted at ICS level by 6th May.
- There is a requirement for an ICS System finance submission for H1 to be submitted by 6th May.
- Funding allocations for Systems and organisations have been identified.
- Mental Health Trusts will receive Mental Health Investment Standard (MHIS) funding, Service Development Transformation funding (SDF) and Recovery funding. This has been allocated to systems for the full year of 21/22 and work is now underway with commissioners to agree how this will be deployed across the year.
- The Trust Resource Planning exercise identifies the profile of expenditure expected through 2021/22.
- Funding arrangements for H1 show CNTW's share of the system envelope funding is £213.6m with SDF and recovery funding in addition to this.
- The resource planning exercise currently shows that, if funding arrangements reverted to those in place at the beginning of 2021/22, there would be an underlying gap between income and expenditure of £23.5m.
- An extensive exercise will be required to understand which costs can be reduced as we emerge from the immediate crisis of Covid, which services need to be maintained, and what resources need to be deployed to new priorities identified against new investment.
- Work will be prioritised through Q1 to identify which elements of additional funding will be available on an on-going basis to reduce the gap and areas where spend needs to reduce by redeploying resources.
- The Board will receive further detail following submission of the system financial plan in May, and once arrangements for October 21 – March 22 (H2) are clarified.

National Planning Guidance

The Government has agreed an overall financial settlement for the NHS for the first half of the year, which provides an additional £6.6bn + £1.5bn for COVID-19 costs above the original mandate. The financial settlement for months 7-12 will be agreed once there is greater certainty around the circumstances facing the NHS going into the second half of the year. In addition, £1.5bn funding has been allocated for elective recovery, mental health and workforce development. Mental Health have been allocated £500m of the £1.5bn.

Systems are being asked to develop fully triangulated plans across activity, workforce and finance for the first half of the year. For mental health the funding identified is for the full year and therefore plans should be for 12 months.

It is within this context that the planning sets out the priorities for the year ahead:

- Supporting the health and wellbeing of staff and taking action on recruitment & retention
- Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19

- Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
- Expanding primary care capacity to improve access, local health outcome and address health inequalities
- Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
- Work collaboratively across systems to deliver on these priorities

The prevalence and complexity of MH issues is rising, on top of the pre-COVID treatment gap, which means the NHS need to continue LTP MH transformation work and particularly staff recruitment. As a result the Mental Health Financial Planning will cover the whole of 2021/22. The funding requirements for 2021/22 are:

- All CCGs individually required to meet Mental Health Investment Standard (MHIS)
- Service Development Funding (SDF) will flow in line with the Implementation Plan
- Additional funding from spending review (£500m) to accelerate recovery from Covid 19 and to bring forward element of LTP
- Mental Health Support Hubs funded through additional SDT funding

Mental Health Planning

The planning process requires that systems set out their plans to achieve their mental health investment requirement by 6th May 2021. The requirements for use of this funding are closely tied to the long term plan, and we will be closely monitored through the year on its delivery. This includes a requirement to review spend on community mental health to ensure investment in baselines supports the film unity transformation agenda, with the focus on those with significant mental health needs. CCGs are required to flow agreed funding to providers equally through the year (on a monthly basis) and not withhold funding until later in the financial year. The Templates must be signed off by the ICS Chief Finance Officer, each CCG Chief Finance Officer and each NHS mental health provider Chief Finance Officer.

Planning April 21 – September 21 (H1)

The funding envelopes for the first H1 have been issued. System funding includes CCG allocations, top-up and Covid-19 fixed allocations. H1 allocations have been set based on the October – March funding envelopes for 2020/21. Organisations have access to additional growth funding. For mental health services the Mental Health Investment Standard funding is included in the system envelope. There is also access to Service Development Funding (SDF) and recovery funding (£500m).

Within the system envelope for H1 there is inflation funding at 0.5% and a general efficiency requirement for NHS Providers of 0.28%. Details of inflation and efficiency for H2 will be advised when there is a better understanding of position for the second half of the year.

The timetable to deliver the planning for 2021/22

Key Task	**Date**
Organisation (provider) capital and cash plan submission	Monday 12th April 2021
• System finance plan submission • Mental Health finance submission **Draft plan submissions deadline** • Draft activity, workforce and Mental Health numerical workforce submission • Draft narrative plan submission	Thursday 6th May 2021
Non mandated provider organisation finance plan submission	w/c 24th May 2021
Final plan submission deadline • Final activity, workforce and Mental Health workforce numerical submission • Final narrative plan submission	Thursday 3rd June 2021

CNTW Financial Planning & Budgets
The Trust Board received a Resource Planning paper at the February board meeting describing the process to identify expected resource use through 2021/22. Delivery of the Trust's Financial Planning & Budgetary arrangements for 2021/22 will be a three stage process.

1. The Trust must deliver a financial plan for H1 to support the System financial plan submission on 6th May.

2. The Trust must approve a financial plan for October 21 – March 22 (H2) to deliver financial break-even across the financial year 2021/22.

3. The Trust must develop a plan to deliver financial sustainable services while transforming services to implement the requirements of the Long Term Plan.

1. H1 Position
The principle behind the move to a resource planning approach is to reflect the actual resource use across the organisation. The table below summarises the expenditure levels identified in the resource planning for H1 against the position at quarter 4. The month 12 position is the Trust forecast. The table below reflects the 20/21 price base. There is no impact of a 2021/22 pay award in the figures.

	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	27.8	28.1	28.3*	28.3	28.2	28.2	28.2	28.2	28.2
Non Pay	7.4*	7.2	7.3	7.3	7.3	7.3	7.2	7.2	7.2
TOTAL	**35.1**	**35.3**	**35.6**	**35.6**	**35.5**	**35.5**	**35.4**	**35.4**	**35.4**

*Figure adjusted for known one off costs (Mar 21 removed £1.5m estimate for A/L provision increase).

The table above shows a continuation of the resource use seen in quarter 4 across H1 for 2021/22. Through the resource planning approach expenditure budgets will reflect current spending levels and workforce running into 2021/22, adjusted only for unavoidable costs. Vacancies will not be budgeted for and instead recruitment and additional expenditure would require management teams to ask the questions:

- Will this replace or reduce an existing cost (eg temporary staffing costs?)
- Is there a source of income to cover this expenditure?
- Have we headroom to commit additional expenditure and still meet our contribution?
- Do we need support or help to deliver this?

The intention is to increase simplicity, transparency and enable resource decisions to be made and accountability to be held at a CBU level, unless there is a specific request for support passed upward.

The Trust has developed the resource planning to include in the expenditure planning the impact of increased sickness levels experienced for H1. The block income arrangements in place through 2021/22 will continue into H1. The income will be based on the income positon from quarter 3 2020/21. The table below shows the levels of income and expenditure the Trust expect for H1. The block allocations have not been received at organisation level at the time of writing this paper.

	H1
	£m
Patient Care Income	(198.5)
Non-Patient Care Income	14.7
TOTAL INCOME	**(213.2)**
Pay	(170.2)
Non Pay	(43.0)
TOTAL EXPENDITURE	**(213.2)**
SURPLUS / (DEFICIT)	**0.0**

The Trust will support the System finance plan submission for H1 figures and expects to participate in the non-mandated provider organisation finance plan submission in the week commencing 24th May.

2. H2 Position

A 12 month 2021/22 income and expenditure profile will be presented to the board following agreement of the funding arrangements for the second half of the year. The guidance requires commissioner to flow agreed funding to providers equally through the year (on a monthly basis) and not withhold funding until later in the financial year. A clearer understanding of the profile of income and expenditure for 2021/22 is expected by quarter 2.

The Trust will receive additional funding for the Mental Health Investment Standard, transformation funding (known as SDF) and recovery funding. This funding will be set out for the full year and agreed as part of the submissions to be made in May. These funds must be utilised to support delivery of the long term plan and to support covid recovery, with specific priorities identified within the guidance. As priorities are agreed they will be mapped against services that we have stepped up in 2020/21. For areas where we have stepped up services or increased spending, for which there is no longer term income source agreed, we will need to plan for a step down in resource use, re-aligning our workforce to deliver agreed priorities. Once the support and investment funding is agreed it will impact on the income and expenditure across both H1 and H2.

3. Underlying Position

The resource planning exercise has shown an underlying financial shortfall from base contract levels and forecast non-contracted income levels against expenditure levels excluding the impact of COVID-19. The underlying financial position is a £23.5m shortfall between income and expenditure, and in the first half of the year, at least, this will be covered by the current organisational and system allocations described in section 1. The table below shows the position: -

	£m
Patient Care Income	364.6
Non-Patient Care Income	28.4
Pay	(331.0)
Non Pay	(85.5)
TOTAL	**(23.5)**

The underlying shortfall has been analysed by service and contractual arrangements. Work will continue through quarter 1 of 2021/22 to identify this at a granular level across the Trust, in the light of agreed investment priorities. Where required, operational services will be supported to review and realign resources to deliver financially sustainable services in line with delivery of the Long Term Planning ambitions. This is a continuation of the work which began pre Covid-19 looking at how we truly integrate our planning around quality goals, activity planning, workforce and financial management. Understanding and sharing the underlying position with all key stakeholders is one of the next stepping stone in this journey.

In 2021/22, as per 2020/21, the national planning guidance is to support organisations to breakeven. As a result the Trust will support the system with a plan to financially break-even over the first half of 2021/22. Over the years the Trust has invested significantly in its estate, partly funded by loans, including PFI. Each year the Trust needs to repay around £5m on

these loans, and in order to maintain these payments, and sustain the Trust cash position, a surplus of £5m is required in normal circumstances. The Trust has taken steps to improve its underlying cash position over the last year, which gives sufficient headroom for us to manage without a surplus, pending an expected re-set of NHS Finances and the long term planning regime from 2022/23 onwards. We will review the need to make future surpluses in the light of longer term planning guidance expected in the latter part of 2021/22, and will build this into our longer term planning process.

4. Capital

The Trust is in the process of finalising its capital plan submission due on the 12th April. Capital spend for 21/22 is currently estimated to be approximately £47m. Capital spend is now managed very tightly, through the allocation of capital spending limits to the Integrated Care System. It has now been agreed how these allocations will be shared across allocations.

The £47m will be made up of the Trust share of £10.1m from the system allocation, in addition to £36.5m of Public Dividend Capital for the CEDAR project and Eradicating Dormitories and £0.5m generated through asset sales. Capital resources, excluding our major Cedar Project are therefore significantly constrained and will be limited to key safety priorities, and to ensure that urgent investment is made into the wards in North Cumbria.

Next Steps

- The Board will receive a paper at the May Board providing the Trust input to the Mental Health finance submission and the CNTW position included in the System finance plan submission.
- The Board will receive a further update on the underlying position after quarter 1.
- The Board will receive a paper providing the financial arrangements for H2 once the funding arrangements have been agreed nationally.

James Duncan
Deputy Chief Executive and Executive Finance Director
7th April 2021

Report to the Board of Directors
1 April 2020

Title of report	**Code of Governance Compliance 2020/21**
Report author(s)	**Debbie Henderson, Director of Communications and Corporate Affairs/Company Secretary**
Executive Lead (if different from above)	**John Lawlor, Chief Executive**

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	

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)	

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

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

Review of Compliance with the NHS Foundation Trust Code of Governance

Executive Summary

The NHS Foundation Trust Code of Governance provides guidance to Foundation Trusts (FTs) to help deliver effective corporate governance. FTs are required to report their compliance against this code each year in their Annual Report, on the basis of either compliance with the Code provisions, or, an explanation where they do not comply ('comply or explain').

NHS FTs are required to provide a specific set of disclosures to meet the requirements of the Code, which should be submitted as part of the Annual Report. This report provides detail of the assessment undertaken by the Deputy Director of Corporate Affairs and Communications on:

- Individual requirements of the Code;
- Confirmation of compliance (or an explanation of non-compliance where required);
- Evidence of compliance; and
- Clarification on reporting and disclosure requirements

The Trust remains compliant with all provisions of the code. All requirements where supporting information is required to be made available is available either on request or on the Trusts website.

Areas for further development

Although the Trust has structures and processes in place to engage with staff, service users and key stakeholders, it should be acknowledged that a wider Trust Communications Strategy is currently under development to further embed the Trusts principles in this regard.

The Board is asked to

- Note the list of disclosures required in the Annual Report (those highlighted in green);
- Note confirmation of compliance with the requirements of the NHS Foundation Trust Code of Governance for the 2020/21 year.

Review of Compliance with the NHS Foundation Trust Code of Governance
As at 31 March 2021

Key	
Amber	Statutory provision, supersedes 'comply or explain'
Green	Requires disclosure in the Annual Report
White	Requires supporting information to be made available by request or on the Trust's website *(but does not require disclosure in the Annual Report)*

Ref	Requirement	Compliant Y/N	Evidence/explanation
Leadership			
A.1.1	The board should meet regularly to discharge its duties effectively. There should be a schedule of matters reserved for its decision, and a statement detailing the roles and responsibilities of the council of governors. It should also describe how any disagreements between the governors and the board will be resolved. The annual report should include a summary statement of how the board and governors operate; a summary of the types of decisions to be taken by each. These arrangements should be kept under review at least annually.	Y	- Schedule of meetings - Policy on engagement with the board of directors - Annual Report content
A.1.2	The annual report should identify the chair, deputy chair, CEO, SID and members of the audit and remuneration committees. It should also set out the number of meetings for each and individual attendance.	Y	- Annual Report content
A.1.3	The board should make available a statement of the Trust's objectives showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for its decision-making and forward planning.	Y	- Strategic/annual plans - Vision and values - Trust website - Annual Report content
A.1.4	The board should ensure that adequate systems and processes are maintained to measure the trust's effectiveness, efficiency and economy as well as the quality of its health care delivery. The board should regularly review the performance of the trust in these areas against regulatory and contractual obligations, and approved plans and objectives.	Y	- Annual Governance Statement/ Annual Report content - In-year and end of year submissions to Regulators
A.1.5	The board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. Where appropriate, independent advice, for example, from the internal audit function, should be commissioned by the board to provide an adequate and reliable level of assurance.	Y	- Board/Committee reporting - In-year/end of year submissions to Regulators - Annual Report content

A.1.6	The board should report on its approach to clinical governance and its plan for the improvement of clinical quality, and record where, within the structure of the organisation, consideration of clinical governance matters occurs.	Y	- Quality and Performance Committee - Clinical Audit Plan and Annual Report - Quality Report content
A.1.7	The CEO should follow the procedure set out by NHSI for advising the board and governors and for recording and submitting objections to decisions considered or taken by the board, in matters of propriety or regularity, and on issues relating to the wider responsibilities of the accounting officer for economy, efficiency and effectiveness.	Y	- Trust Constitution and supporting documentation (including SOs) - Annual Report content
A.1.8	The board should establish the Constitution and standards of conduct for the trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, which includes the Nolan principles.	Y	- Contracts of employment - Letters of appointment (NEDs) - Induction process (NEDs/ Governors) - Trust Constitution and supporting documentation (including SOs) - Standards for Business Conduct Policy
A.1.9	The board should operate a Code of Conduct that builds on the values of the trust and reflect high standards of probity and responsibility. The board should follow a policy of openness and transparency in its proceedings unless this is in conflict with a need to protect the wider interests of the public or the trust (including commercial-in-confidence matters) and make clear how conflicts of interest are dealt with.	Y	- As A1.8; and - Board meetings in public Council of Governor meetings - FOI process
A.1.10	The trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming the governors have acted in good faith and in accordance with their duties, potential for liability for governors should be negligible. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service, where an indemnity or insurance policy is given, this can be detailed in the Trust's Constitution.	Y	- D&O Liability Assurance for Board members in place
A.2.1	The division of responsibilities between the chair and CEO should be clearly established, set out in writing and agreed by the board.	Y	- Role descriptions in place including division of responsibilities
A.2.2	The roles of chair and CEO must not be undertaken by the same individual.	Y	- N/A (separate roles in place)
A.3.1	The chair should meet the independence criteria. A CEO should not go on to be the chair of the same trust.	Y	- Chair appointment process - Annual Chair/NED appraisal review
A.4.1	In consultation with the governors, the board should appoint one of the independent NEDs to be the SID. The SID should be available to other Board members and governors if they have concerns that contact through the normal channels has failed to resolve, or for which such contact is inappropriate.	Y	- SID identified and appointed - Annual NED appraisal review - Annual Report content

A.4.2	The chair should hold meetings with the NEDs without executives present. Led by the SID, the NEDs should meet without the chair present, at least annually, to appraise the chair's performance.	Y	- Monthly Chair/NED meetings in place - Annual Chair/NED Appraisal process, supported by Lead Governor
A.4.3	Where directors have concerns that cannot be resolved about the running of the trust or a proposed action, they should ensure that concerns are recorded in the board minutes. On resignation, a director should provide a written statement to the chair for circulation to the board, if they have any such concerns.	Y	- Robust Board minutes in place and retained - To date, no such action required
A.5.1	The governors should meet sufficiently regularly to discharge its duties. Typically the governors would be expected to meet as a full council at least four times a year. Governors should make every effort to attend the meetings of the council. The trust should take appropriate steps to facilitate attendance.	Y	- Schedule of meetings in place - Attendance recorded and monitored in Annual Report - Process in place regarding non-attendance at meetings
A.5.2	The governors should not be so large as to be unwieldy. The governors should be of sufficient size for the requirements of its duties. The roles, structure, composition, and procedures of the council of governors should be reviewed regularly.	Y	- Annual Report content - Annual Governor Effectiveness Survey - Regular review of Constitution
A.5.3	The annual report should identify the members of the council of governors, a description of the constituency or appointing organisation, and the duration of their term. The annual report should also identify the nominated lead governor. A record should be kept of the number of meetings, and individual attendance.	Y	- Annual Report content
A.5.4	The roles/responsibilities of the governors should be set out in a written document, which should explain their responsibilities towards members/stakeholders and how governors will seek their views and keep them informed.	Y	- Election documentation - Induction documentation - Trust Constitution (and supporting documents)
A.5.5	The chair is responsible for leadership of both the board and the governors and the governors should invite the CEO, as well as other executives and NEDs, as appropriate. In these meetings members of the governors may raise questions of the chair, their deputy, or any other director present about the affairs of the trust.	Y	- Minutes of meetings - CEO/Executive/NED attendance at all meetings
A.5.6	The governors should establish a policy for engagement with the board for those circumstances when they have concerns about the performance of the board, compliance with the provider licence or other matters related to the overall wellbeing of the trust. The governors should input into the board's appointment of a senior independent director.	Y	- Included in Governors Handbook - Process in place for Governor input into SID appointment - Annual Report content

A.5.7	The governors should ensure its interaction and relationship with the board is appropriate and effective. In particular, the availability and timely communication of information, discussion and setting in advance of meeting agendas and, where possible, using clear, unambiguous language.	Y	- Schedule of meetings, agendas, minutes and reports - Governor activity report reviewed regularly - Corporate Affairs support - Annual Governor effectiveness review - CQC Well Led Inspection (Board effectiveness review)
A.5.8	The governors should only exercise its power to remove the chair or any NED after exhausting all means of engagement with the board. The council should raise any issues with the chair with the SID in the first instance.	Y	N/A – process in place via Corporate Affairs Team if required
A.5.9	The governors should receive other appropriate information required to enable it to discharge its duties.	Y	- Support provided by Corporate Affairs Team/Chairman - Regular communication with Governors out-with formal meetings
A.5.10	The governors have a statutory duty to hold the NEDS To account for the performance of the board of directors.	Y	All appropriate mechanisms in place via formal and informal meetings - Annual NED/Chair appraisal/ appointment/reappointment process - Governor attendance at Board/Board sub-committees
A.5.11	The 2006 Act gives the governors a statutory requirement to receive the following documents: (a) the annual accounts; (b) any report of the auditor on them; and (c) the annual report	Y	- Annual General Meeting/Annual Members' Meeting combined
A.5.12	The directors must provide governors with an agenda prior to any meeting of the board, and a copy of the approved minutes as soon as is practicable afterwards. There is no legal basis on which the minutes of private sessions of board meetings should be exempted from being shared with the governors. In practice, it may be necessary to redact some information, for example, for data protection or commercial reasons. Governors should respect the confidentiality of these documents.	Y	- Available on request/website - Board minutes circulated with papers for every Council of Governors meeting

A.5.13	The governors may require directors to attend a meeting to obtain information about performance of the trust or the directors' performance of their duties, and to help the governors decide whether to propose a vote on the trust's or directors' performance.	Y	- Minutes of meetings - All meetings include performance, finance and strategic updates - CEO/Executive attendance at all meetings
A.5.14	Governors have the right to refer a question to the independent panel for advising governors. More than 50% of governors who vote must approve this referral. The council should ensure dialogue with the board takes place before considering such a referral, as it may be possible to resolve questions in this way.	Y	N/A – process in place if required
A.5.15	Governors should use their new rights From the 2012 Act to represent the interests of members/public on major decisions taken by the board. These new voting powers require: • More than half of the governors who vote to approve a change to the constitution; a significant transaction; or any proposal to increase the proportion of the trust's income earned from non-NHS work by 5% a year or more; and • More than half of all governors to approve an application by a trust for a merger, acquisition, separation or dissolution.	Y	- Trust Constitution and Standing Orders - Minutes of meetings and decisions made
Effectiveness			
B.1.1	The board should identify in the annual report each NED it considers to be independent in character and judgement and whether there are relationships or circumstances which are likely to affect the director's judgement. The board should state its reasons if it determines that a director is independent despite the existence of relationships circumstances which may appear relevant to its determination in line with requirements of the Code.	Y	- Annual Report content
B.1.2	At least half the board, excluding the chair, should comprise NEDs determined by the board to be independent	Y	- Trust Constitution - Annual Report content
B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust	Y	- Trust Constitution
B.1.4	The board should include in its annual report a description of each director's skills, expertise and experience and the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the NHS foundation trust's website.	Y	- Annual Report content - Trust website - Executive/NED appointment process

B.2.1	The nominations/remuneration committee(s) are responsible for the nomination of executive and NEDs. The committee(s) should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust and the skills and expertise required within the board to meet them.	Y	- Committee Terms of Reference - Minutes of meetings - Appointment processes
B.2.2	Directors and governors should meet the "fit and proper" persons test described in the provider licence. For the purpose of the licence and application criteria, "fit and proper" persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged). Trusts should also abide by the updated guidance from the CQC regarding appointments to senior positions in organisations subject to CQC regulations.	Y	- Executive Directors/ NEDs/Governors – fully compliant
B.2.3	The nominations committee(s) should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate. They should evaluate, at least annually, the balance of skills, knowledge and experience on the board and prepare a description of the role and capabilities required for appointment of both executive and NEDs, including the chair.	Y	- Committee Terms of Reference and minutes of meetings - Appointment processes - Annual appraisal process - Job descriptions in place for all Board appointments
B.2.4	The chair or an independent NED should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of NEDs and the chairman.	Y	- Terms of Reference - Minutes of meetings - Joint chair/Governor chairing responsibility for Governors' Nomination Committee
B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chair and NEDs. Once suitable candidates have been identified the nominations committee should make recommendations to the council of governors.	Y	- Terms of Reference - Minutes of meetings - NED/Chair appointment process - Minutes of meetings detailing recommendation to full Council
B.2.6	The nominations committee responsible for the appointment of NEDs and the chair should consist of a majority of governors and a majority governor representation on the interview panel.	Y	- Terms of Reference - Minutes of meetings - NED/Chair appointment process
B.2.7	When considering the appointment of NEDs, the governors should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position.	Y	- Director of Corporate Affairs and Communication in attendance at all meetings - Terms of Reference

B.2.8	The annual report should describe the process followed by the governors in relation to appointments of the chair and NEDs.	Y	- Annual Report content
B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s).	Y	- Terms of Reference
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process used for board appointments. The main role and responsibilities of the nominations committee should be set out in publicly available, written terms of reference.	Y	- Terms of Reference - Annual Report content - Trust website
B.2.11	It is a requirement of the 2006 Act that the chair, the other NEDs and – except in the case of the appointment of a CEO – the CEO, are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director appointments should identify suitable candidates to fill vacancies as they arise and make recommendations to the chair, other NEDs and the CEO.	Y	- Terms of Reference - Minutes of meetings - Appointment process - Trust Constitution
B.2.12	It is for the NEDs to appoint and remove the CEO. The appointment of a CEO requires the approval of the council of governors.	Y	- Terms of Reference - Minutes of meetings - Appointment Process - Trust Constitution
B.2.13	The governors are responsible at a general meeting for the appointment, re- appointment and removal of the chair and the other NEDs.	Y	- Minutes of meetings - Terms of Reference - Trust Constitution
B.3.1	For the appointment of a chair, the nominations committee should prepare a job specification defining the role/capabilities required, an assessment of the time commitment expected. A chairperson's other significant commitments should be disclosed to the governors before appointment and included in the annual report. Changes to such commitments should be reported to the governors as they arise, and included in the next annual report. No individual, simultaneously whilst being a chair of a trust, should be the substantive chair of another trust.	Y	- Job description and person specification in place - Appointment process - Minutes of meetings - Terms of Reference
B.3.2	The terms and conditions of appointment of NEDs should be made available to the governors. The letter of appointment should set out the expected time commitment. NEDs should undertake that they will have sufficient time to meet what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved and the governors should be informed of subsequent changes.	Y	- As above - Terms of Reference - Minutes of meetings and full Governor meetings detailing ratification of appointments

B.3.3	The board should not agree to a full-time executive director taking on more than one NED directorship of a trust or another organisation of comparable size and complexity, nor the chairmanship of such an organisation.	Y	- Monitoring via the appraisal and declaration process
B.4.1	The chair should ensure new directors and governors receive a tailored induction. Directors should seek out opportunities to engage with stakeholders. Directors should have access, at the trust's expense, training courses and materials consistent with their individual and collective development programme.	Y	- Induction process for all Board members and Governors in place - Ongoing Board development sessions/away days (for Directors) - Engagement sessions (Governors)
B.4.2	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	Y	- Annual appraisal review process (including PDP) - CEO appraisal by Chair - Exec appraisal by CEO
B.4.3	The board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	Y	- Schedule of meetings/engagement meetings - Induction process - Ongoing Corporate Affairs support - Governor activity in Annual Report
B.5.1	The board and the governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. They should agree their respective information needs with executive directors through the chair. The information for the boards should be concise, objective, accurate and timely, and accompanied by clear explanations of complex issues. The board should have access to any information about the trust that it deems necessary to discharge its duties, including access to senior management and other employees.	Y	- Agenda, minutes and reports for Board, Governor and Sub-Committee meetings - Admin control - Corporate structures in place to ensure accessibility
B.5.2	The board may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area; although they should ensure that they have sufficient information to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis to be carried out in a timely manner, within the trust. On occasion, NEDs may reasonably decide that external assurance is appropriate.	Y	- Board agenda, minutes and supporting papers - Board development sessions/away days for deep dives - Committee structure/Terms of Reference

B.5.3	The board should ensure that directors, especially NEDs have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. Decisions to appoint an external adviser should be the collective decision of the majority of NEDs. The availability of external sources of advice should be made clear at the time of appointment.	Y	- As and when – via the CEO/Director of Corporate Affairs and Communications
B.5.4	Committees should be provided with sufficient resources to undertake their duties. The board should ensure that the governors are provided with resources to undertake its duties with such arrangements agreed in advance.	Y	- Board agenda, minutes and supporting papers - Committee structure/Terms of Reference - Corporate Affairs support
B.5.5	NEDs should consider whether they are receiving the necessary information in a timely manner and feel able to raise appropriate challenge of recommendations of the board, in particular making full use of their skills and experience gained both as a director of the trust and also in other leadership roles. They should expect and apply similar standards of care and quality in their role as a NED of an NHS foundation trust as they would in other similar roles.	Y	- Board agenda, minutes and supporting papers - Committee structure/Terms of Reference - Appraisal process - CQC Well Led Inspection (effectiveness)
B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Y	- Governor involvement in forward planning/ quality report review - Annual Report content
B.5.7	Where appropriate, the board should take account of the views of the governors on the forward plan in a timely manner and communicate to the governors where their views have been incorporated in the trust's plans, and, if not, the reasons for this.	Y	- Strategic/Annual Planning process - Annual Report content - Governor meetings and engagement sessions
B.5.8	The board must have regard for the views of the governors on the trust's forward plan.	Y	- Strategic/Annual Planning process - Annual Report content - Governor meetings and engagement sessions
B.6.1	The board should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chair, has been conducted, bearing in mind the desirability for independent assessment, and the reason why the trust adopted a particular method of performance evaluation.	Y	- Board member appraisal (individual) - CQC Well Led Inspection (Board effectiveness) - Terms of reference annual review

			- Audit Committee Annual Report and assessment of effectiveness - Annual Report content
B.6.2	Evaluation of the board should be externally facilitated at least every three years. The evaluation needs to be carried out against the board leadership and governance framework set out by Monitor. The external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	Y	- CQC Well Led Inspection undertaken in 2017/18 under the new framework - Annual Report content (section reference to be included in the final report)
B.6.3	The SID should lead the performance evaluation of the chair, within a framework agreed by the governors and taking into account the views of directors and governors.	Y	- Terms of Reference and minutes of Nomination Committee - Annual appraisal process
B.6.4	The chair should use the performance evaluations as the basis for determining professional development programmes for NEDs.	Y	- Annual appraisal process
B.6.5	Led by the chair, the governors should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.	Y	- Annual Governor Effectiveness Review
B.6.6	There should be a clear policy and a fair process, agreed and adopted by the governors, for the removal from the council of any governor who consistently and unjustifiably fails to attend meetings of the governors or has a conflict of interest which prevents the proper exercise of their duties. This should be shared with governors. In addition, it may be appropriate for the process to provide for removal from the governors where behaviours or actions of a governor or group of governors may be incompatible with the values and behaviours of the trust. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be requested to consider the evidence and determine whether the proposed removal is reasonable or otherwise.	Y	- Trust Constitution and supporting documentation - Process for removal of a Governor - Code of Conduct for Governors - Declaration of interest process for Governors
B.7.1	In the case of re-appointment of NEDs, the chair should confirm to the governors that following formal performance evaluation, assurance on the performance of the individual for re-appointment. Any term beyond six years (eg, two three-year terms) for a NED should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the board. NEDs may, in exceptional circumstances, serve longer than six years (eg, two three-year terms following authorisation of the trust) but this should be subject to annual re-appointment.	Y	- Annual appraisal process - Nomination Committee Terms of Reference - No NED currently serving a term beyond six years - Annual Report content

B.7.2	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information.	Y	- Election process - Trust Constitution (Model Election Rules) - Annual Report content - Trust website
B.7.3	Approval by the governors of the appointment of a CEO should be a subject of the first general meeting after the appointment by a committee of the chair and NEDs. All other executive directors should be appointed by a committee of the CEO, the chair and NEDs	Y	- Minutes of meetings - Trust Constitution - Remuneration Committee Terms of Reference
B.7.4	NEDs, including the chair should be appointed by the governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.	Y	- NED appointment process - Nomination Committee Terms of Reference and minutes - Trust Constitution
B.7.5	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years.	Y	- Election process - Model Election Rules Trust Constitution
B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	Y	- Remuneration Committee (and Terms of Reference) - Annual Report content
Accountability			
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the report, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	Y	- Annual Report content - Annual Governance Statement
C.1.2	The directors should report that the trust is a going concern with supporting assumptions or qualifications as necessary.	Y	- Annual Report content - Audit Committee and Board minutes

C.1.3	At least annually, the board should set out clearly its financial, quality and operating objectives for the trust and disclose sufficient information of the trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.	Y	- Annual Planning process - Board Assurance Framework - Board and Committee minutes and supporting papers - Governance structure - Trusts website
C.1.4	a) The board must notify NHSI and the governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the trust. b) The board must notify the governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the trust's financial condition; • the performance of its business; and/or • the trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the trust	Y	- Formal consultation processes where required - Minutes and reports of Board, Committee, executive and operational meetings - Minutes and reports of Governor meetings - Board Assurance Framework/Risk Management processes - Annual Report content
C.2.1	The board should maintain continuous oversight of the effectiveness of the risk management and internal control systems and should report to members and governors that they have done so in the annual report. A regular review should cover all material controls, including financial, operational and compliance controls.	Y	- Annual Governance Statement - Board Assurance Framework and Risk Management processes - Annual risk management review - Board minutes and supporting papers - Internal Audit Plan - Annual Report content
C.2.2	A trust should disclose in the annual report if it has an internal audit function, how the function is structured and what role it performs.	Y	- Internal Audit Function in place - Internal Audit Plan and regular reporting to Audit Committee - Annual Report content
C.3.1	The board should establish an audit committee composed of at least three members who are all independent NEDs. The board should satisfy itself that the membership of the committee has sufficient skills to discharge its responsibilities effectively, including at least one member with	Y	- Audit Committee agenda, minutes and reports - Terms of Reference

	recent and relevant financial experience. The chair of the trust should not chair or be a member of the committee. He can attend meetings by invitation as appropriate.		
C.3.2	The main role and responsibilities of the audit committee should be set out in publicly available, written terms of reference. The governors should be consulted on the terms of reference, which should be reviewed and refreshed regularly.	Y	- Annual Report content - Terms of reference - Audit Committee minutes and reporting - Annual Governance Statement
C.3.3	The governors should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors. The governors will need to work hard to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported by the audit committee, which provides information to the governors on the external auditor's performance as well as overseeing the trust's internal financial reporting and internal auditing.	Y	- External Auditor appointment process in place - Governors minutes of meetings - Audit Committee Terms of Reference
C.3.4	The audit committee should make a report to the governors in relation to the performance of the external auditor, including details such as the quality and value of the work and the timeliness of reporting and fees, to enable the governors to consider whether or not to re-appoint them. The audit committee should also make recommendation to the governors about the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor.	Y	- Minutes of meetings - Reports to the Council of Governors
C.3.5	If the governors do not accept the audit committee's recommendation, the board should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the governors have taken a different position.	Y	N/A
C.3.6	The trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the trust. The current best practice is a 3-5 year period of appointment.	Y	- External Auditor appointment process - Minutes of meetings (Audit Committee and Council of Governors)
C.3.7	When the governors end an external auditor's appointment in disputed circumstances, the chair should write to NHS Improvement of the reasons behind the decision.	Y	N/A
C.3.8	The audit committee should review arrangements that allow staff of the trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The audit committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. This should include ensuring safeguards for those who raise concerns are in place and operating effectively. Such processes should enable individuals or groups to draw formal	Y	- Raising Concerns Policy - Incident Reporting Policies - Incident Investigation and processes for shared learning - Audit Committee minutes and reports (incl. Counter Fraud reports) - Audit Committee Terms of Reference

	attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure that valid concerns are promptly addressed. These processes should also reassure individuals raising concerns that they will be protected from potential negative repercussions.		
C.3.9	A separate section of the annual report should describe the work of the Audit committee in discharging its responsibilities.	Y	- Annual Report content - Audit Committee annual self-assessment and Annual Report to Board
Remuneration			
D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.	Y	- Annual Report content – remuneration report - Remuneration Committee and Terms of Reference
D.1.2	Levels of remuneration for the chair and other NEDs should reflect the time commitment and responsibilities of their roles.	Y	- Governors' Nomination Committee Terms of Reference, minutes and supporting papers - Minutes of full Council of Governor meetings
D.1.3	Where a trust releases an executive director, for example to serve as a NED elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Y	- Annual Report content – remuneration report - Declarations of Interest - Remuneration Committee
D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	Y	- Annual Report content – remuneration report - Remuneration Committee
D.2.1	The board should establish a remuneration committee composed of NEDs which should include at least three independent NEDs. The remuneration committee should make available its terms of reference, explaining its role and the authority delegated to it by the board. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.	Y	- Annual Report content – remuneration report - Remuneration Committee

D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The definition of senior management for this purpose should be determined by the board, but should normally include the first layer of management below board level.	Y	- Annual Report content – remuneration report - Remuneration Committee
D.2.3	The governors should consult external professional advisers to market-test the remuneration levels of the chair and other NEDs at least once every three years and when they intend to make a material change to the remuneration of a NED.	Y	- Governors' Nomination Committee Terms of Reference and minutes
D.2.4	The governors are responsible for setting the remuneration of NEDs and the chair.	Y	- Governors' Nomination Committee Terms of Reference and minutes
Relationships with Stakeholders			
E.1.1	The board should make available a public document that sets out its policy on the involvement of members, patients and the local community at large, including a description of the kind of issues it will consult on.	Y	- Annual Report content - Service User and Carer Involvement Strategy
E.1.2	The board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums (eg, Local Healthwatch, the Overview and Scrutiny Committee, the local League of Friends, and staff groups).	Y	- Via formal consultation processes when required - Annual Report content - Service User and Carer Involvement Strategy - Trust wide Communications Strategy in development
E.1.3	The chair should ensure that the views of governors and members are communicated to the board as a whole. The chair should discuss the affairs of the trust with governors. NEDs should be offered the opportunity to attend meetings with governors and should expect to attend them. The SID should attend sufficient meetings with governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors.	Y	- Chair feedback at the Board - Chair/NED/CEO/Executive attendance at Council of Governor meetings - Corporate Affairs support - SID available to Governors
E.1.4	The board should ensure that the trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the trust's website and in the annual report.	Y	- Membership Strategy under development - Corporate Affairs support and ongoing engagement between Trust and Governors - Annual Report content

E.1.5	The board should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the NEDs, develop an understanding of the views of governors and members about the trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Y	- As in E1.3 - Membership Strategy - Engagement with members (i.e., Quality priorities, members e-bulletin, members newsletter) - Annual Report content
E.1.6	The board should monitor how representative the trust's membership is and the level and effectiveness of member engagement and report on this in the annual report. This information should be used to review the trust's membership strategy, taking into account any emerging best practice from the sector.	Y	- Trust Constitution - Membership database - Membership Strategy - Annual Report content
E.1.7	The board must make board meetings and the annual meeting open to the public. The trust's constitution may provide for members of the public to be excluded from a meeting for special reasons.	Y	- Board meetings in public minutes and associated papers - Annual General meeting/Annual Members' Meeting combined - Governor meetings in public
E.1.8	The trust must hold annual members' meetings. At least one of the directors must present the trust's annual report and accounts, and any report of the auditor on the accounts, to members at this meeting.	Y	- Annual General Meeting/Annual Members' Meeting
E.2.1	The board should be clear as to the specific third party bodies in relation to which the trust has a duty to co-operate. The board should be clear of the form and scope of the co-operation required with each of these third party bodies in order to discharge their statutory duties.	Y	- Board meeting in public minutes and associated papers
E.2.2	The board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. The board should review the effectiveness of these processes and relationships annually and, where necessary, take proactive steps to improve them.	Y	- Process in place for ongoing engagement with key stakeholders via corporate and quality governance structures

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Report to Board of Directors 7th April 2021

Title of report	**Provider Collaborative and Lead Provider Sub-committee of the Board ToR**
Report author(s)	**Lisa Quinn, Executive Director 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	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)		**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	
PCLP Committee	24.03.21	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	X	Environmental	
Financial/value for money	X	Estates and facilities	
Commercial	X	Compliance/Regulatory	X
Quality, safety, experience and effectiveness	X	Service user, carer and stakeholder involvement	X

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

Sub-Committee of the Board of Directors
Terms of Reference

Committee Name: Provide Collaborative & Lead Provider Committee (PCLP)

Committee Type: Standing sub-committee of Board of Directors

Timing & Frequency: 4 times a year, Wednesday of week prior to Board of Directors meeting

Personal Assistant to Committee: Vicky Grieves

Reporting Arrangements: Minutes and Report from Chair to Board of Directors

Membership:	
Chair: **Deputy Chair:**	Non-Executive (Michael Robinson) Non-Executive
Members:	Executive Director Commissioning and Quality Assurance Executive Medical Director Executive Nurse Director 2 Non-Executive Directors (including Chair and Vice-Chair)
In Attendance:	~~Provider Collaborative Clinical Directors (ED & CAMHS)~~ Provider Collaborative Programme Managers x3 Head of Income & Contracting Head of Commissioning & Quality Assurance Group Head of Commissioning & Quality Assurance x4 ~~1~~ 2 Governors PA to Committee
Quorum:	Chair or Deputy Chair 2 Executive Director
Deputies:	Deputies Required for all members

Purpose:
Provide assurance to the Board that:

- The Trust has effective systems and processes in place for the management of risks pertaining to Provider Collaborative and Lead Provider Models.
- The Trust has an effective management of Provider Collaborative and Lead Provider Contracts, including the sub-contracts of the lead provider contracts and any partnership agreements.
- The Trust complies with the law, best practice, governance and regulatory standards which are within the Committee's scope.

Scope:

- Oversee and assure the successful delivery of Provider Collaborative and Lead Provider Models, including the sub-contracts of the lead provider contract. In accordance with the business cases and agreements reached by the Board of Directors.
- Each Subcommittee of the Board of Directors takes on the following role for Risks pertaining to their area of focus:
    - Review the management of the Corporate Risk Register and the Groups top risks;
    - Review the Board Assurance Framework to ensure that the Board of Directors receive assurances that effective controls are in place to manage corporate risks;
    - Report to the Board of Directors on any significant risk management and assurance issues.
- Gain assurance that the Trust's action plans in relation to compliance and legislative frameworks, which are within the scope of the Committee, are robust, completed and signed off.
- Gain assurance that each contract is managed and that there are effective systems and processes in place to ensure standards of care, compliance with relevant standards, quality, financial, risk and assurance arrangements.
- On behalf of the Board of Directors provide assurance that the financial and quality risks are articulated, evaluated and managed.

Authority:

To act on behalf of the Board to receive assurances that effective arrangements are in place to manage those areas within the Committee's scope across the organisation.

Deliverables:

Assurance to the Board re:

- The successful implementation and management of Provider Collaborative and Lead Provider models across the Trust.
- The Trust's action plans in relation to compliance and legislative frameworks are robust and completed/signed off, within the scope of this committee.
- The risks, that the Provider Collaborative and Lead Provider Committee are responsible for, are appropriately identified and effective controls are in place.

Sub Groups:

PCLP Quality Group
PCLP Comission/Contracting Group
PC Partnership Board minutes to be received by committee

Current Review Date: March 2021
Date of Previous Committee Review: November 2020
Date of Board Approval: April 2021