Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

COUNCIL OF GOVERNORS GENERAL MEETING

COUNCIL OF GOVERNORS GENERAL MEETING

27 June 2024

14:00 GMT+1 Europe/London

Trust Board Room and via Teams

AGENDA

1. AGENDA

Darren Best, Chair

REFERENCES

Only PDFs are attached

0.0 CoG Business Draft Agenda 27.06.2024.pdf

Council of Governors Business Meeting Agenda

Council of Governors Business Meeting **Venue: Trust Board Room, St Nicholas Hospital and Via Microsoft Teams**	**Date: 27 June 2024** **Time: 2:00pm – 4.00pm**

	Item	Lead	
	Business agenda items		
1.1	Welcome and Apologies for Absence	Darren Best, Chair	Verbal
2	Declaration of Interest	Darren Best, Chair	Verbal
3	Minutes of the meeting held 21 March 2024	Darren Best, Chair	Enc
4	Action log and matters arising from previous meeting	Darren Best, Chair	Enc
5	Chair and Chief Executive update	Darren Best, Chair / James Duncan, Chief Executive	Enc
6	Governor service visit feedback	Darren Best, Chair	Enc
7	Annual plan and priorities	Executive Team	Enc
Strategic Ambition 1 – Quality care, every day			
8	Integrated Performance Report – Quality care, every day	Ramona Duguid, Chief Operating Officer	Enc
9	Quality and Performance Committee Report	Louise Nelson, Committee Chair	Enc
10	Mental Health Legislation Committee Report	Michael Robinson, Committee Chair	Enc
Strategic Ambition 2 – Person led care, where and when it's needed			
11	Integrated Performance Report – Person led	Ramona Duguid, Chief Operating Officer	Enc

	care, when and where it's needed (item 8)		
Strategic Ambition 3 – a great place to work			
12	Integrated Performance Report – A great place to work (item 8)	Lynne Shaw, Executive Director of Workforce and OD	Enc
13	People Committee Report	Brendan Hill, Committee Chair	Enc
Strategic Ambition 4 – sustainable for the long term, innovating every day			
14	Integrated Performance Report – Sustainable for the long term, innovating every day (item 8)	Kevin Scollay, Executive Director of Finance	Enc
15	Finance Report	Kevin Scollay, Executive Director of Finance	Enc
16	Resource and Business Assurance Committee Report	Kevin Scollay, Executive Director of Finance	Enc
Strategic Ambition 5 – working for, and with our communities			
17	Charitable Funds Committee	Kevin Scollay, Executive Director of Finance	Enc
Governance and Regulatory			
18	Audit Committee Assurance Report	David Arthur, Committee Chair	Enc
Any other business / items for information			
	Questions from Governors and the public	Darren Best, Chair	verbal

Date of next meeting
19 September 2024, 2pm – 4pm
St Nicholas Hospital Board Room and via MS Teams

1.1 WELCOME AND APOLOGIES FOR ABSENCE

Darren Best, Chair

Rajesh Nadkarni
Sarah Rushbrooke

2. DECLARATION OF INTEREST

Darren Best, Chair

3. MINUTES OF PREVIOUS MEETING HELD 21 MARCH 2024

Darren Best, Chair

REFERENCES

Only PDFs are attached

3. DRAFT Minutes CoG 21st March 2024 DH.pdf

Draft Minutes of the Council of Governors hybrid Meeting held in public
Thursday 21st March 2024 from 2pm – 4pm
Trust Board Room and via Microsoft Teams

Present:

Darren Best	Chair of the Council of Governors and Board of Directors
Anne Carlile	Lead Governor/Carer Governor Adult Services
Tom Rebair	Deputy Lead Governor/Service User Governor Adult Services
Russell Stronach	Service User Autism Services Governor (online)
Heather Lee	Shadow Public Governor (South Tyneside) (online)
Siobahn Watson	Non-Clinical Staff Governor (online)
William Miskelly	Public Governor North Cumbria (online)
Elaine Lynch	Councillor Governor for Cumberland Council (online)
Russell Bowman	Service User Governor Neuro Disability Services (online)
Fiona Regan	Carer Governor Autism Services
Jodine Milne-Reader	Public Governor Sunderland (online)
Kelly Chequer	Appointed Governor Sunderland Council (online)
Ruth Berkley	Appointed Governor South Tyneside Council (online)
Jane Shaw	Appointed Governor North Tyneside Council (online)
Emma Silver Price	Staff Governor Non-Clinical
Claire Keys	Staff Governor Clinical
Rosie Lawrence	Shadow Carer Governor Learning Disability Services
Michelle Garner	Appointed Governor Cumbria University (online)
Shannon Fairhurst	Shadow Carer Governor Children and Young People's Services (online)
Julia Clifford	Appointed Governor CVS iCan Wellbeing Group (online)
Jessica Juchau-Scott	Carer Governor Older People's Services (online)
Star Ncube	Appointed Governor for Northumbria University
Lee Newman	Shadow Governor Carers for Neuro Disability
Aiden Fairholm	Public Governor for Northumberland
Bea Grove McDaniel	Community and Voluntary Sector Governor

In Attendance:

James Duncan	Chief Executive
Michael Robinson	Non-Executive Director (online)
Kevin Scollay	Executive Director of Finance
Lynne Shaw	Executive Director for Workforce and OD (online)
Louise Nelson	Non-Executive Director (online)
Vikas Kumar	Non Executive Director
Brendan Hill	Non Executive Director and Vice Chair
Debbie Henderson	Director of Communications and Corporate Affairs
Kirsty Allan	Corporate Governance Manager/ Deputy Trust Secretary
Margaret Adams	Member of the Public

1. **Welcome and apologies for absence.**

Darren Best welcomed everyone to the meeting, and apologies for absence were received from:

Fiona Grant	Service User Governor Adult Services
Jane Noble	Carer Governor Adult Services
Ian Palmer	Public Governor South Tyneside
Victoria Bullerwell	Staff Governor Non-Clinical
Thomas Lewis	Staff Governor Medical
Rajesh Nadkarni	Deputy Chief Executive / Executive Medical Director
Ramona Duguid	Chief Operating Officer
Sarah Rushbrooke	Executive Director of Nursing, Therapies and Quality Assurance
David Arthur	Non-Executive Director
Rachel Bourne	Non-Executive Director
Karen Lane	Public Governor, Newcastle and Rest of England
Danny Cain	Non-Clinical Staff Governor
Mary Laver	Public Governor for North Tyneside
Jacqui Rodgers	Appointed Governor Newcastle University

2. Declaration of Interest
None noted.

3. Minutes for approval
The minutes of the meeting held on 9 November 2023 were considered.

Approved:
- **Minutes of the meeting held 9 November 2023 were approved.**

4. Matters arising not included on the agenda and Action Log
There were no outstanding actions on the action log. Darren Best informed the Council this was the first Governor Business meeting within the new format aligned to the Trust strategic ambitions. Going forward the Council will have meetings scheduled in two forums. The First being the development sessions where the focus will be for Governors to build on their existing knowledge and training, aiding the Council to be able to fulfil their responsibilities both individually and as a collective. The second will be the Governors Business meeting where governors are encouraged carry out their statutory responsibility of holding the Board to account and to encourage robust and honest challenge, conversations, and engagement throughout based on their attendance at Trust meetings, events, and service visits.

Business Items

5. Chairs and Chief Executive Update
James Duncan informed the Council of the Trusts financial position and the planning for next year that is in progress. James noted the challenging forecast for next year and at present there has not been any national planning guidance received.

James advised that discussions are ongoing across the organisation to develop the underlying annual plan to achievement of the Trust Strategy. A further update will be provided at the June meeting.

James reflected on the recent events he has attended including the Newcastle Cathedral Recovery Church and Memorial Event for families bereaved by Suicide. Darren also referred to a very positive visit to the S.P.A.C.E Pod which aims to work in partnership to tackle the reduction in suicide rates.

James provided an update on the upcoming proposed Industrial Action and the ongoing discussions with the Government. James assured the Council that plans remain in place to support services during the period to ensure provision of safe care.

Ruth Berkley mentioned attending an event for families bereaved by suicide and noted the work with the Psychiatric Liaison Teams within South Tyneside and Sunderland. Ruth referred to the increased trend from children and young people and the further work required to support those at risk. Bea Groves-Daniel also referred to the high rates of suicide from within the Transgender community and offered the group statics from within that cohort to the Council.

Claire Keys suggested that the Trust needs to do more work with bereaved staff following suicide noting the importance of ensuring appropriate support is in place.

Elaine Lynch noted to the Council suicide rates in West Cumbria remain one of the highest in the Cumbria Region and requested a briefing on the proposed changes to mental health services in West Cumbria to aid further discussions within Cumberland Council as well as with external partners at the North East and North Cumbria Integrated Care System (NENC ICS). In addition to this request Elaine noted the list of service visit opportunities for Governors and highlighted that none of them are in Cumbria and requested a service visit to the Carlton Clinic. James assured the Council that the Executive Team will be providing an update to Governors on proposed service changes across the whole organisation noting positive discussions taking place in Cumberland council around the early help agenda with a meeting being around in the next few weeks.

Darren Best presented the Chairs Report to the group and extended a warm welcome to the Trusts new Non-Executive Directors Vikas Kumar and Rachel Bourne who have been appointed by the Council to complement the skills and experience within the Board. David Arthur is due to step down from his Non Executive Director role in January 2025 and during the recent Non-Executive Directors appointment process, Robin Earl was appointed into David Arthur's position starting in July 2024 which will provide an appropriate handover period prior to David's departure.

Darren also requested the Council to think about the culture within NHS Organisations, particularly in the context of safety, transparency, and supportiveness in ensuring people have the confidence and mechanisms to speak up. Darren noted the key theme coming out in CQC inspections within other organisations relates to culture and encouraged the Governors to provide feedback on the culture within this organisation. Another point to consider 'productivity' of the NHS in the context of the decline in staff retention within the NHS.

Resolved:

- **The Council of Governors received the Chief Executive and Chair's updates.**

Action:

- **Service visits within the Cumbria locality to be included in the programme of visits for the year.**

6. External Auditor appointment for approval

Debbie Henderson presented the report to the Council and advised that as a public benefit corporation, the Trust is required to have an External Auditor appointed by the Council of Governors. The Trusts current External Auditor contract established in 2018 ends following audit of the 2023/24 annual accounts.

As previously agreed by the Council of Governors and Audit Committee in November 2023, a tender process was therefore initiated to appoint an External Audit service which will undertake the necessary role and responsibilities required, whilst maintaining the necessary level of professional independence. The process included a plan to ensure that a contract could commence 1 June 2024 for an initial period of 36 months, with the option to extend a further 24 months (12 months + 12 months).

Debbie advised that the Council representatives, Governor members of the Audit Committee and the Lead Governor, supported by the Audit Committee, embarked on the tender exercise. The tender specification covered the provision of External Audit services for the audit of the Trust's financial statements, quality account and the annual accounts for the Trust Charity along with NTW Solutions accounts. Due to market conditions for NHS External Audit services, it was also acknowledged that the appointment would result in a significant increase of 54% compared to previous years.

The tender was issued to suppliers via the Atamis Tender portal on 12 December 2023 with a submission deadline of 12 January 2024. A core project team was established to oversee the evaluation and selection process which included members of the Council, members of the Audit Committee, NTW Solutions and the Head of Procurement. Only one single bid was received from Mazars, the Trust's current External Audit providers.

Debbie summarised by requesting approval from the Council of the recommendation to award the External Audit contract to Mazars. The company produced a strong submission that gave the panel confidence and assurance in their ability to meet the requirements. The panel unanimously agreed that this was a quality proposal as evidenced in the scoring above.

William Miskelly queried how long have Mazars been the Trust Auditors and whether Governors can be provided with assurance that Mazars price will remain the same for the length of the contract. Debbie explained that Mazars have been the Trust auditors for 6 years but provided assurance on the ongoing independence with regular refresh of Audit Director leads and representatives. Kevin Scollay confirmed that Mazars have submitted a fixed price for the Trusts tender for the period of the contract.

Darren summarised the discussion and drew the Councils attention to Appendix (a) in the paper which highlights the robustness of the process which will also provide valuable assurance.

Approved:

- **The Council of Governors approved the award of the External Audit contract to Mazars to commence from 1 June 2024 for a three-year period with the option to extend a further 24 months (12 months + 12 months).**

7. Governor Steering Group Feedback

Darren Best advised the main items discussed at the previous meeting included the changes around the Governors' meeting schedule and structure. The service visit programme was also discussed. Anne Carlile felt the change to the Governor meeting scheduled and structure was a positive step particularly the alignment to the Board structure and strategic ambitions. Anne also took an opportunity to encourage all Governors to undertake service visits due to the vast learning opportunities these provide.

Resolved:

- **The Council of Governors received the Governors' Steering Group update.**

8. Integrated Performance Report – Quality Care, everyday

Kevin Scollay presented the Month 10 Integrated Performance report to the Council and advised the Council on the key highlights of the report. The Trust continues to report a positive position on Out of Area placements which has been aided by an improved bed management position.

The 4 week waiting standards working age adults shows improvements however significant challenges remain for Children and Young People's Services (CYPS) and Kevin explained ICB consultations are underway to improve the pathway for CYPS. An improvement over the past 9 weeks in relation to Crisis services was noted although position remains challenged.

Incidents of violence and aggression is a key area of focus for the Board.

Sickness continues to be a challenge especially around mental health absence. The Trust recently completed a Training needs analysis reviewing training courses delivered to staff with a proposal to reduce compulsory training requirements and setting achievable training targets for staff. Clinical Supervision rates remain off track but are improving.

Kev also noted that the Trust would be moving to another Occupational Health provider in April 2024. Claire keys raised a concern around the new staff Occupational Health provider and noted that she felt the transfer over to the new provider has not been as seamless as it could have been. Lynne Shaw offered to meet with Claire outside of the meeting to understand the concerns in more detail.

Claire key raised a question on out of area placements asking if those placements were completely out of the Trust footprint. James Duncan confirmed that they are out-with the Trust footprint with the demand on capacity being a significant factor but assured the Council that the Trust is working hard to maintain the reduction of out of area placements.

William Miskelly raised a question regarding the reduction of training for staff and what specific training has been reduced. Darren Best advised Brendan Hill would provide an update as part of the People Committee report.

Resolved:

- **The Council of Governors received the Integrated Performance Report.**

<u>Strategic Ambition 1- Quality Care, Everyday</u>

9.1 Quality and Performance Committee Report

Louise Nelson presented the Quality and Performance Committee report and advised that all meetings now include a 'quality' focus as the first item. The January meeting focused on the new Safer Staffing Report. The committee were given a demonstration of the new Safer Staffing report and how this will align to the Integrated Performance Report (IPR) for enhanced triangulation of data and intelligence.

The Committee discussed the revised terms of reference for the Committee which have been approved by the Board of Directors.

A high level of assurance was provided on the work to reduce out of area placements. An improvement in compliance in the completion of risk assessment and complaints was also noted. There has been a real focus on the Crisis and Urgent Care Pathway, from a 4 hour and 24-hour perspective and mandatory training is being reprioritised across all services and professions.

Committee members received the Community Services Waiting Times Report, and improvements were noted, and assurance received relating to working age adults and older adults 4 week waits to treatment.

The Committee also received the new Risk Management Report detailing the Board Assurance Framework (BAF) related risks for the Committee. This was the first view of the new BAF at Committee which will be further updated and refined going forward.

The Committee were updated about the new service user and carer experience survey 'Your Voice' which has now been agreed and steps are being taken to prepare for its introduction in April 2024. This survey will be offered digitally more often to reduce costs and impact on the environment. The Committee were also assured to hear that there were 1,496 experience surveys completed by Service Users and Carers through Points of You during quarter 3 2023/24. This was the second highest quarterly total since the current survey was introduced September 2020.

Other reports received and discussed by the committee included the serious case review report, the independent Investigation report, the Safer Care report, and the Emergency Preparedness and Resilience Response (EPRR) Compliance Improvement Plan report.

Key decisions made by the Committee were the agreement to close two Must Do action plans as there was sufficient evidence to support actions had been undertaken. The Committee also agreed to reopen one action plan relating to body maps and recording of physical observations following the use of restraint as further work is required to make the necessary improvements following the outcome of a recent clinical audit.

Jodine Milne Reader suggested that the reports contain sometimes complex information and suggested that the report could be made more accessible for people who may struggle to understand some of the content.

Resolved:

- **The Council of Governors received the Quality and Performance Committee report.**

9.2 Mental Health Legislation Committee Report

Michael Robinson presented the report to the Council and advised that the purpose of the committee is to provide assurance that the Trust is compliant with the requirements of the Mental Health Act and MHA Code of Practice. Assurance was provided to the Committee in relation to Mental Health Legislation policies noting that all policies were in date with the content compliant with associated legal obligations. Those nearing review were on schedule to be reviewed.

The Trust Practice Guidance Note relating to the 'Delegation of Statutory Functions under the MHA 1983' was reviewed by the Mental Health Legislation Steering Group ('MHLSG') and the contents agreed to be in line with legislative requirements and the MHLSG Terms of Reference.

An internal audit in relation to the 'Delegation of Statutory Functions under the MHA 1983' PGN 09, resulted in a good level of assurance.

In terms of the current risk and gaps in assurance, the Committee noted and discussed the recording of capacity in relation to medication for mental disorder, Mental Health Legislation Training and Interface of Mental Capacity Act and MHA. Michael also noted that there were no Board Assurance Framework level risks to report as all risks were managed at corporate or local level with appropriate assurance in place.

Resolved:

- **The Council of Governors received the Mental Health Legislation Committee report.**

Strategic Ambition 2 – Person Led Care, Where and When its Needed

10.1 Programme Update

James Duncan presented the report to the Council and advised the Trust has in place an annual plan for 2023/24, which builds on the work introduced in 2022/23 across the key programmes. These programmes are Community Transformation (adults and older people), Urgent and Inpatient Improvement, and CYPS Improvement. The Adult Learning Disabilities and Autism Improvement programme is currently paused.

The new Integrated Performance Report includes key outcomes which are assessed in relation to impact, such as length of stay. The team are reviewing how the impact and benefits which are critical to successful delivery of the programmes can be summarised at a high level for this report for 2024/25.

The Trusts Model of Care is central to the development and evolution of the programmes of work across the Trust and close alignment is in place to ensure the critical tasks support the development of the model during the forthcoming months.

Some key elements of work being taken forward include service user and carer input at key stages of the programmes. While the Urgent and CYPS programmes can create workstreams directly involving service users and carers, the internal oversight of community transformation notes that this involvement activity happens within the 7 place-based programmes, drawing on the varying experience of local service users and carers in each area.

James noted the Trust is in the process of finalising the overarching Trust Annual Plan for 2024/25 as well as implementing a new operating model for the Trust. The transformation programmes and co-ordination of work will be reviewed to ensure smooth transition and support to deliver the key priorities for the Trust.

Star Ncube queried if the Pioneering teams were clinical staff. James Duncan advised that they are based in each of the localities and provided an overview of their role. Star requested that the pioneer teams be included in the Governor service visit programme later in the year.

Elaine Lynch advised the Council of the developments for neuro diversity at Cumberland Council noting a meeting scheduled to take place on 5 April with people from Portsmouth who have put in place a programme on diversity with partners. Elaine noted that the Trust has been invited and expressed the importance of partners working together to address issues around adult services and waiting times.

Tom Rebair raised concerns over demand on services, capacity, and staff issues and asked if the NENC Integrated Care Board (ICB) were looking into ways to recruit more staff and invest more in training. James Duncan advised the collective approach is a focus on how teams can work differently and effectively, and noted the Trust has more substantive staff in place that ever before.

Resolved:

- **The Council of Governors received the Programmes Report.**

Action

- **Include the 7 Pioneer Teams in the Governor Service visit schedule for 2024/25.**

Strategic Ambition 3 – A Great Place to Work

11.1 People Committee Report

Brendan Hill presented the people Committee report to the Council and advised that the Committee will now hold an additional two meetings per year as an additional ‘deep dive’/focus topic workshops.

The terms of reference for the Committee have been reviewed and membership has been expanded to include Group Nursing Director representation. The Employee Relations and Staff Survey reports will be discussed further at the June meeting of the Committee.

In terms of current risks and gaps in assurance, the Committee acknowledged and discussed clinical supervision, staffing establishments, and appraisals, workforce planning and training.

Internal communications had increased significantly during the previous 12 months in relation to staff feedback, ‘you said, we did’, from both the 2022 staff survey and the quarterly People Pulse survey which included promotion and sharing of good practice.

Workforce Leads delivered a presentation on work across localities to manage staff sickness. It was recognised that the highest levels of sickness both locally and nationally relate to anxiety, stress, depression, and other mental health illnesses. This also reflects post-covid challenges including the impact of increased patient acuity, as well as personal social and economic issues i.e., cost of living increases, variations in deprivation/income.

The Committee has previously recognised the challenges to meeting training compliance standards, largely due to the need to release staff to undertake training and the expectation on the workforce around the number of training commitments required. A paper was received by the Committee on work to review the Training Needs Assessment for the workforce. The group reassessed the prioritisation of the 50 current training requirements to establish realistic expectations for staff to comply with the most crucial training requirements given the low compliance rates in 18 of the 27 areas with compliance standards including priority areas such as PMVA, and safeguarding training. The review process resulted in a proposal that 44 courses should remain with others no longer being relevant or required. 8 were considered essential as training would reduce the risk of patient and/or staff serious harm or death. This included suicide training, PMVA and life support.

Examples of Freedom to Speak Up cases are still being explored where this would not compromise those raising issues. The purpose is to promote where speaking up has had a positive outcome and use this to encourage others to speak up, particularly when considering the outcome of the 2023 staff survey.

Claire Keys referred to staff training within inpatient settings and concerns regarding inconvenient training times were making it difficult for staff to attend and requested the Trust may need to explore alternative timings for training to increase training compliance. A discussion ensued on the other challenges staff face with completing training and it was proposed that a further discussion be held on staff training at a future meeting.

Resolved:

- **The Council of Governors received the People Committee report.**

Action:

- **A further discussion to take place specifically on training requirements for staff.**

<u>Strategic Ambition 4 – Sustainable for the Long Term, Innovating Every Day</u>

12.1 Finance Report

Kevin Scollay presented the Month 10 Finance report to the Council and advised the Trust has generated a £3.7m deficit year to date. This deficit is in-line with the financial plan at Month 10 but financial targets have become more challenging again in Month 10, however, the Trust expects to deliver the increasingly challenging targets.

Monthly agency costs are higher than the agency ceiling but are now lower than planned levels. At the end of Month 10 the Trust has spent £13.1m, cumulative, on agency staff against a plan £14.6m and the Trusts nationally applied agency ceiling of £12m.

Expenditure on the Trust capital programme is forecast to be £6.5m lower than planned at Month 10. This is predominantly due to the Treasury approval delays associated with the CEDAR programme which are now resolved.

The Trust has a cash balance of £29.7m at the end of Month 10 which remains ahead of plan but continues to fall quarter on quarter.

Resolved:

- **The Council of Governors received the Finance Report.**

12.2 Resource and Business Assurance Committee (RABAC) Report

Kevin Scollay presented on behalf of Paula Breen, Non-Executive Director and RABAC Chair) and advised the Committee noted and discussed the Northgate land sale, managing ongoing financial planning for the 2024/25 year-end, medium term financial planning, the CEDAR Programme, IFRS 16 Impact on PFI Accounting, digital innovation, and Provider Collaborative – Adult Eating Disorders.

The Committee were advised that the current planning round is moving at significant pace with multiple actions being taken to navigate this. Given the pace of the planning round and the quarterly scheduling of RABAC, it was agreed that regular meetings would be held with the Chairs of both RABAC and Audit Committee to ensure they are appraised of the progress being made in coming weeks.

Resolved:

- **The Council of Governors received the Resource and Business Assurance Committee report.**

Strategic Ambition 5 – Working for and with our communities.

13.1 Charitable Funds Committee

Debbie Henderson presented the report to the Council and advised the Council that the Chair role of the Committee had moved from Louise Nelson to Vikas Kumar, but Louise will continue as a committee member. The Committee received an update on the expenditure log, and fund balances including the Trust's general 'Shine' Fund. Eight new funds were opened during period to account for the Trust's successful bid in securing £154k of the NHS Charities Together Stage 3 Grant funding for eight special projects across the Trust.

The Committee also received an update on progress to deliver the Charity Strategy. During the period, the Charity embarked on a rebrand and relaunch following the additional resource to support the charity. Significant progress has been made in terms of raising awareness of the Charity and fundraising income following the appointment of an apprentice-level post, the appointment of a Band 5 Marketing Officer, following a further successful bid for 12-month period NHS Charities Together, and the move of the charity and fundraising portfolio to the Director of Communications and Corporate Affairs under the leadership of the Trust Marketing Manager.

Resolved:

- **The Council of Governors received the Charitable Funds Committee report.**

Governance and Regulatory

14.1 Audit Committee Assurance Report

Michael Robinson presented the paper to the Council and advised that the key area of focus was consideration of the first review of the new Board Assurance Framework, noting the key risks to the achievement of our strategic ambitions, and the level of assurance received

thereon via the Board Committee framework. The importance of ensuring the new approach to risk management is embedded across the organisation was noted.

The Committee also received assurance in relation to digital risks, review of the new processes and policy relating to the Fit and Proper Person Test, receipt of the External Audit engagement letter, and updates on Internal Audit and counter fraud progress.

A discussion took place regarding the appropriateness of the Trust Audit Committee Chair, taking up the role as Board Member of AuditOne, the Internal Audit service. It was agreed that there was no conflict of interest, and that this appointment should proceed.

The scheduled update on assurance from the Resource and Business Assurance Committee was stood down due to the rescheduling of RABAC, which took place following the meeting of the Audit Committee.

Resolved:

- **The Council of Governors received the Audit Committee report.**

Any Other Business

Darren extended thanks to the Council for a robust and challenging conversations and positive attendance and engagement.

15.1 Questions from Governors and the Public

No questions raised.

Date and Time of next Meeting
Thursday 27 June 2024 2-4pm
St Nicholas Hospital Board Room and via MS Teams

4. ACTION LOG AND MATTERS ARISING FROM PREVIOUS MEETING

Darren Best, Chair

REFERENCES

Only PDFs are attached

4. COG Action Log COG 27.06.24.pdf

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Council of Governors Meeting
Action Log as at 27 June 2024

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

Date/ Item No.	Agenda item	Action	By Whom	By When	Update/Comments
Actions outstanding					
21.3.24 (10.1)	Programme update	There are no current outstanding actions	Kirsty Allan	June 2024	Update to provide under action log update
21.3.24 (11.1)	People Committee report	A further discussion to take place specifically on training requirements for staff	Debbie Henderson	To be agreed	Date to be agreed by Governors' Steering Group
Completed actions					
21.3.24 (5)	Chair and CEO update	Service visits within the Cumbria locality to be included in the programme of visits for the year	Kirsty Allan	June 24	Complete

5. CHAIRS AND CHIEF EXECUTIVE UPDATE

Darren Best, Chair and James Duncan, Chief Executive

REFERENCES

Only PDFs are attached

5a Chairs Report June 2024 DRAFT 02.pdf

5b. CEO Report to Board of Directors June 2024 (002).pdf

Name of meeting	**Council of Governors**
Date of Meeting	**Thursday 27th June 2024**
Title of report	**Chair's Report**
Executive Lead	**Darren Best, Chairman**
Report author	**Kirsty Allan, Corporate Governance Manager / Deputy Trust Secretary**

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

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

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

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

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

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

Meeting of the Council of Governors
Chair's Report
Thursday 27th June 2024

This is a regular report for information and accountability, summarising my activities as Chair and Non-Executive Directors (NED) activities and key events since the last Board meeting on 6th March 2024.

Wearmouth View – Monkwearmouth Hospital

Work began on the new building back in August 2022, with the demolition of the old building which had become structurally unsound and unfit for purpose. I had the opportunity to visit Wearmouth View as the work was completed in March 2024 and the staff are now using the building. This is a fantastic development which brings much needed investment to the Monkwearmouth Hospital site, and has brought real benefits to service users, staff and visitors. The new building provides modern, efficient, purpose-built working environments, designed in partnership with staff, to promote better teamwork and help staff provide excellent care. It will enable us to continue to provide community mental health support, for all ages, from a safe and accessible site in the heart of the community of Sunderland.

Board of Directors and Council of Governors

As Chair of the Council of Governors and Board of Directors, I participated in the following:

- Quarterly Governor representative discussions
- Council of Governors Business Meeting
- Council of Governors Development Session
- Board of Directors meeting
- Board Development Session

I am grateful to Brendan Hill (Vice Chair) for stepping in and Chairing a Board meeting and a Governors meeting that I was unable to attend during this period.

NTW Solutions Board Development

A workshop took place on 30 April, at which the NTW Board, CEO and senior managers reviewed progress against their objectives and identified priorities for the coming year. I attended primarily to hear and learn about the wide ranging and fantastic work that NTW Solutions does with and on behalf of the Trust. I was made to feel very welcome and was given the opportunity to provide some thoughts around the importance of the voice of the service user and carer and our staff in shaping how we do things. I learned an awful lot about the breadth and quality of the services we get from NTW Solutions.

We are lucky to have a business partner who truly understands the importance of how their work impacts on how CNTW delivers services. It was clear to me that the values that NTW Solutions operates with are seamlessly aligned to those of CNTW. I look forward to receiving the NTW Solutions Annual Report at a future Board meeting.

Appointment of Non-Executive Director (NED)

Following the December 2023 recruitment process we interviewed an excellent candidate, Robin Earl who has a strong business background and his values aligns with the values of CNTW. Robin will be joining the Board of Directors as a Non-Executive Director in July which allows for a period of handover for when David Arthur's term of office comes to an end in January 2025. I will be meeting with Robin in his first week of starting in post to oversee the completion of his induction programme and agree objectives as a supporting personal development plan for the current financial year.

I am also in the process of undertaking all Non-Executive Directors appraisals. The appraisals process is important to ensure that Non-Executive Directors develop their skills, feel motivated, well supported, and confident to deal with many issues and challenges they will face in their role. An effective appraisal will enable Non-Executive Directors to evaluate their performance, receive constructive feedback, build on strengths, and address any areas of improvement.

Arrangements are in place for our Trusts Senior Independent Director, David Arthur to complete my appraisal as Chair, in accordance with guidance and a framework issued by NHS England. The outcome of the appraisal process will be shared with the Council of Governors' Nomination Committee (for Chair and NED appraisals) and the Remuneration Committee (for Chief Executive and Executive appraisals) and will be used to inform the overall Board development needs moving forward.

Evaluating Council of Governors Effectiveness

Evaluating Council of Governors effectiveness on an annual basis is essential to ensure that the group is operating as effectively as well as helping in identifying areas for future development. To evaluate the effectiveness of the Council of Governors is not only good practice but is outlined as a recommendation in NHS England's code of governance.

The Council of Governors will be undertaking a self-effectiveness questionnaire during May/June 2024 and once needs are identified, a tangible action plan will be implemented to ensure that the Council continues to make improvements every year. The results will be provided to a future Council of Governors meeting later in the year.

Quality Priorities 2024/25

As we are gearing towards our annual report, work is ongoing to review work that has been undertaken over the last financial year and I am pleased to note the Trust has delivered much of what we set out to do in the year but absolutely recognising that we need to go further. We have engaged with partners and stakeholders to account for what we have delivered in 2023/24 and to agree what our priorities for quality need to be for 2024/25.

As a Trust we are committed to providing the highest standard of care and to achieve this we listen to the views of our service users and carers, staff, partners and other stakeholders with the our aim to ensure we continue to improve our services to achieve our vision to work together, with compassion and care to keep you well over the whole of your life as in all of this the voice of those who need our support is paramount. To help us deliver our commitments and the care we strive to achieve we have five strategic ambitions set out in our Trust strategy 'With you in mind'. The report which will be published soon outlines those priorities for 2024/25 which will help us continue our journey to achieving our strategic ambitions.

Internal Engagement & Discussion

I have regular planned meetings with our lead Governor Anne Carlile and meet weekly with James Duncan our Chief Executive Officer. I have also met with numerous individuals, including Executive Officers, Senior Managers and members of staff; the primary aim of which is to inform discussions with the Board and help shape our thinking and decision making.

During March - May 2024, I visited and / or met with:

- Cleadon Ward - Monkwearmouth
- Safety, Security and Resilience Team
- Trust Innovations
- Disability Network
- Library Services
- Audit One
- Service User and Carer Reference Group
- Carleton Clinic – Carlisle
- Crisis Team – Portland Square Carlisle
- OpCourage Veterans Mental Health and Wellbeing Service
- Mitford – Northgate
- Inpatient Services – St Georges Park
- Ward Managers Community of Practice event

Non-Executive Director and Governor Service Visits

Non-Executive Directors and Governors have started their monthly service visit programme 2024. These visits are hugely important which offers the opportunity for Non-Executive Directors and Governors to see where the work happens within the Trust and build relationships with staff based on mutual trust. The visits are an opportunity to get an overview of what is going on in the workplace, offering the ability to gain insights into potential improvement opportunities and acknowledge the fantastic work of staff and be confident and determined to deliver what we say we will in our strategy, 'With you in mind'.

Freedom to Speak Up

I would like to raise the importance of our Freedom to Speak Up Guardians and Champions. Freedom to Speak Up is about encouraging a positive culture where people feel they can speak up and their voices will be heard, and their suggestions acted upon. When things go wrong, it is vitally important to learn lessons and make improvements and if you think something might go wrong, you must feel able to speak up to prevent potential harm. Even when things are good but could be better, you should feel able to say something. You can speak up about anything that gets in the way of patient care or affects your working life. This could be something that doesn't feel right to you, for example, a way of working or a process that isn't being followed, you feel you are being discriminated against, or you feel the behaviours of others are affecting your wellbeing or that of your colleagues and patients.

I always go by, if in doubt speak up. It doesn't matter if you are mistaken or if there is an innocent explanation for the matters you raise. As an organisation, we will listen and work with you to identify the most appropriate way of responding to the issues you raise.

Local and Regional Network meetings

As part of my role as Chair of CNTW, it is important to continually be connect to the local and national agenda by meeting key individuals for mutual benefit, to sustain strong relationships, and to continue discussions on key issues.

In this period, I have attended:

- ICS FT Chairs Meeting
- ICB Chair and Foundation Trust Chairs Forum
- North East and North Cumbria Foundation Trust Chair / CEO Workshop
- Provider Collaborative CEO / Chairs Meetings
- North Sub ICP Chairs monthly meeting
- Central ICP meeting
- Mental Health Chairs weekly conference calls
- Foundation Trust Chairs Meeting

Myself and James Duncan, Chief Executive recently attended a ICB Chair and Chief Executive workshop / meeting which was attended by all Trusts in the ICB area. The session further highlighted the financial challenges faced by the NHS and the importance of effective and high-quality governance to oversee spending plans and how we need to continually challenge ourselves to ensure resources are used wisely and in the best interest of patients.

By way of some background / explanation, each Integrated Care System (ICS) is overseen by an Integrated Care Board (ICB). The ICS encompasses all the of Trusts that operate within its geographical area, (in our case the North East and North Cumbria) but more widely is a partnership that brings together NHS organisations, local authorities and other organisations to plan services, improve health and reduce inequalities. The ICSs are legally bound to plan and fund most NHS Services in the areas they control including NHS workforce planning. The systems are also required to bring together a broad range of organisations which have an influence on people's health, including councils, voluntary groups, charities and a host of NHS staff – to create a strategy to tackle public health and social care in each area. By bringing all of the resources, planning and delivery under on

system, the ICSs are intended to improve and join up health and social care. They became operational in July 2002 under the Health and Care Act, with a specific aim of 'enhancing productivity and value for money'.

On that basis, it is important that the CNTW Board operates with an understanding that we are part of a wider system, we rely upon the ICB for our funding and therefore should expect to be appropriately accountable to the ICB for our spending plans and service delivery. I fully expect the ICB to introduce further mechanisms to ensure active governance can be demonstrated, I am optimistic that whatever mechanisms are introduced will be proportionate and useful in respect of improving services to patients.

Collaboration & Partnership

Four Northern Hospitals Trusts are looking to work more closely than ever before as part of a new arrangement to be called 'The Great North Health Alliance'. The Newcastle Hospitals, Northumbria Healthcare, Gateshead Health and North Cumbria Integrated Care NHS Trust will work together in hope of improving healthcare pathways for patients. Plans are in the early stages with the idea of building on areas where there is existing collaborative working across hospital teams which will help those Trusts work towards financial and operational sustainability.

For the reasons set out above, i.e. that CNTW operates as part of a wider health care system, and recognising that other organisations such as those involved in the Great North Health Alliance are actively seeking our partnership and collaboration initiatives and activities, it is important that we recognise that we are already a good and successful partnering organisation, but equally recognise that we could do more. On that basis I have asked James, our CEO, to develop a CNTW Collaboration & Partnership Strategy that will help provide clarity, direction and purpose as to what and where we think working with other organisations could be beneficial in terms of service delivery, efficiency and / or financial savings.

Governors Steering Group

The Council of Governors has a sub-group, the Governos' Steering Group which looks at the planning for Governor meetings and scheduling of business, our plans for engagement with local communities, and the governance-related matters of the Council. At the May meeting of the Steering Group, we discussed agenda planning for future meetings and key areas of focus for the Council. We also started discussions about the planning for our Annual Members' Meeting/Annual General Meeting scheduled to take place on Thursday 26 September 2024, 1.00pm in the Jubilee Theatre at St Nicholas Hospital. More information will be available over the coming months.

Darren Best
Chair of the Council of Governors and Board of Directors
May 2024

Name of meeting	**Council of Governors Meeting**
Date of Meeting	**Thursday 27th June 2024**
Title of report	**Chief Executive's Report**
Executive Lead	**James Duncan, Chief Executive**
Report author	**Jane Welch, Policy Advisor to the Chief Executive**

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

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

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

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

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

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

Council of Governors Meeting
Chief Executive's Report
Thursday 27th June 2024

Trust updates

Deaf Mental Health Conference

The Deaf Mental Health Conference was held on 8th May in Deaf Awareness Week. This was a collaborative event held at St. James's Park and organised by CNTW, Northumbria Healthcare, Newcastle Hospitals and Deaf Link North East. The event attracted around 100 attendees and included a range of speakers including Dr Margaret De Feu, a Consultant Psychiatrist with extensive experience setting up and delivering mental health and deafness services across the UK and Ireland. Our Lead for Equality, Diversity and Inclusion Chris Rowlands presented an overview of the legal aspects and organisational responsibilities in terms of providing accessible services and information for our service users. Two service users who have accessed different parts of the pathway – in primary, secondary and tertiary services, shared their stories. Their experiences highlighted some of the challenges and barriers that people face. Claire Hoggeth, a Healthcare Navigator from Deaf Link North East provided an overview of her role and the importance of being attuned to the needs of the Deaf community and working with them to enable access to care.

In the afternoon session, Christine Davidson and Heather Common provided an overview of the Mental Health and Deafness Service. The presentation of a case study generated an in-depth discussion surrounding Deaf people's access to mental health services, and open and honest debate and challenge regarding the current situation and provision available. This discussion then fed into a larger action planning session aimed at making positive changes across the system. These actions were wide-ranging and encompassed smaller practical team-level changes, through to more organisational and commissioning level recommendations.

The organising group are in the process of arranging an evaluation of the event. This will include attendees' views and feedback as well as the full action plan from the day. Progress on some of the actions has already begun in CNTW, including linking up the Mental Health and Deafness Service with the NHS mental health 111 delivery team to ensure the service is accessible for Deaf service users, and linking in with Trust Innovations to improve accessibility within the West Cumbria transformation offer.

Social Work Conference

This month I also attended CNTW's Social Work Conference. The morning session focused on mental health social work developments within CNTW and across the NHS, highlighting a 20% national growth in mental health social work and an impressive 43% growth at CNTW since 2022. We shared workforce intelligence, evidencing how diverse social work is across the Trust and how we meet the needs of our communities, with 146 social workers employed across the Trust and 123 within our newly formed Community Care Group.

We discussed the focus of the social work leadership team, including the implementation of key frameworks, support networks and strategic partnerships necessary for social work to thrive. Our keynote speaker, Jak Savage, shared her journey through services as a person

with lived experience, emphasising how social work within health services was instrumental to her recovery.

In the afternoon, a facilitated workshop allowed myself and other strategic leaders to listen to the social work workforce through a speed dating style Q&A, gathering valuable thoughts and reflections to inform key changes aligned to our Trusts strategic ambitions. The outputs from these discussions will be documented for endorsement by our executive leaders.

HOPE(S) Conference

On Monday 13th May I attended the 2nd National HOPE(S) NHSE Collaborative Progress and Future Planning Event in Liverpool. It was an amazing event with many emotive and often challenging to hear stories from Service Users and Carers. We heard from keynote speakers such as Sir Norman Lamb and Dame Baroness Hollins on the impact HOPE(S) has had to support service users and carers to live a life that is based on their human rights and least restrictions.

The event was attended at full capacity, with some international colleagues joining online. This included 33 healthcare providers, academic institutions, CQC and other regulators, and NHSE and ICB colleagues. In relation to forward planning, there was significant commitment from people at the conference to support the HOPE(S) programme gaining further funding to extend and increase its reach into the future. A number of suggestions were made relating to how the programme may be embedded in ICBs, Trusts and the Independent Care (Education) and Treatment Reviews (IC(E)TR) process.

It was a powerful day and we were challenged to consider how we ensure the HOPE(S) work continues to be embedded in every day practice across our organisations and communities. We are very lucky to have a small HOPE(S) team within CNTW who have led some amazing work and I have asked Sarah Rushbrooke to lead on a comprehensive review of human rights work across the whole trust.

24/7 Community Pilot Bid – West Cumbria

NHS England (NHSE) have invited Providers to submit bids to be included in NHS England's Quality Transformation Programme's Mental Health 24/7 community pilot programme, with submissions due by the 26 May 2024. CNTW are hopeful of success and have secured system wide support for a bid, in collaboration with third sector colleagues, for a centre in Whitehaven which will be an open access, no referral model incorporating up to four short stay beds alongside combined crisis and CTT teams, with third sector input, wrapping around the individual in need and supporting them whilst in crisis and onwards throughout their recovery.

It is anticipated that funding associated with a successful bid would be used to create new services which would make a lasting change to local services in West Cumbria. NHSE will be working with pilot sites for 2 years and testing the approach to understand whether savings can be realised to maintain the new model through transforming existing services and models. NHSE are not specifying a set amount of funding per pilot site, recognising the different sizes and scope of submitted bids although bids of up to £2.5m per site are

expected with funds available from July 1st 2024. The funding is non-recurrent and will be available for 2 years; a second round of funding will be available in April 2025.

National updates

Culture of care standards for mental health inpatient services

NHS England published 'Culture of care standards for mental health inpatient services', which sets out the culture of care everyone should experience as a mental health inpatient, regardless of age. The standards apply to all NHS-funded mental health inpatient services, including those for people with a learning disability and/or autistic people, specialist, secure and children and young people's services. The standards have been co-produced with people with lived experience of inpatient services and their families; nurses, psychiatrists, psychologists, allied health professionals and other staff who work in inpatient settings; voluntary sector organisations; royal colleges; and academic experts. The standards are ambitious and describe a positive workplace culture which is critical for improving patient outcomes and where every person has the power to make a difference. The guidance sets out 12 overarching commitments:

1. Lived experience: We value lived experience, including in paid roles, at all levels – design, delivery, governance and oversight.
2. Safety: People on our wards feel safe and cared for.
3. Relationships: High-quality, rights-based care starts with trusting relationships and the understanding that connecting with people is how we help everyone feel safe.
4. Staff support: We support all staff so that they can be present alongside people in their distress.
5. Equality: We are inclusive and value difference; we take action to promote equity in access, treatment and outcomes.
6. Avoiding harm: We actively seek to avoid harm and traumatisation, and acknowledge harm when it occurs.
7. Needs led: We respect people's own understanding of their distress.
8. Choice: Nothing about me without me – we support the fundamental right for patients and (as appropriate) their support network to be engaged in all aspects of their care.
9. Environment: Our inpatient spaces reflect the value we place on our people.
10. Things to do on the ward: We have a wide range of patient requested activities every day.
11. Therapeutic support: We offer people a range of therapy and support that gives them hope things can get better.
12. Transparency: We have open and honest conversations with patients and each other, and name the difficult things.

For each commitment, the guidance describes a set of standards and what implementing these standards means for providers in practical terms.

Government response to the rapid review into data on mental health inpatient settings

The government responded to the report of the independent rapid review into data in mental health inpatient settings chaired by Dr Geraldine Strathdee, which was published in June 2023. The rapid review was commissioned by ministers to produce recommendations for improving the way data and information is used in relation to patient safety in mental health inpatient care settings and pathways, and followed undercover investigations by BBC Panorama and Channel 4's Dispatches. The rapid review organised its findings into five key themes: 1) Measuring what matters; 2) Patient, carer and staff voice; 3) Freeing up time to care; 4) Getting the most out of what we have; and 5) Data on its own is not enough. The Government's response to the recommendations made by the review under each theme are summarised below:

1. Measuring what matters
    - NHS England will deliver a programme of work to agree with experts by experience, the CQC and system leaders the most impactful metrics for spotting early warning signs of quality and safety by early 2024.
2. Patient, Carer and Staff Voice
    - DHSC and NHS England expect that by Spring 2024, providers will:
        - Review their approach to Board reports to ensure they can identify, prevent and respond to patient safety risks in inpatient mental health settings.
        - Review lived experience representation at Board level and communicate how it will be strengthened if necessary.
        - Review approaches to gathering and acting on patient experience measures in mental health inpatient settings.

Government also highlights the need for trust leaders to prioritise spending time on inpatient wards including unannounced visits. DHSC and NHS England expect providers to implement relevant carer standards, routinely seek carer feedback, develop co-produced quality improvements, and identify ways to incorporate the expertise of carers to, for example, co-deliver staff training programmes. The Government agrees more should be done to strengthen the expectation that all mental health inpatient wards facilitate visitors, and that mechanisms are in place to act on their feedback. It expects all providers to provide information on the ward environment and therapeutic activity to patients in accessible formats.

3. Freeing up time to care

The Government recognises that providers and commissioners should have access to digital platforms containing core patient data, benchmarking data and which avoid duplicating data submissions, but highlights that this would have funding implications. NHS England will scope out options for this in early 2024 to inform the next spending review cycle.

4. Getting the most out of what we have

DHSC and NHS England will work with Integrated Care System Leaders to help them facilitate sharing of best practice across the sector – it is expected that the outcomes of the 'measuring what matters' programme will support this work. ICS leaders are expected to ensure the availability of data.

5. Data on its own is not enough

NHS England and DHSC will work with system leaders to highlight the importance of improving Board members' capacity and capability to identify, prevent and respond to patient safety risks – the National Patient Safety Syllabus module is a key tool in this area. All provider Boards should review their approach to board reports and assessment frameworks.

DHSC has convened a ministerial-led steering group to oversee this work and will provide an update on delivery in July 2024.

Implementation guidance 2024 – psychological therapies for severe mental health problems

NHS England published guidance aimed at supporting the expansion of psychological therapies for people with severe mental health problems (PT-SMHP) by upskilling and expanding the specialist psychological professions workforce. The guidance is focused on community mental health services for adults and older adults, and Early Intervention in Psychosis for people aged 14+. Many other services are out of scope of the guidance. The guidance includes an overview of the vision for community mental health services for adults and older adults, psychological therapies competencies and the national training offer, the role of mental health and wellbeing practitioners, outcomes monitoring and the 4 week waiting time standard, and advancing mental health equalities. It sets out the following actions for mental health providers and systems:

- Mental health providers and integrated care boards (ICBs) should develop a specific local strategy for implementing increased access to NICE-recommended psychological therapies for psychosis, complex emotional needs/ 'personality disorder', eating disorders and bipolar disorder.
- The chief psychological professions officer (CPPO), the most senior psychological professional in provider organisations, should lead on the expansion programme of PT-SMHP and the governance behind expanding the psychological therapy workforce in line with this implementation guidance. The CPPO should report on progress with the expansion directly to the trust or provider organisation's board, where there should be a named board-level sponsor.
- The current national training offer is not intended to lead to local disinvestment from delivery of any other psychological therapies and interventions if they are evidence-based and local priorities.

The guidance also includes advice around capacity modelling for different psychological therapies and implications for workforce growth and training pathways.

Drug and alcohol workforce strategy

NHS England and the Department for Health and Social Care published a '10-year strategic plan for the drug and alcohol treatment and recovery workforce (2024–2034)'. Dame Carol Black's independent review of drugs called for transformation of the drug and alcohol treatment and recovery workforce to deliver better outcomes for the people it serves. This strategic plan for the drug and alcohol treatment and recovery workforce outlines the actions required next year underpinned by a £257m investment, and plan for the next 3 years, 5 years and 10 years to achieve this vision by 2034. It has been developed by OHID and NHS England through extensive engagement with the sector.

The strategy is structured around three interconnected workforce priorities: reform; recruit; train, develop and retain:

1. Reform

Effective clinical supervision supports both professional development and evidence-based treatment and recovery. Regulated professionals have a central role to play in leading clinical governance and supervision structures within organisations. With 800 medical and mental health professionals joining the sector by 2025, this will strengthen and enhance clinical governance structures and promote a culture that prioritises workforce wellbeing and career development. This will lead to improved caseload management and improved practice and establish a firm foundation for future workforce development.

2. Recruit

Local authorities and delivery partners must recruit multidisciplinary teams (MDTs) in line with the drug strategy expansion targets, using the workforce calculator to inform MDT workforce planning and in line with the capability framework. OHID and NHS England are leading national initiatives to support improved recruitment with a focus on attracting regulated professionals into the sector, notably, psychologists and psychiatrists.

3. Train, develop and retain

By formalising the training and skills required of currently unregulated roles such as drug and alcohol workers, peer support workers (PSWs) and commissioning roles, these roles will be better equipped to deliver and commission effective interventions. More training placements and posts for regulated professionals will help attract them into the sector and ensure there is capacity to train the next generation of specialists. Building sustainable pipelines of regulated professionals into the sector is crucial, especially for psychology and psychiatry. OHID supported by NHS England will lead national initiatives to improve these pipelines. By March 2025 NHS England will work to secure additional addiction psychiatry training posts to expand the bank of posts currently available, and OHID will explore with the Royal College of Psychiatrists (RCPsych) development of a pathway for consultants to train and demonstrate equivalence to become addiction specialists (credentialing).

NHS England ADHD Taskforce

NHS England has announced the formation of a new Attention Deficit Hyperactivity Disorder (ADHD) taskforce which will work alongside government to improve care and support.

The taskforce will bring together expertise from a broad range of sectors, including the NHS, education and the criminal justice system, to better understand the challenges affecting those with ADHD and help provide a joined-up approach in response to concerns around rising demand. The taskforce will also engage widely across health and care systems. Taskforce membership and terms of reference will be published in the coming weeks, with findings published later this year.

Alongside the work of the taskforce, NHS England will continue to work with stakeholders to:

- Develop a national ADHD data improvement plan.
- Carry out more detailed work to understand the provider and commissioning landscape.
- Capture examples from local health systems who are trialling innovative ways of delivering ADHD services and to ensure best practice is captured and shared across the system.

Cass Independent Review of Gender Identity Services for Children and Young People

Dr Hilary Cass submitted her final report and recommendations to NHS England in her role as Chair of the Independent Review of gender identity services for children and young people. The Review was commissioned by NHS England to make recommendations on how to improve NHS gender identity services and ensure that children and young people who are questioning their gender identity or experiencing gender dysphoria receive a high standard of care that meets their needs, and is safe, holistic and effective.

Key findings from the review include:

- There are conflicting views about the clinical approach, with expectations of care at times being far from standard clinical practice. This has made some clinicians fearful of working with gender-questioning young people, despite their presentation being similar to many children and young people presenting to other NHS services.
- While a considerable amount of research has been published in this field, systematic evidence reviews demonstrated the poor quality of the published studies, meaning there is not a reliable evidence base upon which to make clinical decisions, or for children and their families to make informed choices.
- The rationale for early puberty suppression remains unclear, with weak evidence regarding the impact on gender dysphoria, mental or psychosocial health. The effect on cognitive and psychosexual development remains unknown.
- The use of masculinising / feminising hormones in those under the age of 18 also presents many unknowns, despite their longstanding use in the adult transgender population. The lack of long-term follow-up data on those commencing treatment at an earlier age means we have inadequate information about the range of outcomes for this group.

The Cass Review makes a series of recommendations which include:

- Expanded capacity through a distributed service model based in paediatric services and with stronger links between secondary and specialist services.

- Children and young people referred to NHS gender services must receive a holistic assessment of their needs to inform an individualised care plan including screening for neurodevelopmental conditions, including autism spectrum disorder, and a mental health assessment.
- Standard evidence based psychological and psychopharmacological treatment approaches should be used to support the management of the associated distress from gender incongruence and co-occurring conditions, including support for parents/carers and siblings as appropriate.
- The option to provide masculinising/feminising hormones from age 16 is available, but the Review recommends extreme caution. There should be a clear clinical rationale for providing hormones at this stage rather than waiting until an individual reaches 18. Every case considered for medical treatment should be discussed at a national Multi-Disciplinary Team (MDT).

NHS England has published its response to the Cass Review, and will publish a full implementation plan in due course. The letter sets out NHS England's immediate priorities following the publication of the Cass report, including bringing forward its review of adult gender dysphoria service specifications.

Revised Oversight and Assessment Framework

On 23 May 2024, NHS England issued a revised Oversight and Assessment Framework for a 3-week consultation period. The draft framework follows discussion and engagement with Integrated Care Boards and providers on our oversight and assessment approach.

The draft framework reflects the desire of patients and system partners for greater clarity of roles and responsibilities; use of a broader range of short and medium-term outcome measures, less subjectivity in measurement of success, and adoption of mature relationships in supporting organisations to improve.

You can access the consultation draft online and we would encourage everyone to respond.

6. GOVERNOR SERVICE VISIT FEEDBACK

Darren Best, Chair

REFERENCES

Only PDFs are attached

6a. Governor Service Visit Form - Akenside 09.04.24.pdf

6b. Governor Service Visit Form Carleton Clinic 09.05.24.pdf

6c. Governor Service Visit Form Castleside 09.04.2024.pdf

GOVERNOR
SERVICE VISIT FEEDBACK REPORT

Date and Time of planned visit: 09.04.2024

Name of Council of Governors attending visit:
Sithandazile Masuku, Emma Silver Price

Service Name:	Akenside Inpatients
Location:	Campus for Ageing & Vitality, Newcastle General Hospital
Care Group:	**Older People services**
Named contact for Visit:	Kelly Barron – Ward Manager Andy Severs – Clinical Manager

KEY FINDINGS / IMPRESSIONS FROM VISIT

We had a lengthy conversation with ward manager Kelly Barron, accompanied and supported by clinical manager Andy Severs. We also managed to speak to Tom (qualified nurse) and Adam (clinical support assistant) to gather informative intel into the running of the ward. We did not have the opportunity to speak to carers or patients. The ward generally had a good feel and staff were all very polite and approachable. Management was welcoming and appeared to have good rapport with staff. Kelly noted that she is relatively new into her ward manager role and found a degree of difficulty building a relationship with longer-term staff, however this seems to be improving as a result of her 'open door' policy with the team.

It was extremely evident that both Kelly and Andy are very passionate about their work. Kelly did become visibly upset when discussing certain frustrations – I have detailed this in section 5 'Ward / Trust Culture'. Andy provides a great support to ward managers.

Everyone we spoke to were pleased to have the opportunity to showcase their work, and discuss positives as well as negatives. They were grateful for the visibility.

The key findings are discussed in detail below:

1. Planned move of older people's services causing a lot of anxiety, staff feel excluded
2. Ongoing Care challenges
3. Staffing issues
4. Celebrations
5. Ward Culture / Trust
6. Leadership

COMMENTS RECEIVED FROM SERVICE USERS / CARERS / FAMILIES DURING THE VISIT

1. **Planned move of older people's services causing a lot of anxiety, staff feel excluded:**
   - Management were very vocal regarding this. They indicated that the proposed move has caused a lot of uproar because the intent was to split the older people's services teams which up to date had worked well together given their close proximity.
   - Both management and staff indicated that the move to St Georges would create more problems than the move to St Nicholas hospital. Management indicated that for both locations, staff had not been consulted in relation to ensuring the environment was fit for purpose. Examples given include concerns regarding the size of the corridors which were said to be narrow in comparison to current

location. Management highlighted that the narrower corridors would make it difficult to manoeuvre moving and handling equipment essential for older people's services back and forth and would also make it difficult for patients requiring assistance from two members of staff to move from point A to point B. Management also felt they need larger doorways to facilitate manoeuvre of required equipment. Management also feared that the layout of the ward was not ideal for people with dementia especially in relation to dark spots which they felt were not safe if patients were to wonder, ideally, a lengthy, wider and well-lit corridor was said to be ideal. Management also did not think an upstairs floor was ideal for elderly care.

- Consultation: Management indicated that if they had been included in the consultation of the new ward, then the above issues would have been addressed but they feel they have not been given an avenue to do this. They also indicated that larger bedrooms and ensuites were required for patients who may be confused and not able to find the toilets in time which impacts on dignity.
- Management felt the poor layout of the building was going to have a negative impact on quality of care and staff morale because it's not purpose built, with worries around CQC input following feedback that the current ward is 'not fit for purpose'.
- Management felt they are kept in the dark in relation to when the move to the new ward is going to be. They described the experience as a 'running joke' amongst staff. They indicated that it would be helpful if they were given exact time frames. The governors also spoke to regular staff who indicated that working at the General was ideal in terms of travel but difficulties may be experienced if the ward moved to St Georges. They did state they would be able to travel to St Nicholas Hospital.
- Management have expressed a keen interest in being involved in the renovations process, suggesting that taking patients along to the new ward to help shape its development would be beneficial.

2. <u>Ongoing Care Challenges</u>

- 10 bed unit for older people inpatient services (functional), complex health needs.
- Quite a lot of Out of Area patients.

3. <u>Staffing Issues</u>

- Kelly explained that staffing is currently at capacity, however it rarely feels adequately staffed. The safe staffing allocation numbers are set by finance and the feeling is that there is no consideration for work undertaken over and beyond observations (mealtimes, escorts, prescriptions, interventions etc.) It is felt that there is little consideration for patient and staff need for a ward that cares for patients with very complex health needs.
- There are many Acute staff being transferred to the ward who are burnt out and stressed from Acute services, which leads to extra stressed as they come under false pretences that older people services are 'easier' or 'less stressful'. It is felt that more could be done to manage the expectations of pressures within older people services, and adequately address the stress levels of staff being transferred.
- It was overwhelmingly articulated that management are increasingly frustrated with having little or no say on which staff come onto the ward. 'You are given who you are given to plug the gaps', without ensuring the correct specialist needs are being met and staff who actually want to work within older people services.
- Tom (qualified nurse) noted that the ideal for every shift would be 2 x qualified staff.

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4. **Celebrations**
   - Staff go above and beyond their role, coming in on their days off to take patients to hair appointments / visit in new care home placements etc.
   - Gardening group very popular.
   - Patients at the centre of care.
   - Received amazing feedback from a care home following discharge of patient (robust formulation and care plan / hand-over).

5. **Ward / Trust Culture**
   - Long term staff less receptive to new staff, culture slowly improving.
   - Kelly actively ensures staff are given opportunities to raise concerns and speak up.
   - Kelly and Andy were very vocal around the lack of autonomy given to create and grow their own teams. There is the feeling that even at ward manager and Band 8 level there is very little opportunity to make decisions that are in the best interest of their teams. There was the belief that when Kelly began her role as ward manager, she would have a lot more 'power' and say over the runnings of the team / ward, however there appears to be a 'brick wall' when it comes to decision-making. This directly contradicts the Trust strategy 'with you in mind', whereby the commitment to staff states "allow me freedom to act, to use my judgement and innovate in line with our shared values". It is felt that management directly below exec-level is where the barriers lie and decision-making or input is not given to clinical or ward managers. This results in the feeling of not being valued or trusted to make necessary changes within the wards.
   - It is felt that Trust strategies and wellbeing initiatives are not trickling down to ground-level staff, particularly as it doesn't seem like 'with you in mind' is being applied.

6. **Leadership**
   - Management felt leadership beyond the ward was not supportive or visible. They indicated that they don't feel they are listened to. They implied that they felt acute services had more of a voice in terms of priorities. They perceived that perhaps this was because acute services generate more incidents and as such they become a priority by default. Management argued that the above misconception then leads to the belief that elderly care is 'easy' leading to those wishing to escape acute care to gravitate towards elderly care. Management claimed that elderly care has more of a physical demand on staff, as a result, they are left to manage the wellbeing of already burnt-out staff.
   - The recurring theme of comments was that higher-level management is never seen on the ward and they would welcome and value that visibility.

IS THERE ANY ASPECT OF THE SERVICE EXPERIENCE THAT YOU WOULD LIKE TO COMMENT UPON?

Both wards indicated that they felt excluded within the decision-making process in relation to the running of the trust. They suggested that managers on the ward are supportive, but it is apparent that they don't make ultimate decisions relating to the ward and are not included in the process either. Management suggested that senior managers tend to make all decisions and appear reluctant to share the risk with the staff and management on the ward. Staff felt that the leadership culture within the Trust was top to bottom. Staff indicated that they would like to see an improvement in processes with a reduction in bureaucracy and excessive paperwork which takes them away from patient care.

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Both wards appeared pleasantly surprised they had a visit from the governors and indicated that this is not something they have had before and going forward, it would be helpful if senior management was visible and accessible.

Staff indicated that they felt the Trust strategy did not translate to practice in relation to staff being listened to and given more autonomy / being trusted by senior leaders.

To address the above, the following could be considered if the Board sees it fit:

1. Consider a consultative process when wards are moving location, especially for specialist services like elderly care to ensure services are fit for purpose. If the move has already been decided, there is still room for consultation. Ward managers, staff, and patients could be given the opportunity for involvement.
2. The timescales related to when the move is expected can be communicated in a timely manner, e.g. management could cascade to staff during team meetings and if there are any changes, the approach could be to consult with the managers instead of informing.
3. The recruitment process could be revised and provision made for managers from elderly care services to formulate an agreement in relation to the skills they find essential/desirable for new staff. Managers can then be invited to review the recruitment process and suggest areas where the above can be implemented. This will give them more ownership in terms of staff development and would also improve the morale.
4. Issues related to early discharge could perhaps benefit from service review with possible focus on bridging this gap and meeting the needs of patients who don't need to be in hospital.
5. Continue planned Council of governors and NED service visits to improve visibility of senior management but also consider formulating some type of communication following a visit. This could be to acknowledge receipt of feedback or a simple 'you said, we did' type of feedback. This will make the ward feel like they have made a contribution and they have been heard.

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GOVERNOR
SERVICE VISIT FEEDBACK REPORT

Date and Time of planned visit: 09.04.2024	
Name of Council of Governors attending visit: Elaine Lynch, Fiona Regan, Shannon Fairhurst and Rosie Lawrence Kirsty Allan was in attendance during the visit.	
Service Name:	Carleton Clinic
Location:	Carlisle
Care Group :	**Older People services**
Named contact for Visit:	David Storm, Associate Director

KEY FINDINGS / IMPRESSIONS FROM VISIT

We were welcomed by the manager David Storm, Associate Director and Joe Desborough, Patient and Carer Involvement Facilitator.

North Cumbria Community Treatment Team

David explained of community transformation (Adult MH Services) working differently with partners to enable easier access to support.

Within the last 3 weeks the team have been notified of a national pilot for a community hub in Whitehaven and have submitted bids to NHS England. A building has been identified in the centre of town. This pilot brings a radically different approach to mental health provision, allocating trust support, help with housing, caring, mental health, allocated team for out of area, admissions, x4 short term beds and intensive care with services under one umbrella.

There is a healthy number of peer support workers who utilise and draw upon their own lived experiences in order to share insight, understanding and compassion with others on their journey to recovery, working with service users when they come into services so they can help access valuable resources. The team feel peer support works are greatly needed and work extremely well within services.

There are no vacancies within the team.

Removal of children crisis services with support amalgamated into children services / assessment team in CAMHS so that Crisis teams have a better understanding of CAMHS treatment services and this is working very well.

Throughout the visit staff were passionate about their work going that extra mile to help service users and carers.

Fairfield Centre overview provided by Karen Heslop and Lucy Telford

Occupational Health Therapists have planted seeds within the children's waiting rooms with the slogan "All about Growth" and change the theme by asking children and families. This has been a great initiative to the waiting room for children to be involved while waiting for assessment. There is also a children's notice board at the main entrance in place of staff information again a

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good initiative with children waiting have drawn pictures and asked to be put into the notice board.

There is currently 8 weeks wait for assessment from referral which is different to crisis pathways.

There is only one vacancy within the team for a Psychologist which is currently going through vacancy control.

The team mention the building is a challenge but working with what they have and ideally would like a new building but understand the financial constraints.

Supervision and training are on track, but it was noted training dashboard could be updated in a timelier manner when staff have completed their training. The stat and man training dashboard were said to be difficult to navigate.

Turnover of staff is very stable and staff feel valued and supported.

Acorn Centre

Acorn Centre is currently being refurbished to have x2 136 suites available from June 2024 as Yewdale 136 suite had closed will bring x2 suites on the same site.

It is hoped to have an ambulance available within Street Triage within the West which is hoped to be in place in the next few months.

Crisis Team Overview provided by Laura White and Clar Robinson

Governors were provided a journey from triage to either being signposted to other services or face to face appointments. Crisis have two bases Carleton Clinic / West Cumbria.

The team provided an overview of 111 service and Right Care, Right Person and the difficulties police colleagues have when dealing with someone in a mental health crisis.

The service is very keen to support unqualified staff through training to a qualified status.

Hadrian Clinic provided by Andrea Cox

Governors were shown an unused seclusion suite which has not been used since February where Oxevision was in place and felt this would be beneficial for an update to be provided to Governors on the use of Oxevision.

Privacy and dignity screens within the seclusion room for outside use – Governors felt the picture on the screen to be over stimulating for those who may suffer from autism etc. It was explained that these screens are being reviewed by Estate colleagues.

Shown around the Omnicell Cabinet where all medication is stored at temperature level.

COMMENTS RECEIVED FROM SERVICE USERS / CARERS / FAMILIES DURING

THE VISIT
IS THERE ANY ASPECT OF THE SERVICE EXPERIENCE THAT YOU WOULD LIKE TO COMMENT UPON?
Throughout the entire visit it was clear the staff were passionate about their work and the care they have putting patients at the heart of everything they do. It was a very pleasant, quite but busy site with not much car parking facility, where cars were parked on the main street next to a housing estate as the housing estate has been built between the hospital facilities. There is a car park adjacent which is not part of CNTW and wonder if thus could be looked at in the interest of the lack of car parking spaces. Governors felt it would be useful to go back and visit once the pilot is up and running with the new community hubs which could be added to a next years' service visit plan.

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GOVERNOR
SERVICE VISIT FEEDBACK REPORT

Date and Time of planned visit: 09.04.2024

Name of Council of Governors attending visit:
Sithandazile Masuku, Emma Silver Price

Service Name:	Castleside Inpatients
Location:	Newcastle General Hospital
Care Group :	**Older People services**
Named contact for Visit:	Kim Dunn – ward Manager Andy Severs

KEY FINDINGS / IMPRESSIONS FROM VISIT

We were welcomed by the manager Kim Dunn and Andy Severs. We spoke at length with both and also had an opportunity to speak to the support workers. We did not have the opportunity to speak to carers or patients. The ward generally had a good feel and staff were all very polite and approachable. Management was welcoming and appeared to have good rapport with staff. We had a general impression that patients were well cared for. During the visit, one of the patients did get agitated and momentarily banged on the office door. The manager and a support worker promptly attended to the patient.

The key findings are discussed in detail below:

1. Planned move of older people's services causing a lot of anxiety, staff feel excluded
2. Ongoing Care challenges
3. Staffing issues
4. Celebrations

i) Innovation

5. Ward Culture
6. Leadership

COMMENTS RECEIVED FROM SERVICE USERS / CARERS / FAMILIES DURING THE VISIT

1. Planned move of older people's services causing a lot of anxiety, staff feel excluded:

Management were very vocal regarding this. They indicated that the proposed move has caused a lot of uproar because the intent was to split the older people's services teams which up to date had worked well together given their close proximity. Castleside is an assessment service and they feel they work well with the day unit, the memory clinic and CMHT because there are all under one building and the referrals from the RVI and the Freeman are all well managed by this cluster of services. There was an indication that staff felt that if split, this would lead to disjointed service provision.

- Both management and staff indicated that the move to St Georges would create more

problems than the move to St Nicholas hospital. Management indicated that for both locations, staff had not been consulted in relation to ensuring the environment was fit for purpose. Examples given include concerns regarding the size of the corridors which were said to be narrow in comparison to current location. Management highlighted that the narrower corridors would make it difficult to manoeuvre moving and handling equipment essential for older people's services back and forth and would also make it difficult for patients requiring assistance from two members of staff to move from point A to point B. Management also felt they need larger doorways to facilitate manoeuvre of required equipment. Management also feared that the layout of the ward was not ideal for people with dementia especially in relation to dark spots which they felt were not safe if patients were to wonder, ideally, a lengthy, wider and well lit corridor was said to be ideal. Management also did not think an upstairs floor was ideal for elderly care.

- Consultation – Management indicated that if they had been included in the consultation of the new ward, then the above issues would have been addressed but they feel they have not been given an avenue to do this. They also indicated that larger bedrooms and ensuites were required for patients who may be confused and not able to find the toilets in time which impacts on dignity.
- Management felt the poor layout of the building was going to have a negative impact on quality of care and staff morale because its not purpose built.
- Management felt they are kept in the dark in relation to when the move to the new ward is going to be. They described the experience as a 'running joke' amongst staff. They indicated that it would be helpful if they were given exact time frames. The governors also spoke to regular staff who indicated that working at the General was ideal in terms of travel but difficulties may be experienced if the ward moved to St Georges. They did state they would be able to travel to St Nicholas Hospital.

2. Ongoing Care Challenges

Management indicated that they are a 10 bedded unit where patients are meant to stay temporarily for a period of time to be assessed. There is a general lack of beds in the community to move people to so patients end up staying longer than they should. Staff indicated that data relating to delayed discharge is reflected on the dashboards with the average stay being 57 days. management suggested that it would be ideal if this length of stay could be reduced and then the unit would be used for its true purpose.

3. Staffing Issues

Current staffing numbers were said to be sufficient at 43-44 with no open vacancies. Management indicated that there was a time when they were using a lot of agency staff leading to a negative impact on the patients who ended up being unsettled. This has improved of late.

However, despite the ward being on full capacity regarding staffing, management expressed concerns at the quality of staff and their limited input in the recruitment process. Management highlighted that people who end up coming to elderly care services appear to come from acute services where they would have experienced some form of burn out and they perceive that elderly care will be less stressful. Management indicated that this is the opposite, they are a specialist service with added pressures of personal care so as a result staff who would have moved from acute services to escape pressure end up experiencing even more stress because the daily duties on the ward are relentless. Management expressed concerns that they are not given any autonomy in relation to the staff being employed on the wards. They indicated that this autonomy would be beneficial

in terms of identifying appropriate staff who are passionate about older care services because it is not for everyone. Management suggested having an input in the recruitment process and expressed concerns that they were excluded from the decision making at this stage. They cited some of the work they are doing on the unit as requiring specialist knowledge, e.g use of alternate therapies like doll therapy and complex communication skills designed to reduce restrictive practices as one of the skills that make a difference. Management indicated that when the Trust perceives that they are issues related to the skills of nurses on the ward, initiatives are normally introduced but these are top to bottom, an input from management in relation to what would help would be ideal. Management indicated that the trust needs to stop moving burnt-out staff to elderly care services because this mars the fact that elderly services are really doing a good job but if staff with limited skills are protocoled to such services it will have a negative impact in quality of care.

4. **Celebrations**

Management felt their recent achievements were not being recognised. Management gave the example of the Newcastle Formulation model which they introduced 5 years ago and since then, there has been a notable transformation on the quality of care on the ward, in addition, relationships with other services where patients move on to has improved because of shared knowledge and joint working. Management were quite keen to show governors this model and described it as holistic. The model involves gathering of holistic information for a service user from family and carers including medical history, triggers, behaviours and management techniques. The formulation is designed to facilitate person centred care in every sense and promote the least restrictive options instead of relying on prn and restraint. The formulation is developed and trialled while the patient is on the ward and when a new placement is identified, the staff on the ward arrange a teaching session with the new unit to guide staff. It is this teaching that is valued as it makes the transition for the patient easy. Staff indicated that the approach they had before implementing this formulation was consultant led and now it is MDT led where everyone who is involved with the patient is invited to attend implying shared leadership. The model was said to have been used to manage challenging behaviour, but they feel it would benefit a lot of patients in the trust. The team feel the impact and success they have had relating to this model has not been celebrated, especially the role played by the manager, Kim Dunn and Andy Severs.

The other areas to celebrate include specific ward initiatives that have been introduced following an analysis of trends related to violence and aggression. The latest being two difficult patients they had 2 years ago who were racially abusive to staff. There was an indication that the agency staff who were generally targeted by the two patients were reluctant to report incidence for fear that they might not get booked again. As a ward, they noted the psychological impact this was having on staff and the ward psychologist, Shirley Tordoff formulated some work aimed at supporting staff in coping with such behaviour leading to reflective sessions being set up to foster support, resilience and growth while identifying staff who might be at risk. Recommendation made following an information gathering exercise included training and education, facilitating reporting, appointment of an Antiracism champion and including the antiracism training as part of induction process. Management also stated that if a patient has been racially abusive and this is identified as a risk it is now included in the formulation with tips of how to manage it This is an initiative that staff felt was very targeted and directly benefited staff and

patients but is not visible to celebrate.

i) Innovation

Staff celebrated provision of personalised care and also continue to explore numerous ways of facilitating wellbeing. The ward has a staffed dog called 'Moss'. Numerous residents have found interaction with the dog beneficial. Recently, a resident was discharged to a care home and took Moss with him. Moss stayed with the resident until the resident died before returning to the ward. The ward is looking at accessing more funding to create similar dolls following Moss's popularity. Moss has won Star of the Week and his picture was framed on the wall.

5. **Ward Culture**

Management reported that there was a time when there were concerns that agency staff did not feel welcome on the ward, particularly on a night shift. The current manager made active changes to make the culture on the ward more inclusive, for example, making an effort to speak to all staff and sometimes returning to the ward at the start of the nightshift. Management perceived that the negative culture that had been noted was a result of poor management following a quick turnover of managers in the last 4 years leading up to Kim's appointment. Both Andy and Kim felt that the negative culture had been driven by instances where people were 'shoved here' and lacked the passion or leadership skills for the area. They indicated that it was important that leaders lead by example, especially in elderly care services.

6. **Leadership**

Management felt leadership beyond the ward was not supportive or visible. They indicated that they don't feel they are listened to. They implied that they felt acute services had more of a voice in terms of priorities. They perceived that perhaps this was because acute services generate more incidents and as such they become a priority by default. Management argued that the above misconception then leads to the belief that elderly care is easy leading to those wishing to escape acute care to gravitate towards elderly care. Management claimed that elderly care has more of a physical demand on staff, as a result, they are left to manage the wellbeing of already burnt-out staff. Management cited the change in demographic of patients as impacting on the changing demands of patients. For example, the increase in people diagnosed with Korsakoff's dementia leading to a more able bodied younger population being admitted instead of the frail and elderly. This mix in patient demographic translates to a demand in skills set in terms of management. As a mixed ward, they make use of different spaces like quiet rooms and individual quiet lounges to manage behaviour. This has direct implications of what the environment should be if this patient group was to be managed safely. If this service was to be led safely, management indicated that they should be given more autonomy regarding staffing needs but at present there was an element of frustration because they felt their hands were 'tied'.

IS THERE ANY ASPECT OF THE SERVICE EXPERIENCE THAT YOU WOULD LIKE TO COMMENT UPON?

This was my (Sithandazile Masuku) first service visit and I was surprised how much the staff were willing to open up. I am hopeful that they felt listened to and appreciated the visit.

Both wards indicated that they felt excluded within the decision-making process in relation to the

running of the trust. They suggested that managers on the ward are supportive, but it is apparent that they don't make ultimate decisions relating to the ward and are not included in the process either. Management suggested that senior managers tend to make all decisions and appear reluctant to share the risk with the staff and management on the ward. Staff felt that the leadership culture within the Trust was top to bottom. Staff indicated that they would like to see and improvement in processes with a reduction in bureaucracy and excessive paperwork which takes them away from patient care.

Both wards appeared surprised they had a visit from the governors and indicated that this is not something they have had before and going forward, it would be helpful if senior management was visible and accessible.

Staff indicated that they felt the Trust strategy did not translate to practice in relation to staff being listened to.

To address the above, the following could be considered if the Board sees it fit:

1. Consider a consultative process when wards are moving, especially for specialist services like elderly care to ensure services are fit for purpose. If the move has already been decided, there is still room for consultation.
2. The timescales related to when the move is expected to be can be communicated in a timely manner, e.g management could cascade to staff during team meetings and if there are any changes, the approach could be to consult with the managers instead of informing.
3. The recruitment process could also be revised and provision made for managers from elderly care services to formulate an agreement in relation to the skills they find essential/desirable for new staff. Managers can then be invited to review the recruitment process and suggest areas where the above can be implemented. This will give them more ownership in terms of staff development and would also improve the morale.
4. Issues related to early discharge could perhaps benefit from service review with possible focus on bridging this gap and meeting the needs of patients who don't need to be in hospital.
5. Continue planned Council of governors and Ned service visits to improve visibility of senior management but also consider formulating some type of communication following a visit. This could be to acknowledge receipt of feedback or a simple 'you said, we did ' type of feedback. This will make the ward feel like they have made a contribution and they have been heard.

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7. ANNUAL PLAN AND PRIORITIES

Executive Team

REFERENCES

Only PDFs are attached

7. Annual plan and priorities 2024-25.pdf

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

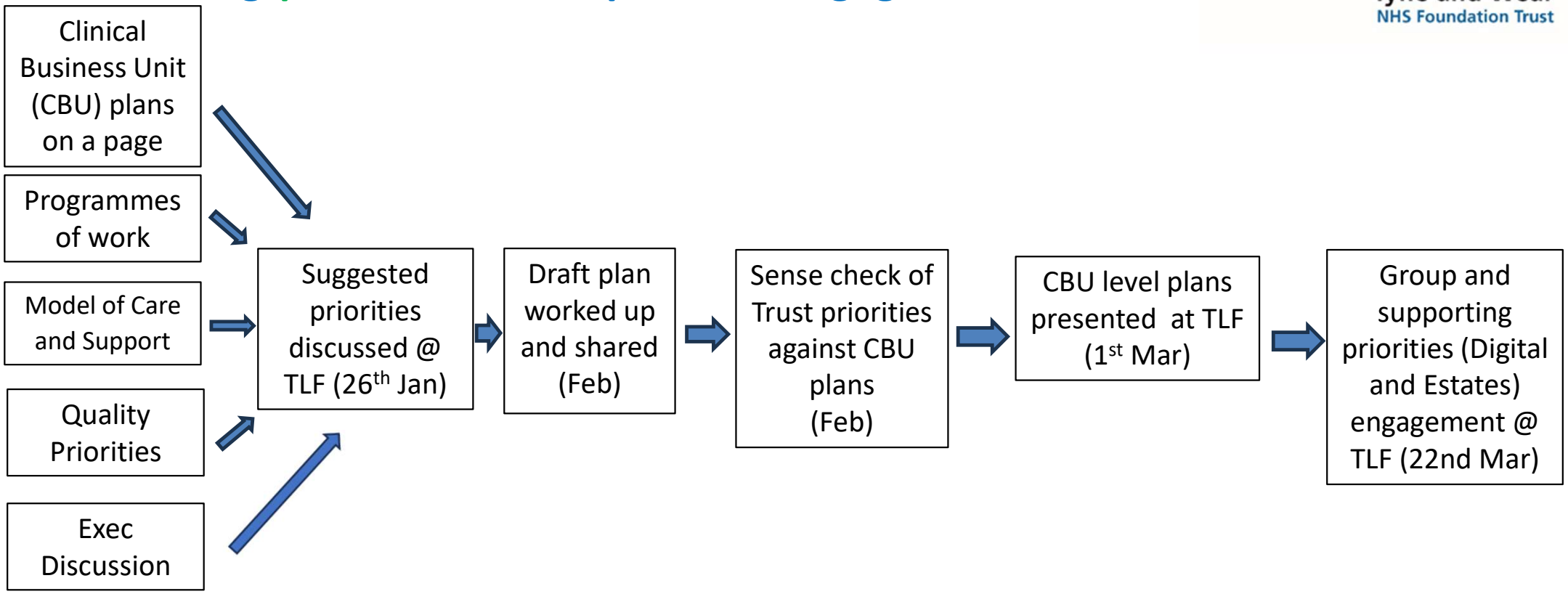
2024/25 Trust Plan and Priorities

June 2024

With YOU in mind

Trust Planning | Trust Leadership Forum Engagement

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust



With YOU in mind

Ambition 1 | Quality of Care Every Day

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Priority	Measurables
Implement PSIRF (Patient Safety Incident Response Framework)	• PSIRF implemented - assured via submissions to the ICB Q&P reports • Measure of psychological safety of staff following incidents • Staff survey
Delivering on the key learning from key safety improvement themes; • Reduce violence • Improve Physical Healthcare • Reduction in Suicides • Reduce restrictive practice	• Reduction in Serious Incidents and Harm Incidents – particularly in themes of violence • Patient related measure in relation to physical health - TBD • Reducing incidents of self harm and suicide • Reducing levels of long term segregation and prolonged seclusion, and restraint
Ensure that the six principles of the Triangle of Care are fully embedded throughout the organisation.	• Improve the performance of the six standards of the Triangle of Standards.
Embed learning through research and informing improvements in care delivery	• Increase staff participation in learning and research
Embed a culture of Trauma Informed Care and its approaches across the organisation	• Delivery of Trauma Informed Care Training plan, moving on to improved 'Your Voice' results following implementation.

Ambition 2 | Person Led Care

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Priority	Measurable
Implement Inpatient Quality Transformation with purposeful admissions, therapeutic care and effective discharges	Zero Out of Area placements, reduce delayed discharges, reduce lengths of stay, and reduced bed occupancy
Develop new models of care and support for those in crisis	Crisis – Very urgent seen within 4 hours and urgent within 24 hours Psychiatric Liaison Assessment – 1hr ED and 24hr acute ward response
Move away from CPA to a new model of care and support	Improvements in the timeliness of the 4 week wait standard
Set up new Wellbeing Hubs at a local level and improve integration with primary care	Increase the number of physical well-being partnership hubs with and without walk-in access
Increase access to evidence-based treatment including review of Specialist Psychological Therapy Services	• Delivery training on evidenced based competencies to staff • Complete and implement review of Specialist Psychological Therapy Services
Redesign and implement a radically different pathway for neurodevelopment needs	Improve waits to be seen, assessed and treated for patients of all ages with Neurodevelopmental needs
Develop with partners an integrated approach to support children and their families	Improve waits to be seen, assessed and treated for patients of all ages with Neurodevelopmental needs

Ambition 2 | Person Led Care

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Priority	Measurable
Transitions – develop effective pathways for CYPS transitions into Adults	Effective transitions pathways implemented
Implement Transforming Care ways of working	Improve the quality of care, enhance community capacity and reduce inappropriate admissions for patients with a learning disability and or autism Deliver against Transforming Care Programme
Identify and address areas at risk of closed cultures – Northgate Cultural Review	Develop and implement a plan for identifying and addressing areas with a closed culture including increased visibility and peer review
Ensure pathways for all localities have a clear and standardised offer for Alcohol and Drug presentations, including appropriate scaffolding and advice.	Pathways for alcohol and drug presentations are clearly defined, standardised and implemented.
ICB review of Neurorehabilitation services including; inpatient, community and specialist placements	Work effectively with the ICB on the review of Neurorehabilitation services
Integrate specialist psychological services with community services	Successful implementation of integrated pathways for patients
Review and improve waiting times in Gender Services – secure funding and transfer responsibility for surgical pathway	Gender Service waiting times improved

Ambition 3 | A Great Place to Work

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Priority	Measurable
Refresh development offer for teams/individuals and agree a delivery plan for the next 1 -3 years. Priorities for 2024/25: • Leadership programme to support new operating model • Roll out healthcare support workers development programme • Introduce comprehensive induction programme for unregistered staff • Introduce Edward Jenner programme for new starters into the Trust if no leadership qualifications held	Numbers of staff attending programmes Increased numbers of unregistered staff progressing within the Trust Increased retention for these staff groups Staff Survey and People Pulse metrics including questions relating to: - leadership/management - development opportunities - career progression - job satisfaction - motivation - engagement
Refresh Freedom to Speak Up approach including development of champion roles	Staff Survey responses relating to Speaking Up
Improve Employee Relations processes supported by just culture principles and implement a Resolution policy	Reduction in: - numbers of formal cases - grievances - timescales for all cases - Suspensions and non-clinical duties

Ambition 3 | A Great Place to Work

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Priority	Measurable
Put in measures to address key Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) indicators: • Reduce discrimination, bullying and harassment • Improve progression for BAME Staff	• Improvements in relevant WRES/WDES indicators • Improvements in Staff Survey and People Pulse metrics relating to discrimination, bullying and harassment • Increased number of BAME staff gaining promotion into more senior roles
Develop a sustainable Trustwide workforce plan	Workforce plan in place Reduction in agency usage
Support the wellbeing of staff by: • Improve the uptake of wellbeing conversations • Review appraisal process in line with you in mind ensuring staff have clarity around roles, responsibilities and objectives • Continue to roll out the management skills programme • Develop Coaching/Mentoring offer for staff	Increase in staff who have had a wellbeing conversation Improved Staff Survey metrics relating to: - staff having an appraisal - quality of appraisal - clarity of roles and responsibilities
Ensure we recognise the importance of veterans across a range of commitments to our workforce, in our service delivery and across our partnerships	Development and delivery of a 'Veterans plan'

Ambition 4 | Sustainable for the long term

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Priority	Measurable
Achieve financial balance in 24/25	Financial position reported to ICB and Board of Directors
Shift the Trust planning horizon to focus on medium term sustainability	Agree 3 year financial improvement trajectories for each service to deliver a sustainable £5m annual surplus
Delivery of Key Digital projects • Development of the shared care record • Implement Manager Self Service ESR • Roll out Allocate across Inpatient Areas • Develop business case for Patient Engagement Portal • Continue to support NENC SDE (funding host) (attracting R&D funding as an ICS)	Successful delivery of projects. Monitored via DPSG and RABAC.
Delivery of Key Estates projects • CEDAR (Ferndene and Bamburgh) • CAV OPS move • Benton House • Hadrian Phase 3 • Acorn s136 and crisis hub • Tweed courtyards Consider how Trauma informed approaches can be incorporated into our process to inform the design of our environments.	Successful delivery of projects. Assurances via RABAC

Ambition 5 | Partnerships

Priority	Measurable
Develop a VCSE approach embedded in place	Record of the number of VCSE organisations working with the localities and Trust in delivering CMH Transformation and other Trust priorities (including narrative on the 'what')
Influence the new structure to ensure we have no internal barriers to providing seamless care to patients.	Feedback through monitoring of transition issues between community, inpatient and specialist services through incidents and complaints. Feedback from service users and carers
Agree a way of working with the ICB at system level which supports a transformative approach which delivers significant improvement for the population and communities of the North East and North Cumbria.	Agreement of framework in place with the ICB.
Work effectively with the Great Northern Alliance at place level to ensure parity of esteem for Mental Health.	Agreed Framework to be discussed at Board
Improve integration of clinical pathways with our partners in TEWV NHS FT	Agreement of a framework & principles to improve integration within the Provider Collaborative.
Developing a health inequalities plan focusing on reducing inequity,	Delivering on the key milestones agreed through the Inequalities

Trust Planning Process

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

- Quarterly monitoring of Annual Plan via Integrated Performance Report+
- Executive Management Group (April) and Board (June) sign off
- Issue template for Group plans – end of March (Plan on a Page)
- Group plans to be submitted by end of April
- Progress against Group plans discussed at Quarterly internal Group Well Led meetings

With YOU in mind

8. INTEGRATED PERFORMANCE REPORT - QUALITY CARE, EVERYDAY

Ramona Duguid, Chief Operating Offficer

REFERENCES

Only PDFs are attached

8a. CoG Cover Sheet - IPR - Month 2.pdf

8b. Trust IPR for Board Jun24 - April2024 Data v2.1.pdf

Name of meeting	**Council of Governors**
Date of Meeting	**27th June 2024**
Title of report	**Integrated Performance Report (May-24 data)**
Executive Lead	**Ramona Duguid, Chief Operating Officer**
Report author	**Tommy Davies, Head of Performance and Operational Delivery**

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

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

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

Management meetings where this item has been considered	
Executive Team	
Executive Management Group	24.06.24
Business Delivery Group	
Trust Safety Group	
Locality Operational Management Group	

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

Board Assurance Framework/Corporate Risk Register risks this paper relates to
SA1 Quality care, every day **BAF Risk 2511** – Risk of not meeting regulatory and statutory requirements of Care Quality Commission (CQC) registration and quality standards. SA1 **SA2** Person-led care, when and where it is needed **BAF Risk 2543 –** Failure to deliver our transformation plans around the model of care to address issues relating to community and crisis infrastructures, and demand for inpatient provision which could compromise quality, safety, and experience of service users. SA2 **SA3** A great place to work **BAF Risk 2542** – Failure to develop a sustainable workforce model to recruit/retain/ and support the development of the right people with the right skills to deliver safe and effective services, our strategic objectives, and contractual obligations. SA3 **BAF Risk 2544** - Risk of poor staff motivation, engagement, and job satisfaction if issues affecting staff experience are not addressed including health and wellbeing support, inclusion and the ability to speak up. SA3 **SA4** Sustainable for the long term, innovating every day **BAF Risk 2546** - Risk that restrictions in capital expenditure imposed regionally / nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments and infrastructure. SA4

Integrated Performance Report

Patients | Quality | People | Person Led Care | Sustainability

2024-25 Month 1 (April 2024)

With YOU in mind

Integrated Performance Report - Headline Commentary

Headline Challenges

- **How was your experience?** is off target and deteriorating the last five months
- **% Training Compliance – Clinical Staff Training–** Not all the Clinically prioritised training for staff is being delivered
- A range of new Quality measures on **Restraint, Seclusion and assaults on staff and patients** have been added to the IPR for 24/25. Despite not having specific targets these areas are focused challenges for the Trust to improve and more sophisticated improvement monitoring is being developed.
- **Record of Capacity/CTT at point of detention -** off target
- **% of Patients with a safety plan-** Live from 15th April 2024. Reporting may be impacted during the transition across to the biopsychosocial risk framework
- **Bed occupancy –** off target but improved over 24 months.
- **Clinically Ready for Discharge** – off track but has improved over last 3 months.
- **Adult inpatients discharged with LOS >60 days** – Remaining stable over last 3 months
- **Crisis Very Urgent Referrals seen within 4 hours –** At 43.0%, reported as below average for 8th consecutive month.
- **4-week national standard waiting times**
  All measures have a low level of performance
- **% waiting < 4 weeks to Treatment Adult and Older Adult Waits to Treatment** – 30.5% of referrals have been waiting 4 weeks or less to treatment, performance improved in the month.
- **% waiting < 4 weeks to Receive Help - All CYPS** – 10.9% of referrals have been waiting 4 weeks or less to receive help (5638 out of 6324), of which (5,273 out of 5,773) 91.3% are within the neurodevelopmental pathway.

Key focus areas of concern

- **% of Training Compliance**
- **Crisis Very Urgent Referrals seen within 4 hours**
- **% waiting < 4 weeks to Receive Help – All CYPS**
- **Live within our means**

Positive Assurance / Improvement

- **Commitments** – Your voice was launched on 2nd April 2024. Do you feel safe is on target and has improved
- **Prone Restraints** – reduced significantly over the last 24 months.
- **Out of Area Placement Bed Days** – There continues to be no reported inappropriate bed days since December 2023.
- **Crisis % very urgent seen with 24hr -** meeting new internal target of 85%
- **Older Adult inpatients discharged with LOS >90 days** – 7% improvement in the month and reported below standard
- **Psychiatric Liaison seen within ED within 1 hour –** At 80.8% highest performance reported in 24 months and meeting new internal target of 80%
- **Psychiatric Liaison seen within Ward in 24 hours –** Highest performance reported in 24 months at 93.0% and meeting new internal target of 85%
- **Clinical Supervision** – 8% improvement in the month but still significantly off 80% target at 59.9%

Mitigations/actions

- **% of Training Compliance —** The new priorities for training have been established and are reported in the IPR for the first time. The 'all staff' training measures are performing well, however, Clinical prioritised staff training is not meeting most of its targets. The targets are for the quarter and the prioritisation and monitoring process has only begun in the last month. With this prioritisation and focus, these key training areas will improve in the quarter. There is still work on going to get all the prioritised metrics into dashboards and this report, this will be completed for the next IPR.
- **Crisis Very Urgent Referrals seen within 4 hours –** There is a continuing review of initiatives related to crisis services, encompassing the flow of the 136-suite, the implementation of Right Care Right Place (which went live in North Cumbria recently), alternatives to admission, community interface, discharge model/in-reach, and the expansion of Mental Health 111 services. Business Units will also provide progress reports on operational performance and measures for Crisis recovery at the Community Oversight Group. *Recovery plans in place & being reviewed*
- **% waiting less than 4-week All CYPS–** The CYPS waiting percentage for those receiving help with 4 weeks is low, largely due to the high volume of Neurodevelopmental patients waiting, caused by significant increases in referrals. There is a new pathway for neurodevelopmental pathways that has been signed off by the Trust and is being rolled out in a phased approach. Further work with NENC system leaders is taking place to discuss how as a system we improve access and experience of CYPS with a neurodevelopmental need. *Recovery plan in place*
- **Live within our means –** The new Groups/Departments have identified specific areas for review to influence financial performance. BDG monthly finance meetings are convened to determine actions regarding the financial status of the Trust and forecasted positions within each locality for the current year. *Recovery plans being developed for 24/25*

Core Trust Integrated Outcome Measures - Summary Overview

Reporting Period: Apr 2024

	Ref	Indicator Name	Variation	Assurance	Performance	Standard	Plan	Risk Rating	Summary Narrative	Exec
Commitments	C01	How was your experience? (FFT)	Normal Variation	Off target	81.2%	90.0%	Internal	High (Action)	Off target and below average for five months	SR
	C02	How was the care we provided?	SPC N/A	SPC N/A	83.5%	90.0%	Internal	High (Action)	Reported below standard, new question implemented April 2024	SR
	C03	Did you feel safe?	Normal Variation	Achieve at Random	92.8%	90.0%	Internal	Low (On Track)	On target and improved in the month	SR
People	P01	Sickness in Month	Normal Variation	Off target	5.6%	5.0%	National	High (Action)	Improved in the month, NTW Solutions data now removed	LS
	P02	Training Compliance - Priority Training - All Staff	Improvement	Off target	77.8%	100.0%	Internal	High (Action)	Newly prioritised training metrics - excludes NTW Solutions	LS
	P03	Training Compliance - Priority Training - Clinical Staff	Concern	Off target	22.2%	100.0%	Internal	High (Action)	Newly prioritised training metrics - excludes NTW Solutions	LS
	P04	Appraisal rate	Improvement	Off target	76.0%	85.0%	Internal	High (Action)	Not on target but has improved in the month - excl. NTW Solutions	LS
	P05	% Clinical Supervision completed	Normal Variation	Off target	59.9%	80.0%	Internal	High (Action)	8% point improvement in month, consistently off target	LS
Quality Care	Q01	MRE Restraints	Normal Variation	N/Ap	6	N/Ap	N/Ap	Med (Monitoring)	Improved in the month reported below average	RN
	Q02	Prone Restraints	Improvement	N/Ap	51	N/Ap	N/Ap	Med (Monitoring)	51 reported in April, significant improvement over 24 months	RN
	Q03	Long term segregation and prolonged seclusion	Normal Variation	N/Ap	15	N/Ap	N/Ap	Med (Monitoring)	Deteriorating trend ended with an improvement in month	SR
	Q04	Assaults on Patients	Normal Variation	N/Ap	77	N/Ap	N/Ap	Med (Monitoring)	Last four months above average, improved last two months	RN
	Q05	Assaults on staff	Normal Variation	N/Ap	459	N/Ap	N/Ap	Med (Monitoring)	Deteriorating trend ended with an improvement in month	RN
	Q06	% of patients with a Safety Plan	SPC N/A	N/Ap	76.1%	100.0%	Internal	Med (Monitoring)	Inpatients (76 out of 88), Community (4,391 out of 5,783)	RN
	Q07	Reducing incidents of self-harm	Normal Variation	SPC N/Ap	1,229	N/Ap	N/Ap	Low (No Standard)	Deteriorating trend ended with an improvement in month	RN
	Q08	Rights at Point of Detention	Normal Variation	Achieve at Random	95.2%	100.0%	Internal	Med (Monitoring)	Deteriorated in month and off target	RN
	Q09	Record of Capacity/ CTT at point of detention	Normal Variation	Off target	67.6%	100.0%	Internal	High (Action)	Improved in month and off target	RN
Person Led Care	A01	Out of Area Placement bed days	Improvement	Achieve at Random	0	14	Plan	Low (On Track)	There continues to be no out of area placements since Dec 23	RD
	A02	Bed Occupancy including leave (open beds on RiO)	Improvement	Off target	92.6%	85.0%	National	High (Action)	Improved over last 24 months, except current month	RD
	A03	% Adult inpatients discharged with LOS > 60 days	Normal Variation	Achieve at Random	22.6%	20.0%	Internal	Med (Monitoring)	Remaining stable, reported below average for 3rd consecutive month	RD
	A04	% OP inpatients discharged with LOS > 90 days	Normal Variation	Achieve at Random	38.9%	40.0%	Internal	Low (On Track)	Improved in the month, below average for 1st time in 3 months	RD
	A05	Clinically Ready for Discharge (formerly DTOC)	Normal Variation	Off target	10.0%	7.5%	National	High (Action)	Remains off track but has improved for the 3rd consecutive month	RD
	A06	Crisis % Very urgent seen within 4 hours (WAA&OP)	Concern	Achieve at Random	43.0%	50.0%	Plan	High (Action)	92 out of 214, less than half very urgent patients seen within 4 hours	RD
	A07	Crisis % Urgent seen within 24 hours (WAA&OP)	Normal Variation	Achieve at Random	87.6%	85.0%	Internal	Low (On Track)	375 out of 428. Performance improved in the month	RD
	A08	% PLT ED Referrals seen within 1 hour	Improvement	Off target	80.8%	80.0%	Internal	Med (Monitoring)	Highest reported performance reported for 24 months	RD
	A09	% PLT Ward Referrals seen within 24 hours	Improvement	Achieve at Random	93.0%	85.0%	Internal	Low (On Track)	Highest reported performance reported for 24 months	RD
	A10	% Waiting 4 wks or less to treatment (WAAOP)	Improvement	Off target	30.5%	35.0%	Plan	High (Action)	69.5% (2,479 of 3,568) have been waiting longer than 4 weeks	RD
	A11	% Waiting 4 wks or less to receive help (CYPS)	Normal Variation	Achieve at Random	10.9%	15.0%	Plan	High (Action)	89.1% (5,638 of 6,324) have been waiting longer than 4 weeks	RD
Sustainable	S01	Live within our means (I&E Surplus/Deficit £)	SPC N/A	SPC N/A	-£2.5m	-£2.5m	Plan	High (Action)	The Trust delivered a £2.5m deficit in month 1 £0.1m above the plan	KS
	S02	Income & Expenditure Forecast	SPC N/A	No Standard	£3.9m def	£3.9m def	Plan	Low (No Standard)	The Trust is planning a £3.9m deficit	KS
	S03	All staff WTEs	SPC N/A	SPC N/A	8,765	No Std	N/Ap	Low (No Standard)	WTE numbers have reduced by 20 wte since last month	KS
	S04	Capital spend compared to plan (£k)	SPC N/A	SPC N/A	£0.7m	£1.0m	Plan	Low (No Standard)	Plan to deliver the approved capital programme, £2.4m over CDEL	KS
	S05	Cash balance compared to plan (£)	SPC N/A	SPC N/A	£39m	£39m	Plan	Low (On Track)	The Trust cash balances are slightly less than plan at month 1.	KS

Commitments to our Carers & Patients - Headline Commentary

Headline Challenges

The standards were reviewed in April along with the implementation of the new Trustwide survey 'Your Voice' and have now been set at 90% (previously 95%). The standards will be reviewed once the survey has had time to embed.

- **How was your experience? (FFT) –** Performance was reported at 81.2% for April, this was lower than March 24 (84.2%). The 90% standard has not be met. The latest national published FFT score for England is reported at 86.0% (January 24).

Selected Your Voice questions

- **How was the care provided?** – this is the first month reporting on this question as we moved to a new survey, with Your Voice replacing PoY.

Key focus areas of concern

- **How was your experience? (FFT)**
- **How was the care provided?**

Positive Assurance / Improvement

- **Did you feel safe?** - was on track this month.
- A new experience survey for service users and carers was introduced during April. This was co-developed with stakeholders and should offer better opportunities for people to share their experience with the Trust as the questions reflect the current themes for questions that emerged through the engagement process.
- Service users are now receiving the option to complete the survey by email and text as well as letter. Service users have the autonomy to choose a preferred option or opt out from the survey.

Mitigations/actions

How was your experience? (FFT)

- 19 of 203 respondents said their experience was poor. 8 of these experiences relate to crisis or initial response services, not being listened to or staff being dismissive or rude are most often discussed.
- Specialist services had the highest satisfaction rating of 91% and community services had the lowest score of 79% during April.

How was the care provided?

- 197 people responded to this question, with 162 reporting a good experience of the care provided.
- 17 people or 9% of respondents reported a poor experience. 7 of these experiences are in relation to crisis or initial response services.

Awareness sessions are to be made available for staff to help them understand the new dashboard. This will hopefully support the organisation to being more responsive to the people accessing our services and support higher satisfaction scores going forward.

The new survey launched on 2nd April 2024, levels of feedback were reduced, leading to small numbers of negative experiences having a higher impact on the score than in a normal month.

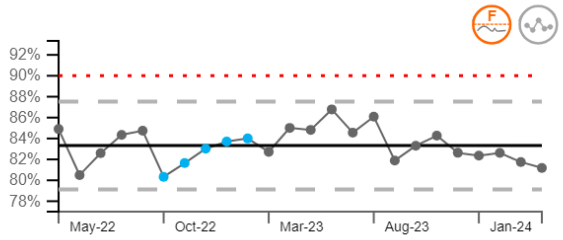
Commitments to our Carers & Patients

Reporting Period: Apr 2024

How was your experience? (FFT)

High (Action)

Ref - C01 Performance - 81.2% Standard - 90.0%



How was the care we provided?

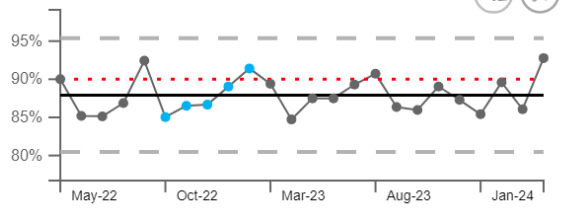
High (Action)

Ref - C02 Performance - 83.5% Standard - 90.0%

Did you feel safe?

Low (On Track)

Ref - C03 Performance - 92.8% Standard - 90.0%



Great Place to Work - Headline Commentary

Headline Challenges

Sickness Absence – The confirmed sickness for March 2024 is reported at 5.6% (excluding NTW Solutions). The provisional sickness for April 2024 is reported at 5.67% remaining above the 5% standard. This now excludes NTW Solutions.

% of Training Compliance (Courses with a standard)

- In March 2024, Priority Training for All Staff is reported at 77.8%.
- Priority Training for Clinical Staff is reported at 22.2%. The reported position for April currently excludes 6 courses that require inclusion, further work is ongoing regarding the addition of these.
- Key challenges remain linked to clinical demand and the ability to release staff to undertake essential training.
- **Clinical Supervision -** performance has improved and is reported at 59.9% compared to March 24 when reported at 51.9%, remaining below Trust 80% standard.
- **Appraisals –** Decreased in the month

Key focus areas of concern

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

Positive Assurance / Improvement

- **Clinical Supervision** – 8% improvement in the month

Mitigations/actions

Sickness Absence

- Analysis of absence in Care Groups to establish themes and trends. Sharing best practice and support mechanisms within new structure.
- Sickness Clinics/sickness meetings continue within the Care Groups monthly, whereby each employee absent for more than 28-days meets with their line manager and Workforce Representative. Short Term absence is monitored, and Review Point Meetings are now well established within groups when staff hit trigger points.
- The Trusts Health and Wellbeing offer continues to be promoted. Our new Occupational Health provider Optima commenced on 1st April 2024.

% of Training Compliance (Courses with a standard)

- The new priorities for training have been established and are reported in the IPR for the first time. The 'all staff' training measures are performing well, however, Clinical prioritised staff training is not meeting most of its targets. The targets are for the quarter and the prioritisation and monitoring process has only begun in the last month. With this prioritisation and focus, these key training areas will improve in the quarter. This data requires further work to add in six courses to the dashboards for reporting purposes.

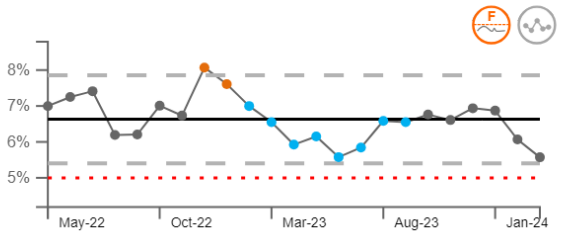
Great Place to Work

Reporting Period: Apr 2024

Sickness in Month

High (Action)

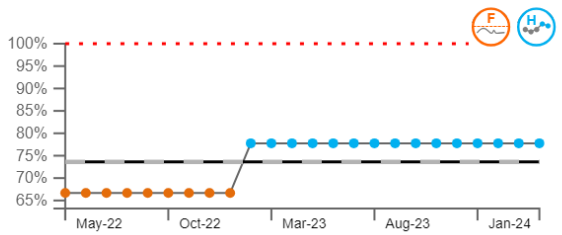
Ref - P01 Performance - 5.6% Standard - 5.0%



Training Compliance - Priority Training - All Staff

High (Action)

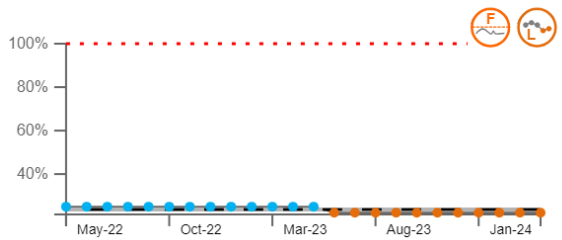
Ref - P02 Performance - 77.8% Standard - 100.0%



Training Compliance - Priority Training - Clinical Staff

High (Action)

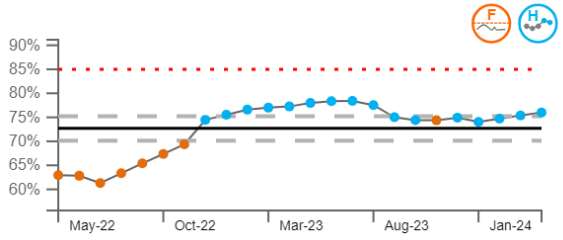
Ref - P03 Performance - 22.2% Standard - 100.0%



Appraisal rate

High (Action)

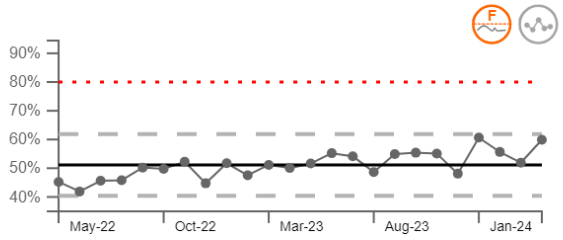
Ref - P04 Performance - 76.0% Standard - 85.0%



% Clinical Supervision completed

High (Action)

Ref - P05 Performance - 59.9% Standard - 80.0%



Quality Care, Everyday - Headline Commentary

Reporting Period: Apr 2024

Headline Challenges

- A range of new Quality measures on **Restraint, Seclusion and assaults on staff and patients** have been added to the IPR for 24/25. Despite not having specific targets these areas are focused challenges for the Trust to improve and more sophisticated improvement monitoring is being developed.

- **% of Patients with a safety plan -** Live from 15th April 2024. Reporting may be impacted during the transition across to the biopsychosocial risk framework
- **Reducing Incidents of self-harm** – is close to target and showing signs of improvement but has consistently not met the target.
- **Rights at Point of Detention** – is consistently off target by 25%

Key focus areas of concern

- **Record of Capacity/CTT at point of detention**
- **% of Patients with a safety plan**

Positive Assurance / Improvement

- **MRE Restraint** - Decreased for the 2nd consecutive month
- **Prone Restraints** – Have reduced at a statistically significantly over the last 24 months.

Mitigations/actions

Record of Capacity/CTT at point of detention

- Following the Mental Health Legislation Steering Group (MHLSG) on 25 April a working group was formed to review the local form to look at any barriers in the completion of the form and to remove those barriers.
- The MHLSG has recommended that an audit on the consent to treatment provisions within the Act is carried out in 2024/2025 by internal audit.

% of Patients with a safety plan

- The new risk framework form went live on 15th April 2024. Metrics have been developed and are live on dashboards to assure delivery and compliance with quality standards.

Staff and patient assaults

- One of the PSIRF priorities for the year is prevention and management of violence and aggression. A separate sub group is being established to co-ordinate this work across inpatient services.

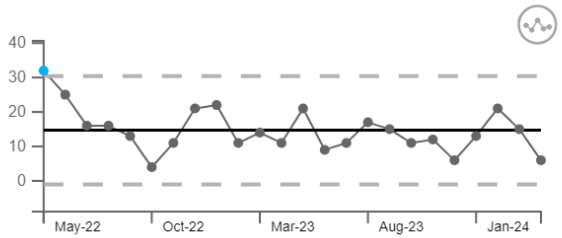
Quality Care, Everyday

Reporting Period: Apr 2024

MRE Restraints

Med (Monitoring)

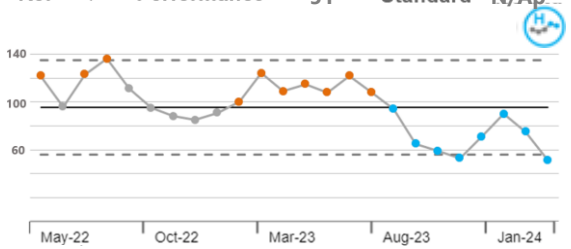
Ref - Q01 Performance - 6 Standard - N/Ap



Prone Restraints

Med (Monitoring)

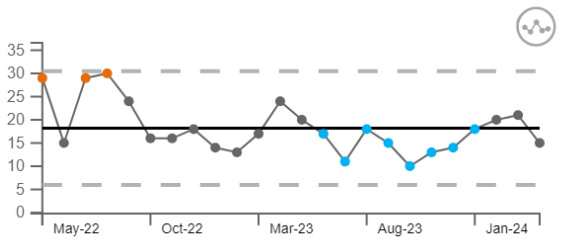
Ref - Q02 Performance - 51 Standard - N/Ap



Long term segregation and prolonged seclusion

Med (Monitoring)

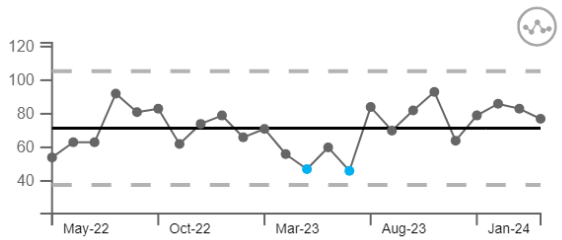
Ref - Q03 Performance - 15 Standard -N/Ap



Assaults on Patients

Med (Monitoring)

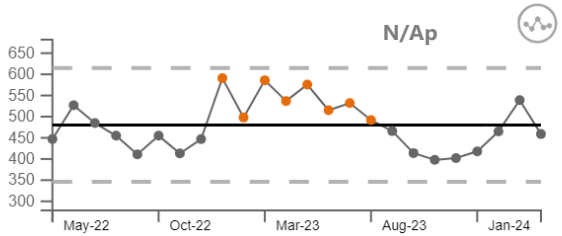
Ref - Q04 Performance - 77 Standard - N/Ap



Assaults on staff

Med (Monitoring)

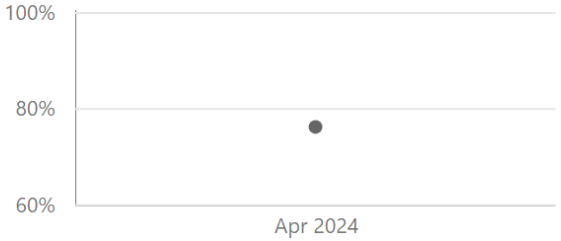
Ref - Q05 Performance - 459 Standard - N/Ap



% of patients with a Safety Plan

Med (Monitoring)

Ref - Q06 Performance - 76.1% Standard - 100.0%

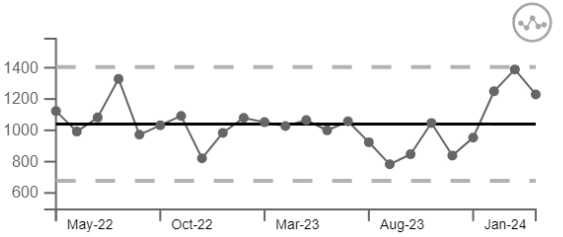


N/Ap

Reducing incidents of self-harm

Low (No Standard)

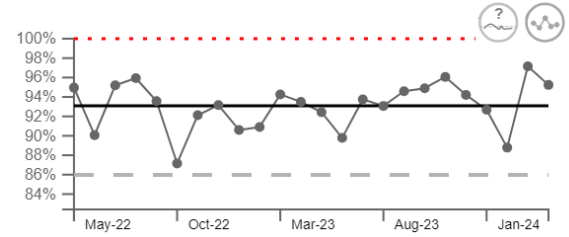
Ref - Q07 Performance - 1,229 Standard - N/Ap



Rights at Point of Detention

Med (Monitoring)

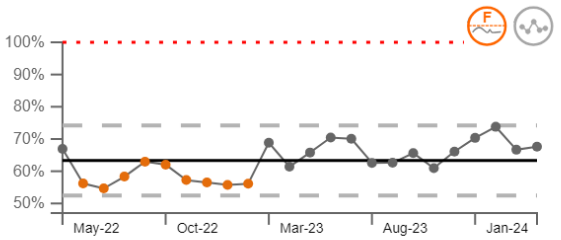
Ref - Q08 Performance - 95.2% Standard - 100.0%



Record of Capacity/ CTT at point of detention

High (Action)

Ref - Q09 Performance - 67.6% Standard - 100.0%



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

Headline Challenges

- **Bed occupancy –** remains high but has improved over 24 months.
- **Clinically Ready for Discharge** – off track but has improved over last 3 months.
- **Adult inpatients discharged with LOS >60 days** – Remaining stable over last 3 months
- **Crisis Very Urgent Referrals seen within 4 hours –** At 43.0%, reported as below average for 8th consecutive month.
- **4-week national standard waiting times**
  All measures have a low level of performance
- **% waiting < 4 weeks to Treatment Adult and Older Adult Waits to Treatment** – 30.5% of referrals have been waiting 4 weeks or less to treatment, performance improved in the month.
- **% waiting < 4 weeks to Receive Help - All CYPS** – 10.9% of referrals have been waiting 4 weeks or less to receive help (5638 out of 6324), of which (5,273 out of 5,773) 91.3% are within the neurodevelopmental pathway.

Key focus areas of concern

- **Crisis Very Urgent Referrals seen within 4 hours**
- **% waiting < 4 weeks to Receive Help – All CYPS**

Positive Assurance / Improvement

- **Out of Area Placement Bed Days** – There continues to be no reported inappropriate bed days since December 2023.
- **Crisis % very urgent seen with 24hr -** meeting's new internal target of 85%
- **Older Adult inpatients discharged with LOS >90 days** – 7% improvement in the month and reported below standard
- **Psychiatric Liaison seen within ED within 1 hour –** At 80.8% highest performance reported in 24 months and meeting new internal target of 80%
- **Psychiatric Liaison seen within Ward in 24 hours –** Highest performance reported in 24 months at 93.0% and meeting new internal target of 85%

Mitigations/actions

- **Crisis Very Urgent Referrals seen within 4 hours –** There is a continuing review of initiatives related to crisis services, encompassing the flow of the 136-suite, the implementation of Right Care Right Place (which went live in North Cumbria recently), alternatives to admission, community interface, discharge model/in-reach, and the expansion of Mental Health 111 services. Business Units will also provide progress reports on operational performance and measures for Crisis recovery at the Community Oversight Group. *Recovery plans in place & being reviewed*
- **% waiting less than 4-week All CYPS–** The CYPS waiting percentage for those receiving help with 4 weeks is low, largely due to the high volume of Neurodevelopmental patients waiting, caused by significant increases in referrals. There is a new pathway for neurodevelopmental pathways that has been signed off by the Trust and is being rolled out in a phased approach. Further work with NENC system leaders is taking place to discuss how as a system we improve access and experience of CYPS with a neurodevelopmental need. *Recovery plan in place*

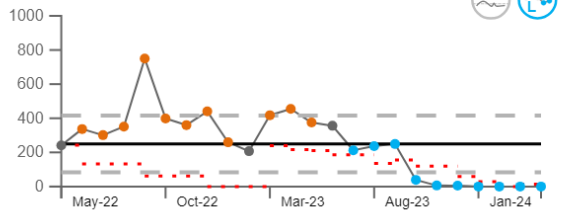
Person Led Care, when and where it's needed

Reporting Period: Apr 2024

Out of Area Placement bed days

Low (On Track)

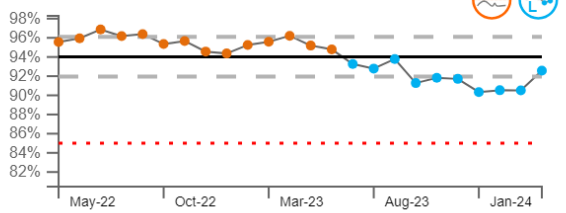
Ref - A01 Performance - 0 Standard - 14



Bed Occupancy including leave (open beds on RiO)

High (Action)

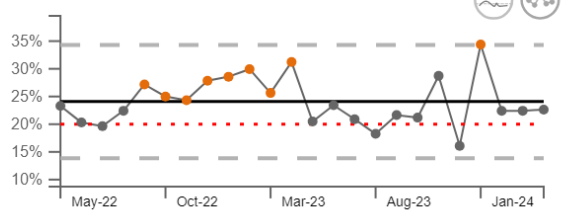
Ref - A02 Performance - 92.6% Standard - 85.0%



% Adult inpatients discharged with LOS > 60 days

Med (Monitoring)

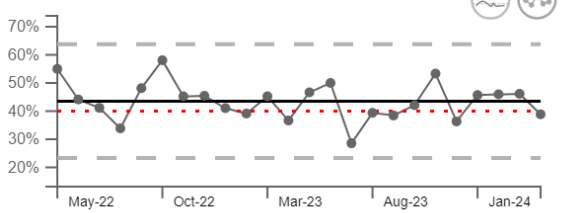
Ref - A03 Performance - 22.6% Standard - 20.0%



% OP inpatients discharged with LOS > 90 days

Low (On Track)

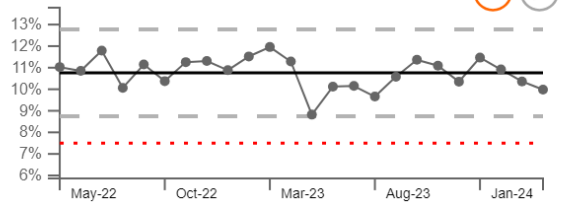
Ref - A04 Performance - 38.9% Standard - 40.0%



Clinically Ready for Discharge (formerly DTOC)

High (Action)

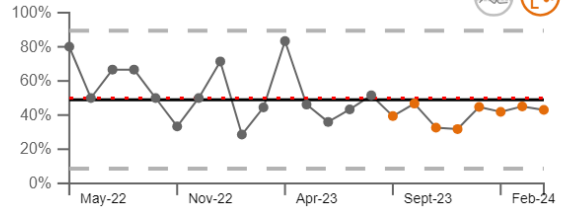
Ref - A05 Performance - 10.0% Standard - 7.5%



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

High (Action)

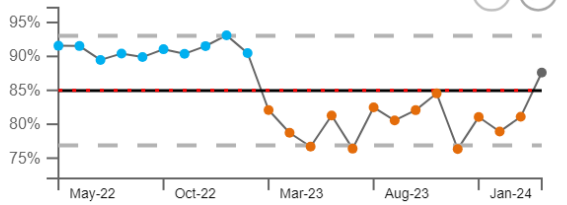
Ref - A06 Performance - 43.0% Standard - 50.0%



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

Low (On Track)

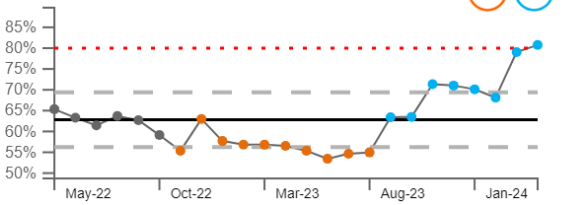
Ref - A07 Performance - 87.6% Standard - 85.0%



% PLT ED Referrals seen within 1 hour

Med (Monitoring)

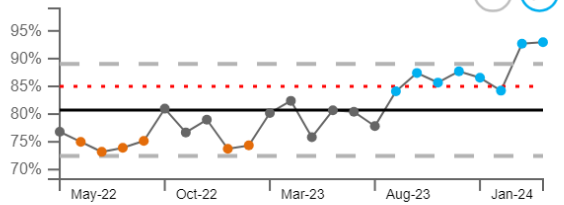
Ref - A08 Performance - 80.8% Standard - 80.0%



% PLT Ward Referrals seen within 24 hours

Low (On Track)

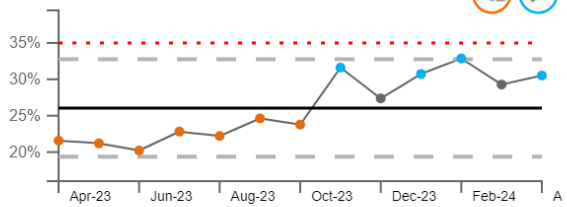
Ref - A09 Performance - 93.0% Standard - 85.0%



% Waiting 4 wks or less to treatment (WAAOP)

High (Action)

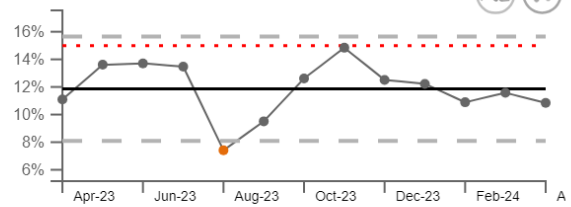
Ref - A10 Performance - 30.5% Standard - 35.0%



% Waiting 4 wks or less to receive help (CYPS)

High (Action)

Ref - A11 Performance - 10.9% Standard - 15.0%



Sustainable for the Long Term - Headline Commentary

Headline Challenges

- At month 1 the Trust is generating a £2.5m deficit.
- This deficit is in line with the financial plan at Month 1. This plan is phased to deliver deficits in the first 9 months of the year and surpluses for the last quarter of the year.
- At the end of Month 1 the Trust has spent £0.9m on agency staff against a plan £0.9m.
- Expenditure on the Trust capital programme is forecast to be £2.4m higher than the plan. The Trust submitted a plan compliant with the CDEL limit allocated to the Trust as requested by the ICB. The trust planned delivery will breach the CDEL limit.
- The Trust has a cash balance of £38.6m at the end of Month 1 which is behind the plan. Trust balances are planned to fall significantly through the year.

Key focus areas of concern

- The Trust is developing detailed plans to deliver the efficiency programme submitted as part of the annual plan.

Positive Assurance / Improvement

- The Trust has reported a reduction of 20 wte from last month. The Trust workforce plan includes a reduction of over 450 wte from April to March. To deliver the financial plan the Trust must manage a significant reduction in the overall wte used.

Mitigations/actions

- BDG monthly finance focus sessions to agree actions to impact on the Trust financial position and review of progress to deliver the Trust efficiency plans.
- BDG monthly finance will focus time on plans for longer term financial sustainability. The Trust will agree trajectories for service to plan to deliver costs in line with the contracted income by 2027.
- Groups / Departments highlighted areas under review to impact on financial performance. BDG discussions to clarify where they improve financial forecast.
- Daily staffing reviews taking place across inpatient areas.
- Ongoing discussions with the ICB re the pressure on the Trust CDEL for 2024/25. Based on the current programme the Trust will breach the allocated limit. The Trust is seeking slippage to increase the CNTW limit for this year.
- Weekly meeting to review and maximise the Trust cash balances.

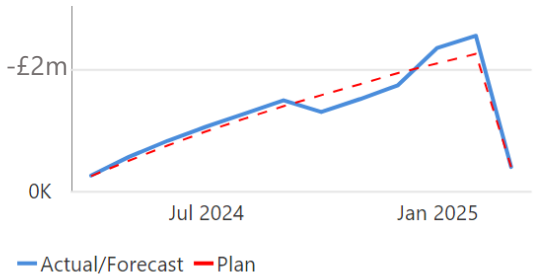
Sustainable for the Long Term

Reporting Period: Apr 2024

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

High (Action)

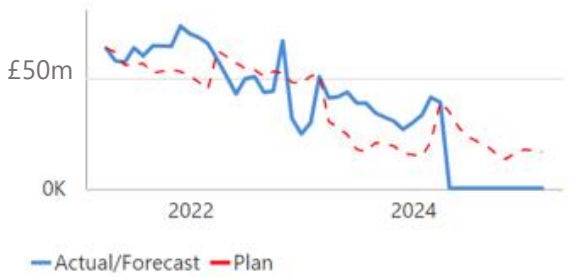
Ref - S01 Actual/Forecast - -£2.5m Plan - -£2.5m



Cash balance compared to plan (£)

Low (On Track)

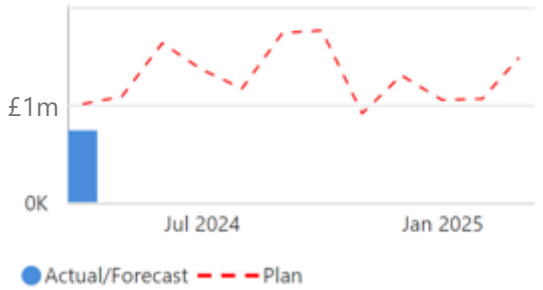
Ref - S05 Actual/Forecast - £39m Plan - £39m



Capital spend compared to plan (£k)

Low (No Standard)

Ref - S04 Actual/Forecast - £0.7m Plan - £1.0m



C01 - How was your experience? (FFT)

Risk Rating - High (Action)

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

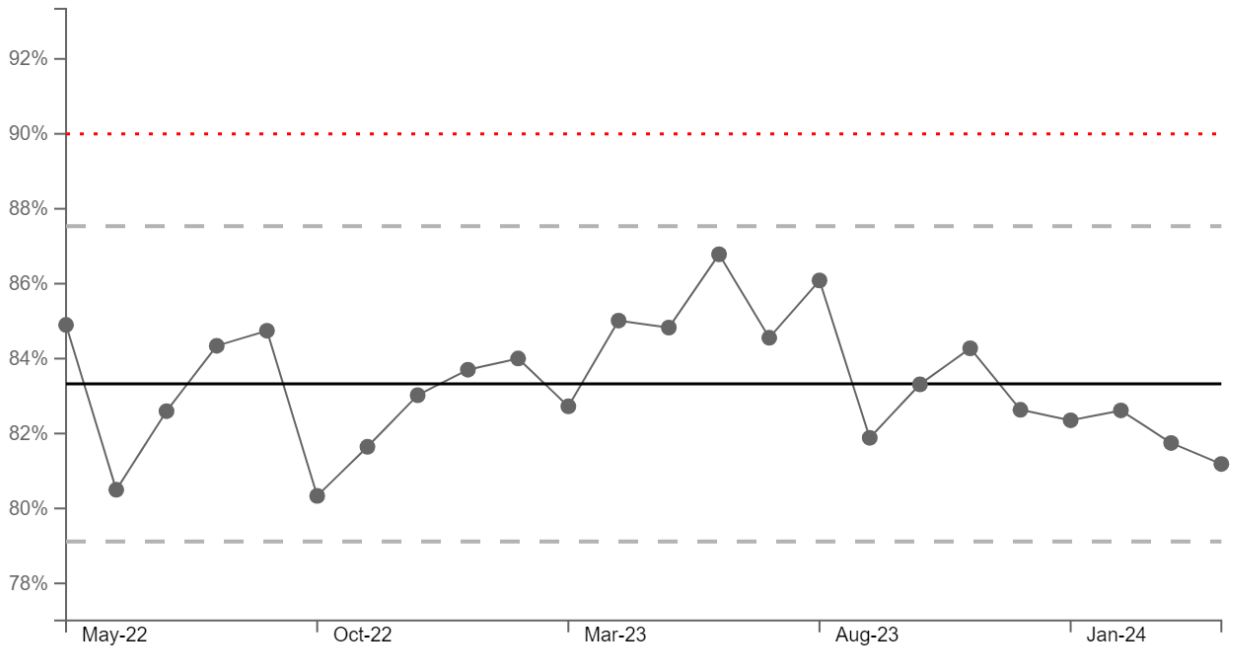
Performance - 81.2%

Standard - 90.0%

Consistently Off target
The standard for this indicator is outside the control limits

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

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



Care Group	Performance	Standard	Variation	Assurance
Community Care Group	75.4%	90.0%		
Inpatient Care Group	88.6%	90.0%		
Specialist Care Group	88.7%	90.0%		

Feedback

What the chart tells us

Performance of 81.2% for April was within the expected range of 81.2% to 89% and remains below the standard of 90%.

Root Cause of the performance issue

19 people reported their experience as being poor (6) or very poor (13) during April.

Specialist services had the highest satisfaction rating of 88.7% and community services had the lowest score of 75.4% during April.

Improvement Actions

Numbers of poor experiences were smaller than in previous months, due to lower levels of feedback being offered overall as a new survey was introduced this months.

A new dashboard is being developed and is already available to all staff. This includes tutorial films and user tips to support understanding of functionality, to support staff to get the best from the experiences offered by service users and carers. Staff should be supported to explore this dashboard and be responsive to themes as they emerge.

Expected impact and by when

The new Trustwide survey 'Your Voice' was launched on 2nd April 2024. The survey will require time to embed therefore we expect to see an increase by Quarter 2

C02 - How was the care we provided?

How was the care we provided?

Risk Rating - High (Action)

Performance - 83.5%

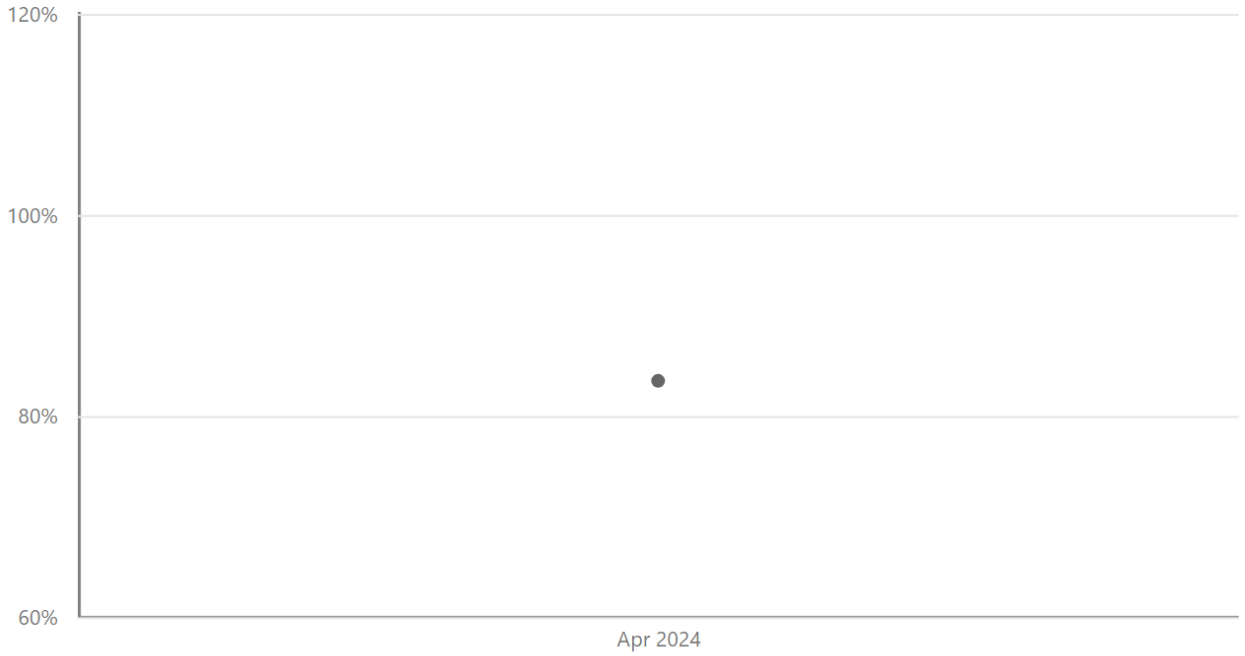
Standard - 90.0%

Not Applicable

Not Applicable

DQ - No Concern

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



Care Group	Performance	Standard	Variation	Assurance
Community Care Group	78.7%	90.0%		
Inpatient Care Group	88.2%	90.0%		
Specialist Care Group	90.4%	90.0%		

Feedback

What the chart tells us

Performance of 83.5% for April was below the standard of 90%

Root Cause of the performance issue

197 people responded to this question, with 162 reporting a good experience of the care provided.

17 people or 9% of respondents reported a poor experience. 7 of these experiences relate to crisis or initial response teams. However, no themes are evident due to the small numbers of associated comments.

Improvement Actions

This continues to be the best performing question for the Trust. Our staff can be considered our best asset for positive experiences of service users and carers.

Expected impact and by when

Ongoing

P01 - Sickness in Month

Percentage of in month sickness absence

Risk Rating - High (Action)

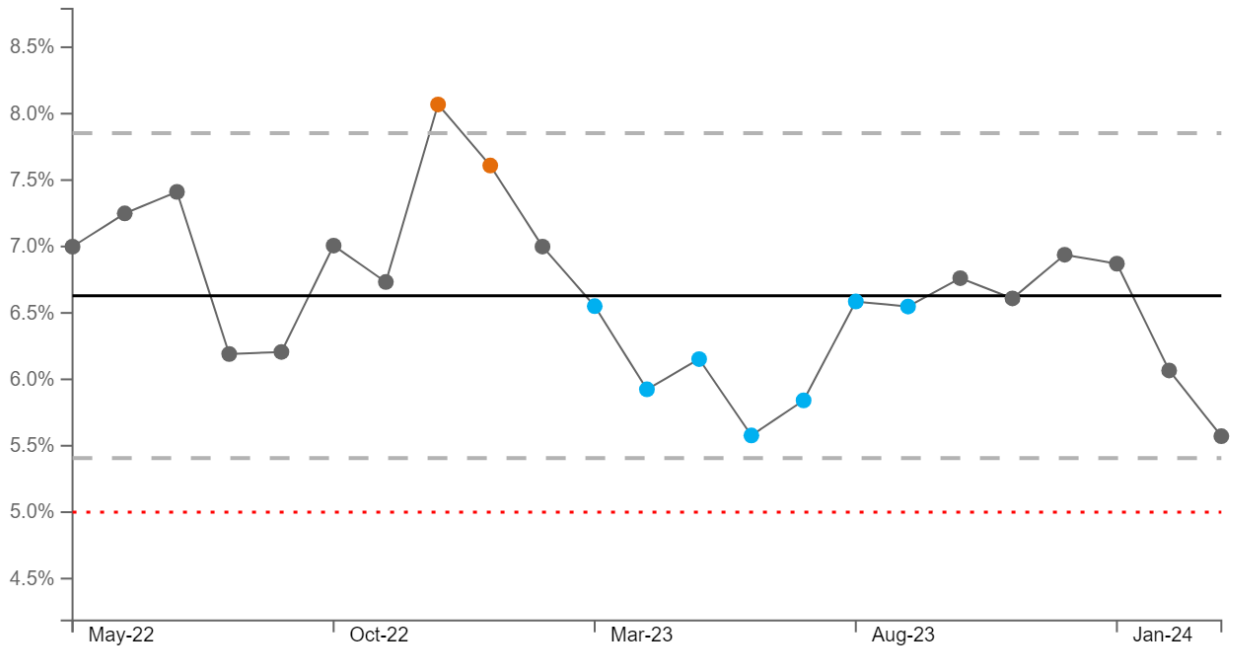
Performance - 5.6%

Standard - 5.0%

Consistently Off target
The standard for this indicator is outside the control limits

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

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



Care Group	Performance	Standard	Variation	Assurance
Community Care Group	5.7%	5.0%	Normal Variation	Consistently Fail
Inpatient Care Group	6.4%	5.0%	Improvement	Consistently Fail
Specialist Care Group	6.4%	5.0%	Normal Variation	Consistently Fail
Support & Corporate	2.7%	5.0%	Normal Variation	Consistently Achieve

Feedback

What the chart tells us

The chart shows the confirmed sickness for March 2024 which is reported at 5.6% (excludes NTW Solutions). The provisional sickness for April 2024 is reported at 5.67% remaining above the 5% standard but improving. Without change the standard will not be met.

Root Cause of the performance issue

- Complex home life stressors, caring responsibilities, bereavements.
- Impact of Employee Relations processes – e.g. suspensions and investigations.
- High levels of clinical activity and use of PMVA within working environment,
- Increased demand on Staff Psychological Centre (SPC), delays impacting people staying well at work or being able to return to work.

Improvement Actions

- Continue with robust absent management and people practice processes.
- Promote and continue to implement the health and wellbeing offer.
- Consider and implement reasonable adjustments and flexibility where possible.
- Analysis of absence in new Care Groups to establish themes and trends. Sharing best practice and support mechanisms.
- Groups considering OD interventions and the value of time out. Team Development sessions supporting health and wellbeing.
- Targeted cultural awareness work with support of EDI Lead and Cultural Allies (Mitford).
- Increase attendance by supporting employees to return or remain in work with any adjustments they may require.
- Focus on reducing long term ER cases.

Expected impact and by when

- Predicted absence reduction as previous year trends.

P02 - Training Compliance - Priority Training - All Staff

Training Compliance - Priority Training - All Staff

Risk Rating - High (Action)

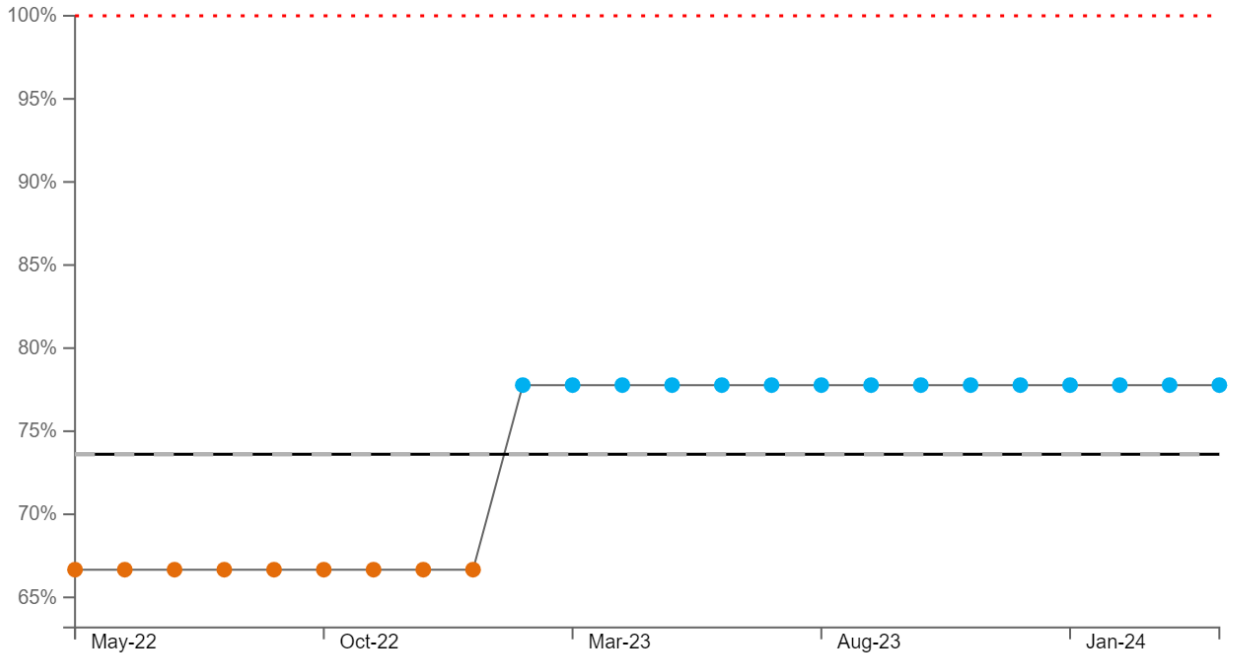
Performance - 77.8%

Standard - 100.0%

Consistently Off target
The standard for this indicator is outside the control limits

Improvement
This indicator is increasing which shows improvement

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



Care Group	Performance	Standard	Variation	Assurance
Other Care Group	77.8%	100.0%	Improvement	Consistently Fail

Feedback

What the chart tells us

Training Compliance for all staff is reported at 77.8% for April 2024. Without change the standard will not be met.

Root Cause of the performance issue

- Capacity to release staff for training
- Late cancellations due to clinical activity
- Cancellation of courses due to trainer availability

Improvement Actions

- Priority training has been agreed within a Training Performance Framework. Includes 53 Corporate and Operational courses with training standards.
- Training working group established to ensure remains organisational focus.
- Continue to improve data quality of needs analysis and who has been trained and not recorded.
- Manage demand and capacity – review offer for all courses and trainers
- Bespoke session planned regarding PMVA within Inpatient Care Group Realign CBU level training trajectory plan following approval of Framework and formation for new Care Groups.
- Ensure return to work plans from absence periods are inclusive of any training compliance needs.
- Focus on ensuring IG training is at 95% standard by the end of the financial year

Expected impact and by when

Increase in training compliance in line with set trajectories.

P03 - Training Compliance - Priority Training - Clinical Staff

Risk Rating - **High (Action)**

Training Compliance - Priority Training - Clinical Staff

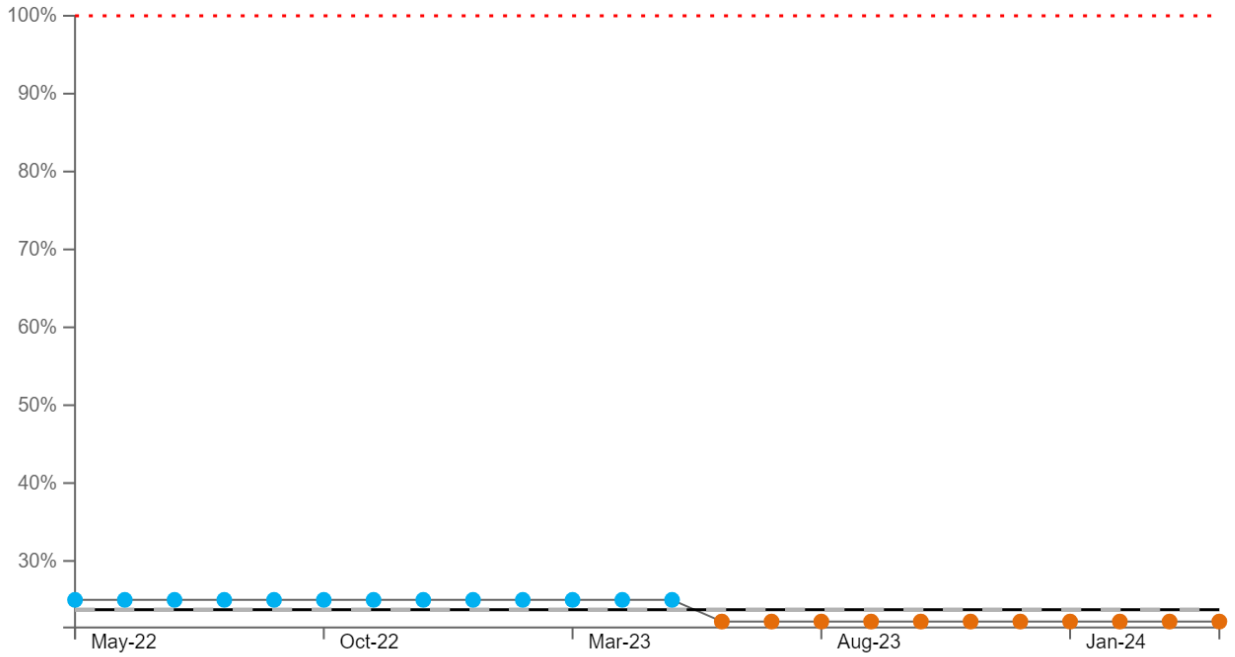
Performance - 22.2%

Standard - 100.0%

Consistently Off target
The standard for this indicator is outside the control limits

Concern
There is concern because this indicator is decreasing

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



Care Group	Performance	Standard		Variation		Assurance
Other Care Group	22.2%	100.0%		Concern		Consistently Fail

Feedback

What the chart tells us

Priority Training Compliance for clinical staff is reported at 22.2% for April 2024. Further work is required on the training data as this percentage currently excludes a number of identified courses.

Root Cause of the performance issue

- Capacity to release staff for training
- Late cancellations due to clinical activity
- Cancellation of courses due to trainer availability

Improvement Actions

- Priority training has been agreed within a Training Performance Framework. Includes 53 Corporate and Operational courses with training standards Training working group established to ensure remains organisational focus.
- Continue to improve data quality of needs analysis and who has been trained and not recorded.
- Manage demand and capacity – review offer for all courses and trainers e.g. PMVA to improve compliance.
- Realign CBU level training trajectory plan following approval of Framework and formation for new Care Groups.
- Ensure return to work plans from absence periods are inclusive of any training compliance needs.
- Focus on ensuring IG training is at 95% standard by the end of the financial year

Expected impact and by when

Increase in training compliance in line with set trajectories. Inclusion of remaining six courses.

Great Place to Work - Training

Corporate Training - All Staff

Ref	Indicator Name	Variation	Assurance	Performance	Standard	Numerator	Denominator	Plan	Risk Rating
TA01	Training - Information Governance	Improvement	Consistently Fail	92.0%	95.0%	8447	9182	Internal	Med (Monitoring)
TA03	Training - Local Induction (Once)	Improvement	Consistently Fail	84.1%	87.0%	7700	9154	Internal	Med (Monitoring)
TA04	Training - Safeguarding Adults Level 1	Improvement	Consistently Achieve	96.3%	85.0%	1629	1692	Internal	Low (On Track)
TA05	Training - Safeguarding Children Level 1	Improvement	Consistently Achieve	95.6%	85.0%	1618	1692	Internal	Low (On Track)
TA06	Training - Fire	Improvement	Achieve at Random	89.0%	85.0%	8168	9182	Internal	Low (On Track)
TA07	Training - Equality & Diversity Introduction	Improvement	Consistently Achieve	95.1%	85.0%	8734	9182	Internal	Low (On Track)
TA08	Training - Health & Safety	Improvement	Consistently Achieve	94.3%	85.0%	8658	9182	Internal	Low (On Track)
TA09	Training - IPC	Improvement	Consistently Achieve	92.4%	85.0%	8482	9182	Internal	Low (On Track)
TA10	Training - Moving & Handling Awareness Training	Improvement	Consistently Achieve	93.5%	85.0%	8588	9182	Internal	Low (On Track)

NB: PSIRF, Corporate Governance and Risk Management Training to be added for the next IPR. Local induction is a trajectory of 87% for Q1, the standard to be met for Q4 is 95%

Operational Staff Training

Ref	Indicator Name	Variation	Assurance	Performance	Trajectory	Numerator	Denominator	Plan	Risk Rating
TC01	Training - Clinical Risk and Suicide Prevention	Normal Variation	Achieve at Random	75.2%	76.0%	2361	3138	Internal	Med (Monitoring)
TC03	Training Resuscitation L2 Adult Basic Life Support	Improvement	Consistently Fail	72.9%	73.0%	1285	1762	Internal	Med (Monitoring)
TC04	Training Resuscitation L3 Adult Immediate Life Supp	Improvement	Consistently Fail	62.1%	64.0%	2242	3610	Internal	Med (Monitoring)
TC05	Training Resuscitation L3 Paediatric Immed Life Supp	Improvement	Consistently Fail	9.9%	24.0%	30	304	Internal	High (Action)
TC06	Training Resuscitation L2 Paediatric Basic Life Supp	Improvement	Consistently Fail	66.1%	65.0%	397	601	Internal	Med (Monitoring)
TC07	Training - PMVA Basic	Improvement	Consistently Fail	67.7%	68.0%	1789	2642	Internal	Med (Monitoring)
TC09	Training - Engagement & Observation (3 years)	SPC N/A		78.5%	78.0%	2643	3365	Internal	Low (On Track)

NB: Dysphagia Awareness and Risk Tool training to be added for the next IPR. These all have Standards of 85% but trajectories to achieve this over the course of the year

P04 - Appraisal rate

Appraisal rate

Risk Rating - **High (Action)**

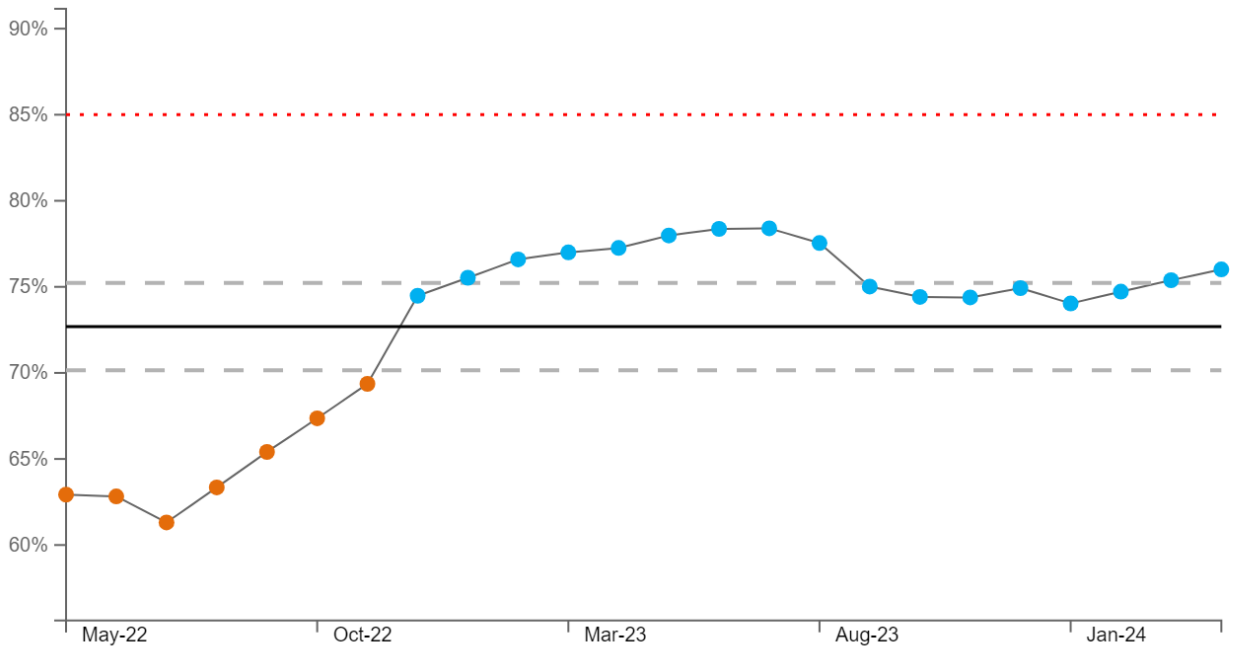
Performance - 76.0%

Standard - 85.0%

Consistently Off target
The standard for this indicator is outside the control limits

Improvement
This indicator is increasing which shows improvement

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



Care Group	Performance	Standard	Variation	Assurance
Community Care Group	79.6%	85.0%	Improvement	Consistently Fail
Inpatient Care Group	74.9%	85.0%	Improvement	Consistently Fail
Specialist Care Group	74.9%	85.0%	Normal Variation	Consistently Fail
Support & Corporate	68.8%	85.0%	Improvement	Consistently Fail

Feedback

What the chart tells us

The reported appraisal rate for April is 76.0% (now excludes NTW Solutions), the seventeenth consecutive month reported higher than the mean average, though it remains below the 85% standard. Without change the standard will not be met.

Root Cause of the performance issue

- Capacity to prepare and undertake appraisal
- Late cancellations due to clinical capacity
- Pressure around other training compliance

Improvement Actions

- Promotion through CBU meetings and Workforce Triage; discuss capacity and appropriate support, delegation where appropriate, forward planning.
- Working towards embedding and promotion of regular appraisal / supervision discussion, ensuing value within discussions.
- Proactively booking appraisals and setting protected time.
- Informing career and talent conversations, leading to development and investment in sustainability of workforce.
- Meaningful discussions with staff.
- A full review of the Appraisal process and documentation is underway to align to the delivery of ESR project timescales.

Expected impact and by when

- Increase in appraisal compliance in line with set trajectories over 24/25.

P05 - % Clinical Supervision completed

Clinical Supervision

Risk Rating - **High (Action)**

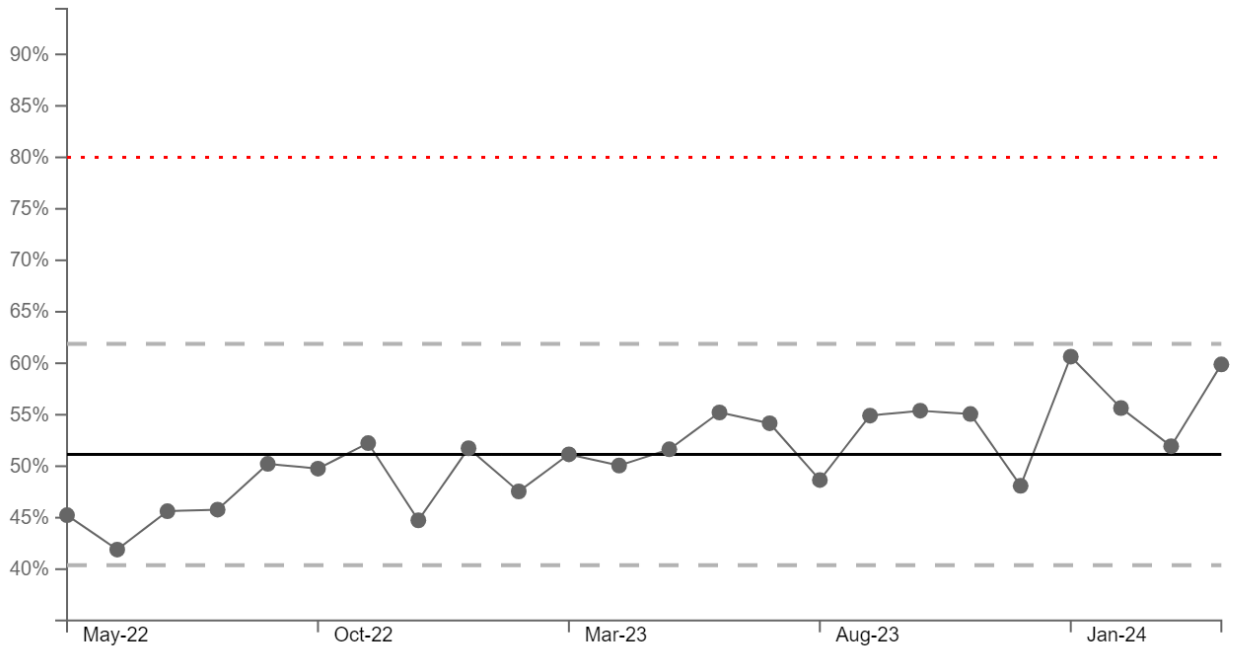
Performance - 59.9%

Standard - 80.0%

Consistently Off target
The standard for this indicator is outside the control limits

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

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



Care Group	Performance	Standard	Variation	Assurance
Community Care Group	68.4%	80.0%	Normal Variation	Consistently Fail
Inpatient Care Group	52.5%	80.0%	Normal Variation	Consistently Fail
Other Care Group	22.6%	80.0%	Concern	Consistently Fail
Specialist Care Group	58.8%	80.0%	Normal Variation	Consistently Fail
Support & Corporate	60.8%	80.0%	Normal Variation	Consistently Fail

Feedback

What the chart tells us

Performance of 59.9% in April is within the expected range but remaining well below the 80% standard. Without change the standard will not be met.

Root Cause of the performance issue

- Capacity to release staff to undertake supervision
- Late cancellations due to clinical capacity
- Recording of supervision taking place doesn't happen in the electronic system

Improvement Actions

- Supervision rate monitored through local Clinical Management Teams, Quality Standards and Oversight meetings within CBU's.
- Setting expectations with CBU leadership team.
- Establishing and escalating any recording and data issues.
- Forward planning - supervision to be pre-booked in advance to ensure that it remains a priority.
- Live supervision to be recorded appropriately.

Expected impact and by when

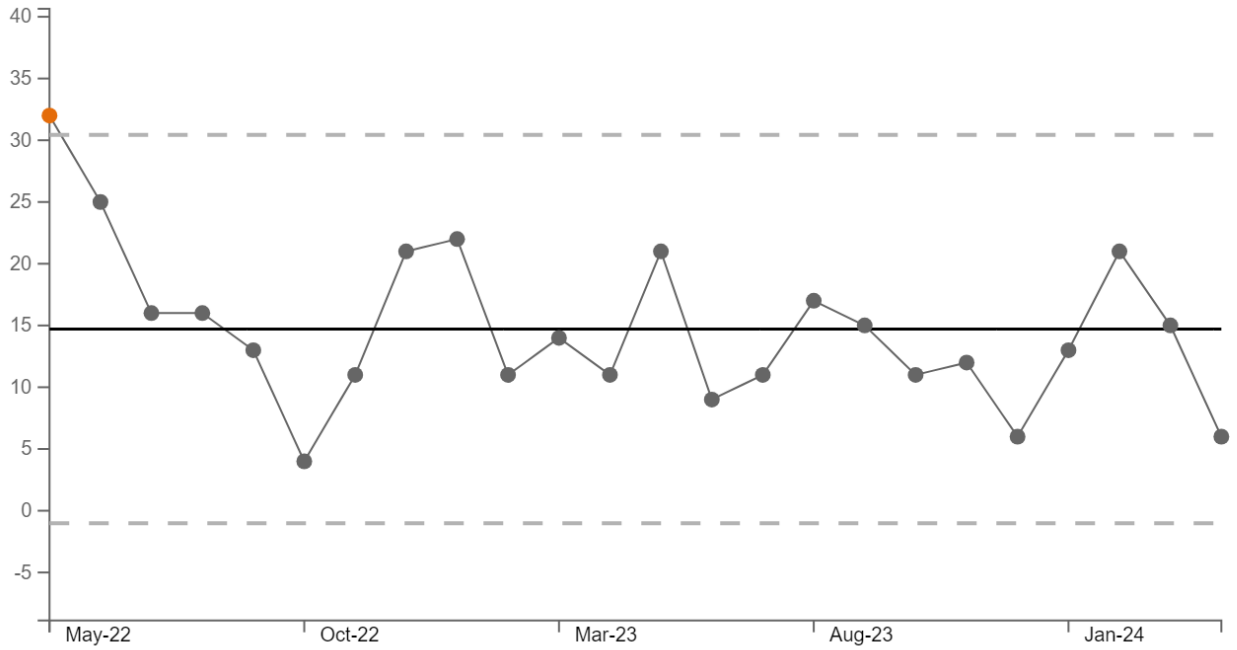
- Increase in appraisal compliance in line with set trajectories over 24/25.

Q01 - MRE Restraints

Number of MRE Restraints

Risk Rating - Med (Monitoring)

Performance - 6	N/Ap	Normal Variation	DQ - No Concern
Standard N/Ap	Assurance cannot be given for this indicator as there is no standard set	The variation for this indicator is within the control limits	There are currently no concerns with the data quality of this indicator



Care Group	Performance	Standard	Variation	Assurance
Inpatient Care Group	1	No Std	Normal Variation	No Standard
Specialist Care Group	5	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

There were 6 MRE restraints reported in April 2024.

Root Cause of the performance issue

- MRE restraint is required when a patient is at very high to themselves or others. This is usually during transfer to and acute hospital for emergency care. It can be dignified if used appropriately, but the aim is to only use it when necessary.

Improvement Actions

- Focussed workshops have taken place within CYPS and LDA pathways , groups have produced action plans which are in place
- Work will be ongoing to ensure MRE use continues to reduce whilst maintain patient and staff safety.
- Following the workshop it was agreed that MRE restraint would only be used for transfer to acute hospital in circumstances that were absolutely necessary and following sign off.

Expected impact and by when

Continued reduction

Q02 - Prone Restraints

Number of Prone Restraints

Risk Rating - Med (Monitoring)

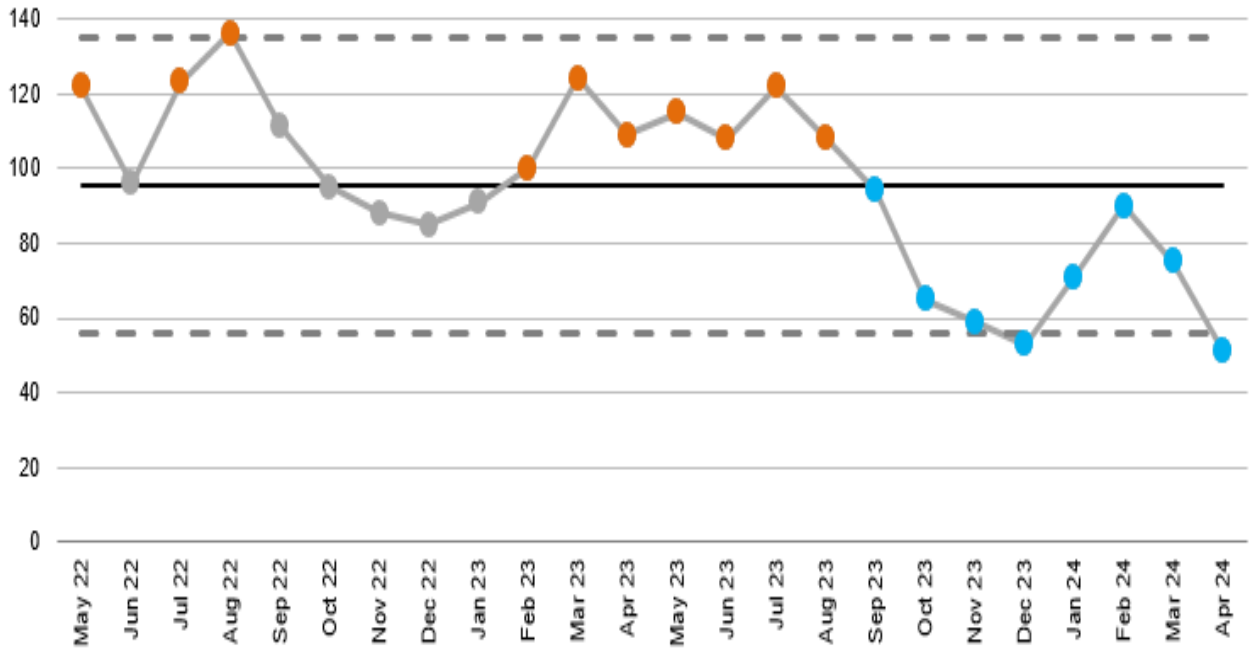
Performance - 51

Standard N/Ap

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

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

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



A breakdown of the reporting for the IPR is being developed

Feedback

What the chart tells us

There were 51 Prone restraints reported in April and there has been a statistically significant reduction in the use of prone restraint.

Root Cause of the performance issue

- Within the Inpatient Care Group, the Older Peoples pathway accounted for the highest number of restraints in the period (47% of all incidents). There is one outlier Older Peoples ward which accounted for 42% of all OP restraints (of which one patient account for 82% of the wards restraint incidents - this reflects the complexity of the patient's diagnosis and the need to support their hygiene and care multiple times per day).

Improvement Actions

- Increased emphasis on safer alternatives to prone restraint have been maintained across both the Positive and Safe Team and PMVA tutors
- Mitford has started to reduce prone restraint within that unit due to focussed work
- The Trust has maintained a significant downward trend in the use of prone restraint across 23-24(excluding Mitford)

Expected impact and by when

Continued reduction will be monitored

Q03 - Long term segregation and prolonged seclusion

Risk Rating - Med (Monitoring)

Long term segregation and prolonged seclusion of 48 hours or longer calculated at the end of the seclusion

Performance - 15

Standard N/Ap

N/Ap

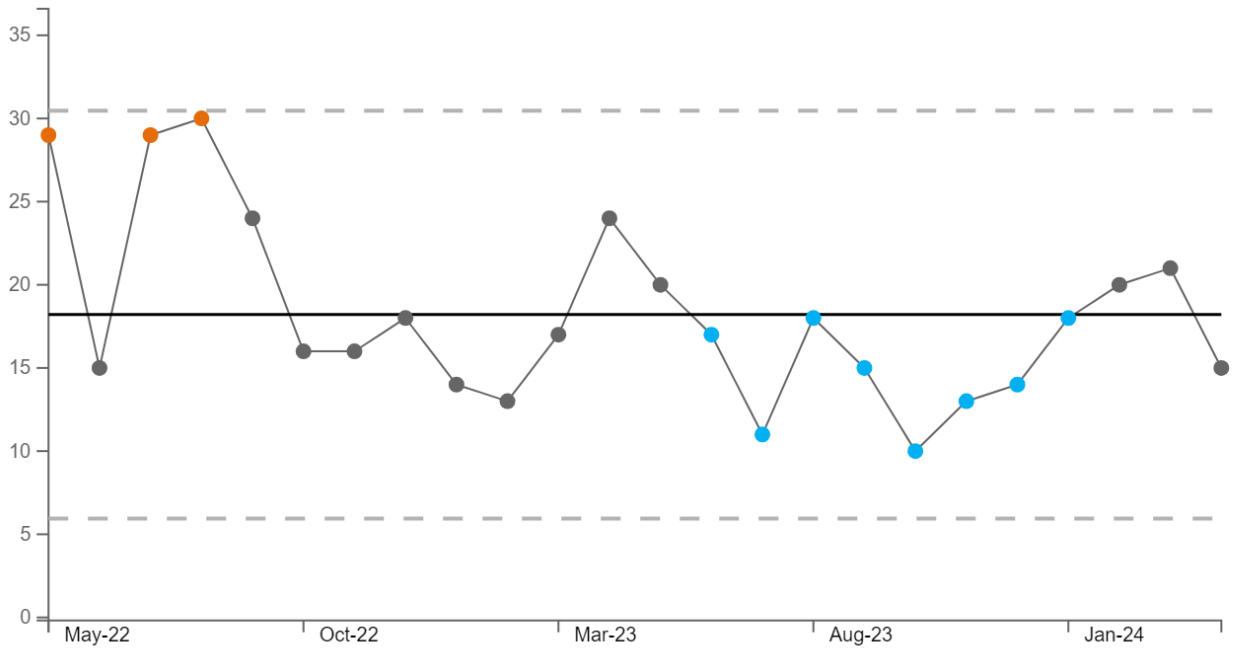
Assurance cannot be given for this indicator as there is no standard set

Normal Variation

The variation for this indicator is within the control limits

DQ - No Concern

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



Care Group	Performance	Standard	Variation	Assurance
Inpatient Care Group	10	No Std	Normal Variation	No Standard
Specialist Care Group	5	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

There were 15 reported in April 2024.

Root Cause of the performance issue

- A decline in its use has been noted , however the panel are aware that this may rise in the near future due to a small number of patients being initiated this month.

Improvement Actions

- The Long-term segregation panel continues to review patients subject to long term segregation and pro longed seclusion on a weekly basis.

Expected impact and by when

Continued reduction

Q04 - Assaults on Patients

Number of Assaults on Patients

Risk Rating - Med (Monitoring)

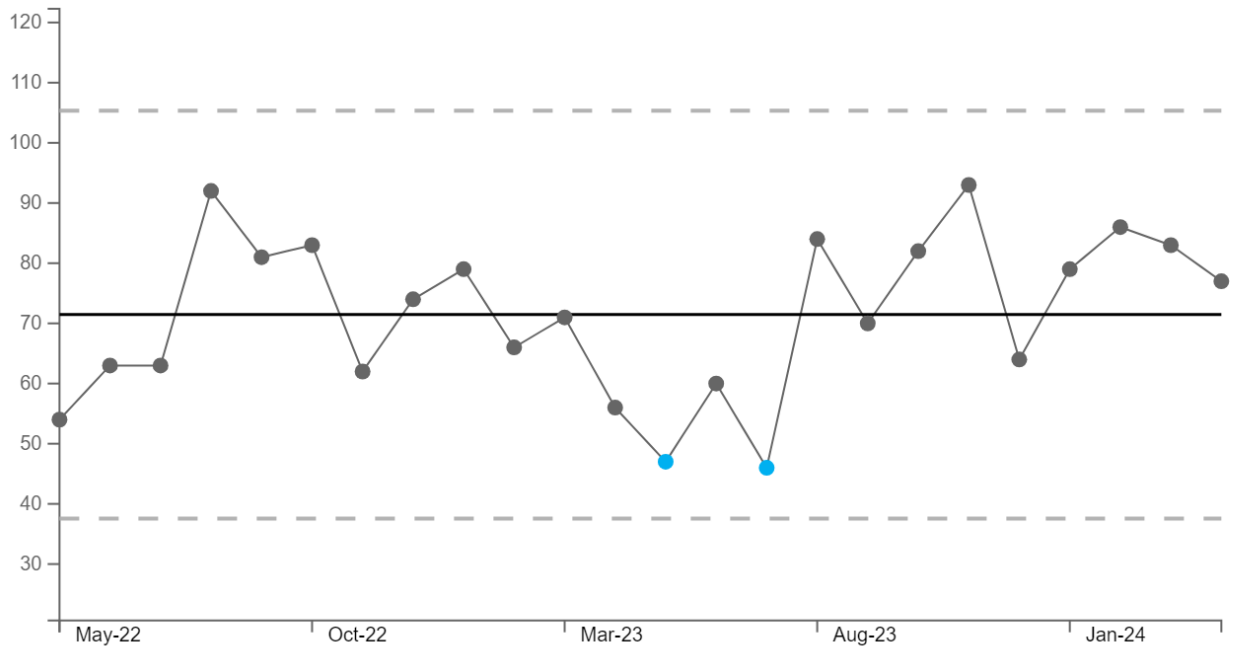
Performance - 77

Standard N/Ap

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

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

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



Care Group	Performance	Standard	Variation	Assurance
Community Care Group	7	No Std	Normal Variation	No Standard
Inpatient Care Group	62	No Std	Normal Variation	No Standard
Specialist Care Group	8	No Std	Normal Variation	No Standard

Feedback

What the chart tells us

There were 77 recorded incidents of assaults on patients during April which falls within the calculated expected range of 38 and 105. Whilst we have seen a rise in assaults since December, the data indicates the numbers have dropped in the last quarter.

Root Cause of the performance issue

- Physical assaults between patients most commonly occurs on female acute admission wards and older people's wards, children's or autism services , which regularly features in all aggression and violence data doesn't appear in the top 10 of services. This is likely due to the levels of staffing and care planning and potential separation of patients.
- April's figure of 77 assaults is higher than the previous April ,but in line with a general incident reporting increase. Most incidents are reported as no or low physical harm.
- Within the Inpatient Care Group, the Acute pathway accounted for the highest number of assaults on patient in the period (66% of all incidents). No clear outlier evident in month (no one patient accounted for more than 10% of all assaults on patient).

Improvement Actions

- When incidents of assault between patients are reported clinical teams will frequently escalate the incident for review by the Safeguarding Team due to vulnerability of both parties , for further advice and support. This activity will be considered in the new aggression and violence group when it meets.

Expected impact and by when

As part of full review of data at the aggression and violence group.

Q05 - Assaults on staff

Number of Assaults on staff

Risk Rating - **Med (Monitoring)**

Performance - 459

Standard N/Ap

N/Ap

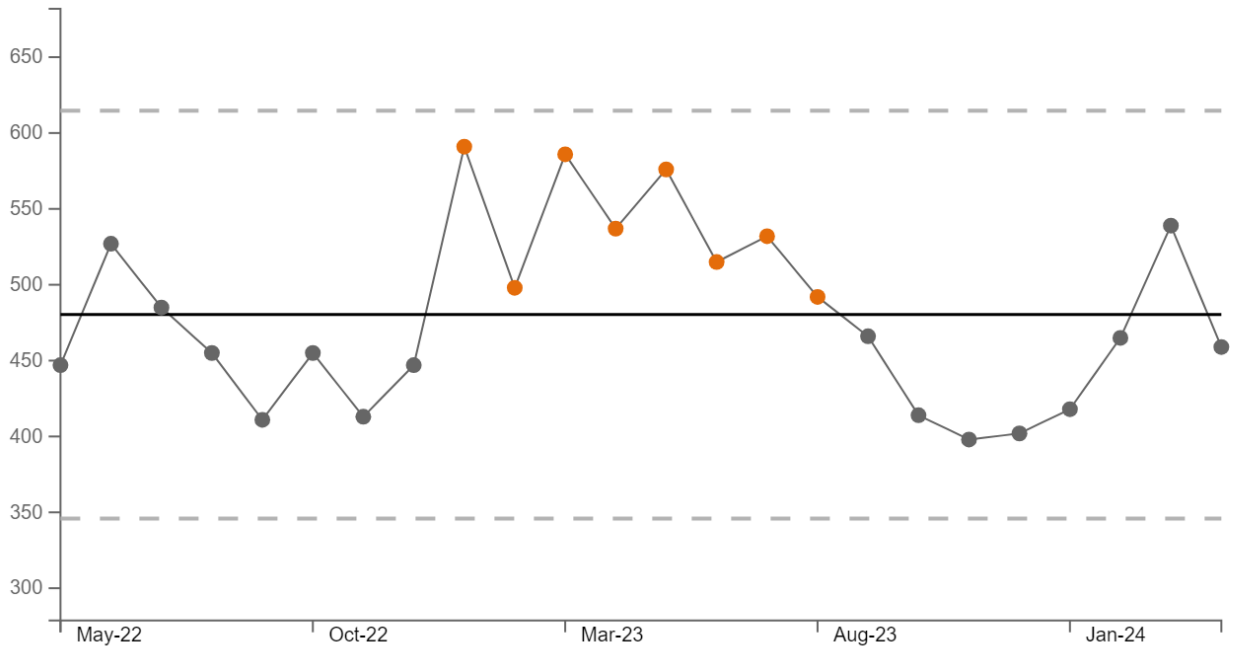
Assurance cannot be given for this indicator as there is no standard set

Normal Variation

The variation for this indicator is within the control limits

DQ - No Concern

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



Care Group	Performance	Standard	Variation	Assurance
Community Care Group	7	No Std	Normal Variation	No Standard
Inpatient Care Group	224	No Std	Normal Variation	No Standard
Specialist Care Group	227	No Std	Normal Variation	No Standard
Support & Corporate	1	No Std		No Standard

Feedback

What the chart tells us

There were 459 recorded incidents of assaults on staff during April which falls within the calculated expected range of 349 and 610. Whilst we have seen a decrease in assaults through 2023 , but started to rise again in January 2024 and April is the first time since then that it has reduced. Further evaluation of violence and aggression will be a key part of the new V&A sub group of Trust wide Safety.

Root Cause of the performance issue

- Physical assaults on staff is a significant focus of the organisation following our response to the HSE Improvement notice. The improvements, controls and support arrangements continue to remain in place in relation to Mitford with Executive Director oversight.
- Within Inpatient care Group the Older Peoples pathway accounted for the highest number of assaults on staff in the period (38% of all incidents). There is one outlier Older Peoples ward which accounted for 45% of all staff assaults in Older People wards (of which one patient account for 49% of the assaults on the ward - the number of assaults related to this patient has decreased as the ward gain greater understanding into their diagnosis and triggers).

Improvement Actions

- Due to the focus on care planning and other safety systems reviews assaults on staff is significantly lower than the previous April with about a 19% reduction, a number of actions have been identified around MDT review, This has resulted in a significant reduction in moderate physical harm incidents as well of the 459 assaults , 441 were reported as no or low physical harm. Form the incidents reported in April only 8 were reported to the HSE under RIDDOR reporting requirements and all related to over 7 day absence from work.. This information is now being reported weekly to Trust-wide Safety Group so that the organisation is more sighted staff related harm from specific incidents.

Expected impact and by when

The new aggression and violence group which is due to meet in June 2024 , will review as part of its terms of reference all aspects of safety that impact on assaults on staff and implement further measures.

Q06 - % of patients with a Safety Plan

% of patients with a Safety Plan

Risk Rating - Med (Monitoring)

Performance - 76.1%

Standard - 100.0%

Not Applicable

Not Applicable

DQ - No Concern

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

Care Group	Performance	Standard	Variation	Assurance
Community Care Group	75.6%	100.0%		
Inpatient Care Group	73.6%	100.0%		
Specialist Care Group	79.6%	100.0%		
Support & Corporate	74.2%	100.0%		

Feedback

What the chart tells us

In April 76.1% of patients were reported to have a safety plan.

Inpatient services – 86.4% (76 out of 88)

Community – 75.9% (4,391 out of 5,783)

Root Cause of the performance issue

- The new risk framework form went live on 15th April 2024. Metrics have been developed and are live on dashboards to assure delivery and compliance with quality standards.

Improvement Actions

- Embedding the framework
- Data quality report is being monitored by the Steering group
- New Risk policy is currently in progress
- A review of the metric methodology is due to take place in June 2024
- Evaluation of the framework is under development

Expected impact and by when

Ongoing as framework is being embedded

Q08 - Rights at Point of Detention

Risk Rating - Med (Monitoring)

Number of clients (Detained) whose detention has started within the reporting period and there is a Record of Rights Given (detained/CTO) - Form H3L within 7 days either side of the detention starting

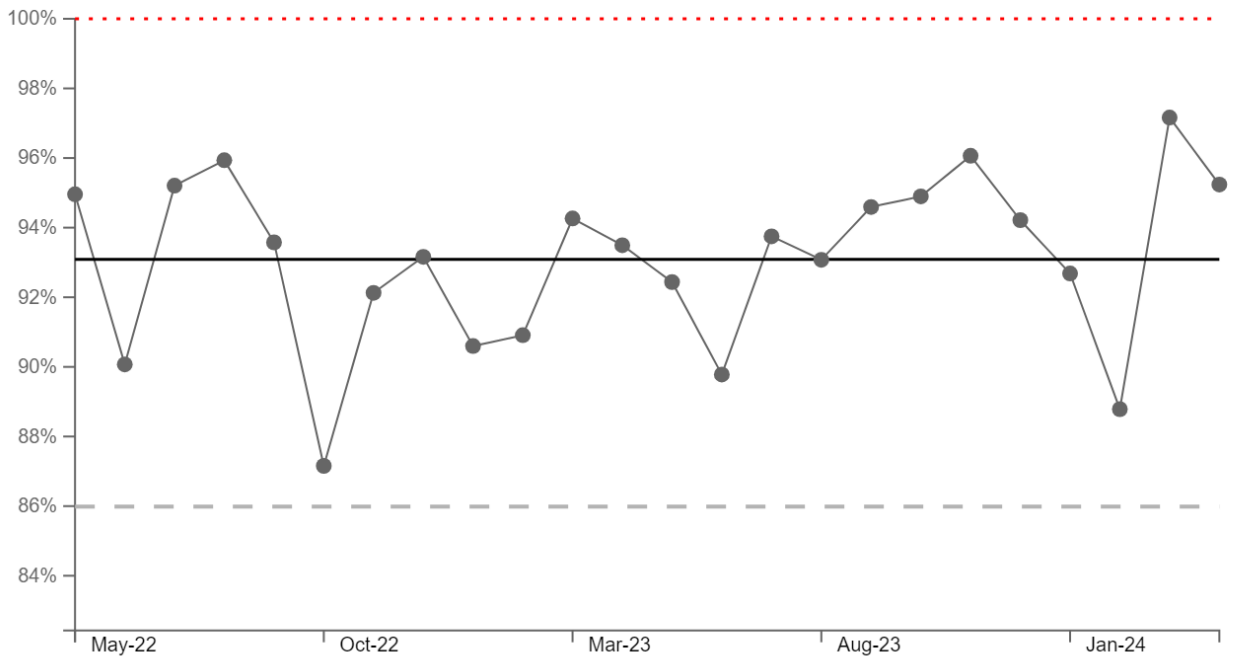
Performance - 95.2%

Standard - 100.0%

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

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

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



Care Group	Performance	Standard	Variation	Assurance
Inpatient Care Group	94.9%	100.0%	Normal Variation	Achieve at Random
Specialist Care Group	100.0%	100.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Compliance in this area continues to fluctuate and is reported for April at 67.6%.

Root Cause of the performance issue

- New nursing staff on the ward who are not aware of our duty to give a person their rights when detained and the requirement to review rights.

Improvement Actions

- Rights on a page poster circulated to all wards to remind nursing staff of our duty to provide patients with their rights when detained under the MHA 1983 in accordance with section 132 and when to revisit rights.
- Nursing staff to continue carry out MHA weekly/monthly checks on aspects of MHL including the monitoring of ensuring patients have been given their rights within 7 days of being detained under the MHA.
- Nursing staff to continue the monitoring of the ward at glance boards to ensure rights are given within 7 days of detention
- MHL Specialist to attend the quality standards groups for inpatients and community to report on compliance on the giving of rights at the point of detention.
- MHL Training to focus on section 132 to educate nursing staff about the giving of rights and the important role that they have to ensure patients can exercise their right to appeal when detained under the MHA.
- Patients rights awareness e learning package to be implemented. The learning package will include interactive session

Expected impact and by when

We would expect to see impact from the actions by the end of quarter 3.

Q09 - Record of Capacity/ CTT at point of detention

Risk Rating - **High (Action)**

Number of Clients with a Record of Capacity/CTT for Detained Clients forms with Part A completed within 7 days either side of the 3 Month Rule starting date.

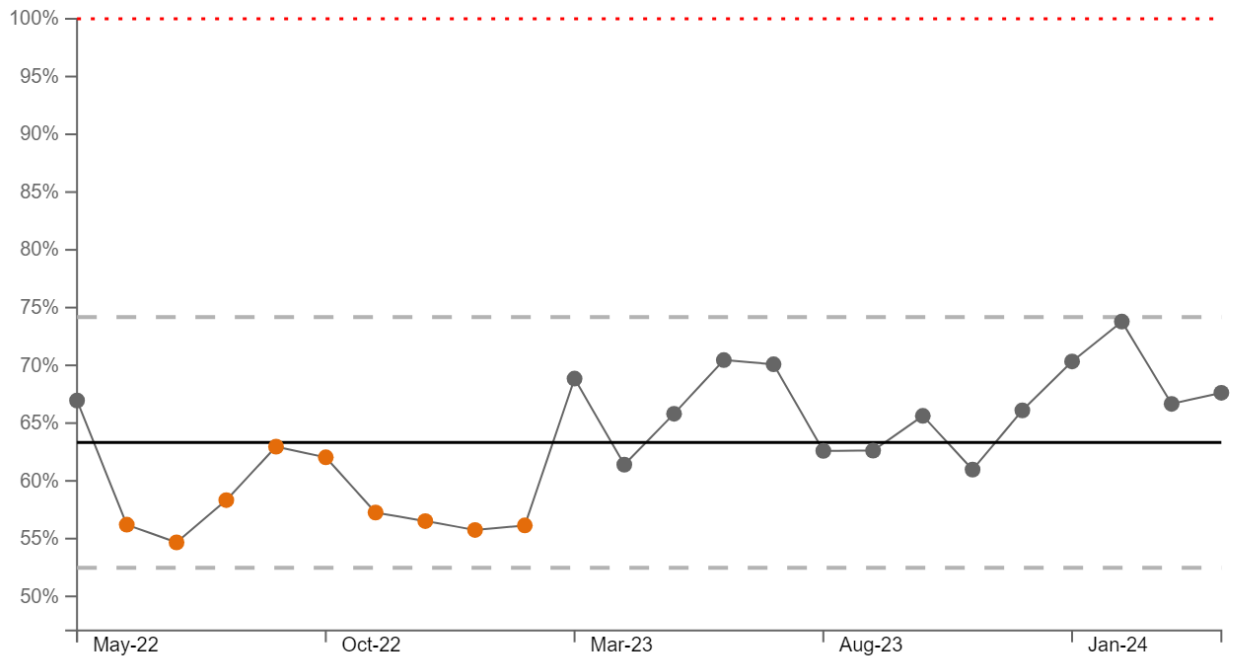
Performance - 67.6%

Standard - 100.0%

Consistently Off target
The standard for this indicator is outside the control limits

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

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



Care Group	Performance	Standard	Variation	Assurance
Inpatient Care Group	70.3%	100.0%	Normal Variation	Consistently Fail
Specialist Care Group	36.4%	100.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

April compliance is reported at 67.6% for the completion of the local form Part A Record of Capacity/CTT, significant improvement is required across the Trust.

Root Cause of the performance issue

- Lack of awareness on the requirement to complete this form
- 7 day timeframe not sufficient time for Responsible Clinicians to complete the form

Improvement Actions

- Group Directors for each locality have been tasked to look at different ways to improve compliance.
- In the Mental Health Legislation Steering Group (MHLSG) it was recommended that an audit on the consent to treatment provisions within the Act is carried out in 2024/2025 by internal audit. The outcome and recommendations from this audit will highlight to the groups what actions are required for improvements to be made.
- Following the MHLSG on 25 April a working group was formed to review the local form to look at any barriers in the completion of the form and to remove those barriers.
- MHL Specialist to attend the quality standards groups for inpatients and community to report on compliance around record of capacity at point of detention.

Expected impact and by when

- We would expect to see impact from the actions by the end of quarter 3.

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

Bed Occupancy including leave (open beds on RiO)

Risk Rating - **High (Action)**

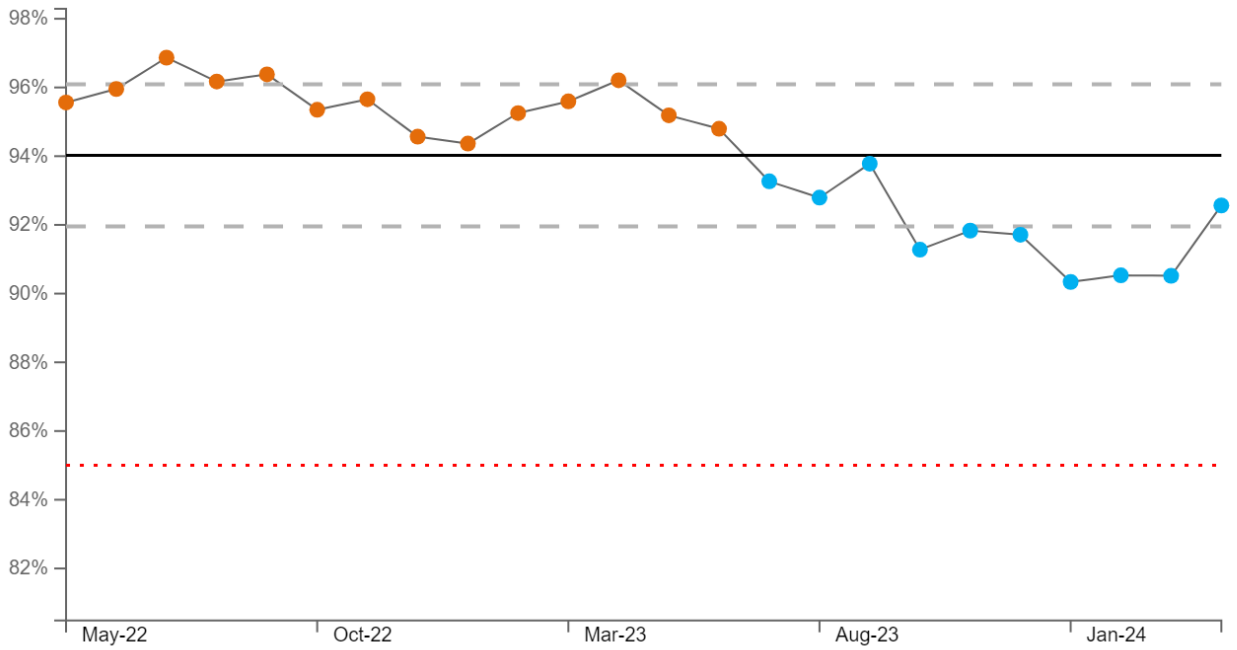
Performance - 92.6%

Standard - 85.0%

Consistently Off target
The standard for this indicator is outside the control limits

Improvement
This indicator is decreasing which shows improvement

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



Care Group	Performance	Standard	Variation	Assurance
Inpatient Care Group	100.8%	85.0%	Normal Variation	Consistently Fail
Other Care Group	0.0%	85.0%	Improvement	Achieve at Random
Specialist Care Group	79.8%	85.0%	Improvement	Achieve at Random

Feedback

What the chart tells us

Bed occupancy was at 92.6% in April and remains higher than the optimal level of 85%.

Root Cause of the performance issue

- Within Autism Inpatients there remains a pause in referrals (for 6 months from January 24). Mitford Bungalows remains empty in terms of beds until the review work is concluded.
- Reporting is based on open beds on Rio, beds may be left open and included in reporting affecting occupancy levels.
- Bed availability in line with national performance and pressures. Some beds are temporarily unavailable. Unable to discharge patients who are clinically ready for discharge due to other pressures outside CNTW.

Improvement Actions

- Enhanced Bed Management discharge facilitators support wards and are attached to each locality for consistency. The localities work closely with enhanced bed management to try and ensure the locality leadership team have oversight and influence around acuity and level loading.
- Implementation of admission and discharge policy. System wide working with third sector.
- There is significant oversight of the beds currently out of use.
- Review open beds on Rio to ensure accurate reporting.

Expected impact and by when

It is predicted bed occupancy will remain above the optimal level of 85% but the actions above will maintain bed occupancy.

A03 - % Adult inpatients discharged with LOS > 60 days

Risk Rating - Med (Monitoring)

Number of adult inpatients discharged during the reporting period with length of stay > 60 days (Q&P Metric 2427)

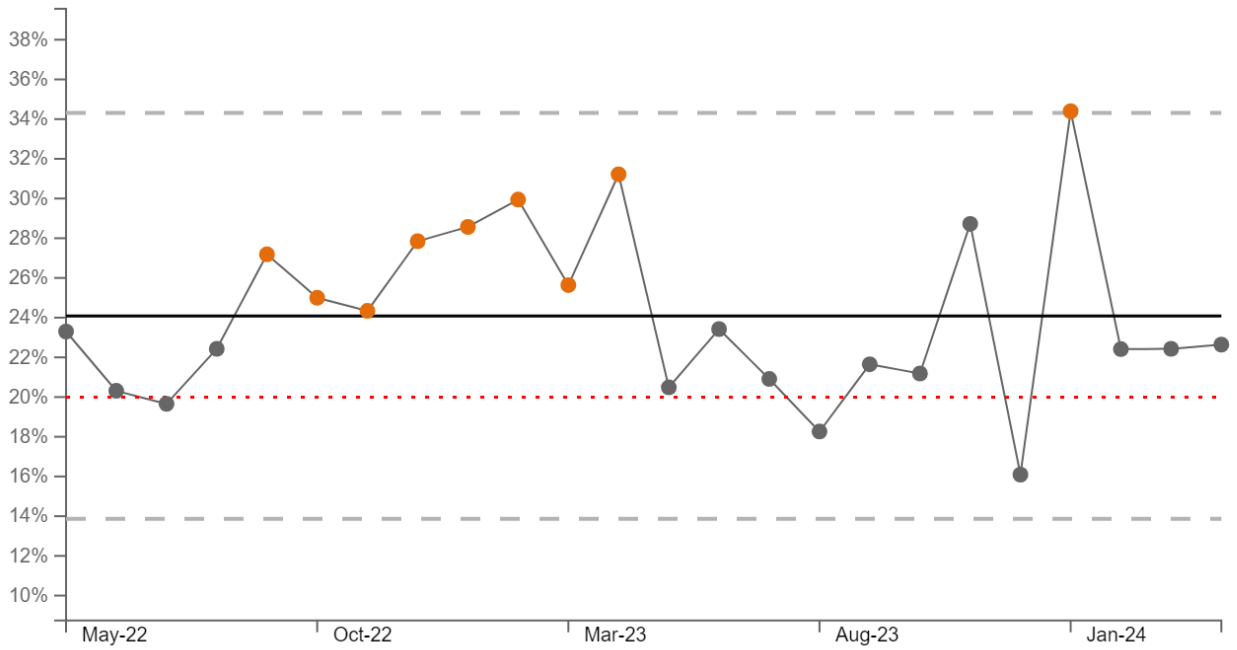
Performance - 22.6%

Standard - 20.0%

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

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

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



Care Group	Performance	Standard	Variation	Assurance
Inpatient Care Group	21.9%	20.0%	Normal Variation	Achieve at Random
Specialist Care Group	100.0%	20.0%	Concern	Consistently Fail

Feedback

What the chart tells us

In April 22.6% of patients were discharged where the length of stay exceeded 60 days. Data relates to adult acute wards within the inpatient care group and Gibside ward within the specialist care group.

Root Cause of the performance issue

- Patient inpatient spells are longer than 60 days, contributing factors include, patients admitted for differing reasons tend to spend longer in hospital, as do individuals with more complex clinical needs. Wider system factors are also impacting LOS, inefficiencies in patient flow, caused by, for example, delays in discharge. This is in the context of high bed use capacity, vacancies and the availability of alternatives in discharge in housing and social care, as such not all factors influencing of LOS are controlled by the group, however we are working to influence wider decision making.

Improvement Actions

- Red to Green days implemented
- Focus on patient discharge from admission
- Meeting are in place with the local authorities to review CRDFs
- Key Lines of Enquiry exercise is underway across inpatients
- Daily huddles are underway.
- Refreshed governance and oversight of factors contributing to LOS are embedding.

Expected impact and by when

It is expected that LOS will improve over summer 2024.

A05 - Clinically Ready for Discharge (formerly DTOC)

Risk Rating - High (Action)

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

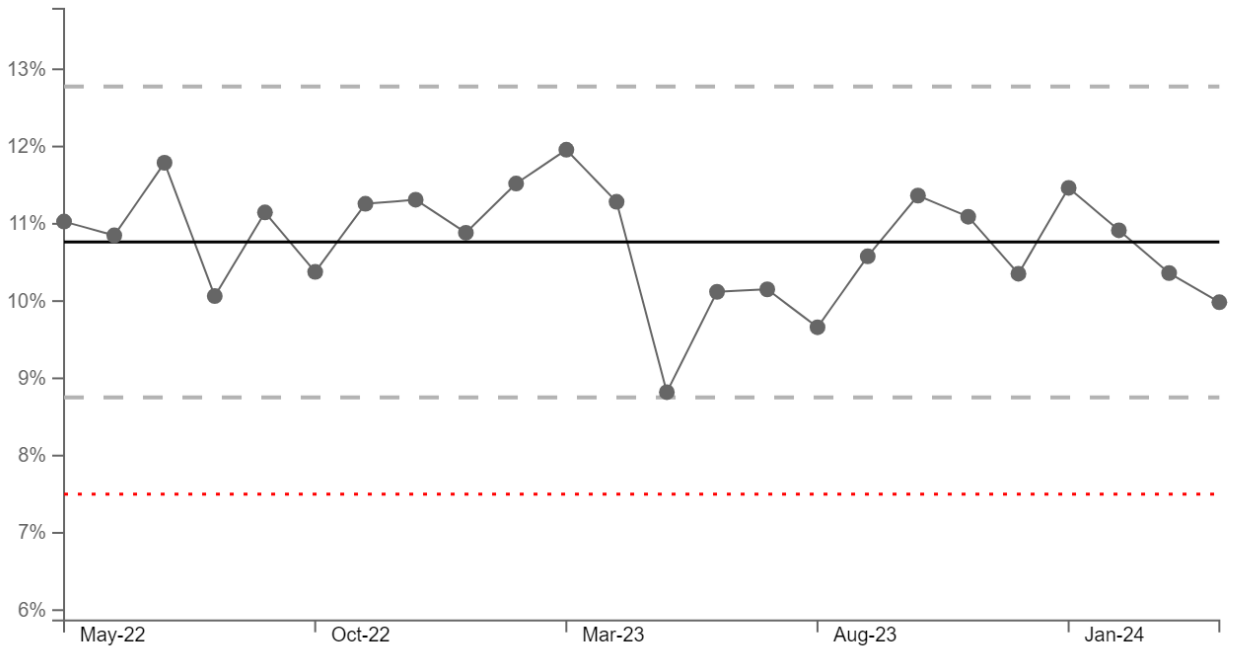
Performance - 10.0%

Standard - 7.5%

Consistently Off target
The standard for this indicator is outside the control limits

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

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



Care Group	Performance	Standard	Variation	Assurance
Inpatient Care Group	10.4%	7.5%	Normal Variation	Consistently Fail
Specialist Care Group	8.3%	7.5%	Improvement	Achieve at Random

Feedback

What the chart tells us

In April 10.0% of patients were clinically ready for discharge. Within CYPS 23.5% were recorded as clinically ready for discharge (excluded from this metric). Without change the standard will not be met

Root Cause of the performance issue

- System wide challenges with complex discharges and lack of appropriate support and care packages.

Improvement Actions

- Red and Green Days implemented across acute wards.
- Dedicated focus by senior case manager to review and support discharge plans for those CRFD
- Fortnightly CRFD meetings with Local Authority and Place based ICB.
- Daily flow meetings.
- Home Group contract in the North for Northumberland residents extended to end of Q1 24/25. With commitment to further extend to March 24/25 through BCF monies.

Expected impact and by when

It is anticipated that CRFD will remain above the optimal level of 7.5% but the actions above are supporting and maintaining performance within the expected range.

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

Risk Rating - High (Action)

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

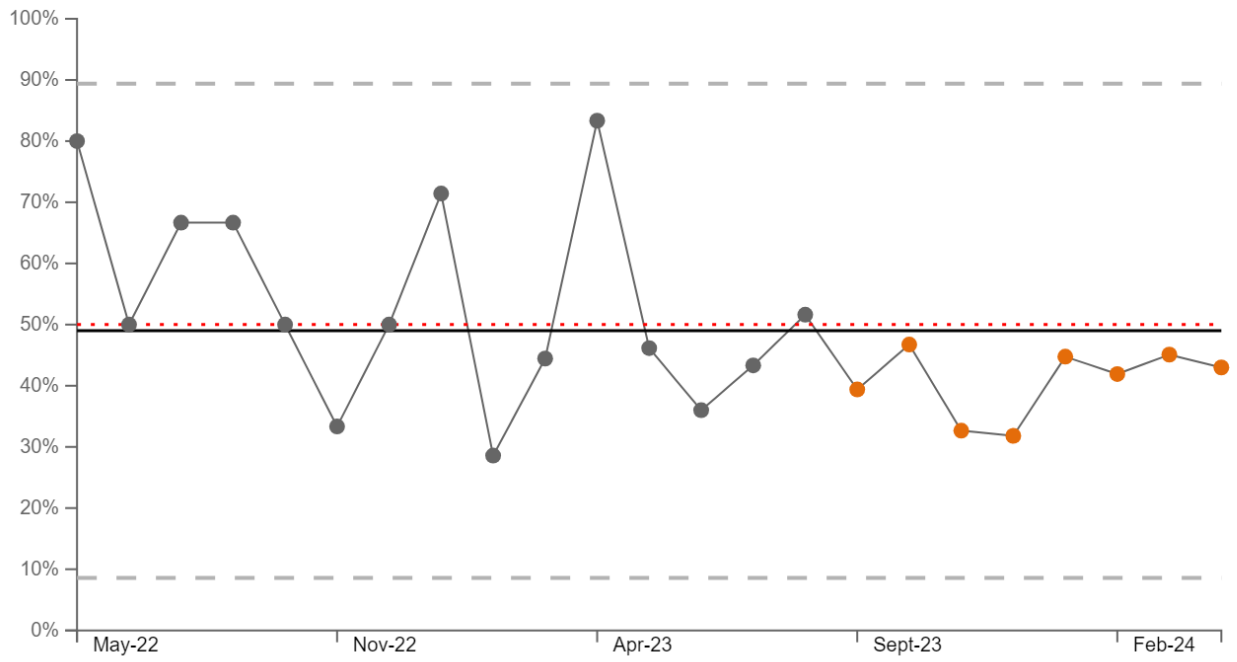
Performance - 43.0%

Standard - 50.0%

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

Concern
There is concern because this indicator is decreasing

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



Place Team	%	Num	Denom	Standard	Variation	Assurance
Newcastle & Gateshead Place Team	35.0%	55	157	50.0%	Concern	Achieve at Random
North Cumbria & Northumberland & North Tyneside Place Team	61.9%	13	21	50.0%	Normal Variation	Achieve at Random
Sunderland & South Tyneside Place Team	66.7%	24	36	50.0%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Very urgent referrals seen within 4 hours achieved 43.0% in April

Root Cause of the performance issue

- Inconsistencies across locality in Very Urgent referral recording and accuracy of contact recording.
- Staffing shortages particularly with Band 6s.
- High level of clinical activity.
- Data quality input issues:.

i. Duplicate referrals opened to teams.
ii. Appointments outcomes not being complete.
iii. Appointments not being put in Rio diaries.
iv. Referrals opened incorrectly (72hrs & 136 suite)

- 136 staffing model and the impact on the crisis service.

Improvement Actions

- Consideration for process when high levels of temporary staffing are used to support capacity to ensure methodology continues to be followed.
- Peer review of referrals urgencies via Access Oversight sub-group
- Standardisation of referral recording, through Access Oversight sub-group
- Staff supported to correct data quality issues

Expected impact and by when

Expected continued improvement across Quarter 1 2024.

A08 - % PLT ED Referrals seen within 1 hour

Risk Rating - **Med (Monitoring)**

% Psychiatric Liaison Team Emergency Dept Referrals seen within 1 hour

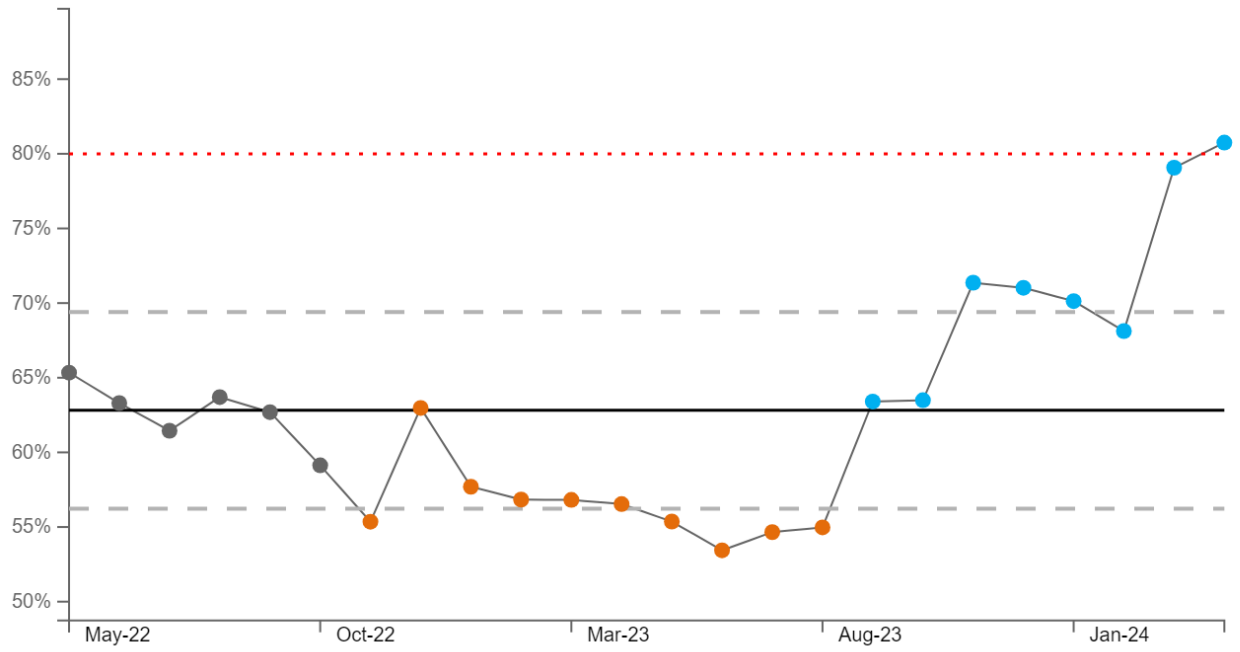
Performance - 80.8%

Standard - 80.0%

Consistently Off target
The standard for this indicator is outside the control limits

Improvement
This indicator is increasing which shows improvement

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



Place Team	%	Num	Denom	Standard	Variation	Assurance
Newcastle & Gateshead Place Team	78.0%	287	368	80.0%	Improvement	Consistently Fail
North Cumbria & Northumberland & North Tyneside Place Team	72.2%	285	395	80.0%	Improvement	Consistently Fail
Sunderland & South Tyneside Place Team	95.1%	292	307	80.0%	Improvement	Achieve at Random

Feedback

What the chart tells us

Performance was 80.8% in April which is above the expected range and the highest performance reported within 24 months.

Root Cause of the performance issue

- Issue with ED staff referring to PLT when patient is not medically fit, patients having physical needs seen to or they refuse to be seen which then causes breach of the target.
- Staffing (recruitment/retention/sickness) remains a challenge when organising cover.
- PLT not resourced sufficiently to provide 24/7 1hr response when clinical demand is high.
- Staffing pressures due to increased short term absence
- Geography of community hospital with North Locality

Improvement Actions

- Place Teams are reviewing breach reports weekly to support any potential data quality issues
- Additional training provided to staff
- Access Oversight sub-group recording guidance has been rolled out to support improvement in data quality (live 20th March 2024).
- Dedicated operational management within the service is now supporting practice review and improvement work.
- Ongoing work within PLT re service specifications and commissioned resource in relation to current demand.
- Ongoing work with the Acute Trust in relation to the referral point

Expected impact and by when

Performance is improving with all areas reporting an improvement

A10 - % Waiting 4 wks or less to treatment (WAAOP)

Risk Rating - High (Action)

The number of service users waiting 4 wks or less to treatment (New National Methodology July 2023)

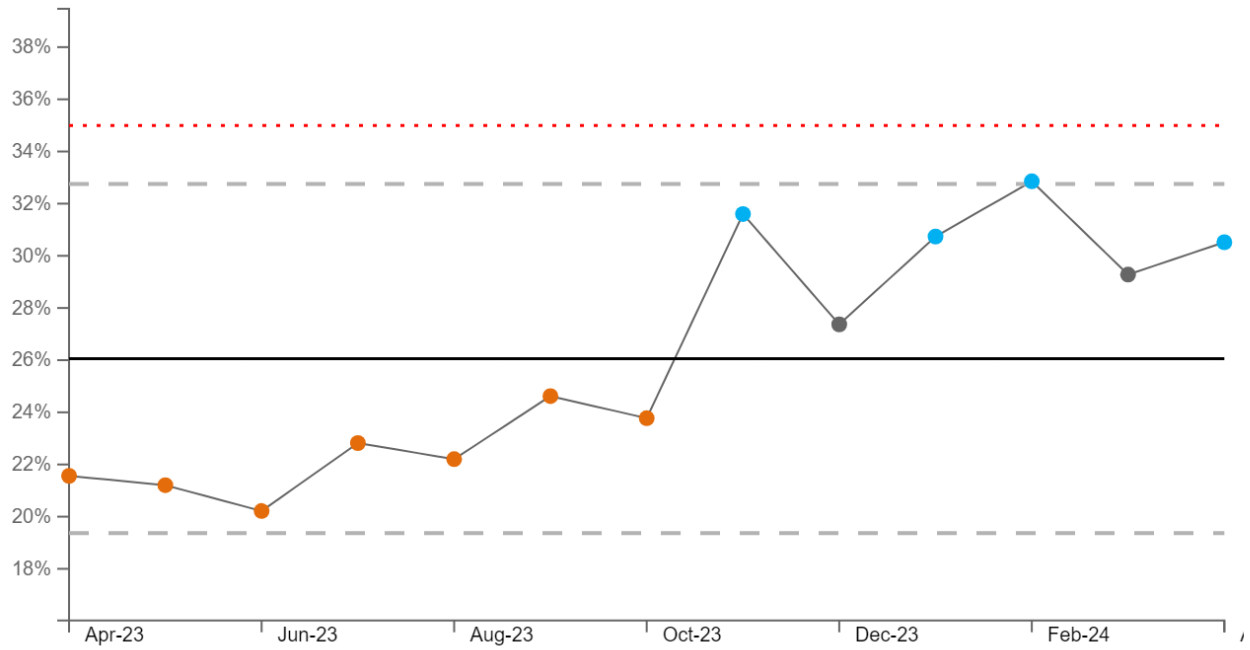
Performance - 30.5%

Standard - 35.0%

Consistently Off target
The standard for this indicator is outside the control limits

Improvement
This indicator is increasing which shows improvement

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



Place Team	%	Num	Denom	Standard	Variation	Assurance
Newcastle & Gateshead Place Team	61.2%	218	356	35.0%	Improvement	Achieve at Random
North Cumbria & Northumberland & North Tyneside Place Team	24.6%	447	1821	35.0%	Normal Variation	Consistently Fail
Sunderland & South Tyneside Place Team	54.1%	278	514	35.0%	Improvement	Achieve at Random

Feedback

What the chart tells us

Performance increased to 30.5% in April.

Root Cause of the performance issue

- A significant amount of work underway to embed new processes alongside data quality work to ensure the position is accurately reflecting operational delivery.

Improvement Actions

- Monthly QI steering group is being re-established in Community CBU
- Fortnightly waiting list meetings overseen by each team.
- Variation in the number of referrals is being looked at to understand if this is linked to the recording of Urgent referral recording and accuracy of contact recording or another factor.

Expected impact and by when

It is expected that this metric continues to improve throughout 2024 with the introduction of Dialog.

A11 - % Waiting 4 wks or less to receive help (CYPS)

The number of service users waiting 4 wks or less to receive help (New National Methodology July 2023)

Risk Rating - **High (Action)**

Performance - 10.9%

Standard - 15.0%

Achieve at Random

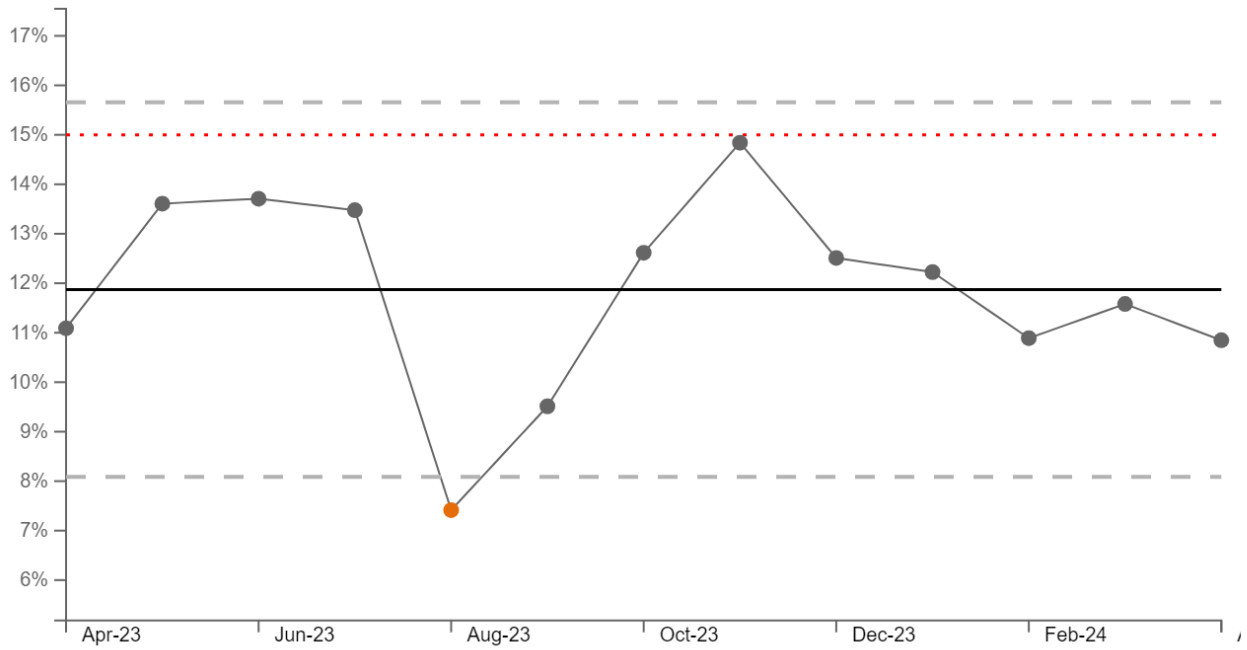
The standard for this indicator is within the upper and lower control limits

Normal Variation

The variation for this indicator is within the control limits

DQ - Investigation

There have been data quality concerns rasied with indicator



Place Team	%	Num	Denom	Standard	Variation	Assurance
Newcastle & Gateshead Place Team	8.5%	365	4313	15.0%	Normal Variation	Consistently Fail
North Cumbria & Northumberland & North Tyneside Place Team	13.1%	253	1934	15.0%	Normal Variation	Achieve at Random
Sunderland & South Tyneside Place Team	88.3%	68	77	15.0%	Improvement	Consistently Achieve

Feedback

What the chart tells us

Performance decreased slightly to 10.9% in April

Root Cause of the performance issue

- Waits are predominantly within the neurodevelopmental pathways with increased demand on the pathway.
- Differences in practice around neuro 'welcome events' across the Trust.

Improvement Actions

- There is a new pathway for neurodevelopmental pathways that has been signed off by the Trust and is being rolled out in a phased approach.
- Further work with NENC system leaders is taking place to discuss how as a system we improve access and experience of CYPS with a neurodevelopmental need.

Expected impact and by when

There is a national focus on neurodevelopmental pathways, which has recognised the amount of demand for diagnosis and how we approach meeting neurodevelopment needs. It is expected that the demand for diagnosis will continue throughout 2024, the expected impacted of actions will be to mitigate the increasing trend of waits during 2024, it is not expected to see a complete reversal due to the continuing demand for neurodevelopmental services.

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

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

Risk Rating - High (Action)

Actual/Forecast - -£2.5m

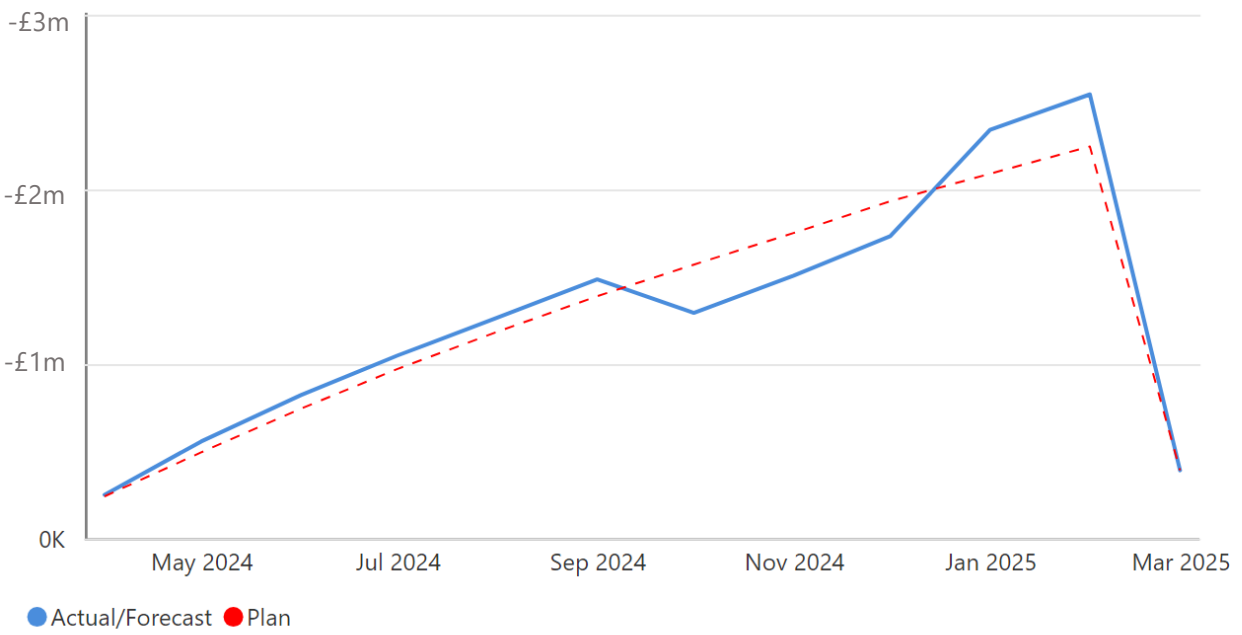
Plan - -£2.5m

Not Applicable

Not Applicable

DQ - No Concern

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



Care Group	Performance	Standard	Variation	Assurance
Community Care Group	-4,206	-4,015		
Inpatient Care Group	-715	-1,220		
Specialist Care Group	-2,214	-2,179		
Support & Corporate	9,648	9,836		

Feedback

Improvement Actions

- BDG monthly finance focus sessions to agree actions to impact on the Trust financial position and review of progress to deliver the Trust efficiency plans.
- BDG monthly finance will focus time on plans for longer term financial sustainability. The Trust will agree trajectories for service to plan to deliver costs in line with the contracted income by 2027.
- Groups / Departments highlighted areas under review to impact on financial performance. BDG discussions to clarify where they improve financial forecast.
- Daily staffing reviews taking place across inpatient areas.
- Ongoing discussions with the ICB re the pressure on the Trust CDEL for 2024/25. Based on the current programme the Trust will breach the allocated limit. The Trust is seeking slippage to increase the CNTW limit for this year.
- Weekly meeting to review and maximise the Trust cash balances.

9. QUALITY AND PERFORMANCE COMMITTEE REPORT

Louise Nelson, Committee Chair

REFERENCES

Only PDFs are attached

9. QP Committee Assurance Report 01.05.24.pdf

Board Committee Assurance Report
Council of Governors Meeting
Thursday 27th June 2024

Name of Board Committee	Quality and Performance Committee
Date of Committee meeting held	1st May 2024
Date of next Committee meeting	12th June 2024

1. Chair's summary

Quality Focus: Trust Approach to Violence & Aggression and Draft Final Response to HSE Improvement Notice. This was a key quality presentation for Q&P and a challenging and robust discussion took place.

Key themes and areas of focus included policies and procedures, people with dedicated skills, day to clinical and managerial leadership, data versus Intelligence, patient safety and staff safety.

The response to the HSE Improvement Notice was also discussed.

To note for assurance:

- The Development of the new Violence and Aggression Steering group
- The IPR will now include high level detail in relation to the number of violence and aggression incidents from both a staff and patient perspective.
- Q&P to undertake a formal review in 6 months both in terms of progress against the improvement notice response and the work undertaken by the violence and aggression sub group.

Integrated Performance Report (IPR)

Ongoing improvement in patient flow, out of area bed occupancy and in sustaining the improvements seen in PLT referrals.

2 indicators relating to crisis remain a concern Q&P will have a Quality Focus in July.

12-month review of the IPR has been undertaken and some changes, removing some indicators and introducing new ones such mental health act indicators relating to human rights. A summary report outlining changes to the IPR will be shared at the next meeting.

Community Services Waiting Times Update

Some of the pathways in relation to working age adults and older people have made significant improvements compared to the same time last year.

93% of the 5,386 children and young people waiting longer than 4 weeks (as of March 2024) are on a Neurodevelopmental pathway. This will be an area of quality focus at the June

committee. The pathway review is progressing well. A significant area of concern relates to the adult ADHD waiting list which currently has over 10K individuals. Early conversations with the ICB regarding the implementation of a radically different approach. A paper will be presented to the EMG in June.

Safer Staffing Report

The revised report presented which is aligned to IPR giving more enhanced commentary on key risks and assurances. The report will also have a focus relating to the Quality topic each month, this will be Crisis for July Q&P.

CQC

Must Do Update report – revised timescales and actions presented. Discussed CQC letter re Bede ward.

Shanley/MMH

The trust's response to the Shanley and Nottinghamshire report recommendations discussed and to be added to the June agenda.

2. Current risks and gaps in assurance, and barriers to closing the gaps

Neurodevelopmental Pathways – Waiting Lists, for Quality focus in June 20204
Crisis Services – for Quality focus at Q&P July 20204

3. Key challenges now and in the medium term
Recommendations and considerations following the Shanley/MMH and Nottinghamshire Reports/Reviews

4. Impact actions taken to date are having on the achievement of our strategic ambitions
Nil to escalate

5. Barriers to progress and impact on achievement of strategic ambitions
Nil to escalate

6. Actions to be taken prior to next meeting of the Committee

Nil to escalate

7. Items recommended for escalation to the Board at a future meeting

For Board to see the revised Safer Staffing report for information and assurance

8. Review of Board Assurance Framework and amendments thereon

4 identified BAF risks for the Quality and Performance Committee, discussed and 2 BAF risks changed.

CQC Compliance – assurance throughout the meeting particularly the response to HSE, V&A steering group and ongoing monitoring of Must Do actions Q&P agreed that this isn't a BAF level risks and would be managed at Corporate risk level.

Failure to Deliver Transformation Plans – This BAF risk relates directly to service delivery therefore it is proposed that both risks are reviewed jointly and merged. Q&P agreed.

It was noted that the revised BAF risks would be presented at the Board of Directors meeting on 5 June 2024.

Quality and Performance Committee		
Risk	**Score**	**Gaps in assurance**
2510 – Due to increased demand and capacity the Trust is unable to meet regulatory standards relating to access, responsiveness, and performance resulting in a risk to quality and safety of services	4(L)X4(I) 16	• Full implementation of SBAR (Situation, Background, Assessment, Recommendation). • Keeping In Touch process for service users on assessment waiting lists. • Introduction of Dialogue+. • Fully implement 4 week waits. • Introduce the Trusted Assessment concept into community services. • Confirm the role and function of both community and crisis services at the interface of these pathways. • Limited acute inpatient alternatives at a place or system level (crisis housing) • Lack of specialist provision for some client groups (autism). • Limited availability of seven-day week service provision from both an inpatient and community perspective. • Lack of intermediate care opportunities.
2512 – Risk of failing to maintain a positive patient safety learning culture resulting in avoidable harm, poor systems, process and policy, and escalation of serious issues of concern	4(L)X4(I) 16	• Implementation of PSIRF requiring extensive engagement and training of staff to ensure that their practice changes to align

		with the new systems, processes and culture changes. • Outcome measures will need to move from numbers and data around compliance with timescales to assessing how learning is shared and improvements embedded.

9. Recommendations

The Board is asked to:

- Note the content of the report.
- Seek further assurance from the Committee Chair and Executive Leads if required.

Louise Nelson
Quality and Performance Committee Chair

Sarah Rushbrooke
Executive Director of Nursing Therapies and Quality Assurance

Date: 20th May 20204

10. MENTAL HEALTH LEGISLATION COMMITTEE REPORT

Michael Robinson, Committee Chair

REFERENCES

Only PDFs are attached

10. MHLC Assurance Report 05.06.24.pdf

Board Committee Assurance Report
Council of Governors Meeting
Thursday 27th June 2024

Name of Board Committee	**Mental Health Legislation Committee (MHLC)**
Date of Committee meeting held	8th May 2024
Agenda items/topics considered	See below
Date of next Committee meeting	7 August 2024

1. Chair's summary

The members were provided with assurance that the Trust are compliant with the requirements of the Mental Health Act and MHA Code of Practice.

Assurances were provided specifically in relation to:

- Mental Health Legislation policies: all policies were in date with the content compliant with associated legal obligations. Those nearing review were on schedule to be reviewed.
- An update was given on all CQC Mental Health Act Reviewer visits in the previous quarter (5 in total) and action plans are in place to meet the issues raised following those visits. Issues raised in previous visits continue to be addressed.
- The legal timescales in relation to section 5, section 4, section 17E and referrals made to the Tribunal: there were NO breaches reported. Assurance was provided that the Trust continues to monitor the use of sections 62/64 and the use of section 4.
- The Trust has further monitored detention in North Cumbria under the MHA to compare with national trends and data. The Trust will further investigate the use of detention across the regions of the Trust through the Mental Health Legislation Steering Group ("MHLSG").
- The Trust as required by new regulation is putting in place processes to monitor detention by ethnicity of service users. This will continue to be reviewed by the MHLSG.
- The Committee received the results of a review of panel membership including a consideration of the practices of other Trusts in this area. The Committee will review and recommend training and appraisal processes for panel members on the basis of that review.

2. Current risks and gaps in assurance, and barriers to closing the gaps

During the meeting, the Committee noted and discussed the following issues in terms of current risks and gaps in assurance.

<u>Recording of capacity in relation to medication for mental disorder</u>
Whilst there continues to be a low compliance rate in the completion of the local forms, the forms have been reviewed and will be amended as appropriate to make completion more straightforward and the MHLSG is taking steps to improve compliance in this area. The Group Directors for each locality have been tasked to look at different ways to improve compliance. It has been recommended that an internal audit on the consent to treatment provisions within the Act is carried out in 2024/2025. Improvement in this area will be beneficial and the outcome of the audit and the recommendations from the audit will

highlight to the groups what actions are required for improvements to be made. MHLSG will also introduce a task and finish group to look at the barriers to completion of the forms and how to remove these barriers. The Committee will continue to monitor this area.

Mental Health Legislation Training

Whilst there was a decrease in compliance from 63% in quarter 2, to 59% in quarter 3 due to long term trainer absence, the trainer has now returned, and compliance has increased to 67 % in January 2024 and to 73% at the end of April 2024. The Trust-wide review of training will report shortly, focusing on those areas and cohorts where training is particularly required. The MHL training team has worked to improve the ease of access to MHL training which is intended to increase further the numbers completing training. The area will be kept under review, looking at improvements over the last 12 months and supporting improvements in the future.

Interface of MCA and MHA

Due to the reorganisation of departments providing services and support to the organisation around legal frameworks (bringing MHA, MCA, Medico Legal, IG together) it has been identified that the Mental Capacity Act is not currently consistently applied across the Trust. Although it is not necessary to amend their terms of reference to reflect any change, the MHLSG will steer and monitor compliance with, and the application of the Mental Capacity Act 2005 and their agendas will reflect this.

3. Key challenges now and in the medium term

The timetable for legislative scrutiny and enactment of the Mental Health Bill is unclear. The draft Bill will replace the MHA 1983 and therefore bring many changes to how we apply the legislation in practice. The MHLSG will ensure the Committee are kept up to date and provided with assurance in respect to any changes although it appears unlikely that there will be any clarity as to the likely introduction of legislation in the short term.

4. Impact actions taken to date are having on the achievement of our strategic ambitions

Monitoring the use of the MHA 1983

The Hospital managers have several responsibilities within the MHA and one of them is to monitor the use of several sections of the MHA. The Committee was given assurance that the Trust is compliant with the Mental Health Act Code of Practice. There continue to be no breaches in timescales in relation to section 5, section 4, section 17E and referrals made to the Tribunal. The Trust continues to monitor the use of sections 62/64 and the use of section 4.

Hybrid hearings

The Committee was advised that the Trust continues to offer a hybrid approach to hospital manager's hearings. This offers patients choice and ensures empowerment and involvement are at the forefront when organising a hearing for CNTW patients.

The giving of patients' rights

Work continues to be undertaken to review the training package/programme on the giving of rights when a person is detained under the Act (s132). The rights training package will provide vital information to our professionals to ensure compliance with the MHA Code of Practice.

Mental Capacity Act

The Committee was given assurance that the agendas for meetings of the MHLSG will include a focus on the MCA as well as the MHA.

Recruitment of panel members

The Committee was given a review of current membership of the hospital manager's panel and the role undertaken by panel members. After recent recruitment, there are currently 47 panel members sitting. The MHL Department have been exploring different ways to increase the representation of panel members from diverse communities and have reached out to groups within those communities. As a result, there are a number of prospective candidates from minority groups in discussions about the role and the Trust was encouraged to pursue those candidates.

There was recognition of the need to have both training and appraisal of panel members on a regular basis. A review of comparable Trusts identified appraisal practices, often taking place on at least a three yearly cycle. Non-executive directors of the Trust acting as panel members was often the case in the past and was welcomed subject to the need for non-executive directors to maintain their independent status. The MHL department will continue its review and report to the Committee on the appropriate training and appraisal process. It was also noted that panel members currently remain in role for a maximum of 10 years (two periods of 5 years). The review will also consider whether this remains appropriate given the introduction of the appraisal system.

5. Barriers to progress and impact on achievement of strategic ambitions

Nothing to highlight at this stage to the Board.

6. Actions to be taken prior to next meeting of the Committee

Those issues identified in section 2 of this form are areas of ongoing review by the Committee and will be considered at its next meeting.

The Committee will receive and consider the outcome of the review of panel membership, training and appraisal.

Following the update received by the Committee on detentions in North Cumbria at this meeting and the agreed further review on the number of detentions under the various sections of the MHA across the Trust as a whole, the Committee will seek further assurance as to the number of detentions under the MHA compared to similar Trusts.

The Committee will seek further assurances that the Trust is compliant with its obligations to hold data on the ethnicity of service users, particularly those detained under the MHA.

7. Items recommended for escalation to the Board at a future meeting

There are no items for escalation to the Board at this stage as regards compliance with the terms of the MHA and MCA. The Committee would draw the attention of the Board to the recent decision of the Employment Appeal Tribunal in *Lancashire and South Cumbria NHS Foundation Trust v Ms R Moon*. This case determined that panel members may be afforded certain employment rights arising from their role. Whilst each case would be assessed on its particular circumstances, the MHL legal team is assessing the possible implications for the Trust.

The Committee would also draw attention to the further work on, panel membership, detention numbers and ethnicity data referred to a paragraph 6 above.

8. Review of Board Assurance Framework and amendments thereon

The Committee holds no BAF risks and therefore there are no such risks to report as all are managed at corporate or local level with appropriate assurance in place. The minutes of the MHLSG showing the consideration of risks aligned to that committee were considered and will continue to be reviewed by the Committee.

9. Recommendations

The Board is asked to:

- Note the content of the report.
- Seek further assurance from the Committee Chair and Executive Lead if required.

Michael Robinson
MHL Committee Chair
Date: 16th May 2024

Dr Rajesh Nadkarni
Medical Director & Deputy Chief Executive
Date: 16th May 2024

11. INTEGRATED PERFORMANCE REPORT - PERSON LED CARE, WHEN AND WHERE IT'S NEEDED (ITEM 8)

Ramona Duguid, Chief Operating Officer

12. INTEGRATED PERFORMANCE REPORT ? A GREAT PLACE TO WORK

(ITEM 8)

Lynne Shaw, Executive Director of Workforce and OD

13. PEOPLE COMMITTEE REPORT

Brendan Hill, Committee Chair

REFERENCES

Only PDFs are attached

13. People Committee Assurance Report June 2024.pdf

Board Committee Assurance Report
Council of Governors meeting
Thursday 27th June 2024

Name of Board Committee	**People Committee**
Date of Committee meeting held	1 May 2024
Agenda items/topics considered	See below
Date of next Committee meeting	31 July 2024

1. Key areas of focus:

- Chair's Business
  - Terms of Reference. Minor amendments have been made to the ToR, including the membership of the Committee. These were agreed for future Board approval.
  - Agenda Restructure. The focus topic item will be removed from the agenda going forward. Bi-annual workshop-style sessions will be held to deep dive into key topics.
  - Workshops. Two workshop dates are confirmed as Wednesday 26 June between 11.00am and 2.00pm and Wednesday 27 November from 10.00am until 1.00pm. 'Employee Relations' and 'Workforce Establishments and Transformation' have been arranged for June and November respectively. Two remaining slots have yet to be agreed.
- Workforce Performance Report – **discussion and assurance**
- Guardian of Safe Working Hours Quarterly Report **- assurance**
- Raising Concerns/Whistleblowing Report – **discussion and assurance**
- EDI Action Plan update – **assurance**
- Health and Wellbeing update – **to note**
- Equality, Diversity and Human Rights Annual Report – **discussion**
- Trade Union Facilities Time Report – **discussion and decision**
- Training Requirements Prioritisation and Framework for Managing Delivery – **assurance**
- 2023 Education and Training Self-Assessment Report – **to note**
- Internal Audit Report – Local Onboarding – **discussion**
- Bank Review - **discussion**
- Freedom to Speak up Action Plan Update - **discussion**
- Board Assurance Framework – **discussion and assurance**

2. Current risks and gaps in assurance and barriers to closing the gaps

During the meeting, the Committee highlighted and discussed the following issues in terms of current risks and gaps in assurance.

<u>Clinical supervision</u>
There continues to be a decrease in clinical supervision, (target of 80%, currently 51.9%) and it was noted that this remains an area of focus for the CQC and part of the Trust's CQC Must Do actions. Action: In depth work is taking place looking at the way supervisions are carried out and recorded. A more comprehensive report will be provided once that work has been undertaken. (Update 31 July 2024)

Staffing establishments
The Committee noted the gap in assurance regarding the development of a process to agree staffing establishments. It was also noted that this would form a significant part of the development of the overarching workforce plan. It was noted that despite the priority focus on reducing temporary staffing, having a substantive and clear workforce plan would significantly contribute to the Trust's strategic ambitions in relation to the provision of high quality, safe care, and the financial position. Action: Workforce Plan and establishments to be reviewed in line with changes to the clinical model and forms part of the annual plan priorities. (Update November 2024)

Local Onboarding

Internal Audit report highlighted limited assurance in terms of local onboarding processes. The audit identified a number of gaps in terms of monitoring and assurance. There is a plan in place to rectify this and corporate and local induction has been included in the workforce performance report to ensure it is monitored. (Update July 2024)

Exit Questionnaires

The response rate for exit questionnaires is low (8.4% this quarter which is a significant reduction from the previous quarter). This impacts the understanding of why staff leave the Trust to enable actions to be taken to support retention. The Trust has moved to the ESR Exit Questionnaire from April 2024 which will hopefully improve the response rate in the future.

3. Key challenges now and in the medium term

- The new operational structure went live in April. This will provide an opportunity from a workforce perspective to provide further clarity on pressure points across the organisation in terms of staffing establishments, use of temporary staff, training needs, and staff development.
- Meeting training trajectories remains a challenge. However, completion of the training review will ensure appropriate focus is given to safety critical training courses.
- Clinical activity remains high which causes some challenges in terms of key metrics eg, training completion, appraisals, clinical and management supervision.
- Freedom to Speak Up Guardians (FTSUGs) have highlighted potential challenges with regards to the speaking up culture in the Trust. Analysis / exploration of this to be further discussed during June.

4. Impact of actions taken to date on the achievement of our strategic ambitions

Turnover
Figures have consistently improved for the past seven months.

Health and Wellbeing
The Committee was updated on a range of wellbeing initiatives which have been developed for staff over the previous 6 month period to support SA3 – Great Place to Work. This included a number of actions around financial wellbeing. A successful NHS Charitable Funds bid has funded a Menopause Advisor Helpline via Vivup Employee Assistance Programme from 1 May 2024. This bid has also funded a bereavement support post for six months within the Staff

Psychological Centre (SPC). It was noted that one of the key areas of absence in terms of trends was around bereavement.

Sickness

Provisional sickness figures are the lowest reported for seven months. Continued focus has been given to support staff to stay at work in terms of reasonable adjustments etc. The regional wellbeing hub continues to provide a service to providers across the region in terms of mental health support.

Appraisals

Positive improvement in appraisal rates towards the 85% standard following a targeted approach.

Training Review

Executive Management Team has approved the recommendations from the Task and Finish Group which has been in place for a number of months. Group was set up to

- Review the current training needs analysis for staff groups and settings (eg, current training commitments for registered clinical staff in inpatient/community settings).
- Prioritise training to ensure that the correct focus is put on the most important training courses.
- Recommend a framework for overseeing performance in training trajectories moving forward.

Prior to the review, 27 training courses had a standard against them, however, there were around 50 courses in total so many had no agreed standard in terms of compliance. Only 9 courses routinely met the trajectory. The group reviewed all training and some courses were removed as they were no longer relevant, whilst a couple of new courses were added.

The group identified 49 courses and these were then prioritised between 10 (greatest priority) and 3 (least priority). Based on the prioritisation all courses now have a standard against them.

The framework developed by the group recommended that only those courses of priorities 9 and 10 will be reported via the IPR to Board. All other courses will be monitored at local level through the Well Led Reviews and will be reported to the People Committee.

Review of Staffing Solutions

The Bank Staff review is ongoing, however, the Committee were updated on the work so far. This has included:

- Detailed review of systems, processes and accountability in place for Staffing Solutions.
- Communications for the bulletin and presentation at the managers meeting to help ward managers understand how to process staff for the bank. Further work will be done in relation to onboarding substantive staff.
- Exploration of ‘customer feedback’ following process map approach.
- Review of rates of pay and incentives.
- Draw down options – wage stream.
- Robust supervision plan.
- Website development.
- Development of a flexi pool.

- More responsive advert for bank only Bands 3 and 5. A shared responsibility between Staffing Solutions and operational group colleagues in short listing and interviewing of candidates.
- Embedded process for reviewing inactive workers and expectations of shifts worked.

The actions so far have seen progress in terms of recruiting to Bank posts and increasing use of Bank staff across teams.

5. Barriers to progress and impact on achievement of strategic ambitions

The key barrier to progress of strategic ambitions is the absence of an overarching workforce plan. A number of actions have been developed and will be progressed over the coming months. This will be further discussed at the People Committee Workshop in November.

6. Actions to be taken prior to next meeting of the Committee

Further analysis of concerns raised via the Freedom to Speak up Guardians where possible. Exploration of the reasons why staff may not wish to raise concerns. Culture of raising concerns to be discussed at Trust Leadership Forum and with Executive Directors during June to ensure a collective approach is taken.

7. Items recommended for escalation to the Board at a future meeting

Two key items will be discussed at Trust Board in June:

Raising Concerns/Whistleblowing Report.
The Equality, Diversity and Human Rights Annual Report.

The detail of which is included in separate papers.

In terms of further escalation, the Committee feels it has an appropriate level of assurance in terms of the risks on the Board Assurance Framework, and Committee reporting.

8. Summary of Approval, decisions and ratification of items taken the meeting

- The Trade Union Facilities Report was approved for publication in line with the Public Sector requirements.

9. Review of Board Assurance Framework and amendments thereon

At the May meeting of the People Committee, BAF risks associated with the delegated responsibility of the Committee were reviewed. The highest scoring BAF risk (scoring 16 and above) is as follows.

Risk	Score	Current gaps in assurance
254 – Failure to develop a sustainable workforce model to recruit/retain/ and support the development of the right people with the right skills to deliver safe and effective services, our strategic objectives, and contractual obligations.	4(L)X4(I) 16	• Absence of a sustainable workforce plan. • Establishment control to be reviewed to ensure accurate recording and reporting of vacancies. • Current workforce skills are not currently recorded and mapped against post requirements. • Skills gaps are not identified, and adequate training put in place to address the shortfalls. • Inclusive recruitment work has had an impact on increasing the BAME workforce but predominantly this is in lower banded posts. • Strengthening of internal process for accessing development monies required. • Release of staff to undertake relevant training and development opportunities is currently a challenge. • Lack of joined up approach between appraisals and training requirements. • Challenges ensuring the temporary workforce maintain the required skills. • More robust recording and reporting mechanisms is required to enable leadership and management development and succession planning.

There were no changes recommended to the BAF risks aligned to the work of the People Committee.

9. Recommendations

The Board is asked to:

- Note the content of the report.
- Seek further assurance from the Committee Chair and Executive Lead if required.

Brendan Hill
People Committee Chair
May 2024

Lynne Shaw
Executive Director of Workforce and OD

14. INTEGRATED PERFORMANCE REPORT ? SUSTAINABLE FOR THE LONG TERM, INNOVATING EVERY DAY (ITEM 8)

Kevin Scollay, Executive Director of Finance

15. FINANCE REPORT

Kevin Scollay, Executive Director of Finance

REFERENCES

Only PDFs are attached

15. Mth 1 Finance Update FINAL.pdf

Name of meeting	**Board of Directors**
Date of Meeting	**Thursday 27th June 2024**
Title of report	**Month 1 Finance Report**
Executive Lead	**Kevin Scollay, Executive Director of Finance**
Report author	**Kevin Scollay, Executive Director of Finance**

Purpose of the report	
To note	
For assurance	**Provide assurance and inform of the financial position reported to ICB**
For discussion	**Inform discussion to support delivery of the Trust's financial commitment**
For decision	

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

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

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

Board Assurance Framework/Corporate Risk Register risks this paper relates to
2545 – Failure to deliver sustainable financial position, 1687 – Managing resources effectively, 1762 – Restrictions in capital expenditure

Month 1 Finance Report

1. Executive Summary

1.1 **At Month 1 the Trust has generated a £2.5m deficit.**

1.2 This deficit is **in line with the financial plan at Month 1**. This plan is phased to deliver deficits in the first 9 months of the year and surpluses for the last quarter of the year.

1.3 At the end of Month 1 the Trust has spent £0.9m on agency staff against a plan £0.9m.

1.4 **Expenditure on the Trust capital programme is forecast to be £2.4m higher than the plan**. The Trust submitted a plan compliant with the CDEL limit allocated to the Trust. The trust planned delivery will breach the CDEL limit.

1.5 **The Trust has a cash balance of £38.6m** at the end of Month 1 which is behind the plan. Trust balances are planned to fall significantly through the year.

2. Key Financial Targets

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

Table 1

	Month 1		
Key Financial Targets	**Trust Plan**	**Actual**	**Variance/ Rating**
I&E – Surplus /(Deficit)	(£2.4m)	(£2.5m)	(£0.1m)
Agency Spend	£0.9m	£0.9m	(£0.0m)
Cash	£39.2m	£38.6m	£0.6m
Capital Spend	£1.0m	£0.7m	£0.3m

3. Financial Performance

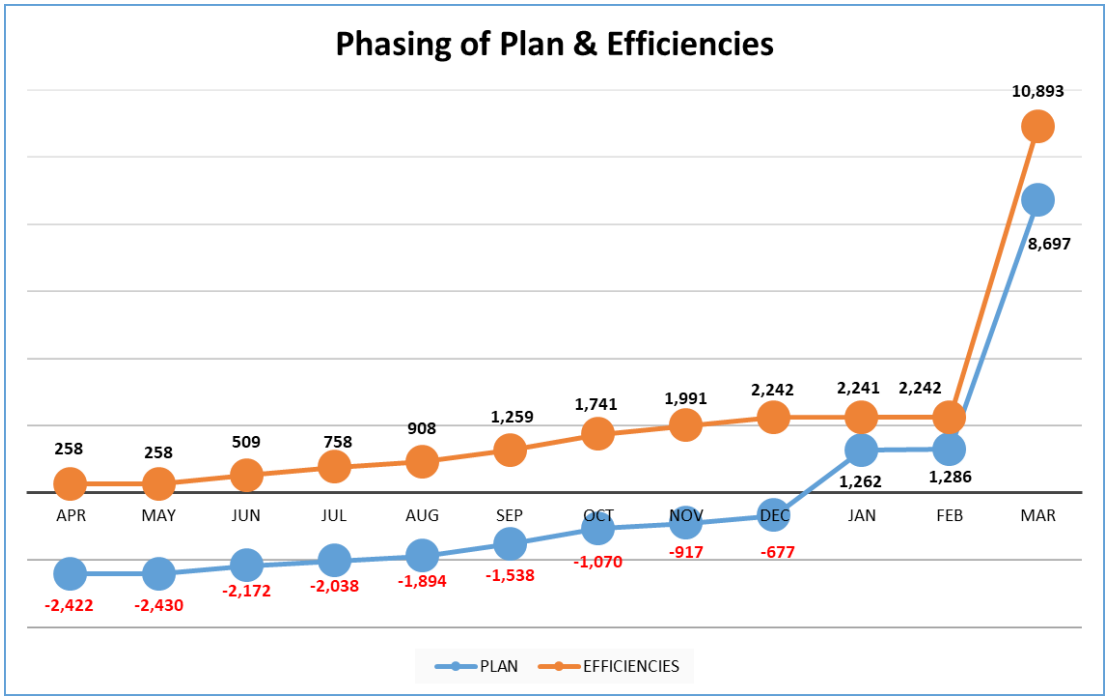
Income and Expenditure

3.1 At the end of Month 1 the Trust has reported a £2.5m deficit on Income and Expenditure, which is in line with the plan submitted to NHSE.

3.2 The Trust monthly planned deficit/surplus is shown in the graph below (blue line). The Trust is planning for deficits through Q1 to Q3 and then surpluses in Q4. The surpluses are generated from delivery of the trust efficiency plan. The graph below includes the phasing of the delivery of the efficiency plan (amber line). The significant increase in delivered efficiency in Month 12 reflects recognition of non-recurrent benefits (such as non-recurrent income) and a gain on disposal planned at the end of the year.

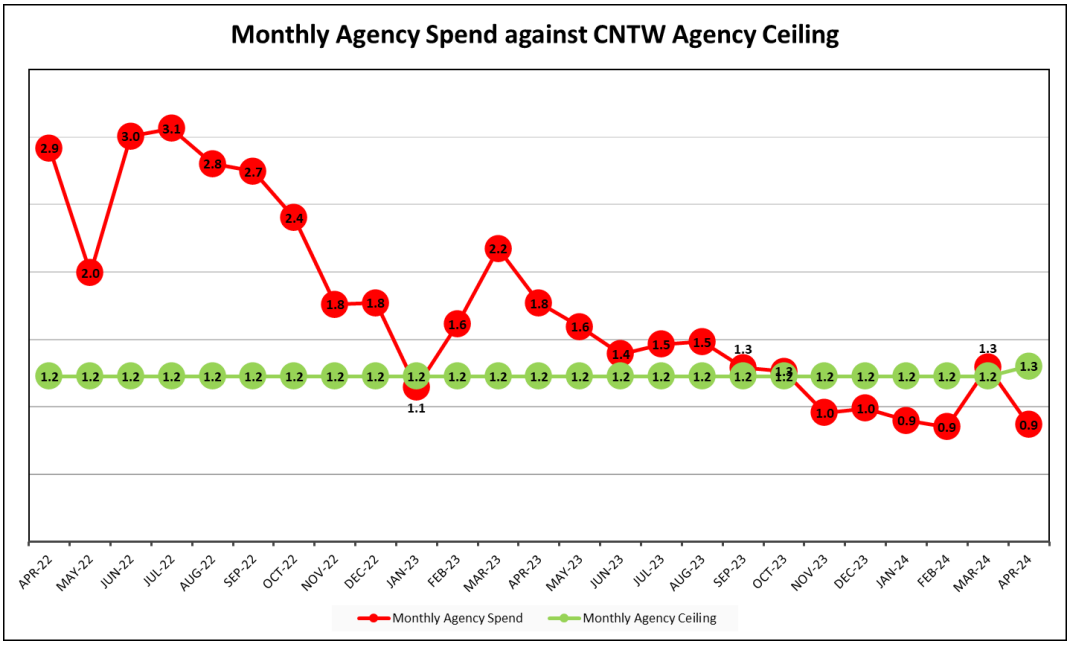
3.3 The trust plan includes £6.2m unidentified efficiencies. The Trust does not have a detailed plan for delivery of these efficiencies at Month 1. It is expected that a plan will be available for the Month 2 closedown and will support an overall financial forecast to submit to the ICB and NHS England as part of the Month 2 reporting process.

Graph 1



3.4 Graph 1 below highlights the agency performance from April 22. The Trust has spend £0.9m on agency in April. This is below the expected agency ceiling for NHS Providers of 3.7% of the Trust paybill. Note the ceiling has increased to £1.3m a month in April reflecting the increase in staff costs for 24/25.

Graph 2



3.5 While the Trust has seen a signifincant reduction in agency staffing through 2023/24 the overall staffing numbers showed a very slight increase. Table 2 below shows the total wte staffing in April against the pre-COVID staffing levels (Dec 19), 24 months ago, 12 months ago and last month.

Total wte have reduced from last month by 20, with a reduction in substantive staff of 66 and agency staff of 53 offset by an increase in bank useage of 99 wte. The trust annual workforce plan identifies a reduction of over 450 wte in 24/25.

Table 2

	Dec-19	Apr-22	Apr-23	Mar-24	Apr-24	Change since last month	Change 12mth	Change 24mth	Change since Dec-19
COMMUNITY CARE GROUP	2,491	2,761	3,011	3,026	3,040	14	29	279	548
INPATIENT CARE GROUP	1,538	1,810	1,976	1,979	1,990	11	13	180	452
SPECIALIST CARE GROUP	1,809	1,772	1,954	1,912	1,920	9	-34	149	111
LOCALITY BASED MGT	34	42	48	50	0	-50	-48	-42	-34
CLINICAL SUPPORT	336	392	441	479	480	1	39	88	144
	6,209	6,777	7,430	7,445	7,430	-15	0	653	1,222
CORPORATE & OTHER	1,159	1,250	1,348	1,340	1,335	-5	-14	85	176
	7,367	**8,026**	**8,778**	**8,785**	**8,765**	**-20**	**-13**	**739**	**1,398**

	Dec-19	Apr-22	Apr-23	Mar-24	Apr-24	Change since last month	Change 12mth	Change 24mth	Change since Dec-19
TRUST PAY	6,798	7,368	8,090	8,233	8,167	-66	77	799	1,369
BANK	302	205	293	342	441	99	148	236	140
AGENCY	268	453	395	210	157	-53	-238	-297	-111
	7,367	**8,026**	**8,778**	**8,785**	**8,765**	**-20**	**-13**	**739**	**1,398**

4. Cash

Table 3

	Year To Date		
	Plan (£m)	**Actual (£m)**	**Variance/ Rating (£m)**
Cash	39.2	38.6	0.6

4.1 Cash balances at the end of April are a little below the plan. The Trust cash balances have reduced by £2.6m from the £41.2m reported at the end of March.

4.2 The Trust is on plan for I&E and has a small underspend on the capital programme which support cash balances the Trust has seen a £5.2m increase in debtors (monies owed to the Trust) while creditors (monie owed by the Trust) has remained consistent with last month. The increase in debtors has reduced cash balances in Month 1.

5. Capital & Asset Sales

5.1 The Trust capital spend at the end of month 1 is £0.3m behind plan.

5.2 The Trust forecast includes a risk of £2.4m over the planned capital programme (CDEL limit) submitted in the annual plan. This is due to the approval of the older people's services business case, which includes the unavoidable movement of services from the CAV site. The Trust continues to forecast slippage against the overall capital programme but is highly likely to overspend based on current information.

5.3 The risk to the Trust CDEL limit of £2.4m does not included several other risks being cited as pressure against the capital programme:

- S136 suite on the SNH site
- Community estate in North Cumbria which is likely to require significant investment
- Replacement of air conditioning system at Benton House
- Inflation attached to CEDAR currently being managed with contractors

Table 4

	Year To Date			Year End		
	Plan (£m)	**Actual (£m)**	**Variance/ Rating (£m)**	**Plan* (£m)**	**Forecast (£m)**	**Variance/ Rating (£m)**
Capital Spend	1.0	0.7	(0.3)	16.6	19.0	2.4
Asset Sales	0.0	0.0	(0.0)	6.4	6.4	(0.0)

6. Recommendations

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

16. RESOURCE AND BUSINESS ASSURANCE COMMITTEE REPORT

Kevin Scollay, Executive Director of Finance

REFERENCES

Only PDFs are attached

16. RABAC Committee Assurance Report - Mar 24.pdf

Board Committee Assurance Report
Council of Governors Meeting
Thursday 27th June 2024

Name of Board Committee	**Resources and Business Assurance Committee**
Date of Committee meeting held	3 May 2024
Date of next Committee meeting	7 August 2024

1. Key areas of Focus

- 23/24 Financial Position Report – **discussion and assurance**
- 24/24 Financial Planning – **discussion**
- CEDAR update – **discussion and assurance**
- Annual Cost Collection – **approval of process**
- Specialist Mental Health Provider Collaborative update (incl. update on Birch Ward) – **assurance**
- Lead provider update – **assurance**
- Digital projects update – **assurance**
- Digital – Cyber and DSPT Update – **discussion and assurance**
- BAF and Risk exception report – **assurance**
- Information items (sub-group minutes) – **information only**

2. Current risks and gaps in assurance, and barriers to closing the gaps

During the meeting, the Committee noted and discussed the following issues in terms of current risks and gaps in assurance.

<u>24/25 Year End</u>
The committee received the Finance report relating to Month 12. The committee heard that although the Trust will report an £85m deficit, from a financial performance perspective the Trust has reported a small favourable variance of £58k. The transactions which generate the significant deficit were explained and relate predominantly to changes in accounting rules for PFI contracts, lease revaluations and impairments relating to assets which have now been fully recognised, such as the Sycamore estates development.

The committee heard the continued positive news on reductions in agency staff costs, which has ended the year below plan and is now consistently below the agency ceiling, which is positive from a regulatory perspective.

The committee heard that the Trust performed in line with ICB expectations around its capital limit (CDEL).

<u>Medium Term Financial Planning</u>
The committee received an update on the 24/25 financial plan, which was discussed and approved at an Extraordinary Board on 2nd May 2024. The committee heard about the key risks inherent in this plan. In essence these are:

- A deficit plan is unsustainable as it depletes financial resources as not adhering to NHS business planning rules.
- Planning risk exists within the current Income and Expenditure plan - £6.2m of savings are currently unidentified. The committee were advised that ideas for further savings are currently being explored.
- Delivery risk exists on existing plans – specifically risk associated with containing costs with ward budgets and corporate savings were flagged as having some risk on delivery
- Capital (CDEL) limits – the committee were advised that approval of the CAV business case creates a significant pressure on the capital envelope and the financial plan assumes slippage. There are a number of other estates developments that may create additional expenditure on the capita programme. Breaking the CDEL envelope is judged as being a high risk.
- Cash – cash reserves are expected to be significantly depleted through 24/25 as a result of how the financial plan is configured (deficit plan, high levels of non-cash items supporting I&E) and there is risk of further reductions if capital expenditure is higher than expected, which is likely based on the current commitments and other risks included in the capital plan.

CEDAR
The Committee noted the verbal update on the CEDAR project. This project has been an area of concern as Treasury approval to proceed with the plan had not been received, but now has. The committee heard an update on the current position with the land sale.

Annual Cost Collection
The committee received an update on the proposed process for the annual cost collection (previously known as reference costs). The process was approved by the committee and authorisation was delegated to the Director of Finance to approve the submission once ready. A further update on this issue is planned for August.

Digital
The committee received assurances around the delivery of digital projects. It also received an update on cyber security arrangements and the DSPT.

Commissioning
The committee heard updates on the provider collaborative and lead provider arrangements. Reporting around provider collaborative arrangements have been developed further this month. An update was received around Birch Ward (adult eating disorders) and the actions being taken to enable this ward to reopen safely.

3. Key challenges now and in the medium term

The key challenge faced by the Trust is the development of a compliant (i.e. breakeven) 24/25 financial plan, alongside the development of a medium-term sustainability plan.

Immediate challenges were reported in relation reopening Birch Ward (an adult eating disorder ward which closed to new admissions earlier this year). At time of writing, this ward was has been reopened with a phased reopening plan.

4. Impact actions taken to date are having on the achievement of our strategic ambitions

Key actions taken:

- Increased focus on delivery plans for identified – particularly in relation to at risk areas such as corporate and containing costs within ward budgets.
- Ongoing discussions are taking place with NHSE Specialised Commissioners to secure bridging income to mitigate the loss of specialist income in relation to the closure of Lennox ward.
- Birch ward (commissioned by the Trust within the Provider Collaborative) entered enhanced monitoring on quality and safety grounds. (This ward has subsequently successfully reopened with a phased plan)

5. Barriers to progress and impact on achievement of strategic ambitions

ICS Resources

The ICS, in-line with the wider NHS, is experiencing a tightening of financial resources available to invest in services and mitigate ongoing, significant underlying financial pressures. This impacts the Trust by constraining financial resources available to the Trust to continue to grow the size of the workforce. Delivery of the financial obligations of the Trust are therefore dependent on improving use of existing resources and containing expenditure within existing income envelopes. This means the Trust is required to repurpose existing resources to better effect to maintain quality and safety whilst remaining financially sustainable. This places significant emphasis on the ability of the Trust to transform its model of care in order to reduce overall costs of service deliver, which is the main focus of the current plan and strategy for the organisation.

6. Actions to be taken prior to next meeting of the Committee

The Committee were advised that focussed work is currently taking place around improving assurances around existing savings schemes. Specifically corporate and ward budgets.

An action plan has been developed around Birch Ward to ensure it is able to be reopened to new referrals safely. This has now taken place. Some elements of monitoring will remain at an enhanced level around this ward to ensure the improvements achieved to date are sustained and assurances received ongoingly in the short term that quality and safety standards are maintained.

7. Items recommended for escalation to the Board at a future meeting

The underlying financial position remains a continued area of emphasis, though no specific items are escalated at this point.

8. Summary of Approval, decisions and ratification of items taken the meeting

The Committee were asked to approve the plan relating to the annual cost collection and delegation of approval of the submission to the Director of Finance.

9. Review of Board Assurance Framework and amendments thereon

At the May meeting of the Resources and Business Assurance Committee, BAF risks associated with the delegated responsibility of the Committee were reviewed. The highest scoring BAF risk (scoring 16 and above) is as follows.

Resource and Business Assurance Committee		
BAF Risk 2545	**Residual Score 16**	
Failure to deliver a sustainable financial position and longer-term financial plan, will impact on Trust's sustainability and ability to deliver high quality care.	**Likelihood**	**Impact**
	4. Likely	**4. Significant**
Gaps in assurance		
• —(No longer relevant as Groups will move to new structures and in year financial position is fully mitigated) • Absence of a medium/long-term financial plan. • Absence of medium financial recovery trajectories by service line • 24/25 plan is unsustainable (£3.9m deficit) and contains £6.2m of unidentified efficiencies		

The Committee noted the scoring attached to the risks and determined that risk 2545 is appropriately score. Given the scoring and the required focus strategically, a specific report is provided to the Board on the financial position.

9. Recommendations

The Board is asked to:

- Note the content of the report.
- Seek further assurance from the Committee Chair and Executive Lead if required.

Paul Breen
RABAC Chair
May 2024

Kevin Scollay
Executive Director of Finance

17. CHARITABLE FUNDS COMMITTEE

Kevin Scollay, Executive Director of Finance

REFERENCES

Only PDFs are attached

17. Charitable Funds Committee Assurance Report June 2024.pdf

Board Committee Assurance Report
Meeting of the Council of Governors
Thursday 27th June 2024

Name of Board Committee	**Charitable Funds Committee**
Date of Committee meeting held	1 May 2024
Agenda items/topics considered	See below
Date of next Committee meeting	31 July 2024

1. Key areas of focus

The meeting was chaired by Louise Nelson as Vikas Kumar who recently took over as Committee Chair dialled in from outside of the country.

A Charity Chairs Network has been recently formed by Newcastle Hospitals with the purpose to bring together Chairity Chairs across the North East and North Cumbria (NENC) to explore not only individual practices in the charities but to learn more about and from one another and to determine whether there was more to understand about the ICB in relation to our charities, fundraising and grant-making as well as exploring future working across the ICB. At the meeting it was suggested for Trusts to identify three needs and options to address health inequalities. The Charitable Funds Committee suggested, health inequalities for ethic groups, a focus on Learning Disability and Neurodiversity as well as exploring community spaces to be taken further at Board level to agree the three priority areas.

The Committee received an update on the expenditure log, and fund balances including the Trust's general 'Shine' Fund. Ten new funds were opened during period. Two applications were declined as the Committee decided that the purpose the application should not be funded through Charitable Funds and that the application could not be equitable across all Trust wards. Three Applications are awaiting further information and discussion.

2. Current risks and gaps in assurance and barriers to closing the gaps

2.1 Charity accounts update

The Committee received an update of the Charity accounts and financial position. Income from donations were comparable with the same period in the previous year. Charitable Activities expenditure shows much higher than the same period last year, this is primarily due to the agreement made in 2021 to donate £100k to the Trussell Trust and a corresponding increase in staffing charge, which is offset by the grants funding, received for the Marketing Officer Post. The net movement in fund balances is a decrease of just over £102k.

Cazenove's portfolio for indirect exposure to tobacco, alcohol and gambling has been received which remained under 1% of the portfolio and will be reported quarterly moving forward so the committee can remain updated.

2.2 Charity resource and support

It should be recognised that the Charity activity, awareness, and fundraising activities has increase significantly since summer 2023 following the move of the portfolio to the Communications Team directorate and investment in the Marketing Officer and Apprenticeship post. The Corporate Trustee (Board of Directors) are asked to note that the Marketing Officer is a temporary post, funded by NHSE up to the end of June 2024. The ability to sustain progress of charity activity will be greatly affected by the loss of this post and the Director of Communications and Corporate Affairs will be discussing this with the Committee Chair and Executive Director of Finance in the coming months.

3. Key challenges now and in the medium term

3.1 Positioning of NHS mental health and disability charities

The key challenge for the Trust Charity remains around our ability to compete with NHS Acute charities and increase the focus on the benefits of our charity on the wellbeing of people with mental health and disability issues. Whilst retaining its original name, the new SHINE brand now provides reference to its connection with the NHS and supporting NHS care.

3.2 Payment to NHS Charities

The Trust received a letter from NHS England to Chief Finance Officers of NHS Providers regarding payments to NHS Charities. The letter states that there have been some instances of Trusts moving money to their Charity, presumably with the intention of avoiding CDEL rules for creating buildings etc. The letter adds that payments from a Trust to their Charity would not be approved by the Treasury. The group confirmed that this would not impact any Trust raising funds for their charity but were asked to note the content of the letter.

4. Impact of actions taken to date on the achievement of our strategic ambitions

4.1 Impact of the charity of patient care and wellbeing

In line with the improved governance arrangements, the Committee continues to meet monthly to review and approve bids for fund use. 17 applications to withdraw from specific funds and 10 applications to withdraw from the Shine Fund. The impact of the funds on patient care, support for carers and staff continues to be shared in line with the Charity Annual Plan and Strategy. The improved communications and engagement to support the charity outlines the positive impact initiatives can have on the wellbeing of those who use our services, as well as our workforce.

A key aim of our marketing approach has been to refresh and relaunch the charity brand promoting the value, support and impact of donors, volunteers, and supporters. This includes encouraging and increasing fundraising efforts and raise the profile of mental health and learning disabilities and help tackle the stigma often associated. The Committee was provided with examples of the new integrated marketing approach has used to develop a wide range of print and digital assets to inform, educate and encourage support and fundraising efforts.

Our approach during the period has resulted in the use of video's, radio promotion and interviews with those who have been impacted positively by charitable donations and

strengthening of online content including use if imagery, stories, and functionality of the intranet and website.

Following the success of the last seven months we plan to increase the number of fundraising activities throughout 2024 and beyond. We have seen a large increase in donations via fundraising events already and we are confident this will continue. We are exploring new opportunities working with external organisations i.e., through corporate giving schemes and relationships with external corporate organisations Starbucks, Newcastle United Foundation, Foundation of Light, Barbour and others. We are also hoping to secure a patron for the Charity over the coming months.

There has been the launch of the new Shine signage on St Nicholas Hospital site and is planned to be rolled out across all sites in the coming months. These signs are colourful and have a QR code enabling easy access for further information or to donate.

4.2 Example of the impact the charity can have…

The Committee received an update on the launch of the Cycle Hub at St Georges Park which has gained lots of engagement through social media promotion and the Committee will receive an update from St Georges in the coming months. Stagecoach in Cumbria have been promoting Shine at Carlilse and Workington bus stations on over 100 posters on buses and via communications on their Twitter account which has over 8,000 followers. Bellway have recently donated £500 to Shine. There have been several Great North Run fundraisers launched and supported as well as a Volunteer Fundraising Committee being launched soon and supporting a number of upcoming fundraisers such as EIP team's voyage, Hadrian's Wall Walk and Hopewood Parks 10-year anniversary.

5. Barriers to progress and impact on achievement of strategic ambitions

See section 2.2 above.

6. Actions to be taken prior to next meeting of the Committee

- Continuous review the charity investment portfolio.
- Update from the Chair following the NHS Charity Chairs meeting and review any learning and opportunities for joint working.
- Discuss future resource support for the Charity.

7. Items recommended for escalation to the Board at a future meeting

There are no items for escalation to the Board at this stage and the Committee feels it has an appropriate level of assurance in terms of management of the Charity on behalf of the Corporate Trustee (Board of Directors).

8. Summary of Approval, decisions and ratification of items taken the meeting

The Committee continues to review and approve individual bids from services in line with the delegated authority outlined in its terms of reference.

9. Review of Board Assurance Framework and amendments thereon

There are no BAF risks associated with the Charitable Funds Committee.

10. Recommendations

The Board is asked to note the content of the report and seek further assurance from the Committee Chair and Executive Lead if required.

Louise Nelson **People Committee Chair** **March 2024**	Debbie Henderson **Director of Communications and Corporate Affairs**	Kevin Scollay **Executive Director of Finance**

18. AUDIT COMMITTEE ASSURANCE REPORT

David Arthur, Committee Chair

REFERENCES

Only PDFs are attached

18. Audit Committee Assurancce Report - May (June Board) 24.pdf

Board Committee Assurance Report
Meeting of the Council of Governors
Thursday 27th June 2024

Name of Board Committee	**Audit Committee**
Date of Committee meeting held	8 May 2024
Agenda items/topics considered	See Appendix A
Date of next Committee meeting	19 June 2024 – Annual Report and Accounts review

1. Chair's summary

The May meeting of the Audit Committee was a particularly busy meeting, which included 'business as usual' assurance items, as well as end of year submissions for review in line with the Trust's annual reporting process.

As well as items covered elsewhere in this report, the meeting received updates in relation to formal reports to support the development of the Trust Annual Accounts and governance statements to support the Trust Annual Report. The full agenda is detailed in Appendix 1. From an internal and external audit perspective, the Committee also reviewed the External Audit Strategy memorandum which summarised the audit approach for the year, highlighted audit risks and areas of key judgements as of 31 March 2024. Local Counter Fraud provided an update on work undertaken between January and April 2024 including an update on correspondence from NHSE regarding a recent judgement made by HM Treasury in respect of payments from NHS Trusts to their respective charities.

Key issues from the meeting are provided in the following sections.

2. Current risks and gaps in assurance, and barriers to closing the gaps

2.1 Limited assurance internal audit report on Duty of Candour

The Associate Director of Safer Care provided an update on the actions taken to address the audit recommendations within the report. The recommendations had been discussed in detail at the Trust wide Safety Group which included a review and update of the Being Open Policy Guidance Note (PGN) to ensure it aligns with national guidance and PSIRF recommendations, a review and update of the practice expectations to ensure that a clear process is in place, and a review of where information needs to be recorded. A collaborative piece of work has been undertaken with the Digital Team to design a new RiO form which will ensure that Duty of Candour will be recorded within a patient record moving forward. Sessions at managers meetings and other forums to raise the profile of Duty of Candour have also been implemented.

The Committee referred to the communications used in the Duty of Candour process, and it was noted that further work was required to ensure accessibility standards were met. Internal Audit confirmed that a clear and robust action plan was in place, and it was agreed that a follow up review will be included in the 2024-25 Internal Audit plan.

2.2 Limited assurance internal audit report on local induction (onboarding process)

Lynne Shaw, Executive Director of Workforce and Organisational Development provided an update on the actions taken in response to the recommendation made. These included strengthening messaging to managers across the organisation, increasing attendance at the

management skills programme which includes induction delivery, improvements in terms of ID checks on individuals on the first day of employment with the Trust, and undertake a review of Trust Induction policy. Again, a follow-up review will be included within the 2024-25 Internal Audit Programme.

3. Key challenges now and in the medium term

In carrying out its work, the Committee will primarily utilise the work of Internal Audit, External Audit, and other independent assurance functions, but will not be limited to these audit functions. The Committee will seek reports and assurance from Directors and managers as appropriate, based on the key risks and issues facing the organisation in the context of integrated governance, risk management and internal control. This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

The Committee received the update on the draft accounts and significant transactions in relation to 2023/24. This included updates on financial performance and the NHS financial framework, impairments (relating to both owned and leased property), and IFRS 16 liability measurement principles to PFI liabilities.

The key challenge remains the long term financial sustainability for both the Trust, NENC Integrated Care System and the NHS as a whole, particularly in terms of the lack of clarity currently at a national level in terms of long term planning.

4. Impact actions taken to date are having on the achievement of our strategic ambitions

4.1 PSIRF Update

The Committee noted the assurance provided in terms of the work undertaken to implement PSIRF, particularly in the context of the three safety priorities in relation to self-harm, violence and aggression and physical health. Training has been provided to 600 clinical staff to date and incident policies and practices have been updated to align with the PSIRF Policy and Plan. The update included an overview of processes associated with Early Learning Reports (ELR) and After-Action Reviews (AAR). The Committee were also advised of the expectation that approximately 10-12 Patient Safety Incident Investigations (PSII) will be undertaken per year. Clarification on the responsibilities of the Board for reviewing and signing off PSIIs will be provided to the August meeting.

4.2 EPRR / staff attack alarms

The Director of Health, Safety Resilience and Innovation provided an update on the Trust's compliance with EPRR Core Standards and staff attack personal alarms. Strong assurance was provided on the work undertaken during 2023-24 to fulfil the EPRR agenda and assurance around business continuity, although it was noted that compliance against the standards was at 62.5% however, the Committee were assured that plans were in place to address non-compliant actions by the end of quarter 2.

With regard to staff attack and personal alarms, an issue was previously identified following receipt of the Health and Safety Executive (HSE) Improvement Notice of a lack of ability for staff attack alarms to work in the grounds between the Mitford Unit and Bungalows. Assurance was provided that the issue had been resolved, with additional sensors being placed on the

site which enable the alarms to work. Additional information was provided on improvement work ongoing in relation to maintaining staff safety across the Trust.

4.3 Cyber-security risks
The Head of Informatics and Infrastructure provided an update in relation to cyber related assurance referring to several ongoing external assessments to provide additional assurance, as well as internal mitigations in place. It was noted that a recent back-up audit provided 'substantial' assurance with no recommendations which is testament to the focused work undertaken in this area.

4.4 Internal Audit progress update
The Internal Audit report provided detail on twelve final reports issued during the period. Delivery of the plan remains on track. The core assurance audits remain on schedule to be completed in time for the Head of Internal Audit Opinion.

Audit involvement has continued with the Patient Safety Incident Response Framework (PSIRF) implementation, with a number of observations including, improving PSIRF Oversight Group meeting attendance, ensuring meetings are minuted, and ensuring expectations are clear for group leads that action plan dates must deliver timely outputs to the Group.

Overall, the Internal Audit programme continues to be aligned to the Trust's Board Assurance Framework and key areas of risk and focus for the organisation.

4.5 Draft Head of Internal Audit Opinion
Internal Audit presented the draft Internal Audit Plan for 2024/25 and reported that the draft Head of Internal Audit Opinion provides good assurance that there is a sound system of internal control, governance and risk management designed to meet the organisation's objectives and that controls are generally being applied consistently.

5. Barriers to progress and impact on achievement of strategic ambitions
See section 3 and section 8.

6. Actions to be taken prior to next meeting of the Committee

- Ensure accessibility issues relating to Duty of Candour are being addressed/actioned.
- Continue in discussions with regional Audit Committee Chairs regarding risk management processes / policies and BAF development.
- Take steps to improvement the position regarding management responses to internal audit recommendations.
- Clarification on the responsibilities of the Board for reviewing and signing off PSIIs will be provided to the August meeting

7. Items recommended for escalation to the Board at a future meeting
Key items which were discussed in detail for the Board's awareness related to governance reports and reviews in line with the Trust's annual reporting process:

7.1 CQC notification
The Executive Director of Nursing, Therapies and Quality Assurance reported that notification was received from the CQC of their intention to undertake further investigation via the National team, following an incident in 2022. This item will be discussed at the June Board meeting.

7.2 Audit Committee annual effectiveness and terms of reference review
The annual effectiveness review was undertaken in line with the guidance from the NHS Audit Committee handbook. Eight members of the committee completed the review, and strong assurance was provided on its performance throughout the year. There were no significant issues to note. The terms of reference have been reviewed and are included for approval in the June Board papers.

7.3 Audit Committee Annual Report 2023/24
This outlines the business of the Committee for the year and will be included in the Trust Annual Report 2023/24 at the Extraordinary Board meeting to be held in June.

7.4 Draft Annual Governance Statement 2023/24
The Committee received the draft Annual Governance Statement, a statutory statement which explains the processes and procedures in place to enable the Trust to operate effectively including, systems of internal control, governance, risk and effective use of resources. The final AGS will be included in the Trust's Annual Report 2023/24.

7.5 Trust compliance against the requirements of the NHS Code of Governance
The Committee received the report on compliance with the Code, noting that the Trust remains compliant for all requirements, except the following:

Section B 2.5 and Section D 2.1 – the requirement that the Trust appointed Senior Independent Director (SID) is not also the Chair of the Audit Committee. It was noted that David Arthur holds the role of both SID and Chair of the Audit Committee.

It has been determined that no conflicts exist in this regard and the Board are asked to support an explain approach to this requirement and the recommendation that David continues in these roles. David will be stepping down from his role in January 2025 at which point, the role of SID will be reviewed.

7.6 Proposed amendments to the Standing Financial Instructions
The Audit Committee supported the proposed amendments which are included on the June Board for approval.

7.7 Proposed collaboration on risk management
David Arthur referred to discussions with Audit Chair colleagues across the region, and proposals around an opportunity to share learning in terms of risk management processes and the development, and use of Board Assurance Frameworks.

7.8 Management responses to Internal Audit Recommendations
David Arthur asked that concerns regarding the management delays in responding to Internal Audit recommendations be escalated to the Board to request support from the Executive Team to ensure timely responses in future.

8. Review of Board Assurance Framework/Corporate Risk Register
Louise Nelson attended the meeting as Chair of the Quality and Performance Committee and provided a strong level of assurance that the Committee continues to monitor, review and discuss risks associated with its remit and delegated authority from the Board.

BAF risks associated with the delegated responsibility of the Committee were reviewed. The highest scoring BAF risk (scoring 16 and above) were as follows.

Quality and Performance Committee		
BAF Risk 2510	**Residual Score 16**	
Due to increased demand the Trust is unable to meet regulatory standards relating to access, responsiveness, and performance resulting in a risk to quality and safety of services.	**Likelihood**	**Impact**
	4. Likely	**4. Significant**
Gaps in assurance		
Gaps in Controls/Assurances include: • Demand for key pathways significantly exceeding capacity and requiring radical redesign. • Ability to recruit and develop skills to provide quicker access to evidence based treatments. • Keeping In Touch process for service users on assessment waiting lists which the numbers are significantly high. • Fully implement 4 week waits. • Embed the Trusted Assessment concept into community services. • Increased external demand on crisis services, specifically Right Care Right Person and NHS 111. • Crisis and alternatives to admission. • Lack of specialist provision for some patient groups. • Limited availability of seven-day week service provision from both an inpatient and community perspective. • Lack of intermediate care opportunities.		
Resource and Business Assurance Committee		
BAF Risk 2545	**Residual Score 16**	
Failure to deliver a sustainable financial position and longer-term financial plan, will impact on Trust's sustainability and ability to deliver high quality care.	**Likelihood**	**Impact**
	4. Likely	**4. Significant**
Gaps in assurance		
•—(No longer relevant as Groups will move to new structures and in year financial position is fully mitigated) • Absence of a medium/long-term financial plan. • Absence of medium financial recovery trajectories by service line • 24/25 plan is unsustainable (£3.9m deficit) and contains £6.2m of unidentified efficiencies.		
People Committee		
BAF Risk 2542	**Residual Score 16**	
Failure to develop a sustainable workforce model to recruit/retain/ and support the development of the right people with the right skills to deliver safe and effective services, our strategic objectives, and contractual obligations.	**Likelihood**	**Impact**
	4. Likely	**4. Significant**
Gaps in assurance		

• Absence of a sustainable workforce plan. • Establishment control to ensure accurate recording and reporting of vacancies. • Current workforce skills are not currently recorded and mapped against post requirements. • Skills gaps are not identified, and adequate training put in place to address the shortfalls. • Inclusive recruitment work has had an impact on increasing the BAME workforce but predominantly this is in lower banded posts. • Strengthening of internal process for accessing development monies required. • Release of staff to undertake relevant training and development opportunities is currently a challenge. • Lack of joined up approach between appraisals and training requirements. • Challenges ensuring the temporary workforce maintain the required skills. • More robust recording and reporting mechanisms is required to enable leadership and management development and succession planning.

A discussion took place at People Committee, Quality and Performance Committee, and Resource and Business Assurance Committee regarding the ongoing appropriateness of the risks, risk descriptors, mitigations, and actions.

It was recognised that the new Board Assurance Framework was providing an important vehicle for Committees to sense-check and seek assurance that agendas, planning, discussions, and areas of focus were relevant and linked to the key issues facing the Trust.

It was agreed that a review of the risks and descriptors be undertaken during Q1 for each of the BAF risks with this learning in mind to ensure the value of the BAF in terms of informing focus remains in place, and indeed improves over time.

Corporate Risk Register (16+ high level risks)

The Committee also reviewed the Corporate Risk Register risks – the risks scoring 16+ with Executive/Director oversight. The risks, where appropriate, were aligned to relevant BAF risks supporting additional assurance in terms of the management of risks associated with the BAF.

The Committees noted that at the Trust's Executive Management Group meeting held 22 April, a discussion and sense-check took place on the Corporate Risk Register and what was perceived as the highest-level risks in the organisation (excluding the Board Assurance Framework risks). It was noted that there were potential gaps in relation to the following:

- Waiting times
- Access to Crisis Services
- Financial planning and delivery

It is proposed that these risks be considered during the next quarter with any additions to the Corporate Risk Register being reflected in the quarter 1 2024/25 report.

9. Recommendations

The Board is asked to:

- Note the content of the report.
- Seek further assurance from the Committee Chair and Executive Lead if required.
- **Support the recommendation** in section 7.5 to take an 'explain' approach to the requirements B 2.5 and D 2.1 of the NHS Code of Governance, which recommends that the Senior Independent Director should not undertake the role of Audit Committee Chair

David Arthur
Audit Committee Chair
Date: 23 May 2024

Appendix A – Audit Committee key agenda items
31 January 2024

- Chairs business
- Update on Patient Safety Incident Response Framework (PSIRF)
- Emergency Preparedness, Resilience and Response (EPRR) including Staff Attack Alarms update
- Update on Cyber Security / Risks
- Quality and Performance Committee review of risk management processes
- Audit Committee self-assessment outcome and Terms of Reference review
- Audit Committee Terms of Reference review
- CQC Visits and NHS Improvement Issues – by exception only
- Board Assurance Framework and Corporate Risk Register Q4 2023/24
- CNTW Audit Strategy Memorandum 2023/24
- Internal Audit Progress Report
- CNTW Group – suggested 2024/25 Internal Audit Plan 2024/25 including Draft Head of Internal Audit Opinion
- Limited Assurance Internal Audit Report on Duty of Candour
- Limited Assurance Internal Audit Report on Local Induction (Onboarding) Process
- CNTW Group Counter Fraud Progress Report January – March 2024
- Payments to NHS Charities – for information
- Significant Transactions 23/24 including Draft Group Annual Accounts 23/24
- Accounting Standards and Accounting Policies
- Finance AC Paper Group Losses and Special Payments
- Going Concern Report
- Group Waivers Report
- TCWG Responses Trust and NTWS
- Draft Annual Governance Statement
- Draft Audit Committee Annual Report 2023/24
- Compliance against the NHS Code of Governance
- Third Parties Annual Report
- Proposed Amendments to Standing Financial Instructions

19. ANY OTHER BUSINESS / ITEMS FOR INFORMATION / QUESTIONS FROM GOVERNORS AND THE PUBLIC

Darren Best, Chair

Date of Next Meeting
19 September 2024
2pm - 4pm
Trust Board Room and via MS Teams