Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

COUNCIL OF GOVERNORS GENERAL MEETING

COUNCIL OF GOVERNORS GENERAL MEETING

28 November 2024

14:00 GMT 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 28.11.2024.pdf

Council of Governors Business Meeting Agenda

Council of Governors Business Meeting **Venue: Trust Board Room, St Nicholas Hospital and Via Microsoft Teams**	**Date: 28 November 2024** **Time: 2:00pm – 4.00pm**

	Item	Lead	
1.	**Business agenda items**		
1.1	Welcome and Apologies for Absence: Debbie Henderson	Darren Best, Chair	Verbal
1.2	Declaration of Interest	Darren Best, Chair	Verbal
1.3	Minutes of the meeting held 19 September 2024	Darren Best, Chair	Enc
1.4	Action log and matters arising from previous meeting	Darren Best, Chair	Enc
1.5	Chair and Chief Executive update	Darren Best, Chair / James Duncan, Chief Executive	Enc
1.6	Governor Steering Group update	Darren Best, Chair	Verbal
1.7	Council of Governors Committee and sub-group terms of reference	Kirsty Allan, Deputy Trust Secretary/ Corporate Governance Manager	Enc
1.8	Lead Governor Appointment – for approval	Darren Best, Chair	verbal
1.9	2025 Governor Service Visits	Kirsty Allan, Deputy Trust Secretary/ Corporate Governance Manager	Enc
2. Strategic Ambition 1 – Quality care, every day			
2.1	Quality and Performance Committee Report	Louise Nelson, Committee Chair	Enc
2.2	Mental Health Legislation Committee Report	Michael Robinson, Committee Chair	Enc

2.3	Integrated Performance Report – Quality care, every day	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance & Dr Rajesh Nadkarni, Deputy Chief Executive/ Medical Director	Enc
2.4	Quality priorities update	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance	Pres
2.5	CQC update	Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance	Verbal
3. Strategic Ambition 2 – Person led care, where and when it's needed			
3.1	Mental Health services – West Cumbria update	Ramona Duguid, Chief Operating Officer	Verbal
3.2	Programmes of work update	Ramona Duguid, Chief Operating Officer	Verbal
3.3	Integrated Performance Report – Person led care, when and where it's needed	Ramona Duguid, Chief Operating Officer	Enc
4. Strategic Ambition 3 – a great place to work			
4.1	People Committee Report	Brendan Hill, Committee Chair	Enc
4.2	Integrated Performance Report – A great place to work	Lynne Shaw, Executive Director of Workforce and OD	Enc
5. Strategic Ambition 4 – sustainable for the long term, innovating every day			
5.1	Resource and Business Assurance Committee Report	Paula Breen, Committee Chair	Enc
5.2	Integrated Performance Report – Sustainable for the long term, innovating every day	Kevin Scollay, Executive Director of Finance	Enc
5.3	Finance Report	Kevin Scollay, Executive Director of Finance	Enc

6. Strategic Ambition 5 – working for, and with our communities			
6.1	Charitable Funds Committee	Vikas Kumar, Committee Chair	Enc
7. Governance and Regulatory			
7.1	Audit Committee Assurance Report	David Arthur, Committee Chair	Enc
8. Any other business / items for information			
8.1	Questions from Governors and the public	Darren Best, Chair	
Date of next meeting Thursday 20 March 2025, St Nicholas Hospital Board Room and via MS Teams			

1.1 WELCOME AND APOLOGIES FOR ABSENCE

Darren Best, Chair

1.2 DECLARATION OF INTEREST

Darren Best, Chair

1.3 MINUTES OF PREVIOUS MEETING HELD 19 SEPTEMBER 2024

Darren Best, Chair

REFERENCES

Only PDFs are attached

1.3 DRAFT Minutes CoG 19.09.2024 DH.pdf

Draft Minutes of the Council of Governors Business Meeting
Thursday 19th September 2024
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
Siobahn Watson	Non-Clinical Staff Governor
Russell Bowman	Service User Governor Neuro Disability Services
Russell Stronach	Service User Governor, Autism Services
Jane Shaw	Appointed Governor North Tyneside Council
Emma Silver Price	Staff Governor Non-Clinical
Claire Keys	Staff Governor Clinical
Shannon Fairhurst	Shadow Carer Governor Children and Young People's Services
Julia Clifford	Appointed Governor CVS iCan Wellbeing Group
Neil Newman	Shadow Governor Carers for Neuro Disability
Amber Cormack	Staff Governor Clinical
Kelly Chequer	Local Authority Governor, Sunderland City Council
Jessica Juchau-Scott	Carer Governor, Older People's Services
Thomas Lewis	Medical Staff Governor
Mary Lavender	Public Governor, North Tyneside
Miriam Mafemba	Local Authority Governor, Newcastle City Council

In Attendance:

James Duncan	Chief Executive
Michael Robinson	Non-Executive Director
Kevin Scollay	Executive Director of Finance
Ramona Duguid	Chief Operating Officer
Lynne Shaw	Executive Director for Workforce and OD
Rachel Bourne	None Executive Director
Brendan Hill	Non Executive Director and Vice Chair
Paula Breen	Non-Executive Director
Robin Earl	Non-Executive Director
Vikas Kumar	Non-Executive Director
Debbie Henderson	Director of Communications and Corporate Affairs
Kirsty Allan	Corporate Governance Manager/ Deputy Trust Secretary

1.1 Welcome and apologies for absence.

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

Heather Lee	Shadow Public Governor (South Tyneside)
Elaine Lynch	Councillor Governor for Cumberland Council
Bea Grove McDaniel	Community and Voluntary Sector Governor
Fiona Grant	Service User Governor Adult Services

Fiona Regan	Carer Governor, Autism Services
Michelle Garner	Cumbria University Governor
Star Masuku	Northumbria University Governor
Rosie Lawrence	Carer Governor, Learning Disability Governor
Louise Nelson	Non-Executive Director
Sarah Rushbrooke	Executive Director of Nursing, Therapies and Quality Assurance
Rajesh Nadkarni	Deputy Chief Executive / Medical Director

1.2 Declaration of Interest
None noted.

1.3 Minutes for approval
The minutes of the meeting held on 27 June 2024 were considered and confirmed as a true record of the meeting.

The minutes of the meeting held 27 June were agreed as an accurate record.

1.4 Action Log and Matters arising from the Previous Meeting
Nothing to note.

1.5 Chair and Chief Executive Update
Darren Best explained the meeting purpose being an opportunity for Governors to fulfil their statutory responsibility of holding Non-Executive Directors to account for the performance of the Board, highlighting that Governors' meetings are important because they allow for the collective decision-making that is necessary to run CNTW effectively.

Darren referred to the Chairs report and the recent riots and public disorder across the region and country. He explained that the way in which the organisation responded to the situation was to be commended including the support and actions put in place to support the workforce. Darren attended a Cultural Diversity Network session which took place to allow people a safe space to share their personal experiences and concerns. Darren emphasised that the Trust does not tolerate any racist or discriminatory behaviour and encouraged anyone to speak up should they have any concerns or wish to seek support. Brendan Hill referred to Non-Executive Director service visits whereby staff are asked for any messages to feedback to the Board and referred to a recent visit where managers explained that the emotional and practical support received by the Trust is appreciated. From a clinical staff member perspective, Claire Keys also fed back that staff were appreciative of the support they had received.

Darren mentioned the importance of culture within any organisation and the CNTW core values being caring and compassionate, honest, and transparent which underpins the Trust Strategy ‘With You in Mind’. The Council of Governors has a significant role to play in ensuring the organisation is living those values, a good example being seeking evidence of this as part of the service visit programme.

Darren Best reminded Governors of the Annual Members / General meeting which was due to take place on 26 September and encouraged everyone to attend.

James Duncan referred to the Chief Executive Report, also referring to the receive events in local communities stating he was humbled by the support people gave, and continue to give, to each other.

James noted the successful bid for a new 24/7 community hub in Whitehaven which is an opportunity to take forward radical changes in the way the Trust delivers services in an area which is challenged by health inequalities including its rurality. The is a powerful example of the strength of collaboration and what can be achieved working across systems together, for the greater good.

James referred to the open day at Northgate Park where families, carers, local residents and staff had an opportunity to meet and see some of the facilities. The day also seen the opening of the new 'Craft Shack' shop on site, run by patients selling items made by themselves part of their recovery programme including artwork, woodwork, and plants.

1.6 Governor Steering Group update

Darren Best provided an update following the August meeting which focused on business planning for future Council meetings. The group discussed the important role played by Council of Governor representatives on Board committees. Non-Executive Director Chairs of Board committees value the input of Governors greatly on committees, and Darren noted the review of representatives to be undertaken following the November election process.

Darren Best referred to Governor service visits appreciating time constraints and personal commitments but encouraged all governors to take part where able. Service visits provide an excellent opportunity to gain a deeper understanding of how various services operate. It's also an opportunity to speak to staff, service users and carers that will help a Governors in their role to contribute to forward planning and strategic discussions. Service visit details are circulated fortnightly via the Governor bulletin.

2. STATEGIC AMBITION 1 – QUALITY CARE, EVERYDAY

2.1 Quality and Performance Committee Report

Ramona Duguid referred to the July meeting which focused on a discussion following the deep dive into Crisis services. Good discussions took place from a range of community teams talking about current service provision, areas where there have been improvements and the work the Trust is undertaking to address the challenges within services.

An update was provided on the actions to address the concerns raised earlier in the year by the Health and Safety Executive around violence reduction to ensure services and environments are as safe as possible.

The committee continues to focus on waiting times and the review of children and young people pathway for neuro-developmental needs. A separate report was discussed relating to Adult ADHD waiting lists which acknowledged the progress being made working with partners within the North East and North Cumbria Integrated Care Board (NENC ICB) on the redesign of the pathway.

Russell Bowman asked how quickly a patient receives support from being in crisis. Ramona advised that the Trust follows the national process for triaging people contacting Crisis services. If someone is triaged as urgent, they will be seen within 4 hours by the crisis team. If someone attends an A&E department and are in urgent need they should be seen by the psychiatric liaison team within the hour.

Claire Keys referred to the Nottingham report and asked if there was any scope to reintroduce Assertive Outreach Teams. Ramona stated that work has been undertaken in light of the

learning from the report which included a review of the Do Not Attend (DNA) policy and policy on keeping in touch with those individuals who are difficult to engage and engaging with the audit teams to provide assurance that policies are working well. There are different versions of assertive outreach in place throughout the Trust including step-up functions in some teams with the Trust making sure that those people within communities with life-long need for mental health care and support have wrap around care in the most appropriate way.

Darren Best suggested that following the interest shown from Governors with the organisation's responses to the Crisis deep dive, a further update on Crisis and waiting times be prioritised for a future Governor meeting.

Darren Best also suggested for a Governors development session an update on understanding the knowledge of what the parameters and processes are of crisis services which will be discussed at the next Governors Steering Group.

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

ACTION: A detailed update on Crisis Services and waiting times to be included as an agenda item on a future meeting.

2.2 Mental Health Legislation Committee Report
Michael Robinson referred to report and a discussion on detention rates. The Trust continues to monitor detentions under the Mental Health Act (MHA) through the Mental Health Legislation Steering Group (MHLSG) to compare with national trends and data and to conform with the Patient and Carer Race Equality Framework (PCREF), monitoring detention by ethnicity of service users. This area will continue to be reviewed by the Mental Health Legislation Steering Group.

The MHLSG continues to monitor compliance with the completion of Parts A and B of local forms on RiO a healthcare electronic record system relating to consent. Whilst there continues to be a low compliance rate in the completion of the local forms, the forms have been reviewed and amended to simplify the process.

Russell Bowman asked if consent is witnessed and countersigned. Michael stated that the consultant completing the form notes that consent has been given.

Most recent data indicates that compliance with Mental Health Legislation training is at 75.2%. Whilst there has been a consistent improvement in compliance rates in recent months, this is still below the target set.

Following changes in the Government, Michael stated that the timetable for legislative scrutiny and enactment of the Mental Health Bill remains unclear. However, the Kings Speech made it clear that this is a priority for the new Government and therefore it is likely that a timetable for review and enactment will emerge soon. Any draft Bill will bring many changes to the application of the legislation in practice. The Committee will continue to monitor any developments.

The Committee received the outcome of a review of panel membership and practices including benchmarking against other Trusts in the region in relation to appraisal of panel members. The Committee will review and recommend training and appraisal processes for panel members in due course.

Claire Keys asked if universities provide learning on mental health legislation noting that new preceptors noted they had no learning on accepting section papers. Michael advised that Trust training is only provided in-house and suggested he discuss this further with Dr Bruce Owen who Chairs the MLSG as an action.

The Council of Governors received the Mental Health Legislation Committee Report.

2.3 CQC Update

Ramona Duguid referred to the unannounced CQC visit in July 2024 to three learning disability wards, Roselodge, Edenwood and Mitford. There were elements of good practice highlighted following the visit and good quality, compassionate care identified from the inspection team. Following a subsequent information request from the CQC, concerns were raised at that point in relation to the use of restrictive practice across learning disability and autism services and aspects of culture and policy implementation.

Immediate action has been taken by the Trust to respond to further requests for information and action to be taken, particularly in relation to Mitford. The Trust responded to the CQC during August – September to those areas of improvement and the CQC attended the Trust on 12 September to review implementation of the actions taken. The Trust is currently awaiting the CQC first draft report, but the CQC have acknowledged the Trusts response and immediate actions taken. The Trust continues to work closely with the CQC in this regard. Ramona explained the Trust have engaged all staff teams involved in the improvements and actions which led positively, to a broader discussion around approach and pace.

The Trust have been working closely with partners the NENC ICB who have responsibility of commissioning of care for services and this includes the work to address delays in transfers of care from all the identified three units which requires a system-wide response.

Amber Cormack queried if violence against staff had been mentioned in the CQC improvements request. Ramona Duguid explained the CQC did refer to the level of violence and aggression, but this was in the context of restrictive practices. Ramona noted that the Trust has discussed the challenges of balancing the safety of staff, and the safety of patients with the CQC, ICB and Health and Safety Executive and the need to look at violence and aggression and restrictive practice together.

Russell Bowman asked when the use of restrictive practice is required how does the team assess this. Ramona referred to the positive behavioural support plans with each plan having a de-escalation curve which sets out what the care team need to do first to de-escalate the situation.

Russell Bowman also asked if the Trust had considered the fear of staff being harmed with regards to violence and aggression. Ramona Duguid advised that the Trust considers the risk of harm to staff every day as well as psychological safety of staff, support and health and wellbeing. This has been and continues to be front and centre of discussions on the violence reduction work the Trust is undertaking.

Anne Carlile asked if the CQC fully understand what it like to be a staff member working with patients with complex needs. Ramona stated that the CQC saw examples when visiting the wards of the lived experience of staff as well as patients however the Trust has a duty to continue raising the profile and doing everything possible to provide safe environments for all.

Neil Newman asked if a further update could be provided to the Council of Governors at a future session on delayed discharges and the challenges faced by the Trust. Ramona noted that delayed discharges are reviewed within the Quality and Performance Committee with regards to occupancy and flow.

The Council of Governors received the update on the CQC.

ACTION: A detailed update on delayed discharges to be given at a future meeting of the Council of Governors.

STRATEGIC AMBITION 2 – PERSON LED CARE, WHERE AND WHEN ITS NEEDED

3.1 Community Hub – West Cumberland update
Ramona Duguid provided an update on the new 24/7 Community Hub in Whitehaven which will provide an opportunity to go much further around transforming care and support for mental health in Whitehaven.

Claire Keys asked for an update on Yewdale Ward. James Duncan referred to the forthcoming engagement process across the community and partners on the model of care across West Cumbria which will include the future of Yewdale ward. The national direction of travel is rightly to highlight the risks around isolated units and moving care from hospital to community, and prevention.

The Council of Governors received the update on the Community Hub in Whitehaven.

3.2 Integrated Performance Report – Person led care, when and where its needed.
The metrics of this report was covered throughout the various agenda items.

3 People Committee Report
Brendan Hill referred to the report and highlighted key areas of focus for the next few months including the work on just culture, workforce establishment planning, leadership development, improving performance on staff training standards and reviewing how service user and carer views influence the Trust priorities and committee work programme.

Lynne Shaw mentioned over the last few months a focus has been on clinical supervision, simplifying the process and policy and noted significant improvement in compliance.

Brendan discussed the concept of a just and learning culture which has an impact on staff wellbeing, patient safety, a sense of psychological safety.

Employee relations was discussed, and assurance was provided of the overall reduction in the number of cases, and a significant reduction in the number of formal cases compared to the previous year. There is a remaining challenge around timescales with actions in place.

The Council of Governors received the People Committee report.

4.2 Integrated Performance Report – A great place to work
The metrics of this report was covered throughout item 4.1.

5. STRATEGIC AMBITION 4 - SUSTAINABLE FOR THE LONG TERM, INNOVATING EVERYDAY

5. Resource and Business Assurance Committee Report

Paula Breen referred to the report and advised that there were no significant issues to highlight. Financial performance was discussed in item 5.2.

The Council of Governors noted the Resource and Business Assurance Committee report.

5.2 Finance Report

Kevin Scollay referred to the report noting that in-year financial performance remains on track with the Trust being slightly ahead of plan due to the early realisation of benefits. The underlying position remains the key focus to achieve the plan in-year and Kevin noted that longer term financial sustainability planning remains a key challenge.

Claire Keys referred to the 5% pay award for staff and 22% for medical staff and asked if this will be funded by central government funds. Kevin advised that the Trust has been informed there will be an uplift in the Trust contract which will cover the costs of the pay award by central government funding however at this current time the uplift amount is unknown with further detail awaited.

The Council of Governors received the Finance Report.

5.3 Integrated Performance Report – Sustainable for the long-term, innovating every day

The metrics of this report was covered throughout the meeting.

6. STRATEGIC AMBITION 5 – WORKING FOR AND WITH OUR COMMUNITIES

6.1 Charitable Funds Committee report

Vikas Kumar referred to the report recognising that the Charity activity, awareness, and fundraising activities had increase significantly following the move of the Charity into the Communications Team directorate and investment in the Marketing Officer post. Vikas stated that NHS Charities Together funding for the Marketing Officer post ended on 31 July 2024 and recognising the value of the post in delivering the objectives of the charity, the Committee approve the proposal to fund the post for a further 12 months.

Time has been allocated at the October meeting to discuss the long-term objectives and purpose of the charity and how to achieve alignment with the Trust's Equality, Diversity and Inclusion and health inequalities ambitions as well as reviewing investment in community services.

The Council of Governors received the contents of the Charitable Funds Committee report.

7. GOVERNANCE AND REGULATORY

7.1 Audit Committee Assurance Report

Kevin Scollay referred to the Audit Committee report noting the planned discussion on the outcome and recommendations of the limited assurance audit relating to duty of candour and

long-term segregation was deferred. Sarah Rushbrooke provided an update via email following the committee on those items with assurance provided.

There was also a limited assurance report relating to onboarding and Lynne Shaw provided an update on the recommendations and actions in place to address the weakness in internal controls.

The number of overdue audit recommendations have increased during the period and action will be taken to improve performance in this area.

Darren Best noted that the handover period had commenced in preparation for Robin Earl taking on the Audit Committee Chair role following David Arthur's departure in January 2025.

The Council of Governors received the Audit Committee Report.

7.2 Governor Nomination Committee Report – for approval

Brendan Hill and Michael Robinson left the meeting for this item.

Darren Best referred to the report and noted that both Louise Nelson and Brendan Hill were appointed by the Council of Governors as Non-Executive Directors (NEDs) for CNTW at their meeting on 11 August 2021. Louise and Brendan commenced in post on 1 October 2021 for a three-year term of office.

The Nomination Committee reflected and discussed the outcome of the annual appraisal process and documentation for both Louise and Brendan during their first term. The Committee discussed and recognised the continuing strong performance of both Brendan and Louise as Non-Executive Directors, and People Committee and Quality and Performance Committee Chair respectively. The Nomination Committee request approval of the following recommendations:

- That Louise Nelson be reappointed as Non-Executive Director for a second three-year term from 1 October 2024 – 30 September 2027
- That Brendan Hill be reappointed as Non-Executive Director and Vice-Chair for a second three-year term from 1 October 2024 – 30 September 2027.

Darren Best also stated that Michael Robinson was appointed by the Council of Governors as a Non-Executive Director of the Trust commencing in post 16 January 2019. Michael has since served a successful first term ending 15 January 2022, and 30 successful months of his second term. Michael's second term of office is due to come to an end 15 January 2025. Michael Robinson has been a key member of the Board during his term of office, and he has provided invaluable support, insight, challenge, and expertise to many of the challenges faced by the Trust during this time.

David Arthur, Non-Executive Director, currently fulfils the role of both Audit Committee and Senior Independent Director and the Trust declared an 'explain' position in the 2023/24 Annual Report against the requirements of the NHS England Code of Governance. David will be stepping down from his role as Non-Executive Director/Senior Independent Director on 13 January 2025 when his second term of office ends.

Darren Best advised that discussions have taken place with Michael Robinson regarding an extension to his role as Non-Executive Director until 30 September 2025. Michael also accepted the proposal to take on the role as Senior Independent Director between 14 January and September 2025. The appointment process to replace the Michael's post in September will also coincide with the process to replace Paula Breen, Non-Executive Director whose term of office will end at that time, allowing the Trust to undertake a single recruitment process for two posts.

The Council of Governors:

- **Approved the re-appointment of Louise Nelson as Non-Executive Director for a second term of office to commence from 1 October 2024 – 30 September 2027.**
- **Approved the re-appointment of Brendan Hill as Non-Executive Director for a second term of office to commence from 1 October 2024 – 30 September 2027.**
- **Approved the extension of Michael Robinson's third term of office to end 30 September 2025.**
- **Approved Michael Robinson to take on the role of Senior Independent Director from 14 January 2025 to 30 September 2025.**

Brendan Hill and Michael Robinson rejoined the meeting.

7.3 Appointment process for Lead Governor
Debbie Henderson referred to the report, noting Anne Carlile as Lead Governor will be sadly stepping down due to completing a full 9 years (3 terms of office) as a Trust Governor. Anne Carlile has kindly agreed to become a charity volunteer for SHINE.

The report provides detail of the process for the appointment of Lead Governor. Expressions of interest in the role must be submitted to Debbie Henderson by 18 October 2024. The outcome of the nomination process will be announced at the November Council of Governors meeting.

The Council of Governors received the Lead Governor appointment process report.

7.4 Fit and Proper Person Test (FPPT)
Kirsty Allan informed Governors that NHS England updated the FPPT Framework on 30 September 2023, which strengthens individual accountability and transparency for Board members therefore enhancing the quality of leadership within the NHS. The framework is designed to assess the appropriateness of an individual to effectively discharge their duties in the capacity of a board member.

Kirsty confirmed the Trust have undertaken the annual fit and proper person checks in April 2024, for all Board members as well as extending the checks out to Board member deputies which provides additional assurance and results satisfy that all board members comply with the framework.

For added assurance, the Trust requested internal Audit to assess the process, controls and compliance supporting the FPPT assessments where random, sampling of testing was conducted, and a full compliance was found providing a substantial level assurance.

Darren Best commended Kirsty on the considerable effort and work undertaken to achieve a substantive level of assurance noting that the work undertaken went above that expected in the first year of implementation.

The Council of Governors received the Fit and Proper Person Compliance report.

7.5 Annual Council of Governors Declaration of Interest
Kirsty Allan referred to the report which related to annual declarations of interest received for the Council of Governors who are required to register all relevant interest onto the Trust register of interests in accordance with the provisions of the constitution even if there is a nil return. Kirsty Allan thanked the Council for their support providing their interest which will be available on the website following this meeting.

The Council of Governors received the Annual Council of Governor Declaration of Interest report.

8. Any other business / items for information

8.1 Council of Governors Elections 2024
Kirsty Allan advised the Trust commenced Governor elections on Monday 16 September for 14 vacant seats which are outlined within the report. Elections will close on Thursday 28 November and results of the election will be received on 29 November which will be made available to the Council.

The Trust has communicated elections widely, however Kirsty Allan welcomed existing Governors to promote awareness throughout their constituencies as well with friends and family.

James Duncan mentioned a member of staff, Gregg Stevenson who works within Opcourage, veterans service recently won Gold in the Paralympics in Paris.

Questions from Governors and the Public
None to note.

Date and Time of next Meeting
28 November 2024 2-4pm
St Nicholas Hospital Board Room and via MS Teams

1.4 ACTION LOG AND MATTERS ARISING FROM PREVIOUS MEETING

Darren Best, Chair

None to note.

REFERENCES

Only PDFs are attached

1.4 COG Action Log COG 28.11.24.pdf

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Council of Governors Meeting
Action Log as at 28 November 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					
19.9.24 (2.1)	Quality and Performance Committee report	A detailed update on Crisis Services and waiting times to be included as an agenda item on a future meeting.	Kirsty Allan	TBC	To be included on the cycle of business for the Governors' Steering Group
19.9.24 (2.3)	CQC update	A detailed update on delayed discharges to be given at a future meeting.	Kirsty Allan	TBC	To be included on the cycle of business for the Governors' Steering Group
Completed actions					
		No completed items to note			

1.5 CHAIRS AND CHIEF EXECUTIVE UPDATE

Darren Best Chair and James Duncan, Chief Executive

REFERENCES

Only PDFs are attached

1.5 Chairs Report Sept.pdf

1.5a CEO Report to Board September 2024.pdf

1.5b. CEO Report - Appendix 1 - NENC ICB Quality Strategy.pdf

Name of meeting	**Council of Governors General Meeting**
Date of Meeting	**Thursday 28th November 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

Council of Governors General Meeting
Chair's Report
Thursday 28th November 2024

It is fair to say that a lot has happened both locally and nationally since my last report in June 2024. Events, including a change of Government, local elections, and more recently the disgraceful racist rioting and disorder that we have seen in some of our towns and cities has understandably caused fear and unrest.

At the beginning of August, I was away on holiday with my family, however I was regularly reading and watching the BBC news; I found myself saddened, disgusted and at times angered by what I was seeing and reading. I was particularly appalled to hear of our healthcare workers being targeted with abuse and violence. There is no excuse or justification for what has been happening, it has been pleasing to see a robust response from the authorities and the courts, combined with strong evidence of communities rejecting the violence and pulling together to repair damage and show support to each other.

Amongst the news reports, I was also receiving the messages that CNTW was sharing with our staff, it was very clear that the organisation had rightly adopted a supportive, caring approach, particularly towards those people who were feeling vulnerable and worried. It was also clear that CNTW sought to show strong moral leadership and absolute support for decency, fairness and humanity in communications and activities that utterly rejected all forms of racism and / or bigotry. Through the Executive Team I have thanked and praised everyone involved for their collective efforts, amongst the lows of that week. I personally took some comfort from the efforts and care that CNTW was taking.

The day after I returned from leave, I attended a meeting that had been organised by our Cultural Diversity Network, the aim of which was to allow people to share their thoughts, experiences and concerns following the rioting. I am hugely grateful to the network for organising the event and to those that shared their experiences. It became even more clear to me that the behaviour and attitudes of the racist bullies and thugs had been profoundly disturbing, and caused real fear, trauma and anxiety to a number of people working for CNTW. I am sure those same feelings will have been, (and likely still are) prevalent in our communities. I learned a lot from the session, a particular example that struck me came from one of the networks who said how in recent days they had felt reassured when people from white backgrounds smiled at them in the supermarket; presumably to show their support and that they did not belong to the groups who had been seeking to frighten and intimidate. I share that here because whilst the example made me sad that it was needed, it also told me that we are a strong society, in which the majority of people are decent, and sometimes even when faced with extreme situations, it can often be relatively small acts of kindness and support that are most vividly remembered.

Anyone who knows anything about CNTW and / or the NHS as a whole, recognises that we would not be able to function properly without the talented people from across the globe that make up our organisation and the wider healthcare system. I am proud to be part of an organisation that readily and regularly celebrates and values diversity.

In this update I want to add further emphasis to the messages that I mention above. CNTW has and will always utterly condemn the violence and the fear that we saw unfold. We should always stand proudly together to say that we all belong, and we are there for each

other. I am incredibly proud of our diverse workforce and the communities we serve and live in. CNTW will never tolerate any form of racism, bigotry and / or abuse. We must continue to support people to discuss their fears and / or concerns in a safe way, we should not forget what happened, but we must learn from it and be open to respectful and compassionate dialogue.

CNTW Culture

During this last period, I have been pleased to see CNTW discussing and working on its organisational culture and what impact culture has on how we do things. I suspect at times the word itself can cause some head scratching in terms of what exactly do we mean by culture, how do we define it and how do we know if we have affected it and / or got it right. I think if people are regularly asking themselves those questions, then in itself that should tell us that we are heading in the right direction.

Since taking up the role of Chair almost a year ago, I have visited numerous wards and services and spoken to lots of our people. Unsurprisingly, with such a large and diverse organisation, I have observed that there doesn't appear to be a single describable culture that is operating across all teams. The nature and history of our services, differing needs of patients and the diversity of our staff means that there are differences in things like daily routines, management styles and how staff work together. That said, what is the same, and should be the basis on which we test and discuss our culture are our Values.

Our strategy, 'With You in Mind', describes what we are collectively seeking to achieve and within that we are very clear about our values. In my view it is those values that form the basis of our CNTW culture; they should be overt and discussed regularly to ensure we are living them. Our values statements should not be seen as passive, from which success will happen without thought or effort, they are active, and we should be determined to see them present every day in all we do. When we are considering doing something, whether it be clinical, or non-clinical, in my view our values should always form the basis for, 'how we do it'. They are statements about how we behave, how we treat others and how everyone should expect to be treated.

- We are Caring and Compassionate – because that is how we'd want others to treat those we love.
- We are Respectful – because everyone is of equal value, is born with equal rights and is entitled to be treated with dignity.
- We are Honest and Transparent – because we want to be fair and open, and to help people make informed decisions.

The Board of Directors has a significant role to play in developing our culture, we must seek assurance and check that we have openness and accountability at every level and that our values are being lived across the organisation.

The culture of the organisation shapes the behaviour of everyone in it, the quality of care it provides and its overall performance, all of which are challenges for CNTW. I recently attended a Trust Leadership Forum where the focus was on culture, it was good to see and hear some very rich discussions and ongoing conversations taking place, with further work being planned. Compassionate and inclusive leadership skills and behaviours are key to enabling cultural changes that will allow us to deliver high quality care, value for money, compassion, freedom to speak up and continuously improve. Signs of high-quality

leadership can be found in environments that support learning, that are free from bullying, where there is no complacency and where there is clarity and alignment with a common set of values.

When developing ‘With you in mind’ we asked service users, carers, their families our staff and partners to describe what matters to them. They asked us to work together, with them in mind, with compassion, humanity and care. This is at the heart of the strategy and adds further emphasis to the importance of, ‘how’ we do things, the people we serve have been clear about what they would like our culture to be; we must listen to them.

I also ask people to also pay particular attention to our commitments. Following on from my June report where I highlighted the importance of Freedom to Speak Up, I continue to encourage anyone to speak up if something that doesn’t feel right to you. Examples might be, 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.

Celebrating Staff Excellence Awards

Our Staff Excellence Awards recognise and celebrate the achievements of our staff, volunteers who despite our challenges have gone over and above to support the Trust. This year, more than ever, it’s important we capture that to give people the opportunity to reflect and remember some of the things we are doing well by highlighting some of the great work which takes place across our organisation. The awards which will be taking place on 27th September is a key annual event celebrating many achievements and recognising how far we have come in 2023/24.

I am really looking forward to the year ahead and seeing us progress again, so that we further improve safety, care and services for our service users, carers and community and your experience of working here. I would like to thank everyone who took the time to nominate.

Annual Members Meeting / Annual General Meeting (AGM)

Every year, we hold an Annual Members / Annual General Meeting and celebration event where we bring together the Trust Members, our staff, our Governors, members of the public and our Board of Directors. It is a fantastic day where Members can find out about some of our great work we have been doing over the last 12 months.

This year we will be holding our meeting on Thursday 26th September and as usual there will be a marketplace stalls available with representatives talking about the work taking place throughout the Trust and within our partner organisations and local communities. From 1pm we will be hosting our Annual Celebration Event, which this year is titled 'Voyage to Recovery'.

Our AGM is a great opportunity to reflect on the year passed, acknowledge the challenges that we have faced and celebrate the achievements and improvements which we often don't get the chance to do working day to day. It is easy to focus on "what we are not doing right" but it is extraordinary what colleagues and services have done to improve the care they are able to provide to service users and carers. Incredible improvements have been made in the last 12 months and we are focussed on the further areas we know we need to improve.

I hope you will be able to join us at our AGM and if you would like to book a place for either a stall or come and hear about our celebration event at 1pm, please email members@cntw.nhs.uk

Outcome of Fit and Proper Persons reviews

In August 2023, NHS England published a revised Fit and Proper Persons Test (FPPT) Framework in response to the recommendations made by Tom Kark KC in his 2029 review of the FPPT. The review highlighted areas that needed improvement to strengthen the existing regime. The Framework introduces a requirement for the Trust Chair to submit an annual return to the NHS England Regional Director. The Framework applies to Executive and Non-Executive Directors and as Chair, I applied FFPT to all members of Board members and participants. The Director of Communications and Corporate Affairs received the individual self-attestation forms, completed all the required checks and provided reports for review.

An NHS Leadership Competency Framework was also published which provides guidance for the competence categories against which a board member should be appointed, developed, and appraised. This Framework was effective in this round of appraisals which was used for all new board level appointments and for annual assessments for all board members.

The appraisal for all board members undertaken by me, and the CEO completed the process. David Arthur, Senior Independent Director completed the review of my reports.

From this, I can determine that all board members and participants comply with the FPPT, and I have submitted the annual summary to the Regional NHS England Director. This year the completed date was 30 June, but this will come forward to 31 March next year.

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.

Following the results of the Council of Governors self-assessment questionnaire where a few suggestions were identified a Governors focus session has been arranged to devise a tangible action plan to ensure the Council continues to make improvements every year.

Internal and External engagement and activity

In addition to our schedule of planned Board and Governor meetings, I continue to 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. I am aware that our Non-Executive Directors have also involved themselves in a range of visits and meetings to help shape their thinking and discussions with the Governors and the Board.

During June - September 2024, I visited and / or met with:

- Crisis Teams at St Nicholas Hospital and Hopewood Park
- Service User Carer Reference Groups (June / August)
- Castleside and Akenside wards
- Roselodge
- Trust Leadership Forum

Local and Regional Network meetings

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 / met with:

- Integrated Care System, (ICS) Foundation Trust (FT) Chairs Meeting – this is a meeting of all of the Chairs operating in the North East and North Cumbria area. The meeting provides a good opportunity to discuss individual Trust and system wide pressures, concerns and learning.
- Integrated Care Board (ICB) Chair and Foundation Trust Chairs Forum – this meeting is attended by all of the FT Trust Chairs and is Chaired by Professor Sir Liam Donaldson (the Chair of the ICB) with the ICB CEO, Sam Allen and other senior ICB personnel. The meeting provides a forum to discuss system and wider NHS related issues, assess how we in the North East and North Cumbria are

performing as a system and understand the strategic / wider issues that impact on the individual Trusts and the system collectively.

- North Integrated Care Partnership (ICP) – our ICS currently has three ICPs' (North, Central and South), albeit the North and Central ICPs' are intending to join together in recognition of the combined authority that operates across the North East. The partnership receives updates on various health related matters and initiatives affecting people in the North East and North Cumbria. CNTW have been asked to provide an update on issues affecting children and young people's mental health services at a future meeting.
- Chair of Tees Esk and Wear Valley (TEWV) NHS Foundation Trust – I met with David Jennings to discuss potential opportunities for CNTW and TEWV to work more closely together with a view to improving services for patients and identifying potential efficiencies. There is much to discuss and further meetings that will include Executive officers will happen in the coming months.

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

Name of meeting	**Council of Governors General Meeting**
Date of Meeting	**Thursday 28th November 2024**
Title of report	**Chief Executive's Report**
Executive Lead	**James Duncan, Chief Executive**
Report author	**Debbie Henderson, Director of Communications and Corporate Affairs**

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 General Meeting
Chief Executive's Report
Thursday 28th November 2024

1. Trust updates

1.1 Response to public disorder in our communities

At the beginning of August riots took place across the country and sadly, in some of our local communities and we saw violence and threatening behaviour in events of public disorder. As a Trust we condemn these attacks – there is no place for racism or discrimination of any kind in our organisation or in our communities.

While many of us have found it difficult to process these events, the attacks have created a climate of fear and uncertainty for many of our patients, carers, and staff from culturally minoritised backgrounds. As a Trust, we took action to keep our patients, carers, and staff safe across community teams. This included offering video or telephone appointments, deferral of face-to-face appointments, in agreement with patients, changing appointment venues, supporting staff to work from alternative locations including from home, and putting additional security in place in high-risk areas. Although this response was positively received, I am sad that we had to do it in the first place.

In response to the attacks, we worked closely with the Police and other partners to support the implementation of local plans based on reliable local intelligence about further disorder.

More recently, our Cultural Diversity Staff Network extended an open invitation to all staff to join a listening session with our Executive Team to share their own personal experiences and concerns following the events of the last few weeks, and at that session, our workforce demonstrated their support and allyship to colleagues from culturally diverse backgrounds and each other. I am proud to be part of organisation which embraces diversity and sees diversity of all kinds as a strength.

As a Trust we are absolutely committed to tackling all forms of discrimination in our services, our workforce and in our communities and this will continue to be a priority for the organisation as we move forward. I would like to thank all our patients, carers, staff, communities, and partners who have worked together to keep each other safe during this extremely distressing period.

1.2 New 24/7 Community Hub - Whitehaven

A new community hub will offer round-the-clock mental health support in the heart of Whitehaven. The hub is part of a pilot to provide more mental health support in local communities. It will be delivered by a group of local organisations, led by CNTW, working in partnership, this includes Cumbria Health, Everyturn Mental Health, Home Group, iCan Wellbeing Group CIO, and The Well Communities CIC.

The hub will be life-changing for people in Whitehaven and the surrounding area and will allow us to transform the way mental health care is provided locally. It will bring together specialist health, social care and community services, so people can get the right help, at the right time. We have worked with local people and organisations to get the right people around the table to develop this new service including service users and carers, and we are

excited to begin the work to make it a reality, together. The hub will also offer advice on issues which often affect people's mental health, like housing, money and employment. And there will be support for the families and carers of people who are unwell.

Most radically, the hub will offer an alternative to people needing to be admitted to hospital, by providing four short-stay beds for people who need to be supported at the hub for that little bit longer. The is a significant example of the power of collaboration and what can be achieved working across systems together, for the greater good.

1.3 Northgate Park – The Craft Shack!

On Saturday 31 August families, carers and local residents are welcomed to the hospital for an open day, with the chance to meet the teams who work there and see some of the facilities. Northgate provides a range of mental health and learning disabilities services, including wards for autism, rehabilitation and forensic services. Northgate also houses Sycamore, a state-of-the-art secure facility which opened last year and looks after men with a mental illness or learning disability, who have come into contact with the criminal justice system.

The day will also see the opening of a new shop on site – the Craft Shack. The shop will be run by patients who will be selling things they have made as part of their recovery programme. Items on sale will range from artwork and woodwork to plants.

The Craft Shack will showcase the craftsmanship, talent and skill of the patients that we work with on the Northgate site. They are some of the most vulnerable and let down members of society and we want to celebrate their talents and creativity as they rebuild their lives. We also hope that by raising awareness of our services, we can reduce the stigma around secure services and mental health and learning disabilities in general.

To add to this, all income made from the shop will be reinvested back into patients, with 50% going directly back into services and 50% going to the Trust's charity, SHINE.

The site will be open 12.30pm – 2pm on Saturday 31 August and The Craft Shack will open its doors at 12.30pm.

2. North East and North Cumbria Integrated Care System (NENC ICS) updates

2.1 NENC Integrated Care Board (ICB) Mental Health, Learning Disability and Autism Sub-Committee

At the August meeting of the Committee, we agreed the NENC Clinical Conditions Strategic Plan for Anxiety and Depression. The Committee received the proposed strategy and action plan for anxiety and depression across system. The aim was to seek support for initiating the socialisation and finalisation of system-wide plans for implementation across the ICS.

It was recognised that we will need to engage on the plan with all partners across the system and there was a sense that more specific detailed actions of what and how this would be achieved needs to be further developed.

We also discussed the direction of travel for the NENC ICB Suicide Prevention Strategy and Plan. The Committee discussed the priorities to deliver suicide prevention activity in NHS settings and supporting local activity where economies of scale are appropriate and available. The discussion also focused on the importance of understanding the variance in suicide rates across NENC footprint which are not always explained by deprivation levels of patients and further analysis of this is needed.

A paper was received on the Housing, Health, and Care Programme Board. The paper outlined the background and scope of the programme and the complex care priority and described the action plan and intended outcomes for 2024/25. The Programme is the region's sector-led housing improvement activity. It is jointly led by the NENC ICB, Directors of Adult Social Services, the Northern Housing Consortium, and the TEC Services Association. It describes a vision that aligns with policy and strategy drivers for the region, focused on three priorities: supporting older people to remain independent, tackling cold and damp homes in the rented sectors, and identifying integrated models of housing and support for people who need complex care and support.

A discussion on the wider determinants of health affect mental health including housing, physical health, wealth and the link to anxiety and depression was also discussed.

2.2. North East and North Cumbria Integrated Care Board – Quality Strategy

In their strategy, Better health and wellbeing for all, NENC ICB share their vision for North East and North Cumbria capturing the need to improve health and broader wellbeing for everyone across the North East and North Cumbria. This includes taking the Learning and Improvement Collaborative comprised of people from across the region to build the learning system as a culture, a community and a collection of assets that support learning at every opportunity. The objectives are to achieve longer, healthier lives for everyone, fairer health outcomes for all, achieve the best start in life for our children and young people and improving health and care services.

The Quality Strategy is being developed to support delivery of the overarching strategy and vision for the system and is underpinned by five strategic themes: culture, patient safety, clinical effectiveness, multi-professional leadership, and positive experiences.

We, along with other Providers across the system, are working with the NENC ICB to ensure that our ambitions and priorities are aligned to those of the wider system so that we can all help bridge the gap between health inequalities, and avoidable harm and provide services which are joined up and meet the needs of those we need us.

The final Quality Strategy will be launched by the NENC ICB on 1 October, the draft is included as Appendix 1 and is available at the NENC ICB website.

3. National updates

3.1 Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust

Following the conviction of Valdo Calocane (VC) in January for the killings of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber, the Secretary of State for Health and Social

Care commissioned the Care Quality Commission (CQC) to carry out a rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT). The first part of the review focused on assessments of patient safety, the quality of care provided by NHFT and the Trust's Rampton high security hospital and was published in March of this year. The second part of the review focuses on evidence related to the care of Valdo Calocane and whether this indicates wider patient safety concerns or systemic issues linked to mental health services in Nottinghamshire. This second part of the review has now been published which include the key findings of the review.

The review makes a series of recommendations for NHFT linked to review of care and treatment plans, clinical supervision of decisions to detain under Sections 2 and 3, medicines monitoring, family and carer engagement, engaging patients who disengage from Early Intervention in Psychosis, and approach to discharge. The review also makes a series of recommendations for NHS England as regulator.

The Trust's response to the review will be discussed at the September Board meeting.

3.2 NHS England guidance on intensive and assertive community mental health treatment

NHS England published guidance to support integrated care boards (ICBs) to undertake reviews of community mental health services to ensure that they have clear policies and practice in place for patients with serious mental illness who require intensive community treatment and follow-up but where engagement is a challenge. The guidance highlights five key messages:

- Services have a duty to engage with people with SMI and their families and carers – taking into account patients' different backgrounds, experiences, and needs.
- Intensive and assertive community care requires dedicated staff.
- No wrong door approach – which is joined up with other statutory and VCSE services.
- Continuity of care is vital – delivered via a competent and experienced key worker.
- Holistic and engaging care – which is trauma informed and uses biopsychosocial formulation-based approaches to meet the holistic needs of the person (including housing, finance, substance use etc).

The guidance also outlines key themes and lessons from serious untoward incidents, features of intensive and assertive community care services, and defines the scope of the reviews and how they should be undertaken.

The reviews will consider all relevant policies and practices for the delivery of care to people presenting with psychosis (including undiagnosed); who may not be able to or want to respond to routine monitoring; who are vulnerable to relapse and deterioration of their condition and this could lead to serious harm; who have multiple social needs including housing, financial issues etc; who are likely to have co-occurring problems including substance use; who may have had negative experiences of mental health services and other public functions including criminal justice; and where concerns may have been raised by families and carers.

ICBs will also review governance, partnership and monitoring arrangements that support the identification of people who might need intensive and assertive community care, as well as the capacity of local services to provide appropriate levels of care. It is also recommended that local reports on serious incidents, patient experience, and complaints should be reviewed. The reviews are a requirement of the 2024/25 NHS Priorities and Operational Planning Guidance and should be completed by the end of September.

3.3 Review into the operational effectiveness of the Care Quality Commission

The Department of Health and Social Care published the interim report of Dr Penny Dash's review into the operational effectiveness of the Care Quality Commission (CQC). The interim report, which will be followed by a final report in the autumn, provides a summary of the emerging findings and outlines a series of recommendations. The interim report's five recommendations for CQC are:

1. Rapidly improve operational performance.
2. Fix the provider portal and regulatory platform.
3. Rebuild expertise within the organisation and relationships with providers to restore credibility.
4. Review the Single Assessment Framework to make it fit for purpose.
5. Clarify how ratings are calculated and make the results more transparent particularly where multi-year inspections and ratings have been used.

These recommendations reflect the review's interim findings which are:

1. Poor operational performance
    - In 2023-24, fewer than half the number of inspections were completed compared to 2019-20.
    - The average length of time since provider ratings were issued is 3.7 years, with the oldest rating completed in 2014.
    - One in five locations the CQC has the power to inspect have never been inspected.

2. Significant challenges with the provider portal and regulatory platform
    - The deployment of new systems designed to improve operations and communication with providers had resulted in significant issues for users.

3. Considerable loss of credibility within the health and care sectors due to the loss of sector expertise and wider restructuring.

    - When the CQC was restructured, sectoral knowledge was removed from assessment and inspection teams, placing far more reliance on generalists. Lack of sector expertise means providers do not trust the outcomes of inspections nor have the chance to learn from experts in their fields.
    - Regular interaction between chief inspectors and senior leaders in health and care and with regular inspection teams at a local level was not taking place, even though this had built confidence and enabled early awareness of emerging problems and the wider sharing of good practice.

4. The review highlights concerns around the Single Assessment Framework (SAF), including:

    - There is no description of what 'good' or 'outstanding' care looks like, resulting in a lack of consistency in how care is assessed.
    - There is a lack of focus on outcomes (including inequalities in outcomes).
    - The SAF is poorly communicated internally and externally.
    - The data used to understand the user voice and experience, how representative the data is, and how it is analysed for the purpose of informing inspection, is not sufficiently transparent.
    - There is no reference to use of resources or efficient delivery of care in the assessment framework which is a significant gap despite this being stated in section 3 of the Health and Social Care Act 2008.
    - The review had found limited reference to innovation in care models or ways of encouraging the adoption of these.

5. Lack of clarity about how ratings are calculated and the use of previous inspection outcomes
    - The review raises serious concerns over the calculation of overall ratings for a provider by aggregating inspection outcomes over several years. Because the CQC is not doing enough inspections to update ratings, the intention of the CQC to phase this practice out over time has not been achieved.

3.4 Labour Government health policy updates

Following the General Election in early July, we now have a new Labour Government and a new Secretary of State for Health and Social Care, Wes Streeting. Since the election, the Government have:

- Announced an independent investigation of NHS performance, which will be led by Lord Darzi and will report in September 2024. The review findings will provide the starting point for developing a ten-year plan for health. The development of the plan will be led by Sally Warren, Director of Policy at the King's Fund, with support from teams at the Department for Health and Social Care (DHSC) and NHS England. Plans for how NHS staff and leaders will be able to contribute to both phases of this work are being developed.
- Agreed a pay deal with the British Medical Association (BMA) Junior Doctors Committee, which if accepted by BMA members, will see junior doctors' salaries rise by 22.3% over two years. The Junior Doctors' Committee has agreed to ballot eligible members on the pay deal. If accepted, the deal will bring an end to industrial action by junior doctors which has been ongoing since March 2023.

The King's Speech was held on 17th July, marking the beginning of the first session of the new parliament since the general election. The King's Speech included several priorities linked to mental health, learning disabilities and autistic people:

- The Mental Health Bill was included in the 2024 King's Speech, demonstrating commitment from the Labour Government to modernise and reform current mental health legislation (the Mental Health Act 1983).

- The speech included a commitment that the government will ‘ensure mental health is given the same attention and focus as physical health’.
- There was significant focus in the speech on children and young people’s health and wellbeing including a commitment to improving mental health provision for young people, and the introduction of a Children’s Wellbeing Bill which will be introduced to raise standards in education and promote children’s wellbeing.

3.5 Nursing and Midwifery Council culture review

An independent review of the Nursing and Midwifery Council's (NMC) culture has highlighted safeguarding concerns and found that employees have experienced racism, discrimination and bullying. The NMC commissioned the review after concerns were raised about the organisation’s culture, including racism and fear of speaking up. Over 1,000 current and former NMC colleagues, plus more than 200 panel members who sit on fitness to practise hearings, shared their lived experiences as part of the review. The report also highlights suicides by nurses subject to delayed fitness to practise investigations, with some nurses under investigation for nearly 10 years. A backlog of 6,000 cases has meant some nurses waiting four or five years for their investigation to be completed, regardless of the severity of the complaint. The NMC has accepted the report’s recommendations.

James Duncan
Chief Executive
September 2024

NHS
North East and North Cumbria

ICB Quality Strategy

David Purdue

Quality Strategy headlines

Quality strategy underpins our ICB strategy, Better health and wellbeing for all

Link between health inequalities and avoidable harm

Five strategic themes to enable us, as a system to continue to improve and be ‘the best at getting better’

Culture and Climate are key

Focus on what it means for our citizens and what it means for our system

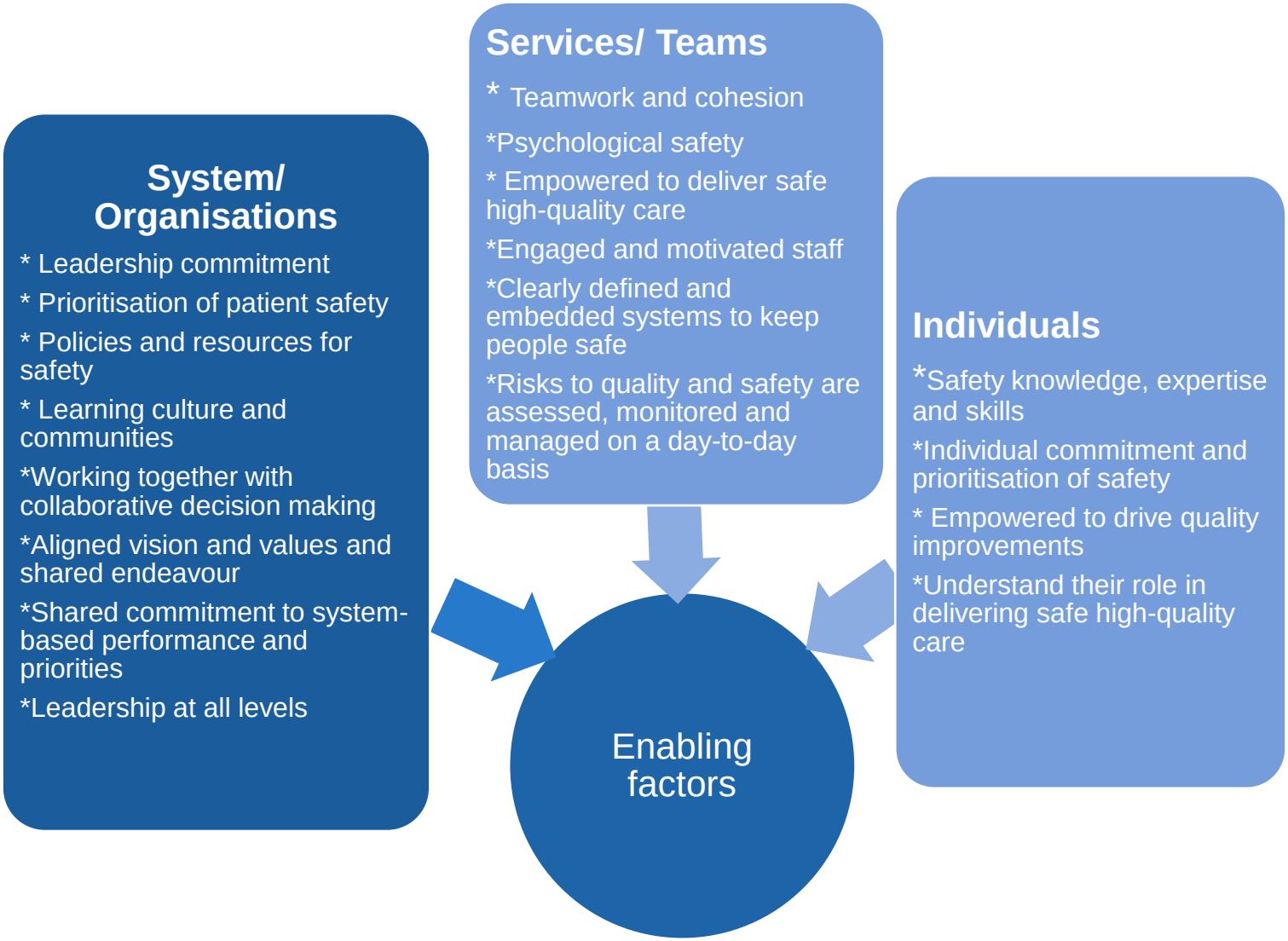
Working together across the system

Our Strategic Themes

Culture and Climate

- Culture matters
- Safety and high-quality care needs to be a priority for all
- Enabling factors and enacting behaviours that will help us to build a safer culture
- We will adopt the following principles:-
  - Professional Curiosity
  - Just Culture
  - Freedom to speak up
  - NHS People promise
  - Equality, diversity and inclusion
- Tackle closed cultures

Creating the culture



I/ we statements- enhancing people's experience of care

I statements:

- help people understand what a good experience of care looks and feels like
- They reflect on what people say matters to them

We statements:

- highlight the collective efforts of individuals, teams, services, organisations and the system in fostering a culture of unity, mutual respect, and shared responsibility in delivering high-quality care.
- From a CQC perspective; the standards against which they hold providers, LA's and ICSs to account

‘I’ statement: When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place.

‘We/quality’ statement: We work in partnership with others to establish and maintain safe systems of care in which people's safety is managed, monitored and assured, especially when they move between different services.

Patient Safety

Patient safety

- Safety is a priority for everyone with a clear commitment to improve safety.
- We will embed processes and systems across the ICS that promotes high quality, safe and effective care.
- We foster a culture of openness, transparency and learning to improve safety for people.
- Care across the system is delivered in a way that minimises things going wrong and maximises things going right.
- We will recognise and celebrate outstanding health and care so we can learn when things go well and when things have not gone well.
- We identify risks and use these as an opportunity to put things right, learn and improve.
- We will consider the impact of health inequalities on patient safety and identify actions that reduce the risks of harm.

What this means to our citizens

- I feel safe and am supported to understand and manage any risks.
- If something goes wrong, I will be supported in an open and honest way and will receive an apology.
- I understand the service recognises when things haven't gone well and uses these to improve the service.
- I am cared for by staff who have the skills and experience to support me.
- I am empowered to be a partner in my care and staff understand my individual needs that promotes my safety.
- I know staff understand my specific needs and vulnerabilities; they tailor care that promotes and delivers better outcomes for me, and that reduces the risk of avoidable harm.

What this means for the system

- We have a culture of safety and learning where staff can raise concerns, these are investigated and learning opportunities are identified.
- There is an environment where we can share learning across organisational boundaries.
- We can demonstrate improvements have been driven across the system that improves people experiences of care, reduces variation and health inequalities.
- We deliver care to meet the individual needs of people, that improves outcomes by reducing disadvantage and the risks of avoidable harm.
- We have encompassed human factors to underpin our approach to patient safety and quality improvement.
- The approach to the patient safety incident response framework across the system has been embedded.
- We have established and developed our communities of practice.
- Staff understand their role and responsibilities in delivering safe care and contributing to quality improvements.

Clinical Effectiveness

Clinical Effectiveness

- Across the system people receive the right care, at the right time, in the right place.
- We will adopt and share evidence-based practices to the care and treatment people receive.
- We will use data and intelligence to drive improvements to ensure effective high-quality care.
- We will measure and publish quality-measuring what matters to people, monitoring quality and safety consistently and use data to inform decision-making.
- We will set clear standards for what high quality care and outcomes look like based on what matters to people and communities.
- We ensure there's co-ordination of services across the system, that considers the needs and preferences of different people, including those with protected characteristics and those at most risk of a poorer experience of care.
- We are alert and responsive to health inequalities, and social determinants of health which may lead to poorer outcomes and premature deaths.

What this means to our citizens

- I have care and support that is co-ordinated, and everyone works well together and with me.
- I am empowered to get the care, support and treatment that I need.
- I know my care is the most effective it can be and is in line with recognised standards.
- I know the services that care for me, are working together to ensure I receive high quality care.
- When I move between services, there is a plan for what happens next, and all the arrangements are in place.

What this means for the system

- We have systems to use data, intelligence and knowledge to inform our decision making.
- Our clinical conditions strategic plans are improving outcomes for people and reducing variation and health inequalities.
- We are staying ahead by embedding research and adopting innovation to ensure progressive high-quality care across the system.
- We have a quality improvement methodology to support our improvement work across the system.
- We design services to meet the needs of our diverse population by promoting equitable access, excellent experience and better outcomes for all, that reduce disadvantage, and the risks of avoidable harm.
- Staff keep up to date with best practice, by delivering care that optimises people's health and improves patient experience and outcomes.

Positive Experiences

Positive Experiences

- We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support.
- We involve people in decisions about their care and tell them what's changed as a result.
- We actively seek out and listen to information about people who are most likely to experience inequalities in experience or outcomes.
- Services across the system are designed by what matters to people, that empowers them to make informed choices and is delivered with compassion, dignity and respect.
- We will co-produce with people with 'lived-experience' as they are often best placed to advise on what support and services will make a positive difference to their lives

What this means to our citizens

- I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and personal goals.
- I am supported to manage my health in a way that makes sense to me.
- I am involved in decisions about my care.
- My feedback was taken seriously, and I know what changes have been made as a result.
- I felt that my voice was heard and that I was listened to and understood.
- I am encouraged and enabled to feedback about my care in ways that work for me, and I know how it was acted on.
- My individual needs and preferences are understood, and these are reflected in my care, treatment and support, and takes account of my personal, cultural, social and religious needs.

What this means for the system

- We listen to people's views and experiences, and they are seen as an integral part of our quality improvement work.
- We use people's experiences as a central component to quality assurance and identification of risk.
- We recognise people's experience could be early warning signs of poor care.
- We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.
- Our patient and public involvement strategies are embedded into our work across the system.
- Staff understand their role in supporting and empowering people to make informed decisions about their care.

Clinical and Multi-Professional Leadership

Clinical and Multi-Professional Leadership

- We will be driven by collective and compassionate leadership which champions a shared vision, values, and learning, delivered by accountable organisations and systems.
- We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of the system.
- Clinical and care professionals are involved in all aspects and every level of system decision-making.
- We have a transparent approach to identify and recruit leaders that promotes equity of opportunity, that also recognises the different kinds of leadership styles required, when working across professional and organisational boundaries.

What this means to our citizens

- When I receive care, services meet my needs and that of the wider community, and all leaders and staff support this.
- I will be involved in designing services and my feedback is heard and valued by leaders in the system.
- I am confident leaders and staff are able to identify poor care and address this quickly.
- I know that staff and leaders with the right skills and experience are making decisions about care services.

What this means for the system

- We have high-quality leadership throughout the system which is sustained through safe, effective and inclusive recruitment and succession planning.
- Our leaders are skilled and confident and can contribute effectively to quality improvement.
- We are alert to examples of poor culture that may affect the quality of people's care and have a detrimental impact on staff and our leaders address this quickly.
- We have embedded leadership strategies and development opportunities within the system.
- Leadership is front and centre of system and service delivery; all staff understand their role and contributions to delivering high quality care.

Working together to deliver Quality

How we will do this together?

As an ICB and commissioner

- Set clear quality standards and expected outcomes when commissioning as part of quality and performance management.
- Developed the system as the 'best at getting better' with established communities of practice.
- Have clear governance frameworks for quality.
- Quality assurance gives a clear and accurate picture of safety, and there are steady improvements in safety over time.
- Develop a positive safety culture that is embedded at all levels of the system.
- Work together across the system to ensure seamless pathways between services that focus on delivery of high-quality care.
- To co-produce with communities to shape services to meet their needs.
- Share learning, best practice, and innovations across the system to influence and improve the quality of services.
- We have consistency in approaches which leads to more standardised practices in services.

For people and communities

- People in our communities know what good care looks like, what they have a right to expect, and what to do when their experience doesn't meet expectations.
- People are partners in their care and are supported in making decisions about the care they want to receive.
- People have care that is personalised, and they are treated with dignity and respect.
- People's voices are heard, listened to, and understood and feedback is used to drive improvements in quality.
- People are included in reviews and contribute to improvements in care.

For all health and care providers

- Experience a coherent system of quality assurance and performance management.
- Are accountable for the quality of care they provide, and driving quality improvements which translates into improved health outcomes.
- Care is co-ordinated across services, organisations and the system and they work collaboratively to meet people's needs.
- Support the system to continually improve and maintain quality and safety standards.
- Work as system partners and understand their role in improving health outcomes, reducing variation and health inequalities.

For all staff

- Staff are seen as partners in delivering safe high-quality care,
- Staff feel safe and confident to speak up without fear of retribution.
- Staff are supported to learn and make improvements to care at every level of the system.
- Staff are engaged and motivated to develop and drive improvement plans.
- Staff are supported to learn and develop to embed quality and safety practices in their everyday work.

Our Quality Strategy foundations and next steps

Culture and Climate

Strategic theme

Culture and climate

Foundations

*Established FTSU processes across the ICB
*ICB assessment of FTSU processes in NHS trusts
*Adoption and implementation of NHS People promise/ Just culture.
*Quality assurance tools developed for some services with specific prompts around closed cultures.
*Recognise the need for clear values and behaviours both within the ICB and across the system
*Closed cultures highlighted as a strategic quality priority.
*Intelligence sharing between stakeholders

Next steps

*Clear set of values and behaviours for the ICB as an organisation and the wider system.
*Review of tools for both commissioning and quality assurance to ensure they include key culture prompts.
*Staff at all levels, regardless of role understand their roles and responsibilities.
*Learning packages about culture/ closed cultures for all staff in the system.
*Staff at all levels understand the inherent risk factors and warning signs of a closed culture.
*Cultural assessment of the system against the 37 features of an open culture and develop culture metrics .
*Develop system wide plan to tackle closed cultures.

Patient Safety

Strategic theme

Patient Safety

Foundations

*Concept developed for our patient safety centre.
*Development and implementation of the ICB PSIRF policy and approach. This includes:-
*Support to organisations and sign off PSIRP plans,
*Training and development including raising awareness, patient safety specialist training and patient safety partner identified and agreed.
*System wide never event deep dive
*System approach identified to the implementation of Martha's rule.
*Data and intelligence monitoring information available for the ICB.

Next steps

*Launch of our patient safety centre in September 2024; the centre will be our focal point to drive patient safety improvements.
*Develop the ICB and system wide patient safety framework.
*Roll out of PSIRF training for all staff, existing patient safety specialists to complete training, approval of the model for patient safety specialists, and learning support specialists.
*Specific learning and improvement sessions starting with never events and sepsis.
*Development and embedding communities of practice.
*Patient safety improvement plans developed, identified by people's experience, data and intelligence.
*Further enhancements to data and intelligence monitoring to incorporate people's experiences.
*Enhance routine reporting requirements for all commissioned services as part of contracts.

Clinical Effectiveness

Strategic theme

Clinical Effectiveness

Foundations

*Clinical conditions strategic plans for adults and children developed.
* NENC healthy and fairer programme including:- prevention, health inequalities and broader social and economic determinants.
* Part of CQC stakeholder forum for the development of the health inequalities self-assessment.
*Women's health conference/ collaborative
*Development of clinical effectiveness committee within the ICB
*Medicine optimisations
*Monitoring of mortality themes and trends.
*Quality improvement methodology approach being developed.

Next steps

*Launch our clinical conditions strategic plans with monitoring of progress.
*Programmes from healthy and fairer including :- tobacco, CORE20PLUS5, and poverty proofing.
*Women's health innovation conference July 2024
* Quality improvement methodology developed and used as part of our quality improvement work

Positive Experiences

Strategic theme

Positive Experiences

Foundations

*Patient and public engagement ongoing work
*Healthwatch- programme of activities
*ICB- complaints management
*Ongoing monitoring of patient experience surveys including CQC.
*Work with voluntary sector groups
*Assessment tool developed to assess the quality of provider complaints systems.
*National learning from the resuscitation council on outcomes for people in our communities.
*In response to patient feedback, identified a need for further work to support those waiting for a CAMHS appointment.

Next steps

*Continue to gather and learn from people's experiences to improve quality of care
*Quality of complaints to be part of quality assurance framework for commissioned services.
*Roll out of restart a heart campaign to targeted groups/ places to tackle health inequalities.
*Develop a practical waiting well approach to support people waiting for CAMHS.

Clinical and Multi-Professional Leadership

Strategic theme

Clinical and Multi-Professional Leadership

Foundations

*Clinical and Multi-professional leadership framework developed.
*System leadership group established across the system.
*Senior leaders meetings/ forums within ICB
*Clinical and Multi-professional leadership framework - wider engagement to take place on the framework.
Boost our learning community offers leadership development to be effective convenors of system change.
*AHP council established

Next steps

*Clinical and Multi-professional leadership framework - wider engagement to take place on the framework.
*Self-assessment/ gap analysis to be undertaken.
*Decision making map to be developed - to show how clinical leaders are involved in every level of decision making.
*Learning and development needs to be reviewed- including generic and profession specific.
*System leadership development at every level.

Quality Governance framework

Quality Governance framework

Foundations

*Quality assurance and monitoring; developing a consistent approach across the ICB- pilot tools developed.
*Standardised tool developed to support assessment of complex care caseload and responsive safety assessment tool.
*System Equality and Quality Impact assessment policy developed including equality and health inequalities- pilot of tool being undertaken.
*Internal audit in relation to governance of commissioned services.
*Independent investigation reports reviewed, and thematic analysis completed of ICB recommendations.
*Some policies identified as requiring updating- tools developed and process established to review all ICB policies.
*Incidents and risk registers- gaps in assurance identified.
*Quality governance meeting proposal developed- engagement started.

Next steps

*Quality assurance and monitoring of commissioned services; developing a consistent approach across the ICB- programme to develop tools for all service types.
*Independent reviews- Key themes identified and plan to be developed to identify actions/ action owners.
*Training and development for all staff about governance.
*Overarching improvement plan linked to audit plan to improve quality governance arrangements and how this correlates with corporate governance.
*NHSE ICS quality functions- Self-assessment tool developed to assess our compliance with the quality functions, this needs to be undertaken.
*Self-assessment against CQC standards- tool to be developed for Key ICS quality statements and also CQC well-led framework for NHS trusts.

1.6 GOVERNOR STEERING GROUP UPDATE

Darren Best, Chair

verbal update

1.7 COUNCIL OF GOVERNORS COMMITTEE SUB-GROUP TERMS OF REFERENCE

Kirsty Allan, Deputy Trust Secretary / Corporate Governance Manager

REFERENCES

Only PDFs are attached

1.7a Steering Group ToR Nov 2024.pdf

1.7b Governors' Nomco ToR Review November 2024.pdf

Governors Steering Group
Terms of Reference

Committee Name:	Governors' Steering Group
Committee Type:	Standing Group of the Council of Governors
Timing & Frequency:	Meetings will be held bi-monthly
Committee Secretary:	Corporate Affairs Office
Reporting Arrangements:	Verbal updates will be provided to the Council of Governors General meetings via the Chair.
Membership	
Chair:	Chair of the Council of Governors and Board of Directors
Members:	• Lead Governor • Deputy Lead Governor • One representative from the Service User Governor Constituency (may include Lead or Deputy Governor) • One representative from the Carer Governor constituency (may include Lead of Deputy Lead Governor) • Three additional Governors from any constituency
In attendance:	• Director of Communications and Corporate Affairs • Deputy Trust Secretary / Corporate Governance Manager
Quorum:	Three members to include the Chair and a minimum of three Governor members.
Purpose	
To keep under review the work of the Council of Governors, ensuring that the Council of Governors continues to fulfil its statutory duties, and receive appropriate assurance on the organisations planning, development, and key risks. Provide advice and support to the Trust Chair, Chief Executive and the Corporate Affairs Team.	
Accountability and authority	
The Committee is accountable to the Council of Governors for its performance and effectiveness in accordance with these terms of reference.	
Responsibilities and duties	
• Support the Chair on matters for inclusion in the agenda of Council of Governor	

General meetings and/or topics for discussion at Engagement Sessions and agreeing the cycle of business for the Council of Governors.
- Coordinate and progress the work of Governor Committees and Groups established by the Council of Governors.
- Review and agree Governor membership of the Board Committees.
- Ownership and review of the Trust's approach to public and stakeholder engagement.
- Oversee, review, and make recommendations to the full Council of Governors on all regulatory and statutory requirements on the Council i.e., Governor elections, Trust Constitution and associated regulatory guidance.
- To review any issues regarding the effective functioning of the Council of Governors and report any recommendations on actions to be taken to the full Council of Governors for approval.
- Work with the Chair and Corporate Affairs Team to develop the agenda and planning of the Annual General Meeting and Annual Members Meeting.

Papers

Meeting papers shall be distributed to members and individuals invited to attend at least five days prior to the meeting.

Minutes and action notes shall be approved formally by the Group at its next meeting.

Review

These terms of reference shall be reviewed by the group annually or more frequently when necessary. The Council of Governors shall be required to approve all changes.

Current review date: November 2024
Date of previous review: September 2023
Next review date: November 2025

Council of Governors: Nomination Committee Terms of Reference November 2024

Group Name:	Governors' Nomination Committee
Group Type:	Statutory Committee of the Council of Governors
Timing and frequency	Meetings will be held on a quarterly basis, however, further meetings can be called at the request of the Chair
Group secretary	Corporate Affairs Office
Reporting arrangements	Verbal updates will be provided to the Council of Governors General meetings via the Chair. Formal reports on formal business will be presented to meetings of the full Council of Governors in line with delegated authority set out in these terms of reference.
Membership	
Chair	Meetings will be Co-Chaired by the Chair of the Council of Governors and Board of Directors and the Lead Governor.
Members	Chair of the Council of Governors and Board of Directors Lead Governor Two Service User and/or Carer Governors (one of which can be the Lead Governor) One appointed Governor One staff Governor Two additional Governors from any constituency Director of Communications and Corporate Affairs Deputy Trust Secretary / Corporate Governance Manager
Quorum	Four members to include the Chair and a minimum of three Governor members
Purpose	
As per the Trust Constitution, the Council of Governors shall establish a committee of its members to be called the Nominations Committee to discharge those functions in relation to the appointment and removal of the Trust Chair and Non-Executive Directors and their remuneration and allowances and other terms and conditions. The committee should comply with NHS England 'Code of Governance' and associated national guidance. The primary purpose of the Nominations Committee is to lead the process for	

appointments, ensure plans are in place for orderly succession to the Board and oversee the development of a diverse pipeline for succession.

NB: When discussing issues relating to the Chairman of the Council of Governors and Board of Directors, the Committee will seek the views and involvement of the Senior Independent Director

Key Responsibilities

- Regularly review the structure, size, and composition (including the skills, knowledge, experience and diversity) of the Board and make recommendations to the Board regarding any changes to be considered relating to the Non-Executive Director cohort.
- To identify any missing skills on the Board, and to incorporate them into the job descriptions and person specifications for Chair and Non-Executive Director posts.
- To review and agree job descriptions and person specifications for all Chair and Non-Executive Director vacancies, taking into consideration the view of the Board.
- Agree the criteria and process for the recruitment and appointment of the Chairman of the Council of Governors and Board of Directors and other Non-Executive Directors (NEDs), taking into consideration the views of the Chief Executive and Board of Directors.
- To agree and recommend to the Council of Governors, the recruitment and selection arrangements for the Chairman and Non-Executive Director posts.
- To decide if external consultants should be appointed to assist in the recruitment process, to interview suitable agencies and to select accordingly.
- To agree the composition of the Interview Panel and other arrangements for the interview process for the Chair and Non-Executive Director posts.
- To agree and recommend to the Council of Governors, the re-appointment process for the Chairman and Non-Executive Directors who wish to stand for further terms of office.
- To recommend the appointment/re-appointment of the Chair and Non-Executive Directors to the Council of Governors
- Contribute to plans for orderly succession to the Board and the development of a diverse pipeline for succession, considering the challenges and opportunities facing the organisation, and the skills and expertise needed on the Board in the future.
- Regularly review the remuneration and terms and conditions for the Chair and Non-Executive Directors taking into consideration national legislation, regulation and guidance.
- Agree the criteria and process for the removal of the Trust Chair and Non-Executive Directors including agreeing the process for investigating any allegations made against the Chair and other Non-Executive Directors.
- Annually review the appraisal process and appraisal outcomes of the Chair and Non-Executive Directors and as such, keep under review their performance.

Review date

Previous review date: November 2023
Review Date: November 2024
Next Review Date: November 2025

1.8 LEAD GOVERNOR APPOINTMENT

Kirsty Allan, Deputy Trust Secretary / Corporate Governance Manager

Verbal update

1.9 2025 GOVERNOR SERVICE VISITS

Kirsty Allan, Deputy Trust Secretary / Corporate Governance Manager

REFERENCES

Only PDFs are attached

1.9 Service visits 2025.pdf

Council of Governor Meeting

Council of Governors Service Visits 2025

- **Introduction**

One of the important areas a Governor can get involved in is informing and developing the Trust Strategy 'With you in mind'.

Governors ongoing responsibilities in relation to this strategy is to assist in its monitoring by informing the Board of their findings. By this, it is meant that through the site visits Governors can collate important feedback from staff, service users and carers on their experiences. This feedback can then inform Council discussions and questions to the Executive team who will have the overall responsibility in regard to its monitoring and implementation.

The Trust is committed to continuous learning and actively encourages feedback opportunities. Governor visits further strengthen our learning framework by providing additional opportunities for triangulation, and rich feedback opportunities. The intelligence that is gathered within this framework is analysed as part of the Trust's wider approach to learning and supports internal and external discussion that ultimately drives enhanced decision making and oversight.

What the Executive team will be looking for is whether the Trust Strategy 'With you in mind' is working well, it is effective and are they meeting its aims. This can only be done with good quality feedback, by hearing directly from staff, service users and carers and stakeholder groups. The Governors therefore are a conduit for the relay of this valuable monitoring information.

- **Responsibilities**

Governors have a statutory responsibility to promote high standards across the Trust. Well planned governor visits will support the Council of Governors in this duty. Governor visits will provide an excellent opportunity to:

- Gain a deeper understanding of how various services operate.
- Demonstrate to staff that Governors take their role seriously, are interested in, and value, the work of the Trust.
- Recognise and celebrate staff, service user and carer achievements.
- Receive assurance on the implementation of Trust policies in action which assists the Council of Governors to see the impact.
- Gain understanding of the progress of services within the Trust to help the Council of Governors contribute to forward planning and strategic discussions.
- Enable individual Governors to ask informed and challenging questions at Council of Governor meetings and to inform collective decision making.

- **Service visit arrangements**

The Corporate Affairs Office will circulate a list of annually planned service visits at the beginning of each year for expression of interest to be received from Governors who wish to attend any of the service visits. There is a limit for each visit for **4** Governors to attend.

If a Governor is unable to attend for whatever reason the Corporate Office Team should be informed as early as possible as spaces are limited

A member of the Corporate Affairs Office will support Governor visits as well as help coordinate the write up of the visit which will then be reported into the Council of Governors' General meetings as well as the Executive team.

Governors must make sure that they do not visit a service that they have had or are having a personal experience of as either a service user or carer.

- **Conclusion**

The Governor Site Visit Programme provides Governors the opportunity to get to know the organisation, to engage with staff, service users and carers, and to enable you to meet your statutory duties. All Foundation Trusts have a responsibility to support Governors to reach out and listen to their membership and most of this support will come from the Corporate Affairs Team.

The service visit schedule for 2025 is attached as appendix A.

- **Recommendation**

Any Governor who has an interest in any of the schedule of visits for 2025, to inform Kirsty Allan via email Kirsty.allan@cntw.nhs.uk who will organise the visit and assist governors on the given day.

Kirsty Allan
Corporate Governance Manager / Deputy Trust Secretary
November 2024

Appendix A – Schedule of Governor Service Visits 2025

Date	Service/Ward Name	Locality	Governor - Visitor
January	Neuropsychiatry Outpatient Team Walkergate Park Benfield Road Newcastle upon Tyne NE6 4QD	Neurological and Specialist Services CBU Specialist Care Group – Andy McMinn	
February	Linhope Sycamore Northgate Park Morpeth Northumberland NE61 3BP	Secure Care Services Specialist Care Group – Andy McMinn	
March	Willow View Rehabilitation and Recovery Unit St Nicholas Hospital Jubilee Road Gosforth Newcastle upon Tyne NE3 3XT	Central inpatient services Russell Patton	

April	Children and Young People Intensive Community Treatment Service Craster St Georges Park Morpeth Northumberland NE61 2NU	North Access Service Chloe Mann/ David Storm	
May	Children's Learning Disability and Behaviour Support Service Unit 9 Lillyhall Business Centre Jubilee Road Workington Cumbria CA14 4HA	North Cumbria Access and Community Services Chloe Mann / David Storm	
June	Digital Services Department St Nicholas Hospital Jubilee Road Gosforth Newcastle upon Tyne NE3 3XT	Support Services Gillian Colquhoun	
July	Early Intervention in Psychosis Team - Northumberland Greenacres Green Lane Ashington Northumberland NE63 8BL	North Community Services Chloe Mann	

August	Mowbray Inpatient Dementia Services Monkwearmouth Hospital Newcastle Road Sunderland SR5 1NB	South Inpatient Services Russell Patton	
September	Ruskin Dementia Assessment and Treatment Unit Carleton Clinic Cumwhinton Drive Carlisle CA1 3SX	North Cumbria Inpatient Services Andy Mcminn / Andrea Cox	
October	Individual Placement Support Employment Service Hartside Management Offices St Nicholas Hospital Jubilee Road Gosforth Newcastle upon Tyne NE3 3XT	Central Community Services Anna English	
November	Shoredrift Acute Admissions Ward Hopewood Park Waterworks Road Ryhope Sunderland SR2 0NB	 North Community Services Chloe Mann	
December	Voluntary Services St Nicholas Hospital Jubilee Road Gosforth Newcastle upon Tyne NE3 3XT	 Support Services	

2. STRATEGIC AMBITION 1 - QUALITY CARE, EVERY DAY

Darren Best, Chair

2.1 QUALITY AND PERFORMANCE COMMITTEE REPORT

Louise Nelson, Committee Chair

REFERENCES

Only PDFs are attached

2.1 QP Committee Assurance Report 31st July 2024.pdf

Board Committee Assurance Report
Council of Governors General Meeting
Thursday 28th November 2024

Name of Board Committee	Quality and Performance Committee
Date of Committee meeting held	31 July 2024
Agenda items/topics considered	See Appendix A
Date of next Committee meeting	25 September 2024

1. Chair's summary

Quality Focus: Crisis referrals. Chloe Mann, Place Director, Community Care Group, North presented an overview of the current service provision, performance and activity data, details relating to the improvement programme and its associated workstreams, what 'success' looks like and Your Voice feedback.

It was noted the variation in referral numbers across the CNTW footprint and reference to the national standards on crisis response rates. It was noted that there had been an increase in negative responses through Your Voice which related to the increased numbers of calls coming through the service and Your Voice providing a much easier mechanism to provide feedback. Clarity was sought from the members around the NHS select Mental Health option and impact of CNTW with assurance given that many of those calls aren't seen by CNTW but signposted to other support services.

Assurance was noted from Q&P of service user and carer involvement in the various working groups and the actions currently underway to address the demand for services and the positive update.

Health & Safety Executive

The committee received an update on the Improvement Notice previously issued to the Trust by the HSE. The trust submitted its response to the Improvement Notice on 3rd May 2024, and the HSE had subsequently responded to request that some areas within the trust's response are strengthened, particularly relating to:

- Policies and associated PGNs need to be strengthened to include reference to violence and aggression risks posed by patients to staff – this has since been actioned.
- The HSE Could not see any evidence that front line staff had been involved in risk assessments, i.e. feeding in their experiences.

Clinical Risk Assessment of Patient Specific Risks in MDTs needs to also focus on staff as the HSE Inspector felt there appears to be nothing on reducing risk to staff

It was noted that the newly established Violence Reduction Steering Group – which, following discussion at the Trustwide Safety Group (TSG), will become a formal part of the governance structure meeting bi-monthly.

Integrated Performance Report (IPR)

Highlights from the IPR:

- FFT performance has improved to 85.7% in June which is comparable with the national score of 85%;
- Clinical supervision performance has improved during quarter 1 and this continues to be a significant area of focus. It is anticipated compliance will have been achieved within Learning Disabilities and Autism by the end of September 2024;
- Violence and aggression incidents remain a significant area of focus with regular reviews of care plans and care delivery approaches being undertaken together with risk assessments on the areas identified as hot spots;
- There has been a marked improvement in the biopsychosocial risk assessment compliance following its introduction in early April;
- There has been a focus, within the Inpatient and Specialist Care Groups, on the reading of rights and capacity at the point of detention;
- There were no inappropriate out of area bed days during June;
- Clinically ready for discharge remains a concern within all inpatient areas and place based areas. There were up to 60 clinically ready for discharge patients within the patch until very recently and collaborative work is underway with the ICB and Local
- Authorities to address this issue;
- At Month 3 the trust has generated a £6.4m deficit which is in line with the Month 3 plan. At the end of Month 3 agency spend was £2.6m against a plan of 2.7m.

Community Services Waiting Times Update

Highlights noted:

<u>Children and Young People Services (CYPS)</u>

- 94% of the 5,881 CYPS waiting longer than 4 weeks (as of June 2024) are on a Neurodevelopmental pathway. Of those waiting over 4 weeks, 3,760 are undiagnosed at this point in time. 567 referrals have waited longer than 2 years.
- The Community Services Oversight meeting continues to meet on a weekly basis to look at waiting list management and discuss potential areas of recovery
- The CYPS redesigned neuro developmental pathway has been agreed by the Executive Management Group – this will be aligned to the work underway via the ICS

<u>Working Age and Older Adults</u>

- There are 1,769 working age adult patients waiting longer than 4 weeks for Treatment as of June 2024, down from 3,051 in July 2023.

- There are 390 older adult patients waiting longer than 4 weeks as of June 2024, this has improved from 843 waiting more than 4 weeks in July 2023.

Adult ADHD

- There are currently circa 12,000 patients waiting assessment for Adult ADHD and this trend is increasing month on month.
- The average wait to be assessed for adult ADHD (if joining the waiting list in February 2024) is 7 years.

It was noted that the adult ADHD waiting list was highlighted at the ICB Public Board meeting on 30th July by a Local Authority colleague and there was a reflection that whilst the issue has been discussed widely, limited progress has been made. The ICB CEO made a plea that partners look into identifiable actions that will make a difference and a meeting has been arranged to discuss this issue further.

Safer Staffing Report

- Work is in progress to enhance the accessibility of the care hours per patient day information by including contextual information including turnover, vacancy, sickness and temporary staffing usage information which will be included in future reports.
- The latest Mental Health Optimal Staffing Tool (MHOST) exercise has been completed and the information will be collated to inform the staffing skill mix review which will be presented at the September Committee.
- Newly registered nurse recruitment for nurses who quality in September 2024 has been completed and focussed work is underway in relation to retention.

Q&P noted the ongoing improvements to the report

CQC

Must Do Update report – the Committee approved a short extension to the action timescales relating to debriefs, body maps and physical health/rapid tranquilisation and explained that this is to allow some further time for the intensive pieces of work in these areas to continue.

The Committee also approved the closure of the Clinical Supervision action plan.

The Committee were advised that the CQC undertook an unannounced inspection on Learning Disability and Autism wards during week commencing 15th July 2024.

Quality & Safety Report

The Committee received the first iteration of the Trustwide Quality and Safety Report (which replaces the previous Safer Care Report), highlighting that the aim of the report will change each time to ensure that safety data aligns, where necessary, to PSIRF aims and objectives. Your Voice feedback data from Service Users and Carers will also be incorporated into future reports

Committee Members were asked to digest the report and feed any comments.

Additional Reports Received

IPC BAF & IPC Annual Report
CNTW Pandemic Plan
Research & Development Annual Report
Service User & Carer Experience Report
Positive & safe Annual Report

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

Discussions are underway in relation to incidents that do not meet the threshold for a more detailed investigation in terms of identifying any learning themes. A discussion will take place at a future meeting in relation to how the Committee can be assured that learning is happening (and is appropriate) and what the confidence is around some of the incidents which have not reached the threshold for further investigation

There are currently circa 12,000 patients waiting assessment for Adult ADHD and this trend is increasing month on month

Capacity, consent and rights

3. Key challenges now and in the medium term

Recommendations and considerations following the recent unannounced CQC Inspection

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

The topics to be agreed for the Quality Focus to be agreed

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

Community services, waiting lists and activity.

8. Review of Board Assurance Framework and amendments thereon

Committee reviewed the BAF with the most significant risk for the Committee in relation to the demand and access to services. Corporate Risk 2508 which relates to GPs handing back medication management to community teams was discussed and the outcome of the GP ballot and the potential impact of this on the trust's services is something the Committee should be aware of.

Colleagues agreed that one of the main areas of concern and discussion at the Committee has been around community services, waiting lists and activity.

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.

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

22nd August 20204

Sarah Rushbrooke
Executive Director of Nursing Therapies and Quality Assurance

2.2 MENTAL HEALTH LEGISLATION COMMITTEE REPORT

Michael Robinson, Committee Chair

REFERENCES

Only PDFs are attached

2.2 MHLC - Board Committee Assurance Report September.pdf

Board Committee Assurance Report
Council of Governors General Meeting
Thursday 28th November 2024

Name of Board Committee	**Mental Health Legislation Committee (MHLC)**
Date of Committee meeting held	7 August 2024
Agenda items/topics considered	See below
Date of next Committee meeting	6 November 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 although no formal feedback had yet been received. In relation to feedback received from previous visits, action plans are in place to meet the issues raised following those visits and the issues raised 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 continues to monitor detentions under the MHA in all its regions through the Mental Health Legislation Steering Group (MHLSG) to compare with national trends and data and to conform with the Patient and Carer Race Equality Framework (PCREF).
- The Trust is required by PCREF to monitor detention by ethnicity of service users and the necessary processes are in place to comply with these obligations as are those to develop the CNTW PCREF Plan and to produce a Health Inequalities Annual Report. This area will continue to be reviewed by the MHLSG.
- The Committee received the further results of a review of panel membership and practices including a consideration of the practices of other Trusts in this area in relation to appraisal of panel members. The Committee will review and recommend training and appraisal processes for panel members on the basis of that review and further work being undertaken by MHLSG.
- The MHLSG continues to monitor compliance with the completion of Parts A and B of local forms on Rio. Local groups are urged to look for ways to improve compliance and to report to MHLSG on the steps taken at a local level. The Committee will continue to monitor this area and seek signs of increased compliance.

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 and consent under Parts A and B of local forms</u>
Whilst there continues to be a low compliance rate in the completion of the local forms, the forms have been reviewed and amended as appropriate to make completion more straightforward and to ensure that they are user friendly and capture the relevant information. 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. MHLSG has asked local groups to report on steps taken to improve compliance at its next meeting and those steps will continue to be monitored by MHLSG. The Committee and the Quality and Performance Committee of the Board will continue to monitor this area for signs of improvement in compliance

Mental Health Legislation Training
Most recent data indicates that compliance with MHL training is at 75.2% of the workforce. Whilst there has been a consistent improvement in compliance rates in recent months, this is still below the target set. 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.

3. Key challenges now and in the medium term

With the changes in Government, the timetable for legislative scrutiny and enactment of the Mental Health Bill is unclear. However, in the Kings Speech it was made clear that this is a priority for the new Government and therefore it is likely that a timetable for review and enactment will emerge in the relatively short term Any 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.

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 will offer a hybrid approach to hospital managers hearings from 1 September 2024. 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 training package is available via the Trust intranet. The rights training package provides vital information to our professionals to ensure compliance with the MHA Code of Practice and includes a relevant quiz.

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

After recent recruitment, there are currently [51] panel members sitting with a further [10] new members about to commence their induction process. 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. [2] of those prospective members about to commence the induction process are from minority ethnic communities. The Committee will continue to monitor this area and encourage recruitment from these groups. 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. The MHL department is working with the MHLSG to identify the preferred approach to training and appraisal and will report to the next meeting of the Committee. will continue its review and report to the Committee on the appropriate training and appraisal process.

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 recommendations of the MHL Department and MHLSG following the review of panel membership, training and appraisal.

Following the update received by the Committee on detentions and PCREF, the Committee will continue to monitor detentions and seek comparators from other areas and Trusts.

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

The Committee would draw the attention of the Board to the work being done to improve compliance with Parts A and B of local forms and assure the Board that it will continue to review this area and seek improvements.

The Committee previously drew the attention of the Board to the decision of the Employment Appeal Tribunal in Lancashire and South Cumbria NHS Foundation Trust v Ms R Moon which determined that panel members may be afforded certain employment rights arising from their role. The MHL legal team is in discussion with other Trusts as to the possible implications of this decision and the implications for the Trust.

The Committee would also draw attention to the further work on panel membership, detention numbers and ethnicity data referred to at 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: 7th August 2024

Dr Rajesh Nadkarni
Medical Director & Deputy Chief Executive
Date: 7th August 2024

2.3 INTEGRATED PERFORMANCE REPORT - QUALITY CARE, EVERYDAY

Sarah Rushbrooke, Executive Director of Nursing, Therapies and Quality Assurance & Dr Rajesh Nadkarni, Deputy

Please note this report will also cover agenda items covered under 3.3 / 4.2 and 5.2

REFERENCES

Only PDFs are attached

2.3 Trust IPR - July 2024 - Final.pdf

NHS
Cumbria, Northumberland,
Tyne and Wear
NHS Foundation Trust

Integrated Performance Report

Patients | Quality | People | Person Led Care | Sustainability

2024-25 Month 4 (July 2024)

With YOU in mind

Integrated Performance Report - Headline Commentary

Reporting Period: Jul 2024

Headline Challenges

- **Training (All Staff courses)** – 3 of the 10 prioritised 'all staff' training courses are close to target. 7 of the 10 are on target
- **Sickness** – 6.4% against a target of 5%
- **Appraisal rate** – Improved in the month to 76.7% (75.1% in June) against a target of 85%
- **Clinical Supervision** – off 80% target at 66.2% although current performance as at 28/08/24, excluding exemptions, is 78.7%
- **Prone Restraints** – There have been significant reductions from levels at 100 a month 12 months ago. However, there has been an uptick from 17 in June to 48 in July due to two patients on two wards (Mitford 1&2 and Riding) accounting for 30 of the 48 incidents.
- **Assaults on Patients** – Increased in the month. 51% involved no physical harm and 48% was due to low physical harm. 1% (1 patient) with moderately physical harm
- **% of patients with a Risk Plan** – off 100% target at 80.2%
- **Reducing Incidents of self-harm –** Significant increase in the month. 99% were low or no physical harm, 1% (17) of the incidents were moderate physical harm and 0.1% (2) of the incidents were severe physical harm.
- **Record of Capacity/Consent to Treatment (CTT) at point of detention**– is consistently off target remaining 33.6% below target
- **Out of Area Placement Bed Days -** 2 inappropriate placements at the end of the month. Although still on target these are the first since December 2023. This is due to current bed pressures within mainly female Adult Acute MH beds and Older Persons.
- **Bed occupancy –** remains off target despite improving in the month.
- **Clinically Ready for Discharge** – remains off target, no significant change. Most patients are waiting for external packages of, housing and care homes places.
- **Adult inpatients discharged with LOS >60 days** – remains off target
- **Crisis Very Urgent Referrals seen within 4 hours –** At 29.3%, the lowest reported performance since February 23 with significant deterioration in the month (43.6% in June).
- **4wks Referral to Treatment - Adult and Older Adult** – 34.4% of referrals have been waiting 4 weeks or less to treatment.
- **4wks to Referral to Receive Help - All CYPS** – 8.4% of referrals waiting 4 weeks to receive help. Overall, a total of (5,953 out of 6,400) 93.0% are within the neurodevelopmental pathway.

Key focus areas of concern

- **Clinical Supervision**
- **Crisis Very Urgent Referrals seen within 4 hours**
- **% waiting < 4 weeks to Receive Help – All CYPS**
- **Live within our means**
- **Prone Restraints/Assaults on Patients/Self Harm –** See next page headline for detailed summary

Positive Assurance / Improvement

- **Do you feel safe? -** remains above target for the 4th consecutive month.
- **Clinical Priority Training Courses -** 7 of the 9 courses are meeting the Quarter 2 trajectory within July, two months before quarter end, all 9 courses are showing improvement.
- **Older Adult inpatients discharged with LOS >90 days** – 40% target has been achieved in the month.
- **Psychiatric Liaison seen within ED within 1 hour –** At 80.9% remaining above the internal trajectory of 80%
- **Psychiatric Liaison seen within Ward in 24 hours –** Reported at 90.9% in the month, remains above the internal target of 85% for the 5th consecutive month
- **Long term segregation and prolonged seclusion** – Specialist Care Group reported a reduction in LTS with the successful ending of one case in Secure CBU following LTS Panel.

Mitigations/actions

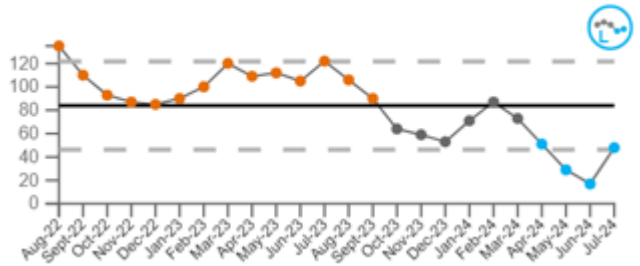
- **Clinical Supervision–** A paper was presented to EMG and BDG outlining the following key areas for performance enhancement: enhancing guidance and supervision quality, improving data accuracy and the ease of recording, and advancing the monitoring, audit, and management of clinical supervision. Current performance at August 27th 2024 is 83.6% compared to 66.4% in July. *Recovery plan in place.*
- **Crisis Very Urgent Referrals seen within 4 hours –** At the July Quality and Performance Committee there was a deep dive into the Crisis service to review the data and the four key improvement areas in progress. These included; 1. Very Urgent and Urgent response times/performance, 2. Crisis Model Review, 3. 136 Optimum Model, and 4. Interface and Trusted assessment *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. A strategic meeting has taken place with ICB leaders and both Trusts across NENC to discuss how as a system we improve access and experience of patients with a neurodevelopmental need. This group agreed to develop immediate recovery plans and a longer-term whole pathway system, approach. The group will meet again to finalise plans in September. *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*

Patient/Staff safety – Headlines and actions summary

Reporting Period: Jul 2024

Prone Restraint

Ref: Q02 Performance: 48 Plan: n/a



Analysis

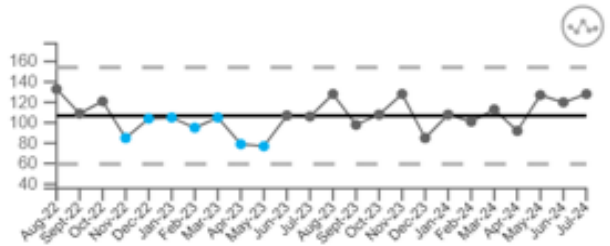
There were 48 Prone restraints reported in July 2024, an increase from 17 in June 2024. This is due to an increase in incidents of two patients on two separate wards (Mitford 1&2 and Riding) who accounted for 30 of the 48 incidents. These two patients accounted for only 3 of the 17 incidents of prone restraint in June 2024.

Improvement actions

- On-going monitoring use of safety pods within clinical areas.
- Robust de-brief to support learning from incidents and review individual care planning to identify earlier none restrictive intervention.
- PAUSE (Talk 1st initiative) training undertaken in CYPS services both at Ferndene and Lotus in July and August.
- Prone restraints receive regular review in key management and governance groups, which have been further strengthened.
- Robust de-brief to support learning from incidents and review individual care planning to identify earlier none restrictive intervention.
- Additional PMVA workshops hosted locally to support in reducing use of restrictive interventions.
- Increased emphasis on safer alternatives maintained across Positive and Safe Team and PMVA tutors.

Assaults on Patients

Ref: Q04 Performance: 128 Plan: n/a



Analysis

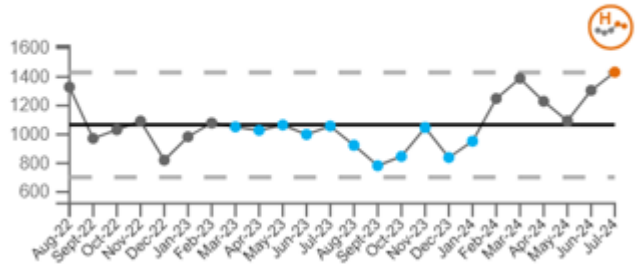
There were 128 assaults on patients in July 2024 which is within expected variation.
Of the 128 assaults in July 2024, 50% of the assaults involved no physical harm and 49% resulted in low physical harm with 1% (1 incident) classified as moderate physical harm. Between May and July 2024 Ruskin and Longview have the had the highest rates of incidents.

Improvement actions

- One of the PSIRF priorities for the year is prevention and management of violence and aggression.
- The Trust has created a dedicated group for violence reduction. Focussing on improved staff health and wellbeing, improved risk management of violence and aggression and regular review of care plans and consideration of other environmental factors and care delivery approaches take place by the MDT.
- Embedding the debrief process including staff and patients to improve psychological safety.

Incidents of self-harm

Ref: Q07 Performance: 1,433 Plan: n/a



Analysis

In July there have been 1,433 reported incidents of self-harm, the highest level reported within 24 months and an increase from 1,305 in June 2024. 54% (773) of the incidents were no physical harm, 45% (641) were low physical harm, 1% (17) of the incidents were moderate physical harm and 0.1% (2) of the incidents were severe physical harm. 15% of the incidents are from the same three patients on CYPS wards. Lamesley (Female Acute) and Lotus (CYPS) are the wards with the highest incidents of self-harm.

Improvement actions

- Incidents of Self Harm is a PSRIF priority - a steering group with project management support has been established.
- On inpatient areas after incidents of self harm, debriefs occur which provide an opportunity to discuss the incident with the patient and to update care plans, safety plans and risk assessments.
- Adopt and monitor the quality of biopsychosocial risk assessments with safety planning both on inpatient wards and within the community
- Review of observations
- Individualised care planning / Review of care plans based on formulation is taking place where it is required.

Core Trust Integrated Outcome Measures - Summary Overview

Reporting Period: Jul 2024

	Ref	Indicator Name	Variation	Assurance	Performance	Target	Target Type	Risk Rating	Summary Narrative	Exec
Commitments	C01	How was your experience? (FFT)	Normal Variation	Consistently Off Target	84.5%	90%	CNTW Std	High (Action)	Deteriorated in the month and remains below target	SR
	C02	How was the care we provided?	SPC n/a	SPC n/a	87.9%	90%	CNTW Std	High (Action)	Improved in the month though remains below target	SR
	C03	Did you feel safe?	Normal Variation	Achieve at Random	90.8%	90%	CNTW Std	Low (On Track)	Remains above target for 4th consecutive month	SR
People	P01	Sickness in Month	Normal Variation	Consistently Off Target	6.4%	5%	NHSE Std	High (Action)	Deteriorated in month, excludes NTW Solutions data	LS
	P02	All Staff Priority Training	Normal Variation	Consistently Off Target	70.0%	100%	CNTW Std	High (Action)	7 out of 10 prioritised training courses achieved target in July	LS
	P03	Clinical Staff Priority Training	SPC n/a	SPC n/a	77.8%	100%	CNTW Std	Med (Monitoring)	7 out of 9 prioritised training courses achieved trajectory in July	LS
	P04	Appraisal rate	Normal Variation	Consistently Off Target	76.7%	85%	CNTW Std	High (Action)	Remains off target but improved in the month - excludes NTW Solutions	LS
	P05	% Clinical Supervision completed	Improvement	Consistently Off Target	66.2%	80%	CNTW Std	High (Action)	Current live data is 78.7% @ 28/08/24	LS
Quality Care	Q01	MRE Restraints	Normal Variation	n/a	8	n/a	n/a	Med (Monitoring)	Decreased in the month, 4th consecutive month below average	RN
	Q02	Prone Restraints	Improvement	n/a	48	n/a	n/a	Med (Monitoring)	Increased in the month, significant improvement over 24 months	RN
	Q03	Long term segregation and prolonged seclusion	Normal Variation	n/a	14	n/a	n/a	Med (Monitoring)	Improved in the month, no significant change	SR
	Q04	Assaults on Patients	Normal Variation	n/a	128	n/a	n/a	Med (Monitoring)	Increased in the month	RN
	Q05	Assaults on staff	Normal Variation	n/a	489	n/a	n/a	Med (Monitoring)	Marginal increase in the month	RN
	Q06	% of patients with a Safety Plan	SPC n/a	SPC n/a	80.2%	100%	CNTW Std	Med (Monitoring)	Improved in the month	RN
	Q07	Reducing incidents of self-harm	Concern	n/a	1,433	n/a	n/a	Med (Monitoring)	Significant increase for the 2nd consecutive month	RN
	Q08	Rights at Point of Detention	Normal Variation	Consistently Off Target	93.2%	100%	CNTW Std	High (Action)	Performance improved in the month	RN
	Q09	Record of Capacity/ CTT at point of detention	Improvement	Consistently Off Target	66.4%	100%	CNTW Std	High (Action)	Decreased in the month, remains consistently off target	RN
Person Led Care	A01	Inappropriate Out of Area Placements (OAPs)	Improvement	Achieve at Random	2	3	NHSE LTP	Low (On Track)	2 Out of Area Placements reported active at the end of July	RD
	A02	Bed Occupancy including leave (open beds on RiO)	Normal Variation	Consistently Off Target	92.9%	85%	NHSE Std	High (Action)	Improved in the month, reported below average	RD
	A03	% Adult inpatients discharged with LOS > 60 days	Normal Variation	Achieve at Random	22.8%	20%	CNTW Std	Med (Monitoring)	Improved in the month but off target	RD
	A04	% OP inpatients discharged with LOS > 90 days	Normal Variation	Achieve at Random	40.0%	40%	CNTW Std	Low (On Track)	Improved in the month reported at target	RD
	A05	Clinically Ready for Discharge (formerly DTOC)	Normal Variation	Consistently Off Target	11.9%	7.5%	NHSE Std	High (Action)	Remains off track and has deteriorated in the month	RD
	A06	Crisis % Very urgent seen within 4 hours (WAA&OP)	Concern	Achieve at Random	29.3%	60%	CNTW Traj	High (Action)	53 out of 181, less than a 3rd very urgent referrals seen within 4 hours	RD
	A07	Crisis % Urgent seen within 24 hours (WAA&OP)	Normal Variation	Achieve at Random	82.8%	85%	CNTW Std	Med (Monitoring)	322 out of 389, deteriorated in the month and below target	RD
	A08	% PLT ED Referrals seen within 1 hour	Improvement	Consistently Off Target	80.9%	80%	CNTW Std	Med (Monitoring)	On target for the last 4 months, improved last 12 months	RD
	A09	% PLT Ward Referrals seen within 24 hours	Improvement	Achieve at Random	90.9%	85%	CNTW Std	Low (On Track)	Reported above the internal target for the 5th consecutive month	RD
	A10	% Waiting 4 wks or less to treatment (WAAOP)	Normal Variation	Consistently Off Target	34.4%	45%	CNTW Traj	High (Action)	65.6% (1,520 of 2,316) have been waiting longer than 4 weeks	RD
	A11	% Waiting 4 wks or less to receive help (CYPS)	Concern	Consistently Off Target	8.4%	25%	CNTW Traj	High (Action)	91.6% (5,860 of 6,400) have been waiting longer than 4 weeks	RD
	A12	EIP – starting treatment in 14 days	Normal Variation	Consistently Achieve	87.9%	53%	CNTW Std	Low (On Track)		RD
Sustainable	S01	Live within our means (I&E Surplus/Deficit £)	SPC n/a	n/a	-£6.3m	-£8.4m	n/a	High (Action)	The Trust delivered a £6.3m deficit in line with the financial plan	KS
	S02	Income & Expenditure Forecast	SPC n/a	n/a	-£3.2m	-£3.1m	n/a	Low (No Target)	The Trust is planning to deliver against the requirements for the year	KS
	S03	All staff WTEs	SPC n/a	n/a	8,615	n/a	No Target	Low (No Target)	WTE numbers have decreased by 65 wte since last month	KS
	S04	Capital spend compared to plan (£)	SPC n/a	n/a	£1.0m	£1.4m	n/a	Low (No Target)	Plan to deliver the approved capital programme, £2.4m over the CDEL	KS
	S05	Cash balance compared to plan (£)	SPC n/a	n/a	£37.2m	£23.4m	n/a	Low (On Track)	The Trust cash balances are higher than plan at month 4	KS

Commitments to our Carers & Patients - Headline Commentary

Reporting Period: Jul 2024

Headline Challenges

- **How was your experience? (FFT) –** Performance was reported at 84.5% for July, this was a slight decrease on June 24 (85.7%). The 90% target has not been met. The latest national published Mental Health Services FFT score for England is reported at 85.0% (April 24) compared to the CNTW position of 81.2% (April 24).

Selected Your Voice questions

- **How was the care we provided?** – 87.9% of people said care was Good or Very Good, an increase on June (86.4%). Although not reaching the 90% target we will be able to identify the areas of poor experience in the coming months and mitigate.
- **Did you feel safe? –** 511 people responded to this question, of which, 47 reported not feeling safe, in comparison to 425 feeling safe. 8 of the people not feeling safe reported this in relation to the 111 service. A total of 39 people either didn't know or did not answer the question.

Key focus areas of concern

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

Positive Assurance / Improvement

- **Did you feel safe? –** remains the best performing question with 90.8% of people feeling safe, the 4th consecutive month reported above the 90% target

Mitigations/actions

How was your experience? (FFT)

- 56 of 534 respondents said their experience of our services was poor or very poor.
- Inpatient services have the highest satisfaction rating of 89.5%, Specialist services reported 87.8% and Community services reported the lowest score of 81.8% during July.

How was the care we provided?

- 519 people responded to this question, with 456 (88.2%) reporting a good (100) or very good (356) experience of the care provided.
- 45 people (8.7%) of respondents reported a poor (14) or very poor (31) experience.

Awareness sessions are being delivered for staff to help them understand the new dashboard and the feedback options for service users and carers. Sessions at Hopewood Park have been well attended by a range of roles and inpatient settings.

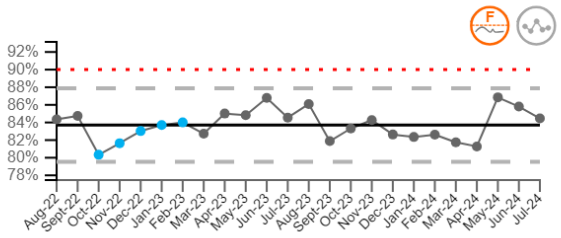
Feedback and You Said – We Did posters are discussed on all local/CBU agendas, most commonly through Quality Standards meetings, with good practice and areas for improvement being discussed.,

Commitments to our Carers & Patients

How was your experience? (FFT)

High (Action)

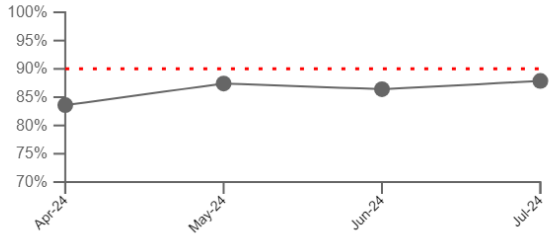
Ref: C01 Performance: 84.5% CNTW Std: 90%



How was the care we provided?

High (Action)

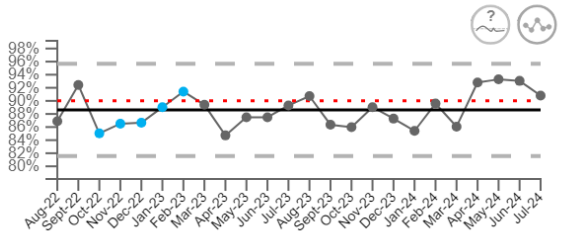
Ref: C02 Performance: 87.9% CNTW Std: 90%



Did you feel safe?

Low (On Track)

Ref: C03 Performance: 90.8% CNTW Std: 90%



Great Place to Work - Headline Commentary

Reporting Period: Jul 2024

Headline Challenges

Sickness Absence

- The confirmed sickness for June 2024 is reported at 6.4% (excluding NTW Solutions).
- The sickness metrics runs one month behind to allow time for ESR to be updated from Allocate on the 10th of every month.
- The provisional sickness for July 2024 is reported at 6.39% remaining above the 5% standard.

% of Training Compliance (Courses with a standard)

- In July 2024, Priority Training for All Staff is reported at 70.0%. Currently 7 out of the 10 identified priority training requirements are achieving target. Information Governance, Corporate Induction and Local induction remain below target.

Clinical Supervision

- Performance has improved and is reported at 66.2% compared to July 24 when reported at 59.3%, remaining below Trust 80% standard although current performance as at 28/08/24 excluding exemptions 78.7%

Appraisals

- Performance has increased and is reported at 76.7% compared to June 24 when reported at 75.1%, remaining below Trust 80% standard.

Key focus areas of concern

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

Positive Assurance / Improvement

- **Clinical Priority Training Courses -** 7 of the 9 courses are meeting the Quarter 2 trajectory within July, two months before quarter end, all 9 courses are showing improvement.

- **All Staff Priority Training**
  - **Local Induction** – improvement in performance from 84.9% to 86.8% in July, following focussed work related to updating records.

Mitigations/actions

Sickness Absence

- Sickness Clinics/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 Care Groups when staff trigger points. Ensuring wellbeing conversations take place, reasonable adjustments considered and referrals support (e.g. Staff Psychological Centre, Optima – occupational Health)
- The Trusts Health and Wellbeing offer continues to be promoted through the Thrive website.

% of Training Compliance (Courses with a standard)

- Monitored within weekly Group Safety meetings and Operational Management Groups (OMG).
- Trajectories established in line with Trust priorities.

Clinical Supervision

- The Director of Allied Health Professionals and Psychological Services will continue to work with Group Nurse Directors to establish methods to improve awareness and understanding of clinical supervision.
- Pilot to be launched recording Clinical Supervision with ESR within Bridgewell and Newcastle and Gateshead Community CBU.

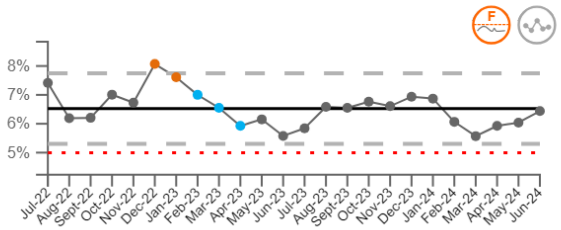
Great Place to Work

Reporting Period: Jul 2024

Sickness in Month

High (Action)

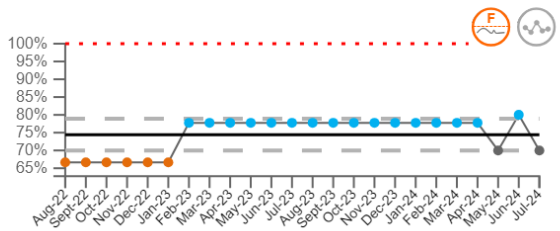
Ref: P01 Performance: 6.4% NHSE Std: 5%



All Staff Priority Training

High (Action)

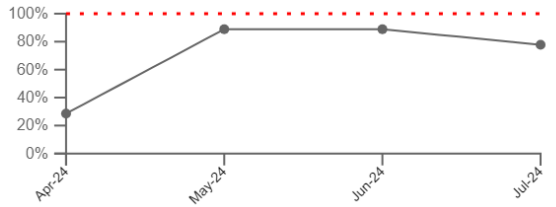
Ref: P02 Performance: 70.0% CNTW Std: 100%



Clinical Staff Priority Training

Med (Monitoring)

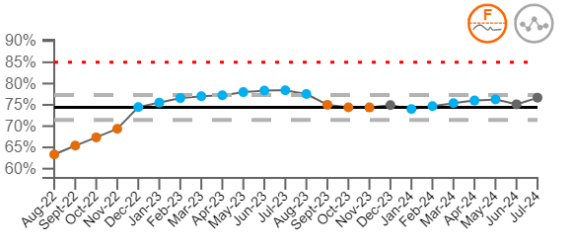
Ref: P03 Performance: 77.8% CNTW Std: 100%



Appraisal rate

High (Action)

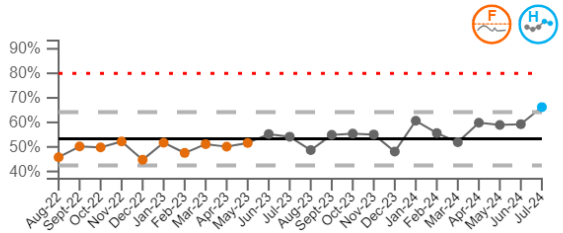
Ref: P04 Performance: 76.7% CNTW Std: 85%



% Clinical Supervision completed

High (Action)

Ref: P05 Performance: 66.2% CNTW Std: 80%



Quality Care, Everyday - Headline Commentary

Reporting Period: Jul 2024

Headline Challenges

- **% of Patients with a Risk Management and Personalised Safety Plan -** Metrics have been developed and are live on dashboards to assure delivery and compliance with quality standards. Community metric methodology is going through review.
- **Record of Capacity/Consent to Treatment (CTT) at point of detention - rights at Point of Detention** – is consistently off target, in July performance decreased and remains 33.6% below target.
- **Prone Restraints** – There have been significant reductions from levels at 100 a month 12 months ago. However, there has been an uptick from 17 in June to 48 in July due to 2 patients on two wards accounting for 30 of the 48 incidents.
- **Assaults on Patients** – Increased in the month, highest level reported for 24 months. 54% involved no physical harm and 46% was due to low physical harm. There were no higher levels of harm.
- **Reducing Incidents of self-harm –** 54% (773) of the incidents were no physical harm, 45% (641) were low physical harm, 1% (17) of the incidents were moderate physical harm and 0.1% (2) of the incidents were severe physical harm.
- **Long term segregation and prolonged seclusion** – Decreased in the month and remains reported below average. Several patients require specialised placements therefore system blocks are a significant factor in the use of LTS

Key focus areas of concern

- **Prone Restraints**
- **Staff and Patient Assaults**
- **Reducing Incidents of self-harm**

Positive Assurance / Improvement

- **MRE Restraint** – Decreased in the month, remains reported below average.
- **Prone Restraint –** despite a recent uptick in July the overall trend of use of prone restraint has reduced over the last two years.

Mitigations/actions

- **Prone restraints -** Strengthening governance and overall ambition for prone restraint as part of RRI commenced. On-going monitoring use of safety pods within clinical areas. Robust de-brief to support learning from incidents and review individual care planning to identify earlier none restrictive intervention. PAUSE (Talk 1st initiative) training undertaken in CYPS services both at Ferndene and Lotus in July and August. Additional PMVA workshops hosted locally to support in reducing use of restrictive interventions..
- **Staff and Patient Assaults –** One of the PSIRF priorities for the year is prevention and management of violence and aggression. The Trust has created a dedicated group for violence reduction. Focussing on improved staff health and wellbeing, improved risk management of violence and aggression and regular review of care plans and consideration of other environmental factors and care delivery approaches take place by the MDT. Embedding the debrief process including staff and patients to improve psychological safety.
- **Incidents of self-harm -** Following these incidents debriefs occur which can be used to share learning across the inpatient care group. Review of patient care plans based on formulation is taking place where it is required. Monitoring of the quality of biopsychosocial risk assessments with safety planning both on inpatient wards and within the community.

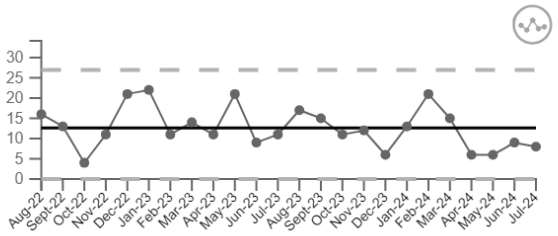
Quality Care, Everyday

Reporting Period: Jul 2024

MRE Restraints

Med (Monitoring)

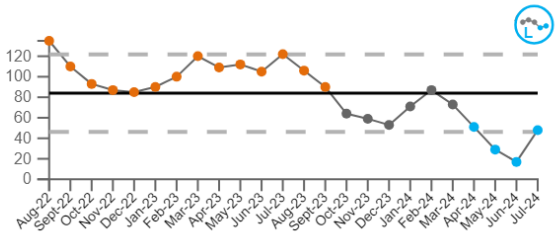
Ref: Q01 Performance: 8 Plan: n/a



Prone Restraints

Med (Monitoring)

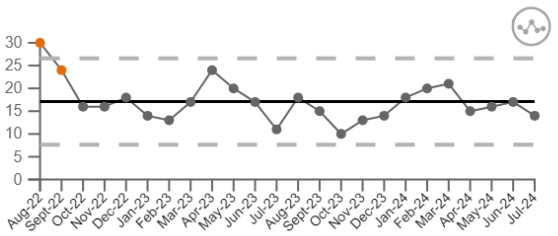
Ref: Q02 Performance: 48 Plan: n/a



Long term segregation and prolonged seclusion

Med (Monitoring)

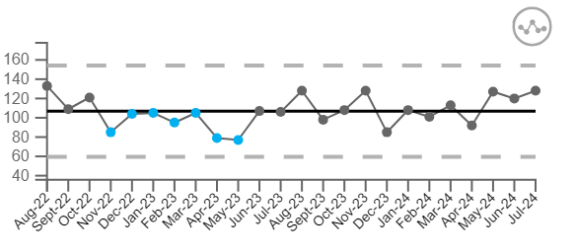
Ref: Q03 Performance: 14 Plan: n/a



Assaults on Patients

Med (Monitoring)

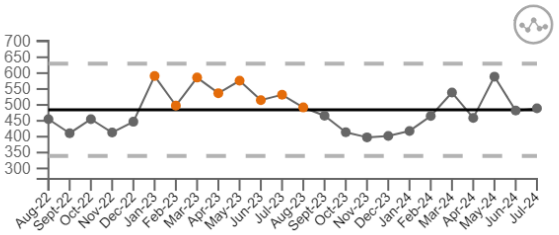
Ref: Q04 Performance: 128 Plan: n/a



Assaults on staff

Med (Monitoring)

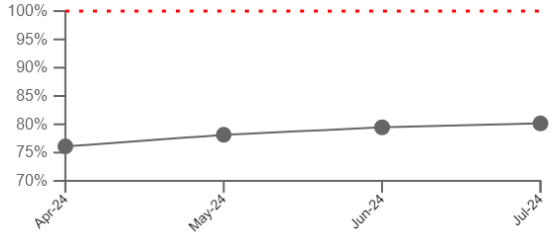
Ref: Q05 Performance: 489 Plan: n/a



% of patients with a Safety Plan

Med (Monitoring)

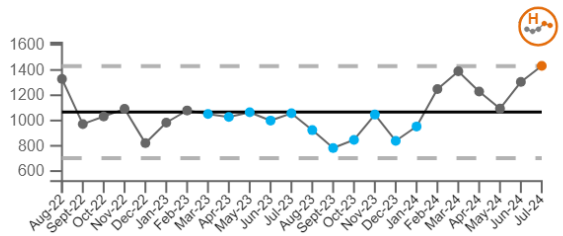
Ref: Q06 Performance: 80.2% CNTW Std: 100%



Reducing incidents of self-harm

Med (Monitoring)

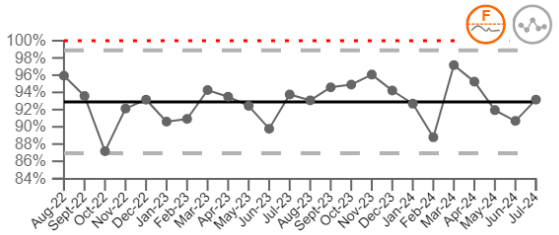
Ref: Q07 Performance: 1,433 Plan: n/a



Rights at Point of Detention

High (Action)

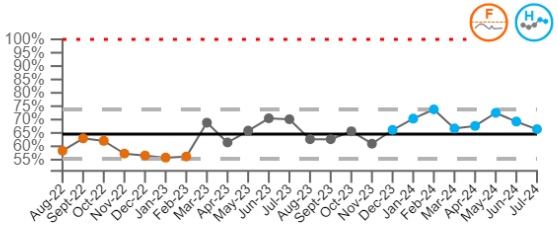
Ref: Q08 Performance: 93.2% CNTW Std: 100%



Record of Capacity/ CTT at point of detention

High (Action)

Ref: Q09 Performance: 66.4% CNTW Std: 100%



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

Reporting Period: Jul 2024

Headline Challenges

- **Out of Area Placement Bed Days** – 2 inappropriate placements at the end of the month. Although still on target these are the first since December 2023. This is due to current bed pressures within mainly female Adult Acute MH beds and Older Persons.
- **Bed occupancy –** remains consistently off target despite improving over the last two years, however, bed occupancy has decreased in the month.
- **Clinically Ready for Discharge** – remains consistently off target.
- **Adult inpatients discharged with LOS >60 days** – remains off target
- **Crisis Very Urgent Referrals seen within 4 hours –** At 29.3%, it's the lowest reported performance since February 23. Significant deterioration in the month (43.6% in June).
- **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** – 34.4% of referrals have been waiting 4 weeks or less to treatment, performance improved in the month.
  - **% waiting < 4 weeks to Receive Help** – 8.4% of referrals have been waiting 4 weeks or less to receive help. Overall, a total of (5,953 out of 6,400) 93.0% waiters 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

- **Older Adult inpatients discharged with LOS >90 days** – 40% target has been achieved in the month.
- **Psychiatric Liaison seen within ED within 1 hour –** At 80.9% performance remains above the internal trajectory of 80%
- **Psychiatric Liaison seen within Ward in 24 hours –** Reported at 90.9% in the month, remains above the internal trajectory of 85% for the 6th consecutive month

Mitigations/actions

- **Crisis Very Urgent Referrals seen within 4 hours –** At the July Quality and Performance Committee there was a deep dive into the Crisis service to review the data and the four key improvement areas in progress. These included; 1. Very Urgent and Urgent response times/performance, 2. Crisis Model Review, 3. 136 Optimum Model, and 4. Interface and Trusted assessment *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. A strategic meeting has taken place with ICB leaders and both Trusts across NENC to discuss how as a system we improve access and experience of patients with a neurodevelopmental need. This group agreed to develop immediate recovery plans and a longer-term whole pathway system, approach. The group will meet again to finalise plans in September. *Recovery plan in place*

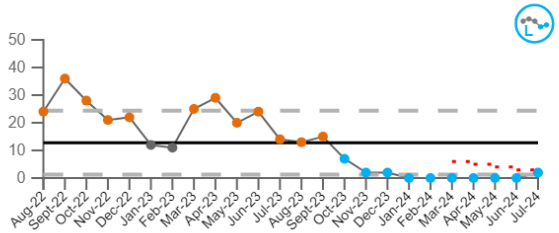
Person Led Care, when and where it's needed

Reporting Period: Jul 2024

Inappropriate Out of Area Placements (OAPs)

Low (On Track)

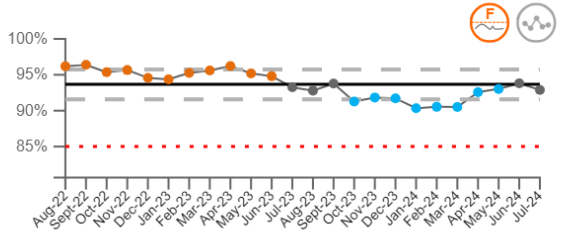
Ref: A01 Performance: 2 NHSE LTP: 3



Bed Occupancy including leave (open beds on RiO)

High (Action)

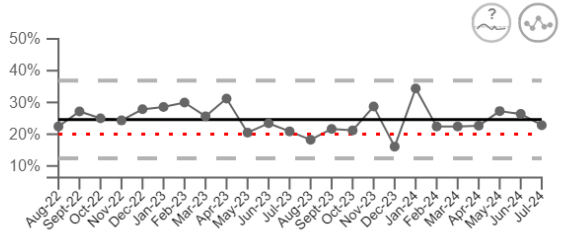
Ref: A02 Performance: 92.9% NHSE Std: 85%



% Adult inpatients discharged with LOS > 60 days

Med (Monitoring)

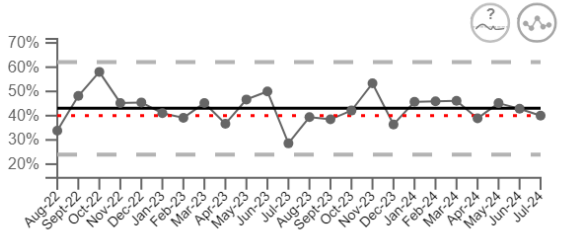
Ref: A03 Performance: 22.8% CNTW Std: 20%



% OP inpatients discharged with LOS > 90 days

Low (On Track)

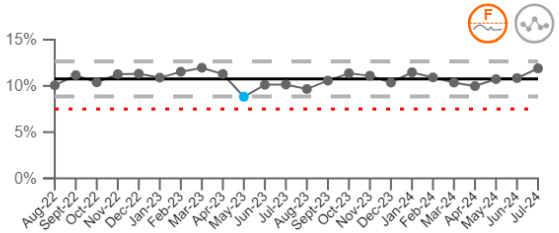
Ref: A04 Performance: 40.0% CNTW Std: 40%



Clinically Ready for Discharge (formerly DTOC)

High (Action)

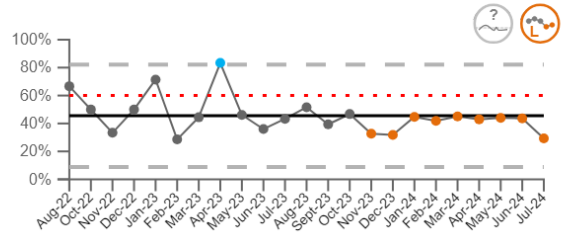
Ref: A05 Performance: 11.9% NHSE Std: 7.5%



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

High (Action)

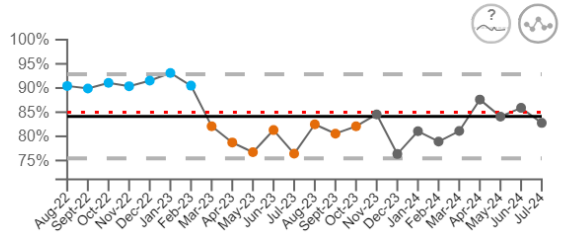
Ref: A06 Performance: 29.3% CNTW Traj: 60%



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

Med (Monitoring)

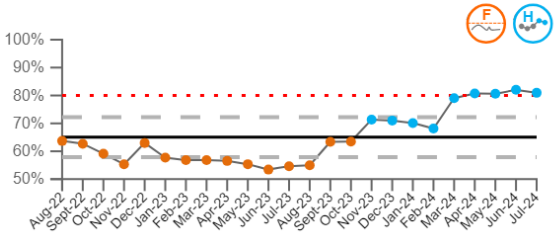
Ref: A07 Performance: 82.8% CNTW Std: 85%



% PLT ED Referrals seen within 1 hour

Med (Monitoring)

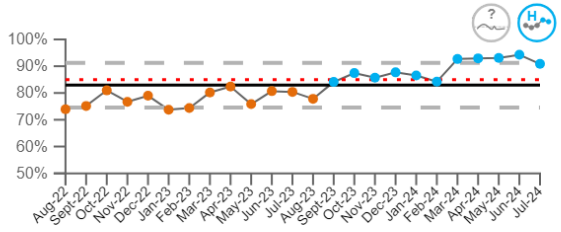
Ref: A08 Performance: 80.9% CNTW Std: 80%



% PLT Ward Referrals seen within 24 hours

Low (On Track)

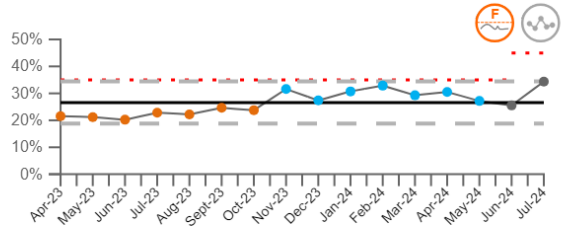
Ref: A09 Performance: 90.9% CNTW Std: 85%



% Waiting 4 wks or less to treatment (WAAOP)

High (Action)

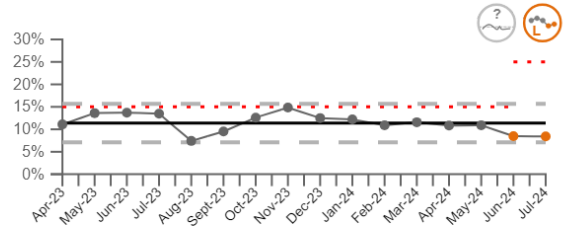
Ref: A10 Performance: 34.4% CNTW Traj: 45%



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

High (Action)

Ref: A11 Performance: 8.4% CNTW Traj: 25%



Sustainable for the Long Term - Headline Commentary

Headline Challenges

- Up to month 4 the Trust is generating £6.2m deficit. This reflects delivering a £0.3m financial surplus in July. The in month surplus has been generated from the ongoing review the balance sheet. The one-off benefit comes from the reduction of some specific pension balances which are no longer a liability. There is no cash benefit from the reduction of these balances sheet totals.
- The £6.2m deficit £2.1m ahead of the Trust plan at month 4 for a £8.4m deficit. The Trust 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 4 the Trust has spent £3.5m on agency staff against a plan £3.6m.
- 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 £30.2m at the end of Month 4 which is higher than the plan at month 4, but 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.
- Trust cash balances are reducing month on month.

Positive Assurance / Improvement

- The Trust is reporting a reduction of 150 wte from April to July. The reduction is mainly across Substantive staff (72wte and bank 86 wte).
- The Trust has seen as reduction in wte from June to Jul of 65 WTE (35wte in substantive and 30 in agency).
- 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 / worsen the financial forecast. A upside and downside scenario is being prepared.
- 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.

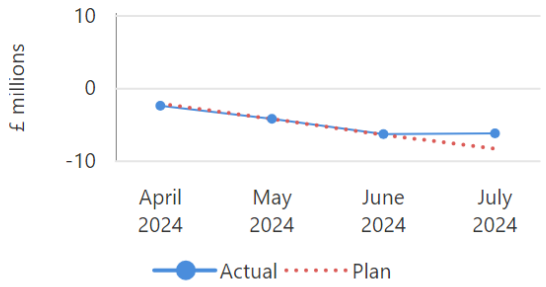
Sustainable for the Long Term

Reporting Period: Jul 2024

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

High (Action)

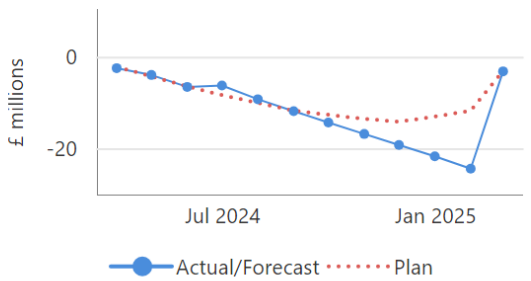
Ref: S01 **Performance: -£6.3m** **Plan: -£8.4m**



Income & Expenditure Forecast

Low (No Target)

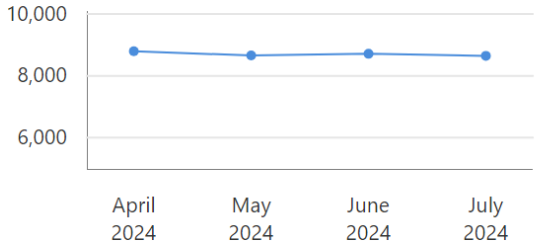
Ref: S02 **Performance: -£3.2m** **Plan: -£3.1m**



All staff WTEs

Low (No Target)

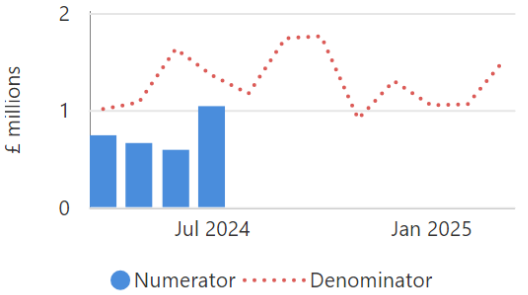
Ref: S03 **Performance: 8,615** **No Target: n/a**



Capital spend compared to plan (£)

Low (No Target)

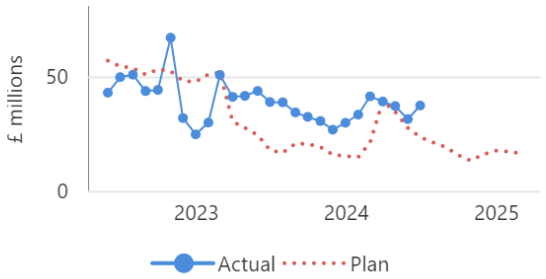
Ref: S04 **Performance: £1.0m** **Plan: £1.4m**



Cash balance compared to plan (£)

Low (On Track)

Ref: S05 **Performance: £37.2m** **Plan: £23.4m**



C01 How was your experience? (FFT)

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

Risk Rating: High (Action)

tgt. = target n. = numerator d. = denominator

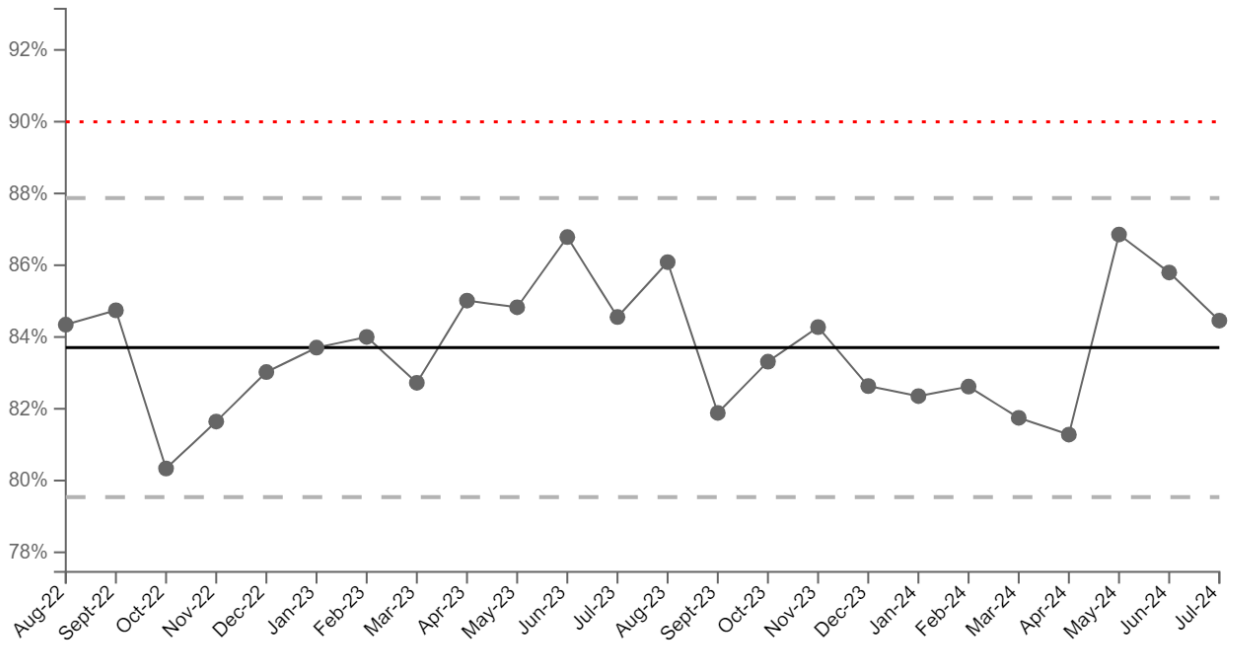
84.5%

tgt. 90%
n. 451
d. 534

Consistently Off Target
The target 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	N	D	Target	Variation	Assurance
Community Care Group	81.8%	261	319	90%	SPC n/a	SPC n/a
Inpatient Care Group	89.5%	51	57	90%	SPC n/a	SPC n/a
Specialist Care Group	87.8%	137	156	90%	SPC n/a	SPC n/a
Support & Corporate	100.0%	2	2	90%	SPC n/a	SPC n/a

Feedback

What the chart tells us

Performance was reported at 84.5% for July, which is a decrease from June (86.4%) remaining below the 90% target.

Root Cause of the performance issue

- Most negative experiences are reported in Initial Response Northumberland (4 very poor, 1 poor) and the 111 service (3 very poor, 5 poor).

Improvement Actions

- Staff are being supported to explore service user and carer experience relating to their service(s) through the Your Voice dashboard.
- The Care Group leadership teams are supported with information on which of their teams have created You Said – We Did posters, including a mid-month position. Supporting groups to be responsive to feedback in a meaningful way.

Expected impact and by when

The survey is beginning to embed, with over 500 service users and carers sharing their experience, in May (570), June (521) and July (550). This offers the Trust good feedback to respond to when looking to shape services to suit the needs of people accessing them.

If feedback levels remain consistently high, there will be opportunities to be responsive to emerging themes at team/CBU/Group and Trust level.

C02 How was the care we provided?

How was the care we provided?

Risk Rating: **High (Action)**

tgt. = target n. = numerator d. = denominator

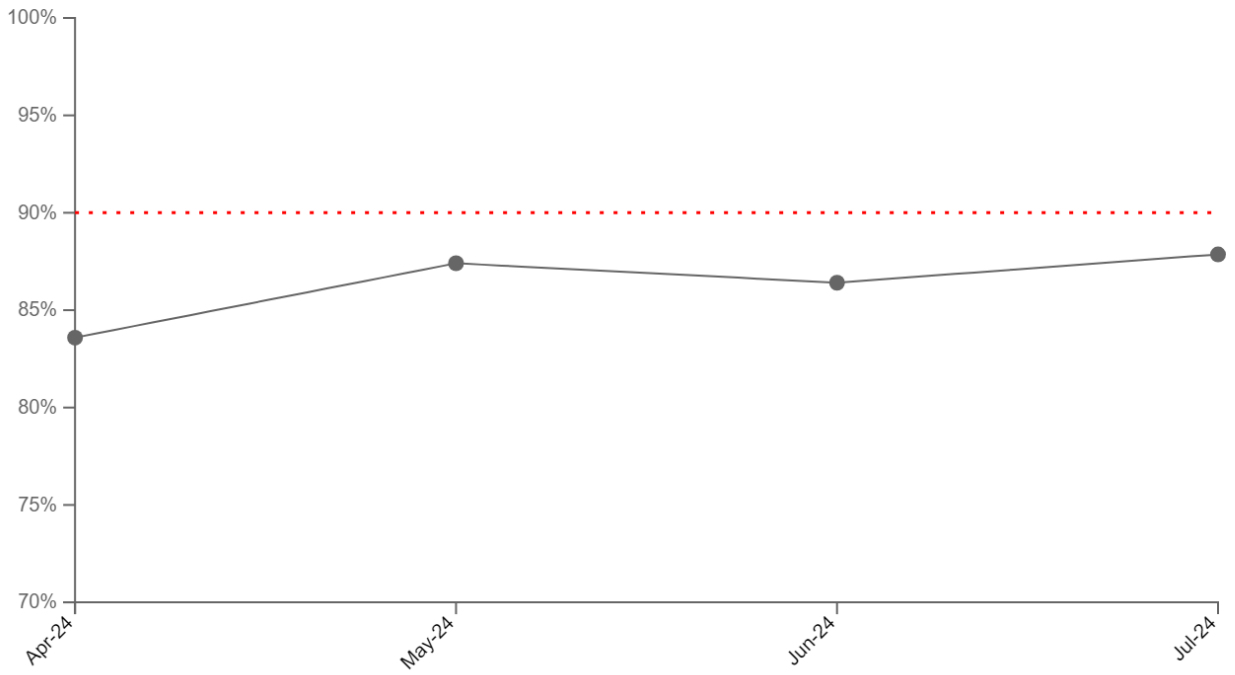
87.9%	tgt.	90%
	n.	456
	d.	519

SPC n/a

SPC n/a

DQ - No Concern

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



Care Group	Performance	N	D	Target	Variation	Assurance
Community Care Group	85.4%	264	309	90%	SPC n/a	SPC n/a
Inpatient Care Group	91.1%	51	56	90%	SPC n/a	SPC n/a
Specialist Care Group	91.5%	139	152	90%	SPC n/a	SPC n/a
Support & Corporate	100.0%	2	2	90%	SPC n/a	SPC n/a

Feedback

What the chart tells us

Performance was reported at 87.9% for July, which is an increase from June (86.4%), remaining slightly below the 90% target.

Root Cause of the performance issue

- 519 people responded to this question, with 456 reporting a good experience of the care provided.
- 45 people of respondents reported a poor experience (31 very poor and 14 poor).

Improvement Actions

- The 111 service had the most very poor experiences (5). It is an opportunity to explore this as a team and identify improvement options.
- The new dashboard is available to staff and support is being offered to help staff explore the data and respond to themes as they emerge.
- Inpatient services had the lowest feedback levels for this question during July with 56 responses, 11 of these were from carers. Ensuring the carer voice is heard requires focus within relevant care groups.

Expected impact and by when

The survey is offering good levels of experience data, offering all levels of the organisation the opportunity to be responsive and improve experiences.

You Said – We Did posters are a useful way of showing responsiveness.

P01 Sickness in Month

Percentage of in month sickness absence

Risk Rating: High (Action)

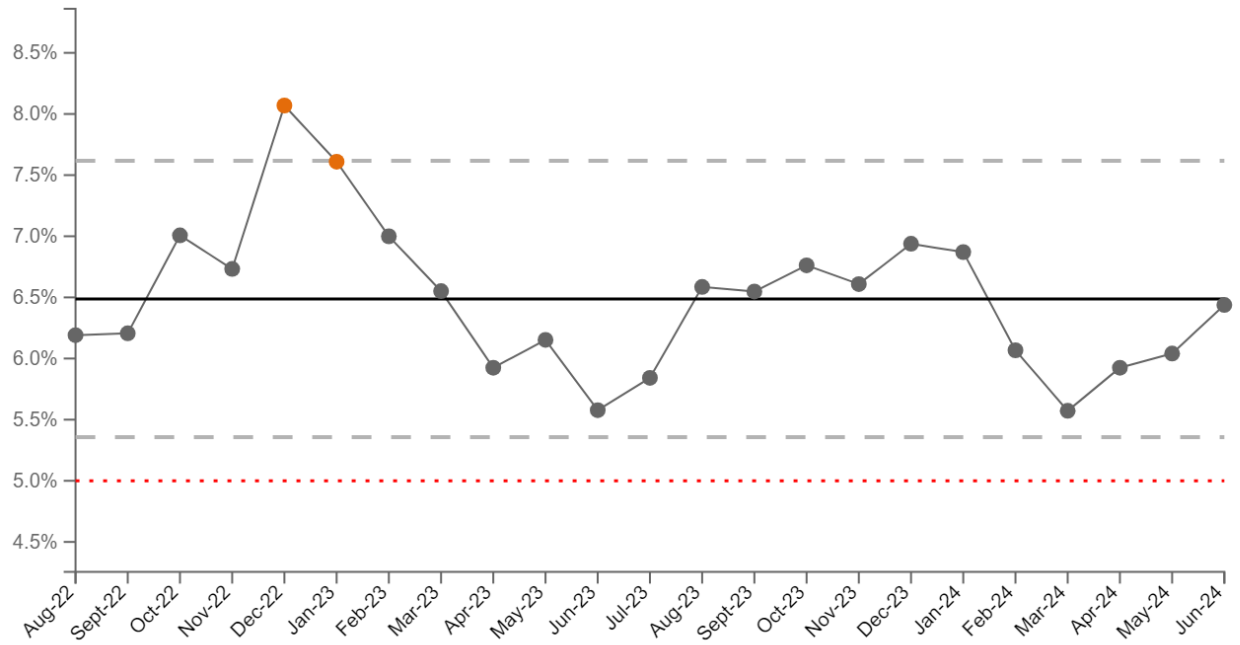
tgt. = target n. = numerator d. = denominator

6.4% tgt. 5% n. 14,234 d. 221,100

Consistently Off Target
The target 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	N	D	Target	Variation	Assurance
Community Care Group	6.4%	5,834	90,551	5%	Normal Variation	Consistently Off Target
Inpatient Care Group	7.5%	3,722	49,939	5%	Normal Variation	Consistently Off Target
Other Care Group	0.0%	0	0	5%	Improvement	Achieve at Random
Specialist Care Group	7.2%	3,704	51,309	5%	Normal Variation	Consistently Off Target
Support & Corporate	3.3%	974	29,302	5%	Normal Variation	Consistently Achieve

Feedback

What the chart tells us

The chart shows the confirmed sickness for June 2024 which is reported at 6.4% (excludes NTW Solutions). N.B The sickness in month is reported one month behind to allow ESR to be fully updated from Allocate to accurately reflect the position. 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 cases.

Expected impact and by when

- Predicted absence reduction as previous year trends.

P02 All Staff Priority Training

All Staff Priority Training

Risk Rating: High (Action)

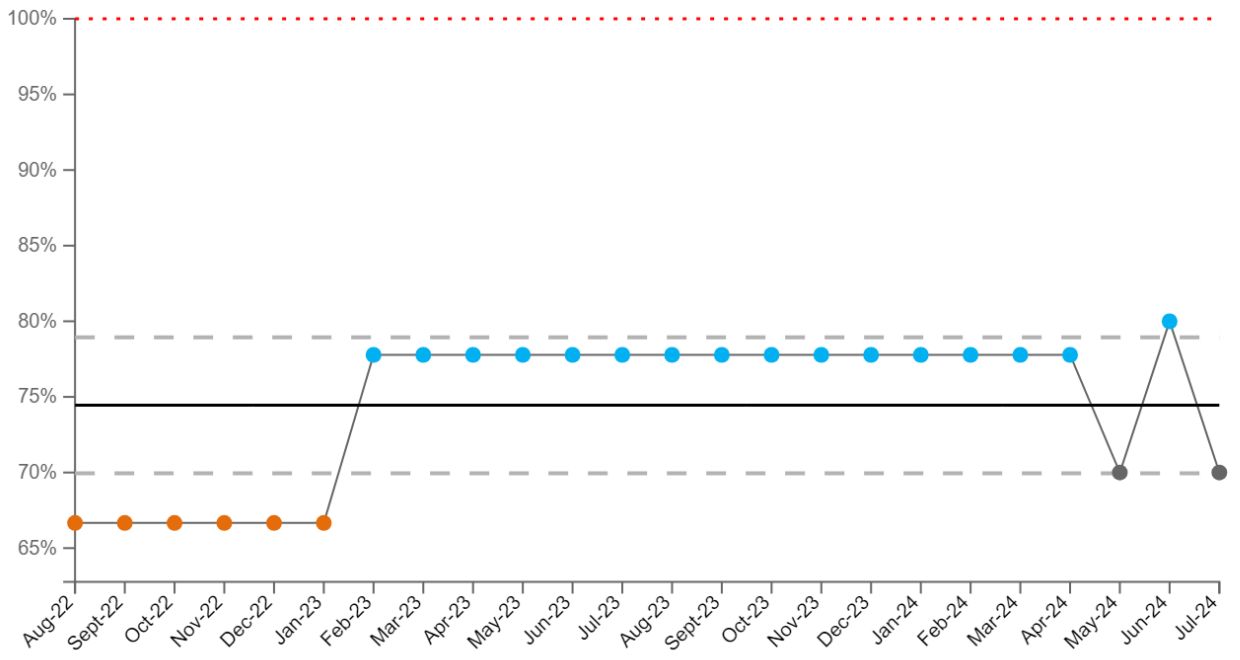
tgt. = target n. = numerator d. = denominator

70.0%		
	tgt.	100%
	n.	7
	d.	10

Consistently Off Target
The target 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	N	D	Target	Variation	Assurance
Community Care Group	100.0%	10	10	100%	Improvement	Consistently Off Target
Inpatient Care Group	80.0%	8	10	100%	Improvement	Consistently Off Target
Other Care Group	50.0%	5	10	100%	Normal Variation	Consistently Off Target
Specialist Care Group	80.0%	8	10	100%	Normal Variation	Consistently Off Target
Support & Corporate	60.0%	6	10	100%	Concern	Consistently Off Target

Feedback

What the chart tells us

Training Compliance for all staff is reported at 70% for July 2024. Currently 7 out of the 10 identified priority training requirements are achieving target. Information Governance, Corporate Induction and Local Induction remain below target. Further work is required on the training data as this percentage currently excludes Web Risk Register and PSIRF (Patient Safety Incident Response Framework). 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
- Local Inductions not recorded at time of commencement

Improvement Actions

- Priority training has been agreed within a Training Performance Framework. Includes 53 Corporate and Operational courses with training standards.
- Continue to improve data completeness of needs analysis and who has been trained and not recorded.
- Manage demand and capacity – review offer for all courses and trainers.
- CBU level training trajectory plans established in line with Trust priorities.
- Ensure return to work plans from absence periods are inclusive of any training compliance needs.
- Focus on ensuring IG training remains consistently at the 95% standard.

Expected impact and by when

Increase in training compliance in line with set trajectories.

P03 Clinical Staff Priority Training

Clinical Staff Priority Training

Risk Rating: Med (Monitoring)

tgt. = target n. = numerator d. = denominator

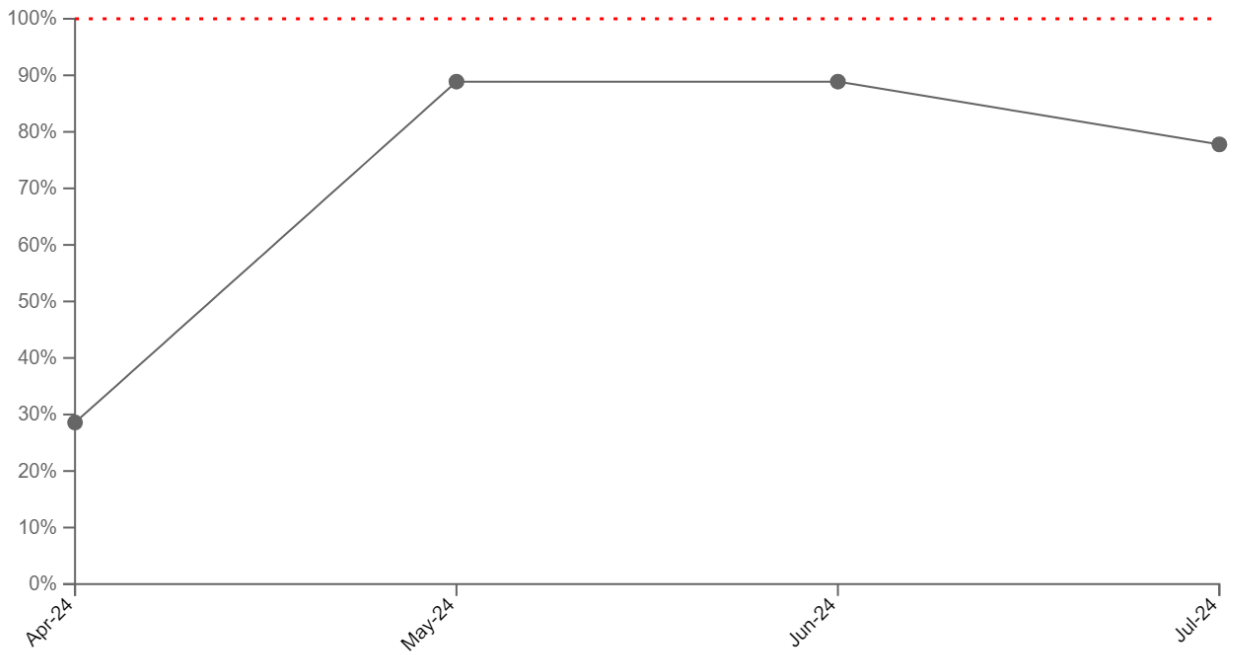
77.8%	tgt.	100%
	n.	7
	d.	9

SPC n/a

SPC n/a

DQ - No Concern

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



Care Group	Performance	N	D	Target	Variation	Assurance
Community Care Group	71.4%	5	7	100%	SPC n/a	SPC n/a
Inpatient Care Group	85.7%	6	7	100%	SPC n/a	SPC n/a
Other Care Group	0.0%	0	6	100%	SPC n/a	SPC n/a
Specialist Care Group	88.9%	8	9	100%	SPC n/a	SPC n/a
Support & Corporate	0.0%	0	5	100%	SPC n/a	SPC n/a

Feedback

What the chart tells us

Priority Training Compliance for clinical staff is reported at 77.8% for July 2024. Currently 7 out of the 9 identified priority training requirements are achieving the agreed trajectories. Clinical Risk and Suicide prevention and Resuscitation L3 Adult Immediate Life Support training remain below the agreed trajectory.

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 completeness of needs analysis relating to who has been trained but not recorded.
- Manage demand and capacity – review offer for all courses and trainers e.g. PMVA to improve compliance.
- Bespoke session planned regarding PMVA within Inpatient Care Group.
- CBU level training trajectory plans established in line with Trust priorities.
- Ensure return to work plans from absence periods are inclusive of any training compliance needs.

Expected impact and by when

Increase in training compliance in line with set trajectories.

Great Place to Work - Training

All Staff Priority Training

Ref	Indicator Name	Variation	Assurance	Performance	Target	Target Type	Numerator	Denominator	Risk Rating
TA01	Information Governance	Improvement	Consistently Off Target	93.0%	95%	CNTW Std	8,501	9,142	Med (Monitoring)
TA02	Corporate Induction	SPC n/a	SPC n/a	94.4%	95%	CNTW Std	8,630	9,142	Low (On Track)
TA03	Local Induction (Once)	Improvement	Consistently Off Target	86.8%	90%	CNTW Traj	7,928	9,138	Med (Monitoring)
TA04	Safeguarding Adults Level 1	Improvement	Consistently Achieve	96.1%	85%	CNTW Std	1,624	1,690	Low (On Track)
TA05	Safeguarding Children Level 1	Improvement	Consistently Achieve	95.4%	85%	CNTW Std	1,613	1,690	Low (On Track)
TA06	Fire	Improvement	Achieve at Random	89.1%	85%	CNTW Std	8,146	9,142	Low (On Track)
TA07	Equality & Diversity Introduction	Improvement	Consistently Achieve	95.1%	85%	CNTW Std	8,695	9,142	Low (On Track)
TA08	Health & Safety	Improvement	Consistently Achieve	94.7%	85%	CNTW Std	8,661	9,142	Low (On Track)
TA09	Infection Prevention & Control (IPC)	Improvement	Consistently Achieve	92.8%	85%	CNTW Std	8,484	9,142	Low (On Track)
TA10	Moving & Handling Awareness Training	Improvement	Consistently Achieve	94.1%	85%	CNTW Std	8,599	9,142	Low (On Track)

Clinical Staff Priority Training

Assurance is based on 24 months of data

Ref	Indicator Name	Variation	Assurance	Performance	Target	Target Type	Numerator	Denominator	Risk Rating
TC01	Clinical Risk and Suicide Prevention	Normal Variation	Achieve at Random	77.3%	79%	CNTW Traj	2,402	3,106	Med (Monitoring)
TC02	Biopsychosocial at Risk Assessment & Safety Planning	SPC n/a	SPC n/a	85.5%	62%	CNTW Traj	2,654	3,106	Low (On Track)
TC03	Resuscitation L2 Adult Basic Life Support	Improvement	Consistently Off Target	77.2%	77%	CNTW Traj	1,356	1,757	Med (Monitoring)
TC04	Resuscitation L3 Adult Immediate Life Support	Improvement	Consistently Off Target	70.3%	71%	CNTW Traj	2,534	3,605	Med (Monitoring)
TC05	Resuscitation L3 Paediatric Immed Life Support	Improvement	Consistently Off Target	46.2%	45%	CNTW Traj	18	39	Med (Monitoring)
TC06	Resuscitation L2 Paediatric Basic Life Support	Improvement	Consistently Off Target	73.7%	72%	CNTW Traj	437	593	Med (Monitoring)
TC07	PMVA Basic	Improvement	Consistently Off Target	76.3%	74%	CNTW Traj	2,026	2,654	Med (Monitoring)
TC09	Engagement & Observation (3 years)	Improvement	Consistently Off Target	82.9%	81%	CNTW Traj	2,785	3,360	Med (Monitoring)
TC10	Dysphagia Awareness	Improvement	Consistently Off Target	83.5%	75%	CNTW Traj	2,264	2,713	Med (Monitoring)

NB: PSIRF, Corporate Governance and Risk Management Training to be added when available

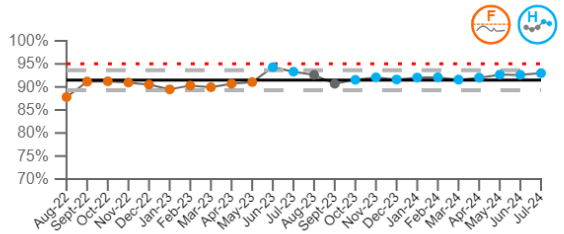
All Staff Priority Training

Reporting Period: Jul 2024

Information Governance

Med (Monitoring)

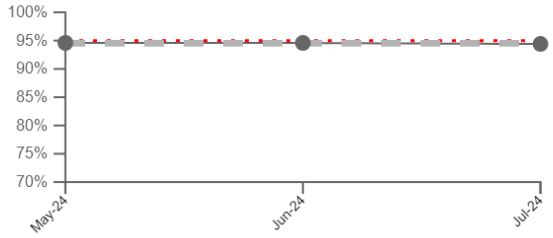
Ref: TA01 Performance: 93.0% CNTW Std: 95%



Corporate Induction

Low (On Track)

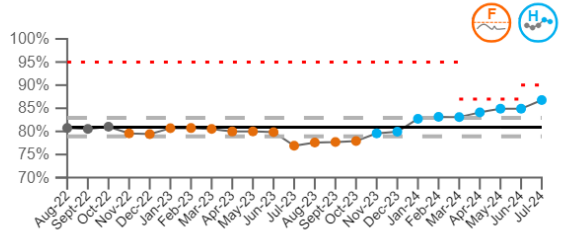
Ref: TA02 Performance: 94.4% CNTW Std: 95%



Local Induction (Once)

Med (Monitoring)

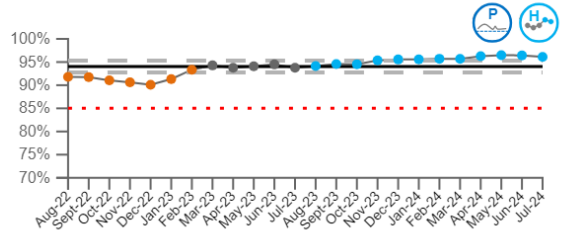
Ref: TA03 Performance: 86.8% CNTW Traj: 90%



Safeguarding Adults Level 1

Low (On Track)

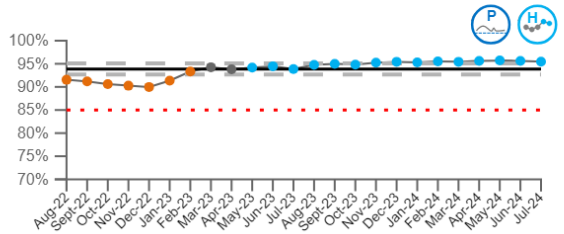
Ref: TA04 Performance: 96.1% CNTW Std: 85%



Safeguarding Children Level 1

Low (On Track)

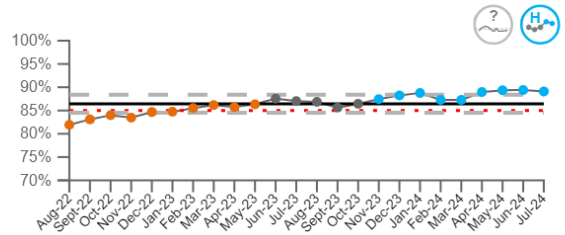
Ref: TA05 Performance: 95.4% CNTW Std: 85%



Fire

Low (On Track)

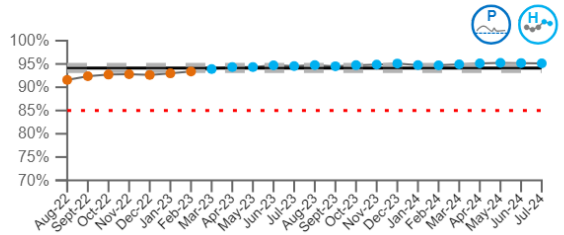
Ref: TA06 Performance: 89.1% CNTW Std: 85%



Equality & Diversity Introduction

Low (On Track)

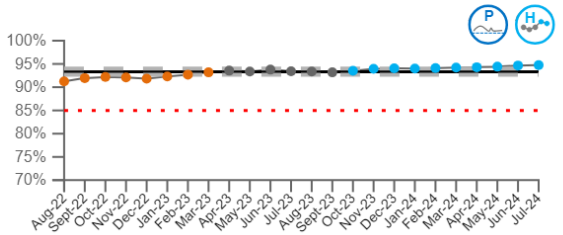
Ref: TA07 Performance: 95.1% CNTW Std: 85%



Health & Safety

Low (On Track)

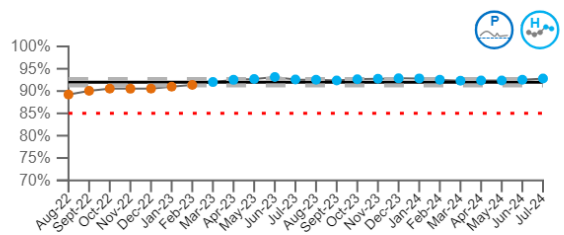
Ref: TA08 Performance: 94.7% CNTW Std: 85%



Infection Prevention & Control (IPC)

Low (On Track)

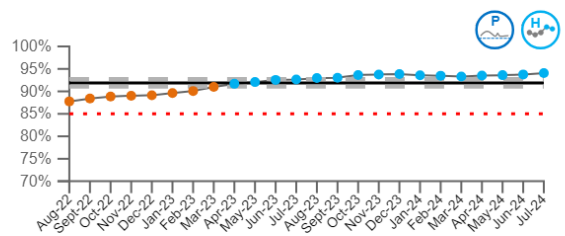
Ref: TA09 Performance: 92.8% CNTW Std: 85%



Moving & Handling Awareness Training

Low (On Track)

Ref: TA10 Performance: 94.1% CNTW Std: 85%



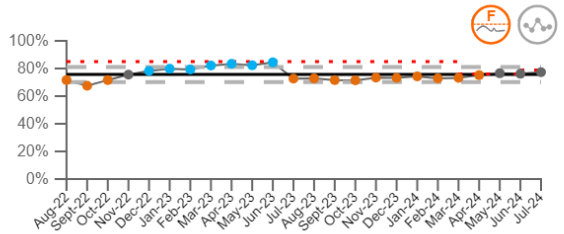
Clinical Staff Priority Training

Reporting Period: Jul 2024

Clinical Risk and Suicide Prevention

Med (Monitoring)

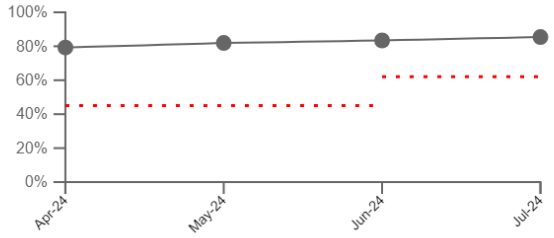
Ref: TC01 Performance: 77.3% CNTW Traj: 79%



Biopsychosocial at Risk Assessment & Safety

Low (On Track)

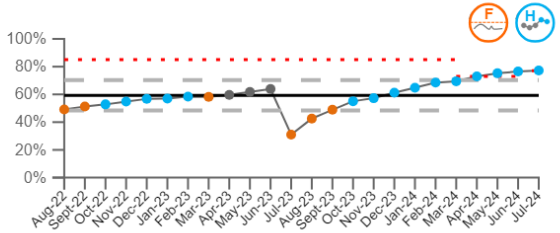
Ref: TC02 Performance: 85.5% CNTW Traj: 62%



Resuscitation L2 Adult Basic Life Support

Med (Monitoring)

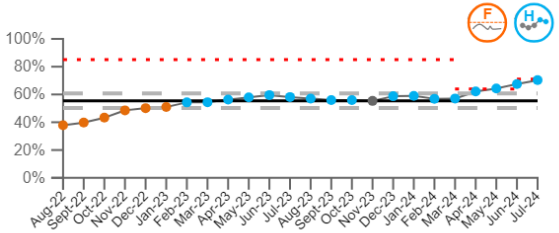
Ref: TC03 Performance: 77.2% CNTW Traj: 77%



Resuscitation L3 Adult Immediate Life Support

Med (Monitoring)

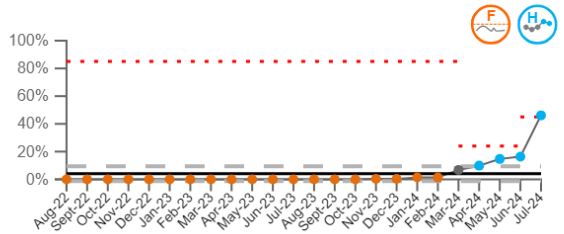
Ref: TC04 Performance: 70.3% CNTW Traj: 71%



Resuscitation L3 Paediatric Immed Life Support

Med (Monitoring)

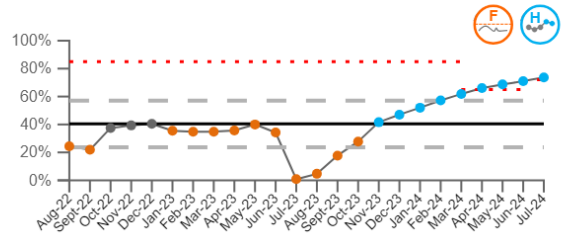
Ref: TC05 Performance: 46.2% CNTW Traj: 45%



Resuscitation L2 Paediatric Basic Life Support

Med (Monitoring)

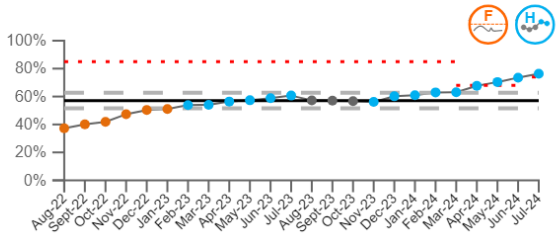
Ref: TC06 Performance: 73.7% CNTW Traj: 72%



PMVA Basic

Med (Monitoring)

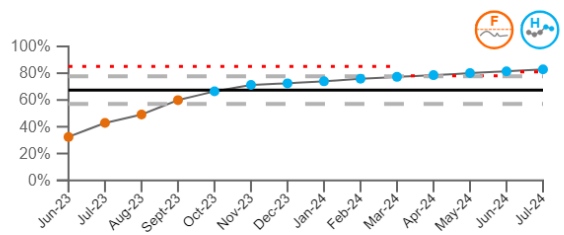
Ref: TC07 Performance: 76.3% CNTW Traj: 74%



Engagement & Observation (3 years)

Med (Monitoring)

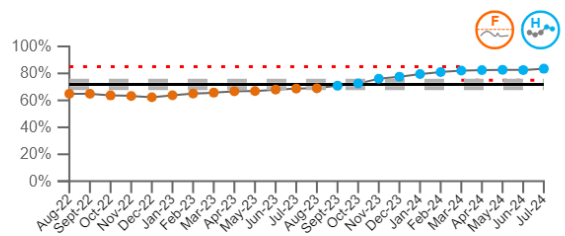
Ref: TC09 Performance: 82.9% CNTW Traj: 81%



Dysphagia Awareness

Med (Monitoring)

Ref: TC10 Performance: 83.5% CNTW Traj: 75%



Please note: From April 2024 the above training is monitored on the agreed trajectories, prior to this date they were monitored on the Trust standard.

P04 Appraisal rate

Appraisal rate

Risk Rating: High (Action)

tgt. = target n. = numerator d. = denominator

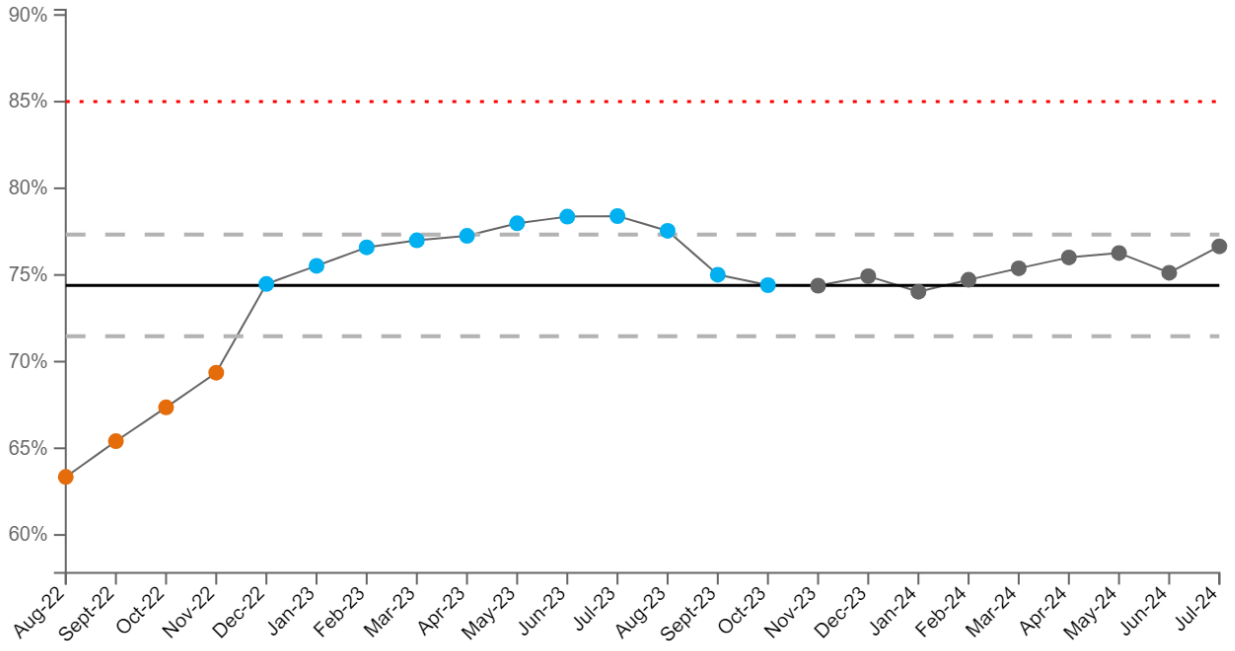
76.7%

tgt. 85%
n. 6,294
d. 8,211

Consistently Off Target
The target 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	N	D	Target	Variation	Assurance
Community Care Group	81.5%	2,748	3,370	85%	Improvement	Consistently Off Target
Inpatient Care Group	73.6%	1,351	1,836	85%	Normal Variation	Consistently Off Target
Specialist Care Group	76.0%	1,434	1,887	85%	Normal Variation	Consistently Off Target
Support & Corporate	68.1%	761	1,118	85%	Normal Variation	Consistently Off Target

Feedback

What the chart tells us

The reported appraisal rate for July is 76.7% (excluding NTW Solutions), continuing to be reported higher than the mean average, but remaining 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 target of 85%.

P05 % Clinical Supervision completed

Clinical Supervision

Risk Rating: High (Action)

tgt. = target n. = numerator d. = denominator

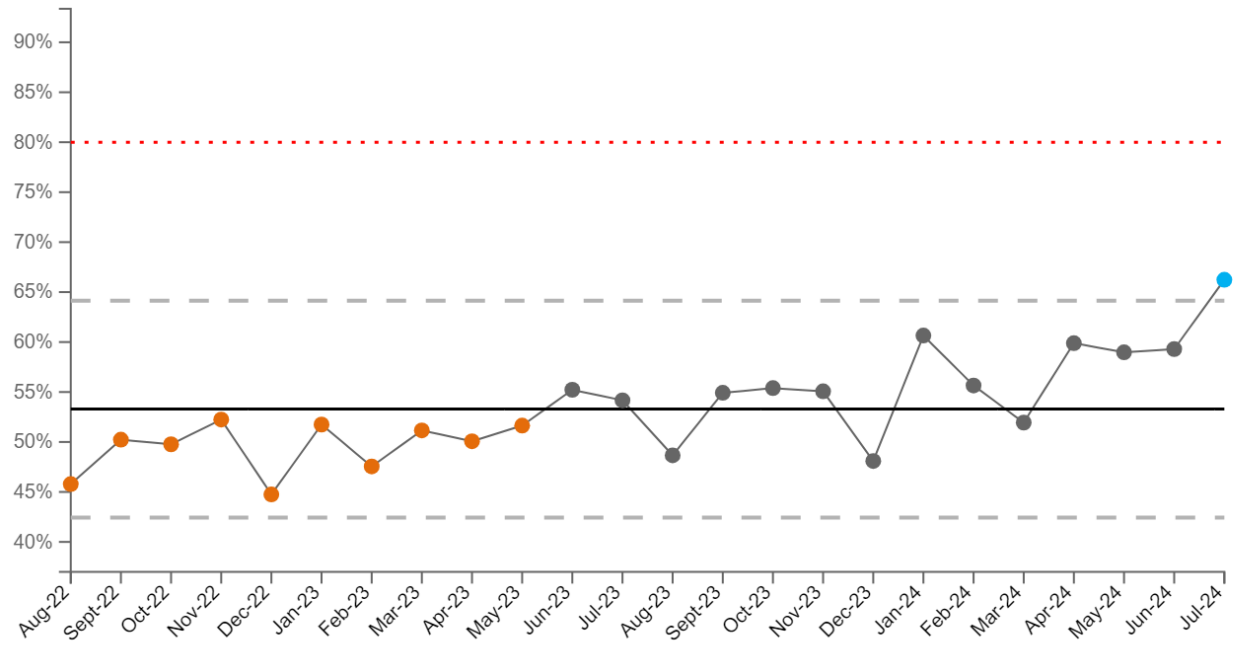
66.2%

tgt. 80%
n. 3,717
d. 5,612

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



Care Group	Performance	N	D	Target	Variation	Assurance
Community Care Group	72.9%	1,655	2,269	80%	Improvement	Consistently Off Target
Inpatient Care Group	59.5%	870	1,463	80%	Normal Variation	Consistently Off Target
Other Care Group	24.9%	45	181	80%	Concern	Consistently Off Target
Specialist Care Group	68.2%	969	1,420	80%	Improvement	Consistently Off Target
Support & Corporate	63.8%	178	279	80%	Improvement	Consistently Off Target

Feedback

What the chart tells us

Performance of 66.2% in July is above the expected range and showing improvement though remains below the 80% standard. Without change the target 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
- Staff delivering supervision may not be linked to staff record or may have more than 1 supervisor providing supervision
- Metric includes staff who are currently exempt or on long term sick leave (Position as at 28/08/24 excluding exemptions 78.7%)

Improvement Actions

- Supervision rate monitored through local Clinical Management Teams, Quality Standards and Oversight meetings within CBU's.
- Setting expectations with CBU leadership team.
- Specific focus and trajectories within Mitford as a hotspot
- Specialist care group have developed trajectories for all CBU's to meet compliance
- Establishing and escalating any recording and data issues.
- Live supervision to be recorded appropriately.
- Mapping required to accurately report who is supervising those staff who require clinical supervision
- Ability to measure the quality of clinical supervision received
- Metric review is underway to understand the differences in reporting across dashboards to ensure consistent reporting.
- Discussion at BDG Workforce on training/awareness for support staff. Director of Allied Health Professionals and Psychological Services to work with Group Nurse Directors to establish methods to improve awareness and understanding of clinical supervision.
- Pilot to be launched recording Clinical Supervision with ESR within Bridgewell and Newcastle and Gateshead Community CBU.

Expected impact and by when

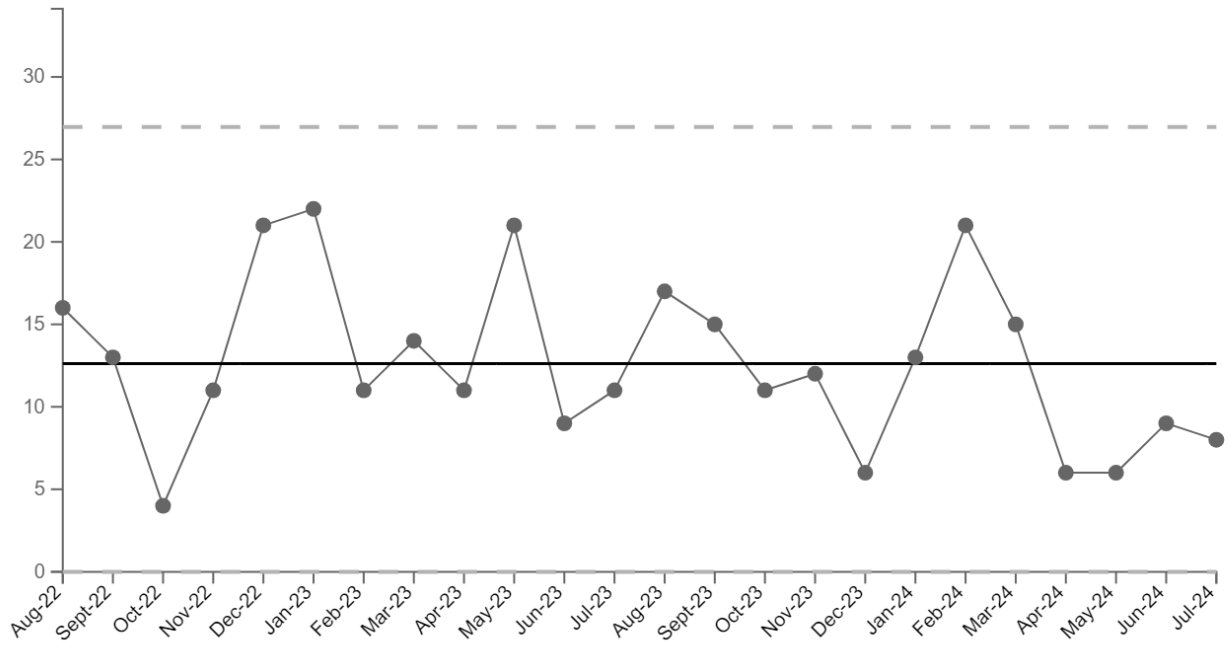
- Commitment from all Care Groups compliance will be achieved by Q3

Q01 MRE Restraints

Number of MRE Restraints

Risk Rating: Med (Monitoring)

8	Not Applicable	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	Target	Variation	Assurance
Community Care Group	0	n/a	Improvement	SPC n/a
Inpatient Care Group	1	n/a	Normal Variation	SPC n/a
Other Care Group	0	n/a	Improvement	SPC n/a
Specialist Care Group	7	n/a	Normal Variation	SPC n/a
Support & Corporate	0	n/a	Normal Variation	SPC n/a

Feedback

What the chart tells us

There were 8 MRE restraints reported in July 2024, relating to 5 patients which is a slight decrease on previous month.

Root Cause of the performance issue

- The necessity for moving complex individuals for external appointments. Some under the direction of the Ministry of Justice
- High levels of perceived/historical risk
- High levels of complexity and acuity within Specialist Care Group, with 3 out of the 4 CBU's having reported usage of MRE in the month of July

Improvement Actions

- Addressed within cohorts and through recent Trauma- informed Care presentations
- Workshops have taken place for CYPS services and Secure Services to develop plans to reduce the use of MRE.
- Robust de-brief process to support learning from incidents and review of care plans.
- Within Mitford Talk 1st initiatives including safewards interventions are used primarily, as well as the Positive Behavioural Support (PBS) model to help support a reduction in situations that may lead to a restrictive intervention.
- Talk 1st training has commenced within induction and is also now within the Healthcare Support Worker Certificate (HCSW) programme
- MRE incidents are being reviewed via the Early Learning Review (ELR)
- Agreed appropriate numbers of staff (within cohorts - day pool, night pool, NSC staff and ward staff on acute wards) to be trained on MRE. This is due to availability of training as well as in line with reducing restrictive practice.

Expected impact and by when

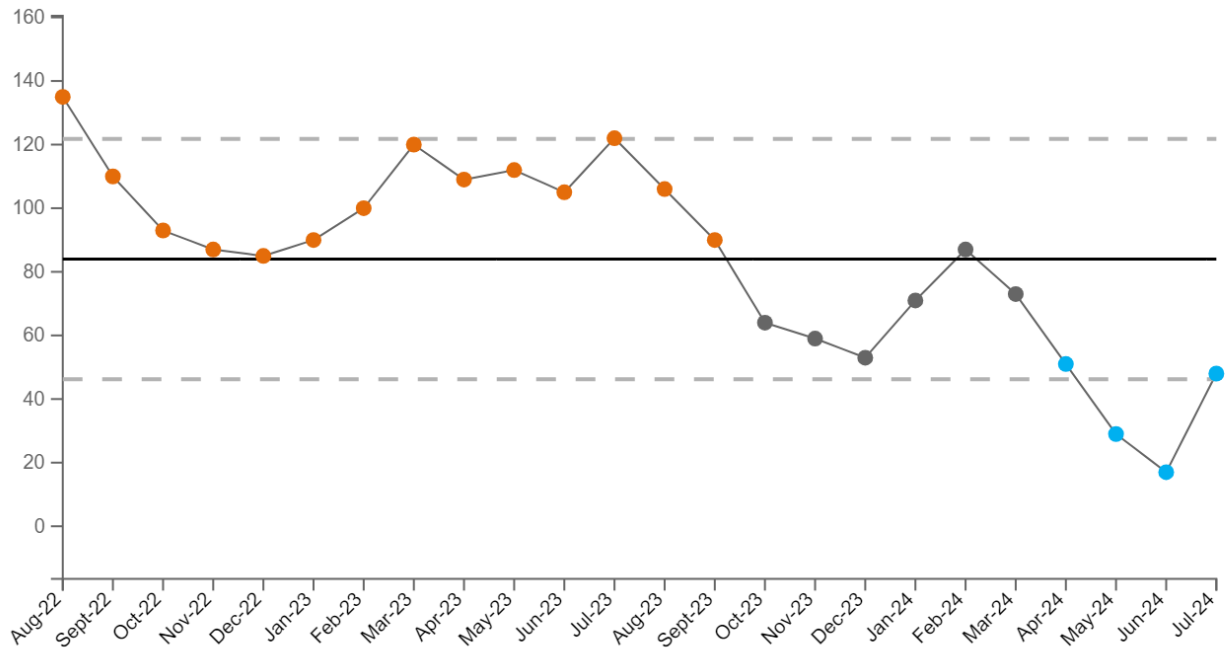
Whilst work ongoing is supporting reduction in use of MRE, reporting is likely to see variance month on month, however usage has reduced overall. Continued reduction throughout 24/25

Q02 Prone Restraints

Number of Prone Restraints

Risk Rating: Med (Monitoring)

48	Not Applicable	Improvement: This indicator is decreasing which shows improvement	DQ - No Concern: There are currently no concerns with the data quality of this indicator



Care Group	Performance	Target	Variation	Assurance
Community Care Group	1	n/a	Normal Variation	SPC n/a
Inpatient Care Group	5	n/a	Improvement	SPC n/a
Other Care Group	0	n/a	Improvement	SPC n/a
Specialist Care Group	42	n/a	Normal Variation	SPC n/a
Support & Corporate	0	n/a	Normal Variation	SPC n/a

Feedback

What the chart tells us

There have been 48 Prone restraints reported in July, an increase from June where 17 prone restraints were reported. There has been a statistically significant reduction in the use of prone restraint.

Root Cause of the performance issue

- Two patients on two wards (Mitford 1&2 and Riding) account for 30 of the 48 incidents.
- Projected yearly figures for Trust-wide prone incidents are currently down by 58% from last year
- The proportion of prone restraint within Inpatient Care has remain largely unchanged following significant reductions, with all in month prone restraint incidents occurring in the urgent care pathway. PICU (Beckfield) has the highest number of prone restraint incidents YTD.
- Specialist Care Group have seen an increase in acuity across all pathways within the Group, particularly within Autism Inpatient and Specialist CYPS. Many of the reported restraints are relating to specific individuals within the wards.
- Talk 1st initiatives including safewards interventions are used primarily, as well as the PBS model to help support a reduction in situations that may lead to a restrictive intervention

Improvement Actions

- On-going monitoring use of safety pods within clinical areas,
- Robust de-brief to support learning from incidents and review individual care planning to identify earlier none restrictive intervention.
- PAUSE (Talk 1st initiative) training undertaken in CYPS services both at Ferndene and Lotus in July and August
- This area continues to receive regular review in key management and governance groups.
- Robust de-brief to support learning from incidents and review individual care planning to identify earlier none restrictive intervention.
- Additional PMVA workshops hosted locally supporting reduced use of restrictive interventions.
- Increased emphasis on safer alternatives to prone restraint have been maintained across both the Positive and Safe Team and PMVA tutors.

Expected impact and by when

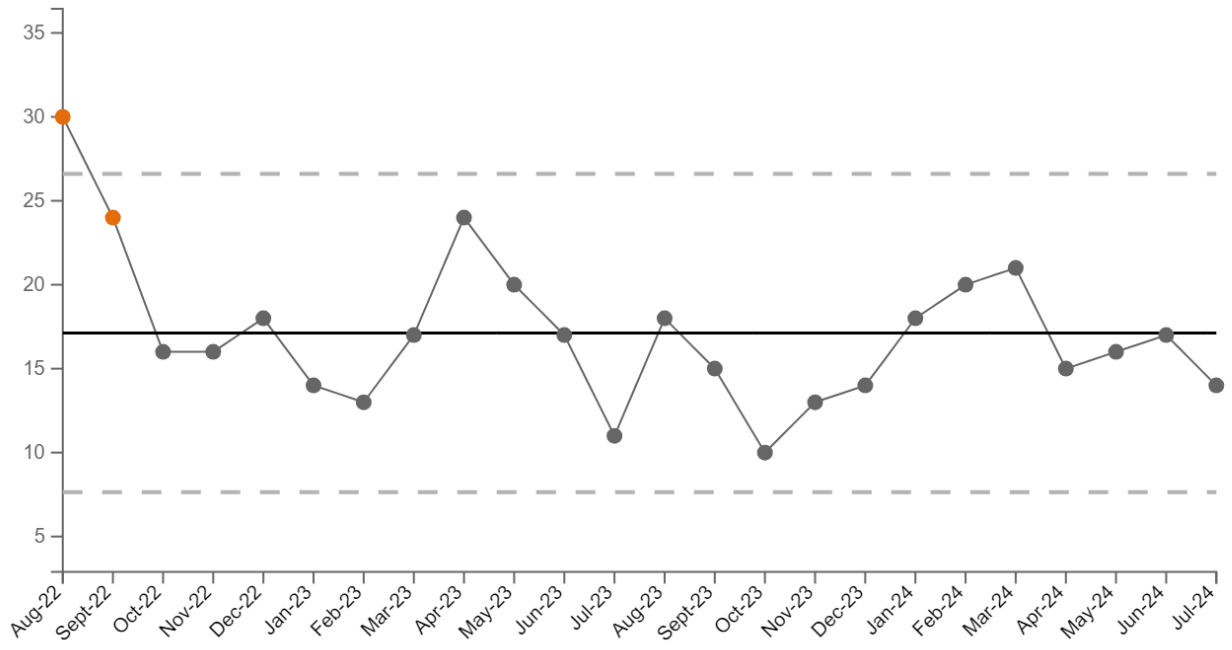
Continued reduction within yearly projections

Q03 Long term segregation and prolonged seclusion

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

Risk Rating: Med (Monitoring)

14	Not Applicable	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	Target	Variation	Assurance
Inpatient Care Group	12	n/a	Normal Variation	SPC n/a
Specialist Care Group	2	n/a	Normal Variation	SPC n/a

Feedback

What the chart tells us

There were 14 incidents reported in July 2024.

Root Cause of the performance issue

- Current cohort has significant numbers awaiting external accommodation/ transfer to higher levels of security

Improvement Actions

- Awareness and two day HOPEs training available, and inclusion of HOPEs principles included within PMVA training
- The Long-term segregation panel continues to review patients subject to long term segregation and pro longed seclusion on a weekly basis.
- Long Term Segregation and Prolonged seclusion panel to review and consider all alternatives.
- Group oversight of Clinically Ready for Discharge (CRFD) cases across all CBUs within Specialist Care Group to support access to appropriate placement and care packages
- Specialist Care Group reported a reduction in LTS with the successful ending of one case in Secure CBU following LTS Panel.

Expected impact and by when

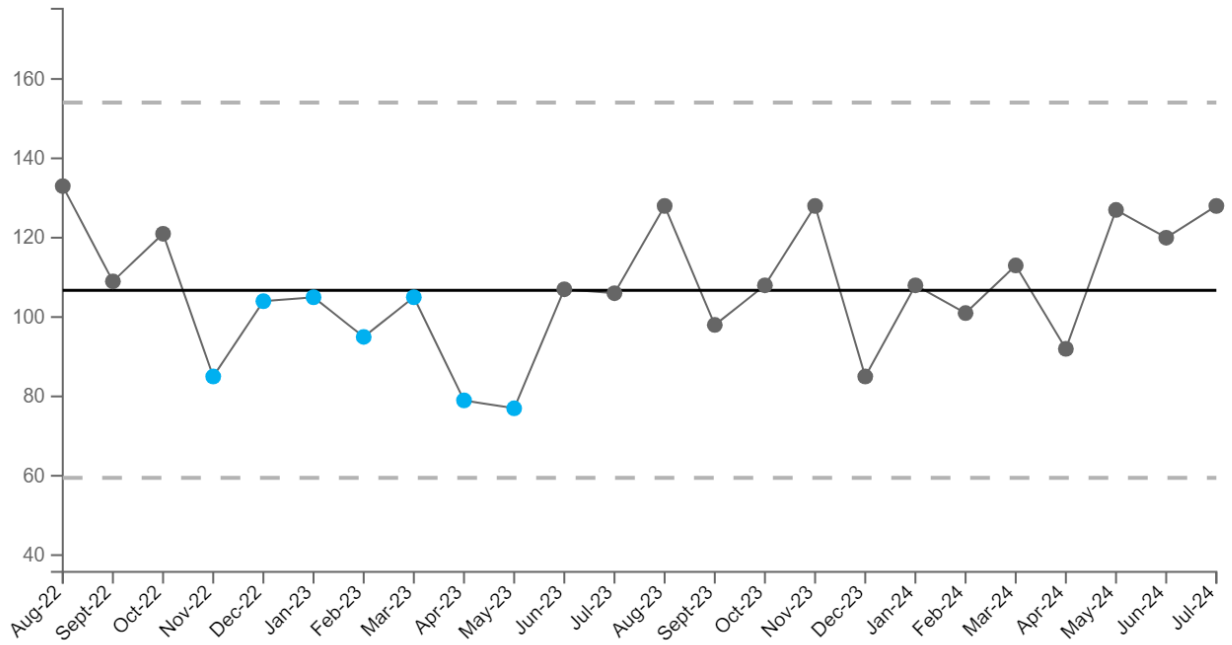
The system blocks remain outside CNTWs control therefore the Trust is dependent upon availability of specialised placements being made available/ built for those patients who require these placements.

Q04 Assaults on Patients

Number of Assaults on Patients

Risk Rating: Med (Monitoring)

128	Not Applicable	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



Breakdown of assaults on patients currently being reviewed to look at specific pathways and services – for example Older Persons, Adult Acute, Specialist CYP, LD&A and Secure. This will be included for August performance reporting period.

Feedback

What the chart tells us

There were 128 recorded incidents of assaults on patients during July.

Root Cause of the performance issue

- Of the 128 assaults in July 2024, 50% of the assaults involved no physical harm and 49% resulted in low physical harm with 1% (1 incident) classified as moderate physical harm.
- Between May and July 2024 Ruskin and Longview have the had the highest rates of incidents.
- We have seen a minor rise in assaults on patients in the last month, and in comparison, to July 2023, there has been a significant increase.
- High levels of acuity across the care groups
- Assault between patients featured more on male acute admission wards, PICU, Older Peoples wards and the Children's admission wards.

Improvement Actions

- The Violence reduction group met recently and started to scope the work plan going forward, including a review of aggression and violence incidents including hate crime, and this baseline data will be used as a measure as new guidance is implemented.
- Risk assessment and mitigation plans being introduced as part of policy change.
- Regular review of care plans and consideration of other environmental factors and care delivery approaches take place by the MDT.
- Embedding the debrief process including staff and patients to improve psychological safety.
- Four wards are involved in the NHSE Culture of Care programme where learning and good practice will be shared across all areas.

Expected impact and by when

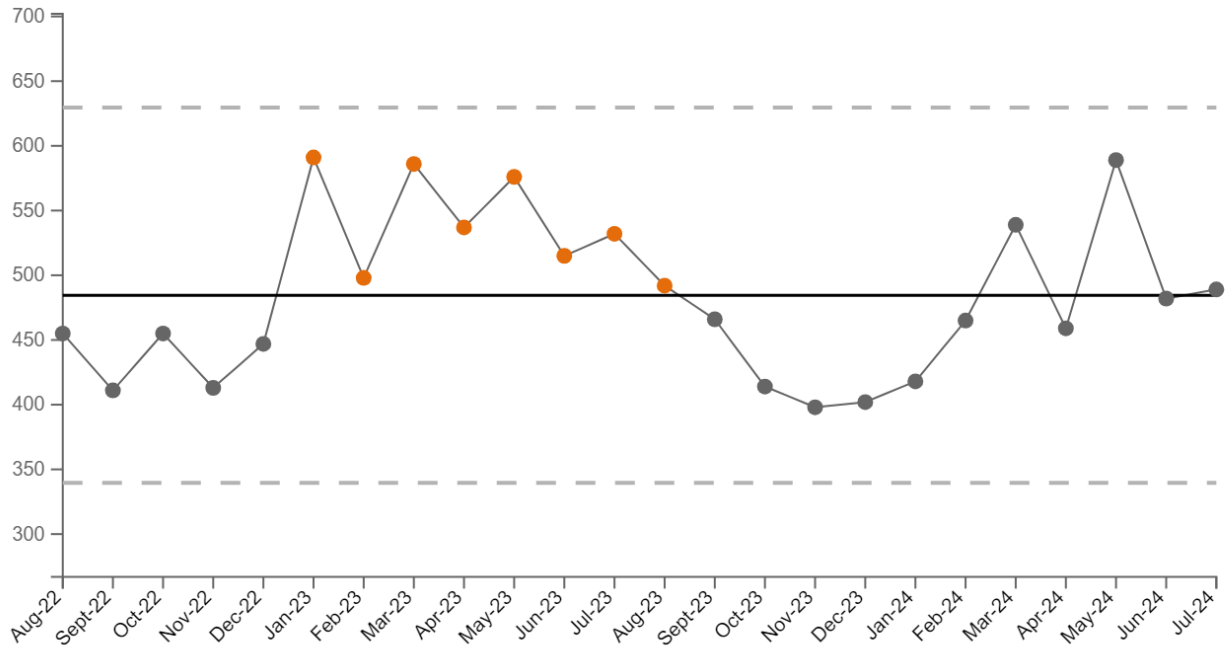
Monitoring of assaults on patients is reviewed following every incident and care planning, MDT review and updating of risk assessments is part of mitigation to prevent further harm, where there is known targeting between patients. This can be difficult where new incidents occur between patients for the first time, but this is built into risk planning after the event to minimise harm.

Q05 Assaults on staff

Number of Assaults on staff

Risk Rating: Med (Monitoring)

489	Not Applicable	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	Target	Variation	Assurance
Community Care Group	6	n/a	Normal Variation	SPC n/a
Inpatient Care Group	225	n/a	Normal Variation	SPC n/a
Other Care Group	0	n/a	Improvement	SPC n/a
Specialist Care Group	258	n/a	Normal Variation	SPC n/a
Support & Corporate	0	n/a	Normal Variation	SPC n/a

Feedback

What the chart tells us

There were 489 recorded incidents of assaults on staff during July which falls within the calculated expected range of 340 and 630.

Root Cause of the performance issue

- Assaults are comparable for the previous 2 months , whilst we have seen incident reporting increase significantly in the month of July from previous years, and the most incidents reported in any month ever.
- Of the 489 assaults, 225 (46%) of the harm was no harm, 250 (51%) are low harm, 14 (3%) are moderate harm, there were no severe harm incidents in July 2024.
- RIDDOR related activity has also dropped in July and is the 2nd lowest at 7 incidents since the concerns were raised to the HSE in December 2023.
- Whilst aggression and violence incidents generally have increased by over 26% on the previous year, assaults on staff by patients have decreased by 9.5% on the previous year.
- High areas of reporting continue to be Autism and Learning Disability Services, and Childrens Services, and in our recent focused inspection from the Care Quality Commission for Autism and Learning Disability in-patient services, there was a particular focus on physical intervention and assaults and injuries to staff.
- Incident proportions are closer distributed across pathways except for rehab (rehab seeing 11% of assaults on staff; 31% urgent care, 31% older peoples and 28% learning disability for in month).

Improvement Actions

- The violence reduction group has met recently, and considered are the improvement actions including improved guidance for staff to mitigate and respond to violence risk, this included a strengthening of all our governance policies that have a role to play in reducing violence.
- A workshop has been held that brought together over 60 front line clinicians and support staff to agree plans to improve our debrief processes and plans.
- PMVA drop-in sessions with specialist nurses within Specialist CYPS CBU
- RIDDOR Log, monitored via group safety meeting
- Four wards are involved in the NHSE Culture of Care programme where learning and good practice will be shared across all areas.

Expected impact and by when

Assaults on staff has been a key focus for the organisation and continues to be going forward as we implement improvements articulated in our response to the HSE improvement notice and PSIRF priority.

Assaults - Type of Harm

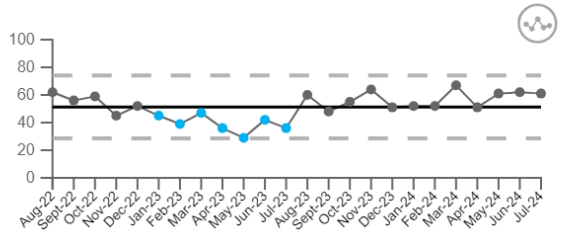
Reporting Period: Jul 2024

Assaults on Patients - Type of Harm

Assaults on Patients - No Physical Harm

Low (No Target)

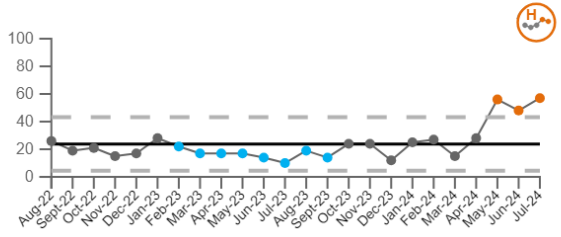
Ref: AP01 Performance: 61 Plan: n/a



Assaults on Patients - Low Physical Harm

Med (Monitoring)

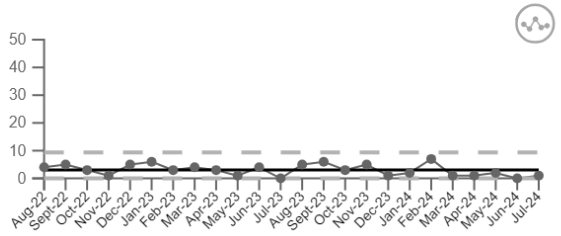
Ref: AP02 Performance: 57 Plan: n/a



Assaults on Patients - Moderate Physical Harm

Low (No Target)

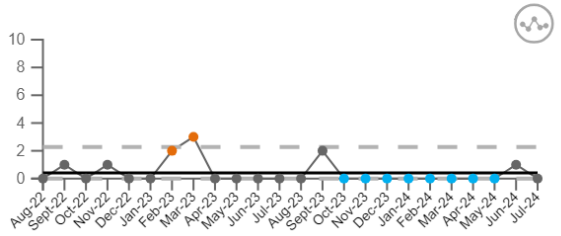
Ref: AP03 Performance: 1 Plan: n/a



Assaults on Patients - Severe Physical Harm

Low (No Target)

Ref: AP04 Performance: 0 Plan: n/a



In the last 24 months there have been 0 fatal assaults on patients

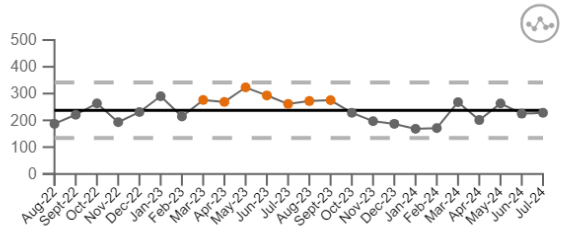
The system shows 0 assaults on patients over the last 24 months with no type of harm currently recorded

Assaults on Staff - Type of Harm

Assaults on Staff - No Physical Harm

Low (No Target)

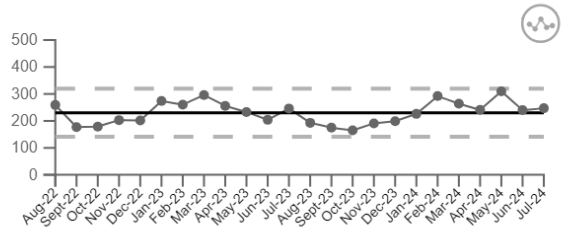
Ref: AS01 Performance: 228 Plan: n/a



Assaults on Staff - Low Physical Harm

Low (No Target)

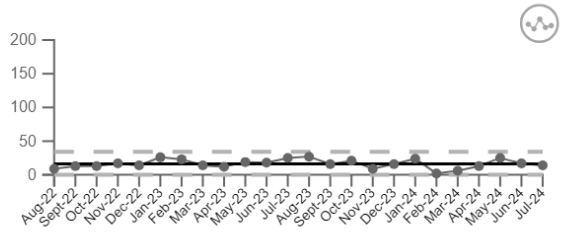
Ref: AS02 Performance: 247 Plan: n/a



Assaults on Staff - Moderate Physical Harm

Low (No Target)

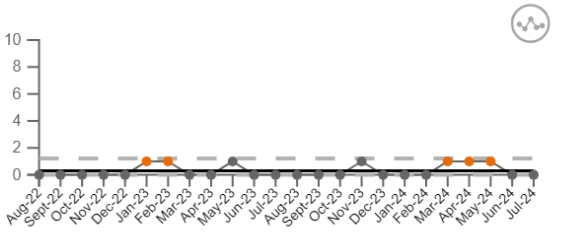
Ref: AS03 Performance: 14 Plan: n/a



Assaults on Staff - Severe Physical Harm

Low (No Target)

Ref: AS04 Performance: 0 Plan: n/a



In the last 24 months there have been 0 fatal assaults on staff

The system shows 0 assaults on staff over the last 24 months with no type of harm currently recorded

Q06 % of patients with a Safety Plan

% of patients with a Safety Plan

Risk Rating: Med (Monitoring)

tgt. = target n. = numerator d. = denominator

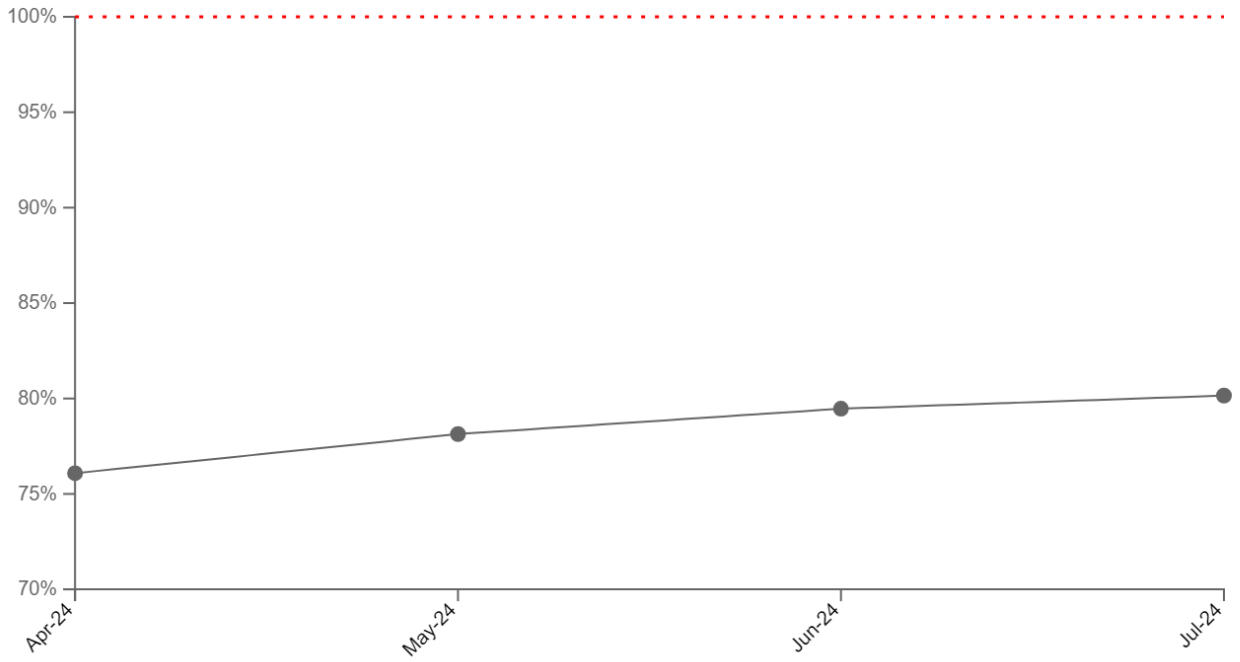
80.2% tgt. 100% n. 16,182 d. 20,189

Not Applicable

Not Applicable

DQ - Investigation

There have been data quality concerns rasied with indicator



Care Group	Performance	N	D	Target	Variation	Assurance
Community Care Group	78.0%	11,856	15,209	100%	SPC n/a	SPC n/a
Inpatient Care Group	93.2%	870	934	100%	SPC n/a	SPC n/a
Specialist Care Group	85.0%	3,275	3,855	100%	SPC n/a	SPC n/a
Support & Corporate	94.8%	181	191	100%	SPC n/a	SPC n/a

Feedback

What the chart tells us

In July 80.2% of patients were reported to have a Risk Management and Personalised Safety Plan.

Root Cause of the performance issue

- The new risk framework form went live on 8th April 2024. Metrics have been developed and are live on dashboards to assure delivery and compliance with quality standards.

Improvement Actions

- Community metric methodology is under review to ensure the correct patient group is being identified to be included in the metric.
- Embedding the framework
- Data quality report has been developed and is monitored by the Steering group. DQ issues are being raised regularly.
- Review of metric methodology taking place as part of the evaluation of the new framework (August 2024)
- New Risk policy is currently being developed
- Evaluation of the framework is under development
- Focus to improve medical training compliance in relation to biopsychosocial risk training.

Expected impact and by when

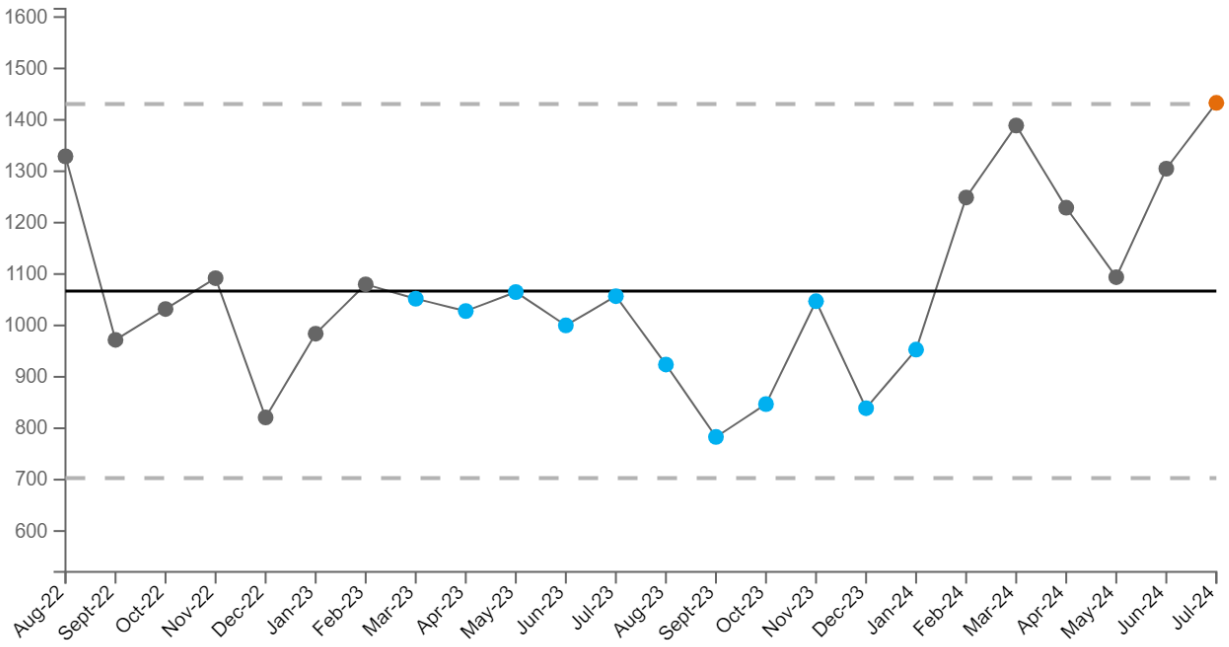
Evaluation planning commenced during June 2024 with recommendations for changes to form/metrics being suggested as part of this.

Q07 Reducing incidents of self-harm

Number of incidents of self-harm

Risk Rating: Med (Monitoring)

1,433	Not Applicable	Concern	DQ - No Concern
		There is concern because this indicator is increasing	There are currently no concerns with the data quality of this indicator



Care Group	Performance	Target	Variation	Assurance
Community Care Group	552	n/a	Concern	SPC n/a
Inpatient Care Group	455	n/a	Concern	SPC n/a
Specialist Care Group	425	n/a	Normal Variation	SPC n/a
Support & Corporate	1	n/a	SPC n/a	SPC n/a

Feedback

What the chart tells us

In July there have been 1,433 reported incidents of self-harm, the highest level reported within 24 months.

Root Cause of the performance issue

- 54% (773) of the incidents were no physical harm, 45% (641) were low physical harm, 1% (17) of the incidents were moderate physical harm and 0.1% (2) of the incidents were severe physical harm.
- Self-harm incidents continue to be a concern which require management focus in the short term. There are particularly high levels within our female facilities which account for 91% of the incidents within the acute pathway. Two wards continue to have high level of activity (Lamesley and Longview – activity on both wards accounted for 70% of all the self-harm incidents across the acute care pathway).
- In Specialist Care Group 68% of incidents of self-harm were reported within Specialist CYPS CBU

Improvement Actions

- Following these incidents debriefs occur which can be used to share learning across the inpatient care group.
- Requirement to establish a steering group and project management support
- Adopt and monitor the quality of biopsychosocial risk assessments with safety planning both on inpatient wards and within the community
- Review of observations
- Individualised care planning
- Review of patient care plans based on formulation is taking place where it is required.

Expected impact and by when

Ongoing monitoring 2024/25

Q08 Rights at Point of Detention

Key: Tgt = Target, n = Numerator, D = Denominator

Risk Rating: **High (Action)**

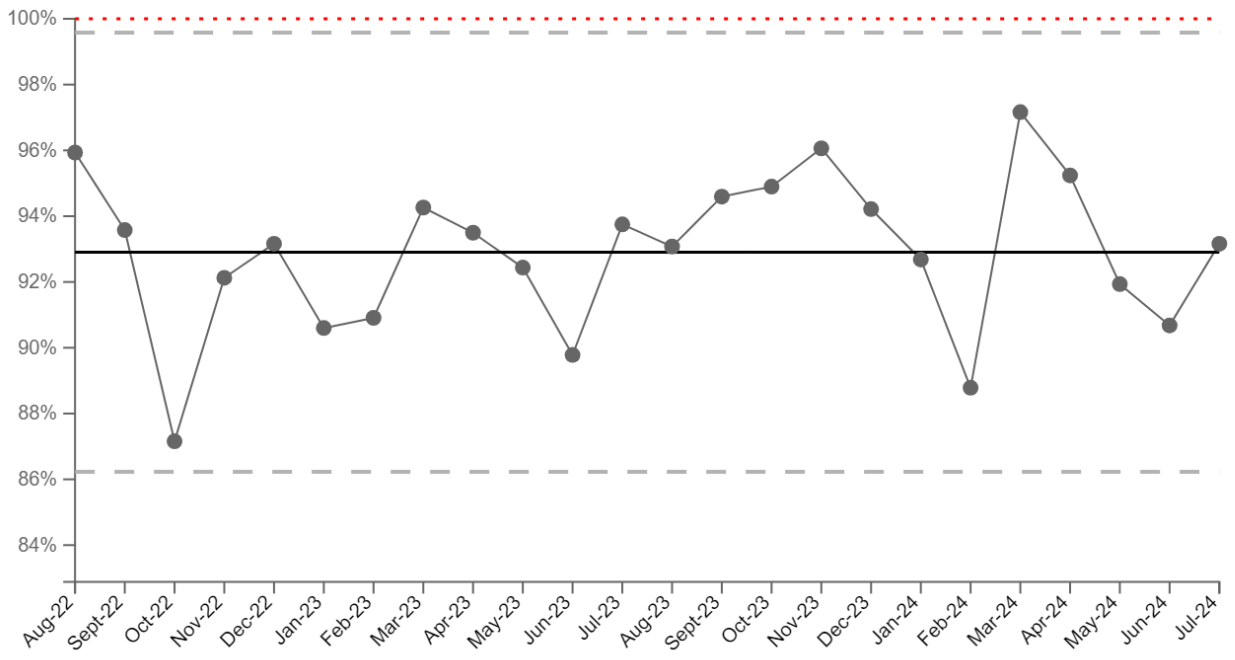
Number of clients (Detained) whose detention has started within the reporting period and there is a Record of Rights Given (detained/CTO) - Form H3L within 7 days either side of the detention starting

93.2%		
	tgt.	100%
	n.	109
	d.	117

Consistently Off Target
The target 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	N	D	Target	Variation	Assurance
Inpatient Care Group	93.3%	98	105	100%	Normal Variation	Consistently Off Target
Specialist Care Group	91.7%	11	12	100%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Compliance in this area continues to fluctuate and is reported for July at 93.2%.

Root Cause of the performance issue

- Staff on the ward may not be aware of our duty to give a person their rights when detained and the requirement to review rights.
- Significant number of pertinent requirements to be complete at the point of admission.
- Availability and consistency of training.

Improvement Actions

- 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.
- MHL specialist participates in CQC mock visits and reviews compliance in this area and feeds back to the clinical team.
- 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 developed and on intranet.
- The MHLSG meet quarterly to discuss the giving of patients' rights, this will be raised within the Care Groups monthly and actions reported back through the Steering Group for assurance.
- Increase compliance in MHA, MCA and DOLS training (impacted by cancelled courses).
- Developed rights on a page poster (outlines key duties in relation to the reading of rights).

Expected impact and by when

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

Q09 Record of Capacity/ CTT at point of detention

Risk Rating: High (Action)

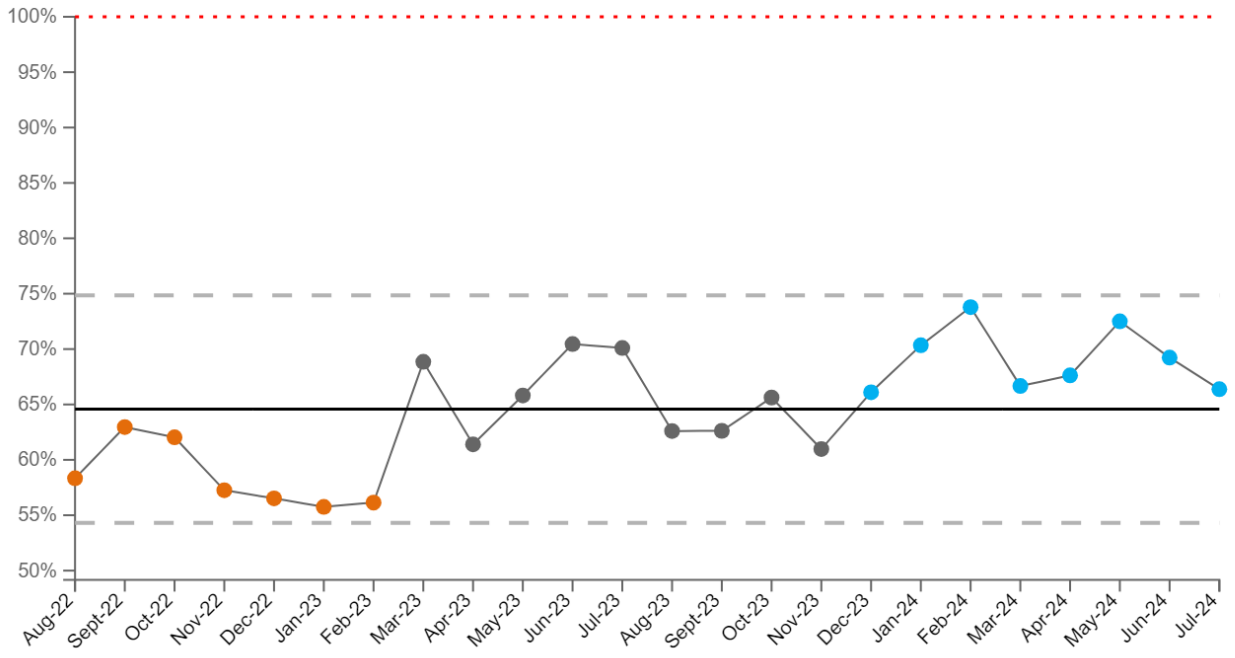
Number of Clients with a Record of Capacity/CTT for Detained Clients forms with Part A completed within 7 days either side of the 3 Month Rule starting date. **Key:** Tgt = Target, n = Numerator, D = Denominator

66.4%	tgt.	100%
	n.	77
	d.	116

Consistently Off Target
The target 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	N	D	Target	Variation	Assurance
Inpatient Care Group	65.4%	68	104	100%	Normal Variation	Consistently Off Target
Specialist Care Group	75.0%	9	12	100%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

July compliance is reported at 66.4% 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 (RC) to complete the form
- Local form rather than legal requirement (legal requirement at 3 months).

Improvement Actions

- Group Directors for each locality have been tasked to look at different ways to improve compliance.
- MHL specialist participates in CQC mock visit and reviews compliance in this area and feeds back to the clinical team.
- MHL Specialist to attend the quality standards groups for inpatients and community to report on compliance around record of capacity at point of detention.
- Gain understanding in relation to difficulties from RCs why the timeframe cannot be met
- The MHLSG meet quarterly to discuss the giving of patients' rights, this will be raised within the Care Groups monthly and actions reported back through the Steering Group for assurance
- Presentation from MHA office at consultant meetings.
- MHA office continue to prompt Responsible Clinicians (RC) to complete this form at point of detention.
- Discussed in a number of medical/ consultant meetings to raise awareness and focus.

Expected impact and by when

- We would expect to see improvement 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)

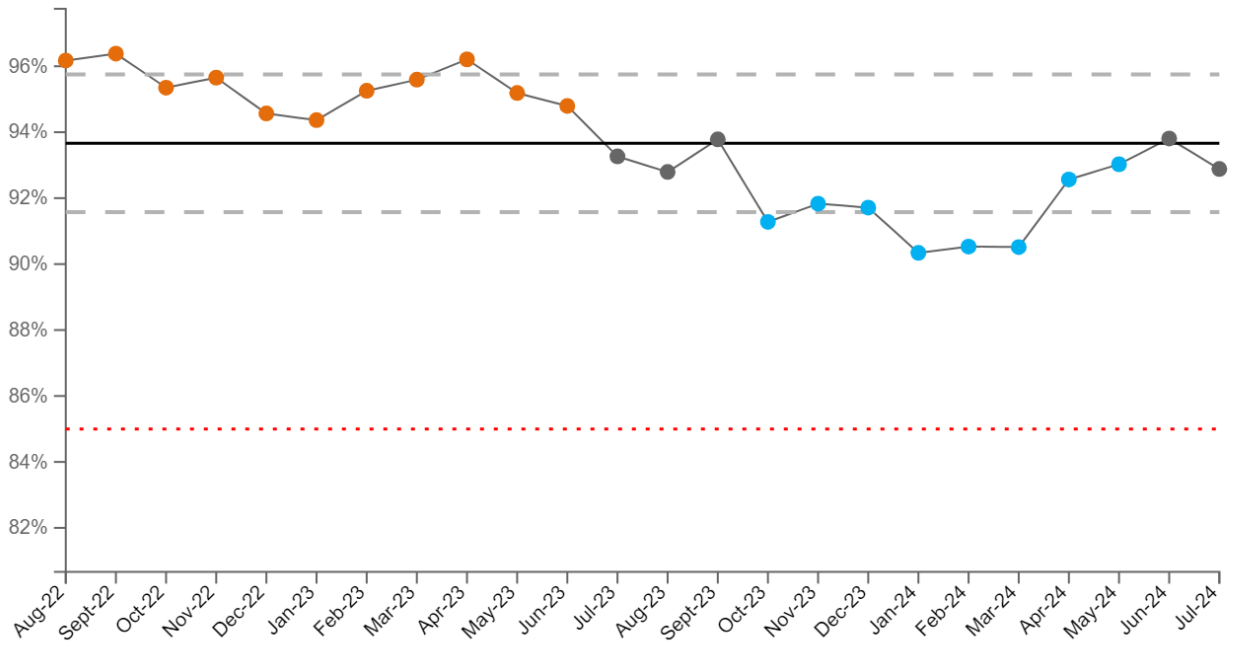
tgt. = target n. = numerator d. = denominator

92.9% tgt. 85% n. 20,973 d. 22,580

Consistently Off Target
The target 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	N	D	Target	Variation	Assurance
Inpatient Care Group	100.7%	14,862	14,754	85%	Normal Variation	Consistently Off Target
Other Care Group	0.0%	0	0	85%	Improvement	Achieve at Random
Specialist Care Group	78.1%	6,111	7,826	85%	Improvement	Achieve at Random

Other Care Group relates to wards that were closed prior to new operational structure and will continue to show for next 20 months

Feedback

What the chart tells us

Bed occupancy was reported at 92.9% in July, remaining 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 extended for a further 6 months until January 2025). Mitford Bungalows remains empty in terms of beds until the review work is concluded but the beds are included within the overall occupancy level.
- Reporting is based on open beds on Rio, beds may be left open and included in reporting affecting occupancy levels.- Secure care currently have open RiO beds, however these are being utilised to support bespoke care packages, and not currently commissioned.
- 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

- Following a review, local / locality discharge facilitation teams now form part of EBM which will help promote standard work and flow.
- Implementation of admission and discharge policy (draft policy specific for older people's inpatients developed).
- System wide working with third sector.
- There is significant oversight of the beds currently out of use.
- The ICB has confirmed the 24/25 (and 25/26) allocations for Providers in relation to Inpatient Quality Transformation (IPQT)and Crisis Service Development Funding (SDF). The Group are developing the proposals / investment plans which align with the NENC IPQT plan and support the effective use of the inpatient bed stock.

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

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

Risk Rating: Med (Monitoring)

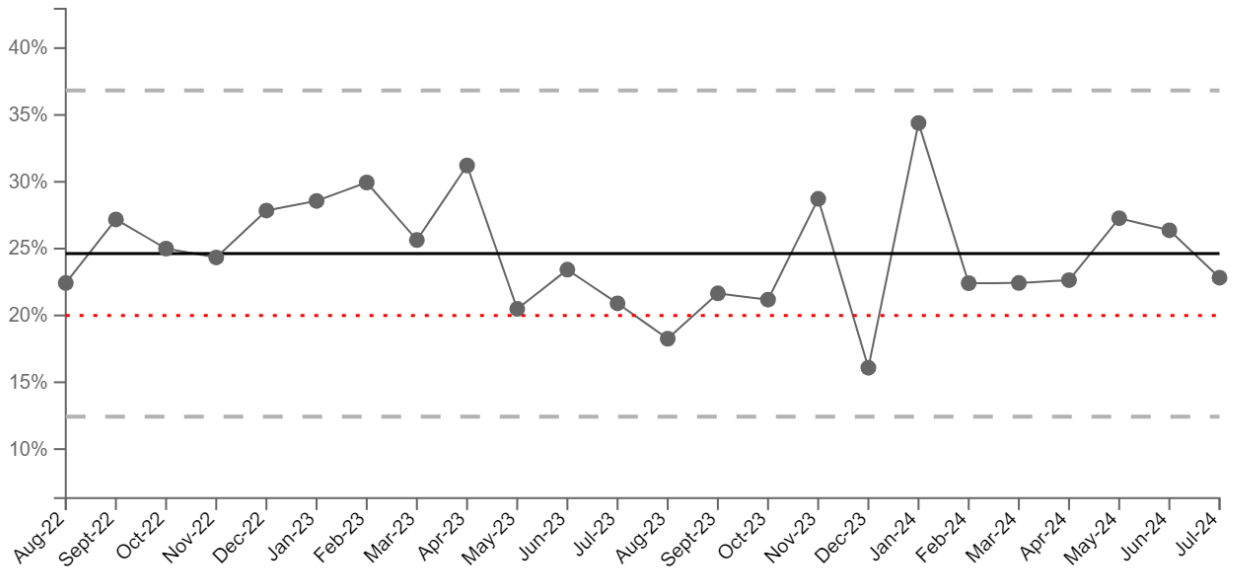
tgt. = target n. = numerator d. = denominator

22.8%	tgt.	20%
	n.	21
	d.	92

Achieve at Random
The target 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



Place Team	Perf	N	D	Target	Variation	Assurance
Central Inpatient CBU	19.2%	5	26	20%	Normal Variation	Achieve at Random
North Cumbria Inpatient CBU	15.4%	4	26	20%	Normal Variation	Achieve at Random
South Inpatient CBU	20.0%	4	20	20%	Normal Variation	Achieve at Random
North Inpatient CBU	36.8%	7	19	20%	Normal Variation	Achieve at Random
Neuro Rehabilitation & Specialist Services CBU	100.0%	1	1	20%	SPC n/a	SPC n/a

Feedback

What the chart tells us

In July 22.8% 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

- High levels of risk and need evidenced by high detention rates within the acute wards (circa 83% of patients detained).
- Medication changes and stabilisation (treatment resistant cohort).
- Increasing number of learning disability and autism patients
- Periods of leave to facilitate successful discharge into the community.
- Delayed discharges due to challenging and complex presentations and limited appropriate housing and or social support.

Improvement Actions

- Focus on patient discharge from admission
- Meetings are in place with the local authorities to review those who are Clinically Ready for Discharge (CRFD)
- Daily huddles are underway.
- Enhanced MDT work being progressed to improve the therapeutic offer.
- Discussions to commence/ re-commence a focused Clinically Ready for Discharge (CRFD) system meeting (focus on made events).
- In-reach model
- Consistent approaches to Care Treatment Reviews (CTRs)

Expected impact and by when

It is expected that LOS will improve over summer 2024.

A05 Clinically Ready for Discharge (formerly DTOC)

Key: Tgt = Target, n = Numerator, D = Denominator

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)

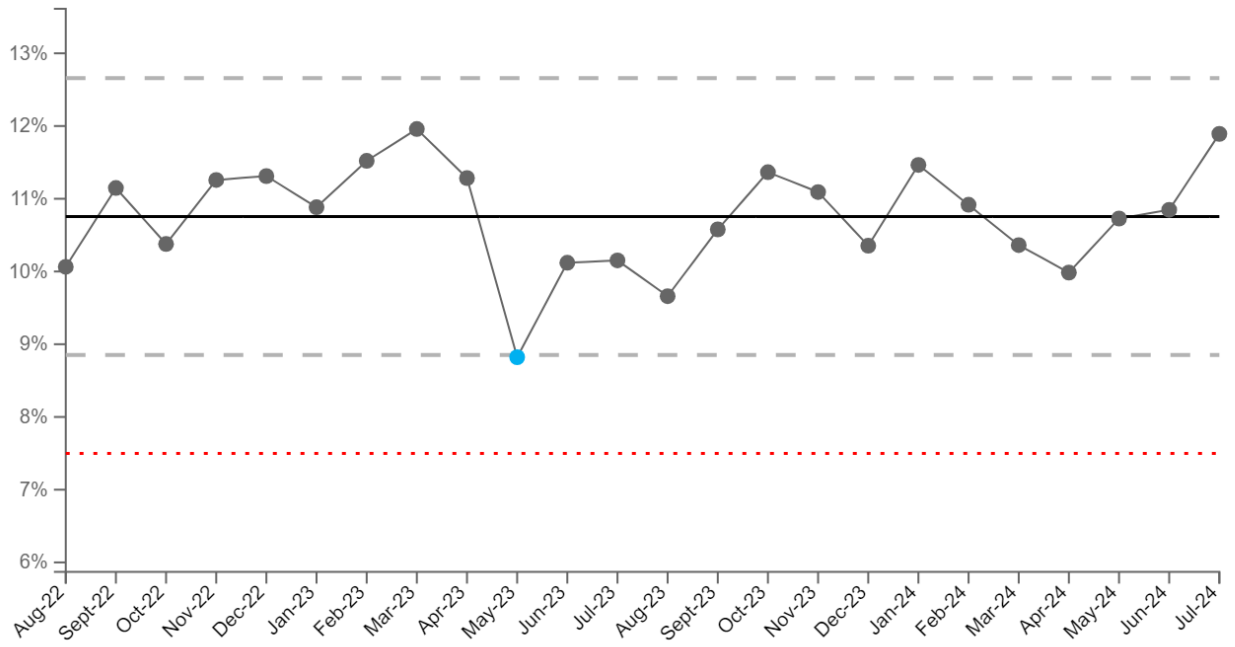
11.9%

tgt. 7.5%
n. 2,143
d. 18,021

Consistently Off Target
The target 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	N	D	Target	Variation	Assurance
Inpatient Care Group	12.9%	1,915	14,803	7.5%	Normal Variation	Consistently Off Target
Specialist Care Group	7.1%	228	3,218	7.5%	Improvement	Achieve at Random

Feedback

What the chart tells us

In July 11.9% of patients were Clinically Ready for Discharge (CRFD). Within CYPS 18.8% of current patients at 31.07.24 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

- Dedicated focus by senior case manager to review and support discharge plans for those CRFD
- Weekly 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 March 24/25 through Better Care Fund (BCF) monies.
- The Group has been approached by Cumberland Council to participate in a review of the residential nursing homes to increase and improve their knowledge and competencies in manging people with dementia.
- Following a review, local / locality discharge facilitation teams now form part of Enhanced Bed Management (EBM) which will help promote standard work and flow.
- Discussions to commence/ re-commence a focused CRFD system meeting (focus on made events)

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

tgt. = target n. = numerator d. = denominator

29.3%

tgt.	60%
n.	53
d.	181

Achieve at Random

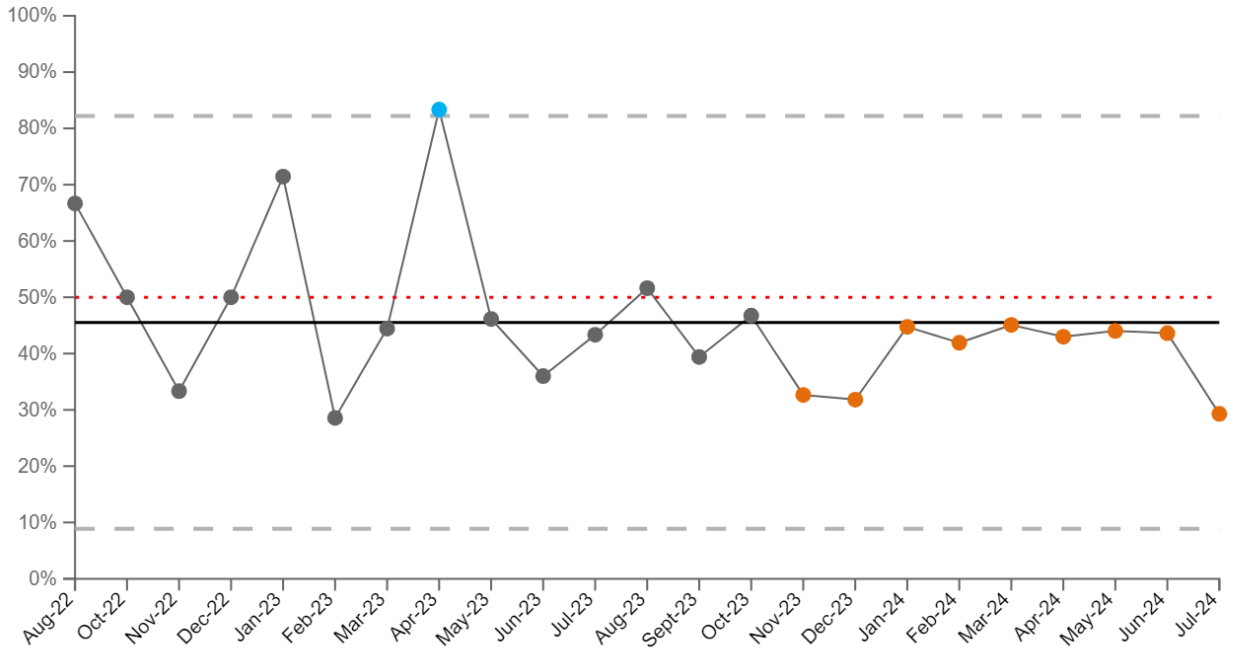
The target for this indicator is within the upper and lower control limits

Concern

There is concern because this indicator is decreasing

DQ - Investigation

There have been data quality concerns rasied with indicator



Place Team	Perf	N	D	Target	Variation	Assurance
Newcastle & Gateshead Place Team	21.0%	29	138	60%	Concern	Achieve at Random
North Cumbria & Northumberland & North Tyneside Place Team	44.4%	8	18	60%	Normal Variation	Achieve at Random
Sunderland & South Tyneside Place Team	64.0%	16	25	60%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Very urgent referrals seen within 4 hours achieved 29.3% in July, the lowest performance since February 2023.

Root Cause of the performance issue

- Inconsistencies across locality in Very Urgent referral recording and accuracy of contact recording, see denominator for each place.
- 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)

- Staffing shortages particularly with Band 6s.
- Triage system being reviewed to reduce missed opportunities for contact with patients.
- 136 staffing model and the impact on the crisis service.

Improvement Actions

- Daily Sitrep reporting in place for Crisis services regarding staffing levels, currently crisis staffing is challenging across all localities, with a specific focus on Newcastle & Gateshead.
- Consideration for process when high levels of temporary staffing are used to support capacity to ensure methodology continues to be followed.
- Review metric definition in line to ensure reporting is in line with national methodology
- Peer review of referrals urgencies via Access Oversight sub-group
- Standardisation of referral recording and staff supported to correct data quality issues
- Development of crisis triage hub will reduce variation in referral urgencies.
- Referral urgency guidance has been revisited with Newcastle Gateshead crisis team and will be utilised.

Expected impact and by when

Expected continued improvement across Quarter 2 2024.

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

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

Risk Rating: Med (Monitoring)

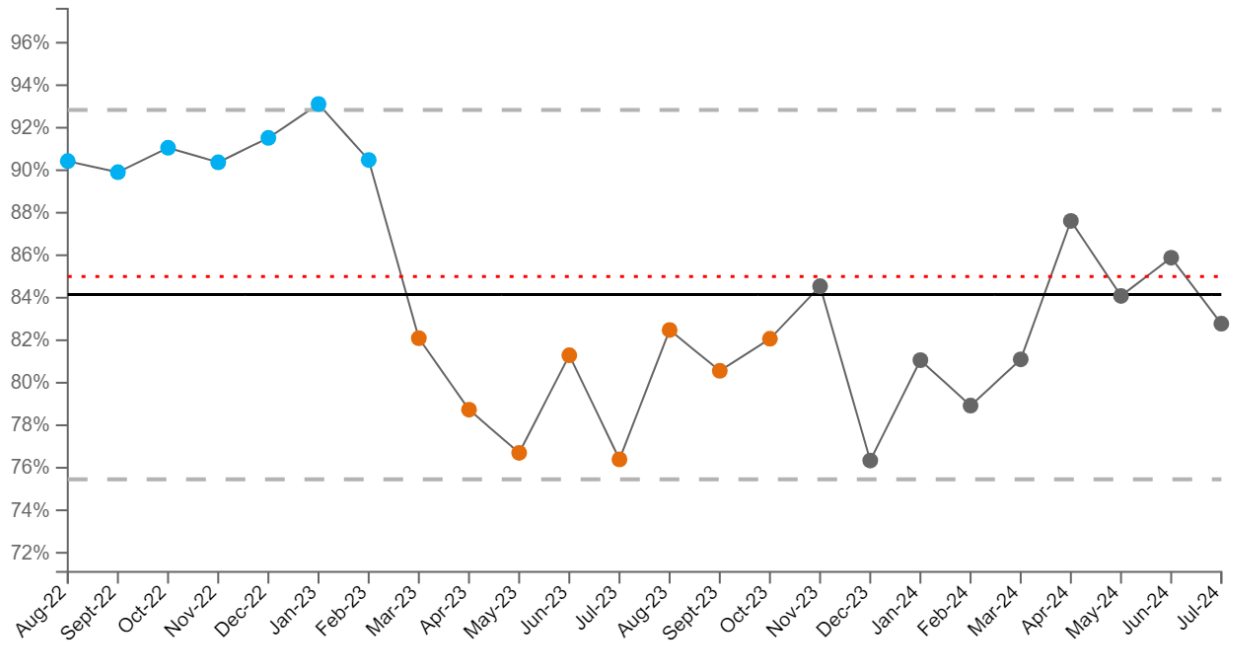
tgt. = target n. = numerator d. = denominator

82.8%	tgt.	85%
	n.	322
	d.	389

Achieve at Random
The target 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	Perf	N	D	Target	Variation	Assurance
Newcastle & Gateshead Place Team	71.4%	25	35	85%	Normal Variation	Achieve at Random
North Cumbria & Northumberland & North Tyneside Place Team	78.4%	160	204	85%	Normal Variation	Achieve at Random
Sunderland & South Tyneside Place Team	91.3%	137	150	85%	Normal Variation	Achieve at Random

Feedback

What the chart tells us

Urgent referrals seen within 24 hours achieved 82.8% in July

Root Cause of the performance issue

- Staffing shortages particularly with Band 6s.
- Inconsistencies across locality in Urgent referral recording and accuracy of contact recording, see denominator for each place.
- 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.
- ICTS providing input to ED in areas where there is no CYPS PLT.

Improvement Actions

- Daily Sitrep reporting in place for Crisis services regarding staffing levels, currently crisis staffing is challenging across all localities.
- 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
- Review metric definition in line to ensure reporting is in line with national methodology
- 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 2 2024.

A08 % PLT ED Referrals seen within 1 hour

% Psychiatric Liaison Team Emergency Dept Referrals seen within 1 hour

Risk Rating: **Med (Monitoring)**

tgt. = target n. = numerator d. = denominator

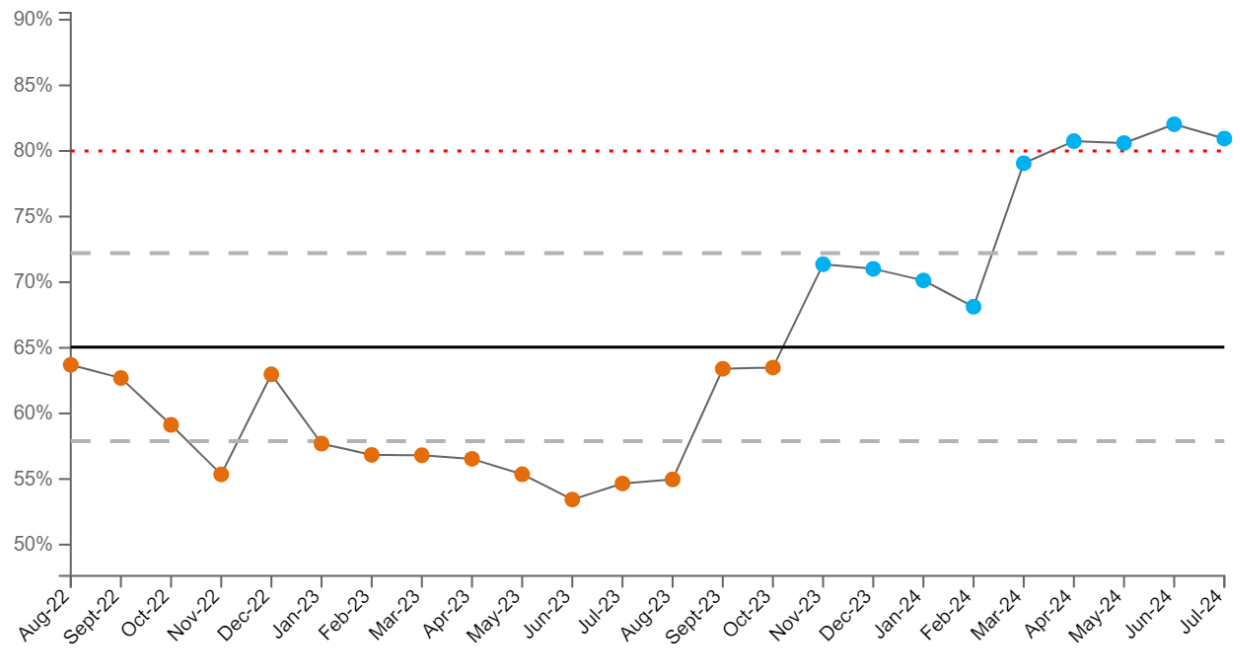
80.9%

tgt. 80%
n. 875
d. 1,081

Consistently Off Target
The target 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	Perf	N	D	Target		Variation		Assurance
Newcastle & Gateshead Place Team	71.5%	304	425	80%		Improvement		Consistently Off Target
North Cumbria & Northumberland & North Tyneside Place Team	80.4%	296	368	80%		Improvement		Consistently Off Target
Sunderland & South Tyneside Place Team	95.5%	275	288	80%		Improvement		Achieve at Random

Feedback

What the chart tells us

Performance was 80.9% in July which is above the expected range.

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
- Commissioned resource does not meet demand for a 1-hour response at busy times during the evening and nights.

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.
- 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)

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

Risk Rating: High (Action)

tgt. = target n. = numerator d. = denominator

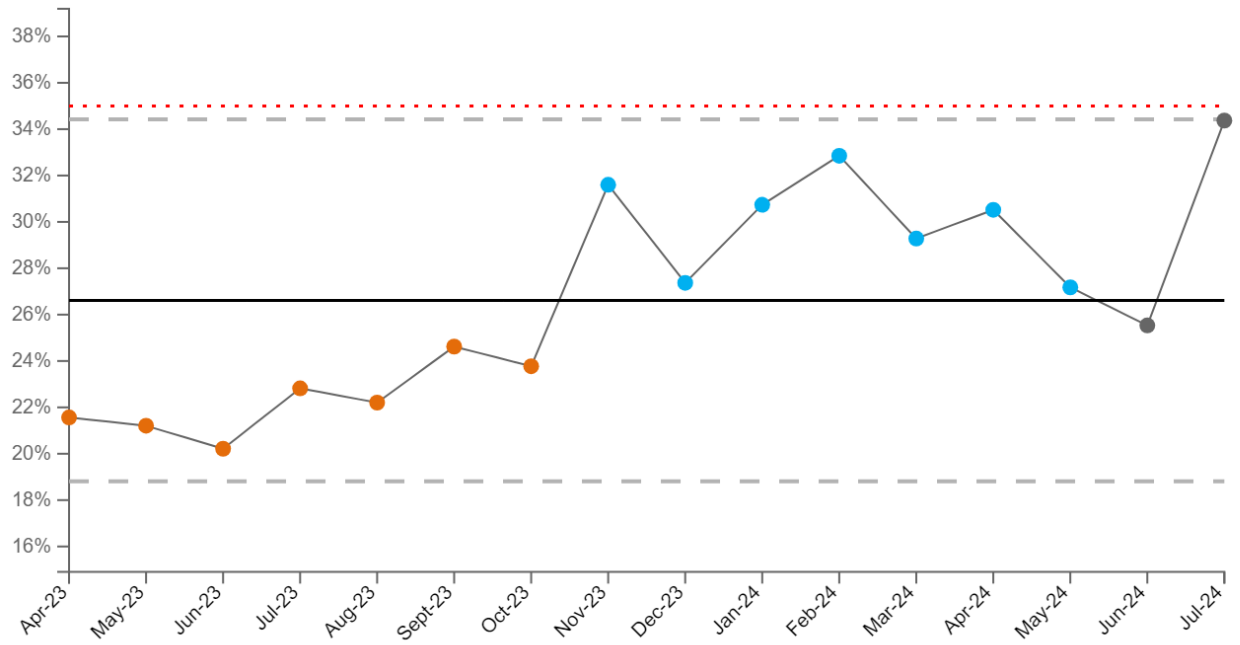
34.4%

tgt. 45%
n. 796
d. 2,316

Consistently Off Target
The target 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	N	D	Target	Variation	Assurance
Community Care Group	36.0%	754	2,092	45%	Improvement	Consistently Off Target
Specialist Care Group	18.8%	42	224	45%	Normal Variation	Consistently Off Target

Feedback

What the chart tells us

Performance increased to 34.4% in July.

Root Cause of the performance issue

- The number of patients starting treatment is lower than the number of referrals in the latest 4-week period.
- There are several patients waiting over 4 weeks to start treatment, this impacts new referrals which are waiting.

Improvement Actions

- A significant amount of work underway to embed new pioneer process alongside data quality work to ensure the position is accurately reflecting operational delivery.
- Weekly steering group has been re-established in Community CBU
- Fortnightly waiting list meetings overseen by each team.
- Weekly waiting times oversight meetings re-established with CBU's reporting back monthly.
- Work on data quality and recording is a focus area, ensuring that all elements linked to treatment beginning have been completed.
- We are working to ensure that we are not restarting waiting time once a patient has accessed treatment by improving the knowledge and understanding for how the waiting time methodology works.

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)

Risk Rating: High (Action)

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

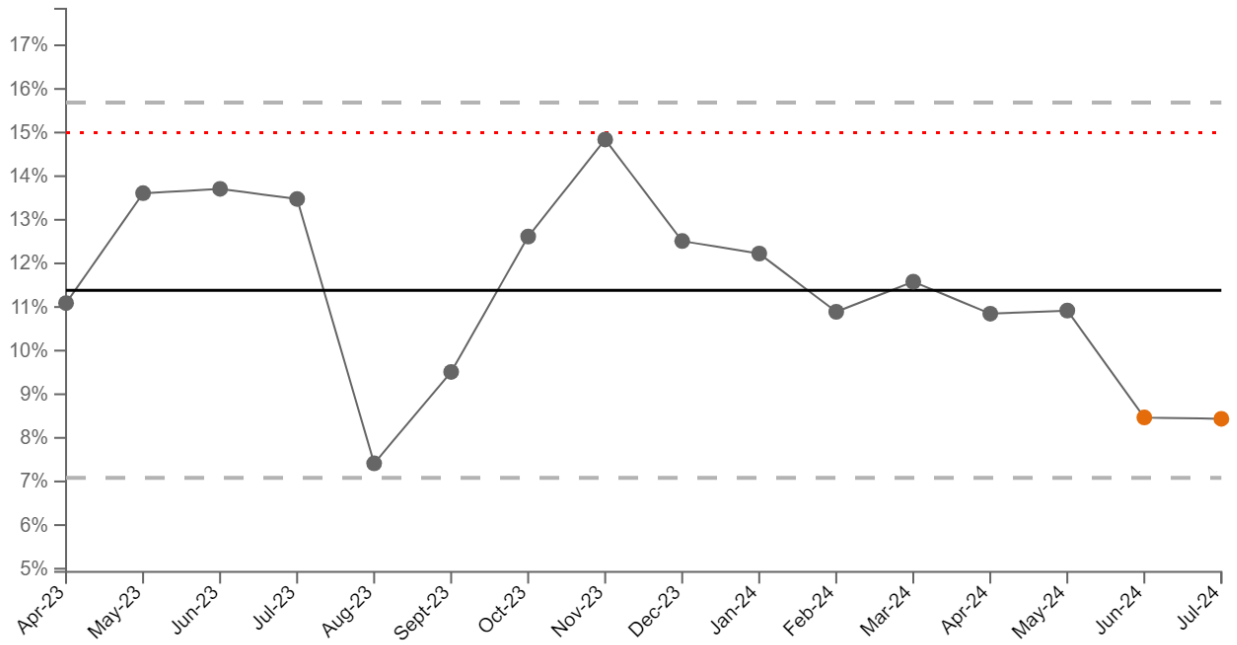
8.4%

tgt. 25%
n. 540
d. 6,400

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

Concern
There is concern because this indicator is decreasing

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



Place Team	Perf	N	D	Target	Variation	Assurance
Newcastle & Gateshead Place Team	5.2%	246	4,740	25%	Concern	Consistently Off Target
North Cumbria & Northumberland & North Tyneside Place Team	15.3%	245	1,606	25%	Normal Variation	Consistently Off Target
Sunderland & South Tyneside Place Team	90.7%	49	54	25%	Improvement	Consistently Achieve

Feedback

What the chart tells us

Performance deteriorated in the month. 8.4% of referrals have been waiting 4 weeks or less to receive help. Overall, a total of (5,953 out of 6,400) 93.0% waiters are within the neurodevelopmental pathway.

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 model 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.
- Central CYPs in discussion with partners around 'welcome events'
- Central - Toby Henderson Trust has been commissioned to continue to support ASD assessments and welcome events using ICB funding.

Expected impact and by when

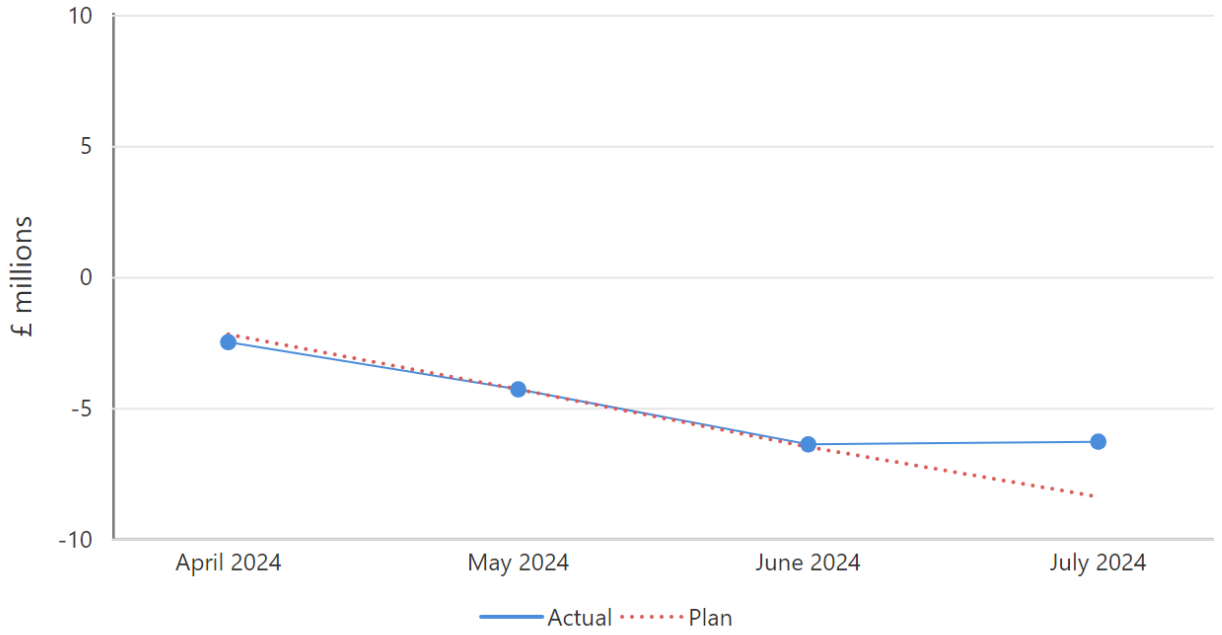
There is a national focus on neurodevelopmental pathways, which has recognised the amount of demand for diagnosis and how we approach meeting neurodevelopment needs. It is expected that the demand for diagnosis will continue throughout 2024, the expected impacted of actions will be to mitigate the increasing 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)

-£6.3m	Plan -£8.4m	Not Applicable	Not Applicable	DQ - No Concern: There are currently no concerns with the data quality of this indicator



Care Group	Actual	Plan	Variation	Assurance
Community Care Group	£15.9m	£16.4m	SPC n/a	SPC n/a
Inpatient Care Group	£2.8m	£5.4m	SPC n/a	SPC n/a
Specialist Care Group	£9.5m	-£4.7m	SPC n/a	SPC n/a
Support & Corporate	-£34.5m	-£25.5m	SPC n/a	SPC n/a

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 / worsen the financial forecast. A upside and downside scenario is being prepared.
- 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.

2.4 QUALITY PRIORITIES UPDATE

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

verbal update

2.5 CQC UPDATE

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

verbal update

3. STRATEGIC AMBITION 2 ? PERSON LED CARE, WHERE AND WHEN IT'S NEEDED

Darren Best, Chair

3.1 MENTAL HEALTH SERVICES - WEST CUMBRIA UPDATE

Ramona Duguid, Chief Operating Officer

verbal update

3.2 PROGRAMME OF WORK UPDATE

Ramona Duguid, Chief Operating Officer

verbal update

3.3 INTEGRATED PERFORMANCE REPORT ? PERSON LED CARE, WHEN AND WHERE IT'S NEEDED

Ramona Duguid, Chief Operating Officer

Please note the report under 2.4 item will be used to discuss this item

4. STRATEGIC AMBITION 3 ? A GREAT PLACE TO WORK

Darren Best, Chair

4.1 PEOPLE COMMITTEE REPORT

Brendan Hill, Committee Chair

REFERENCES

Only PDFs are attached

4.1 People Committee Assurance Report September 2024.pdf

Board Committee Assurance Report
Council of Governors General Meeting
Thursday 28th November 2024

Name of Board Committee	**People Committee**
Date of Committee meeting held	31 July 2024
Agenda items/topics considered	See below
Date of next Committee meeting	30 October 2024

1. Key areas of focus:

- Chair's Business

  The Chair of the Committee commented on the first workshop held on 26 June 2024 which had a focus on retention, employee relations and just culture. Feedback from the workshop was positive. The workshop on 27 November will include an update on the priorities outlined in the Great Place to Work ambition of the Annual Plan, including OD and progress around workforce establishment planning.

  The Chair also commented on the key areas of focus for the Committee for the next few months which are linked to the Trust Annual Plan. These are the areas where he would like the Committee to demonstrate meaningful progress by the end of 2024/25. The key areas are:

  - How our work on 'just culture' is being embedded
  - Workforce establishment planning
  - Leadership development
  - Improving performance on revised staff training targets
  - Review how service user and carer views influence our priorities and work programme

- Workforce Performance Report – **discussion and assurance**
- Guardian of Safe Working Hours Quarterly Report **- assurance**
- EDI Action Plan 2024/25 – **assurance**
- Employee Relations Annual Report – **discussion**
- Medical Revalidation Report – **update and agreement to approve outside of formal meeting**
- WRES / WDES Annual Report – **discussion and assurance**
- CPD Allocation – **to note**
- 2024 People Committee Review of Performance against ToR - **discussion and approval**
- Health and Wellbeing Steering Group Terms of Reference – **to note**
- 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.

Clinical supervision

Action from previous meeting: 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. (To update 31 July 2024)

The task and finish group set up to review the way supervisions are carried out and recorded continues to meet. There is a significant improvement in compliance since the last meeting on 1 May 2024, however, it is acknowledged there is still some work to do to consistently meet the target. This remains an area of focus for the CQC and part of the Trust's CQC Must Do actions. Whilst the governance of this item remains with Q&P, the ongoing work on supporting improvement will remain in our performance reports along with appraisal and related training priorities.

Staffing Establishments

Action from previous meeting: Workforce Plan and establishments to be reviewed in line with changes to the clinical model and forms part of the annual plan priorities. (To update November 2024)

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. The plan to review the establishments and progress of the workforce plan is still on track for November's workshop.

Local Onboarding

Action from previous meeting: Corporate and Local Induction to be included in future Workforce Performance Reports (to update July 2024)

This action has now been completed.

There have been two onboarding internal audits in recent months (one for temporary and one for substantive staff). Both reports showed some gaps in assurance. Remedial action is progressing, and it was agreed to provide a paper for the October meeting to show progress against all actions raised as part of the two audits (Update October 2024)

Sickness

Provisional sickness figures have increased from those reported at the previous meeting. There has been an increase in Covid 19 nationally over recent weeks and there have been a number of staff absences due to this.

Continued focus has been given to support staff to stay at work in terms of reasonable adjustments etc. A task and finish group has been set up to review the current provision. The regional wellbeing hub continues to provide a service to providers across the region in terms of mental health support. The Trust internal Staff Psychological Centre is experiencing some capacity issues (as reported in April 2024) and there is an estimated 6 month waiting list currently. The team is having an Away Day in September facilitated by CNTW Innovations to

review the model and this will be discussed at a future BDGW with feedback through to the People Committee in due course.

Employee Relations

Creating a compassionate, just and learning culture has an impact on staff wellbeing, patient safety, a sense of psychological safety which in turn will reduce sickness absence, turnover and the number of investigations. This is a key BAF risk aligned to Strategic Ambition 3.

This was a topic area for the June workshop where detailed discussion took place. It was further discussed at the People Committee where the key points within the Capsticks HRA Annual Report were summarised. This included:

- An overall reduction in the number of cases.
- A significant reduction in the number of formal cases, in particular compared to the previous year.
- An improved position in the number of open cases as many longstanding cases have come to a conclusion.
- There remains a challenge around timescales and the report details that only one grievance and no disciplinaries were concluded within the timescales outlined in policies over the last year.

The Committee was advised that there has been a focus on timescales over the last quarter and several mechanisms are in place including having an Exec and Director Lead on long-standing cases.

In terms of just culture, this was a focus at the last Trust Leadership Forum. The National NHS Just Culture Framework has been in place for some time, and this is a key priority for Strategic Ambition 3 for this year. The Disciplinary policy will be reviewed in the coming months to ensure just culture principles are a key element. The Grievance policy is currently being reviewed with a focus on resolution rather than grievance.

The Trust Trauma Informed Approach Lead is working with the workforce team to ensure TI principles are embedded throughout workforce policies.

Equality Diversity and Inclusion

The Committee discussed the Workforce Race Equality Standard and Workforce Disability Equality Standard reports from the previous year and noted the areas of improvement and outstanding work needed. The EDI Action Plan was discussed which shows, at a high level, the priorities for the remainder of 2024/25, acknowledging that some of this work will take considerably longer to address. The key objectives were previously approved at Trust Board:

- Eliminate conditions and environment in which bullying, harassment and physical harassment occurs
- Address progression within the Trust for staff protected under the Equality Act
- Engage with racialised and ethnic minority communities to identify and agree core organisational competencies requiring further development.

The People Committee will receive quarterly updates on these actions.

3. Key challenges now and in the medium term

- 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. Since the last People Committee, Executive Directors have met with the Guardians to explore this further. Further analysis to be undertaken and the NHS Staff Survey 2024 will help inform this work.

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

Turnover

Figures have consistently improved for several months, and the Trust turnover is 9.2% which is the lowest rate for several years.

Exit Questionnaires

The response rate for exit questionnaires has improved to 22.5% (8.4% the previous quarter). Since April, the ESR exit questionnaire has been utilised. The responses can now be better aligned to the NHS People Promise. Exit Interviews are undertaken on request. There will be ongoing communication regarding the Exit Questionnaire as part of the ESR roll out.

Clinical Supervision

The Workforce Performance Report saw a slight improvement in the number of staff with a recorded clinical supervision. However, it was noted that a significant improvement in uptake had occurred since the report had been produced with dashboards that morning indicating compliance well over 70%. Groups were thanked for their continued focus in this area. It was noted that August is often a period where training, clinical supervision and appraisal rates drop slightly due to the holiday period, but this will be monitored.

Training

Since the completion of the training review and introduction of trajectories to give focus to key topic areas there has been significant improvement in these areas.

Equality, Diversity and Inclusion

The Committee was provided with an update in terms of the Workforce Race Equality Standard and Workforce Disability Equality Standard. Some positive progress has been seen, particularly around the numbers of Black, Asian and Minority Ethnic staff who now work for the Trust with these staff totalling 11% of the workforce, an increase from 9.06% last year and 7.5% the previous year. This is largely the result of the significant work which has been undertaken in recent years in respect of inclusive recruitment and the agreement to provide sponsorship to staff when visas expire. The increase in Black, Asian and Minority Ethnic staff is positive progress, however, this tends to be in the lower banded posts and focus over coming years is to improve numbers in higher bandings.

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

No specific actions were noted.

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

There is one key item which will be discussed at a future Trust Board:

Medical Revalidation Report

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 which was discussed in detail at the meeting.

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

The 2024 People Committee Review of Performance against the Terms of Reference was approved at the meeting with an acknowledgement that amendments may be required once the governance around Health Inequalities is agreed.

9. Review of Board Assurance Framework and amendments thereon

At the July 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.

People Committee		
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
August 2024

Lynne Shaw
Executive Director of Workforce and OD

4.2 INTEGRATED PERFORMANCE REPORT ? A GREAT PLACE TO WORK

Lynne Shaw, Executive Director of Workforce and OD

Please note the report under 2.4 item will be used to discuss this item

5. STRATEGIC AMBITION 4 ? SUSTAINABLE FOR THE LONG TERM, INNOVATING EVERY DAY

Darren Best, Chair

5.1 RESOURCE AND BUSINESS ASSURANCE COMMITTEE REPORT

Paula Breen, Committee Chair

REFERENCES

Only PDFs are attached

5.1 RABAC Committee Assurance Report - Aug 24 DRAFT.pdf

Board Committee Assurance Report
Council of Governors General Meeting
Thursday 28th November 2024

Name of Board Committee	**Resources and Business Assurance Committee (RBAC)**
Date of Committee meeting held	7 August 2024
Date of next Committee meeting	TBC – under consideration

1. Key areas of Focus

- 24/25 Financial Position
- CEDAR update
- Trust Treasury Policy
- Agency Expenditure and usage
- Utility Report
- PLACE report
- Corporate Benchmarking Return 23/24
- Cost Collection Results 22/23
- Cost collection return 23/24
- Financial Sustainability and underlying position
- Digital Highlight Report
- Digital Maturity Assessment
- Briefing on Global Crowdstrike incident
- Provider collaborative integrated update

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.

24/25 Financial Position
The committee received the Finance report relating to Month 3. Key risks to the financial position were outlined in the finance report:

Unallocated savings targets. This reduced this month as items were allocated as outlined in the previous months board report. Several avenues are being explored for the remaining value (£3.9m) including retention of Lennox income from NHSE, ICB income and further cost savings from loss making services (Specialist Group)

Inpatients – forecast overspend of c£1.6m – a recovery plan is being developed with the Group and the frequency of well led meetings are being increased to increase support to the Group to deliver.

Corporate savings – shortfall on corporate savings targets is being addressed through peer review of savings schemes in September, underspends in underspent corporate services being held and 'going further' options being explored.

Medium Term Financial Planning
The committee received an update on the underlying position of the Trust and next steps on production of the medium plan (25/26 and beyond) is expected in September.

CEDAR and capital planning
The Committee noted the verbal update on the CEDAR project and the challenges posed from NHP approval processes. The committee noted the wider capital plan risks and the reforecasting exercise currently being undertaken to explore ways of mitigating the current forecast position.

Annual Cost Collection & Corporate Benchmarking
The committee received an update on the submission of cost collection data for 23/24 and noted this was in line with the approved plan for the last committee meeting. It also received the output from the 22/23 cost collection exercise which reported and aggregate index of 112 – implying the Trust is 12% more expensive than average for the sector. The committee noted the data quality issues around inpatients experienced nationally and lack of nuance around specialist services in this benchmarking.

The committee noted corporate benchmarking data was submitted and awaits the output form this exercise.

Digital
The committee received assurances around the delivery of digital projects. It also received an update on the crowdstrike incident including initial learning. The committee received the Digital Maturity Assessment (DMA) and noted the weaknesses identified in the leadership and governance domain. The committee has requested a report to address these weaknesses for consideration which is intended to inform a future full board discussion on this topic.

Commissioning
The committee heard updates on the provider collaborative and lead provider arrangements.

Estates
The committee received an update on utilities and noted the increase in consumption and prices. Electricity and water usage were up whilst gas consumption was down. The Trust continues to work with its energy broker to maximise benefits from the current contracts where possible.

3. Key challenges now and in the medium term

The key challenge faced by the Trust is the development of a medium-term sustainability plan. A planning paper is expected in September to support mitigation of these challenges beyond the current year.

The threat of cyber-attack remains elevated given current geopolitical environment and the increasing reliance on digital technology increases this through time. The committee continues to develop its expertise in this area to provide assurances to the Board of Directors on cyber security. It should be noted that the Trust is DSPT compliant.

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 schemes – particularly in relation to at risk areas such as corporate and containing costs within ward budgets. Well led meetings are increasing in frequency to support improvement in these forecasts.
- 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.

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.

The committee requires increased levels of detail to enhance assurance on the financial position and is considering increasing the frequency of meetings. The finance report is also being reviewed to ensure it focuses clearly on the key risk areas for the Trust from a strategic perspective.

A planning paper will be developed to support planning for 25/26 and beyond. This is due in September.

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. The committee noted that progress in containing the size and cost of the workforce requires increased pace to remain sustainable.

The committee has commissioned a report from the Digital team to consider gaps identified in the Digital Maturity Assessment. This will be escalated to Board of Directors for discussion following review by the committee.

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

The Committee were asked to consider whether the Treasury Policy should continue to come back in future for comment. It agreed it would not and the Treasury policy would be treated like any other policy and did not require explicit oversight of the committee. The committee agreed that a review of the SFIs/ SORAD would take place to ensure governance around any future drawdowns of working capital support can be operationalised sensibly given the changes in frequency of board meetings recently. It is not expected this is an imminent issue, but rather a sensible response to the Board arrangements.

9. Review of Board Assurance Framework and amendments thereon

At the August 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		
• 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 received a recommendation to de-escalate the temporary staffing risk to the directorate risk register and introduce a new BAF risk which concerns affordability of the workforce and the impact of sustainability.

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
August 2024

Kevin Scollay
Executive Director of Finance

5.2 INTEGRATED PERFORMANCE REPORT ? SUSTAINABLE FOR THE LONG TERM, INNOVATING EVERY DAY

Kevin Scollay, Executive Director of Finance

Please note the report under 2.4 item will be used to discuss this item

5.3 FINANCE REPORT

Kevin Scollay, Executive Director of Finance

REFERENCES

Only PDFs are attached

5.3 Public - M04 Finance Update.pdf

Name of meeting	**Council of Governors General Meeting**
Date of Meeting	**Thursday 28th November 2024**
Title of report	**Month 4 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	
Quality and Performance	
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	X
Charitable Funds Committee	
People	
CEDAR Programme Board	
Other/external (please specify)	

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

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

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

Council of Governors General Meeting
Thursday 28th November 2024

Month 4 Finance Report

1. Executive Summary

1.1 **At Month 4 the Trust has generated a £6.3m deficit.**

1.2 This deficit is **ahead of the financial plan at Month 4 by £2.1m**. This is because the Trust has completed a quarterly review of liabilities and released accruals no longer deemed to result in a liability. There are also underspends on some budgets year to date, not expected to be maintained to the year end.

1.3 At the end of Month 4 the Trust has spent £3.5m on agency staff against a plan £3.6m.

1.4 **Expenditure on the Trust capital programme is £1.6m lower than expected** at the end of Month 4. This budget is currently assumed to breakeven by year end due to slippage, but there is a significant risk of overspending by up to £2.4m due to commitments to move services away from the CAV site.

1.5 **The Trust has a cash balance of £30.2m** at the end of Month 4 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 4.

Table 1: Key Financial Metrics

	Month 3		
Key Financial Targets	**Trust Plan**	**Actual**	**Variance/ Rating**
I&E – Surplus /(Deficit)	(£8.4m)	(£6.3m)	(£2.1m)
Agency Spend	£3.6m	£3.5m	(£0.1m)
Cash	£23.4m	£30.2m	(£6.8m)
Capital Spend	£4.6m	£3.0m	£1.6m

3. Financial Performance

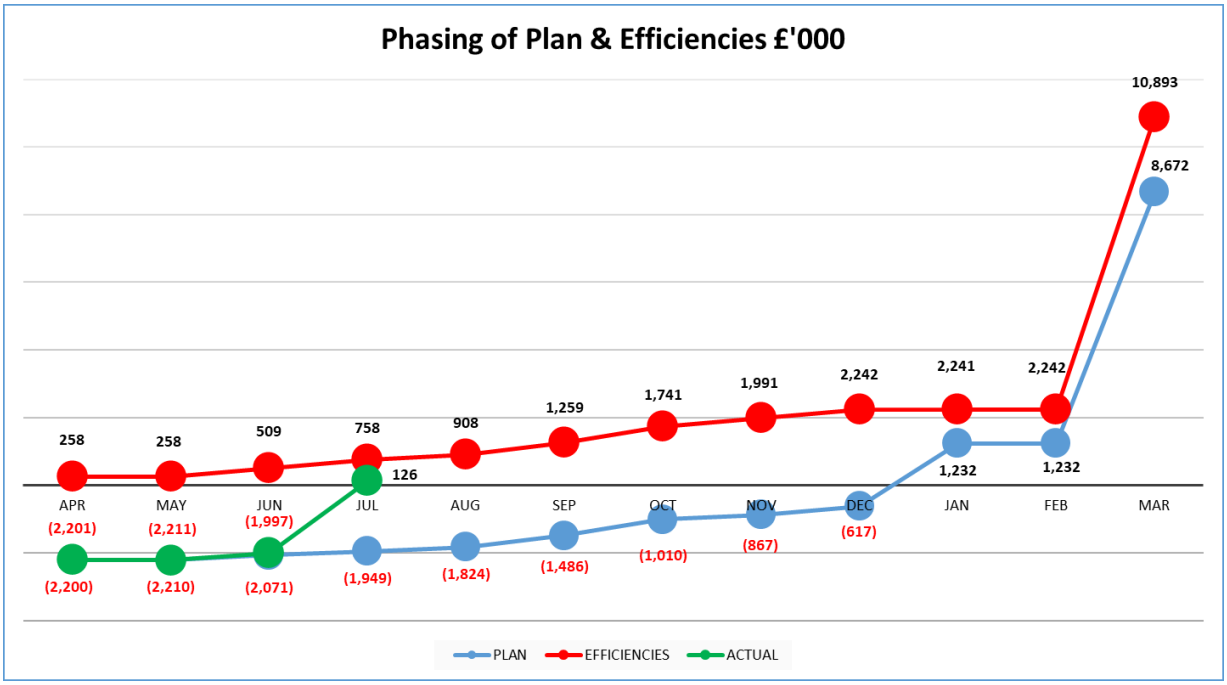
Income and Expenditure

3.1 At the end of Month 4 the Trust has reported a £6.3m deficit on Income and Expenditure, which is better than the plan submitted to NHSE by £2.1m.

3.2 The Trust monthly planned deficit/surplus is shown in the graph below. 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. 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.

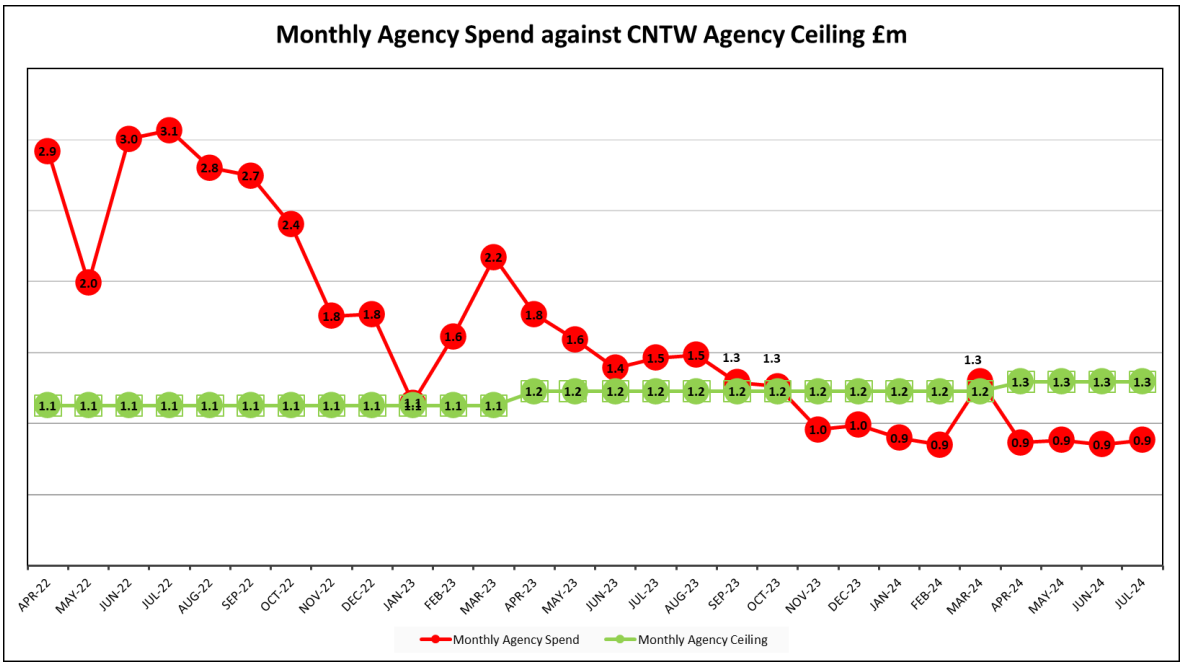
3.3 The trust plan included £6.2m unidentified efficiencies. This has reduced to £3.9m at the end of Month 4 and is expected to fall to £0m in the Month 5 reported position. The Trust will therefore have a de-risked financial plan and will be focusing on managing in year variation and the production of a its medium-term plan from 25/26 and beyond.

Graph 1: Monthly Financial Performance



3.4 Graph 2 below highlights the agency performance from April 22. The Trust has spend £3.5m on agency in to the end of July against a plan of £3.6m. 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: Monthly Agency Performance



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 July against the pre-COVID staffing levels (Dec 19), 24 months ago, 12 months ago, March 24 and last month.

Total wte have reduced from last month by 65, with a reduction in substantive staff of 35 and agency staff of 30 with no change in bank staffing overall. The trust annual workforce plan identifies a reduction of over 450 wte in 24/25.

Table 2: Whole Time Equivilient (WTE) movements

	Dec-19	Mar-24	Apr-24	Jun-24	Jul-24	Change since Dec 19	% Change	Change Since March 24	% Change	Change since last Month
COMMUNITY CARE GROUP	2,491	3,026	3,040	3,017	3,002	510	20%	(24)	-1%	(15)
INPATIENT CARE GROUP	1,538	1,979	1,990	1,991	1,962	425	28%	(16)	-1%	(28)
SPECIALIST CARE GROUP	1,809	1,912	1,920	1,871	1,857	48	3%	(55)	-3%	(15)
LOCALITY BASED MGT	34	50	0	0	0	(34)		(50)		0
CLINICAL SUPPORT	336	479	480	476	473	137	41%	(6)	-1%	(3)
	6,209	7,445	7,430	7,356	7,295	1,086	17%	(150)	-2%	(61)
CORPORATE & OTHER	1,159	1,340	1,335	1,324	1,320	161	14%	(20)	-1%	(4)
	7,367	8,785	8,765	8,680	8,615	1,247	17%	(170)	-2%	(65)

4. Cash

Table 3: Year to Date (YTD) Cash performance

	Year To Date		
	Plan (£m)	Actual (£m)	Variance/ Rating (£m)
Cash	23.4	30.2	(6.8)

4.1 Cash balances at the end of July are higher than planned. The Trust cash balances have reduced by £0.9m since last month.

4.2 The Trust is ahead of plan for I&E and has an underspend on the capital programme which is currently supporting cash balances being better than planned.

5. Capital & Asset Sales

5.1 The Trust capital spend at the end of Month 4 is £1.6m lower than planned.

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

5.4 The Trust is currently reviewing capital forecasts to identify any opportunities to mitigate the £2.4m risk associated with the CAV site move.

Table 4: YTD Capital Position

	Year To Date		
	Plan (£m)	**Actual (£m)**	**Variance/ Rating (£m)**
Capital Spend	4.6	3.0	(1.6)
Asset Sales	0.0	0.0	(0.0)

6. Recommendations

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

6. STRATEGIC AMBITION 5 ? WORKING FOR, AND WITH OUR COMMUNITIES

Darren Best, Chair

6.1 CHARITABLE FUNDS COMMITTEE

Vikas Kumar, Committee Chair

REFERENCES

Only PDFs are attached

6.1 Charitable Funds Committee Assurance Report September DRAFT.pdf

Board Committee Assurance Report
Council of Governors General Meeting
Thursday 28th November 2024

Name of Board Committee	**Charitable Funds Committee**
Date of Committee meeting held	31 July 2024
Agenda items/topics considered	See below
Date of next Committee meeting	30 October 2024

1. Key areas of focus

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. The group are in the process of developing their Terms of Reference. Colleagues from Public Health joined the Chairs meeting where the group discussed how NHS Charities can align with Corporate Social Responsibility and the Community Promise Framework addressing health inequalities.

The Committee are currently exploring options for a Patron for the SHINE Fund.

Time has been allocated at October meeting to explore long-term objectives and how these will align to the Trust's Equality, Diversity and Inclusion and health inequalities strategic ambitions as well as reviewing investment in community services, our fundraising strategy to allocate larger sums of money whilst keeping service users and carers voice at the forefront and will also be working closely with Staff Networks.

The Committee received an update on the expenditure log, and fund balances including the Trust's general 'Shine' Fund. There has been one new fund open in the period relating to the Hadrian Ward at Carleton Clinic. There have been 9 applications to withdraw from specific funds and 10 SHINE fund applications during the period.

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

2.1 Charity accounts update

The Committee received an update on the expenditure log, and fund balances including the Trust's general 'Shine' Fund. There has been one new fund open in the period relating to the Hadrian Ward at Carleton Clinic. There have been 9 applications to withdraw from specific funds and 10 SHINE fund applications during the period.

2.2 Charity resource and support

It should be recognised that the Charity activity, awareness, and fundraising activities has increase significantly 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 work over the last 12 months to raise the profile of the charity has also increased linkages between the charity and other activity / key developments.

NHS Charities Together funding for the Marketing Officer post ended on 31st July 2024 and recognising the ability to deliver on the Charity strategic objectives would be adversely impacted by the loss of the post, the Committee approve the proposal to fund the Marketing Officer post recurrently from the SHINE fund for a further 12 months.

3. Key challenges now and in the medium term

3.1 Funding externally

The key challenge for the Trust Charity is to review potential plans to fund externally as currently SHINE find only supports the Trust's service users and carers. At the October meeting the original trustee document dated 2017 will be reviewed to help understand if the Charity can include funding externally.

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

Time has been allocated at October meeting to explore long-term objectives and how these will align to the Trust's Equality, Diversity and Inclusion and health inequalities strategic ambitions as well as reviewing investment in community services, our fundraising strategy to allocate larger sums of money whilst keeping service users and carers voice at the forefront and will also be working closely with Staff Networks.

4.2 Example of the impact the charity can have…

The Committee received an update of the Cycle Hub at St George's Park who were successful in their bid and now have 10 mountain bikes, 2 smaller bikes, 2 electric bikes and 1 trike. The electric bikes are beneficial for those with additional access needs. Following on from the bikes the site now has a Cycle Hub which is a designated space for our service users to keep active. There are sessions on a Monday and a Friday held by both the Exercise Therapy Team and Occupational Therapists. This involves using the Hub as well as riding on designated cycle routes in the surrounding area. This gives our service users a sense of freedom and change of environment. There are plans to move forward to ride in other areas such as Newcastle. There are hopes to establish a similar set up at St Nicholas Hospital and Hopewood Park. It will also be beneficial for Cumbria to have a Hub and the Exercise Team in Cumbria which is currently being reviewed.

The work over the last 12 months to raise the profile the charity has also increased linkages between the charity and other activity / key developments. This includes the new Woodwork Shop at Sycamore opening 31 August 2024 will donate proceeds to the Shine fund. All self-help guide sales now include a 5% donation to the Shine Fund (we have already confirmed income of £75k in two months from the sale of self-help guides – 5% of which will go to Shine), New Shine visuals across entrances at all Trust sites.
The Charity has also been contacted by two external donors in recent months who wish to leave legacy donations. The value of these is pending.

Future plans for the Charity include:

- Establishment of a Volunteer Fundraising Committee
- Rebuild of a new website/platform.
- Increase charity income through partnerships.

- Exploring how the charity can play a role in supporting our commitment to equality, diversity, and inclusion by engaging communities to tackle mental health stigma and promote mental health wellbeing.
- Exploring how the charity can play a key role in addressing health inequalities and tackling stigma around mental health, learning disabilities and autism.
- Linking in with the Chamber of Commerce to gain support and raise the profile of mental health charity giving within the private sector.
- Meetings with Amazon via Amazon attendance at employee events
- New fundraising opportunity for staff contributions (Pennies from Heaven).

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.

Vikas Kumar **Charitable Funds Chair**	Debbie Henderson **Director of Communications and Corporate Affairs**	Kevin Scollay **Executive Director of Finance**

September 2024

7. GOVERNANCE AND REGULATORY

Darren Best, Chair

7.1 AUDIT COMMITTEE ASSURANCE REPORT

David Arthur, Committee Chair

REFERENCES

Only PDFs are attached

7.1 Audit Committee Assurance Report - Aug 24 DRAFT v2.pdf

Board Committee Assurance Report
Council of Governors General Meeting
Thursday 28th November 2024

Name of Board Committee	**Audit Committee**
Date of Committee meeting held	Wednesday 7 August 2024
Agenda items/topics considered	See Section 1
Date of next Committee meeting	Wednesday 6 November 2024

1. Key areas of focus

- Update on Duty of Candour Training progress (deferred)
- Update on Long term segregation and prolonged seclusion progress (deferred)
- Onboarding process update
- Committee assurance update – RABAC
- CQC visits (deferred)
- CQC unannounced (visit 16th July) update (deferred)
- BAF Update
- Mazars terms and conditions update
- NTWS engagement letter
- Internal Audit Progress Report (including outstanding actions exception report)
- Local Counter Fraud Progress Report

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

2.1 Duty of Candour and Long-Term Segregation updates

The Director of Nursing, Therapies and Quality Assurance was due to present and update on the progress made in these areas but was unable to due to involvement with the organisational response to potential public disorder in Newcastle on the day of the committee. This item was therefore deferred.

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 within this audit. The committee received assurance that all actions highlighted in the audit have now been completed. A new process has been introduced that supports managers to conduct ID checks on the first day of work and a DPIA has ben conducted which supports this process from an Information Governance perspective. The Integrated Performance Report now includes a quarterly update on local induction compliance quarterly. A follow up audit has been added to the list of prospective audits to ensure changes have been effective.

2.3 Limited assurance internal audit report on Mental Health Act – s136 Place of Safety

The committee received the internal audit update which included a limited assurance report which reviewed compliance with the PGN which covers compliance with s136 of the Mental Health Act. The audit also reviewed record keeping and adherence to timescales included within the PGN. The report identified a number of instances of incomplete and inconsistent record keeping which undermine the ability to demonstrate compliance with the PGN and the MHA.

2.4 Outstanding Audit Recommendations

The committee were presented with a report which highlighted that the number of audit recommendations that have no current update has increased over the last 12 months. The number of recommendations without current updates has increased to 45 in the August 24 report. Audit One briefed the committee that since the report was prepared this number had fallen to 18 following a series of reminders issued by the Director of Finance to relevant managers.

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 BAF identifies 3 key strategic risks for the organisation:

- 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.
- The ability of the Trust to meet its regulatory standards in relation to access, responsiveness and performance, resulting in a risk to the quality and safety of services.
- Failure to develop a sustainable workforce model to recruit/retain and support a workforce which meets the strategic aims of the organisation.

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

4.1 Internal Audit progress update

The Internal Audit report provided detail on five final reports issued during the period. Delivery of the 24/25 plan remains on track and has accelerated over the last quarter.

These reports were:

- Mental Health Act: s136 A place of Safety - LIMTED ASSURANCE
- Allocate: North Cumbria - REASONABLE ASSURANCE
- Bank and Agency – Pre-employment Screening and Onboarding - GOOD ASSURANCE
- Benchmarking of recommendations – BENCHMARKING REPORT
- Medical Job Planning Policy – BENCHMARKING REPORT

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.

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

- Bring back assurances for those updates that were deferred
- Escalate the issue identified in relation to Audit Recommendations with no current update to Board of Directors and Executive Directors should ensure teams are engaging appropriately to reduce this number.

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 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

Paula Breen attended the meeting as Chair of the Resources and Business Assurance 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: • 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.		

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		
• 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 Resource and Business Assurance Committee regarding the ongoing appropriateness of the risks, risk descriptors, mitigations, and actions with the recommendation that that the agency BAF risk is de-escalated to the directorate risk register and new risk introduced regarding affordability of the workforce, which the committee supported.

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.

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 8 to de-escalate the agency risk from the BAF, downgrading to the directorate risk register and instead introduce a new risk in connection to the affordability of the size of the workforce.

David Arthur
Audit Committee Chair
Date: August 2024

8. ANY OTHER BUSINESS / ITEMS FOR INFORMATION

Darren Best, Chair

8.1 QUESTIONS FROM GOVERNORS AND THE PUBLIC

Darren Best, Chair

Date of Next Meeting:
Thursday 20th March 2025, St Nicholas Hospital, Trust Board Room and via Microsoft Teams