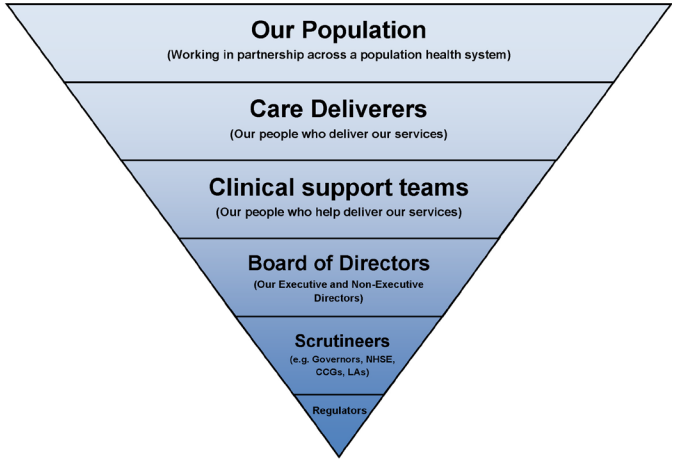
W1 Leadership	W2 Vision	W3 Culture	W4 Governance
W5 Risk	W6 Information	W7 Engagement	W8 Learning



NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

#cwpQI

Board of Directors *(held in Public)*

At 1:00pm on Wednesday 25th May 2022

Hybrid Approach – Sycamore House. Visitors via video conferencing

Ref	Title of item	Well-led theme	Format	Presented by	Time
	ASSURANCE				
22/23/01 - Meeting Governance					
22.23.01 a	Welcome, apologies and quoracy		Verbal	Chair	1:00 (5 mins)
22.23.01 b	Declarations of interest		Verbal		
22.23.01 c	Minutes of the previous meetings held 30 March 2022		Paper		
22.23.01 d	Matters arising and action schedule		Paper		
22.23.01 e	2022/23 Business cycle		Paper		
22.23.01 f	Chair's Announcements		Verbal		1:05 (10 mins)
22.23.01 g	Chief Executive's Announcements *(to include Place Based Reports)*		Verbal	Chief Executive	1:15 (15 mins)
22/23/02 - Internal reporting from committees; matters of escalation and assurance					
22.23.02 a	**Operational Committee** • Chair's report from Operational Committee – April 2022 & May 2022 • To Include the following Highlight Reports:- o Monthly Safer Staffing Report *(Feb and March 2022) – For Noting* o DPST / GDPR – *For Approval*	W4 Governance W5 Risk	Paper / Verbal	Chief Executive	1:30 (10 mins)

Ref	Title of item	Well-led theme	Format	Presented by	Time
22.23.02 b	**Quality Committee** • Chairs report - 2nd March 2022 Committee • To Include the following Highlight Reports:- ○ Mental Health Law, Research & Medicines Management and Optimisation annual reports ○ Learning From Experience report (incl Learning from Deaths) – December 2021 – March 2022. ○ Quality Improvement Report (Edition 4, 2021/22)	W4 Governance W5 Risk	Paper	Quality Committee Chair & Medical Director	1:40 (20 mins)
22.23.02 c	**Audit Committee** • Chairs Report – 10 May 2022	W4 Governance W5 Risk	Paper *(to Follow)*	Audit Committee Chair	2:00 (10 mins)
22.23.02 d	**Board Assurance Framework & Report Against Strategic Objectives**	W4 Governance W5 Risk W6 Information	Paper	Medical Director & Director of Business and Value	2:10 (10 mins)
22.23.02 e	**Guardian of Safe Working – quarterly report**	W3 Culture W4 Governance W5 Risk W7 Engagement	Paper	Medical Director	2:20 (5 mins)
Break – 2:25 – 2:35 (10 mins)					
22/23/03 – Effective Systems of Governance					
22.23.03 a	**Register of Interests (Directors and Governors)**	W4 Governance	Paper *(to note)*	Chair	2:35 (20 mins)
22.23.03 b	**Fit and Proper Persons annual assurance**	W4 Governance	Paper *(to note)*	Director of People and OD	
22.23.03 c	**Annual Provider Licence Compliance and Self-certification statements**	W4 Governance	Paper *(to note)*	Director of Business and Value	
22.23.03 d	**Register of Seals**	W4 Governance	Paper *(to note)*	Director of Business and Value	
22.23.03 e	**CEO/Chair – Division of Responsibilities**	W3 Culture W4 Governance W6 Information	Paper *(to approve)*	Chair / CEO	
22/23/04 – Strategy and Development					

Ref	Title of item	Well-led theme	Format	Presented by	Time
22.23.04 a	**Autism Strategy**	W3 Culture W7 Engagement	Paper / Presentation *(for approval)*	Associate Director LD, NDD & ABI	2:55 (30 mins)
Break – 3:25 – 3:35 (10 mins)					
22/23/05 – SO 7 – Enabling our People - Update					
22.23.05 a	**To include** • Staff Survey *(themes and improvement plan)* • Attraction Campaign • Cost of Living	W3 Culture W7 Engagement W8 Learning	Paper	Director of People and OD	3:35 (10 mins)
22/23/06 - Any other business					
22.23.06 a	Any other business		Verbal	Chair/ All	3:45 (10 mins)
22.23.06 b	Matters for referral to any other groups				
22.23.06 c	Matters impacting on policy and/ or practice				
22.23.06 d	Review risk impact of items discussed				
22.23.06 e	Three things to communicate				
22.23.06 f	Review the effectiveness of today's meeting – Board Wash Up				
CLOSE [3:55 pm]					
Date, time and venue of the next meeting: 27th July 2022. Time - TBC					

Version No	1	Date issued	

Cheshire and Wirral Partnership NHS Foundation Trust

DRAFT - Minutes of Board of Directors Meeting – held in Public

At 1:30pm on Wednesday 30th March 2022
Via Video Conferencing

Present	Sheena Cumiskey	Chief Executive Officer
	Isla Wilson	Chair
	Farhad Ahmed	Non-Executive Director
	Andrea Campbell	Non-Executive Director
	Elizabeth Harrison	Non-Executive Director
	Dr Faouzi Alam	Joint Medical Director, Effectiveness, Medical Education and Medical Workforce & Caldicott Guardian
	Suzanne Edwards	Director of Operations
	Gary Flockhart	Director of Nursing, Therapies and Patient Partnership
	David Harris	Director of People and Organisational Development
	Dr Anushta Sivananthan	Joint Medical Director, Quality, Compliance and Assurance
	Andy Styring	Director of Partnerships and Strategy
In attendance	Suzanne Christopher	Head of Corporate Affairs
	Laura Elliott	Corporate Affairs Manager
	Philip Makin	Equality and Diversity Coordinator (for item 21/22/29a)
	Fiona Pender	Strategic Clinical Director - CYPF Care Group (for item 21/22/28b)
	Cathy Walsh	Associate Director of Patient and Carer Experience (for item 21/22/29a)
	Members of the Public:	
	Rod Thomson	Incoming Non-Executive Director
	Tim Seabrooke	Governor
	Amanda Risino	Managing Director and Deputy CEO, Health Innovation England
Apologies	Katherine Wright	Associate Director of Communications, Engagement and Corporate Affairs
	Rebecca Burke Sharples	Senior Independent Director
	Edward Jenner	Non-Executive Director
	Tim Welch	Director of Business and Value

Ref	Title of item	Action
	Meeting governance	
21/22/27a	**Welcome, apologies and quoracy** The Chair welcomed all to the meeting. Apologies were noted as above. The meeting was confirmed as quorate. Members of the public were also welcomed to the meeting, as above.	
21/22/27b	**Declarations of interest** There were no declarations of interest.	

Ref	Title of item	Action
21/22/27c	**Minutes of the previous meeting held 24th November 2021** The minutes of the meeting held on the 24th November 2021 were reviewed and **approved**.	
21/22/27d	**Matters Arising and Action Points:** D Harris updated on the recruitment campaign, its effectiveness and analysis and hoped to share an attraction campaign shortly. I Wilson confirmed that completion dates would be reviewed and added to the actions.	D Harris S Christopher/L Elliott
21/22/27e	**2021/22 Business Cycle:** **2022/23 Business Cycle:** The business cycle for 2021/22 was **noted**. The business cycle for 2022/23 was **approved.**	
21/22/27f	**Chair's Announcements** I Wilson made announcements to include: • **Social Value Award** - CWP gained the Cheshire and Merseyside Social Value Award, which aimed to support and recognise organisations which "help local people and communities live valued and fulfilled lives and improve the place that we live." It highlights local organisations rooted in their respective communities and whose approach focuses on reducing avoidable inequalities and improving health and wellbeing. • **Autism Awareness Week** – CWP's supporting #AutismAcceptanceWeek recently took place, with a full week of information, resources, and good news stories which can be found via Trust Twitter account, @cwpnhs. • **CANDDID Conference –** CWP held its annual CANDDID (Centre for Autism, Neurodevelopmental Disorders and Intellectual Disability) conference on Friday 18 March. This year's theme was Advances in Neurosciences and Therapeutic Interventions; experts were welcomed from both CWP and the UK and internationally. Thanks, were given to Dr Julie Brown, President of the Skills System LLC in Rhode Island, USA, Dr Samir Dalwal from the New Horizon Development Trust in Mumbai, India, as well as to everyone involved. I Wilson also highlighted that today was S Cumiskey's final Public Board meeting and took the opportunity to thank her for the incredible leadership and service given to the organisation, over the years. The Board of Directors **noted** the above updates.	
21/22/27g	**Chief Executive's Announcements** S Cumiskey introduced the item; she took the opportunity to thank the Board for its support and expressed that it had been a privilege to serve the local communities in her role as CEO. S Cumiskey also discussed the outcome of a recent service visit to Wirral CAMHS, and the pride felt in seeing such wonderful work in practice. An outline of matters discussed at Private Board was given as follows: • COVID-19 – during Private Board, the response to the challenges of COVID-19 had been addressed at length.	

Ref	Title of item	Action
	• Operational Committee – the Board had discussed progress on recruitment and the increased need and pressure on services. With regards to beds there had been discussion in response to increasing capacity whilst also enabling Transformation. • Staffing (Operational and Quality Committees) – risk and mitigation had also been discussed at length. S Cumiskey confirmed that this would continue to be closely monitored with a focus on effectiveness of mitigation and assurance through to Operational and Quality Committees. • SystmOne – the Board had discussed the next steps on implementation. • Waiting List for ADHD – an initiative had been agreed to continue to address inequalities within the list and SystmOne would enable this appropriately. This will also continue to be addressed with commissioners. • Commissioning Assurance Committee – the Board thoroughly discussed the report from the committee and considered LPC oversight. • SUI – the Board was given an update on SUIs. • Finance – the Trust was on target to achieve its financial plan for this year. The plan for 2022/2023 was considered, as was system wide financial plan. The Trust financial plan would be agreed at the following Board Meeting in April. • Imagining the Future Update – taking forward the strategy was explored and considered. The Board of Directors **noted** the summary.	
	Internal reporting from committees, matters of governance and assurance	
21/22/28a	**Operational Committee: Chair's Report of the Operational Committee held February 2022 & March 2022** S Edwards introduced the item, as per the circulated documentation, drawing attention to staffing and the commitment to safe and effective care, G Flockhart echoed S Edwards's comments on the flexibility and commitment of staff. The Board of Directors **noted** the Chair's report.	
21/22/28b	**Quality Committee: Chair's Report of the Quality Committee held 2nd March 2022** *F Pender joined the meeting at 1.55.* <u>Chair's Report:</u> A Campbell discussed the Quality Committee Chair's Report highlighting matters on Escalation – such as a request to extend the CQC's timeline for improvement actions for ADHD services and the discussion of Rosewood's continuous improvement plan and regulatory actions - as well as Assurance – inclusive of Review of the Providing High Quality Care dashboard report and Review of the Clinical Effectiveness framework 2022/25. A Campbell reported that the Trust's Autism strategy would be reviewed in May 2022, to enable further debate. <u>Effectiveness Strategy:</u> A discussion on Effectiveness Strategy followed, in which F Alam confirmed its approval at the Quality Committee. A conversation took place regarding the strategy, inclusive of matters on links to the Quality	

Ref	Title of item	Action
	Improvement Strategy, continuous improvement, and the Imagining the Future strategy. F Alam confirmed that a further paper would follow and be delivered to the Operational Committee, delivered by the Care Group. F Pender joined the meeting and discussed the framework overlaying effective care, further detail for which could be shared. The discussion came to a close with an action to review in a year. The Board of Directors **noted** the Chair's report. *F Pender left the meeting at 2.07.*	F Alam A Campbell
21/22/28c	**Audit Committee: Minutes from the meetings held 8th March 2022** E Harrison introduced the item as per the circulated documentation. She discussed the Escalations – Board Assurance Framework, and SystmOne Audit– in addition to matters of Assurance – Internal Audit, External Audit, Anti-Fraud Progress Report and Audit Progress and Future Plans. A Sivananthan added that the SystmOne Improvement report would go to the Operational Committee in April and thereafter to the Audit Committee. The Board of Directors **noted** the update.	
21/22/28d	**Board Assurance Framework & Report Against Strategic Objectives** <u>Board Assurance Framework:</u> A Sivananthan introduced discussion, outlining the process of review, from the Board, Quality Committee and Operational Committee. Following the BAF's review in March by both the Quality and Operational Committees, new risks/risks in scope were addressed, alongside current risks, with a request to approve the archived risk. A conversation followed on risk and staffing and the appropriate mitigations, which were believed to be having an appropriate effect, but the risk itself remained under constant scrutiny. F Alam declared an interest in Risk 5 (in his work for the HSE). He likewise queried when the risk would be further addressed; it was highlighted that the risk itself pertained to the practice of evacuation which was regularly monitored in the Operational Committee; the mitigation was making effective progress. This was further confirmed by the setting of trajectories through online training and once all was in place, the risk would be revisited. Fire drills however, remained in place. The Board of Directors **noted** and **approved** the process outlined, and the progress made to date. <u>Report Against Strategic Objectives:</u> S Cumiskey began discussion, pointing out that the metrics for the Strategic Objectives would be changing following the April workshop, therefore that discussed today was based around previous Strategic Objectives. With this in mind, the highlights of the discussion included: • Bed occupancy. • SystmOne challenges. • High vacancy rates. • Reducing appraisal rates.	

Ref	Title of item	Action
	A discussion followed in which these matters were debated. With regards to appraisal rates in particular, the reduction had been anticipated due to staffing and redeployment; but there was ongoing work to improve supervision. Similarly, vacancies and staff turnover were now heading in the right direction, but sickness was still somewhat escalated. With regards to the cost of living, risk was being scoped regionally, nationally and locally; it was requested that this topic return to the next Board meeting. A question was raised about the Friends and Family test and it was clarified that the reporting would require aligning with new systems. The Board **noted** the report.	D Harris
21/22/28e	**Equality, Diversity and Inclusion Policy and Human Rights Policy** G Flockhart discussed the policy (GR10), which provided the Trust's overall framework to meet its commitment to promoting equality, diversity, inclusion, and human rights. The document underpinned the Trust's strategic objectives to be a model employer and to have a caring, competent, and motivated workforce. It illustrated the commitment to provide an inclusive culture, which treats all individuals with dignity and respect. A small number of minor updates had been made to the paper and feedback had been accepted from partners who felt the policy to be a comprehensive document. A minor error was noted on the date of the front cover, which required updating. It was also explored that as part of anti-discrimination, it would be appropriate to consider amending the language within the document next time. Although this aligned to the current language within the legislation, it was suggested that this now required updating. The Board of Directors otherwise **approved** the policy.	G Flockhart
21/22/28f	**Modern Slavery Act Statement** D Harris discussed the item, which provided a revised statement on Modern Slavery for publication on the Trust's website, setting out the Trust's approach to minimising the potential for modern slavery and human trafficking. Amendments were made to the geographical area covered, the number of staff and locations, and an update to the turnover figure. A brief discussion followed in which it was highlighted that the LPC had formed since the policy had been refreshed, alongside other commissioner arrangements. It was also suggested that it would be appropriate to consider amending the language within the document next time, to enable more inclusive language. The Board of Directors otherwise **approved** the statement.	
Break 2.36 – 2.46		
21/22/28g	**Publication of the Trust Strategy** D Harris began discussion regarding the Trust Strategy, its purpose being to provide the Board with the final version of the high-level Strategic Intent document approved at Private Board in December 2021; it was now being brought to Public Board for noting.	

Ref	Title of item	Action
	D Harris took the opportunity to thank Katherine Wright, David Williamson and Jodie D'Enrico for their work on the document, and likewise confirmed that an easy read version and summary document would be made available. A glossary was also being devised. The Board **noted** the contents of the CWP Strategic Intent Document, the plans to publish a summary plain English version and an easy-read version of the document by the end of April 2022 and recognised that work was underway to address the range of colleague feedback.	
	In Depth Discussion – Reducing Inequalities	
21/22/29a	**Prevention Pledge Update** *C Walsh and P Makin joined the meeting at 2.56.* G Flockhart introduced the item, and handed over to C Walsh and P Makin, who gave a presentation outlining the Five Key Strategic Priorities (Restore Services Inclusively, Mitigate against digital exclusion, Ensure datasets are timely and complete, Accelerate Preventative Programmes and Leadership & Accountability), alongside the Core 20Plus Population Groups (Core20 (most deprived quintile), plus (ethnic minorities, etc locally determined using PHM data) and the five clinical focus areas (to include CVD, Cancer, Respiratory Disease, Maternity and Mental Health Including CYP). The presentation was concluded with an analysis of the situation so far – Engagement (Imagining the Future), Board Seminars and Networks (People at CWP). A discussion followed, investigating the actuality of inequality, poverty and income, the function of anchor institutions and the need to consider effective consideration and action to address Left Behind Neighbourhoods. The resulting actions were as follows: • Utilise appropriate data and ensure to hold ourselves to account. • Ascertain how all communities can get access to the right services through, for example the use of roving clinics. • Coming alongside our communities to better understand how our services can even better meet their needs. • Consider rewording the phrasing of EDI and Green Plan within the SBAR. • C Walsh to circulate a report on Left Behind Neighbourhoods. I Wilson thanked C Walsh and P Makin for their presentation. *C Walsh and P Makin left the meeting at 3.44.*	
	Closing Business	
21/22/30a	**Any other business** No other business was raised.	
21/22/30b	**Matters for referral to any other groups** None.	
21/22/30c	**Matters impacting on policy and/ or practice** None.	
21/22/30d	**Review Risk Impact of Items Discussed** This was discussed in Private Board.	
21/22/30e	**Three Things to Communicate:** None.	
21/22/30f	**Review of Meeting Performance:** Questions and comments were invited from the attending public. R Thomson thanked the Board for the interesting conversation on item 21/22/29a, with which A Risino agreed.	

Ref	Title of item	Action
		Meeting closed at 3.47.
Date, time and venue of the next meeting:		
25th May 2022 Time - TBC		

Cheshire and Wirral Partnership NHS Foundation Trust
Open Actions Action Schedule

		Board of Directors: Open meeting action schedule: May 2022			

Meeting date	Group/ Ref	Action	By Whom	By when	Status
26.01.2022	21.22.23 d	**Matters arising and action points** Green Plan - A further discussion will be scheduled for Board members to focus on the sustainability agenda against the CWP and Place agendas.	CA		Propose Close - Being considered against Board Workshop Programme for 22/23.
26.01.2022	21.22.23 f	**Chair's announcements** Anti-Discrimination Declaration. The results of the engagement will be shared at a future Board meeting to consider next steps.	GF		
26.01.2022	21.22.24 d	**Board Assurance Framework & Report Against Strategic Objectives** Additional time for Board members to consider people issues would be considered (possible Board workshop).	CA		
26.01.2022	21.22.24 d	**Board Assurance Framework & Report Against Strategic Objectives** SystmOne and Current Data Gaps - Data to be available for the next report. If not, timescales for this to be established to be reported to the Board of Directors and assurance that the metrics are supporting the strategic objectives.	Asiv	May 2022	
26.01.2022	21.22.25 a	**Freedom to Speak Up – Six Monthly Report** Freedom to Speak Up requirements to be considered against System Working arrangements. Andy Styring to raise at the Partnership Board.	ASty / GF	July 2022	
26.01.2022	21.22.25 a	**Freedom to Speak Up – Six Monthly Report** Consideration of increased diversity across Freedom to Speak Up Guardians.	GF	July 2022	
30.03.2022	21/22/28b	**Quality Committee: Chair's Report of the Quality Committee held 2nd March 2022 - Effectiveness Strategy** F Alam confirmed that the Effectiveness Strategy had been approved at the Quality Committee. F Alam also confirmed that a further paper would follow and be delivered to the Operational Committee, delivered by the Care Group.	FA	July 2022	
30.03.2022	21/22/28b	**Quality Committee: Chair's Report of the Quality Committee held 2nd March 2022 - Effectiveness Strategy** A Campbell confirmed that this would be reviewed in a year.	AC	March 2023	Propsoe close - added to business cycle
30.03.2022	21/22/28d	**Board Assurance Framework & Report Against Strategic Objectives - Report Against Strategic Objectives:** With regards to the cost of living, risk was being scoped regionally, nationally and locally; it was requested that this topic return to the next Board meeting.	DH	May 2022	Propose Close - On Agenda and June workshop
30.03.2022	21/22/28e	**Equality, Diversity and Inclusion Policy and Human Rights Policy** It was also explored that as part of anti-discrimination, it would be appropriate to consider amending the language within the document next time. Although this aligned to the current language within the legislation, it was suggested that this now required updating.	GF	May 2023	Propose Close - GF to take away for next annual report

Cheshire and Wirral Partnership
NHS Foundation Trust

Board of Directors
Business Cycle 2022/23
(Meeting held in Public)

	Item	Lead	Scope	Well-led domain	May	Jul	Sep	Nov	Jan	Mar
Meeting Governance	Chair and CEO report and Announcements	Chair / CEO	To update on development not on agenda	W1 W6	✓	✓	✓	✓	✓	✓
	Review minutes of the previous meeting	Chair	To approve minutes	W4 W5	✓	✓	✓	✓	✓	✓
	Quality Committee Chairs Report To include:- *1. Annual Safeguarding report* *2. Annual Medicines Report* *3. Annual Research Report* *4. Six monthly Infection, Prevention and Control Report* *5. DIPC Annual report (inc. PLACE).* *6. CQC Patient survey and response* *7. Learning from Experience Report, incl. learning from deaths* *8. LEVEN Report* *9. Effectiveness Strategy – reviewed March 22 – to be reviewed in 12 months – March* ***All above reports to be accompanied by a Highlight report.***	QC Chair	Review Chair's Report and any matters for note/ escalation and provide assurance to the Board of Directors	W4 W5	✓ 7	✓ 1	✓ 5&7&8	✓ 2&6	✓ 4&3&7	✓ 8 &9
	Audit Committee Chairs Report 1. *Bribery Act – Board Statement – annual review* 2. *Modern Slavery Act – Board Statement*	AC Chair	Review Chair's Report and any matters for note/ escalation	W4 W5	✓	✓	✓	✓	✓ 1 2	✓

	Operational Committee Chairs Report To include:- *1. Monthly safer staffing* *2. Health and Safety and Fire annual report (and LINK Certification)* *3. PLACE* *4. DPST/GDPR* *5. Capital Plan* ***All above reports to be accompanied by a Highlight report.***	OC Chair	Review Chair's Report and any matters for note/ escalation	W4 W5	✓ 1&4	✓ 1&2	✓ 1&3	✓ 1	✓ 1&5	✓ 1
	Place Based reports / updates including ICP Board/s (minutes)	CEO	To note system developments	W6	✓	✓	✓	✓	✓	✓
	BOD draft Business Cycle 2023/2024	Chair / CEO	Ensure matters reported to the Board in a timely fashion	W4						✓
	Review risk impacts of items	Chair / CEO	Identify any new risk impacts	W4	✓	✓	✓	✓	✓	✓
	Strategic Objectives	All	In-depth discussion in regards to individual strategic objectives.	W1 W2 W4 W5	SO7 Staff survey and EDI focus	SO6	SO8	SO4	SO1	SO2 SO3
	Board Assurance Framework / Performance report against strategic objectives	Medical Director (ASiv) / Director of Business and Value	Review performance and risk – and note for assurance	W4 W5 W6	✓	✓	✓	✓	✓	✓
Effective Systems of Governance	Annual Provider Licence Compliance and self-certification statements	Director of Business and Value	Review and note for assurance/ regulatory requirement	W4	✓					

	Annual Report, Accounts and Quality Account	Director of Business and Value	Statutory requirement	W4 W6	✓					
	CQC Statement of Purpose	Medical Director (ASiv)	Regulatory requirement	W4	✓					
	Corporate Governance Manual	Director of Business and Value	Best practice annual review	W4	✓					
	Integrated Governance Framework – annual review	Medical Director (ASiv)	Best practice annual review	W4	✓					
	CEO/Chair Division of Responsibilities	Chair / CEO	Governance requirement	W3 W4 W6	✓					
	Register of Interests (Directors and Governors)	Chair	Governance requirement	W4	✓					
	Fit and Proper Persons annual assurance	Director of People and OD	Regulatory and Licence requirement	W4	✓					
	Register of Sealings	Director of Business and Value	Governance requirement	W4	✓					
	Terms of Reference and effectiveness reviews: • Quality Committee • Audit Committee • Operational Committee	Committee Chairs	Governance requirement	W4	✓	✓				
Enabling our people	Equality and Diversity responsibilities inc. WRES, WDES and Staff Networks. – including Annual Equality, Diversity, and Inclusion Monitoring Report.	Director Nursing	Review and note for assurance	W7			✓ (Annual Report)			✓ (Incl.EDI & HR Policy approval)

	Freedom to speak up six monthly report	Director of Nursing	Review and note for assurance	W3 W5 W7 W8		✓			✓	
	Medical Appraisal Annual Report and annual declaration of Medical revalidation	Medical Director (FA)	Review and note for assurance	W4 W5		✓				
	Guardian of Safe Working quarterly report	Medical Director (FA)	Review and note for assurance	W4 W5 W3 W7	✓	✓		✓	✓	
	People and OD strategy delivery	Director of People and OD	Review and note for assurance	W2 W3 W7		✓		✓		✓
	NHS Staff Survey (themes and improvement plan)	Director of People and OD	Review and note for assurance	W3 W7	✓					
	Digital Strategy	Director of Business and Value	Review and note for assurance	W2 W3 W8		✓				✓
	Estates Strategy	Director of Operations	Review and note for assurance	W2 W3 W8		✓				✓
	Research Strategy	Medical Director (FA)	Review and note for assurance	W2 W3 W8		✓				✓
	Communication and Engagement Strategy	CEO	Review and note for assurance	W2 W3 W8		✓				✓
Quality of Care	Quality Improvement report/ strategy implementation	Medical Director (ASiv)	Review and note for assurance	W2 W3 W8	✓		✓		✓	

W1 Leadership	W2 Vision	W3 Culture	W4 Governance
W5 Risk	W6 Information	W7 Engagement	W8 Learning

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STANDARDISED CHAIR'S REPORT

CHAIR'S REPORT DETAILS	
Name of meeting:	Operational Committee
Chair of meeting:	Tim Welch
Date of meeting:	19/04/2022

ESCALATION

Quality, clinical, care, other risks identified that require escalation:

Continuous Improvement Performance Report:
It was observed that as many staff had completed SystmOne training prior to the Go Live; there was now a need to refresh training to support full system utilisation.

It was also noted that the transfer of data files was being worked though and issues identified during the implementation phase were now being addressed.

COVID Transmission Rates:
The increase in COVID transmission within communities was noted and the impact on various Care Groups was also acknowledged, particularly that affecting Neighbourhoods and the NMABs and home oximetry services, in addition to Specialist Mental Health and annual dementia reviews. Care Groups continue to monitor the situation and escalate vis Operational Committee.

Delayed Transfers of Care:
DTOCs were acknowledged and discussed, and the roles of the Local Authority and third sector partners were duly explored, with recommendation for further liaison.

72 Hour Follow Up:
The 72 hour follow up period was discussed, particularly the need to ensure appropriate delivery and that the targets met patient safety requirements; the improvement in these rates particularly with regards to the Specialist Mental Health Care Group, was duly noted.

ASSURANCE

On which matters did the meeting make a decision, e.g. what did it approve?

Recommendations were made for the Internal Audit Follow Up Report, Assurance Framework Review, and Risk Management Advisory Review, to be discussed at the Audit Committee.

Other matters discussed that provide assurance

Financial Update:
A £71k surplus was expected for the year, which also took into account technical adjustments to the system.

Children, Young People and Families
The Care Group reported an improvement for KPIs, particularly those with regards to clinical supervision, staffing and wait times.

Staffing:
Staffing challenges were noted across the Care Groups, in addition to ongoing resilience under mitigating circumstances. There were various discussions around possible solutions and support was offered from People and OD, HR and Education.

IMPROVEMENT	Developments/ achievements
	The outcome for the Risk Management Advisory Review was very positive. CYP Waiting Times were noted to have improved and shared learning around this was recommended. The Committee welcomed Gemma Ratcliffe, Allied Health Professional Lead.

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Ward Daily Staffing Levels February 2022
Agenda ref. number:	22.23.02 a
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	25/05/2022
Presented by:	G Flockhart

Which strategic objectives this report provides information about:	
Improving Care, Health and Wellbeing	Yes
Working within Communities	No
Working in Partnership	No
Delivering, Planning and Commissioning Services	Yes
Making Best Value	Yes
Reducing Inequalities	Yes
Enabling our People	Yes
Improving and Innovating	Yes

Which NHSI Single Oversight Framework themes this report reflects:	
Quality	Yes
Finance and use of resources	Yes
Operational performance	Yes
Strategic change	No
Leadership and improvement capability	No

CWP Quality Framework:		
Patient Safety	Safe	Yes
Clinical Effectiveness	Effective	Yes
	Affordable	Yes
	Sustainable	Yes
Patient Experience	Acceptable	Yes
	Accessible	Yes

http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No
All strategic risks	

Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	Yes/ No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

This report details the ward daily staffing levels during the month of February 2022 following the submission of the planned and actual hours of both registered nurses (RN) and clinical support workers (CSWs) to UNIFY (Appendix 1). The themes arising within these monthly submissions identify the actions that are being taken to try to ensure patient safety is being maintained in the continued context of the impact of COVID-19.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The monthly reporting of daily staffing levels is a requirement of NHS England/Improvement and the National Quality Board in order to appraise the Board and the public of staffing levels within inpatient units.
The recommendations made within the latest six monthly reports are being taken forward in line with the ongoing COVID-19 response and continued development of the Transformation plans and new models of care being implemented across all care groups that provide inpatient services.

Assessment – *analysis and considerations of the options and risks*

During February 2022 the trust achieved average staffing levels of 93.2% (3.5% decrease on last month) for registered nurses and 96.5% (1.6% increase) for clinical support workers on day shifts and 95.6% (maintain) and 101.5% (1.8% increase) respectively on night shifts. Therefore overall slightly better that January 2022 and contributing to an improved position over the past 2 consecutive months, December & January.

All inpatient areas continue to experience some level of challenge to ensure minimum safe staffing levels and staff continue to be redeployed across clinical areas to support this. The impact of the Omicron Covid continues to place additional demands and staffing pressures. Other contributory factors included registered nurse vacancies and also the requirement to redeploy staff to other wards as they have had no registered nurse cover. Covid and vacancies contributed to these issues. Indigo Ward has experienced a reduction in filling rates for both Registered Nurses (67.6% days and for night shifts 76.5%. Mulberry (82.4%) and Coral (81.4%) experienced below 85% fill rates for registered nurses for day shifts only. Both Beech and Rosewood experienced difficulties covering for registered nurses on night duty and had a 71.4% and 84% fill rate respectively. These risks were mitigated by combining Indigo and Coral when required or by agreeing a reduction in bed numbers or in some case for adult wards agreeing not to admit patients to those clinical areas at that time.

Willow PICU had 80.5% fill rate for registered staff on day duty and a clinical support worker fill rate of 116.2%. Conversely, Greenways had a lower fill rate for clinical support workers (74.2% days and 81.4% nights), and they have covered the night deficit with registered staff at 105.4%. In order to maintain safety if additional registered nurses were not available to fulfil the shortfall in staff numbers, then additional support workers were rostered, (hence over 100% fill rates). If additional registered nurses were required for a specific area, then these would be requested and made available via the bleep holder and would be redeployed where necessary.

Many RN vacancies exist, especially with the development of new community teams. Greenways have some new starters who are CSW's so it is anticipated this will have an impact in May.

Note: Only full shifts are covered within the percentage rates, where wards are supported for less than this, this is not captured in the return. For example, if the matron spends 2 hours on the ward this is not reflected in the return, nor are the hours the multi-disciplinary team who provide care to support the wards.

Appendix 1 details the fill rates for all inpatient services.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors are asked to note the report.

Who has approved this report for receipt at the above meeting?	Gary Flockhart, Director of Nursing, Therapies and Patient Partnerships
Contributing authors:	

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued

Appendices provided for reference and to give supporting/ contextual information:

Appendix No.	Appendix title
1	Ward Daily Staffing fill rates February 2022

Appendix 1

NHS
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		Day				Night				Fill Rate			
		Registered midmives/nurses		Care Staff		Registered midmives/nurses		Care Staff		Day		Night	
	Ward	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
East	Alderley Unit	911	847.25	1329	1261.5	596.5	555	674.5	681.5	93.0%	94.9%	93.0%	101.0%
	Greenways A&T	1074.25	1007	1598.5	1186.75	644	678.5	1288	1048.25	93.7%	74.2%	105.4%	81.4%
	Mulberry	1450	1195.5	1817	1694	644	607	1932	1805.5	82.4%	93.2%	99.8%	98.3%
	Silk	1222.5	1218.9	2062	1961.5	644	608.5	1966.5	1920.5	99.7%	95.1%	94.3%	93.5%
	Saddlebridge	927.5	810.5	1374.5	1374.5	621	621	663	663	87.4%	100.0%	94.5%	97.7%
Wirral	Brackendale	939.5	969.5	1343	1455	713	711.75	862.5	971.5	103.2%	108.3%	100.0%	100.0%
	Brooklands	834	831	1750.5	1713	675.5	710	1474.5	1512.5	99.6%	97.9%	99.8%	112.6%
	Lakefield	799.5	803.5	1138.5	1052.5	524.5	537.5	908.5	831	100.5%	92.4%	105.1%	102.6%
	Meadowbank	880	860.75	1563	1483	517.5	522	1081	1110	97.8%	94.9%	102.5%	91.5%
	Riverwood	868	887.5	719.5	696	506	488.5	655.5	676.5	102.2%	96.7%	100.9%	102.7%
	Oaktrees	1040.5	1019	1131	1133.5	540.5	507	363	409.5	97.9%	100.2%	96.5%	103.2%
West	Willow PICU	840	676	966	1122.5	644	460	644	954.5	80.5%	116.2%	93.8%	112.8%
	Beech	967	967	1093	1058	372	372	886	874.5	100.0%	96.8%	71.4%	148.2%
	Cherry	936	849.5	1212	1179	345	345	1317	1270.5	90.8%	97.3%	100.0%	98.7%
	Coral	391.5	318.5	540.5	548	253	165	506	517.5	81.4%	93.2%	100.0%	96.5%
	Eastway A&T	1309.2	1197.8	905.9	844	538.3	514.9	1088.3	1076.6	91.5%	93.2%	95.7%	98.9%
	Indigo	1735	1173.5	2541.5	2196.5	1035	792	2392	2168.5	67.6%	86.4%	76.5%	90.7%
	Juniper	821	813.5	1188.5	1132	448	442	1003.5	967	99.1%	95.2%	98.7%	96.4%
	Rosewood Unit	823.5	754.5	1253.5	1259	575	483	1058	1115.5	91.6%	100.4%	84.0%	105.4%
	Maple Unit	858.5	887.5	1178	1109.5	460	459	678.5	667	103.4%	103.4%	99.8%	98.3%
	Trustwide	19628.45	18088.20	26705.40	25459.75	11296.80	10579.65	21442.30	21241.35	93.2%	96.5%	95.6%	101.5%

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Ward Daily Staffing Levels March 2022
Agenda ref. number:	22.23.20 a
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	25/05/2022
Presented by:	G Flockhart

Which strategic objectives this report provides information about:	
Improving Care, Health and Wellbeing	Yes
Working within Communities	No
Working in Partnership	No
Delivering, Planning and Commissioning Services	Yes
Making Best Value	Yes
Reducing Inequalities	Yes
Enabling our People	Yes
Improving and Innovating	Yes

Which NHSI Single Oversight Framework themes this report reflects:	
Quality	Yes
Finance and use of resources	Yes
Operational performance	Yes
Strategic change	No
Leadership and improvement capability	No

CWP Quality Framework:		
Patient Safety	Safe	Yes
Clinical Effectiveness	Effective	Yes
	Affordable	Yes
	Sustainable	Yes
Patient Experience	Acceptable	Yes
	Accessible	Yes

http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No
All strategic risks	

Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	Yes/ No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

This report details the ward daily staffing levels during the month of February 2022 following the submission of the planned and actual hours of both registered nurses (RN) and clinical support workers (CSWs) to UNIFY (Appendix 1). The themes arising within these monthly submissions identify the actions that are being taken to try to ensure patient safety is being maintained in the continued context of the impact of COVID-19.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The monthly reporting of daily staffing levels is a requirement of NHS England/Improvement and the National Quality Board in order to appraise the Board and the public of staffing levels within inpatient units.
The recommendations made within the latest six monthly reports are being taken forward in line with the ongoing COVID-19 response and continued development of the Transformation plans and new models of care being implemented across all care groups that provide inpatient services.

Assessment – *analysis and considerations of the options and risks*

During March 2022, the trust achieved average staffing levels of 92.1% for registered nurses (a slight reduction of 1.1% on last month) and 98.1% for clinical support workers (an increase of 1.1%) on day shifts and 92.8% (2.8% reduction) and 97.9% (3.6% reduction) respectively on night shifts. So a slight decline in the month on month improvements that had been noted in January and February.

All inpatient areas continue to experience some level of challenge to ensure minimum safe staffing and Covid continues to place additional demands and staffing pressures.

Other contributory factors included registered nurse vacancies and some long-term sick leave. In addition maternity and paternity leave has also been a factor. The staffing fill rate details for March identify a number of wards dropping below the 85% fill rate, Greenways and Mulberry in East Cheshire and the remaining areas being Bowmere and Ancora in West Cheshire.

Gaps in staffing continue to be covered via bank in the first instance, then overtime and finally agency staff. Shift leaders also take the action to reallocate staff to specific areas as and when required to ensure safe care is maintained. For example if registered nurses were required for a specific area, then these would be requested and made available via the bleep holder and would be redeployed where necessary.

Many staff vacancies have arisen as the development of new community services and teams, as staff take opportunities to gain skills in other clinical areas. Greenways have recruited to some CSW vacancies; however these will only have a positive impact on the numbers in the month of May data.

Note: Only full shifts are covered within the percentage rates, where wards are supported for less than this, this is not captured in the return. For example, if the matron spends 2 hours on the ward this is not reflected in the return, nor are the hours the multi-disciplinary team who provide care to support the wards.

Appendix 1 details the fill rates for all inpatient services.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors are asked to note the report.

Who has approved this report for receipt at the above meeting?	Gary Flockhart, Director of Nursing, Therapies and Patient Partnerships
Contributing authors:	

Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued

Appendices provided for reference and to give supporting/ contextual information:	
Appendix No.	Appendix title
1	Ward Daily Staffing fill rates March 2022

NHS
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		Day				Night				Fill Rate			
		Registered midmives/nurses		Care Staff		Registered midmives/nurses		Care Staff		Day		Night	
	Ward	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
East	Alderley Unit	957	884.75	1624.85	1546.85	690	678.5	701.5	690	92.5%	95.2%	98.3%	98.4%
	Greenways A&T	1227	1064.5	1294	1262	713	678.5	1426	1129.5	86.8%	97.5%	95.2%	79.2%
	Mulberry	1389.75	1097	2031.5	1858	747.5	730	2116	1969	78.9%	91.5%	97.7%	93.1%
	Silk	1306.5	1265.5	2123.15	1928.15	851	821	2093.5	1919.5	96.9%	90.8%	96.5%	91.7%
	Saddlebridge	1038	999.3	1473	1447.3	678.5	667	736	736	96.3%	98.3%	98.3%	100.0%
Wirral	Brackendale	1091	1040.5	1691	1637.5	832	756.5	897	944	95.4%	96.8%	90.9%	105.2%
	Brooklands	985.5	973	1914	1927.25	747.5	688.5	1887.5	1915.5	98.7%	100.7%	92.1%	101.5%
	Lakefield	952	920.5	1078	1063.5	736	706.5	1024	970.5	96.7%	98.7%	96.0%	94.8%
	Meadowbank	1275.5	1257	1260	1232	536	523.5	1002	1046.5	98.5%	97.8%	97.7%	104.4%
	Riverwood	911	870	724.5	664	571	554	765	707.5	95.5%	91.6%	97.0%	92.5%
	Oaktrees	1074	1149.7	1462.5	1465.75	606	606.5	513	528.5	107.0%	100.2%	100.1%	103.0%
West	Willow PICU	943	738	1069.5	1253.5	713	391	713	931.5	78.3%	117.2%	54.8%	130.6%
	Beech	1049.5	1033.5	1117	1036.5	667.5	667.5	874	828	98.5%	92.8%	100.0%	94.7%
	Cherry	1298	1268.5	1204.5	1182	402.5	414	1380	1327.5	97.7%	98.1%	102.9%	96.2%
	Coral	1201.5	956.5	1575.5	1786	713	544.5	1426	1404	79.6%	113.4%	76.4%	98.5%
	Eastway A&T	1394.8	1257.55	1006.9	898.6	595.6	561.2	1204.1	1129.85	90.2%	89.2%	94.2%	93.8%
	Indigo	1227	851.5	1495	1489	713	544.5	1426	1386	69.4%	99.6%	76.4%	97.2%
	Juniper	1192.5	1183	1247.5	1236	758	758	807	807	99.2%	99.1%	100.0%	100.0%
	Rosewood Unit	816.5	740	1426	1420.5	713	667	1069.5	885.5	90.6%	99.6%	93.5%	82.8%
	Maple Unit	992	942.5	1172.5	1107	529	518.5	711	718.5	95.0%	94.4%	98.0%	101.1%
	Trustwide	22322.05	20492.80	27990.90	27441.40	13513.10	12476.70	22772.10	21974.35	92.1%	98.1%	92.8%	97.9%

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Annual Information Governance Board Report 2021/22
Agenda ref. number:	22.23.02 a
Report to (meeting):	Board of Directors
Action required:	Discussion and approval
Date of meeting:	25/05/2022
Presented by:	Dr Faouzi Alam, Medical Director, Effectiveness, Medical Education and Medical Workforce

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes

Which NHSI Single Oversight Framework themes this report reflects:		CWP Quality Framework:		
Quality	Yes	Patient Safety	Safe	Yes
Finance and use of resources	Yes	Clinical Effectiveness	Effective	Yes
Operational performance	Yes		Affordable	Yes
Strategic change	Yes		Sustainable	Yes
Leadership and improvement capability	Yes	Patient Experience	Acceptable	Yes
			Accessible	Yes
		http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No

Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

To brief the Board of Directors on information governance resources, issues, risks and improvement plans undertaken in 2021/22, and to seek approval for the 2021/22 annual Data Security & Protection Toolkit (DSPT) submission.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The Information Governance & Data Protection Sub-Committee monitors the Data Security and Protection Toolkit (DSPT) action plan through audits, spot checks and review of incidents. Risks are reported to the Operational Committee. The DSPT online self-assessment tool allows organisations that process health and care data to measure their performance against the National Data Guardian's 10 Data Security Standards.

Health and care organisations that have access to NHS Patient Data and Systems are required to complete and publish a DSPT self-assessment every year against the standards. This provides assurance that they are practising good data security and they are handling personal information correctly, including maintaining the security of patient information. Publishing an annual DSTP self-assessment also helps an organisation to demonstrate their GDPR and cyber maturity, and their NHS contractual obligations.

Assessment – *analysis and considerations of the options and risks*

The 2020/21 toolkit release was delayed due the Coronavirus epidemic. The total number of mandatory evidence items was reduced from 111 to 110 and the overall total number of evidence items reduced from 149 to 142. A baseline submission was completed in February 2022 and the final submission is due by the end of June 2022. All evidence items were uploaded to the toolkit and the requirement to achieve 95% staff compliance for mandatory annual data security awareness training has been achieved. Mersey Internal Audit Agency have recently undertaken an audit of the current toolkit and an assurance level report is expected in quarter 1.

The Coronavirus pandemic (Covid-19) has continued to present many Information Governance challenges as staff worked from home and clinical staff continued to provide services. The Trust's data protection officer has continued to attend NHSx weekly briefings and has provided regular feedback to senior staff and the Information Governance & Data Protection Sub-Committee. Trust staff have received briefings in relation to safe handling of information when working remotely, the Control of Patient Information (2002) Regulation notices (COPI) and video conferencing guidelines.

The focus of the Trust's work plan for 2021/22 was:

- Work towards cyber essentials with annual penetration testing.
- Implement Wide Area Network replacement.
- Implementation of TPP SystmOne.
- Continued replacement of our end point estate.
- SharePoint migration.
- Continued migration from Microsoft Office 2010 to O365.
- Licence gap analysis.
- Identity Manager (Subject to NHS Digital Guidelines).
- Introduce standard telephony solutions.
- Scope penetration scans for the Trust infrastructure.
- Completion of the DSP Toolkit.
- Focus on waiting times data cleansing exercise and setting clear guidance for the recording of referral dates and treatment start criteria. Collaborating with care Groups to ensure understanding of waiting list management is understood.
- Improvement in the quality of data capture reporting for MHSDS, by setting internal data validation processes to highlight outliers which can be checked, and corrected where appropriate, with service prior to the submission of the monthly refresh data set. Monthly group setup to review the specific measure of Ethnicity recording, further areas will be targeted during next year.
- Data checking, validation of data and review of on-going reporting facility as per new EPR system (SystmOne).
- Review of performance framework and move to a Business Intelligence platform for cascade of performance and quality data.
- Audit review of clinical coding following move to new EPR system (SystmOne).
- Refreshing and producing new policies and procedures to ensure they are clear, concise and easily accessible to all staff.
- Requiring all staff to undertake the mandatory data security awareness training on an annual basis.
- Monitoring of compliance with Freedom of Information Act requests.
- Monitoring of compliance with Subject Access requests.
- Monitoring of Information Governance incidents.
- Scanning of approximately 58,000 paper health records to be available directly via the CWP network.
- Further development of a Caldicott training plan
- Development and implementation of monthly Trust wide `Caldicott Law or Ethics' scenario based training sessions facilitated via MS Teams
- Refreshed Information Governance staff hand book
- Strengthening Data Security & Protection Toolkit evidence.
- Monitoring of the Data Security & Protection Toolkit action plan by the Information Governance & Data Protection Sub-Committee and any variances escalated to the Operational Committee.

The focus of the Trust's work plan for 2022/23 will be to:

- Implement Wide Area Network replacement.
- Implementation of TPP SystmOne.
- Continued replacement of our end point estate.
- Completion of the SharePoint migration.
- Continued feature improvements within Office 365.
- Completion of a planned penetration scans for the Trust infrastructure.
- Completion of the DSP Toolkit.
- Regular phishing campaigns.
- Scoping of the Trust Cloud/Data Centre requirements.
- Completion of the DSP Toolkit.
- Focus on waiting times data cleansing exercise and setting clear guidance for the recording of referral dates and treatment start criteria. Collaborating with care Groups to ensure understanding of waiting list management is understood.
- Improvement in the quality of data capture reporting for MHSDS, by setting internal data validation processes to highlight outliers which can be checked, and corrected where appropriate, with service prior to the submission of the monthly refresh data set. Monthly group setup to review the specific measure of Ethnicity recording, further areas will be targeted during next year.
- Data checking, validation of data and review of on-going reporting facility as per new EPR system (SystmOne).
- Review of performance framework and move to a Business Intelligence platform for cascade of performance and quality data.
- Audit review of clinical coding following move to new EPR system (SystmOne).
- Refresh all relevant policies and procedures to ensure they are clear, concise and easily accessible to all staff.
- Require all staff to undertake the mandatory data security awareness training on an annual basis.
- Provide additional ongoing Caldicott training sessions.
- Undertake information governance spot checks on a risk basis where new services join CWP or information governance concerns are raised.
- Strengthen Data Security & Protection Toolkit evidence.
- Paper free solutions group to implement a programme of activity including draft of a PID, QEIA, Business Case, Action and Risk Log together with all administrative requirements.
- The Data Security & Protection Toolkit action plan will monitored by the Information Governance & Data Protection Sub-Committee and any variances will be escalated to the Operational Committee.

Information governance arrangements have been reviewed during 2021/22 firstly against the latest version of the toolkit, and then against guidance released throughout the year. This supports the case that current information governance arrangements within Cheshire & Wirral Partnership are appropriate and fit for purpose.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

- That the Board approves the Annual Information Governance Board Report
- That the Board approves the submission of the 2021/22 Data Security & Protection Toolkit

Who has approved this report for receipt at the above meeting?	Dr Faouzi Alam, Medical Director, Effectiveness, Medical Education and Medical Workforce
Contributing authors:	Gill Monteith, Trust Records & Information Governance Manager/Data Protection Officer

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Information Governance & Data Protection Sub-Committee	16/05/2022

Appendices provided for reference and to give supporting/ contextual information:

Appendix No.	Appendix title
1	Annual Information Governance Board Report 2021/22

Annual Information Governance Board Report 2021/22

1. Purpose of the report

To brief the Board of Directors on information governance resources, issues, risks and improvement plans undertaken in 2021/22, and to seek approval for the 2021/22 annual Data Security & Protection Toolkit (DSPT) submission.

2. Summary

The Data Security and Protection Toolkit (DSPT) online self-assessment tool allows organisations that process health and care data to measure their performance against the National Data Guardian's 10 Data Security Standards.

Health and care organisations that have access to NHS Patient Data and Systems are required to complete and publish a DSPT self-assessment every year against the standards. This provides assurance that they are practising good data security and they are handling personal information correctly, including maintaining the security of patient information. Publishing an annual DSTP self-assessment also helps an organisation to demonstrate their GDPR and cyber maturity, and their NHS contractual obligations.

The 2020/21 toolkit release was delayed due the Coronavirus epidemic. A baseline submission was completed in February 2022 and the final submission is due by the end of June 2022.

The standards are broken down into assertions (questions) with the following changes for 2021-22:

- Deadline 30th June 2022
- Incorporate NHSX "Information Governance simplification" feedback into the DSP Toolkit.
- Rationalise evidence items where they are now considered "business as usual" or where there is overlap between evidence items.
- Total mandatory evidence items reduced from 111 to 110
- Total number of evidence items reduced from 149 to 142
- Update technical requirements to reflect the current threat landscape.
- Incorporate relevant requirements from the Information Commissioner's Office Data Protection Self Assessment.
- Reflect feedback from stakeholders.
- Specific Improvements on Unsupported Operating systems and asset criticality assessment and other technical requirements.
- Additional requirements for CSUs

All evidence items were uploaded to the toolkit and the requirement to achieve 95% staff compliance for mandatory annual data security awareness training has been achieved.

Mersey Internal Audit Agency have recently undertaken an audit of the current toolkit and an assurance level report is expected in quarter 1. The Information Governance & Data Protection Sub-Committee monitors the DSPT action plan through audits, spot

checks and review of incidents. Risks are reported to the Operational Committee. Actions to strengthen toolkit evidence and ensure the requirement to achieve 95% staff compliance with annual information governance training continued to be persistent targeted communications with staff who were not compliant. The Midland and Lancashire Commissioning Support Unit Information Governance Service sent targeted emails to non-compliant staff. The IG Lead also targeted managers for their non-compliant staff. As a result, the Trust has achieved the required 95% target in time for the June 2022 toolkit submission.

The Coronavirus pandemic (Covid-19) has continued to present many Information Governance challenges as staff worked from home and clinical staff continued to provide services. The Trust's data protection officer has continued to attend NHSx weekly briefings and has provided regular feedback to senior staff and the Information Governance & Data Protection Sub-Committee. Trust staff have received briefings in relation to safe handling of information when working remotely, the Control of Patient Information (2002) Regulation notices (COPI) and video conferencing guidelines.

A new red rated corporate risk of the IG Lead/DPO role single point of failure was identified with a score of 16 (4x4). Cover arrangements were identified as too sparse and not safe. There is no succession plan for the role within CWP. The Trust also entered into a commissioner role with the LPC therefore the IG Lead/DPO role single point of failure was as a provider as well as a commissioner. Short term (6 months) funding for IG support for two days a week from Midland and Lancashire CSU was agreed. A further extension of 6 months support was agreed as an interim mitigating solution whilst formulating a long term mitigation strategy. The risk score reduced to 12 (3x4) and will be reviewed dependent upon effectiveness of CSU support

Information governance arrangements have been reviewed during 2021/22 firstly against the latest version of the toolkit, and then against guidance released throughout the year. This supports the case that current information governance arrangements within Cheshire & Wirral Partnership are appropriate and fit for purpose.

3. Information Governance 2020/21

3.1 Review of information governance work undertaken in 2021/22

The focus of the Trust's work plan for 2021/22 was:

- Work towards cyber essentials with annual penetration testing.
- Implement Wide Area Network replacement.
- Implementation of TPP SystmOne.
- Continued replacement of our end point estate.
- SharePoint migration.
- Continued migration from Microsoft Office 2010 to O365.
- Licence gap analysis.
- Identity Manager (Subject to NHS Digital Guidelines).
- Introduce standard telephony solutions.
- Scope penetration scans for the Trust infrastructure.

- Completion of the DSP Toolkit.
- Focused on waiting times data cleansing exercise and setting clear guidance for the recording of referral dates and treatment start criteria. Collaborating with care Groups to ensure understanding of waiting list management is understood.
- Improvement in the quality of data capture reporting for MHSDS, by setting internal data validation processes to highlight outliers which can be checked, and corrected where appropriate, with service prior to the submission of the monthly refresh data set. Monthly group setup to review the specific measure of Ethnicity recording, further areas will be targeted during next year.
- Data checking, validation of data and review of on-going reporting facility as per new EPR system (SystmOne).
- Review of performance framework and move to a Business Intelligence platform for cascade of performance and quality data.
- Audit review of clinical coding following move to new EPR system (SystmOne).
- Refreshing and producing new policies and procedures to ensure they are clear, concise and easily accessible to all staff.
- Requiring all staff to undertake the mandatory data security awareness training on an annual basis.
- Monitoring of compliance with Freedom of Information Act requests.
- Monitoring of compliance with Subject Access requests.
- Monitoring of Information Governance incidents.
- Scanning of approximately 58,000 paper health records to be available directly via the CWP network.
- Further development of a Caldicott training plan
- Development and implementation of monthly Trust wide `Caldicott Law or Ethics' scenario based training sessions facilitated via MS Teams
- Refreshed Information Governance staff hand book
- Strengthening Data Security & Protection Toolkit evidence.
- Monitoring of the Data Security & Protection Toolkit action plan by the Information Governance & Data Protection Sub-Committee and any variances escalated to the Operational Committee.

The following annual audits have all been undertaken:

- Patient IG survey
- Staff IG survey
- Information asset register/data flow mapping review
- Health records audit
- CCTV Audit

The above audits which are required by the DSPT have been completed with satisfactory results which have been monitored by the Information Governance & Data Protection Sub-Committee.

3.2 Wide Area Network Scoping

The replacement of our aged Wide Area Network has been scoped, ordered and the installation of new building links is well under way. Increased bandwidth, improved

security, more efficient data flow and resilience will be the main improvements once the Project is completed.

3.3 TPP SystmOne Implemented

MIAA have undertaken a Cyber Essentials Gap Analysis Review. A report has been received and ICT are working through the tasks, this is now being linked in with the DSP Toolkit.

3.4 Engagement and Innovation Programme

Phases 4 and 5 of the E&I programme have been completed and phase 6 has been scoped.

3.5 Office 365 Migration

The migration to Office 365 has now resulted in all aged and unsupported Office 2010 licences being removed from the Trust.

SharePoint is currently being migrated to SharePoint Online and is 75% completed.

All server Operating Systems have been upgraded to “in support” versions.

3.6 Data Quality

Standard Operating Procedures have been created as move to new ePR system (SystmOne) to support the accurate capture and recording of key information, to improve data quality in this area. The effectiveness of this will be measured and based on its success other areas will adopt the approach.

Review of Data Quality in relation to recording and reporting NHS Oversight Framework performance measures and other external submissions is being carried out. This will involve re-development of SOP’s assigning and measuring DQ levels with clear escalation to monitor improvement.

3.7 Review of information governance incidents 2021/22

Data on information governance incidents (IG) and near misses was reviewed for 2021/22 as reported on the Trust’s Datix risk and incident reporting system. There was one serious incident relating to information governance in 2021/22 that was reportable to the Information Commissioner’s Office/ Department of Health & Social Care in the Data Security Incident Reporting Tool. The incident related to a patient letter being sent to another patient in error. The Information Commissioner’s decision was to take no further action due to mitigating action taken by the Trust.

There were 258 IG incidents reported during 2021/22 compared to 211 the previous year which is an increase of 22%. Of the 258 incidents there were 62 incidents of external emails being sent to the incorrect destination. Of the 62 incidents 37 were to destinations within the NHS (other Trusts). There were 67 incidents of incorrect data on

clinical systems.

Other incidents have included:

- lost smart cards
- internal emails sent to incorrect destinations
- care given but not recorded
- paper information left in clinical and office areas
- verbal breach of confidentiality
- patient's taking photographs in clinical areas

The Quality Surveillance Team provided a summarised analysis of information governance incidents to each Information Governance & Data Protection Sub-Committee meeting. Information governance reminders have been issued to staff based on IG incidents throughout the year, including reminders of Trust policy and hi-lighting areas for improvement. The Information Governance & Data Protection Sub-Committee will continue to monitor trends in the coming year and take rememdial action where necessary.

3.8 Subject Access Requests

The Information Governance & Data Protection Sub-Committee monitors compliance with subject access requests.

Disclosure logs are maintained by the medical records function to capture subject access requests and the information which is being disclosed. Under the data protection legislation (GDPR), the legal timeframe for requests is 1 calendar month, however, for large or complex cases the longer time frame of up to 3 months may be utilised. During the Covid19 period the Information Commissioner has stated that whilst she cannot alter the legal timeframes, she will not take regulatory action against organisations who breach the timescales due to the pandemic. Since March 2020 all requestors have been written to advising that the request will be processed as soon as possible, however, in the current Coronavirus (Covid19) circumstances the NHS is under unprecedented and increasing pressure. It may therefore not be possible to complete requests within the usual timeframes.

Overall, the number of requests received in 2021/22 was 604 compared to 727 in 2020/ 21 which is a decrease of 17%.

There were 30 breaches during 2021/22 compared to 21 breaches in 2020/21 which is a increase of 43%. The majority of the breaches were due to a delay in services authorising release of records which could be the effect of Covid19 and staff availability.

The Information Governance & Data Protection Sub-Committee will continue to monitor compliance with Access to Health Records statutory time frames as a standing agenda item.

3.9 Freedom of Information Act Requests

The Information Governance & Data Protection Sub-Committee also monitors compliance with statutory timeframes associated with Freedom of Information Act requests.

A Freedom of Information (FoI) Log is maintained to capture FoI requests and the information which is being disclosed. Under the Freedom of Information Act 2000 the legal timeframe for requests is 20 working days. During the Covid19 period the Information Commissioner has stated that whilst she cannot alter the legal timeframes, she will not take regulatory action against organisations who breach the timescales due to the pandemic. Since March 2020 all requestors have been written to advising that the request will be processed as soon as possible, however, in the current Coronavirus (Covid19) circumstances the NHS is under unprecedented and increasing pressure. It may therefore not be possible to complete requests within the usual timeframes.

Overall, the number of requests received in 2021/22 was 401 compared to 279 in 2020/21 which is an increase of 44%. There were 105 breaches during 2021/22 compared to 66 breaches in 2020/21 which is an increase of 59%. Breaches during 2021/22 were due to a delay in services supplying information which could be the effect of Covid19 and staff availability. The FoI team has contacted all of the requesters whose responses have breached and the reason for the delays has been explained. This is in line with guidance from the Information Commissioner's Office.

The Information Governance & Data Protection Sub-Committee will continue to monitor compliance with Freedom of Information Act statutory time frames as a standing agenda item.

3.10 Caldicott Champions

Work to strengthen the Caldicott support function has continued throughout the year. Several corporate services Caldicott Champions have joined the existing care group Caldicott Champions.

The Caldicott champions have continued to meet virtually during 2021/22 and achievements so far include:

- Further development of a training plan
- Development and implementation of monthly Trust wide `Caldicott Law or Ethics' scenario based training sessions facilitated via MS Teams
- Refreshed Information Governance staff hand book

3.11 Document Scanning & Paper Free Solutions

CWP has historically archived its legacy paper health records to an offsite storage facility. The Trust has also successfully undertaken several document scanning projects to digitise its health records enabling the scanned image files to be successfully stored and accessed directly via the CWP network. Document scanning now provides a viable alternative to manage the Trust's legacy paper records.

CWP has an appetite to be paper free. The Information Governance and Data Protection (IGDP) sub-committee has raised a risk that paper records continue to be

held across the trust in two forms – historically and newly generated. This can be broken down further into clinical and non-clinical categories.

IGDP Sub-Committee has formed a paper free solutions sub-group to take forward a programme of activity that will seek to deliver on CWP's ambition of being paper free. Initially this will concentrate on clinical records to mitigate any potential clinical risks that already exist and continue to be created.

3.12 Information Governance Structure Risk

A new red rated corporate risk of the IG Lead/DPO role single point of failure was identified with a score of 16 (4x4). Cover arrangements were identified as too sparse and not safe. There is no succession plan for the role within CWP. The Trust also entered into a commissioner role with the LPC therefore the IG Lead/DPO role single point of failure was as a provider as well as a commissioner. Short term (6 months) funding for IG support for two days a week from Midland and Lancashire CSU was agreed. A further extension of 6 months support was agreed as an interim mitigating solution whilst formulating a long term mitigation strategy. The risk score reduced to 12 (3x4) and will be reviewed dependent upon effectiveness of CSU support

3.13 Data Security & Protection Toolkit Submission 2021/22

NDG 1. Personal Confidential Data

Met (4 / 4)

Not Met (0 / 4)

100 % complete

NDG 2. Staff Responsibilities

Met (1/ 1)

Not Met (0 / 1)

100 % complete

NDG 3. Training

Met (4 / 4)

Not Met (0 / 4)

100 % complete

NDG 4. Managing Data Access

Met (5 / 5)

Not Met (0 / 5)

100 % complete

NDG 5. Process Reviews

Met (1 / 1)

Not Met (0 / 1)

100 % complete

NDG 6. Responding to Incidents

Met (3 / 3)

Not Met (0 / 3)

100 % complete

NDG 7. Continuity Planning

Met (3 / 3)

Not Met (0 / 3)

100 % complete

NDG 8. Unsupported Systems

Met (4 / 4)

Not Met (0 / 4)

100 % complete

NDG 9. IT Protection

Met (6 / 6)

Not Met (0 / 6)

100 % complete

NDG 10. Accountable Suppliers

Met (2 / 2)

Not Met (0 / 2)

100 % complete

4. Information governance work plan 2022/22

The focus of the Trust's work plan for 2022/23 will be to:

- Implement Wide Area Network replacement.
- Implementation of TPP SystmOne.
- Continued replacement of our end point estate.
- Completion of the SharePoint migration.
- Continued feature improvements within Office 365.
- Completion of a planned penetration scans for the Trust infrastructure.
- Completion of the DSP Toolkit.
- Regular phishing campaigns.
- Scoping of the Trust Cloud/Data Centre requirements.
- Completion of the DSP Toolkit.
- Focus on waiting times data cleansing exercise and setting clear guidance for the recording of referral dates and treatment start criteria. Collaborating with care Groups to ensure understanding of waiting list management is understood.
- Improvement in the quality of data capture reporting for MHSDS, by setting internal data validation processes to highlight outliers which can be checked, and corrected where appropriate, with service prior to the submission of the monthly

refresh data set. Monthly group setup to review the specific measure of Ethnicity recording, further areas will be targeted during next year.

- Data checking, validation of data and review of on-going reporting facility as per new EPR system (SystmOne).
- Review of performance framework and move to a Business Intelligence platform for cascade of performance and quality data.
- Audit review of clinical coding following move to new EPR system (SystmOne).
- Refresh all relevant policies and procedures to ensure they are clear, concise and easily accessible to all staff.
- Require all staff to undertake the mandatory data security awareness training on an annual basis.
- Provide additional ongoing Caldicott training sessions.
- Undertake information governance spot checks on a risk basis where new services join CWP or information governance concerns are raised.
- Strengthen Data Security & Protection Toolkit evidence.
- Paper free solutions group to implement a programme of activity including draft of a PID, QEIA, Business Case, Action and Risk Log together with all administrative requirements.
- The Data Security & Protection Toolkit action plan will monitored by the Information Governance & Data Protection Sub-Committee and any variances will be escalated to the Operational Committee.

5 Information risk management approach

CWP has access to a number of sources of information, guidance and assurance concerning information governance. NHS digital maintains a comprehensive library of exemplar materials, supports the data security & protection toolkit and provides guidance on ethics and the health and social care record guarantees. The Information Commissioner's Office provides guidance on the Data Protection and Freedom of Information Legislation and the Environmental Information Regulations.

Audit opinions are provided by both external and internal audit and the Trust incorporates mandatory information governance audit within its annual audit programme. CWP takes a risk-based approach to information governance, evaluating incidents and being appraised of potential gaps in assurance. It should be noted that compliance with the requirements of the Data Security & Protection Toolkit does not necessarily imply that there are no areas of risk within the Trust, the toolkit cannot accommodate every eventuality and therefore the Trust needs to consider the level of risk in collecting, processing, disclosing and disposing of data. The Information Governance & Data Protection Sub-Committee monitors overall compliance with Information Governance principles, escalating risks and ensuring mitigating actions are in place. Lesson learned from investigations and reviews are incorporated into training materials, communication notices and policy as appropriate.

6 Assessment of information governance arrangements

Information governance arrangements have been reviewed during 2021/22 firstly against the latest version of the Data Security & Protection Toolkit (DSPT), and then against guidance released throughout the year. The Information Governance & Data Protection

Sub-Committee monitors the DSPT action plan through audits, spot checks and review of incidents. Risks are reported to the Operational Committee. Actions to ensure the requirement to achieve 95% staff compliance with Data Security awareness training were targeted communications with staff who are not compliant with the mandatory annual training. This supports the case that current information governance arrangements within Cheshire & Wirral Partnership are appropriate and fit for purpose.

7 Recommendations to the Board of Directors

a. That the Board approves the Annual Information Governance Board Report.
b. That the Board approves the submission of the 2021/22 Data Security & Data Protection toolkit.
c. That the Board approves the statement that current information governance arrangements are fit for purpose.

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED CHAIR'S REPORT

CHAIR'S REPORT DETAILS	
Name of meeting:	Quality Committee
Chair of meeting:	Andrea Campbell, Non-Executive Director
Date of meeting:	04/05/2022

ESCALATION

Quality, clinical, care, other risks identified that require escalation:

- On reviewing the strategic risk register, the Quality Committee noted a real-time update in relation to risk 3 (data completeness associated with 'SystmOne electronic patient record' recording). CWP has had a constructive meeting with the Directors of Quality at the Cheshire and Wirral Clinical Commissioning Groups (CCGs) and agreed, moving forwards, a single point of contact in CWP to facilitate provision of ongoing assurance in response to any gaps identified through system-wide quality surveillance of CWP services. For the purposes of risk 3, CWP is developing a data quality improvement plan around improving Trust reporting from SystmOne to share with the CCGs.
- On reviewing the Providing High Quality Care dashboard report, Quality Committee has requested ongoing progress updates against improvement actions required in relation to measures concerning restrictive practices, self-harm and out of area placements.

ASSURANCE

On which matters did the meeting make a decision, e.g. what did it approve?

- Review of the following reports, recommending approval by the Board of the:
  - Autism strategy
  - Quality Improvement report (Edition 4, 2021/22)
  - Learning from Experience report (December 2021 – March 2022)
  - Mental Health Law, Research & Medicines Management and Optimisation annual reports

Other matters discussed that provide assurance:

- Further updates received against the ongoing regulatory actions related to the provision of (i) intensive rehabilitation services; and (ii) ADHD services – with a high assurance rating recommended to the Board. The CQC has agreed to an extension for completion of the improvement actions required in relation to (i) to 30 September 2022. The CQC have advised that CWP are required to continue to provide progress against the ongoing improvement actions required in relation to (ii) which will be submitted on a fortnightly basis.
- On reviewing the Learning from Experience report, assurance received of learning and improvements against the broader themes of the Final report of the Ockenden review, i.e. safer staffing, knowledge and skills, incident reporting/ review, and openness with families – particularly in relation to perinatal services and the support CWP gives to women and babies.
- On reviewing the Mental Health Law report and on approving the Lived Experience, Volunteering & Engagement Network report, assurance received that the Patient Experience and Carer Experience team are leading on ongoing improvement work around detention under the Mental Health Act of those with protected characteristics and performance against the NHS Workforce Race Equality Standard. The Quality Committee noted that the Equality, Diversion and Inclusion essential learning is now a three-yearly update rather than one-off compliance.

IMPROVEMENT

Developments/ achievements:

- The Quality Improvement report continues to demonstrate the Quality Improvement work being delivered, despite ongoing operational pressures and challenges, across the breadth of our clinical and clinical support services. The Quality Committee recommends this be acknowledged by Board.
- A presentation was received around the "sustainability" and "affordability" domains of the CWP quality framework. These were delivered by Business & Value and each of the Care Group strategic Clinical Directors. Quality Committee discussed how CWP, in working with its partners, can optimise the Triple Aim and deliver sustainable care, especially in relation to delivering better value. Quality Committee referred the question around having the capacity to demonstrate value to Operational Committee for discussion in the future, so that Quality Committee can revisit this as part of its thematic agenda.
- On reviewing the Research annual report, Quality Committee recommended that a future Board seminar be held around the wider Clinical Effectiveness framework 2022/25 as a key enabling document to the overarching Imagining the Future strategy.

Cheshire and Wirral Partnership
NHS Foundation Trust

MENTAL HEALTH LAW ANNUAL REPORT
PROTECTING HUMAN RIGHTS AND REDUCING HEALTH INEQUALITIES
2021/22

This report provides information regarding activity on the use of the Mental Health Act and Mental Capacity Act (Deprivation of Liberty Safeguards) during 2021/22 in line with the Trust's Quality Framework and Care Quality Commission key questions.

MANAGEMENT OF RISK AND PERFORMANCE

Assurance systems to monitor quality performance, risks and regulatory requirements

1. Use of the MHA

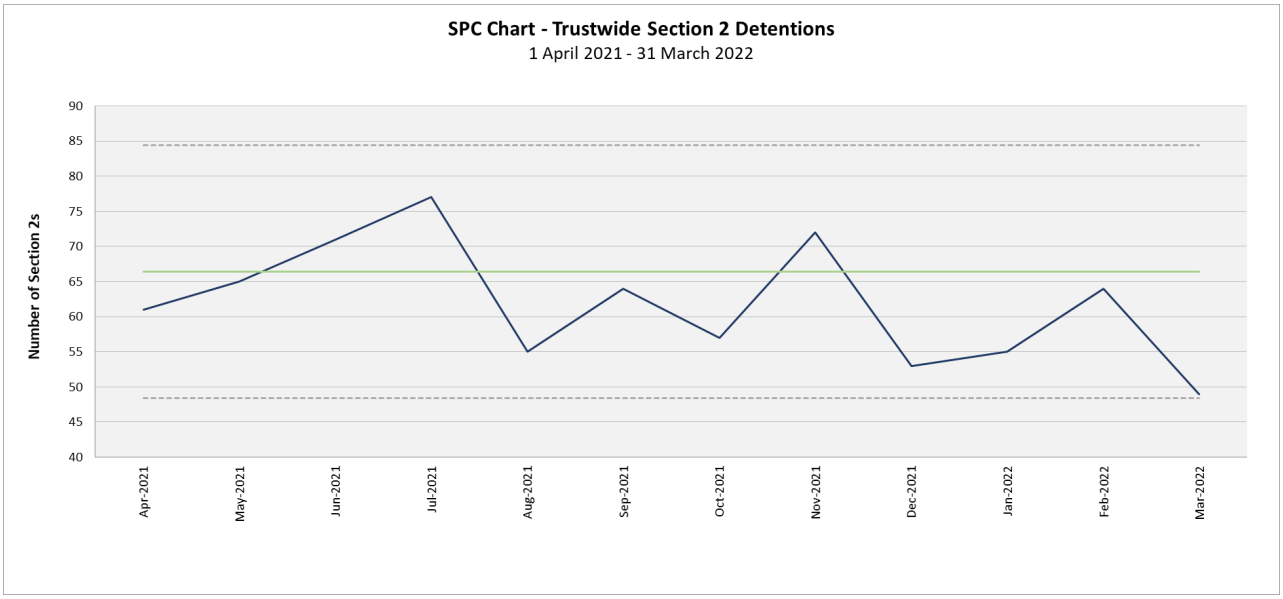
The information presented in the charts below includes data migrated from the CAREnotes to SystmOne electronic patient record systems, which has required some work to ensure the background coding was correct. The MHL Manager is liaising with the Head of Information Management and Business Intelligence to ensure the quality of data inputting in order to maximise the quality and effectiveness of future MHA reporting

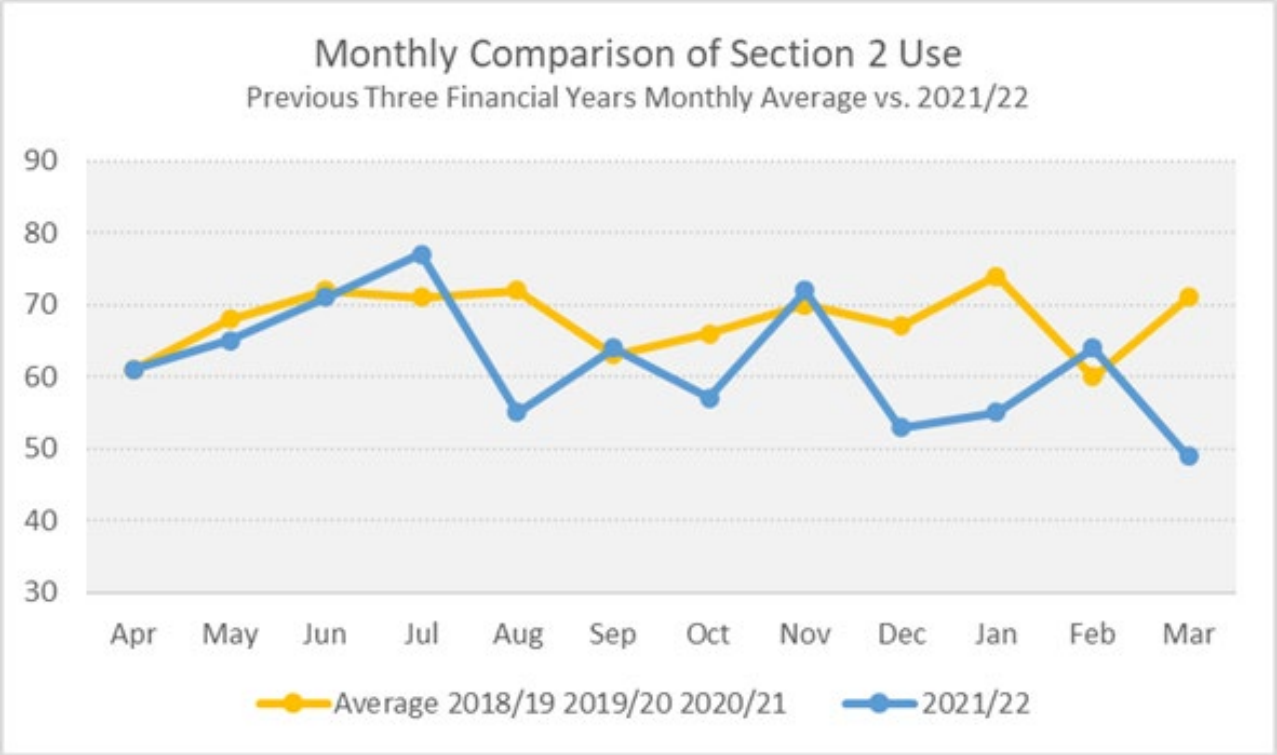
Good practice:
MHL Team Manager is networking with colleagues in Rotherham Doncaster and South Humber NHS Foundation Trust to learn from their experiences regarding the management of MHA recording and reporting, as they have used SystmOne for several years.

The following Statistical Process Charts (SPCs) shows monthly use of MHA during 2021/22. Further analysis undertaken on the use of MHA is presented in the graphs below, showing a three-year average run comparison.

People detained under Section 2

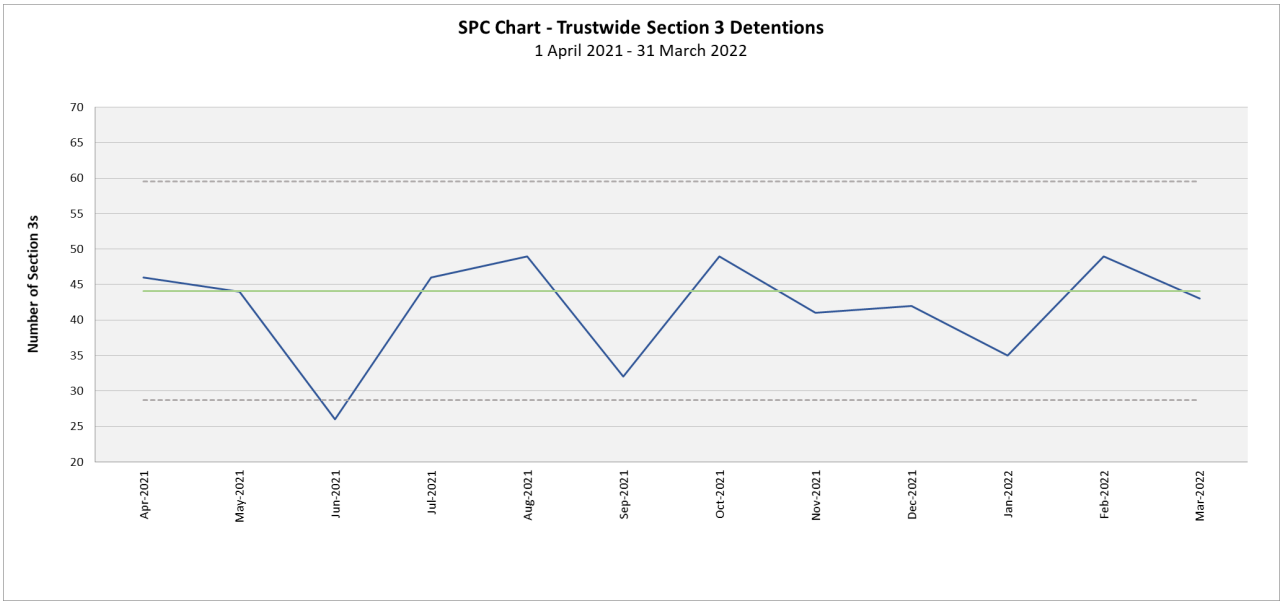
During 2021/22 overall there has been a reduction in the use of s.2.

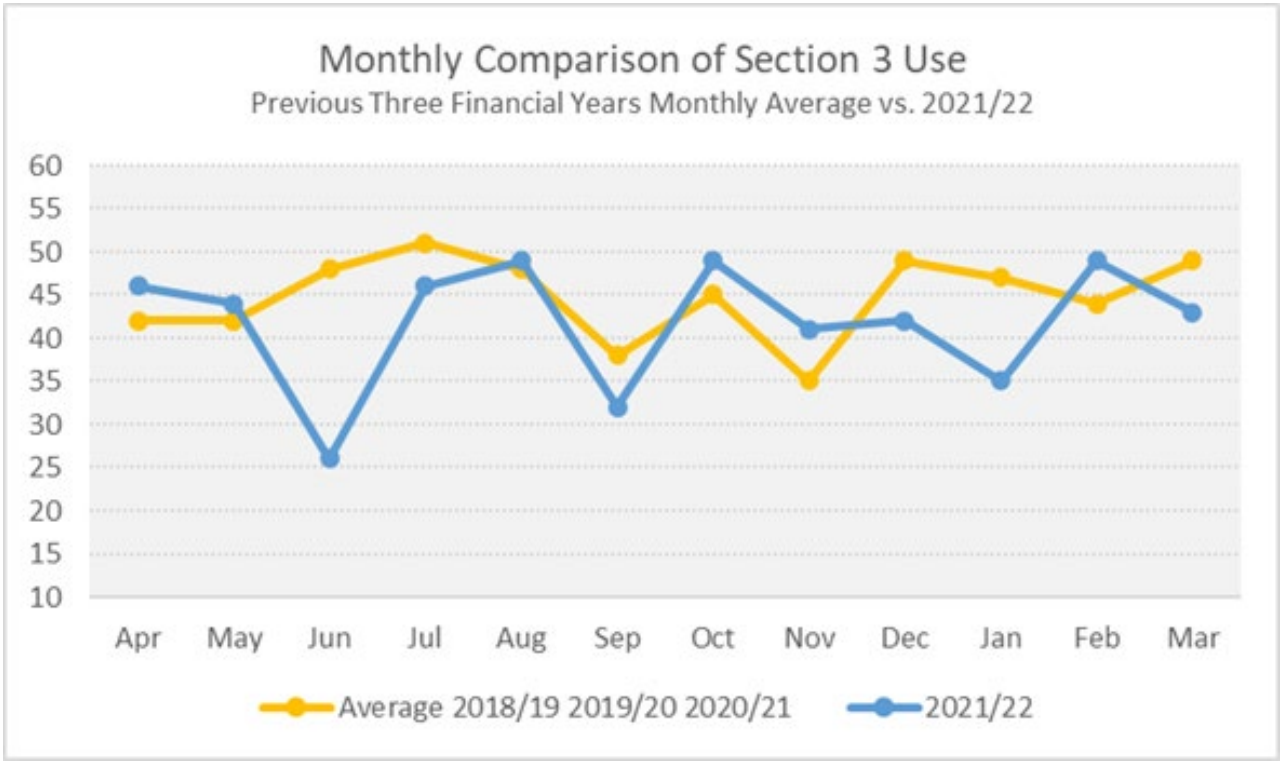




People detained under Section 3

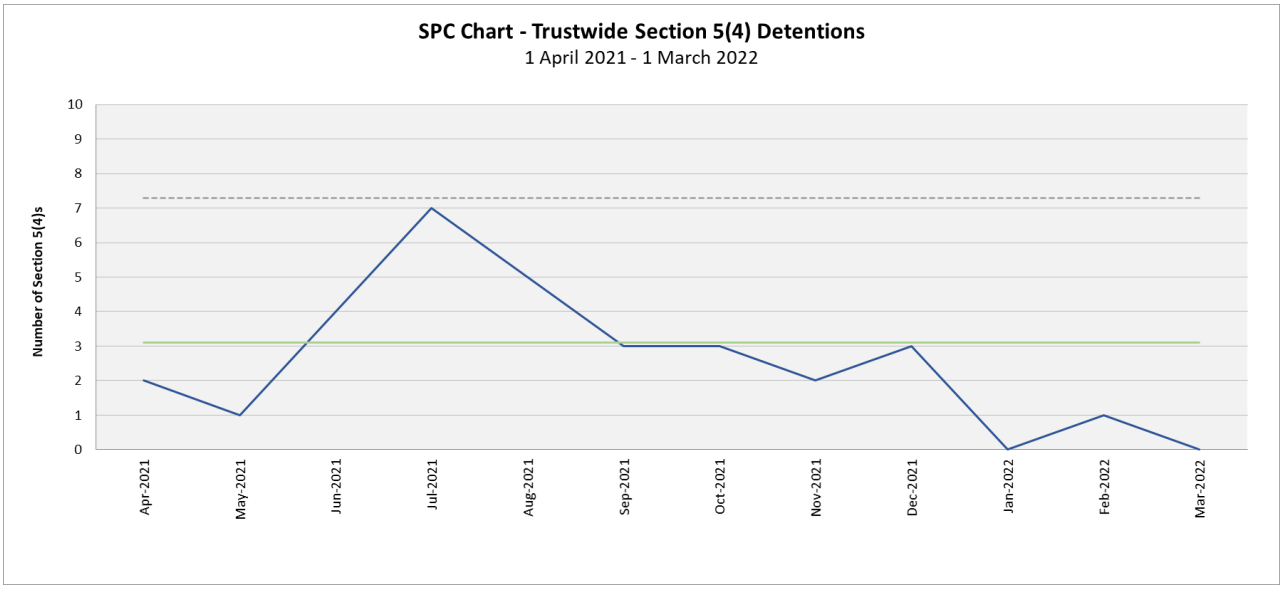
During 2021/22, considering the monthly variations, the use of s.3 has remained relatively stable.

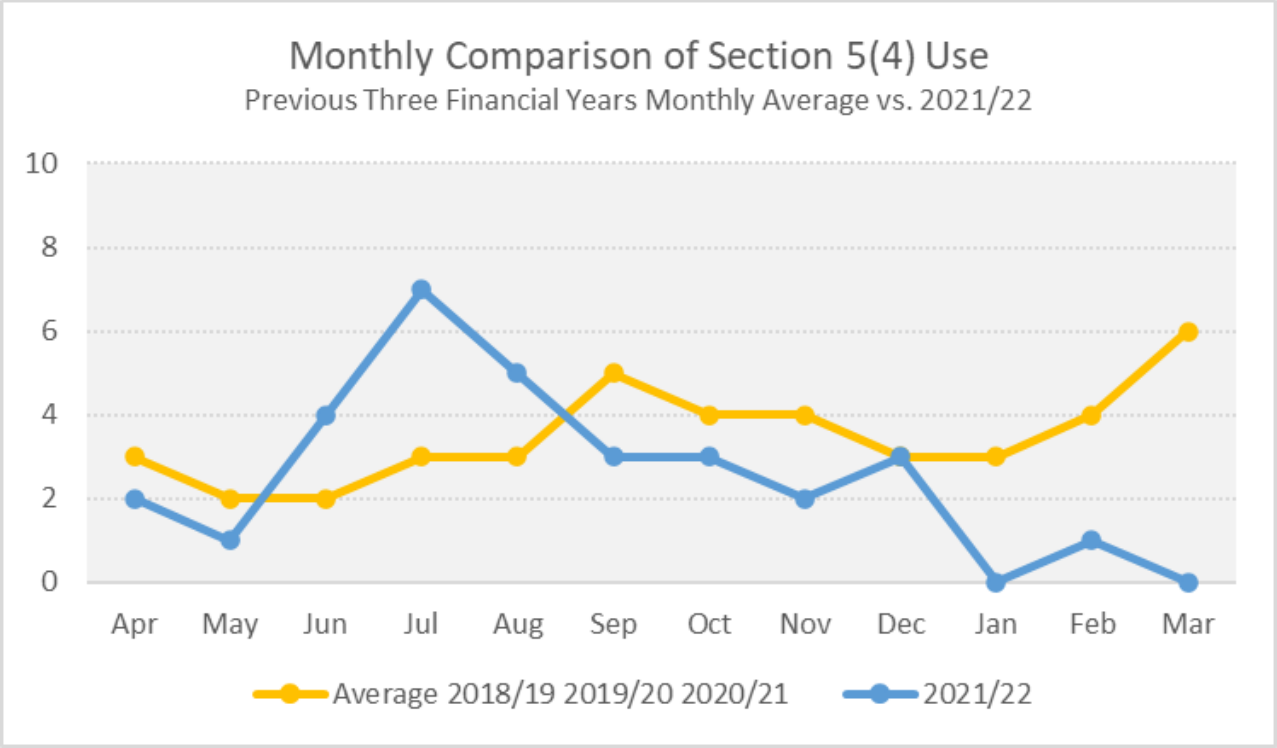




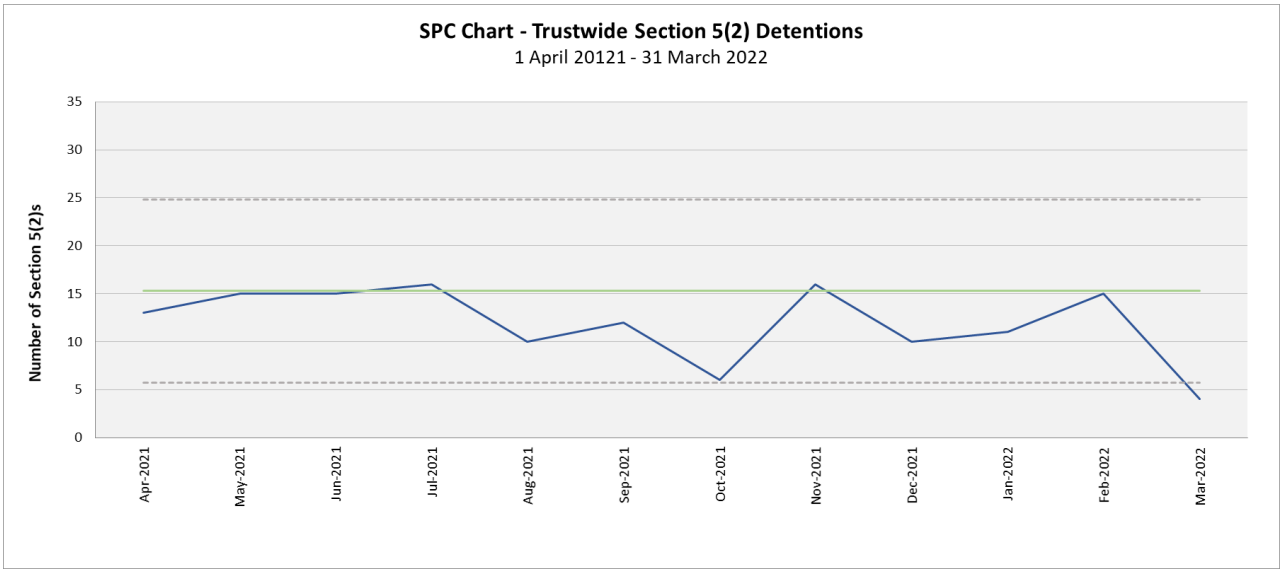
People detained under Section 5(4)

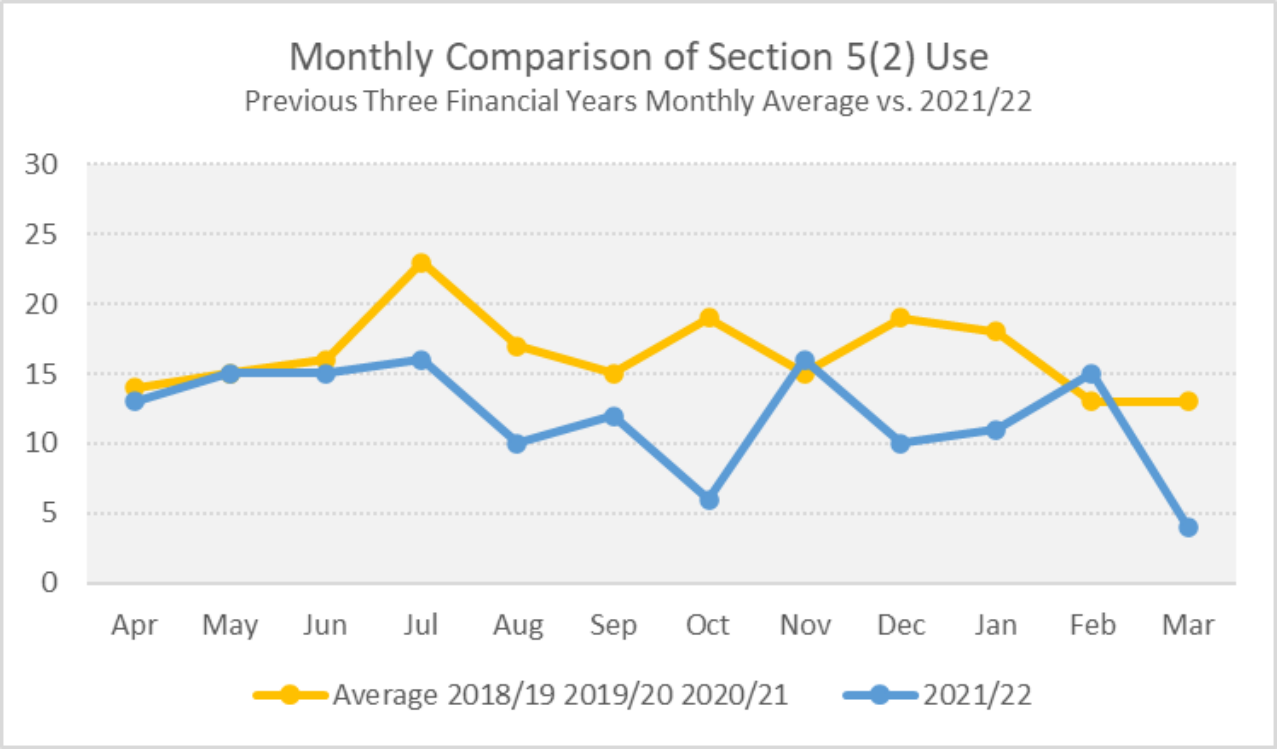
During 2021/22 there has been an overall decrease in the use of s.5(4), compared to an upward trajectory of the previous three-year average.





People detained under Section 5(2)
The use of s.5(2) during 2021/22 was less than the previous three-year average.





People detained under Section 4
During 2021/22, s.4 was used on 2 occasions, compared to 6 occasions during 2020/21. S.4 should only be used in an emergency where the need for urgent assessment outweighs the delay in waiting for a second doctor.

In accordance with the MHA Code of Practice, the MHL Team monitor the use of s.4 to ensure it is not misused, escalating any reported difficulties in obtaining a second doctor to the Medical Director (Executive Lead for the MHA).

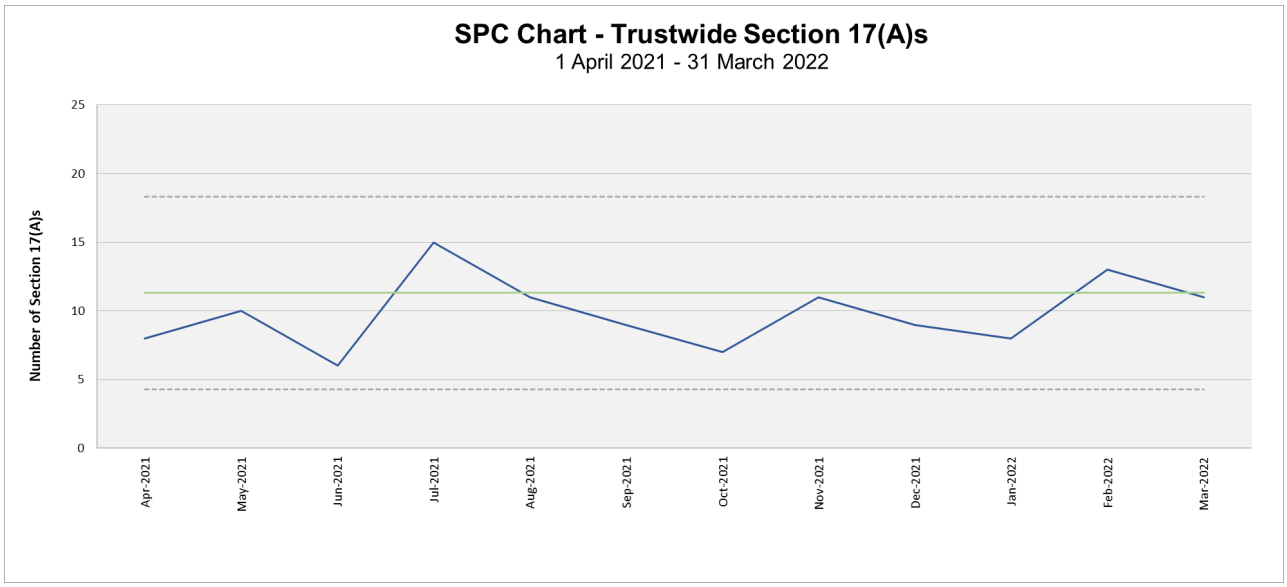
People who are subject to CTOs

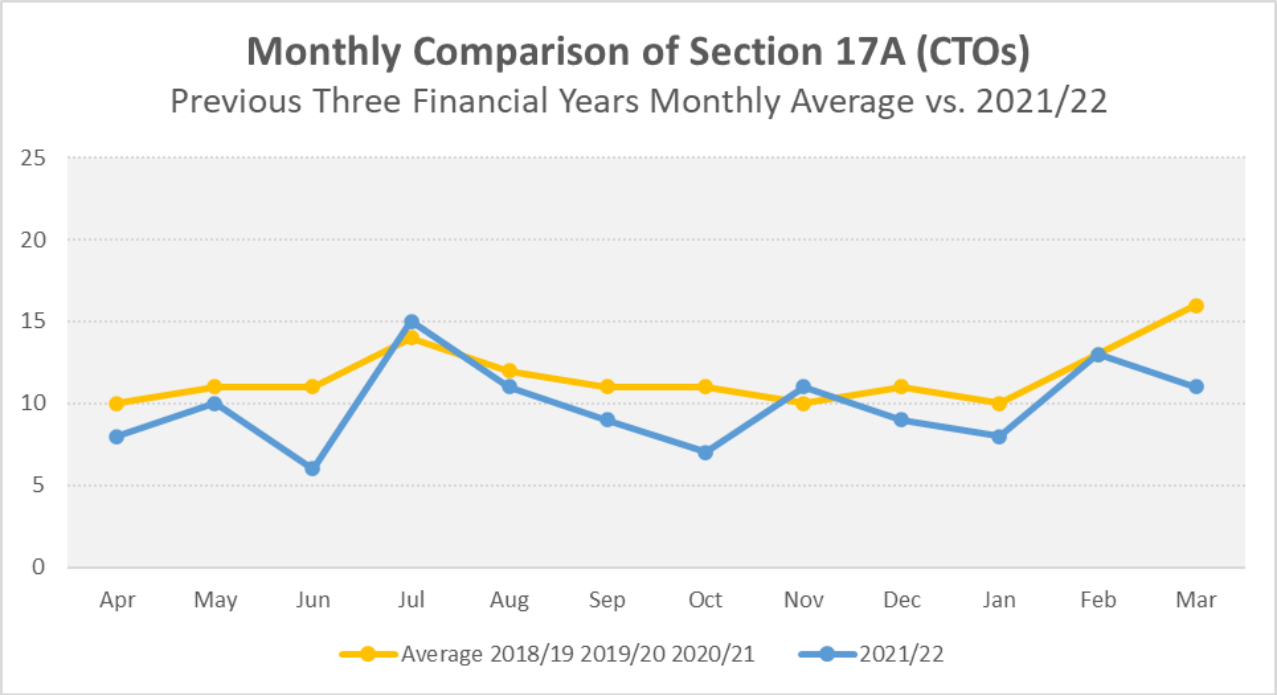
The following SPC chart shows monthly use of CTO since April 2020. Further analysis undertaken on the use of CTOs during 2021/22 is presented in the graphs below, including a monthly comparison.

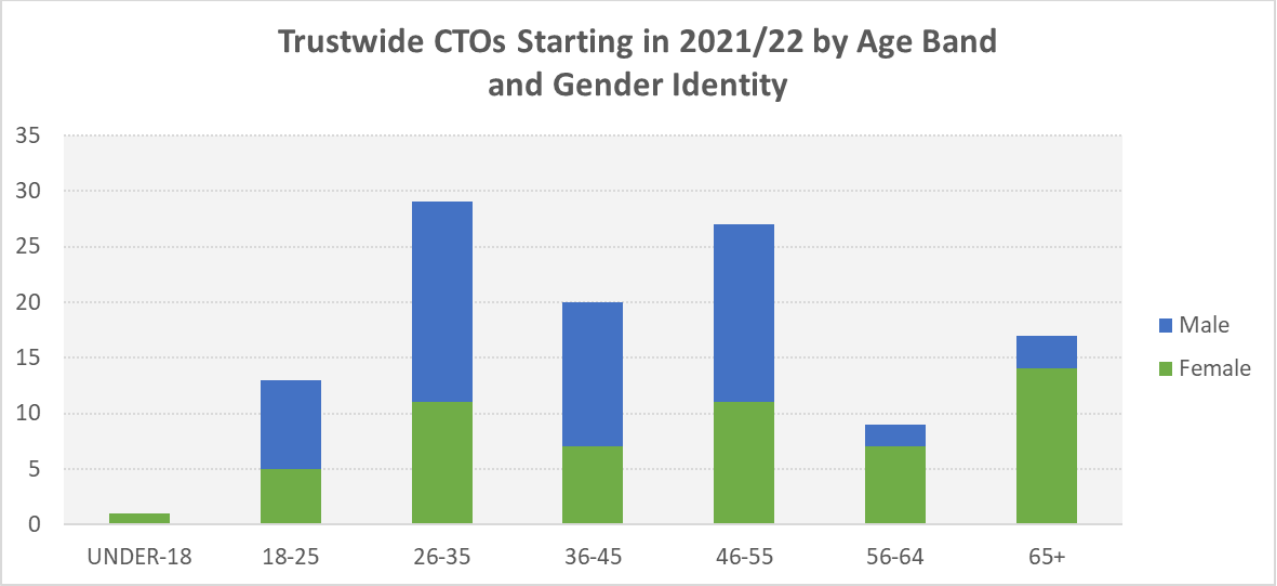
As at 31 March 2022 there were 156 active CTOs Trustwide.

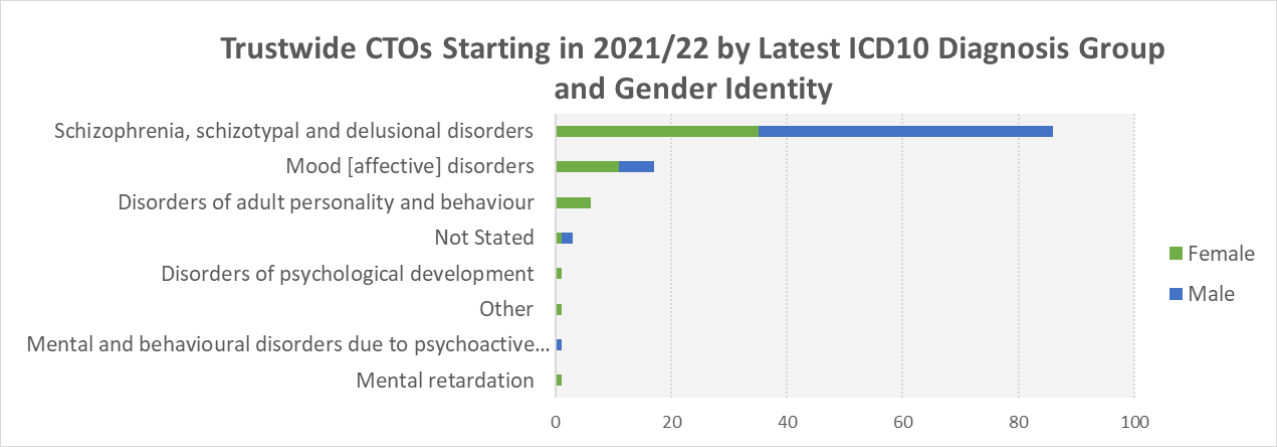
In preparation for proposed changes to the use of CTOs as outlined in the MHA White Paper, CWP has commenced a clinical peer review process of CTOs that have been in place for over three years, commencing with legacy CTOs. This process will be ongoing and reviews undertaken prior to the three year limit. Where queries arise regarding the criteria being met and therapeutic value of the CTO, these will be directed to the person's Responsible Clinician for assurance that the CTO remains appropriate and necessary. This process followed discussion around CTO effectiveness at Quality Committee and a resulting recommendation arising from that meeting.

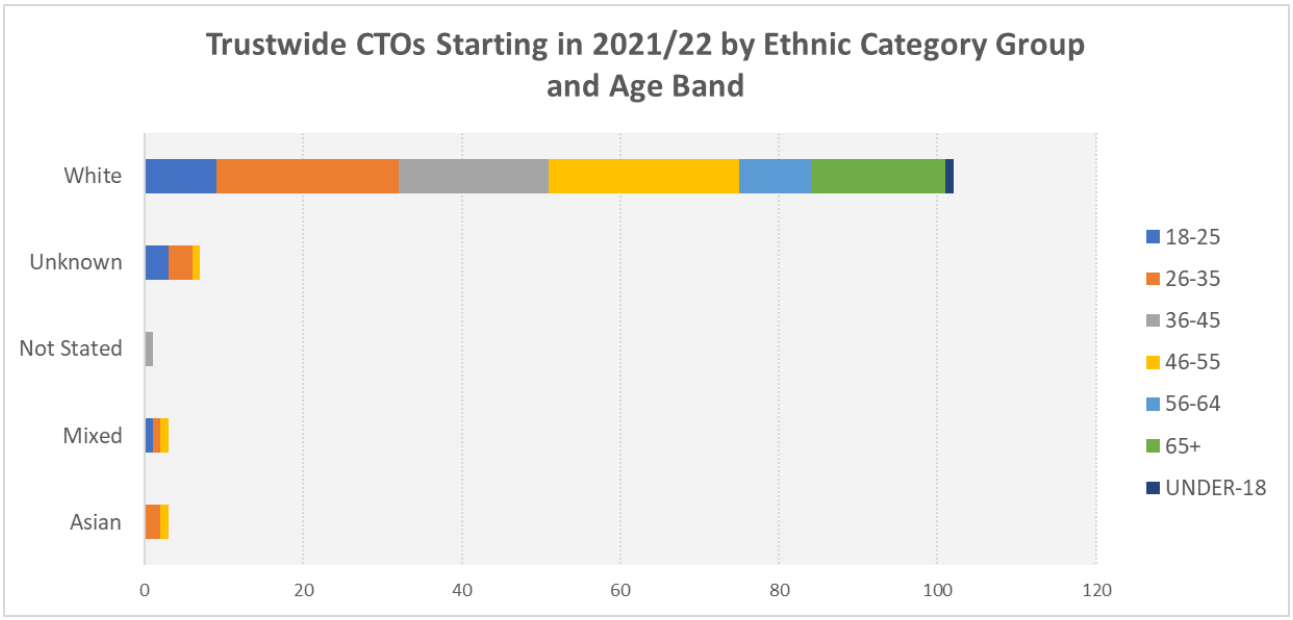
The review panel consists of three consultants across CWP who review the most recent MHA documentation, including First-tier Tribunal reports and hearing decision. The panel meet monthly, the next meeting to include feedback on the first two cases being reviewed. Progress on this review and outcomes will be reported in future MHL reports.




Monthly Comparison of Section 17A (CTOs)
Previous Three Financial Years Monthly Average vs. 2021/22
25
20
15
10
5
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Average 2018/19 2019/20 2020/21
2021/22

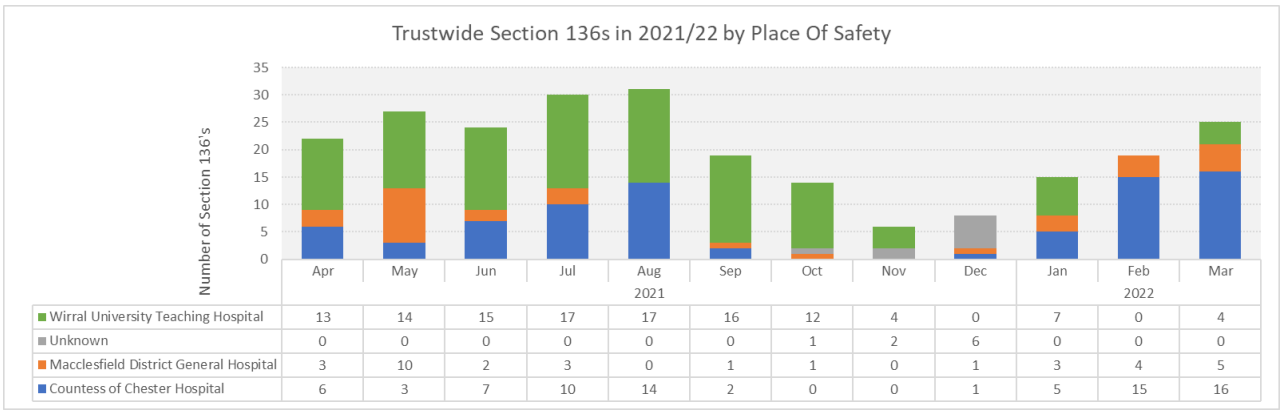

Trustwide CTOs Starting in 2021/22 by Age Band and Gender Identity
35
30
25
20
15
10
5
0
UNDER-18
18-25
26-35
36-45
46-55
56-64
65+
Male
Female


Trustwide CTOs Starting in 2021/22 by Latest ICD10 Diagnosis Group and Gender Identity
Schizophrenia, schizotypal and delusional disorders
Mood [affective] disorders
Disorders of adult personality and behaviour
Not Stated
Disorders of psychological development
Other
Mental and behavioural disorders due to psychoactive...
Mental retardation
0
20
40
60
80
100
Female
Male



2a. Use of Section 136

Between 1 April 2021 and 31 March 2022, 205 completed s.136 records were received Trust wide. This is compared to 228 in 2020-2021. There are some limitations concerning this data associated with delays in receiving completed s.136 forms from the places of safety and an outstanding benchmarking exercise with data from Cheshire and Merseyside Police forces for 2021/22.



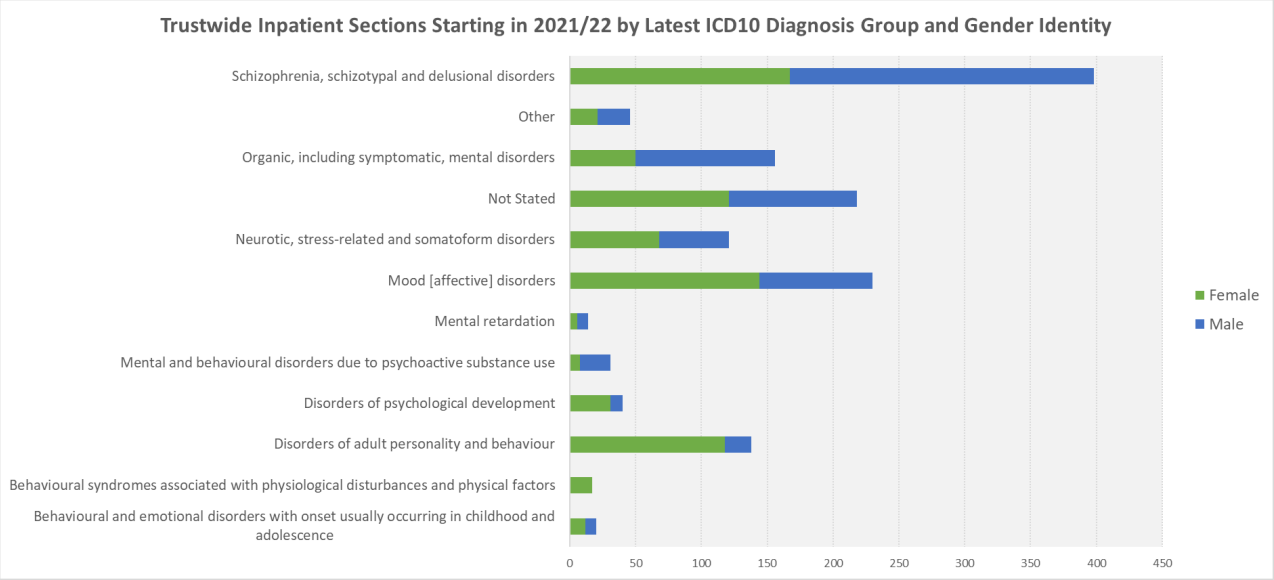
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Wirral University Teaching Hospital	13	14	15	17	17	16	12	4	0	7	0	4
Unknown	0	0	0	0	0	0	1	2	6	0	0	0
Macclesfield District General Hospital	3	10	2	3	0	1	1	0	1	3	4	5
Countess of Chester Hospital	6	3	7	10	14	2	0	0	1	5	15	16

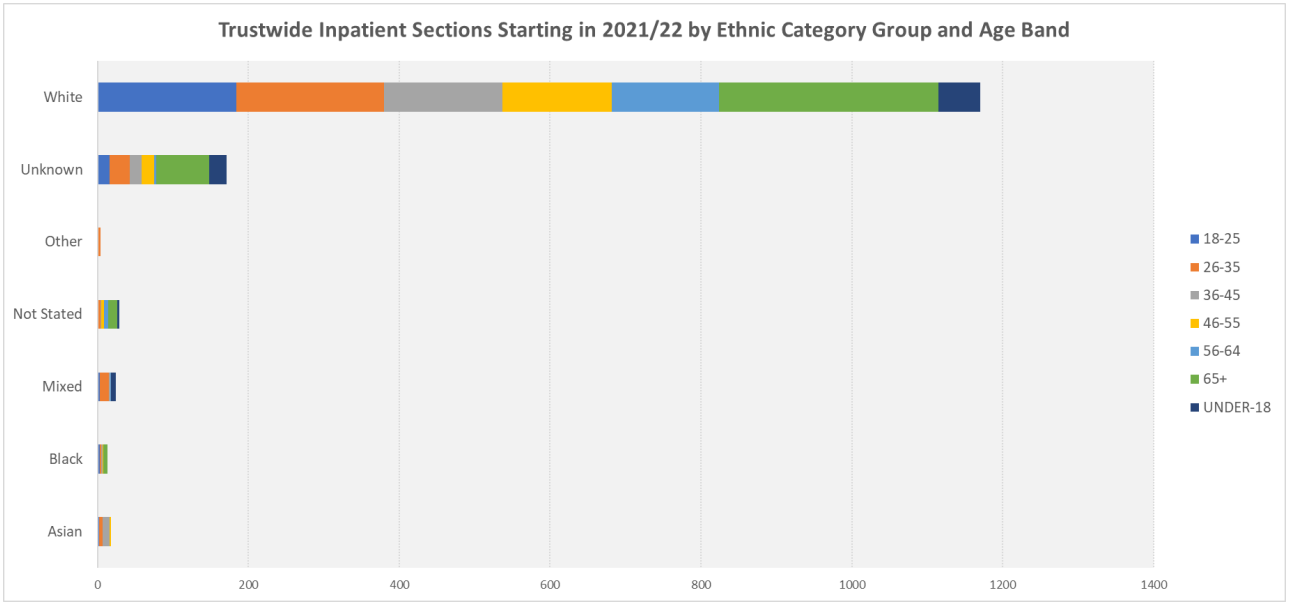
ACHIEVING EQUITY THROUGH ACCESSIBLE CARE

Services that are delivered, made accessible and coordinated to take account of the needs of different people, including those with protected characteristics under the Equality Act and those in vulnerable circumstances

2. Analysis concerning those with protected characteristics

The charts below show diagnosis and ethnicity analysis by gender for those detained in hospital during 2021/22.





Of note:

3.85% of those detained in hospital Trust wide during 2021/22 were from the Black, Asian, Minority Ethnic communities. However, in 15.66% of cases ethnicity was recorded as not stated/not known. This compares to the total ethnic make-up of CWP population during 2021/22 of 2.7%; 33% of cases recorded as ethnicity not stated/ not known.

- This will continue to be monitored and reported in future MHL reports and benchmarked with national trends once this data is available.

2a. DoLS activity during 2021 – 2022

- Six urgent DoLS authorisations have been implemented for those on inpatient wards, five within the Learning Disability Care Group and one for older people.
- Nine Standard Authorisations have been implemented, six within the Learning Disability Care Group, one on an adult ward and two at Crook Lane Respite Unit.
- The court has used its powers of Inherent Jurisdiction to deprive one young person of their liberty at Ancora House on three occasions.

CQC notifications were submitted for Standard Authorisations/ Inherent Jurisdiction Orders during 2021/22. However, on one occasion this requirement was not met, with the following learning identified.

Learning and improvement:
Following an index incident in which a CQC notification was not submitted, the MHL Team reviewed and improved their Standard Operating Procedure to ensure future compliance. No further breaches have occurred.

The MHL Team continue to monitor deprivation of liberty within the Trust and will continue to do so following the implementation of LPS (see section 8).

2b. Electronic MHA documentation

The Independent Review of the Mental Health Act in December 2018 recommended a legislative change to allow the use of electronic statutory MHA forms; the Mental Health Act (Amendment) Regulations 2020 brought this into legislation on 1 December 2020. The implementation of electronic forms, therefore, was not a reaction to the COVID-19 pandemic, but its implementation was accelerated as a result.

Since April 2020, the MHL Team has been working with 'Thalamos', who provide bespoke software solutions to digitise the use of MHA, with the aim of moving towards a paperless and more efficient/ effective process. Thalamos provides a secure, digital platform which:

- enables clinicians to complete MHA documents electronically and share securely.
- reduces the risk of errors/ unlawful detention
- ensures completed forms are clear and legible
- reduces the risk of paper forms being lost
- enables quicker uploading of MHA forms to the electronic patient record
- saves time and reduces waste

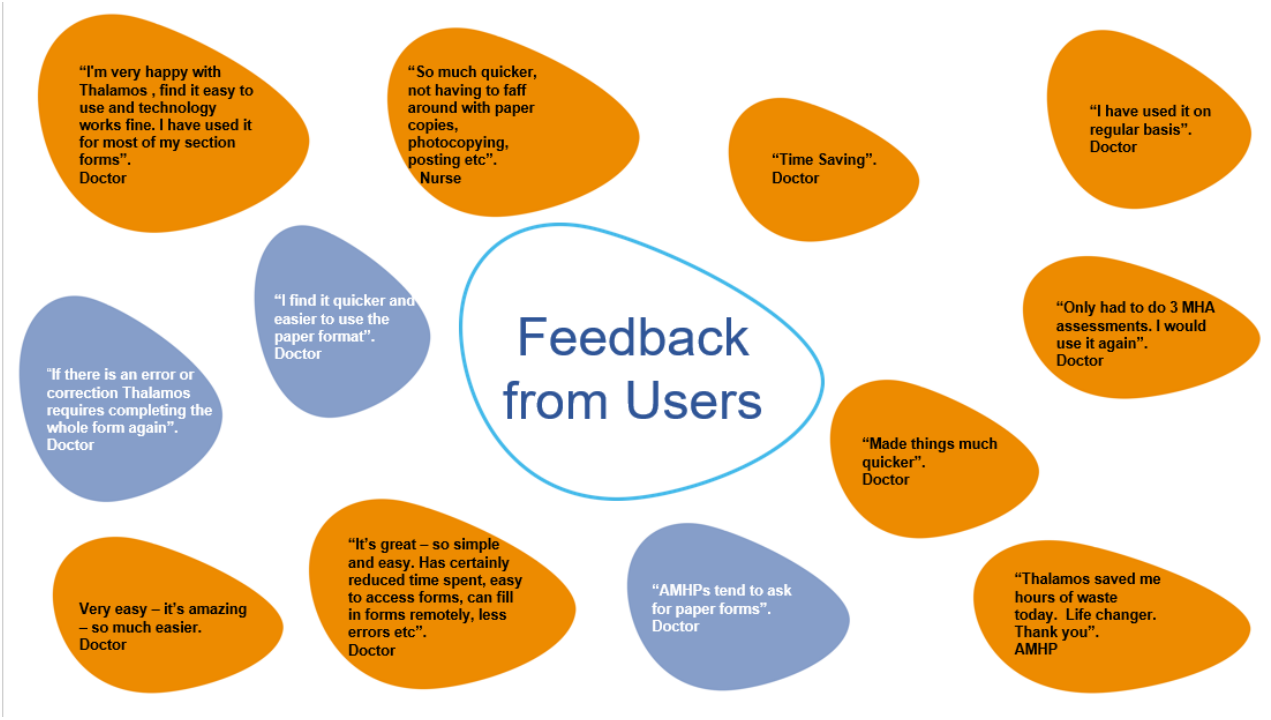
A pilot was undertaken initially within the SMH Care Group in the Cheshire West locality in collaboration with Cheshire West and Chester Local Authority (LA) AMHPs. This was later rolled out to Wirral locality and Wirral LA AMHPs. During this trial period, a Quality Improvement (QI) project was undertaken to ascertain the benefits.

Benefits realisation reported during the pilot:

- The average time for ward staff to process new sections was significantly reduced from 24 minutes with paper forms, to 11 minutes on Thalamos.
- By removing the administrative burden completely from ward staff during weekdays this saved approximately 25 minutes of clinical time per section.

- S.15 errors on MHA papers were significantly reduced, only two out of 47 amendments required were on Thalamos. Both errors related to patient details and cannot be mitigated by check and balances within Thalamos.
- No unlawful detentions were recorded when completed on Thalamos.
- The reduction in errors will over time will result in a reduction in category B incidents being reported and subsequent time spent on investigations.

Positive feedback was also received from clinicians and AMHPs using Thalamos, examples include:



A successful bid for funding, led by CWP in partnership with Mersey Care NHS Foundation Trust, to support work around the MHA , secured £65,350 funding from Health Education England towards the plan for digitisation. A contract has now been signed to fully roll-out Thalamos Trustwide. Regular meetings are held with the Client Lead at Thalamos, and a Project Board is currently being set up to drive this forward, bringing on board Cheshire East LA, Children & Young People and Learning Disability Care Groups.

Partnership working:
The MHL Manager is a member of the Thalamos Steering Group and has actively contributed to the Thalamos development programme, including collaboration and partnership working with other trusts using, or considering the use of Thalamos.

Practice improvement:
Most forms received from Second Opinion Appointed Doctors (SOADs) are now via Thalamos.
Consent forms are available much quicker, are clear and legible, resulting in speedier access to authorised treatment.

RESPONSIVE

Delivering person-centred care and services that take account of the needs of different people

3. Access to IMHA/ IMCA services

Variation in access to advocacy services, specifically IMHAs, has been raised in CQC MHA Reviewer visits to wards during the last year. Independent Review Panels have also noted variation in the presence of advocacy support at hearings since the start of the COVID-19 pandemic – mainly due to IMHAs not visiting wards.

Practice improvement:
To improve routes of access to the IMHA service in Cheshire and promote the support available, the MHL Manager met with advocacy leads and agreed a process for informing the advocacy hub weekly of new detentions under the MHA. A pilot was undertaken for Rosewood ward and following extremely positive feedback, the new process was rolled out across Cheshire.

To support this, Age UK and Disability Positive developed a joint flyer with service and contact details given to all patients following admission.

The MHL Manager has also reached out to Wirral Advocacy Service with a view to expanding this approach for those detained at Springview Unit.

Future development:
A new advocacy service for Cheshire, to commence in September 2022, is currently being commissioned. The MHL Manager was approached for feedback on the current service and any improvements which could be made. Liaison will continue with the new service to ensure those detained under the MHA are supported effectively.

3a. MHL Team support to teams

Since the start of the COVID-19 pandemic, the MHL Team have taken a hybrid approach to working, ensuring a physical presence in the office to support teams and to deal with MHA documentation. The team have adapted and been innovative in their approach as a response to the challenges posed by the pandemic, whilst continuing to provide an effective support service.

Support continues to be provided to wards and CMHTs across the Trust in the form of advice, support for changes in process and legislation/ guidance and updates on the use of the MHA. Although the face-to-face training programme offer did not operate during the pandemic, the MHL Team have provided ad hoc bite-sized MS Teams training for staff. The ability to use MS Teams in this way has proved successful due to its flexibility and ability to respond at short notice, setting up impromptu remote discussions to specific queries. The MHL Team also continue to facilitate training for junior doctors as part of their induction programme.

The MHL Team continues to support wards regarding CQC MHA Reviewer visits (see item 6b below). A programme of ward visits is in place to provide ongoing support with action plans to ensure improved compliance with the MHA Code of Practice. Collaborative working

with the Incidents and Complaints Teams enables the triangulation of information to support development of these action plans, informing learning and driving the most effective improvements.

To support the EPR Transformation Team with the introduction of SystmOne, the MHL Team worked collaboratively to develop the MHA element, including a process of data validation, and reviewing migrated data to ensure accuracy. A guide to inputting MHA data was developed to ensure consistency of recording and a robust process implemented during the cutover period to ensure all data was subsequently entered once SystmOne was live.

3b. MHA activity in acute trusts

CWP now has three Service Level Agreements (SLAs) for MHA Administration with acute trusts within its footprint; East Cheshire NHS Trust, Mid Cheshire Hospitals NHS Foundation Trust and the Countess of Chester Hospital NHS Foundation Trust. There has been some progress made to formalise an agreement with Wirral University Teaching Hospital NHS Foundation Trust, however this has not yet been agreed. The MHL Team informally scrutinise MHA documentation for Arrowe Park Hospital upon request and advise on any potential errors.

SLAs enable the MHL Team to support acute trusts in the administration of the MHA and ensure patient rights are upheld. The number of known detentions in acute trusts are monitored by the MHL Team.

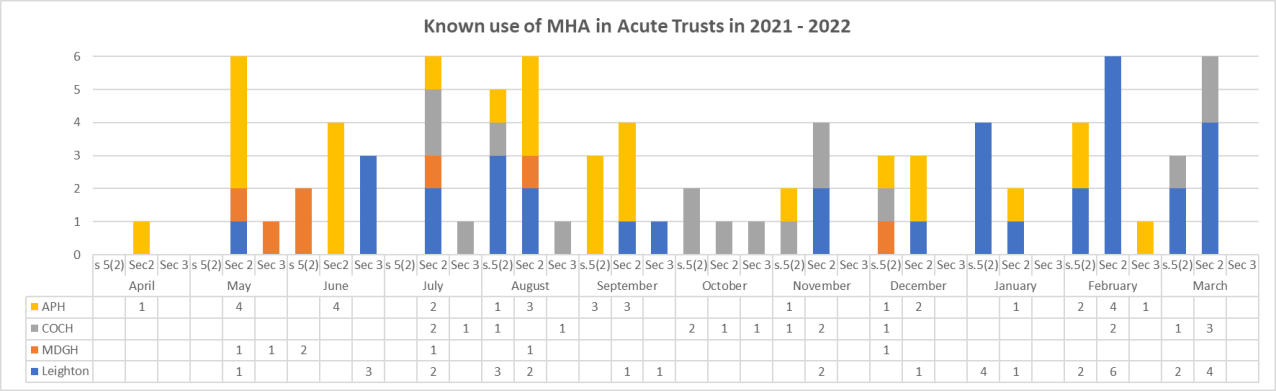
An increase in the use of the MHA in acute trusts has been noted during 2021/22, particularly at Leighton Hospital. To support acute trust staff in the use of the MHA, the MHL Team liaise with the Dignity Matron and have offered training/ support sessions, with the inclusion of liaison psychiatry, to ensure effective processes and support structures are in place.

During 2021/22, there was one reported incident regarding the implementation of MHA in acute trusts – a consent to treatment form was not in place when required for a young person detained at Leighton Hospital.

Learning and improvement:

The MHL Team improved their processes for monitoring compliance with the MHA in acute trusts in response to an incident. An aide memoire clarifying the duties of the Responsible Clinician was developed by the MHL Manager and Speciality Clinical Director, Tier 4 CAMHS. This has been shared with all CAMHS consultants to support them in their role as Responsible Clinicians for young people detained in acute trusts.

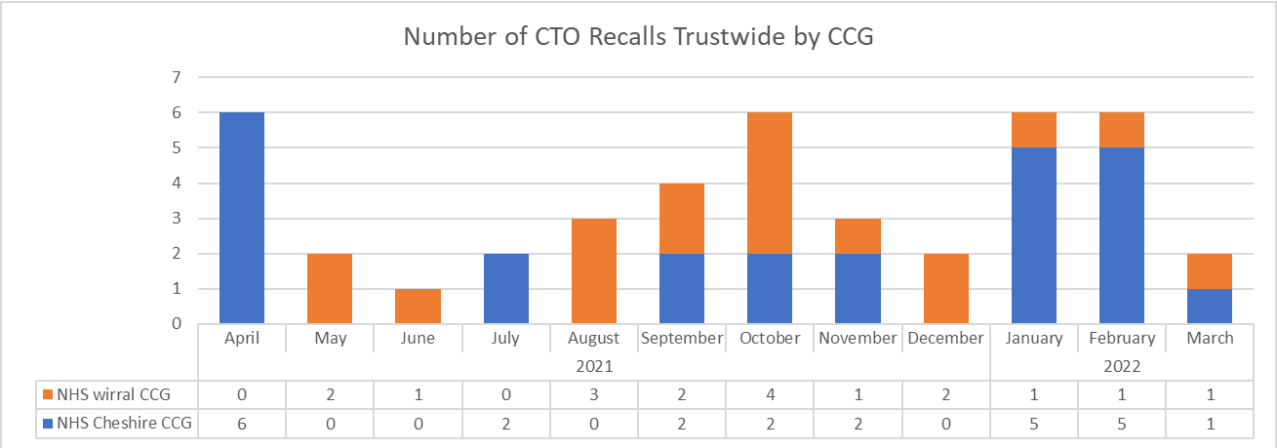
EFFECTIVE



People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

4. CTO recall

The MHL Team continue to monitor the use of CTO recall. The charts below present the use of CTO recall activity between 01/04/21 and 31/03/2022.



	April	May	June	July	August	September	October	November	December	January	February	March
NHS wirral CCG	0	2	1	0	3	2	4	1	2	1	1	1
NHS Cheshire CCG	6	0	0	2	0	2	2	2	0	5	5	1

Of the 43 recalls during this period, 38 (88%) were revoked resulting in further detention in hospital. A comparison with the previous year shows that in 2020/21 there were 79 recalls, of which 56 resulted in revocation (71%). Although there was a higher number of recalls the percentage of revocations was less. Benchmarking against national statistics will be undertaken when this data is available.

GOOD GOVERNANCE AND MANAGEMENT

Ensuring robust arrangements to make sure that hospital managers discharge their specific powers and duties according to the provisions of the MHA

5. Hearing activity

Between 01/04/21 and 31/03/22, the following applications/ appeals were submitted (this includes automatic referrals and Independent Review Panel (IRP) hearings following renewal of detention/ CTO):

	Type	Number of applications	Total
First-tier Tribunal	Inpatient	500	528
	CTO	28	
Independent Review Panel	Inpatient	95	269
	CTO	174	

The First-tier Tribunal continue to hold hearings via video conferencing. Following some initial issues with the Tribunal virtual platform experienced nationally, there have been no further incidents. The Tribunal Service have recently written to CWP informing of a future change to the video conference platform for hearings. The Networks and Telecommunications Manager is liaising with the Tribunal Service to test the new platform, ensuring there is no disruption to the process.

5a. Independent Review Panels

A QI project to refine the process for Hospital Managers' hearings continues. To promote the independent nature of the panel, in discussion with the Medical Director, Non-Executive Director lead for the MHA, Associate Director of Safe Services and the MHL Manager, the name was changed to Independent Review Panel (IRP), with positive feedback from professionals attending hearings.

Despite some initial challenges, virtual hearings via MS Teams have overall been effective and efficient. Hearing arrangements have become more flexible, reducing the impact on clinical time; participation in hearings not being dependent on travel time to specific locations. The impact on patients has been kept under consideration throughout this process. The IRP panels are ensuring patients have a safe and fair hearing, are encouraged and supported to participate in their hearing, and are supported by an IMHA should they wish. On occasions, hearings have been adjourned to enable an IMHA to be present.

Since virtual hearings have been introduced, an increase in attendance by patients subject to CTO has been noted . Feedback from panel members has shown that whilst they prefer face-to-face hearings, consideration should be given to a hybrid process, enabling both face-to-face and virtual hearings going forward. Discussions regarding future hearing arrangements will include identification of appropriate community venues and the provision of an option for CTO patients to have a face-to-face or virtual hearing.

The IRP hold an annual meeting to reflect on the previous year, to receive updates on legislation/ caselaw and to drive future improvements. This also includes a training programme. In June 2021 this was facilitated by the Medical Director on the Protection of Patient Rights. The next meeting, scheduled for the end of April 2022, is to include a session by Hill Dickinson solicitors on Nearest Relative applications for discharge and Barring Orders.

There are currently thirteen Associate Hospital Managers, five of whom chair hearings. One is newly recruited and is being supported by way of an induction period. In addition, the Trust Non-Executive Directors sit on panels whenever possible.

To ensure effective governance of the Independent Review Panels and to comply with the MHA Code of Practice, CWP has an appointed Non-Executive Director Lead (NED) for MHA who regularly meets with the MHL Manager to monitor to quality and effectiveness of hearings, learn from issues raised in monitoring forms and promote learning. Where required, concerns are raised with the Executive Lead.

A significant increase in the number of Nearest Relative applications have been recorded in 2021/22. During this time there have been a total of 35 applications for discharge, of which 17 resulted in a Barring Order. Whilst there is no duty under the MHA to hold a hearing to review a Barring Order, it is good practice to do so. Of the 17 Barring Orders, 8 hearings were held, resulting in two patients discharged from detention by the panel. Five nearest relatives opted out of the hearing process and four patients were discharged by the Responsible Clinician prior to a hearing being arranged. There were no cases where the nearest relatives exercised their right of appeal to the First-tier Tribunal in response to the Barring Order. Some of these cases have proved extremely challenging for the IRP when addressing the additional criteria laid out in the MHA. Training has been arranged to support their decision-making process for Barring Orders (as previously noted).

During 2021/22, there were five adjournment issues reported via the Datix incident reporting system: three due to technical difficulties, and two due to relevant professionals not attending.

Learning and improvements identified from IRP incidents:

- The MHL Team offered support to the IRP Chair to ensure they were able to access MS Teams on their new personal device.
- Ward managers were asked to ensure suitable devices were available on wards to enable patient participation in their hearing.
- Learning shared with CAMHS Team Manager regarding the importance of care co-ordinators attending IRP hearings as part of the legal framework.
- An Aide Memoire produced to support staff in preparation for hearings.

The MHL Manager continues to liaise with the Non-Executive Director MHA Lead to provide assurance regarding governance of the hearing process.

SAFE

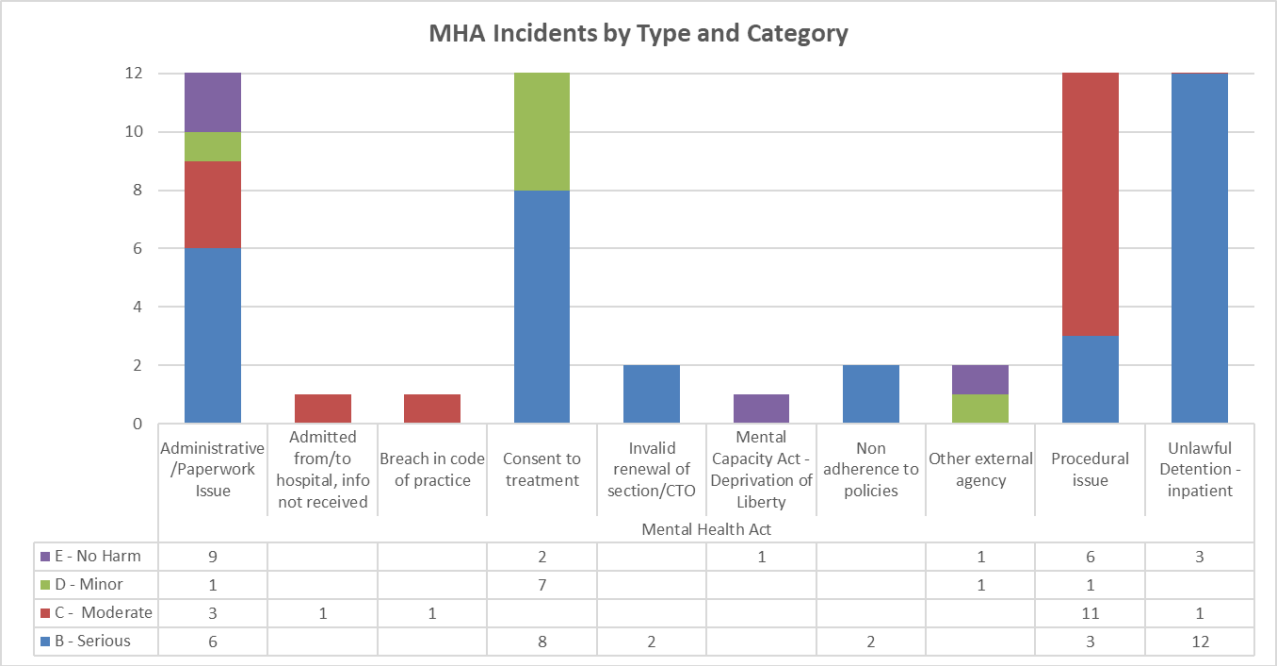
Protecting people who access our services from abuse and avoidable harm

6. Consent to Treatment

Following an incident regarding delayed receipt of a SOAD form the MHL Team developed a robust plan to ensure delays in receipt of consent forms are escalated. Improvement has been evidenced due to the MHL Team being proactive in ensuring SOAD requests are being submitted when required, earlier liaison with the CQC SOAD team to ensure the request has been received and actioned, and speedier receipt and uploading of consent forms due to the use of Thalamos.

6a. MHA incidents

The chart below shows the number of MHA incidents reported by type and severity for 2021/22.



	Administrative /Paperwork Issue	Admitted from/to hospital, info not received	Breach in code of practice	Consent to treatment	Invalid renewal of section/CTO	Mental Capacity Act - Deprivation of Liberty	Non adherence to policies	Other external agency	Procedural issue	Unlawful Detention - inpatient
E - No Harm	9			2		1		1	6	3
D - Minor	1			7				1	1	
C - Moderate	3	1	1						11	1
B - Serious	6			8	2		2		3	12

During this period, there were 33 category B MHA incidents reported. The MHL Team continue to work with colleagues to review incidents and identify more appropriate systems-based learning in line with the NHS Patient Safety Strategy.

Following the identification of specific themes, the MHL Team link with the Head of Patient Safety Incidents to ensure learning is shared via the Learning from Incidents Bulletin.

Examples of learning shared:

- Use of alert prompts in clinical areas to check consent to treatment dates and forms in place prior to prescribing/ administering medication.
- Regular audits to ensure compliance with MHA consent to treatment provisions, including using the MHL online audit tool which is reported monthly to ward managers and matrons.
- MHA training sourced via the CWP Learning Academy. The MHL Team offer of bite-sized training/ support sessions on specific aspects of the MHA.
- Recording of section expiry dates in ward round agendas to ensure sections are reviewed prior to expiry.
- The bed hub now send daily updates on patient movements to the MHL Team to support effective communication with clinical teams.
- Clarification on the process for transferring CTO patients into CWP to ensure the CTO is lawfully transferred and any required actions are addressed.

The MHL Team are supporting wards and community teams regarding learning about improvements required in the completion of MHA documentation. Going forward, whilst the use of Thalamos will mitigate most common errors, the electronic systems will not be incident-free, therefore the MHL Team will monitor emerging incidents and support teams with learning and improvement.

6b. MHA complaints

During 2021/22, 29 complaints were received relating to the MHA. These have been categorised as follows:

Type	Number of Complaints
MHA sectioning	10
Staff attitude	5
Discharge from hospital	3
Dissatisfied with access to services	3
Communication/ information	2
Medication	1
Seclusion	1
Assault/ violence physical	1
Infection Prevention and Control	1
No Subject applicable	1

Themes arising from these complaints include:

- Unhappy about being detained
- Lack of explanation of rights
- Thought they were being admitted informally, but was sectioned

- Wanted s.17 leave, or s.17 leave was cancelled
- Care on the ward
- No understanding of why they were recalled and then put in seclusion

The number of complaints received evidences the promotion and awareness of the complaints procedure to support compliance with the rights of those detained under the MHA.

The MHL Team liaise with the complaints team to ensure appropriate responses are provided, particularly. Complaints regarding the MHA are triangulated with reported incidents and themes raised in CQC MHA Reviewer visits to support improvements and ensure learning is shared.

Example of improvement:
Feedback from complaints regarding a lack of explanation of patient rights and the cancellation of leave was shared to (i) improve responsiveness of care and patient access to clinical teams, (ii) enable detained patients more opportunities to discuss their concerns and care plan whilst on the ward.

6c. CQC MHA Reviewer visits

During 2021/22, 6 CQC MHA Reviewer visits took place, one to each of the following wards:

- Indigo ward
- Alderley unit
- Juniper ward
- Rosewood ward
- Coral ward
- Eastway Assessment & Treatment Unit

and a follow-up visit to Coral ward at Ancora House.

No actions were raised following remote visits to Alderley Unit or Eastway Assessment & Treatment Unit . A further face-to-face follow-up visit was made to Alderley Unit and an action plan is currently being developed.

Below is a summary of main themes from MHA Reviewer visits:

- Environmental – faulty heating thermostats, damage to walls/ paint flaking, missing observation mirror
- Ward activities – some patients said there were not enough activities, with poor availability at weekends
- Access to psychology input was limited
- Lack of awareness of the role of an IMHA and how to access for support
- Gender specific areas for young people/ LGBT+ awareness
- RC availability to see patients outside of ward round
- Effective 1:1 time with named nurse
- Concern regarding staffing levels

Some examples of improvements made following CQC MHA Reviewer visits:

- A programme of interim refurbishment measures was put in place at Bowmere pending a planned refurbishment programme which is underway.
- Access to psychology services has improved by the appointment of a psychologist in each locality.
- The MHL team implemented a process to improve access to the IMHA service in Cheshire.
- The ward team engaged with young people to see their views on single sex lounges.
- A continuous improvement plan is in place to support the recruitment and retention of staff across the Trust.

The MHL Team continue to support wards with the delivery of action plans following CQC MHA Reviewer visits and to raise awareness of recurrent themes. All action plans are signed off by the service Clinical Director and the Head of Clinical Services prior to submission to the CQC.

A heat map was introduced in 2021, to schedule supportive visits to ensure compliance with the MHA and MHA Code of Practice. The visits are undertaken by the MHL Team and Compliance Team with follow up by the MHL Team to ensure learning has been embedded into practice and to further identify, and deliver, training needs.

6d. CQC Monitoring the Mental Health Act Report 2020/21

The CQC Monitoring the Mental Health Act in 2020/21 report sets out CQC activity and findings from engagement with those subject to the MHA, and reviews of services registered to care for people detained under the MHA.

Due to the national restrictions in place at the time, it looked at the issue of service provision during the pandemic, and it cited Juniper ward as an example of good practice:

Staff told us that the community mental health team staff had supported the ward on site at the beginning of the pandemic when staffing levels decreased. This had enhanced both teams' skill sets and improved liaison between the two teams. Staff felt that this had considerably improved the patient pathway from admission to discharge.

Juniper ward, Bowmere Hospital, Cheshire and Wirral Partnership NHS Foundation Trust, June 2021

The national themes identified in the CQC report will also be triangulated to inform learning. For example:

- *The CQC report raised key points regarding access to advocacy services and the difficulties faced during the pandemic due to not being able to visit wards.* This correlated to issues raised within CWP/ this report. Cited examples of improvement in the national report will be considered in future discussions regarding service provision.
- *Tackling inequalities raised key issues regarding the overrepresentation of certain minority ethnic groups of people subject to CTO*. This is reflected in CWP's data for CTOs detailed in this report. The final report of the Commission for Equality in Mental Health will inform future Trust work in this area.

6e. Legislative updates

Reform of the Mental Health Act – Following the publication of the White Paper: Reforming the Mental Health Act, the MHL Team shared the document and actively encouraged all staff/ Governors/ carers to submit their comments either individually or by contributing to a collective response. The associate hospital managers' panel also submitted a collective response.

The Government's response to this consultation was published on 17/07/2021.

Liberty Protection Safeguards – The draft MCA Code of Practice, including guidance on the new framework of Liberty Protection Safeguards (LPS), was published on 17 March 2022, the consultation period running up to 7 July 2022.

The MHL Team has circulated the online link to the consultation documents to all clinical staff/ carers/ Governors and the associate hospital managers for submission of comments either individually or collectively from the Trust.

7. Summary of Quality Improvement projects during 2021/22

- Ongoing project to digitise the MHA via Thalamos (see 2b above).
- Hospital Managers' Panel Improvement Plan (see 5a above).
- Consent to treatment pathway (see 6 above)

8. Recommendations

The Quality Committee is asked to note and approve this annual report and recommend this be accepted by the Board of Directors.

Jan Devine
MHL Manager

Stephanie Bailey
Compliance Manager
21/04/2022

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Annual Research Report

2021 – 2022

Helping people to be **the best they can be**

ABOUT CWP RESEARCH

The National Institute of Health Research has been put in place to help improve the health and wealth of the UK population. This has been shown to be extremely important during the pandemic when research staff were mobilized to conduct urgent public health research and treatment trials of drugs for Covid 19. Cheshire and Wirral Partnership NHS FT (CWP), as all NHS trusts, are expected took part in this and worked on vaccine trials. All NHS trusts are now returning to the valuable work they do in other areas of research.

The UK Policy for Health and Social Care Research states that *"evidence suggests the quality of current are may be higher in organisations that take part in research, adopt a learning culture and implement research findings"*. The Care Quality Commission (CQC) have also identified that the volume of research carried out by a trust correlates with better outcomes for patients and so now includes this as part of the 'Well Led' domain. CWP has always aimed to prioritise and grow research as part of its core business. CWP has invested in research and seeks opportunities to participate in as many clinical trials and research studies as possible to help drive improvement in care for the population we serve.

The pandemic has had a major impact on research in CWP. All research requiring visits to patient's homes stopped, non-essential visits to hospitals stopped and the genetic studies and lab studies were suspended due to equipment being utilised for the pandemic. Only a few studies remained those that were being conducted by telephone or could be conducted electronically. The staff were then redeployed to help on the wards or on projects for several months. Large research projects started very quickly in acute trusts into treatment of Covid19. These studies were intensive and used all acute research staff available. With the commencement of the Oxford Vaccine study at Liverpool School of Tropical Medicine in May 2020 CWP made its research staff available to work on this study and subsequent vaccine studies we are still following up patients from the original AstraZenica study to look at long term effects.

CWP are now returning to its core business and although there are not many mental health research studies, those studies that were in planning before the pandemic are now going forward.

RESEARCH STRATEGY – 2019/20 – 2023/24

The Research Strategy that has been developed is based on CWPs organisational values and will reflect the identity, principles and beliefs. There are seven strategic objectives that we will be working towards over the next five years these are:

1. Deliver high quality, integrated and innovative services that improve outcomes
2. Ensure meaningful involvement of service users, carers, staff and the wider community
3. Be a model employer and have a caring, competent and motivated workforce
4. Maintain and develop robust partnerships with existing and potential new stakeholders
5. Improve quality of information to improve service delivery, evaluation and planning
6. Sustain financial viability and deliver value for money
7. Be recognised as an open, progressive organisation that is about care, well-being and partnership.

These objectives are based on those of a number of other major national organisations including;

- NHS Long Term Plan (January 2019),

- National Institute of Health Research (NIHR) the nation's largest funder of health and care research with a mission to improve the health and wealth of the nation through research
- NHS Patient Safety Strategy (July 2019)
- Care Quality Commission and the Framework for Mental Health Research (Department of Health, 2017)

Additionally the Academic Heath Science Network (AHSNs) which support rapid evaluation and early adoption of new innovations in health care and the Higher Education Establishments (HEIs) where academics working in universities and other HEIs bring considerable experience and expertise in designing and undertaking research studies, these are also part of our wider strategy.

Locally consideration has been given to the Clinical Research Network (CRN) North West Coast, the local Applied Research Collaboration (ARC), Cheshire and Merseyside Health and Care Partnership and local HEIs where we have close links with both Chester and Liverpool Universities.

Underpinning this strategy are four main Aims:

AIM 1:	Deliver high quality research that informs the best ways to promote the health and well-being of the population we serve

Objective 1.1: To develop academic capability within our workforce to enable us to lead research relevant to the health and well-being of our population

Objective 1.2: To secure external funding to allow us to undertake this research.

Objective 1.3: To attract appropriate studies to CWP to address issues related to the health and well-being of our population.

Objective 1.4: To facilitate research studies in CWP that answer questions linked to the health and well-being of our population.

Objective 1.5: To support and undertake research that informs the protection and promotion of the health and well-being for our population.

AIM 2:	Ensure service users, the public and health care professionals are centrally involved in the design and delivery of research
Objective 2.1: To deliver research that is prioritised by people who use our services, the public and clinicians. **Objective 2.2: To ensure strong and consistent patient, public and clinician involvement in the development of research questions.** **Objective 2.3: To ensure our research is designed and led by teams comprising people who use our services, members of the public and clinicians.** **Objective 2.4: To offer more opportunities for people who use our services to participate in research.** **Objective 2.5: To support the development of academic expertise within our workforce.**	
AIM 3:	**Promote research which aligns with our strategic objectives**

Objective 3.1: To support studies whose objectives align with our strategic objectives.

Objective 3.2: To translate the priorities of our Care Groups and corporate services into researchable questions.

Objective 3.3: To support research that address priorities identified by the Cheshire and Merseyside Health and Care Partnership, (HCP).

Objective 3.4: To encourage research that links with priority initiatives (e.g. person-centred and trauma-focused care approaches).

Objective 3.5: To promote awareness of the impact on improved outcomes of being a research active organisation.

AIM 4:	**Strengthen collaborative links with our academic partners to deliver innovative research**

Objective 4.1: To consolidate collaborative partnerships with key universities in the North West to support aims 1, 2 & 3,

Objective 4.2: To foster links with a wider network of relevant external academic groups to achieve our aims,

Objective 4.3: To work with other health and social care providers to undertake studies over a wider geographical footprint,

Objective 4.4: To collaborate with acute care health providers to develop a portfolio of integrated health research

This strategy was presented and approved by the Board in Autumn 2019. Progress was made against each of the strategic aims in the second half of 2019/20 although the COVID pandemic had an impact in the final month of th year. As a result of COVID a number of trials were halted and a number of others were delayed.

DEVELOPING CWP RESEARCH

Aim	
Deliver high quality research that informs the best ways to promote the health and wellbeing of the population we serve	Through recruiting to portfolio studies and undertaking our own non-portfolio studies (please see below), we have delivered high quality research relevant to the health and well-being of our population.
Ensure service users, the public and health care professionals are centrally involved in the design and delivery of research	A notable example of our involvement of service users and carers in our research is in relation to the COVID research project. Not only have service users been involved in the oversight of this work, but also in the data analysis and interpretation. In addition to this project, we have undertaken a series of research studies that have been informed by clinician identified priorities (e.g. clinical decision-making in acute psychiatric scenarios, conceptualization of risk in clinical settings, physical health metrics of patients with learning disabilities).
Promote research that aligns with our strategic objectives	The studies we have undertaken and supported have been prioritized on the extent of the alignment between the research question that the study addresses and one or more of CWP strategic objectives.
Strengthen collaborative links with our academic partners to deliver innovative research	We have developed new CWP clinical academic posts (including a professorial position) and established an MSc program with the University of Chester. We are working closely with Liverpool John Moores on a Phd project (on pathways for patients experiencing suicidal crisis) and on a study examining patient experience, clinical profile, resource use and clinical decision-making in relation to patients with complex needs. A professorial post at the University of Manchester has been part funded. Continued close work is ongoing with the University of Liverpool, particularly through the ARC (NWC). We have established new collaborative relationships with the Universities of Birmingham and Salford.

EXAMPLES OF ONGOING RESEARCH STUDIES

Surveillance Towards Preventing Paediatric incidence of Respiratory Syncytial Virus (STOPRSV) attributable Respiratory Tract Infections (RTI)

RSV infection is very common particularly in the winter. In most children this leads to mild disease, but it can also lead to a lower respiratory tract infection commonly known as bronchiolitis. As many as 4 children per 100 are admitted to hospital each year. Approximately 10% of all Pediatric Intensive Care Unit (PICU) admissions (over 1000 children a year) are admitted to Intensive Care in England. Each year approximately 20 young children die from this condition1. RSV rapidly spreads to others including staff and patients requiring barrier nursing in wards and PICU. Very young children <3 years of age, particularly those with other health conditions are more vulnerable to severe infection.

Purpose of The Study

At present there is very limited surveillance information with laboratory confirmed RSV, particularly in the community setting. The main aim of this observational surveillance study is to assess the number of children with respiratory symptoms with laboratory confirmed Respiratory Syncytial Virus (RSV). Also, to determine the health economic burden to the family and health care.

In future: these data will contribute to informing vaccination strategies to prevent bronchiolitis.

How Was the Study Designed?

The study is looking at Children under 3 years of age presenting to Primary and Secondary/Tertiary healthcare settings, in Merseyside and Bristol, with RTI's. Surveillance will be conducted from October 2021 until 2023. A nasal swab is taken for virological testing. Follow-up questionnaires for parents are conducted 14 +/- 28 days after study enrolment to assess the clinical outcome of the infection, health care use and economic burden to the family.

Progress to Date

So far practice-based surveillance is active via CWP Research department across 5 GP practices on the Wirral and in Cheshire including the 3 CWP run practices. To date the team have successfully recruited 31 participants to the study and are actively supporting practices to identify further potential participants. Alder Hey Children's hospital, The Women's Hospital in Liverpool, Arrowe Park Hospital and Countess of Chester Hospital are also actively involved in study

Safety and efficacy of the ChAdOx1 nCoV-19 vaccine (AZD1222) against SARS-CoV-2

What do these studies aim to find out?

As the COVID-19 pandemic, caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), continued to unfold, with widespread impact on health, including substantial mortality among older adults and those with pre-existing health conditions, and repercussions for the global economy, caused by physical distancing measures, with the greatest consequences for the most vulnerable in society. This study was designed to identify a safe and efficacious vaccine against Covid 19.

How were the studies designed?

Participants aged 18 years and older were randomly assigned (1:1) to ChAdOx1 nCoV-19 vaccine or control (meningococcal group A, C, W, and Y conjugate vaccine or saline). Participants in the ChAdOx1 nCoV-19 group received two doses containing 5×10^{10} viral particles (standard dose; SD/SD cohort); a subset in the UK trial received a half dose as their first dose (low dose) and a standard dose as their second dose (LD/SD cohort). The primary efficacy analysis included symptomatic COVID-19 in seronegative participants with a nucleic acid amplification test-positive swab more than 14 days after a second dose of vaccine.

What are the findings so far?

This vaccine was given a license for use and first doses of this vaccine were used on a wide scale from December 2020. We are still continuing with this trial to make sure that the vaccine hos no long term side effects.

Prevalence of Pathogenic Antibodies in Psychosis (PPiP2)

There is some evidence to suggest that the body's auto immune system may be one of the causes of psychotic illness. The immune system is meant to keep us safe from infections and disease. However sometimes it mistakenly attacks healthy parts of the body. If the auto immune system attacks the brain it can become 'inflamed', leading to psychosis. A blood test for pathogenic antibodies can often tell us if this might be happening.

What does the study aim to find out?

The study aims to find out the prevalence of pathogenic antibodies in people experiencing psychosis. Currently it is estimated that between 1 to 10 percent of cases have an auto immune origin...

How was the study designed?

The study is looking for people between 16-70 years with symptoms of psychosis for longer than two weeks but less than two years. A small sample of blood is collected; these samples are studied and stored along with information about the person's symptoms and background. If the blood test shows that the immune system is not working properly this will be discussed and a referral will be made and a patient can also be treated with immune suppressant therapy and plasma exchange.

Findings so far?

So far we have taken samples from 50 people three of these have tested positive for pathogenic antibodies. Without this test these people were likely to end up taking antipsychotics for the rest of their lives and remain in mental health services.

Pramipexole for Bipolar Depression – PAX-BD

What do these studies aim to find out?

The PAX-BD study aims test the drug pramipexole which is currently approved for usage by the NHS in Parkinson's disease to treat treatment resistant depression in bipolar disorder. They aim is to use pramipexole in conjunction with a mood stabilizer rather than using an antipsychotic. There is some evidence from small studies that this drug reduces depression both in Parkinson's patients and bipolar patients. This trial is to see if this is an effective treatment in bipolar disorder

How were the studies designed?

This is a randomized placebo controlled trial of pramipexole and placebo. Initially patients will be gradually taken off antipsychotic medication and then will be given pramipexole and a mood stabilizer. They will be regularly reviewed and be able to contact the study team if they have any problems.

What are the findings so far?

There are no findings as yet – this study was suspended due to Covid 19 and has only recently restarted. It is very difficult to recruit to but we have recruited half of our target and expect to complete our recruitment in the next three or four months well within the time allocated.

RESEARCH PERFORMANCE

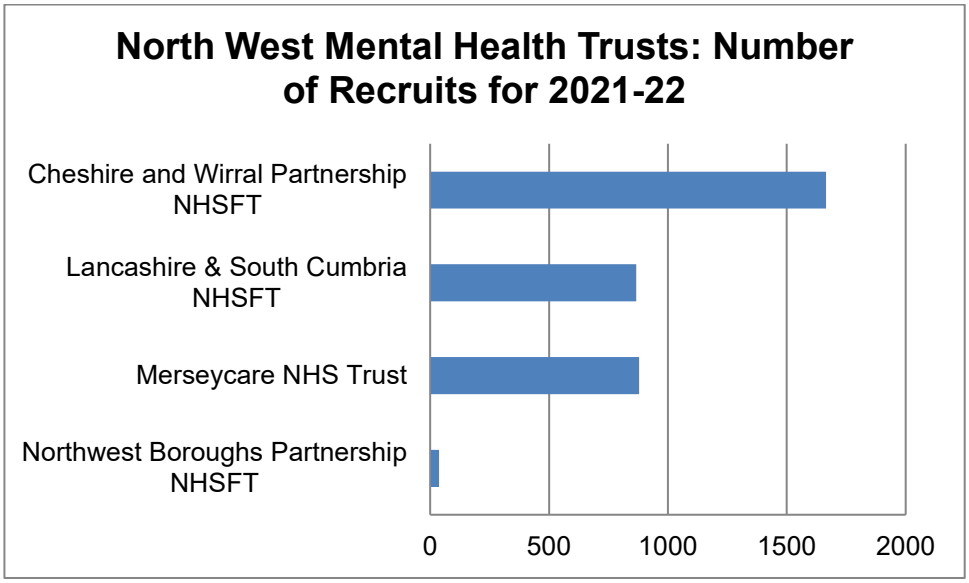
Performance in research is monitored by the Comprehensive Research Network, North West Coast. It monitors the number of trials and recruitment in real-time via the EDGE database and the National Open Data Platform Database. Report are normally submitted quarterly to the Clinical Trials Performance (CTP) where performance in initiating and delivering research is monitored, however during the last year this has been suspended so that they could concentrate on the pandemic. There has been regular Zoom meetings to coordinate the effort in getting as many people in to the Urgent Public Health Studies – these have been priortised by the NIHR across the UK. The CRN are now moving to returning to it core business and no longer focusing on Covid 19 although they are completing any ongoing studies.

Time and target

CWP Research has not been monitoring time and target over the year 2021-22 due to the pandemic. Large numbers of studies were either suspended or stopped at the end of March 2020. Priority was then given to the Urgent Public Health Studies and collaboration across all trust was key to deliver these studies. This has now changing and we will be returning to this metric as we return to normal functioning.

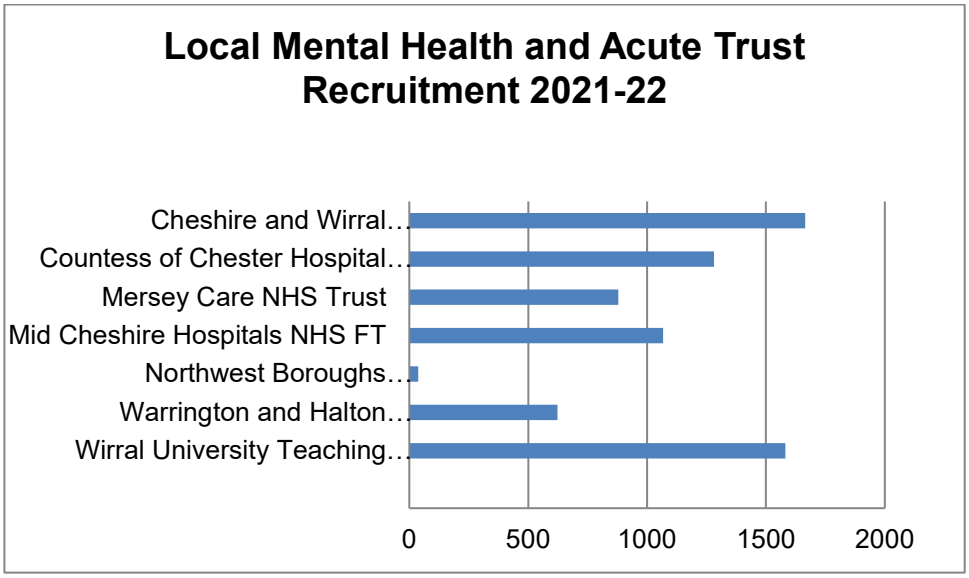
Recruitment to National Portfolio Studies

CWP has responded positively to all the metal health studies offered during 2019/20 . However, very few of these have been initiated and those that the Trust has been able to participate in have resulted in low numbers of recruits.. CWP has therefore recruited only 659 research subjects which is half the number we recruited in previous years. The Trust continue to recruit well compared to other MH providers who have much larger populations and research opportunities.



*figures as of 31st March 2022

Performance has also been good in the context of the Cheshire and Wirral Local Delivery System considering the size of the trust and its population, as demonstrated



*Figures at 31st March 2022

We hope to continue to recruit well to studies however this is dependent on the studies we attract to CWP and the current Covid 19 restrictions...

RESEARCH FUNDING

CRN Funding

The Trust receives funding every year to support recruitment costs to portfolio studies. The NHS Support Funding covers the cost of staff employed to recruit to portfolio studies and their related travel expenses. There is also a small amount of funding to cover some staff time for research governance/ Health Research Authority related work. This funding is based on staff grade and incremental point for each individual member of staff employed.

CRN Funding 2018- 2019	
Budget	211,906
Contingency	20,000
LCRN Leadership	11,04.75
Total	**£242,954.75**

CWP have a standard budget for staffing, additionally we receive funding for a member of staff who provides a Leadership role at the CRN across the NW Coast. We have bid and received Contingency Funding to support infrastructure to help one of our larger studies.

Sustainability

Funding from the CRN is allocated each year and can change. The CRN has just introduced a new way of allocating funding based not only on the number of recruits which has been the main metric used but upon work conducted on Strategic categories of research of which Mental Health is one, Agile Working which is working between trusts and Collaboration which is about working with other Trusts and universities to develop research. We should meet the new metrics easily and at least maintain or increase our budget for next year. Long term funding has been fairly constant for since the inception of the NIHR in 2006 and with the importance research has played recently during the pandemic it is likely to continue.

CWP research development

CWP is developing research within the Care Groups. Each has a Consultant with academic time to support this development, Initially most are conducting evaluations and with a view to applying for funding down the line. Below is an update from each of these Groups.

Neighbourhood care group research progress April 2022

The Neighbourhood care group have staff at varying stages of the research process from beginning research studies through to master's level awards. A nursing PhD scholarship has also been awarded to one of our advanced clinical practitioners by Liverpool John Moores University.
The care group is also championing the Chief nursing officer's "National research strategy", to embed research into everyday practice. To facilitate this a temporary research and effectiveness lead nurse is currently in post.

A survey has been undertaken with the Neighbourhood care group to gain insight and understanding into staff's thoughts and ideas about research and how we can embed research into practice. We had a good response rate from our staff with plenty of suggestions to support future research activities. The main findings demonstrated that staff wanted a better understanding research, how we could embed it into everyday practice, protected time to undertake research and more support when undertaking academic studies.

Following these finding it is hoped that collaborative working with the research team, library and education can support these ideas for the future. Research information from the survey and the CNO research strategy has been presented at the clinical quality group meetings and will also be placed onto the individual care team's information boards.

A research for practice toolkit is also being developed nationally in response to the CNO research strategy through the "clinical matrons research group", of which Neighbourhoods has representation and involvement in its development.

This is a great time to be involved in research and really champion the good practice and innovation that is happening. Neighbourhood care group want to celebrate our successes, support new ideas and wider collaboration to ensure that evidence based practice, research and evaluation is part of our everyday culture.

LD, NDD & ABI Care Group R&D Update
Developing CWP Research

We continue to focus on strengthening research capability and capacity within our workforce.

In 2021, the SORT-IT programme was successfully completed by two clinicians and there is significant interest from others to engage in the process. We continue to encourage and support multi-disciplinary research across the care group.

To develop expertise within our workforce, and following the Covid-19 pandemic pressures, we are re-starting research seminars to support staff to develop their research proposals. Research surgeries are also starting for staff once a project is underway to ensure support is available at every step. This also ensures development of capacity as more staff go through the process.
We currently have one staff member doing a research-based PhD through Chester University and funded by CANDDID. We are developing projects and opportunities for further MRes and PhD programmes.
We have recruited to a number of research posts to support research in general and specific projects.

We have the following projects at various stages

- Experience of intensive support teams in learning disability services
- Development of inpatient resource tool (UNBRA)
- Evaluation of health stratification tool for people with learning disabilities (DST-PH)
- Validity of Autism diagnostic Assessment (ADA) tool
- Use of group Cognitive Stimulation Therapy (gCST) for dementia in people with intellectual disability
- Development of anxiety management programme for people with intellectual disability
- Development of Dynamic Needs Assessment Tool for Special Education Needs (DNAT-SEN
- Complex Continuing Care and inpatients with intellectual disability in the North of England
- Use of virtual reality for improving access to health services for people with intellectual disability
- Prescribing patterns in adult ADHD services and pharm Abnormal and Restrictive Food Intake Disorders
- Abnormal and Restrictive Food Intake Disorders

In order to strengthen collaborative links with our academic partners and to deliver innovative research, we have partnered with the following organisations in research projects:

- University College London
- University of Plymouth
- University of Manchester
- Manchester Metropolitan University
- Pennine Care NHS Foundation Trust

Promoting research in the field of Learning Disabilities and Neurodevelopmental Disorders
We have now had two CANDDID conferences 2021 which focused on ADHD and other Neurodevelopmental Conditions and 2022 focused on Learning Disabilities – Advances in Neurosciences and Therapeutic Interventions. The diverse programme brought together researchers from across a range of national and international sources, including people with lived experience. CWP researchers presented their work as keynotes and through workshops at both these conferences. At the 2022 conference, a significant number of the care group workforce also submitted posters of their research (attached).

Through CANDDID, we have so far submitted three NIHR funding applications:

- DST-PH validation
- Evaluation of DSD as a feasibility study (with UCL)
- Management of Anxiety in people with Intellectual Disability

We have also received funding from alternative sources for the following projects:

- DST-PH
- DSD
- DNAT-SEN
- Complex Continuing Care
- Virtual Reality

We are in the process of applying for further funding

SMH Care Group Annual Update

Vision and Strategic Plans

Over the past 12 months SMH has developed a strong vision and strategic plan as to what research in the Care Group will look like, its role, and most importantly, how it will be aligned to improved care for our patients. Next steps are to operationalise this plan.
In May 2021 SMH invested in a two day per week Consultant/Clinical Academic to lead research in the Care Group. Initial steps involved a benchmarking exercise in which SMH activity was measured against the Trust wide research strategy. Following on from this there has been the gradual development of an ambitious SMH vision for research in the Care Group.

In brief, SMH aims for a model in which research is inherently linked with our effectiveness strategies. That is, our decisions around transformation and service delivery should be informed by an academic rigor which can support strategic decisions with local evidence and expertise. SMH is committed to research which has local patient experience at its centre and produces tangible benefits for the CWP population. As a Care Group we are committed to the notion that Trusts with a research active culture can deliver superior outcomes for patients and to offer a more positive experience for the workforce.
The SMH Research Lead has drawn up a proposal and draft Terms of Reference for an SMH research institute which has provisionally been entitled CWP REAL (Research, Effectiveness, Academia, Learning). This will be presented for approval to the SMH Business and Governance meeting in Quarter 1. CWP REAL will be the entity linking research with effectiveness and improved patient outcomes. SMH research will have patient centredness as its core. CWP REAL will set out the SMH stall for a culture of excellence and innovation within our transformation agenda. The aspiration is that in the medium to long term CWP REAL will allow SMH and CWP to develop a reputation as a leader in the delivery of mental health care, education and training. Funding for an 8a project manager has been secured. (The advert for the post is due for release in mid-April 2022 and key roles will be expanding research capacity within SMH and securing grant funding.)

Brief review of SMH Research Activity Highlights
The research lead for SMH linked in with trainee doctors to complete an analysis of CTO recalls and revocations which fed directly into SMH service improvement work via Quality Committee. A second project around the analysis of a pilot project around 7-day Consultant working is nearing completion and will be fed back into the Trust effectiveness strategy in Q1. The research lead has also joined the Acute Care Review team in order to embed an academic viewpoint. SMH is keen that research outputs with tangible benefits are fed back into Trust staff training packages. With this in mind, the SMH research team worked with the Director of Research to produce training material focusing on risk assessment for the Trust. Here, novel approaches and academic expertise were leveraged to design a bespoke in-house training package. It is the intention that in the future CWP REAL will deliver income generating training packages.
A key aim of SMH is to increase research capacity within the Care Group. To this end, we are establishing a monthly 'Research Clinic' (beginning in May 2022) to support practitioners who are undertaking small project development work. A typical project was designed by the Research Lead and is being undertaken by an Advanced Nurse Practitioner team and focuses on long term wellbeing outcomes of patients discharged from Early Intervention Teams. The sessions are also going to involve the Neighbourhood Care Group so as to foster links and encourage cohesive working. We are also committed to supporting the ongoing delivery of the SORT-IT programme which will further enhance research capacity (SORT IT (sortitresearch.com)). The SMH Care Group is also able to provide academic support to other areas of the Trust. For example, the SMH research team are currently advising around a project led by the pharmacy team which is funded by NHSX and centres around the use of mobile ECG devices in improving patient safety.

Led by the Director of Research, and with support from the strategic CD, the SMH Care Group has formalised and significantly enhanced links with local Higher Education Institutions. These links have provided for the establishment of larger research projects which significantly contribute to research capacity within the Care Group. The result has been a developing portfolio of high-quality research which is directly contributing to improved patient outcomes. The COMPAT study, in association with Liverpool John Moores University, is providing vital insights into 'complex care' and how as a Trust we need to structure services for an optimal patient experience. (Complex Mental Health Needs Project | Liverpool John Moores University (ljmu.ac.uk))
Another project (led by the Director of Research) involves a partnership with the University of Chester in which the project team are developing a novel staff training package focusing on the care of those patients with long term complex mental health needs. It will be cutting edge, co-produced and evidence based; and initially rolled out to the newly established Mhist team. A project manager is soon to be appointed. Thirdly, as part of the SMH drive to embed research and academic focus in effectiveness strategies; a formal partnership between CWP and Liverpool John Moores University has been established to academically evaluate the three transformation projects within the Care Group; acute care, urgent care and community.

PUBLICATIONS

CWP has published or contributed to 195 papers between 2019 and 2022 (see Appendix 1) and these have been published in a variety of journals, some of which have a high impact. These papers are used to provide better treatment to patients both nationally and internationally. A list of all the publications is available in Appendix 1 or from the CWP Library. But each

CONCLUSIONS

CWP has seen an increase in the number of participants recruitment to NIHR portfolio studies in 2021/22, (a total of 1665 participants were recruited) however this is mostly one study. The variation in the number and type of studies has reduced due to the pandemic but hopefully it will return gradually to pre pandemic levels over the next year or so.

We have increased our collaborations now we work closely with Liverpool School of Tropical Medicine and also we are supporting primary care – two GP practices in Wirral and three of CWP GP practices.

In house research has been steadily gaining momentum, the pandemic has slowed the progress but each Care Group have now started developing projects.

The Trust will continue to progress the delivery of the aims and objectives set out in the Research Strategy for 2019/24.

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

2020-2021

MEDICINES MANAGEMENT & OPTIMISATION ANNUAL REPORT

Compiled by: Pharmacy Team, CWP
Executive Sponsor: Dr Anushta Sivananthan, Medical Director
March 2022

Table of Contents

Executive Summary

This report provides the Board with assurance for the delivery of the medicines optimisation work plan over 2020-21, ensuring the safe and effective use of medicines within the Trust.

The report highlights the progress we have made over 2020-21 towards effective Medicines Optimisation, aligned with CWP's Forward View, the Carter recommendations of productivity and efficiency, the NHS 10-year plan and Covid Pandemic response. Key achievements are outlined under the following areas of the report:

- Governance, Assurance and Regulatory Standards
- Challenges
- Quality Improvements in medicines
- Workforce innovations

A key focus of the work over the past year has been around a continuous improvement in patient safety through learning from incidents and understanding how we can improve our internal processes to ensure we minimise potential harm from medicines. The challenges of the pandemic in delivering business as usual encouraged us to look at key priorities and how we delivered clinical care in a manner that was safe and protective of our limited workforce whilst ensuring it was very much patient centred. The pandemic also shone a torch on the valuable contributions that Pharmacy Professionals can make through the work of the vaccination programme and reaching out to the hard to reach communities. Further development of the pharmacy workforce as a key colleague in multidisciplinary teams across community as well as inpatient services is anticipated to continue to be a key feature during 2021-22.

Much has been achieved over 2020-21 despite the challenges we faced and there is much more to do over the coming years to continue to build on previous years' high standards in pharmaceutical care, including the continuous strive for excellent patient care, innovation and value from medicines.

Fiona Couper, MRPharmS, MSc Clinical pharmacy, BSc pharmacy.

Chief Pharmacist & Associate Director for Medicines Management,
Controlled Drugs Accountable Officer.

1. Governance, Assurance and Regulatory Standards

1.1 Medicines Management Group (MMG)

The MMG is the regulatory meeting in the Trust's integrated governance structure that is accountable for the safe and effective use of medicines and their associated policies and procedures. The MMG has met 6 times over the year; with an additional extraordinary small meeting in April'20 to approve a suite of Covid related procedures and guidelines as part of the Trust Covid Response. Quoracy was a struggle during the year due to competing staff priorities.

The new chair, Dr Miles Jefferson, took up the position in April 2020. This was an unprecedented year due to the requirements of the Covid pandemic response however the Group have worked hard and delivered against the priority areas of the business cycle and took on additional work related to medicines and vaccination by way of the CWP and Cheshire West response to the pandemic.

1.2 Care Pathways, Standard Operating Procedures (SOPs) and Guidelines

During the year various guidelines and procedures have been developed and approved to support clinical practice across our community care teams, mental health teams and bed-based areas. The key areas we have worked on are:

- Safe administration of controlled drugs by community care teams (single nurse administration process) with evaluation of impact in 6 months' time
- Non-Clinical Staff supporting visiting GPs to check stock balance of controlled drugs – approved, complemented with a CD audit taking place every 3 months
- Medication reviews in Learning Disability Care Homes in Wirral during Covid-19 -Plans for prioritisation. Psychotropic Medicines Briefing for Care Homes during Covid-19 developed
- VTE SOP for prophylaxis and treatment of DVTs
- Vitamin D updated patient guidance & new staff guidance based on NICE recommendations
- Approval of training material for GPs on management of clozapine induced constipation to include the treatment algorithm of choice
- Revised shared care guideline for the use of Methylphenidate in CAMHs for East Cheshire area.
- Introduction of PGDs (Nitrofurantoin & Trimethoprim) for the management of lower urinary tract infections that present at GP OOHs by permitting the triage nurses to make the decision following a clinical decision-making tool. This reduced the need for face to face appointments post telephone assessment and wait time for patients.
- Revised guidelines approved for MP26, Olanzapine long acting injection monitoring.
- Never events assurance framework annual medicines audit approved
- Safe administration of CDs by the community care teams west Cheshire for End of Life care. The roll out of the procedure of single nurse administration has demonstrated improved patient outcomes, timely interventions and minimal errors with CD handling.

Various Patient Group Directions (PGDs) for clinical services and Written Instructions for the workforce well-being service were reviewed and updated in line with the business cycle.

A set of new Procedures for the safe handling, administration and storage of the Covid-19 vaccines were developed for the Mass Vaccination Centre Cheshire West and approved alongside the associated National Protocols and PGDs for the administration of the vaccines.

1.3 CQC Feedback

Due to the pandemic response there was no formal medicines engagement meeting with the pharmacy inspector during this period.

1.4 Trust Assurance for Controlled Drugs (CDs)

Accountability for CDs sits with the Trust Board of Directors as detailed in legislation – *The Controlled Drugs (Supervision of Management and Use) Regulations 2013.*

The Board devolve the role of Controlled Drugs Accountable Officer (CDAO) to a designated person who either sits on the Board or is accountable to a Board member. The CDAO has organisational responsibility for CDs as designated in the legislation.

The CDAO in CWP is the Chief Pharmacist & Associate Director for Medicines Management.

The CDAO protects the Board of Directors for the Trust from:

- Corporate Manslaughter and Corporate Homicide Act 2017
- Health and Safety Offence Act 2008

This is in line with Regulation 8 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013, which states that Designated bodies must appoint a controlled drugs accountable officer, who will quality assure processes for managing controlled drugs in their organisation.

The CDAO has a statutory duty to report to the NHS England Local Intelligence Network (LIN) for Controlled Drugs, for CWP this is the North West LIN. The CDAO is supported in this role by the Medicines Safety pharmacist.

Quarterly reports compiled from CD Datix incidents and CD audits across all inpatient wards and GP Out-of-Hours are submitted to the LIN to provide assurance that controlled drugs are being handled in line with legislation across the Trust. Attendance at CDAO North West meetings enables the sharing of good practice across the network. Twice yearly the CDAO provides a controlled drugs report to MMG to provide Trustwide assurance for the prescribing and administration of controlled drugs. Summary details of the types of incidents involving controlled drugs are highlighted in the medicine safety section (section 1.5). It should be noted that the number of reported low grade (schedule(s) 4 and 5) controlled drug incidents rose during the year and involved codeine preparations (painkillers) and anxiolytic medicines (lorazepam, Diazepam). Such that 49% of all incidents reported related to S4 and S5 controlled drugs in Q3 and 4 and 33% in Q1 and Q2. A similar pattern also occurred in other organisations. Due to learning from one CD investigation a Share Learning Bulletin was issued to clinical staff in July'20 to raise awareness about the controlled drug schedules and the role of the Trust CDAO.

Going forward the CDAO would recommend that the Board of Directors receive a more detailed report annually on the management of controlled drugs to provide robust assurance on the processes employed within the organisation.

1.5 Medicine Safety – Learning from Incident Reporting and Medicines Errors

1.5.1 Incident Reporting of Medication Errors

Table 1 below shows the context of this year's medicines-related incidents, within the previous five years of data. The number of reported incidents has risen since 2019/20, probably due to increased awareness of reporting incidents. The proportion of moderate / serious incidents has increased slightly over the past year (6.9% in 2020/21 vs 5.7% in 2019/20). This is in line with the overall pattern of increased low-level harm incident reporting for the Trust indicating a positive safety culture.

Year/Severity	A	B	C	D	E	Total
2016/17	0	0	27	98	392	**517**
2017/18	0	0	20	85	304	**409**
2018/19	0	3	7	63	253	**326**
2019/20	0	2	17	64	253	**336**
2020/21	0	6	26	126	309	**467**

Table 1: Five-year trend of medication incidents by severity: April 2016 – March 2021

The chart below illustrates the number of reported medicines-related incidents over the last 12 months broken down by severity. The majority of the incidents fall into category E. It can be seen that there was 6 B grade medication incidents in 2021/21.

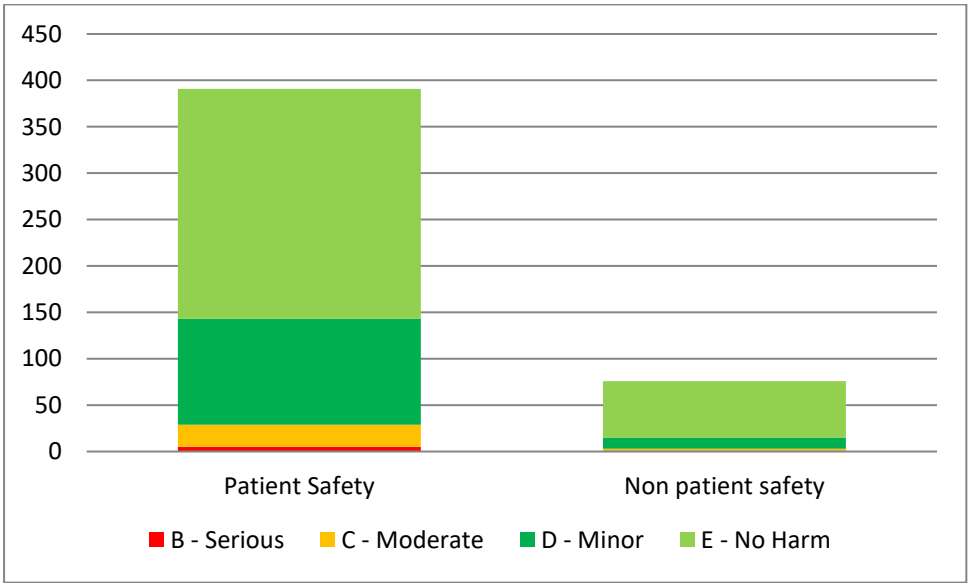


Figure 2: Medicines Safety Incidents by Severity over 2020-21

All were investigated and discussed at the weekly Immediate Safety Assurance Forum.

The patient safety incidents involved incorrect administration of medication (3), duplication of prescribing of antipsychotics (1), non- availability of buccal midazolam in emergency situation (1). A medication error policy has been developed over the year led by the Associate Director of Nursing and Therapies (Mental Health and Learning Disabilities) which is due to be launched in Q1 2021/22 following approval.
The non-patient safety incident involved a number of missing codeine tablets from a rehabilitation ward. This was reported to the Local Intelligence Network as codeine is a S5 controlled drug and a thorough investigation was carried out by the Modern Matron.

A Share Learning Bulletin was issued following the 2 grade B controlled drug incidents to highlight that there was a gap in knowledge and understanding of the:

- role of the Controlled Drugs Accountable Officer (CDAO) for the Trust,
- type of incidents and when they must be reported to the CDAO; and
- the Controlled Drug (CD) classification of medicines.

1.5.2 Trends in reported medicine related incidents

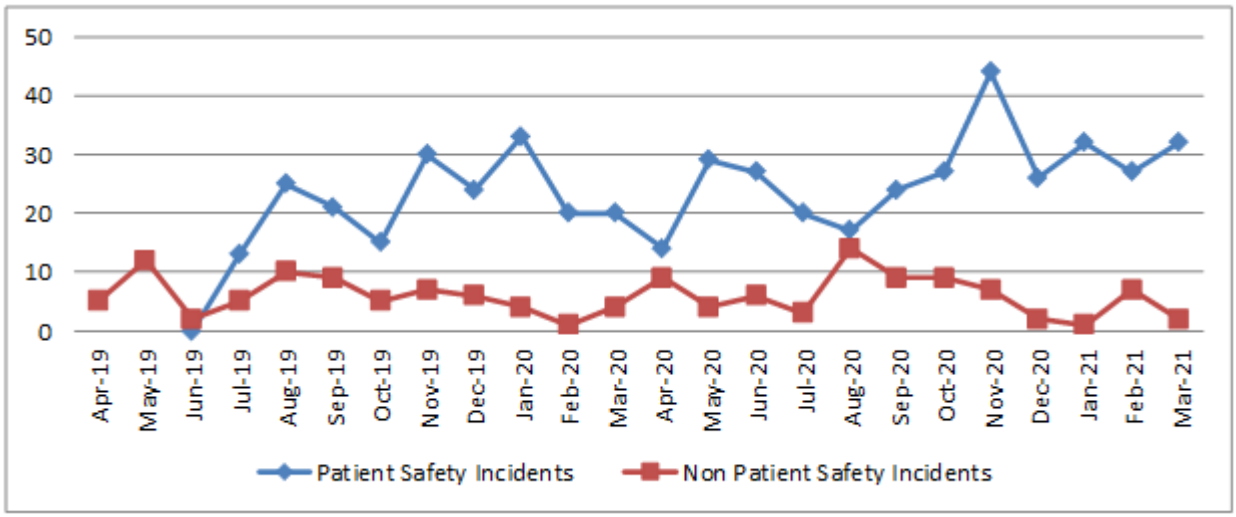


Figure 3: Times series of medication patient safety incidents and non-patient safety incidents

The SPC charts for both types of incidents shows whilst the non patient safety incidents are fairly consistent there does appear to be an increase in the number of patient safety incidents

1.5.3 Patient Safety Incidents

These include incidents under the following categories: administration, dispensing, prescribing, advice, monitoring and supply of medicines. These incidents are reportable to the National Reporting and Learning System and as expected, have the greatest prevalence.

- The highest number of reported incidents relates to the administration of medicines n=247 (n=178 in 2019/20). 26% of administration incidents are related to omission of medicines and 7.3% are related to administration of incorrect drug. Of the incorrect drugs administered 89% (16) occurred in in-patient units and 11% (2) in community physical health teams.

- There were 88 prescribing incidents reported in 2020/21 compared to 59 in 2019/20. 64% of prescribing incidents are related to prescribing of incorrect dose (25), omissions (12), frequency (9) and incorrect drug (10).

The majority of these incidents were identified by the pharmacy team during the process of medicines reconciliation and ward visits. Any trends are highlighted at the Medicines Safety Sub-Group and then to the Medicines Management Group where recommendations are made for improvement. It is known that there is under-reporting of prescribing incidents and work continues to try and improve the reporting rate.

1.5.4 Non patient safety incidents

These include incidents involving damage, discrepancy, missing keys etc. Table 4 shows the breakdown by incident type. There were 70 non patient safety incidents in 2020/21 which was the same as in 2019/20.

Controlled drug discrepancies comprise 53% of non-patient safety incidents and loss of prescriptions, charts or medications comprise 34% of the total. None of these incidents impacted on patient care.

Controlled drug discrepancies	37
Loss of prescription or pad/drug chart lost/missing medication	24
Non-adherence to policies	7
Failure to monitor medication fridge/room temperature/ breakdown	3
Miscellaneous	4

Table 4: Table showing breakdown of non-patient safety incidents 2020/21

1.6 Non-formulary/Named Patient Requests

Throughout the year, MMG have received a total of 187 named patient requests, 182 of which have been approved for use. This is quite a significant drop which can possibly be explained by the COVID pandemic causing a reluctance to initiate new therapy during the months of lockdown. Most requests were for atypical depots due to non-compliance with oral medication.

Named Patient Requests 2020-21

Locality	Antipsychotics	Other (e/g antidepressants/anxiolytics)	
East	49	20	
West	38	12	
Wirral	51	17	
Total	**138**	**49**	**187**

Table 5: Named Patient Requests 2021-22

1.7 Antimicrobial Stewardship

1.7.1 Inpatient Services Antibiotic Audits 2020/21

Throughout the year the inpatient pharmacy team have worked with the Infection Prevention Control (IPC) team to conduct a quarterly deep dive audit. The purpose being to audit adherence to the trust's antibiotic formulary and to evaluate the appropriateness of antibiotics prescribed within CWP inpatient areas. All data was collected by the inpatient pharmacy team and each report was produced collaboratively between the IPC link pharmacist and the IPC team.

The report produced for quarter 1 was based upon data gathered over a 4-week period, the 13th April to 8th May 2020. For quarters 2 and 3 it was decided to collect data for a 1-week period per calendar month. Unfortunately, data was not collected during quarter 4 due to the pharmacy team being in business continuity.

The overall findings of each audit were positive with high adherence to trust policy. However, the reports did identify scope for improvement in antibiotic prescribing, particular areas requiring improvement were the annotation of medication charts with indication, stop dates/course length of antibiotic prescribed. The audits also identified electronic documentation of prescribing as an area for improvement.

The quarter 3 report identified a focus on the education and training of prescribers would enable improved antimicrobial stewardship at CWP. This has been addressed by including antimicrobial stewardship responsibilities for doctors at the trainee doctor education programme.

Throughout each quarter the Covid-19 pandemic presented additional challenges, antimicrobial guidelines across the local acute trusts differed. It was decided that choice of antibiotic was to be led by the formulary of the acute trust within that locality's footprint.

1.7.2 GP Out of Hours Service and Urgent Treatment Centre

Due to vacancies in the Neighbourhood Care Pharmacist position, support to the GPOOH was limited over this period. However, support included antimicrobial audit analysis, development of pathways for triage for urinary tract infections through the development of Patient Group Directions.

1.7.3 Old Hall, Westminster and Willaston Surgeries

A PCN Pharmacist employed by CWP was appointed in quarter 4 2020/21 covering Westminster and Old Hall GP practices through One Ellesmere Port PCN and aligned with the National Centre for Pharmacy Post-graduate Education (CPPE) programme for this role. The post holder having significant experience in mental health brings expertise in this field to the role.

1.8 Outsourced Medicine Supplier – Rowlands Pharmacy

The second year of our three-year contract term with Rowlands Pharmacy has continued to bring success. Partnership working has been key during this year as the pharmacy team continued to work in business continuity and the Rowlands team were supportive in the Trust's measures to the pandemic response.

1.9 Pharmacy Interventions and Multi-disciplinary Team (MDT) Working

The clinical pharmacy team are an integral component of inpatient MDTs and undertake pharmaceutical interventions which are recorded in the CareNotes clinical system. The top three specific categories of interventions made in 2020/21 were:

- Advising on Adverse Drug Reactions/Side Effects
- Medicines education (patient counselling)
- Choice of Therapy

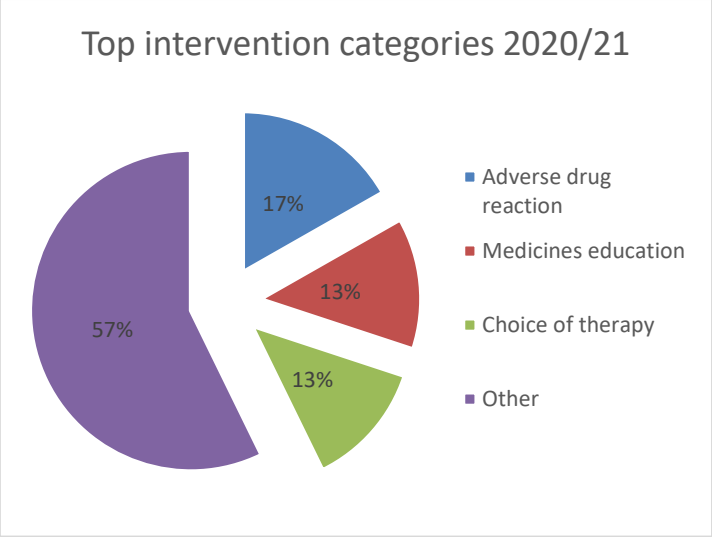


Figure 6: Top intervention categories 2020/21

In 2019-20, medicines education was the largest specific intervention at 27%. This figure has come down considerably which may be explained by the COVID lockdown and social distancing measures which will have reduced the numbers of patients seen face to face by the team in 2020-21.

Interventions in the 'other' category equated to 57% of all interventions made; this includes antibiotic prescribing, compliance assessment/discharge planning, dose adjustment and titration/switching recommendations, drug interactions, formulation choices, medicines reconciliation, monitoring – Therapeutic Drug Monitoring(TDM) / physical health checks and prescribing Issues.

1.10 Flu planning

The Flu planning group was chaired again by the Chief Pharmacist for the 2020/21 campaign with the aim of having clinical leadership for the campaign. Further clinical support was provided by the Director of Nursing & Therapies and a project manager was employed to co-ordinate the delivery of the campaign based on learning from previous years. The pharmacy team ensured that robust governance processes were in place for the vaccines including adherence to PGDs and Written Instructions, correct storage and cold chain processes, and timely support with any problems. The campaign focussed on engaging staff with a patient centred approach and vaccination was brought to teams organised via an online booking system. The Trust achieved its best year for flu vaccinations with an uptake in patient facing areas of 80.5% (71% 2019/20).

1.11 Place Based and System Approaches to Medicines Optimisation

Over 2020-21 the Place Based Healthy Wirral Mental Health Medicines Optimisation Group met monthly and is chaired by the Deputy Chief Pharmacist, CWP. This meeting is part of a formal subgroup to the Healthy Wirral Medicines Optimisation Board and is aligned to governance structure for the Healthy Wirral Partners programme of work

Priorities included:

a) Clozapine QI workstream and work with Primary Care. This was as a result of both national, international and local warnings regarding clozapine care including:
    - Information sharing agreement completed for CWP with social care, GPs, CCG and CSU
    - Development of criteria for a Primary/ Secondary Care clozapine dashboard to improve health outcomes and mitigate risk
b) Management of Lithium Brand cessation and associated monitoring
c) Learning Disabilities Care Home Programme including development of medicines guidance for LD Care Homes during the pandemic

Developments arising from the group were reported to CWP's Medicines Management Group.

2. Challenges

2.1 Staffing Challenges

The pharmacy team went into business continuity in January 2020 due to an inability to recruit to vacant positions and continued during the year as a result of staffing pressures caused by the pandemic. This was exacerbated by the requirement to support the COVID mass vaccination centre.

2.2 Impact of Covid 19 and critical responses

The following adaptions were implemented in our response to the Covid-19 pandemic.

- Rapid review of the 'National Clinical guide for the management of palliative care in hospital during the coronavirus pandemic' and advised the Trust Tactical Command Group on the feasibility of implementation of the medicine's component of the recommendations. This included supply issues and local procurement anticipated problems for end of life care medicines, advice on the use of oxygen and availability of syringe drivers
- Rapidly facilitated the supply and review of medicines for patients who were moved to Covid-19 Positive Cohort wards, ensuring that medicines were not transferred across wards to reduce risk of infection transfer
- Reviewed all medicines charts for in-patients and proactively assessing medicines with a risk of respiratory depression in line with the Royal College of Psychiatry recommendations.
- Education provided to ward teams on Covid related medicines guidance and in line with the Royal College of Psychiatry guidance
- Assessed stock lists for wards, ensuring rapid access to specific medicines including low molecular weight heparins, antibiotics, nebules and palliative care medicines for both Cohort Wards and all inpatient wards
- Continued with clinical pharmacist input into daily board rounds and weekly MDTs to provide valuable medicines interventions and recommendations to the medical workforce, and to support safe discharge. Care homes were contacted for copies of MAR charts and there were no barriers to obtaining these.
- The Senior Team attended daily Medicines / IPC cells and SITREP meetings for Specialist Mental Health and provided a two-way cascade system to the Clinical Operational Teams for rapid communication relating to medicines, bed-state and clinical or procedural issues
- At the outset of the pandemic communication was sent to all patients prescribed clozapine to provide advice about Covid-19 as well as wider risks, such as constipation in view of the potential impact of social isolation.
- Supported the Trust with the development of the Trust Clinical Prioritisation tool to identify high and moderate risk patients
- Reviewed working practices and where possible any operational processes that could be completed remotely away from the clinical environment were implemented to protect the workforce, reduce spread of the virus and sustain a resilient workforce. A Covid-19 workforce planning tool was developed at the outset which identified core functions that needed to continue as a priority during this time. This included, amongst a wide range of detail, a detailed plan for remote working, ward contact, medicines reconciliation, clinical reviews and checks, non-stock orders, leaves and discharges.
- Medicines reconciliation modelling was revised to use summary care records, Health Information Exchange, visits to wards to reconcile any medicines brought into the hospital using the Action Card for this, and where required contacting the GP.

- A suite of Action Cards and medicines guidance documents were produced, and these were approved by the relevant Cells or through Medicines management Group Chair's action, to support the clinical teams and maintain effective patient care. These were communicated Trust Wide via communications, through the Trust Intranet and where relevant to the wider system. A few examples include vitamin D for inpatients, Guidance for Clozapine, Lithium and Depot Antipsychotic prescribing, guidance on the use of FP10s for the community teams, circulation of community pharmacy opening hours and contact details, rationalising psychotropic medicines in the acute / general hospital setting.

- Input was provided to support the development of the Regional End of Life Care Medicines guidance, with attendance at the weekly Regional cells to take this action forward.

- A new Medicines Enquiry Email Hotline was introduced early on in the pandemic and this has been used for clinical queries across the Trust

- Input to the one day a week CMHT Pharmacist input was suspended to reduce team pressures; however, a large number of queries continued to come through and they were all responded to, notwithstanding the significant local pressures. Visits to outpatient clinics to support clinic room standards were also suspended.

- The Pharmacy Team supported the introduction of the Mental Health 24/7 crisis line by providing a point of contact for queries and liaising with NHS 111 to replicate models relating to mental health care that are currently effective. A Ten Point Prompt for medicines was developed at pace for the local call handler and feedback on the use of it has been very positive.

2.3 Covid Vaccination Centre for Cheshire West

CWP was asked to support the mobilisation of a mass vaccination centre for Cheshire West commencing in February'21. The Chief pharmacist and deputy were instrumental in the planning and mobilisation of this new CQC registered service. This involved the establishment of a cold chain vaccine dispensary team, preparation of various procedures for vaccine ordering, storage, movement and preparation for administration. As well as training of staff in the handling of the vaccines and oversight of vaccine related incidents and implementation of any associated learning and improvements to the patient journey through the centre.

2.4 Medicine supply challenges

We had two specific medicine supply challenges during the year which were declared on the Medicines risk register.

- Proposed national Priadel discontinuation of both 200mg and 400mg MR tablets by April 2021 as a result of a pricing competition with competitors. We engaged with the North West plan around a controlled switch programme for all persons on this brand of lithium. Fortunately, due to lobbying by patient and carer groups nationally the discontinuation was overturned in September'20.
- National shortage of the Pfizer lorazepam IM injection was declared in November'20. A Canadian brand was then ordered as the most suitable replacement however an injectable risk assessment (NPSA) had to take place on the product to confirm its safety in practice as this product is a multi-dose vial and doesn't require dilution unlike the Pfizer product that had been used for years. The Canadian brand was introduced safely into clinical practice across CWP.

3. Quality Improvements in Medicines

Below represent the priority areas of focus for quality improvement during the year. In addition, there were smaller scale audits conducted on high dose antipsychotic prescribing, safe use of Valproate (compliance with the pregnancy prevention plan) and medicines administration across bed-based areas.

3.1 Prescribing Observatory for Mental Health (POMH) Audits

The Trust completed the following audits for POMH over 2020/2021

The use of depot/LAI antipsychotic medication for relapse prevention	Re-audit	2020
Use of clozapine	Re-audit	2021
The quality of valproate prescribing in adult mental health services	Baseline	2021
Antipsychotic prescribing in people with learning disabilities	Supplementary	2020

Table 7: POMH Audits 2020/21

3.2 Clozapine Quality Improvement Initiative

Over 2020-21, an initiative was established across CWP, Primary Care and Data Analytics to develop a QI programme to improve clozapine care, which although is a specialist only medicine, specifically around management of side effects which can cause severe harm. This included underpinning learning support from the NHS Digital Academy /Imperial College London as well as a Yale Global Health Leadership Initiative, the latter involving this as a field-based project across health and social care.

This QI programme included

a) Process mapping current processes and establishing areas for improvement
b) Re-modelling clozapine clinics to allow increased time for side effect monitoring and physical health checks
c) Development of a 7-minute video for General Practice as part of awareness raising – this received significant positive feedback
d) Review of past incidents and undertaking a thematic analysis
e) Development of an Information Sharing Agreement across health and social care
f) Development of a Wirral prototype prescribing dashboard, which was 1st of type in the country with Cerner to extract relevant primary care data as part of this tool. Plans to expand to Cheshire continue to take place
g) Development and achievement across a range of metrics

The work is ongoing to test, refine and utilise the dashboard. The work has informed remodelling of clozapine clinics through the SMH Care Group, of which 6 monthly audits have demonstrated continuous improvement. The results have been shared at Clinical Practice and Standards Sub-Committee with positive feedback, with sustainability plans being implemented.

3.3 Medicines Optimisation into Learning Disability Care Homes

A 12-month pilot initiative in collaboration with NHS Wirral CCG and NHS England for medication reviews for patients with learning disability residing in 38 Care Homes was completed in December 2020. 1089 interventions were made with 159 face to face reviews and 99 virtual reviews completed using a novel model comprising of Specialist Mental Health Pharmacist as well as Community Pharmacist reviews. The interim results, which demonstrated a reduction in inappropriate prescribing, were published in two peer reviewed journals, BMJ Open[1] and International Journal of Pharmacy Practice (Thayer N *et al*, 2021)[2]. The work also featured in the CWP Book of Good Practice.

3.4 Rapid Tranquillisation Audit (RT)

The audit took place in, May 2020, when patients were routinely swabbed and secluded until swab results were received. Due to significant associated pressures on the clinical service, the audit collection period was reduced to two weeks.

It was noted that there was documented evidence of physical health monitoring in 95% (n=19) of cases (compared with 69% in March 2019 and 93% in August 2019). Although physical health observations post RT have improved since the previous audits, there is still room for further improvement. The audit is now carried out on a 6-monthly basis.

4. Workforce Innovations

4.1 Wirral University Teaching Hospitals with Specialist Mental Health Pharmacist In-Reach

Face to face visits were paused for most of 2020-21 due to the pandemic with change to everyone's priorities and ways of working.

- A guidance document was produced for rationalisation of mental health medicines for Covid positive patients admitted to the acute hospital and resources about Covid-19 and mental health medicines were shared.
- Communication was maintained with the mental health pharmacist providing advice and support by phone and email.
- Advice was provided about a wide range of topics including: monitoring and dosing of lithium, choice of therapy and interpretation of interactions information, management of physical health effects of antipsychotics, use of promethazine in anxiety, reducing the risk of serotonin syndrome or extrapyramidal side-effects, reducing regimens for antidepressants or benzodiazepines, medicines choice when unable to take oral medicines.

4.2 LJMU Teacher Practitioner Role & Students

Teaching has continued over the past 12 months at Liverpool John Moore's University. The post continues to be 0.4WTE with a mental health pharmacist Teacher Practitioner (TP) delivering specialist mental health lectures, workshops and Masterclass Days. Due to Covid all learning moved online, with synchronous delivery of workshops and Masterclass days and lecture material recorded for asynchronous delivery. Students continued on the "Mental Health Pathway" for those with a specialist interest, although recruitment was suspended for 20-21 due to impact of Covid. Specialist mental health focused "Patient Centered Care" and "Transferring Patients safely" work schemes written and delivered by TP over 6-week schedule. Students all performed exceptionally well in these programmes with high levels of

engagement. Students continue to show high levels of enthusiasm for the role of the pharmacist in Mental Health, which has raised the profile of CWP as a potential employer. Bi-annual delivery of weekend post graduate mental health study days has also continued. Pharmacists have requested unit visits following delivery of study days due to increased interest in mental health.

4.3 Non-Medical Prescribing (NMP) Roles

The pharmacy team continues with the plan to have one pharmacist per year trained as a non-medical prescriber. Presently there are four NMP pharmacists in the team.

4.4 Education Support across services

The team have provided a 30-minute rapid tranquillisation session on day 3 of the PAT (Proactive Approach Training) throughout the year. A video has also been recorded to be utilised when pharmacy staff cannot attend.

Manchester University pharmacy students attended MS Teams workshops with the pharmacists, which also allowed them to meet and talk to other health professionals as part of the session.

As part of the LJMU post-graduate clinical diploma, the team present teaching sessions every 6 months. Sessions are run over 4 hours, covering Bipolar, Schizophrenia, Dementia and Depression. Students study the presentation and treatment of the conditions and to consolidate learning work through mental health case studies in these conditions.

Pre-registration pharmacist student placements have been facilitated at West and East despite Covid. Remaining pre-registration pharmacists from COCH and WUTH were invited to attend an MS Teams question and answer session with a pharmacist. A mental health education session was facilitated for East pre-registration pharmacists via MS Teams.

Medicines management training for ward nurses has been provided in East and Wirral.

A training session on managing clozapine in the acute hospital has been delivered to the Pharmacy Team at Macclesfield General Hospital. A mental health induction checklist has been prepared for pharmacy staff at WUTH, providing appropriate resources to answer some test scenarios. As part of the educational in-reach role between WUTH and CWP, a document was prepared to enable acute trust staff to rationalise mental health medicines during the pandemic.

One pharmacist is currently undertaking the NMP course and two are completing the Postgraduate Diploma in Psychiatric Pharmacy with Aston University. Two pharmacy technicians are completing the BTEC Level 4 Professional Diploma in Pharmacy Clinical Services with Bradford University.

5. Recommendations

The Quality Committee and the Board of Directors are requested to:

- Discuss the Annual Report
- Approve the Annual Report

6. References

1. Thayer N, White S, Islam J, et al Reducing risks associated with medicines and lifestyle in a residential care population with intellectual disabilities: evaluation of a pharmacy review initiative in England BMJ Open 2021;11:e046630. doi: 10.1136/bmjopen-2020-046630

2. N Thayer, S White, J Islam, W Jones, S Kenzie, R Kullu, Evaluation of a collaborative pharmacy service initiative for people with intellectual disabilities in residential care homes, *International Journal of Pharmacy Practice*, Volume 29, Issue Supplement_1, April 2021, Pages i44–i45, https://doi.org/10.1093/ijpp/riab015.054

STANDARDISED HIGHLIGHT/ EXCEPTION REPORT

Cheshire and Wirral Partnership NHS Foundation Trust

REPORT DETAILS	
Subject matter of report:	Learning From Experience report
Report provided by:	Gary Flockhart Director of Nursing, Therapies and Patient Partnerships
Date of report:	20/04/2022

SUBJECT MATTER
What is this report about? Summarise why this report requires the attention of the

Summarise the purpose of the report:

The Learning from Experience report covers the period from November 2021 to the end of March 2022. The report aggregates qualitative and quantitative analysis from a variety of sources, including feedback from individuals who access Trust services as well as from those who deliver the services and commission services. It includes learning gained from undertaking patient safety incident reviews, case reviews, complaint investigations and learning from inquests.

The report demonstrates how learning is integrated across the Trust and strengthens assurances of sustainability of changes made to practice to continuously improve over time. It identifies the themes and emerging themes and how these are being addressed by the Trust.

ESCALATION
What do you need to escalate to the Committee?

Quality, clinical, care, other risks that require escalation:

The report highlights that self-harm continues to be the category with the highest number of incidents reported overall. Of note, the number of self-harm incidents reporting category has fallen within the SMH care group during this reporting period. Self-harm continues to remain the category with the highest number of incidents reported within the CYP&F care group with most of these incidents being reported within Tier 4 CAMHS - an increase from T2 and T3 (20/21) figures.

Both the LD, ND and ABI and All Age Disability Care Groups continue to report their highest number of incidents within the physical violence and aggression category with the Neighbourhood Care Group continuing to report their highest number of incidents within the pressure damage category.

The Trust is looking closely at the role of the Family Liaison Officer (FLO) and what CWP requires, currently staff are asked to take up the role, we have no clear guidance on who can be a FLO or training in place.

ASSURANCE
What assurance or evidence of improvements are you providing to the Committee?

Other key matters to highlight:

Quality Committee approved all recommendations in the Learning From Trimester 3 report.

The trust has successfully reduced the number of System Based Investigations (SBI's) that have not been concluded within 60 days and as at the end of March this has been reduced to 8 reviews as not concluding.

The Trust continues to be committed to Duty of Candour and is looking to introduce a training module which will compliment our current training. CWP is also taking part in Podcast hosted by NHS Resolution.

The 3 day Rapid Review Event which looked at complaints and incident management was well received by staff, this has enabled workstreams to focus on quality improvement areas.

99 complaints closed. The complaints team offer support to people to help resolve their concerns with the clinical service, they are also offered contact with PALS before commencing a complaints investigation. This trimester there were 32 out of 99 (32%) closed complaints which were withdrawn following local resolution with clinical services and PALS. Complaint investigations have concluded for the remaining 67 closed complaints: 14 were upheld, 29 were partially upheld and 24 were not upheld.

	The Learning from Deaths Group has established the Mortality Review Working Group and work has commenced, the Group met in February. The Executives met with the Medical Examiner (ME) from the Acute Trust so we can look at the processes and guidance required. The Trust had completed 100% of case record review during this trimester.

Learning from Experience Report

Trimester 3

2021/2022

1.0 Introduction

This Learning from Experience (LFE) report covers the period from November 2021 to the end of March 2022. The report aggregates qualitative and quantitative analysis from a variety of sources, including feedback from individuals who access Trust services as well as from those who deliver the services and commission services. It includes learning gained from undertaking patient safety incident reviews, case reviews, complaint investigations and learning from inquests. As previously agreed at Quality Committee, the Learning from Experience Report will exclude information and data that is currently incorporated in the 'Providing High Quality Report'.

This report compares current themes, trends and exceptions across a 4 trimester time series to mitigate seasonal variations. The report demonstrates how learning is integrated across the Trust and strengthens assurances of sustainability of changes made to practice to continuously improve over time.

The report includes an analysis of the main themes that have been identified from incident reviews that have been undertaken during the past year, the progress that the Trust has made in responding to these themes as well as identifying any new themes that have emerged in trimester 3

Finally, a progress report on previous recommendations made in trimester 1 2021/2022 is contained within the report and will conclude with any further recommendations for services, care groups and the Trust to consider as a result of the analysis of the data and the learning gained.

2.0 Incident Reporting

Figure 1 shows the total number of incidents by month and per care group (with Specialist Mental health Care Group split into Placed based and Bed based services).

Figure 1: Incidents reported per month and by care group

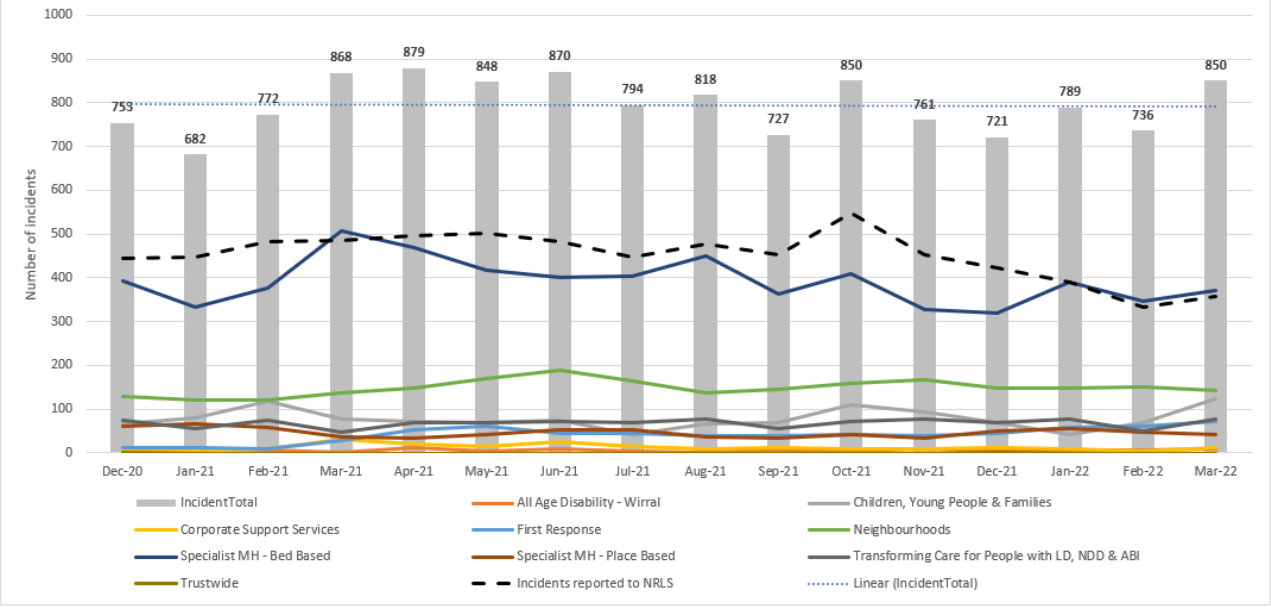


Figure 2: Top Five Incident Categories Reported by The Trust

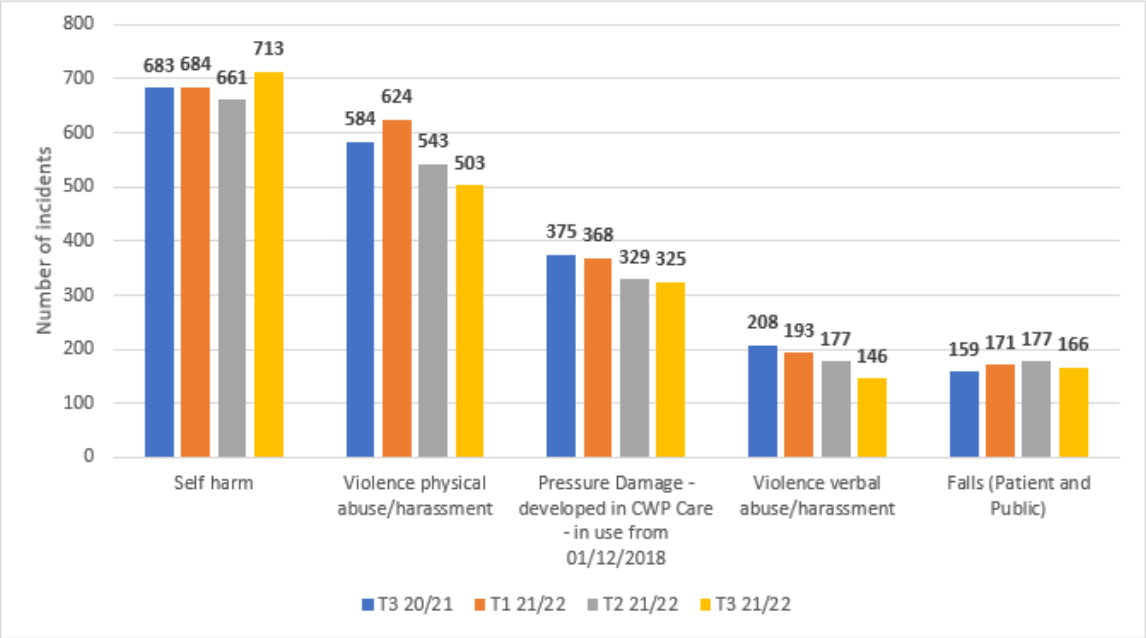


Figure 2 illustrates the five categories with the highest number of incidents reported within the trust. self-harm continues to be the category with the highest number of incidents reported overall. We have seen an increase in T3.

A breakdown of the five categories with the highest numbers of reported incidents for each care group can be found in Appendix 1. Of note, the number of self-harm incidents reporting category has fallen within the SMH care group during this reporting period. Self-harm continues to remain the category with the highest number of incidents reported within the CYP&F care group with most of these incidents being reported within Tier 4 CAMHS, - an increase from T2 and T3 (20/21) figures. Both the LD, ND and ABI and All Age Disability Care Groups continue to report their highest number of incidents within the physical violence and aggression category with the Neighbourhood Care Group continuing to report their highest number of incidents within the pressure damage category

The Trusts incident reporting and Immediate Safety Assurance Review E-learning packages have received positive staff feedback and the quality of incident information has improved as evidenced at the Immediate Safety and Assurance Forum (ISAF). At the end of March 2022, 2556 staff had completed the training module, “How to report an Incident”, 116 staff had completed, “How to Check and sign off an Incident and 93 had completed, “How to Complete an Immediate Safety Assurance Review (ISAR)”. The incident training also provides staff with information and training on the Duty of Candour.

During T3 the Trust carried out a 3 Day Rapid Review Deep Dive Improvement Event, which looked at incident and complaints management across the Trust. As a result of this we have developed Working Groups / Consultation Groups who are looking at quality improvements within these areas. For example, the Trust is looking into the role of the Family Liaison Officer (FLO) and how to develop this further, so we are assured patients, families and staff are being supported. We need to ensure staff are trained in this vital role and are confident when supporting our patients and their families. We are also looking at the FLO models and learning from other trusts how they carry out the role.

The Trust continues to be focussed on Duty of Candour and how we can support staff with this statutory and professional duty. In T3 we reviewed Datix, the Duty of Candour field is now classified as a ‘must’ complete field, the result of which means that staff are prompted more to consider the duty. We are expanding our training and looking to make this a standalone mandatory module for

regulated staff. In T3 we met with NHS Resolution regarding their Duty of Candour video, this will be used as a training tool at CWP. CWP is also collaborating with them on the creation of a podcast which will examine staff's experience around application of the duty. Going forward there will also be a twice weekly Duty of Candour alert implemented, which will allow us to track progress.

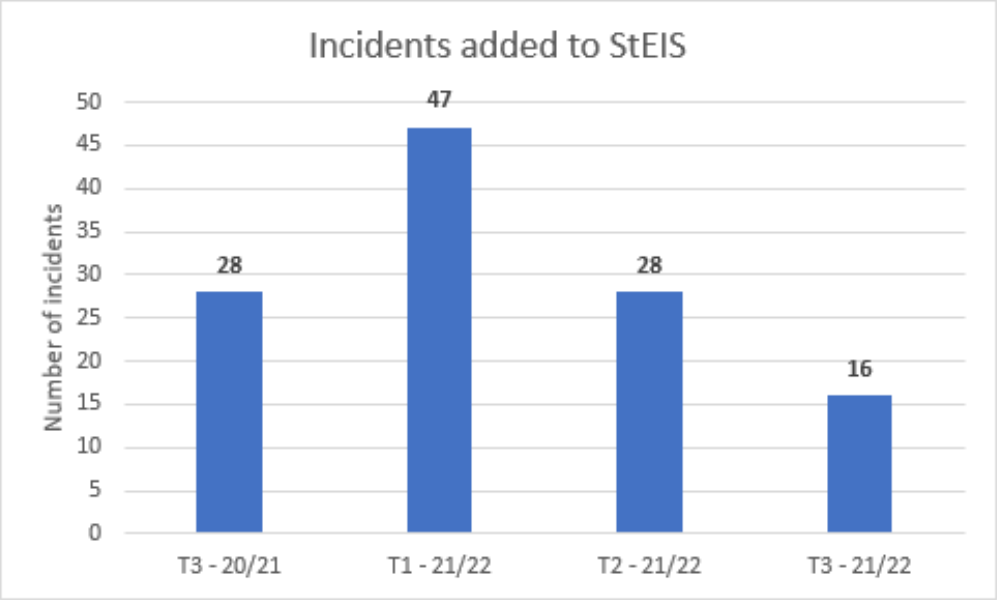
The Patient Safety Syllabus training has commenced. The Trusts Lead Patient Safety Specialist has drafted a new safety priority covering this training which will be included in the Quality Strategy for 2022-2023. The Trusts solicitors are going to provide Mental Capacity Act (MCA) training, this is planned for delivery in June 2022

A Safeguarding Adult Review (SAR) has been commissioned (Wirral), the first panel was held in March 2022. In July 2020, Cheshire East Safeguarding Children's Partnership carried out a local Children Safeguarding Practice Review (CSPR) the review has now been published and several areas of learning has been identified and shared in relation to communication with father.

2.1.1. Serious Incident Reporting

Immediate Safety Assurance Reviews (ISARS) are completed for all serious incidents that are reported at the Trust. If a serious incident meets the specific criteria this is uploaded onto the NHS England serious incident database (StEIS) in line with national reporting guidance. Most incidents reported on StEIS have been unexpected deaths of individuals known to Trust services. This Trimester has seen a decrease in the number of incidents reported onto StEIS compared to the previous trimester (See Figure 3) and in line with the number of serious incidents reported in T2 and T3 in 2020/21.This decrease is also as a result of the Trust working in line with Patient Safety Incident Response Framework (PSIRF), the revised framework is expected to be formally published in June 2022. The PSIRP process that the Trust is proposing to use is currently out to staff consultation, the plan details CWP's approach to PSI and will be shared with stakeholders when the consultation ends.

Figure 3. The number of incidents reported onto StEIS over the past 4 trimesters.



The quality of safety reviews continues to improve, which in turn ensures the improvement in quality of information uploaded on to the StEIS system. This is due to appropriate staff attending the Trusts weekly ISAF meeting; where they are aware of the quality of the information that is required. In alignment with the NHS Patient Safety Strategy, and our draft Patient Safety Incident Response Plan (PSIRP) the Trust had begun to embed different methodologies for reviewing serious incidents. These methodologies are considered to be alternatives to undertaking comprehensive reviews

and/or root cause analysis investigations. Within this trimester 3, the Trust carried out 4 serious incident reflective reviews. The reviews were facilitated by the Lead Patient Safety Specialist and immediate learning was shared with staff. Staff reported that they found this a positive learning experience and opportunity.

During this trimester, the increased focus continued upon completing outstanding reviews that have exceeded expected timescales for completion. As a result, the number of System Based Investigations (SBI's) that the Trust has completed within the 60-day timeframe has increased. The numbers outstanding are:

- SBI 8 reports over the 60 days – the progress of these are monitored at SIRM
- 10 ISAR's which were outstanding at the CCG, these are escalated at ISAF to the Care Groups
- 24 ISARS that were outstanding at ISAF; these are escalated at ISAF to the Care Groups

Even though there continues to be a national pause on the 60day timescale, and permission for extensions are not required. The Trust continues to request extensions with the respective CCG, and we have ensured that families are kept updated and that they have been informed when it appears the review will not be concluded within 60 days.

The Serious Incident Review meeting (SIRM) continues to have robust oversight over the quality and timeliness of SBI's reports. The respective Care Groups are providing regular updates and assurances about the quality of their services. During T3 the process changed, investigation extensions are now presented at SIRM which enables and facilitates discussions on the issues faced by care groups, whilst at the same time supporting them to investigate the issues thoroughly.

The Trusts serious incident tracker (underpinned by an escalation process) allows for robust tracking and oversight of all the reviews being undertaken and provides assurance to the commissioners. In Trimester 3 the tracker was updated to include the confirmation that an Investigating Manager and Family Liaison Officers (FLO's) are being commissioned, this assures the Trust that the investigations are underway, and patients and their families are being supported. The role of the FLO is currently under review.

2.2 Learning from Incidents

The Immediate Safety Assurance Forum members have identified the emerging themes. Table 1 highlights these following a review of the Immediate Safety Reviews completed during trimester.

Emerging Theme
Next of Kin not recorded within the patient's clinical records
In patient falls with severe harm
Recording of physical health checks
System One issues around documentation
Monitoring of food and fluid intake and in particular to those patients who as part of their mental health condition illness may refuse diet or fluid
Timeliness of ISARs to ISAF
Unlawful detention and consent to treatment.

The importance of staff debriefs following an incident
Recording Duty of Candour on Datix
Family Liaison Officer (FLO) not commissioned, commissioned late, unable to locate a FLO/ FLO role overlapping within the incident process.

Table 1: Emerging Themes

As the themes are emerging, they are being shared with appropriate work streams and care group Quality Safeguarding and Learning forums and governance groups to ensure the learning is cascaded and responded to. The Trust wide monthly 'ISAF Learning from Incident' bulletin continued throughout T3. Table 3 highlights the learning that has been shared within the bulletins.

What staff should do in a medical emergency regarding resuscitation and escalation –
Healthcare Safety Investigation Branch – HSIB Unintentional overdose of paracetamol in adult patients with low bodyweight
External organisation: A coroner's prevention of future deaths report has detailed how the wearing of face masks may have contributed to the death of a patient in another NHS trust. A man died from a fatal overdose of phenytoin following miscommunication between doctors wearing face masks
Updates on the NHS Patient Safety Strategy 2019 / Patient Safety Incident Response Framework (PSIRF). CWP's Patient Safety Incident Response Plan (PSIRP staff consultation
The importance of reporting incidents onto Datix and how to access the incident training Timeliness of ISARs to ISAF / Completion of ISARS
What we must do if a patient is being transferred into the Trust on a Community Treatment Order - the documentation process and who to inform.
Duty of Candour – professional and the statutory duty – recording on Datix, support available for staff/ staff training
Medicines Safety Bulletin issued in January 2022 This focussed on medication related incidents and covered a reminder that 'potting up' of medicines is prohibited at CWP, a reminder about CD recording, a reminder about chemical restraint and rapid tranquillisation and information on the known risk of suicide with all antiepileptic medicines.

Clarity of the Mental Health Crisis Line, the service it provides for patients and families, accessibility, and contact details
The importance of staff debriefs following incidents
The importance of clinical risk assessments to ensure patient safety
Updates on the Patient Safety Syllabus
The importance of administering critical medications and how to access these.
The importance of risk assessing patients pre and post falls/ reducing the risk of falls

Table 2: Learning shared in the bulletins November – March 2022

The learning from Incident Bulletins are devised jointly with clinical staff and clinical support services so bulletins are meaningful, this helps to ensure better staff engagement and helps promote learning.

Following a review of serious incidents that have been approved by the Serious Incident Review Meeting key learning themes are being identified. Table 3 has been updated to add to themes identified and the agreed/ progress or required responses in relation to these themes are detailed:

Theme	Outcome required	Progress
Family Liaison Officer (FLO) not commissioned following an SBI or allocated late. FLO was a theme from an Inquest	Who can be a FLO is clearly defined, expectations and competency is required?	FLO allocation is monitored at ISAF and SIRM. The role of the FLO is under staff consultation / training / comparing to other Trusts. The Learning from Deaths Group is leading on this.
ISAR's not presented timely at ISAF ISARs overdue at the CCG	Immediate assurance is required at ISAF when a serious incident may have occurred.	Staff have and are completing the incident management training (DATIX) therefore they are trained on the importance of timely / submission of reports. ISAF monitors this weekly. The Lead Patient Safety Specialist is supporting the review of the overdue incidents
Duty of Candour not clearly evidenced on Datix	CWP needs to be able to evidence this duty and be assured CWP regulated staff are aware on the professional and statutory duty.	The Duty of Candour field is now a mandatory field within Datix, staff are signposted to consider the duty and its relevance to an incident. Duty of Candour twice weekly alert to care groups to commence.

		Duty of Candour is monitored weekly at ISAF. Training is included within the incident module. CWP is looking to make the training a standalone module. A Duty of Candour module is being developed. Duty of Candour features regularly within the ISAF Learning from Incidents Bulletin. The Trusts Solicitors are due to deliver training in June 2022. A staff experience Podcast is planned for July 2022 / hosted by NHS Resolution.
In patient falls with severe harm	Reduction in falls.	The Trust completed a themed review of falls in 2020; the review is to be repeated to monitor progress and any themes. Learning added to the ISAF Learning from Incidents Bulletin.
Staff debriefs following incidents must be carried out	Staff are supported and have time to learn and reflect	Importance of this added to the ISAF Lessons Learned Bulletin
Next of Kin (NOK) not recorded / available in the patient's clinical records	We must try and obtain the patients NOK and record if this is not available this allows us to contact NOK for clinical issues and to carry out Duty of Candour	Importance of this added to be added to the ISAF Lessons Learned Bulletin
Opportunity for improvement in relation to a consistent approach for review of carer's needs and completion of carer's assessments.	Supporting carers	The Quality Assurance & Improvement Practitioner, alongside a care community team manager is in the process of reviewing the assessment of needs templates within EMIS and will consider inclusion of prompts around carer's needs as part of this

Sexual Safety Incidents (SSI) Sexual Safety Pathway not fully followed	Safeguarding patients from harm / potential harm	The Trust is planning to repeat a review of the previous SSI review– the review looked at 6 months of incidents. ISAF supports staff with the pathway and what is required/ staff tools/ guidance is available (leaflets for patients and staff). The Sexual Safety Group continues to have oversight of the incidents
Physical Health conditions not being consistently assessed and managed within SMH inpatient services	Physical Health conditions must be being consistently assessed and managed within SMH inpatient services to ensure patient safety.	Princeway CCT have reported they attend the Community Mental Health Team (CMHT) MDT meetings and can see a clear benefit to joined up patient care where the person is under the care of the CCT and the CMHT. All CCTs are to be made aware of the opportunity to attend CMHT MDTs. ISAF has developed an ISAF checklist which prompts the discussion around physical health checks
Identified that although a person-centred shared care agreement had been put in place, it became apparent that the family providing care did not understand this as fully as they needed to.	Ensuring that family members are confident and competent with shared care arrangements, clear communication is key.	Discussed at clinical lead meeting and clinical quality group. Incorporated into update to CP78 - Guidance for the Prevention, Treatment and Management of Pressure Ulcers
Gate Keeping Process / allocation of ward	Theme from T2 Patients allocated wards according to their risks	Process under review with the Care Groups
System One issues around documentation / access	Clinical records must be accessible for staff	Issues are raised via the portal and the working group.
Monitoring of food and fluid intake and in particular to those patients who as part of their mental health condition illness may refuse diet or fluid	Nutrition and hydration – fundamentals of care	Lead Patient Safety Specialist – Task and Finish Group to look at the themes
Unlawful detention and consent to treatment – issues around documentation	Legal requirement	The Trusts solicitors are going to deliver Mental Capacity Act (MCA)

• MHA paperwork not being completed correctly resulting in invalid section papers • Section expiring without appropriate review.		training, this is planned for June 2022 The Mental Health Law Team continues to support staff with this legal duty and review the incidents for actions and lessons learned. The learning was circulated in the ISAF Learning from Incidents Bulletin: Thalamos will reduce the risk of this happening as the in-built checks will not allow MHA documents to be saved, for example if mandatory fields are not completed, papers are not signed, dates are incomplete/in the future or the wrong year. It will not totally mitigate errors, but these should be errors which can be amended under s.15 rather than errors which would invalidate a section. For the AMHPS hospital addresses will be on a drop-down list so once they pick the correct hospital the rest will automatically be input, In the pilot we were able to demonstrate a reduction in errors when papers are completed on Thalamos. Completing digital papers also means there is no delay in receipt by the MHL Team, enabling prompt administrative scrutiny during working hours. This will stop any incidents where the MHL Team have not received papers for several days following detention. The MHL Team have a process to send section expiry e-mails to the ward team and Responsible Clinician to inform them of pending section expiries. Wards

		have been asked to ensure they accurately record the expiry date of sections in the ward diary and that it is a standing agenda item on ward reviews to ensure this is addressed prior to section expiries. SystmOne ward view also gives details of the section, including expiry date and so should be referred to. The MHL Team also receive daily updates from the bed hub on patient movements to support the reminder process.

In September 2021, the Board of Directors approved the Level 3 internal report and the recommendations following the death of an individual who died whilst they were an inpatient on an SMH ward. The key recommendations from this review focus on the quality of risk assessments, the conduct and composition of the Multi-Disciplinary Team meetings and the organisational response to therapeutic observations and risk items. The Action Plan is progress and needs to be finalised and provided to the family, coroner, and the CCG

During T3 1503 incidents were uploaded onto National Reporting and Learning System (NRLS). This is a reduction of 105 incidents on the last Trimester and may possibly be associated with reduction of staff as a result of absence due to Covid. We are unable to provide the Trusts reporting to NRLS median days due to issues with NRLS website. Most incidents reported onto NRLS relate to low harm incidents.

During T3 the Medication Safety Subgroup of the Medicines Optimisation and Safety Group (MOSG) continued to meet, other than in January when the meeting was cancelled due to pressures within the Trust. The MOSG review all safety publications including Medicines and Healthcare products Regulatory Agency (MHRAw) Drug Safety Updates, Health Healthcare Safety Investigation Branch (HSIB) reports and Regulation 28 prevention of future death reports.

In March 2022 one regulation 28 report highlighted the need for clear communication when wearing a mask. This was due to an incident in another trust where a dose of phenytoin 15mg/Kg was misheard as 50mg/Kg. Both clinicians were wearing masks at the time. This incident has been highlighted in the ISAF Learning from Incidents Bulletin.

Following an increase in omitted doses of critical medicines, the critical medicine list has been reviewed to enable easier identification of critical medicines in ward areas. Laminated copies of the update have been distributed to clinical areas and previous versions removed. The latest version has been updated on the intranet along with the process for obtaining medicines outside of pharmacy opening hours. The monthly clean utility security audits have continued, and these include the security of medicines in ward areas but also ensure that all areas display the same safety posters e.g. safer use of insulin. The ISAF bulletin in January 2022 focussed on medication related incidents and covered a reminder that ‘potting up’ of medicines is prohibited at CWP, a reminder about Controlled Drug recording, a reminder about chemical restraint and rapid tranquillisation and information on the known risk of suicide with all antiepileptic medicines.

All incidents relating to controlled drugs are reported to the regional Local Intelligence Network (LIN) every quarter. The themes identified from these incidents has then been reported to the MOSG.

Recommendation

- The Quality Committee are asked to note the emerging serious incident themes and response. Care groups are to ensure the themes and emerging themes are being addressed within their respective care group through their governance and service quality improvement programmes.

2.3 Learning from Deaths

Currently the Trust undertakes a case record review when a death is reported that does not meet the criteria for notification to StEIS. If significant concerns or gaps are noted, a comprehensive system-based investigation would be undertaken. The full data set relating to case record reviews is not yet available following the electronic patient record migration from Carenotes to SystmOne. During trimester 3, there were 392 deaths reported to the Trust of which 68 (17%) deaths where within scope for requiring a review. Figure 4 highlights the number of reviews that have been undertaken in trimester 3 with 100% of deaths in scope for a review [68 deaths] being subject to a case record and/or an immediate safety assurance review. The percentage of deaths reviewed through a case record review and/or an immediate safety assurance review are part of the Trusts key performance indicators which are presented to the Board bi-monthly (Appendix 2).

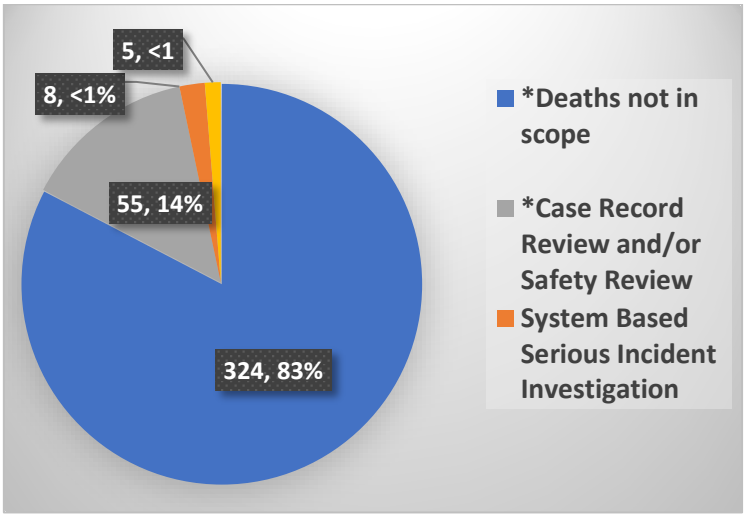


Figure 4. Proportion of reviews undertaken for deaths reported in trimester 3 - Note: % have been rounded up.

During trimester 3 the Learning from Deaths Groups (LDG) met. The Mortality Working Group which reports to the LDG continues to ascertain whether current mortality review systems are fit for purpose, review policy and screening tools in line with best practice (Structured Judgement Reviews SJRs). The Group is also reviewing current practice in line with the Patient Safety Strategy and the role of the Medical Examiner. A meeting was held in February 2022, due to lack of staff availability the meeting did not take place in March. The LDG has previously identified a theme regarding the inconsistent use of Family Liaison role across the Trust, the role is under staff consultation. The Trust are currently implementing the Medical Examiner national requirement, CWP has met with the local trust regarding agreeing the respective pathways.

Recommendation:

- The trust will to confirm the pathways in relation to the implementation of the role of the Medical Examiner

- Learning from Deaths Group to provide a recommendation to the Trust regarding the Family Liaison role to ensure it is used consistently and reduces variation.

2.4 Learning from LeDeR

The Trust have been supporting the LeDeR Programme by reporting deaths via LeDeR and by providing information to support the reviews undertaken by the CCG. The Trust will be focusing on delivering clinical outcomes and on sharing and implementing the learning across the system from the findings and recommendations. This will be overseen by the Learning from Deaths Group.

The requirements of the new National LeDeR Policy 2021 came into effect from June 2021. The local Integrated Care Systems (ICSs) are responsible for ensuring that LeDeR reviews are completed for their local area and that actions are implemented to improve the quality of services for people with a learning disability and people with autism to reduce health inequalities and premature mortality. The policy includes people with autism within the scope of LeDeR for the first time and will have an impact on the number of deaths reported by the Trust to LeDer.

The Trusts incident management system (DATIX) has been updated to ensure staff are identifying individuals who have died and who have a diagnosis which is LeDeR reportable.

2.5 Learning from Inquests for individuals who had contact with CWP services prior to their death

Inquests continue to be held in an online format and in the Coroners Court. The trust continues to see high activity with 27 listed in T3. This activity is set to continue with several inquests having been postponed due to the Covid pandemic now being re-scheduled and many inquests being set with a minimum notice period. This increase in inquest activity is having an impact on the Specialist Mental Health Care group in particular.

Figure 5 shows the patient death inquest outcomes by calendar year. This is a snapshot as of the Coroner's inquest conclusions provided by 31/03/2022. There are 30 conclusions available for inquests that have taken place in this trimester; members of staff were required to attend 10 of these inquests and were adequately supported.

The Coroner's conclusions were as follows.

- 1 death by misadventure
- 2 accidental deaths
- 6 were concluded as alcohol and drug related deaths
- 4 inquests were concluded as narrative verdicts.
- 2 were concluded as natural causes
- 1 was concluded as an open verdict
- 14 inquests were concluded as suicide.

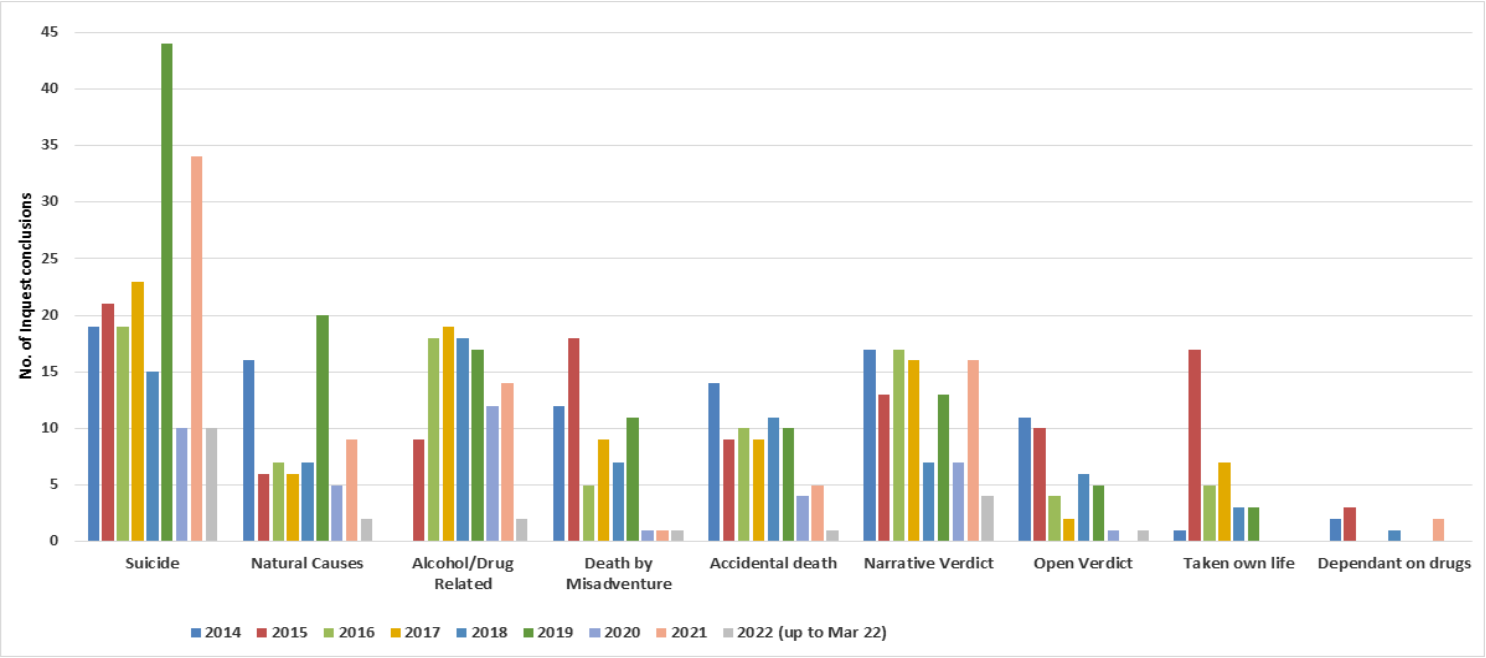


Figure 5. Inquest Coroner conclusions 2014 to March 2022

2.6 Learning identified

As stated previously, the Trust is seeing high activity around Inquests and knows they can be very stressful and daunting for staff. To help alleviate this the Trusts solicitors are going to deliver awareness raising / training sessions which will explain and define the requirements of attending a Coroner's Inquest process and what is required when presenting lessons learned statements, this is planned for June 2022.

3.0 Learning from Complaints

There has been a decrease in the total number of complaints received compared to the previous trimesters. There were 76 complaint investigations commenced this trimester. Figure 6 shows a breakdown of the number of complaints received per care group. There is an emerging seasonal decrease in complaints received over the Christmas and New Year periods of 2020/2021 and 2021/2022. There has been an increase in complaints regarding communication and discharge planning across Specialist Mental Health – Bed Place services during February and March 2022.

During trimester 3, there were 99 complaints closed. The complaints team offer support to people to help resolve their concerns with the clinical service, they are also offered contact with PALS before commencing a complaints investigation. This trimester there were 32 out of 99 (32%) closed complaints which were withdrawn following local resolution with clinical services and PALS. Complaint investigations have concluded for the remaining 67 closed complaints: 14 were upheld, 29 were partially upheld and 24 were not upheld.

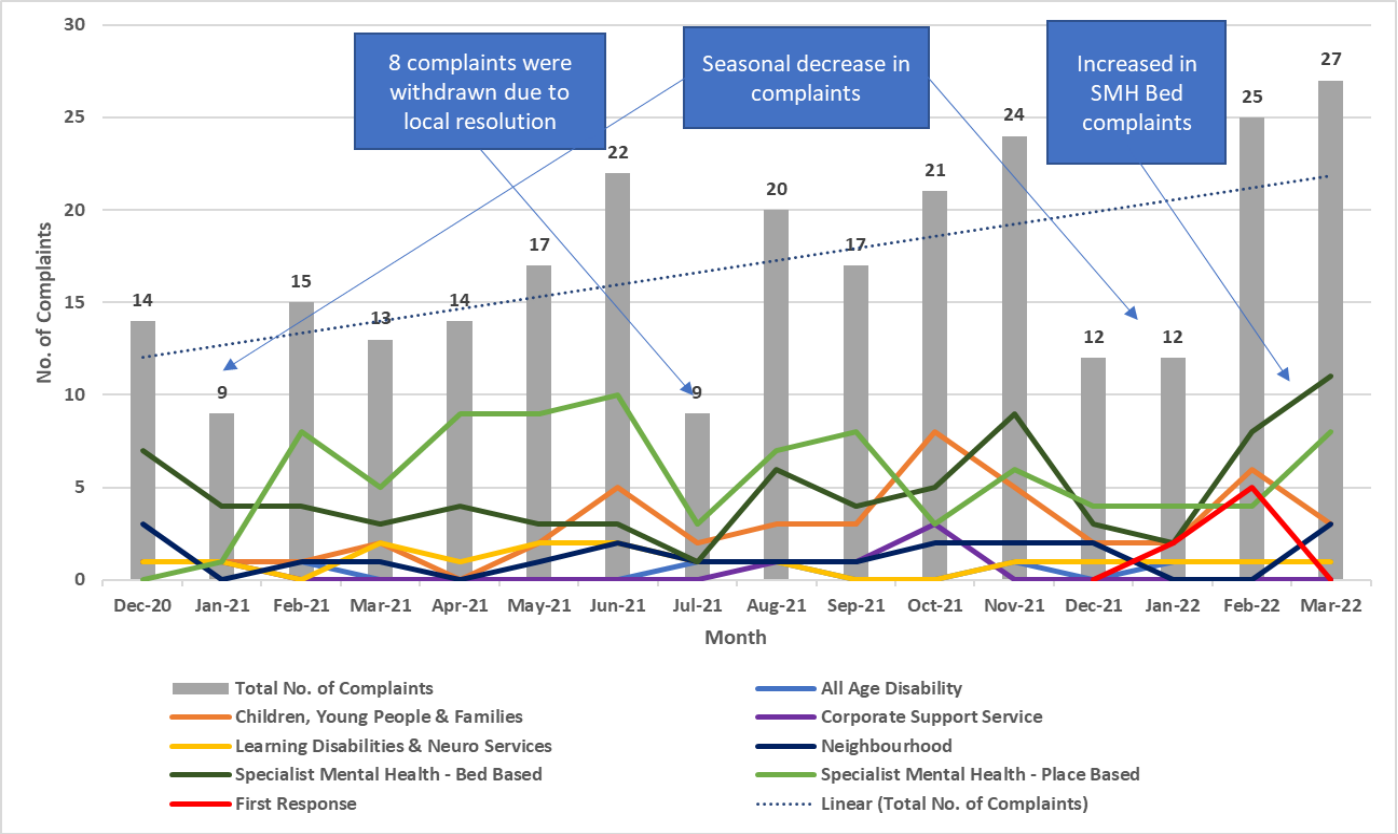


Figure 6 Number of complaints received by care group

The five main themes from the complaints recorded within this trimester are as follows:

- Dissatisfied with access to services
- Communication/information
- Staff attitude
- Care Planning/Continuity of Care
- Discharge from hospital/service

A review of the complaint investigations logged within trimester 3 highlighted an increase in the number of complaints recorded under the 'Dissatisfied with access to services' subject theme, as displayed in figure 7.

There is an emerging theme regarding the communication with people and families when they have been discharged from inpatient and community services. People have reported being discharged from services makes them feel that clinicians do not believe they have a mental health illness. The Specialist Mental Health care group have relaunched the acute care standards during trimester 3 in line with the principles of the long-term plan for mental health. One aspect will be to support people to be able to manage their own care independently and to access services when required. Services will be moving away from using language such as 'discharged from service'.

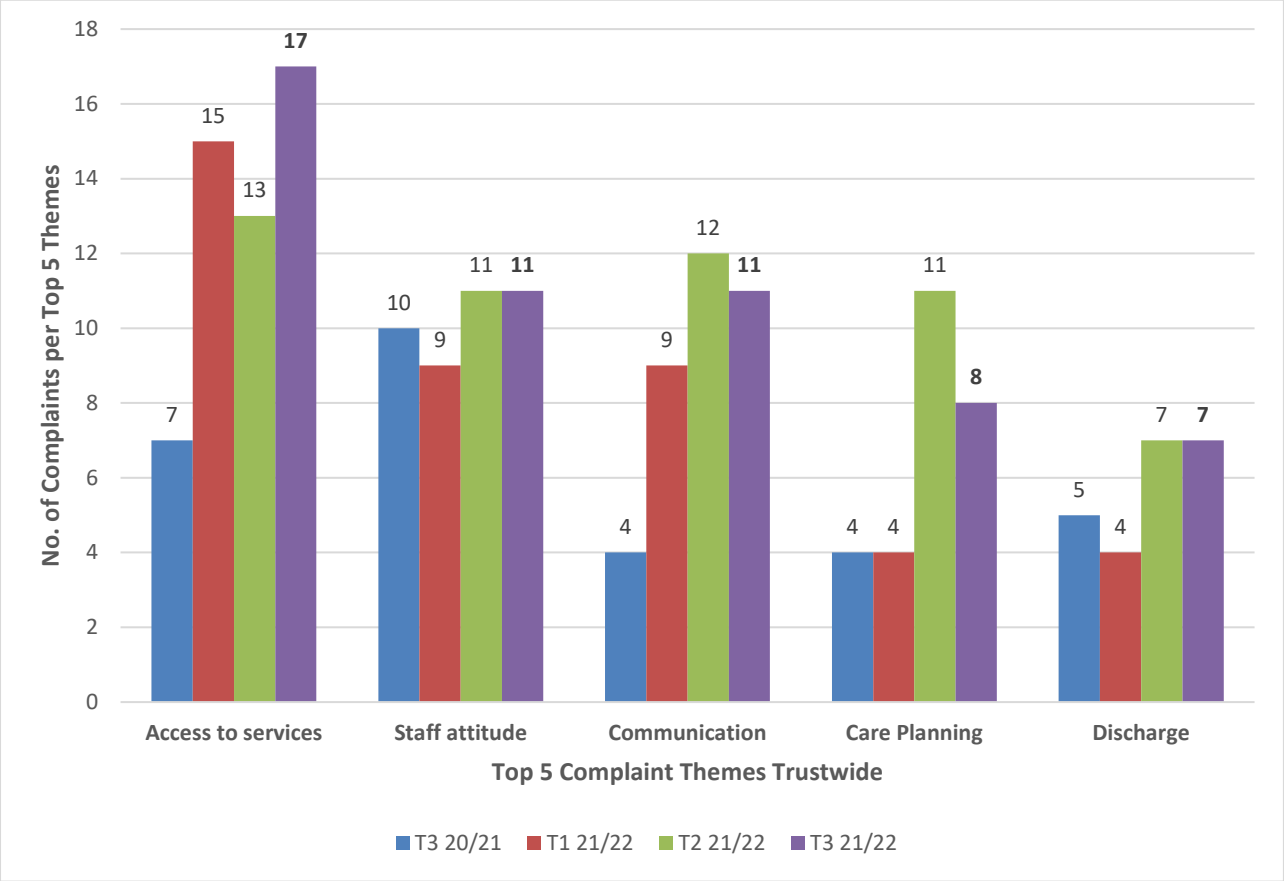


Figure 7: Top 5 complaints themes trust wide

A review of the learning themes identified further to complaint investigations that have concluded during trimester 3 identified that communication continues to be the most significant theme. Following an investigation of the concerns raised, it was identified that the people who complained about access to services did not feel they were fully involved in the care and treatment being offered. Investigations identified learning in relation to how experience can be improved upon. Table 4 shows the themes identified following the conclusion of complaint investigations during trimester 3.

Theme	Response required/agreed
Communications not being followed up People reported poor customer service People reported long waits in reception area without being updated	The care group Quality, Safeguarding and Learning meetings have reflected on. 1. Review local communication/ scheduling of communication with individuals. 2. Review contingency plans for unexpected absences The Cheshire community Children Young People and Families are working together to standardise room booking processes, improving admin access to clinicians diaries and developing standard operating procedures for various routine office situations such as clinicians ringing in sick, Risk assessment bookings, DNA's, rearranging appointments.
Communication when a person is in crisis People reported they did not feel supported People who have reported experience of past trauma are feeling of being retraumatised during consultations or contacts with crisis line.	The Specialist Mental Health care group have identified alternative ways to support people who are in crisis. There is a range of material to help staff promote how people can access support when they are in crisis. The following staff toolkit has been shared across the Trust. StaffToolkitWirral.pdf (cwp.nhs.uk) StaffToolkitCheshire.pdf (cwp.nhs.uk) Transformation work is taking place to embed the principles of the long-term plan for mental health to enable people to tell their story and experience once.

Use of language People reported inappropriate tone and unprofessional language used by reception and clinical staff People reported ambiguous language used in clinic letters Families and people with a diagnosis of autism reported that adjustments were not always made to suit the communication style of the individual.	Quality, Safeguarding and Learning meetings and SMH team briefings have reflected on the way language can be interpreted in different ways. A person-centred approach should be taken to adapt to individual communication needs. Individual communication plans have been developed with people/families who have raised concerns. It is important to follow through agreed plans with contingency plans to manage expectations. Person centred communication methods should be agreed with all people and their families to meet individual needs. No further complaints have been recorded following the training provided to Delemere resource centre to increase staff awareness of ensuring people accessing services feel listened to and given time to respond.
Complaint processes Lack of terms of reference agreed at the start of a complaint investigation. Dissatisfied with timeliness of contact made by family liaison officer.	The feedback from people who raised a complaint was consider during a rapid improvement event January 2022. Representatives from each care group and corporate support services undertook a review of the complaint management systems and processes. A Complaint and Incident Experience Improvement Group will monitor and oversee the longer term action plan. Workstreams including a Quality and Equality Impact Assessment have commenced to co-produce a new complaints model. The Parliamentary Health Service Ombudsman are introducing NHS Complaints Standards to be rolled out across all Trusts in 2023. The NHS Complaint Standards sets out a single vision for staff and people using NHS services to make sure that everyone experiences a culture that seeks out learning from complaints. The Trust has been asked to become an NHS Complaints Standards Earlier Adopter to test out the NHS Complaints Standards model of complaint handling procedure and 'my expectations'. So far the Trust undertook an initial benchmarking audit of the NHS Complaints Standards and established a Task and Finish Group to prepare the Trust with the implementation of the NHS Complaint Standards. A new complaints model in under initial consultation and will be co-produced in readiness to implement the NHS Complaints Standards during 2022/2023. All feedback is to be provided to the Task and Finish Group Representatives. The Complaints and PALS recording systems have been merged to enable streamlined analysis and reporting from April 2022.
ADHD waiting lists	New referrals have been closed. The Trust is working in partnership with Clinical Commissioning Groups to increase the capacity of the service and enhance support available through primary care. The ADHD service are triaging referrals/risk stratification for people on existing waiting lists and offering priority assessments based on their clinical need. People are being signposted to the ADHD Foundation Website

Access to services Poor customer care experience when a person has been passed to multiple teams (such as reception to duty team to crisis line to PALS to GP) when trying to access services. People reported limited access to psychological therapies during their inpatient treatment. Families and People with a diagnosis on autism have reported difficulties in accessing care adjusted to their care needs	The Cheshire community Children Young People and Families held an Admin Rapid Improvement Event in December 2021 to improve communication pathways and enhance people's experience. Several tasks have been agreed to: ▪ Standardise admin processes across Cheshire including standard letter templates ▪ Reduce variation and develop appropriate and timely admin processes ▪ Define admin roles and responsibilities separate with a collective understanding of clinical processes. ▪ Define checkpoints to ensure pathway processes are being followed. The Trust is currently in the process reviewing the in-patient psychology offered and exploring ways in which this can be expanded. The Specialist Mental Health care group are introducing practitioner roles within the primary care network to provide a bridge between primary care and specialist mental health providers under the Additional Roles Reimbursement Scheme (ARRS). The new roles will support the integration of pathways and reduce escalation into secondary care and improve people's experience. Staff should always consider inviting families and carers to meetings. This can also be important to consider during assessment and discharge.
Discharge from Services Lack of communication and clarity regarding discharge planning. People reported they were not always aware of the reasons they had been discharged.	
Lack of family involvement Families raising concerns regarding lack of involvement in the care of their family member. Joined up mediation meetings involving senior managers, responsible clinician and complaints manager has enabled resolution.	Families provide insight to the challenges their relative faces. Engaging with families provides clinical teams with the opportunity to influence care plans and support people to access the right care and treatment. The Triangle of Care and Care Strategy is being launched across the Trust at the start of the Experience of Care week at the end of April 2022. The principles of Co-production across the care groups have been promoted to influence our engagement with people to help shape future services. Feedback from experience has helped inform the acute care review and transformation programme plans. Senior managers from the Children, Young People and Families care group will review how they can strengthen parental involvement in the pre, and post 16 years age groups considering the consent and wishes of young people. The NHS Complaint standards focusses on all staff in including senior managers to support people with concerns to seek early resolution. A training needs analysis is currently in progress with the view to develop a toolkit for staff to enable difficult conversations. The toolkit will be tested throughout 2022/2023. All Teams across the Trust are asked to reflect on how mediation meetings can have a positive impact in enabling early resolution.
Duty of Candour Families raised a complaint after an incident occurred.	In 2021 CWP introduced mandatory incident training via Datix, Trust incident reporting system and updated guidance for staff reporting incidents which also included Duty of Candour. The need to be open and transparent with patients and families is also discussed and

Delay in the allocation of Family Liaison Officers Early involvement and feedback from people and their families using our services is important when things go wrong.	monitored at the Trusts Immediate Safety Assurance Forum and the Serious Incident Review Meeting (SIRM). In March 2022, NHS Resolution (NHS R) published a Duty of Candour animated video to support staff working in health and social care regarding the duty. CWP are working with NHS Resolution to publish a staff podcast to capture staff experience. The learning and feedback will allow CWP to take actions which will further support staff learn, share best practice.

Table 3: Themes from Complaints

3.1 Parliamentary and Health Service Ombudsman (PHSO)

There are no investigations being undertaken by the Parliamentary Health Service Ombudsman (PHSO) relating to CWP complaint investigations as of 31/03/2022. One person contacted the PHSO about a CWP complaint investigation during trimester 3. Following the initial assessment by the PHSO, they were satisfied that CWP undertook an open and transparent complaint investigation in line with NHS complaints regulations.

The Care Quality Commission investigated a complaint from a person who received inpatient care in 2020. The person had made multiple complaints regarding their medication and reported that no one listened to her concerns. The CQC agreed with CWP's complaint conclusion which identified that the Pharmacy and ward staff had made reasonable attempts to reassure the person about their concerns regarding their medication.

4.0 Learning from Claims

In Trimester (3) 7 new claims were received (3 clinical negligence claims and 4 employee liability claims). The Trust settled 2 Personal Injury (PI) claims:

The learning from claim 1 was as follows.

- medications must be prescribed in a timely manner

The learning from claim 2 was as follows;

- We must have sufficient time to arrange discharge care plan
- Social problems not addressed
- Poor communication with patient and family
- No record of communication between ward and HTT

5.0 Summary of Recommendations

The Quality Committee are asked to consider and approve the following recommendations:

- The Quality Committee are asked to note the serious incident themes and learning identified from safety reviews and the progress in how the trust are responding to them. Care groups are to ensure the themes and emerging themes are being addressed within their respective care group through their governance and service quality improvement programmes.

- The Trust will have confirmed the Learning from Death pathway in relation to the implementation of the role of the Medical Examiner

- Learning from Deaths Group to provide a recommendation to the Trust regarding the Family Liaison role to ensure it used consistently and reduce variation.

- The Quality Committee are asked to note the emerging complaint themes in relation to communication regarding to people being discharged from services. Care groups are to ensure the themes and emerging themes are being addressed within their respective care group through their governance and service improvement processes.

- Notes the suggestion and agree around Duty of Candour training being mandatory and a standalone module for regulated staff.

6.0 Updates and Assurances received against Trimester 3 recommendations

The following is a summary and an update on the progress on the recommendations that were made in the LFE Trimester 2 (2020/2021) report:

- **Within the next trimester the Trust to review the audit/assurance process for Learning from Deaths.**
  The task and finish group has been established and the work has been commenced, meeting was held in February 2022. This is being led by the Head of Patient Safety Incidents and Complaints

- **Complaints Standards Benchmarking and proposed Implementation Plan to be presented at PACE Subcommittee in Trimester 2.**

  The benchmarked audit has been completed and the findings and recommendations are to be presented at the January Pace Subcommittee.

- **The Quality Committee are asked to note the emerging complaint themes. Care groups are to ensure the themes are being addressed within their respective care group through their respective governance and service improvement processes**.

  Learning themes from complaints have been shared with care groups and reflective discussions have taken place respective quality, safeguarding and learning governance meetings. Transformation work through the Acute Care Pathway review has progressed. A person discharged from inpatient care and their family met with the Head of Operations and Acting Head of Complaints to share a presentation of their personal feedback on how discharge planning can be improved to enhance people's experience. Further coproduced work is being progressed which will be shared across inpatient services.

- **The Third-Party Liability Claims and the learning from this will be reviewed with the People Organisational Development Subcommittee.**

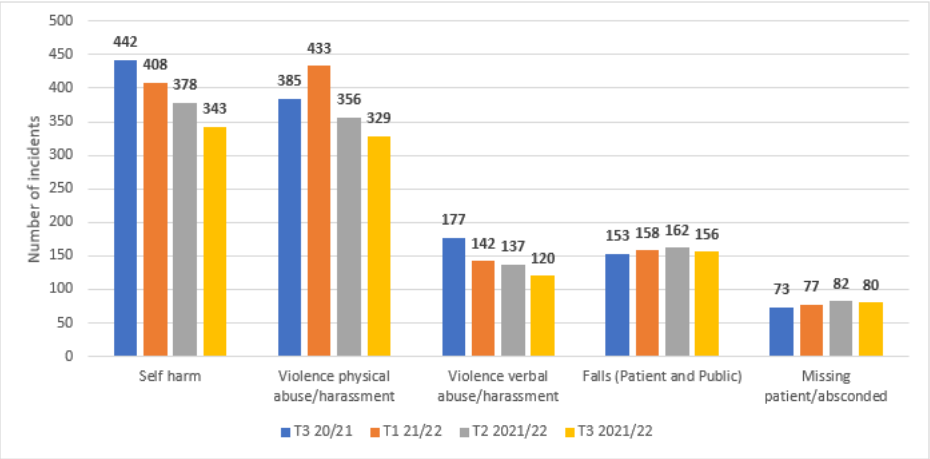
  Information has been shared with the chair of the subcommittee to consider.

- **The Quality Committee is asked to note the completion of the 3 Day Rapid Review event which looked at CWP's complaints and incidents processes.**

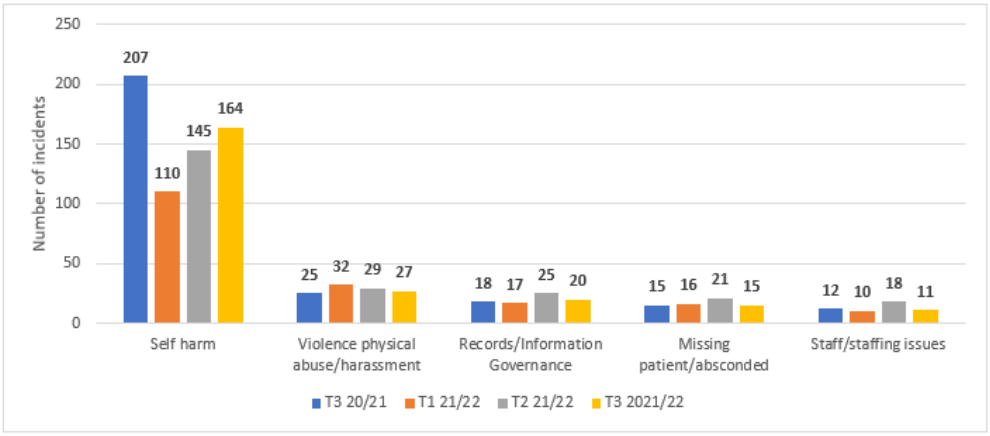
  There is an Action Plan in place and consultation groups have been established to look at the quality improvement areas.

Appendix 1 – Top 5 Incident Themes per care group

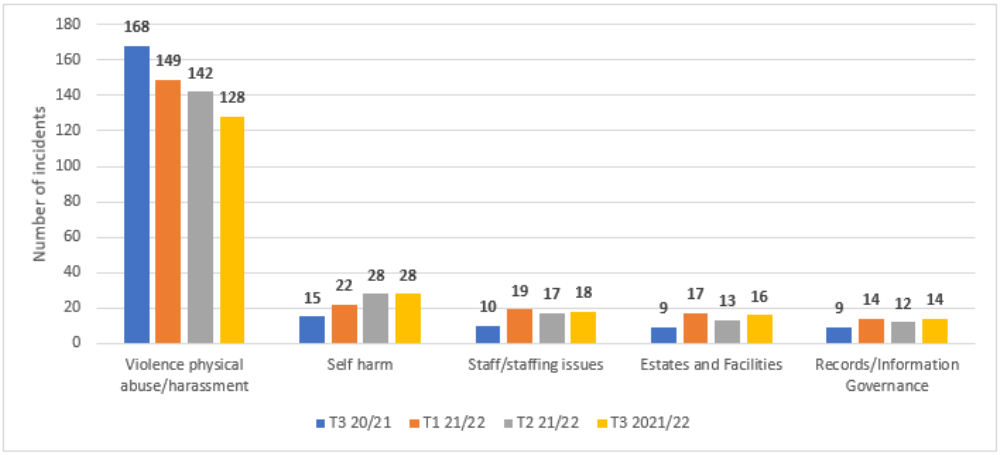
1.1 Specialist Mental Health Care Group Top 5 Incidents



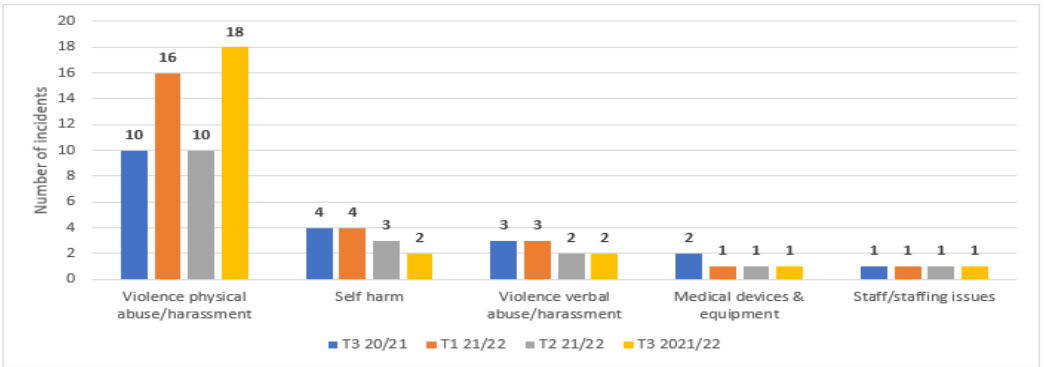
1.2 Children and young People Care Group- Top 5 Incident Categories



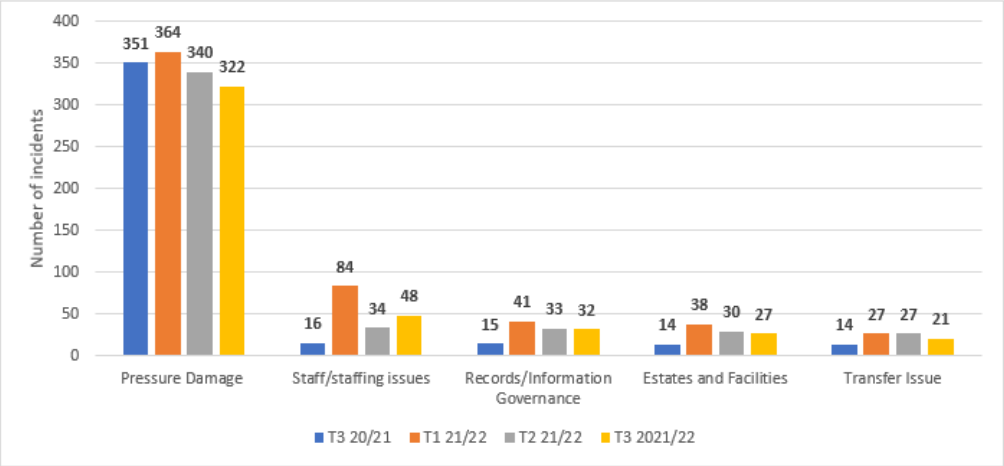
1.3 Learning Disability, NDD & ABI Care Group – Top 5 Incident Themes



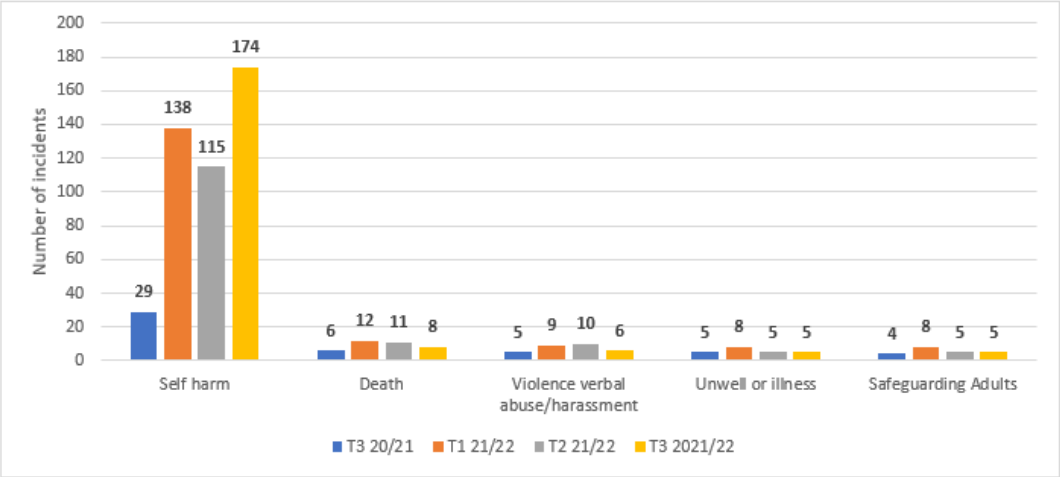
1.4 All Age Disability Care Group – Top 5 Incident Themes



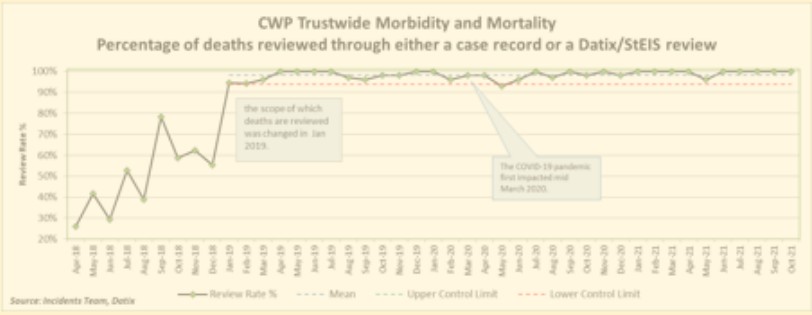
1.5 Neighbourhood Care Group Top Five incidents



1.6 First Response Care Group Top Five incidents

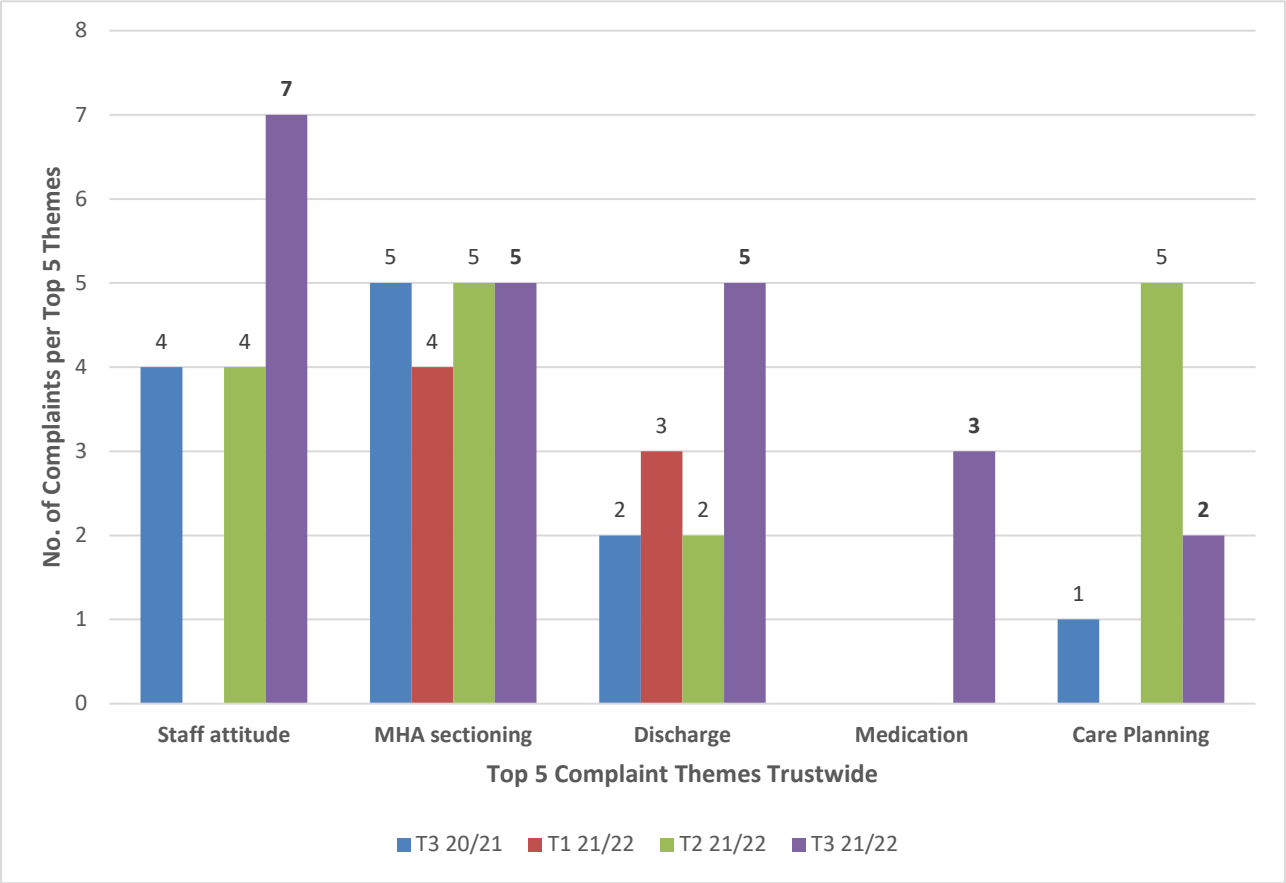


Appendix 2 – Trust wide percentage of deaths reviewed by case record or safety review

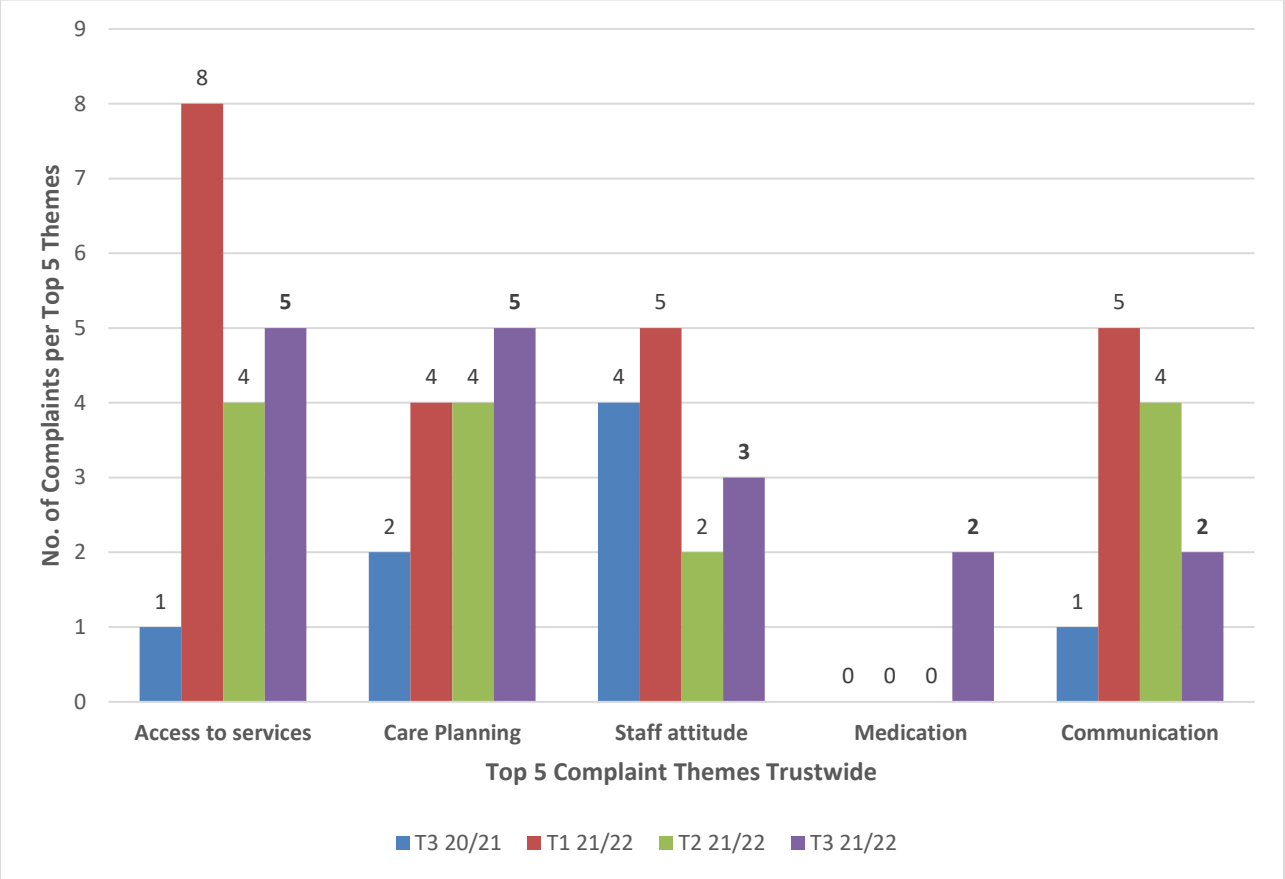
Improve the quality of information to improve service delivery, evaluation and planning		
Metric	**Data**	**Further Explanation**
Morbidity and Mortality	 This information is not yet available following the EPR migration from Carenotes to SystmOne. The chart will be updated once the information flow is reinstated.	Metric owner: Gary Flockhart Monitored by: Quality Committee Data source: CWP Incidents team

Appendix 3 – Top 5 Complaint Themes per Care Group

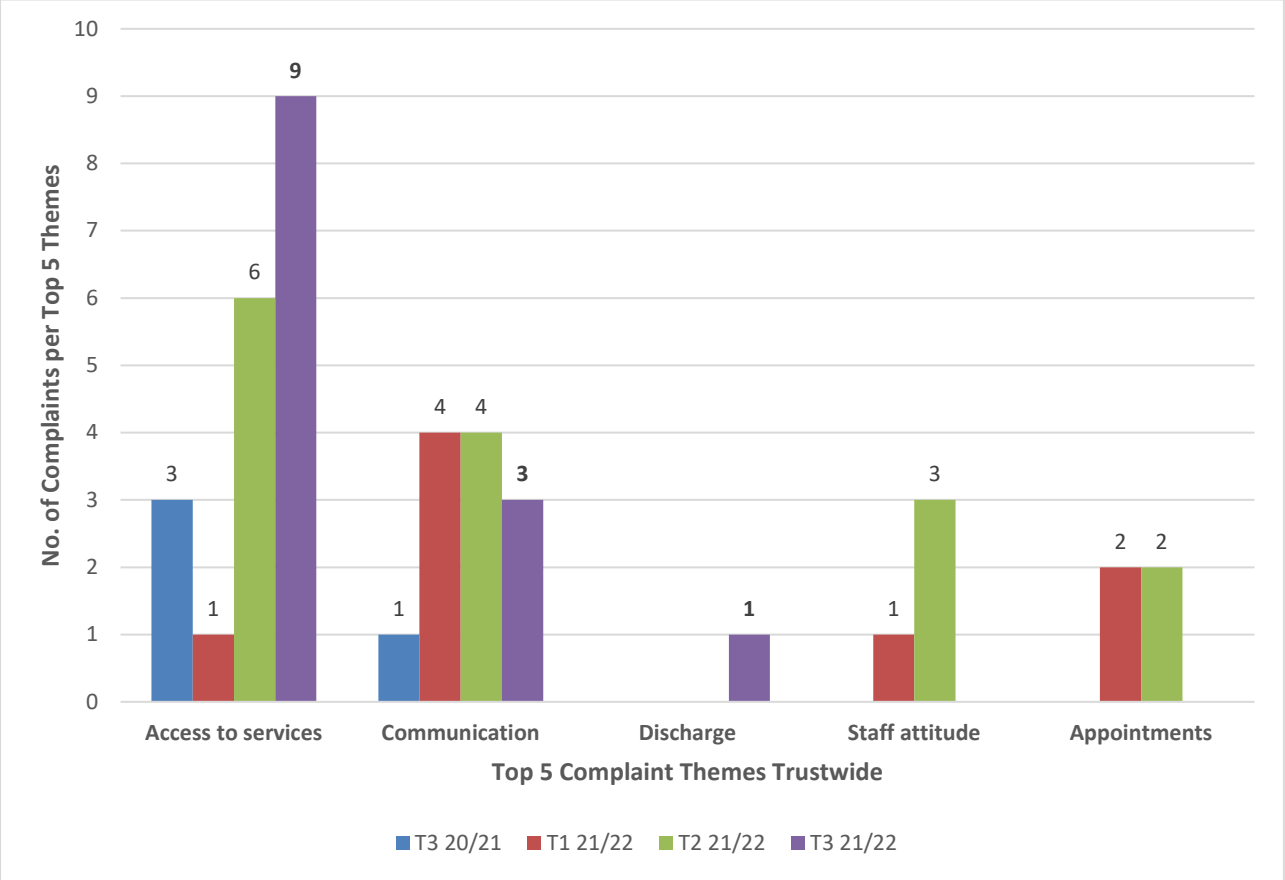
3.1 Specialist Mental Health Bed & First Response Care Group – Top 5 Complaint Themes



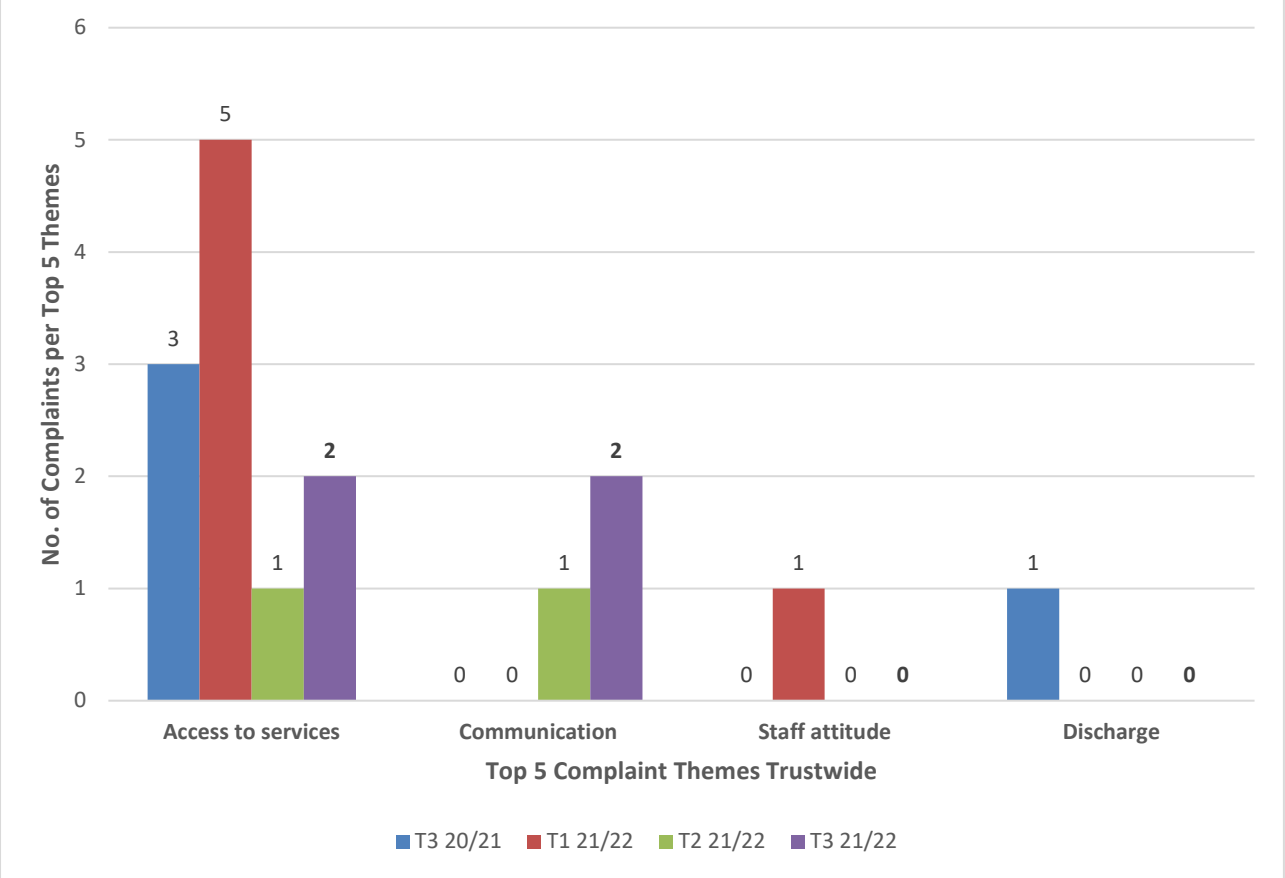
3.2 Specialist Mental Health Place Based



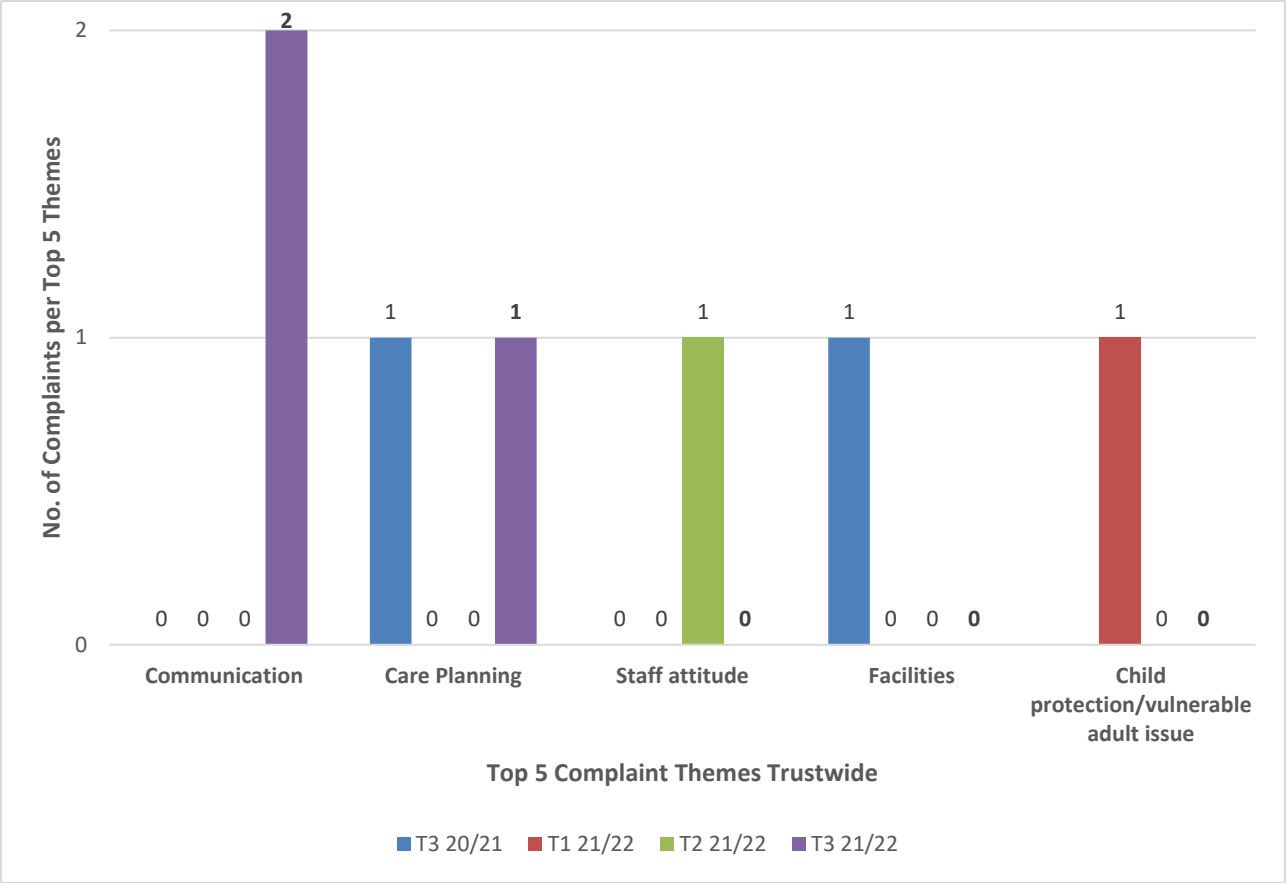
3.3 Children & Young People Care Group – Top 5 Complaint Themes



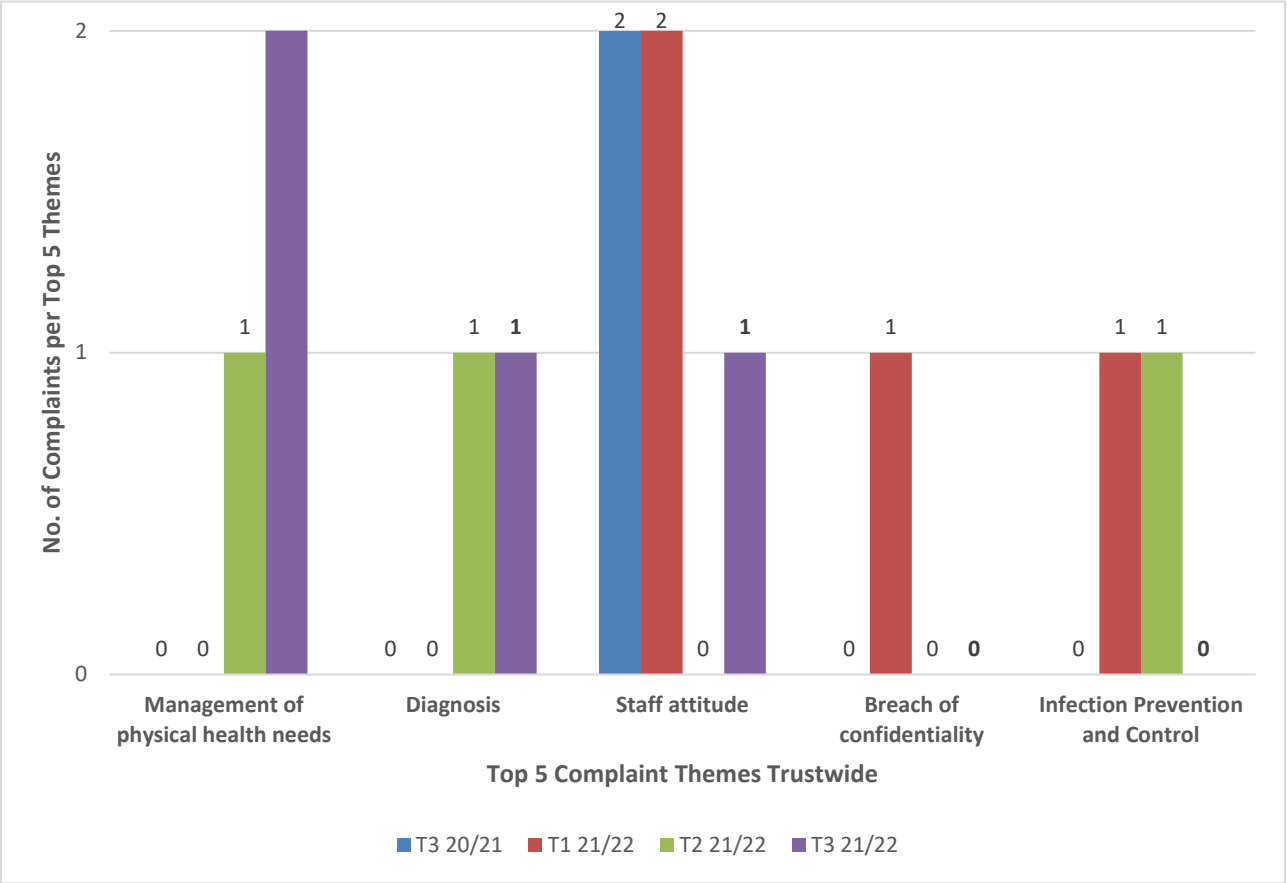
3.4 Learning Disability, NDD & ABI Care Group – Top 5 Complaint Themes



3.5 All Age Disability Care Group – Top 5 Complaint Themes



3.5 Neighbourhoods Group – Top 5 Complaint Themes



NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Quality Improvement Report

Edition 4
January – March 2022

Vision:
Working in partnership
to improve health and well-being by providing high quality care

The Ancora House Nursing Preceptorship Package Project
(see page 5)

Helping people to be **the best they can be**

Welcome to CWP's fourth and final *Quality Improvement Report* of the 2021/22 year

Our *Quality Improvement report*s update people who access and deliver our services, carers, the public, internal groups, our NHS and non-NHS partners, commissioners, and external scrutiny groups, on our progress in improving quality across our services.

At CWP, including at our Quality Committee, we look at **quality** in detail to better demonstrate where we are making real improvements, with the aspiration to achieve **equity** of care through **Quality Improvement (QI)**. We are using international ways of defining quality to help us with this aim.

CWP's *Quality Account* and *Quality Improvement Report*s are available via: http://www.cwp.nhs.uk/resources/reports/?ResourceCategory=2335&Search=&HasSearched=True

Reporting on the quality of our services in this way enhances involvement of people by strengthening our approach to listening and involving the public, partner agencies and, most importantly, acting on the feedback we receive.

QUALITY					
Patient safety	**Clinical effectiveness**			**Patient experience**	
Safe	**Effective**	**Affordable**	**Sustainable**	**Acceptable**	**Accessible**
Achieving **Equity** and **Person-centred Care** through **CO-PRODUCTION, CO-DELIVERY, QUALITY IMPROVEMENT & WELL-LED SERVICES**					
Delivering care in a way which minimises harm by using effective approaches that reduce unnecessary risks	Delivering care that follows an evidence base and results in improved health outcomes, based on people's needs	Delivering care in a way which maximises use of resources and minimises waste	Delivering care that can be supported within the limits of financial, social and environmental resources	Delivering care which takes into account the preferences and aspirations of people	Delivering care that is timely, geographically reasonable, and provided in a place where skills and resources are appropriate to meet people's needs

This report is just one of many reviewed by the Trust's Board of Directors that, together, give a detailed view of CWP's overall performance.

This *Quality Improvement Report* provides a highlight of what CWP is doing to continuously improve the quality of care and treatment we provide. It also provides examples of **Quality Improvement (QI)** projects.

Our Quality Account for 2020/21 is available to read on our public website and NHS website:
NHS website: https://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=2807
CWP's public website: https://www.cwp.nhs.uk/resources/reports/quality-account-2020-21/

QUALITY IMPROVEMENT HEADLINES FOR THIS EDITION

Executive summary

QUALITY IMPROVEMENT PRIORITIES

We set three **Trustwide QI priorities** for 2021/22. They reflect our vision of **working in partnership to improve health and well-being by providing high quality care**. They are linked to our Trust strategic objectives and reflect an emphasis on **patient safety**, **clinical effectiveness** and **patient experience**. We have made a commitment in our *Quality Account* to monitor and report on these goal driven measures in our *Quality Improvement Report*s.

	QI priority	Progress update
Patient safety priority	Improvement in patient safety systems and culture at a team level.	✓ Our approach in working with teams to review their patient safety systems and culture has continued throughout the year. This work built on our improved Trustwide rating of 'Good' for delivering 'Safe' care that we achieved in 2020 following our Care Quality Commission inspection. ✓ We have developed a short survey to evaluate the preparedness of senior managers and Board members for the forthcoming involvement of 'Patient Safety Partners' that will be appointed to CWP later in 2022/23. The survey will be repeated every six months, over a two-year period, to identify and measure any changes that could be attributed to promotion of a positive patient safety culture. ✓ As a result of our 'team around the team' approach, ward champions have been identified to focus on ward culture, issues and areas requiring improvement against the CQC quality of care domains.
Effectiveness priority	Consistent and improved recording/ use of paired outcome measures across inpatient teams that use the HoNOS outcome scale	✓ A dashboard has been developed to monitor the percentage of people being discharged from an inpatient stay who have had a HoNOS assessment at both admission and discharge. ✓ An e-learning package to improve the recording and utilisation of outcome measures to inform practice, with an initial focus on HoNOS, has been launched to improve access to information, training and support around HoNOS. ✓ Since August 2021, HoNOS performance has been above the mean performance over the average of the past 3 years.
Patient experience priority	Improvement in asking people who access our services about their experience of care, and learning from what they tell us to make changes to our services and improve their experience.	✓ We have completely refreshed the FFT at the Trust, to include updated training for staff teams, improved engagement with people accessing our services, and better support for teams taking action and making improvements based on the FFT data. This enables teams to make changes to services and improve the experience for people. ✓ We are regularly offering people who access our services the opportunity to record a digital story, sharing about their experience of receiving care. Several people at CWP have now been trained in digital storytelling, and these are shared in Care Group meetings, at the start of Board meetings, and available on the CWP website. ✓ People with lived experience are involved in ongoing research activities at the Trust and continuing to support project work via focus groups. Moreover, volunteers and people with lived experience are regularly involved in staff recruitment, sitting on interview panels and actively contributing to CWP's values-based recruitment.

Patient Safety is about increasing the things that go right and minimising the things that go wrong for people who access our services

Clinical Effectiveness is a range of activities that support practitioners to examine and improve the quality of care

Patient Experience is what the process of accessing and receiving care and what treatment feels like

The Ancora House Nursing Preceptorship Package Project improves the skills, knowledge and confidence of newly qualified practitioners

Background

The Ancora House Nursing Preceptorship Package has been devised to supplement the standard Trust Preceptorship programme. It has been designed to support newly registered nurses to make the transition from learner to autonomous practitioner, while developing in confidence and proficiency within the specialist clinical area.

Preceptorship is a period of structured transition to guide and support all newly qualified practitioners from student to autonomous professional in order to develop their practice further

What we wanted to achieve

The aim was to:

- ✓ Provide Preceptees with a consistent approach and detailed structure to facilitate their learning and development within clinical practice
- ✓ Improve Preceptees' experience to attract and retain nurses within inpatient services
- ✓ Enhance the skills and knowledge of the workforce to improve people's experience

What we did

- Established current Preceptees and Preceptors experience of utilising the standard Trust package. This highlighted inconsistencies in approach and a lack of detail regarding how competencies could be achieved.
- Created a task and finish group and utilised a PDSA approach to consult with key stakeholders to design a package, agree the content, pilot the package, evaluate the package using a pre and post questionnaire, and refinemint of the package. The Ancora House Nursing Preceptorship Package was presented Trustwide at the Matron Forum and Inpatient Service Improvement Forum. The package has been disseminated to all inpatient areas.

PDSA
Plan, do, study, act (PDSA) cycles are used to test an idea by trialing a change on a small scale and assessing its impact

Results

Data from the questionnaire completed by Preceptees following receiving the Trust standard package and following receiving the Ancora package demonstrates an increase in confidence and understanding as follows:

Question	Standard package	Ancora package
How do you rate your understanding of preceptorship?	100% "reasonable"	100% "very confident"
How do you rate your confidence in undertaking your preceptorship?	25% "not confident" 75% "reasonably confident"	100% "very confident"
How do you rate your understanding of what you need to submit as evidence for preceptorship?	50% "no/ little" 50% "reasonably good"	100% "very good"

A selection of comments from people involved in the project:

"Having a structure is so much better, I feel more confident already!"

"This helps Preceptees to achieve the Trust preceptorship requirements"
"Ensures a consistent approach that we would like to replicate across the Trust"

Next steps

- Continued evaluation of the package and making amendments as required.
- The package is to be adopted Trustwide across all care groups, with adaptations to meet the needs of the specific specialist areas.
- Currently updating and developing additional documents and guidance to support Preceptees and new starters including the staff welcome pack, staff local 2-day induction and ward resource file.
- Production of a similar Preceptorship package for occupational therapists.

For further information, please contact Rachel Sevillano at r.sevillano@nhs.net

Two New Mental Health Crisis Cafés for Cheshire East improve patient experience

Background

The two new mental health crisis cafés, which were opened in February 2022 in Crewe and Macclesfield, are the result of a partnership between CWP, Cheshire East Council, Independence Supported, and East Cheshire Housing Consortium (ECHC). The vision for both cafés has been co-produced with people who access mental health services, families, and communities including the police, social services, the fire service and health and social care professionals.

The aim of a **Crisis Café** is to be a safe, welcoming place where people can go outside of normal working hours, instead of A&E or other urgent services, if they are feeling emotionally distressed or are in a 'mental health crisis'

What did we want to achieve

Our aim was to develop both cafés to work together with people who access mental health services, families and communities as well as the police, health and social care professionals. Crisis cafés form a vital part of improving experience of urgent mental health care as non-clinical, warm, and welcoming, safe spaces for people seeking support whilst in mental health distress. This is also a way for people to get help from trained staff and peers on coping with or preventing future mental health crisis.

What we did

The 'Crewcial' opens from 1pm-10pm, seven days per week and people aged 18+ have been self-referring into the service by simply turning up on the day or by referral from a health or social care professional. The Weston Hub is located at The Weston Centre, Earlsway, Macclesfield, Cheshire, and opens from 10am-10pm, seven days per week and can be accessed by referral from health and social care professionals, as well as through other voluntary organisations.

Results

The feedback recieved have been positive and was measured by the following comments from people, for example:

"I am delighted that they have now opened their doors and are providing a safe and supportive alternative to A&E or hospital admission for those suffering during a mental health crisis."

"I'm delighted that we've been able to work collaboratively with partners to put these much-needed services in place for people in Cheshire East. We've been really encouraged with the feedback from people accessing crisis cafés in Chester and Birkenhead and hope the new Crewe and Macclesfield venues will help to make a real impact in addressing, supporting and preventing poor mental health."

Next steps

- To continue to work closely with health and social care partners to deliver community-based options for people suffering a mental health crisis.
- To continue making the café more central to our offer in Crewe.
- To improve people's experience with the crisis café, which forms a vital part of urgent mental health care as non-clinical, warm and welcoming, safe spaces for people seeking support whilst in mental health distress.
- We expect to continue being a way for people to get help from trained staff and peers on coping with or preventing future mental health crisis.

For more information please contact Sean Boyle at sean.boyle@nhs.net

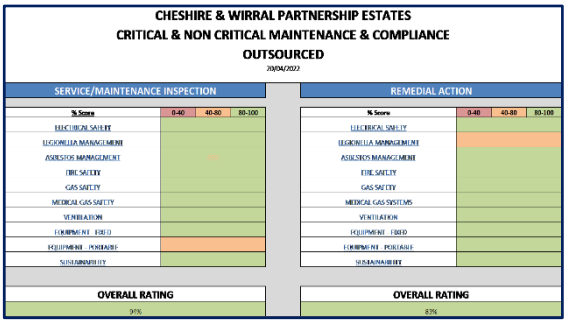
Estates Statutory Compliance Dashboard improves assurance and promotes improvement

Background

The Estates Statutory Compliance Dashboard was developed to provide assurance to the Trust that its legal duties relating to the Estate (e.g. asbestos, fire, electrical, legionella) are being met. A system was required that would 'close the loop' from inspection through to remedial actions being closed; and would generate concise reports for a non-technical/ specialist audience.

What we wanted to achieve

We felt that most 'off the shelf' estate compliance systems did not provide the adequate level of assurance to the Trust, as the focus was on the inspection element of compliance with little regard to the remedial works arising from the findings of inspection.



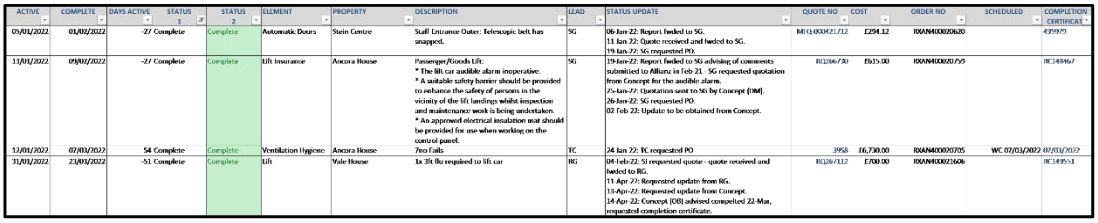
What we did

We have developed a system (and supporting processes) that evidences the whole process from inspection, analysis of findings, raising of works orders through to sign off.

The front-end dashboard graphically reports an overall compliance percentage, with a breakdown by inspection and remedial works for each statutory compliance subject.

Results

- ✓ At the click of a button, we can report when a Trust asset was last inspected, whether it required any remedial works and provide either the purchase order or internal job reference for when the works were completed. Through the dashboard we can view the 'live' compliance status for each compliance subject.
- ✓ This system is now the cornerstone of operational estates operations. This performance data is reviewed monthly by the operational estates teams and a quarterly report is produced for the Infrastructure Sub Committee.
- ✓ The Estates Ststutory Compliance Dashboard has been developed completely in-house with no set up or recurrent costs. The system was recently audited by internal audit and was deemed to provide 'substantial assurance' to the organisation.



ACTIVE	COMPLETE	DAYS ACTIVE	STATUS 1	STATUS 2	ELLEMENT	PROPERTY	DESCRIPTION	LEAD	STATUS UPDATE	QUOTE NO	COST	ORDER NO	SCHEDULED	COMPLETION CERTIFICAT
05/01/2022	01/02/2022	-27 Complete	Complete	Automatic Doors	Stein Centre	Staff Entrance Outer: Telescopic belt has snapped.	SG	06-Jan-22: Report fwded to SG. 11 Jan 22: Quote received and fwded to SG. 19 Jan 22: SG requested PO.	MECHDOOR21/12	£294.12	RXAN4500020620		439979
11/01/2022	09/02/2022	-27 Complete	Complete	Lift Insurance	Ancora House	Passenger/Goods Lift: * The lift car audible alarm inoperative. * A suitable safety barrier should be provided to enhance the safety of persons in the vicinity of the lift landings whilst inspection and maintenance work is being undertaken. * An approved electrical insulation mat should be provided for use when working on the control panel.	SG	19-Jan-22: Report fwded to SG advising of comments submitted to Allianz in Feb 21. SG requested quotation from Concept for the audible alarm. 25-Jan-22: Quotation sent to SG by Concept (DM). 26-Jan-22: SG requested PO. 02 Feb 22: Update to be obtained from Concept.	RE286/30	£615.00	RXAN4500020709		RC148467
12/01/2022	07/03/2022	54 Complete	Complete	Ventilation Hygiene	Ancora House	Zero Fails	TC	24 Jan 22: TC requested PO	3958	£6,730.00	RXAN4500020705	WC 07/03/2022		07/03/2022
31/01/2022	23/03/2022	-51 Complete	Complete	Lift	Vale House	1x 3ft flo required to lift car	RG	04-Feb-22: SJ requested quote - quote received and fwded to RG. 11 Apr 22: Requested update from RG. 13-Apr-22: Requested update from Concept. 14 Apr 22: Concept (OB) advised completed 22-Mar, requested completion certificate.	RE28/312	£700.00	RXAN4500021606			RC149558

Next steps

The Estates Statutory Compliance Dashboard has been a product of continual improvement and has been through several iterations over the previous 18 months. We expect that the system will continue to evolve, however a specific area of improvement will be the development of 'compliance on a page'. This will be an infographic that can be shared Trustwide and with people that access our services.

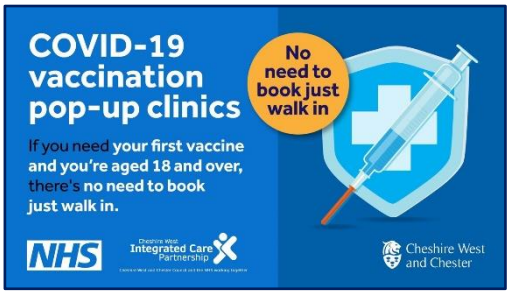
For more information, please contact Dan Allmark at daniel.allmark@nhs.net

A **dashboard** is a visual display of data which often provides at-a-glance views of key performance indicators relevant to a particular objective or business process. Dashboard is also another name for "progress report" or "report" and considered a form of data visualisation.

Development of CWP's Vaccination Service – providing a responsive offer

Background

Coordinated in partnership with Cheshire CCG, Local Authorities and Healthwatch Cheshire, and managerially and clinically delivered by CWP, the Cheshire COVID-19 vaccination service has provided an innovative and agile offer to the local communities and people across Cheshire.



What we wanted to achieve

In response to the evolving nature of the national vaccination programme, the service has provided an array of options for local people to access a vaccine in a way that best meets their needs. These options are built upon CWP's hub and spoke model for delivery: its hub, a fixed vaccination centre 'hospital hub', providing mass vaccination access to the local population. While initially commissioned to deliver just this element of provision, evaluation of population uptake data (broken down by both geographic and demographic) highlighted areas and communities across the borough where vaccine uptake was notably lower than others. Through this evaluation, partners identified not just the geographical themes, but also the social and cultural factors influencing access. This insight led to the introduction of CWP's roving vaccination service in June 2021 – which now arranges pop-up vaccination clinics in targeted locations. Crucially, these are informed by community feedback via a meaningful engagement strategy.

What we did

Since mobilising the roving service, the team has offered hyper-local clinics in the heart of underserved communities. This has had a profoundly and demonstrably positive impact on thousands of people from areas of high deprivation, ethnically diverse backgrounds, faith groups, refugees, Gypsy, Roma and Traveller sites and people with wider/ complex needs.

In addition to this dedicated hyper-local offer, the agility of the service's clinical model – combined with the close collaboration and shared resources with CCG and Local Authority partners – has enabled the team to step up additional resource when gaps in provision elsewhere have emerged. This has included separate programmes for housebound, schools, care homes and health/ social care staff, as well as support for people with a learning disability or other complex needs such as severe mental illness or needle phobia, providing desensitisation and individualised adjustments on a 1:1 basis.

Results

Since mobilisation in January 2021, CWP's fixed 'mass vaccination' centre has provided:

- ✓ over 150,000 vaccinations to the population of West Cheshire
- ✓ over 20,000 vaccines (219 clinics) provided by the roving service – making it one of the largest providers of vaccinations in Cheshire and Merseyside

Since the introduction of the Cheshire East roving vaccination service in June 2021, CWP's vaccination service has provided:

- ✓ 101 pop up clinics across the footprint of Cheshire East, with a total of 4,085 vaccines being given so far.

Next steps

The programme is now harnessing this further by broadening its remit and flexibility by offering a wider range of basic health checks or social care interventions during sessions. While providing a more holistic offer to communities that makes every contact count, we aim for this work to also reduce pressure elsewhere across the system.

For more information please contact Louis McDermott at louis.mcdermott@nhs.net

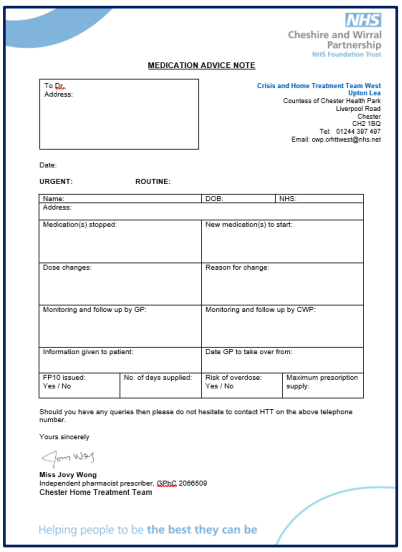
Standardised communication has reduced delays and medication errors

Background

Previously, medication advice was communicated to GPs and other professionals by fax. This is not the preferred method of communication because of the risk to confidentiality, amongst other things. As well as this, in the past few months, there have been a few occasions where decisions of medication changes within West Home Treatment Team were not communicated to the GP, resulting in a delay and/ or incorrect dosage of medication being prescribed by the GP.

What we wanted to achieve

West Home Treatment Team wanted to standardise communication of medication changes across all three Home Treatment Teams in CWP. There have been incidents where consultants and doctors covering the Home Treatment Team over the weekend have authorised certain medication changes, such as an increased dose of Sertraline from 50mg daily to 100mg daily and practitioners within the team were advised to communicate these changes to the GP. However, due to the lack of a common mechanism to do this information was not always passed on, leading to delays in issuing new prescriptions and the people accessing our services getting their new medication dose.



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MEDICATION ADVICE NOTE

To Dr.
Address:

Crisis and Home Treatment Team West
Upton Lea
Countess of Chester Health Park
Liverpool Road
Chester
CH2 1BQ
Tel: 01244 397 497
Email: cwp.ohttwest@nhs.net

Date:

URGENT: ROUTINE:

Name:	DOB:	NHS:
Address:		
Medication(s) stopped:	New medication(s) to start:	
Dose changes:	Reason for change:	
Monitoring and follow up by GP:	Monitoring and follow up by CWP:	
Information given to patient:	Date GP to take over from:	
FP10 issued: Yes / No	No. of days supplied:	Risk of overdose: Yes / No	Maximum prescription supply:

Should you have any queries then please do not hesitate to contact HTT on the above telephone number.

Yours sincerely

Miss Jovy Wong
Independent pharmacist prescriber, GPhC 2066509
Chester Home Treatment Team

Helping people to be the best they can be

What we did

A standard form has been created, the 'Medication Advice Note', and it has been agreed at the Home Treatment Team strategic meeting to use this across CWP.

Results

Early feedback from practitioners is that the form is easy to use and clear what information is required. It is hoped that by using this standard form of communication, there will be a clear reduction in delays of prescriptions and incorrect dosages being prescribed to people being cared for by the Home Treatment Team.

Next steps

The form has been sent to some of our Community Mental Health Teams and Early Intervention Teams for comments with a view to roll out the use of the Medication Advice Note in their services.

For more information, please contact jovy.wong2@nhs.net

Home Treatment (HT) teams are made up of specialist mental health professionals who can respond to acute mental health problems by providing intensive home based therapies and support as a safe alternative to admission as an inpatient

Update on the High Intensity User Service

Background

CWP employ a High Intensity User (HIU) Lead who works with around 50 people a year in the Cheshire West area. They work with people who regularly use unplanned health care services such as the Accident & Emergency Department, 111/ 999 service and non-elective admissions.

The **HIU Service** offers a robust way of supporting people who make high intensity use of health services, in particular A&E, non-elective admissions, primary care and mental health services

What we wanted to achieve

The service aims to help people who are 'stuck', relying on these unplanned health care services to identify and access planned system and community resources to meet their ongoing needs, therefore reducing their need for and use of these services.

What we did

The HIU Lead used regularly updated data from the Clinical Commissioning Group (CCG) to identify the people who currently access services most frequently. They connected with the people accessing these services and the services themselves to fully understand them and their story of how they had come to be in A&E and other unplanned services so often.

From there, they helped them to understand their own presentation better, explaining specialist knowledge and applying it in the context of their own lives. They helped these people to identify areas of their lives that they wished to change (and could improve their health), available support/ opportunities for these areas and provided the help they needed to access these, e.g. attending together, providing advocacy.

The initial comparison from the first three months of data to the first six months of the project was impressive (detailed in Edition 2 of the 2021/22 *Quality Improvement Report*).

Results

A 12-month evaluation of the project has now been completed and has demonstrated a significant benefit to both the client base, and wider health and social care system partners.

Quantitatively, the project has delivered significant reductions in a range of NHS and social care interactions. Reductions in service demand across all measured health and care providers ranges from 34% to 79%, as demonstrated below:

Service	Target reduction	Actual first year reduction
A&E Attendances	30%	53%
Non elective admissions	20%	50%
GP appointments	15%	79%
999 calls	15%	34%
111 calls	10%	64%
Mental health attendance	N/A	47%

The financial benefits of this service are also significant; the estimated cost of providing services to the 53 clients in the 3 months prior to the HIU was £335,015, and during the first year it has been calculated that the total savings were £140,000.

The service also sought to measure the qualitative impact on people in several ways; a bespoke 'Outcome Star', Goal Attainment Scoring (GAS) and feedback from both clients and professionals.

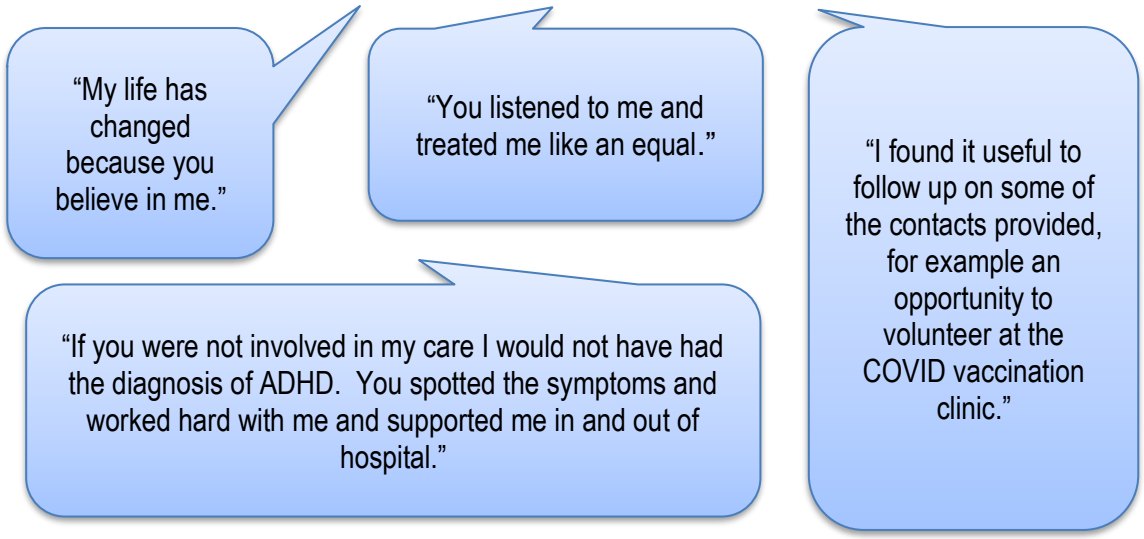
The Outcome Star measures how independently a person is managing an area of their life (as opposed to, for example, how good their physical condition is). A client scoring '1' would be totally

unwilling even to discuss that area of their life, and scoring '10' would have no foreseeable need for support from professionals in that area. The data below shows a noticeable improvement in each point of the star:

Outcome Star measure	Average score on assessment	Average score at discharge	Average of improvement
Mental health and wellbeing	3.7	4.7	1.0
Meaningful use of time	3.9	4.8	0.9
Social networks and relationships	4.3	5.0	0.7
Physical Health	4.7	5.5	0.8
Living skills and self-care	5.4	5.7	0.3
Total	**4.4**	**5.1**	**0.7**

This demonstrates that changes have been greater in areas with a lower starting point, indicating that the service is more effective at helping and has more opportunity to help those who are lower functioning to start with.

Some feedback from those people accessing the HIU service is shown below:



Next steps

CWP have committed to funding the existing HIU Lead on a permanent basis to ensure the continuity of the service. A number of future service options have been assessed, ranging from continuing with one HIU Lead to a scaled-up service of five HIU Leads taking on a caseload of ~250 clients across Cheshire West. Active analysis has demonstrated the need and opportunity for this level of future service, and could potentially deliver up to £440,000 of savings and demand reduction per year.

For more information, please contact timothy.hughes6@nhs.net

COMPLIMENTS

Between January and March 2022, CWP formally received 400 ompliments from people accessing our services, and others, about their experience. Below is a selection of the comments and compliments received:

Children, Young People & Families
"Thanks again for everything. You have been amazing and helped us both so much through this journey. I am sure we will succeed in continuing the journey going forward remembering your words of wisdom and for our family member to remember what she needs to do when feeling OCD is raising its head."

All Age Disability
"Just wanted to say Thank You So Much for all your help (and patience) throughout this process, you have been a Godsend, helping us with the biggest thing either of us have had to deal with, and it is very appreciated."

Neighbourhoods
"I wanted to let you know how much you are all appreciated. I had been especially concerned about the vaccine, but you spared time to listen to me, giving me enough reassurance to "go for it". I am glad I did and all is well. Knowing you are all have experienced difficult and demanding times. I hope light is beginning to emerge at the end of the tunnel."

Specialist Mental Health – Bed Based
"Family member contacted the ward and informed staff how they feel extreme comfort with their family member being a patient on the ward due to the high level of person-centred care provided on the ward by all staff. When the family member visited them, they mentioned two staff members who they observed that make them feel "safe" and "listened to", by engaging on "eye level" and communicating effectively to that individual's needs. Family member wanted to thank all staff for the care they provide."

Specialist Mental Health – Place Based
"It's been absolutely invaluable and life changing. It has changed most aspects of my life, my whole outlook. I feel a different person and it has given me skills for life. I have appreciated the patience and skill that you have shown to get me to where I am now."

Learning Disability, Neuro Developmental Disorders & Acquired Brain Injury
"We wanted to say a huge thank you for all your help with our daughter over the past few months. We have experienced such a traumatic time, but your constant presence, kindness and reassurance has been a life saver. Knowing that you are there supporting and wanting what's best for our daughter has helped us through these very testing times and we are truly grateful for your support."

Share your improvement work!

We welcome your best practice examples and Quality Improvement successes; please share your work via the Safe Services Department using the QI Hub page on the intranet or contact the Patient Safety Improvement Team at cwp.patientsafetyteam@nhs.net

Look out for more about Quality Improvement in Edition 1 2022/23 of the Quality Improvement Report

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Board Assurance Framework and Strategic Risk Register
Agenda ref. number:	22.23.02 d
Report to (meeting):	Board of Directors (meeting held in public)
Action required:	Discussion and Approval
Date of meeting:	25/05/2022
Presented by:	A Sivananthan, Medical Director

Which strategic objectives this report provides information about:	
Improving Care, Health and Wellbeing	Yes
Working within Communities	Yes
Working in Partnership	Yes
Delivering, Planning and Commissioning Services	Yes
Making Best Value	Yes
Reducing Inequalities	Yes
Enabling our People	Yes
Improving and Innovating	Yes

Which NHSI Single Oversight Framework themes this report reflects:		CWP Quality Framework:		
Quality	Yes	Patient Safety	Safe	Yes
Finance and use of resources	Yes	Clinical Effectiveness	Effective	Yes
Operational performance	Yes		Affordable	Yes
Strategic change	Yes		Sustainable	Yes
Leadership and improvement capability	Yes	Patient Experience	Acceptable	Yes
			Accessible	Yes
		http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Any matters that will impact on the CWP Green Plan?	
	No

Equality, Diversity, and Inclusion	
Does this report present any equality related impacts / risks in relation to any of the following protected characteristics; age, disability, ethnicity/race, gender reassignment, marriage & civil partnership, pregnancy & maternity, religion & belief, sex or sexual orientation ?	
No	

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	Yes
All strategic risks	

Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	Yes
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

To apprise the Board of Directors of the current status of the Board Assurance Framework (BAF) and Strategic Risk Register (SSR), to inform discussion of the current risks to the delivery of the organisational strategic objectives and to meet the requirements outlined within the Trust's integrated governance framework.

At the time of reporting (April 2022) the Trust has nine strategic risks – five are rated red and four are rated amber.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The Medical Director (Executive Lead for Quality) and the Quality Committee are the designated officer and committee respectively for risk management. The Quality Committee reviews the strategic risk register. The Board of Directors reviews the board assurance framework and receives assurances on risk via the Quality Committee. Complemented by Audit Committee's oversight of the system of internal control, this framework provides assurance regarding the quality and safety of the services that the Trust provides. Additional to this Operational Committee receives the strategic risk register to increase operational awareness of strategic risks and strengthen integrated governance in terms of the synergy between Care Group and strategic risk registers.

Assessment – *analysis and considerations of the options and risks*

The Strategic Risk Register was recently reviewed by the Quality Committee at its meeting on the 4 May 2022 and by the Operational Committee at its meeting on the 18 May 2022.

New risks/ risks in-scope

None

Current risks

Risk 2 - *CWP may not have sufficient capability (capacity, confidence and competence) to deliver, or support delivery of, safe and effective person-centred care or to enable the transformation of services and contribute to system working.* (score: 20 – Red). The risk was reviewed and updated following the Quality Committee discussion on 2nd March 2022 and the likelihood and target Scores were reviewed. The likelihood score was amended to 4, taking the overall score to 20. This was further considered and agreed at the March Operational Committee meeting. At the March Board of Directors meeting, it was agreed that the risk would be further considered at the next scheduled Quality Committee meeting to assess additional mitigations and further review the score. Further to the Board of Directors meeting, mitigations have been reviewed and updated.

Risk 3 - *Adverse impact on patient care and operational effectiveness due to the SystmOne training deficits and data entry/reporting delays.* (score: 20 – Red). It was reported to the April Operational Committee, that the ePR team is working to improve data entry, however, this continues to impact on the trust's ability to report accurately. Waiting list data is also being considered by the team with senior managers across the trust. Training needs are being identified and addressed accordingly. It was also confirmed that the migration of cut over records into SystmOne is now complete. SystmOne audits have commenced, to review how SystmOne is being used by clinical services and to identify any issues with the design or use of the system. Progress on inpatient wards has been hindered due to current staffing pressures.

Risk 9 - *Demand for ADHD services which exceeds current contract values and commissioned capacity.* (Score: 20 – Red). The March Board of Directors requested the service undertake an internal review of waits led by Consultant staff across all Care Groups and to consider the appropriateness of sub-contracting to a private provider to support those currently waiting services. This work was reported to the April Operational Committee as in progress. An interim report was provided direct to the CQC (8.04.22).

Risk 4 – *Potential adverse impact on the delivery of safe and effective care to the population of Cheshire and Wirral due to the COVID-19 pandemic*. (Score: 16 - Red). The national approach of 'living with COVID' and the stepping down of control measures was recently introduced. Further to this, a rise in community transmission has been seen which has also impacted on staffing. The TCG continue to meet and a number of working groups are operational to support the delivery of safe and effective care.

Risk 1 – *Risk of supervision compliance rates falling below the Trust target of 85%.* (Score: 12 – Amber)
At the April 2022 Operational Committee it was noted that supervision rates had seen a level of improvement (78% clinical supervision and 72% management supervision). It was acknowledged that sick absence within Care Groups continued to hamper carrying out and recording supervision. The Organisational Development team is investigating if Appraisal and Management Supervision processes and associated templates can be combined into a single entity. This would reduce the administerial burden across the Trust and bring about a single metric for measurement. The risk Lead has been amended as follows; Head of OD (Management Supervision) / Associate Director of Nursing and Therapies (Clinical Supervision).

Risk 5 - *Failure to respond in accordance with Health & Safety Regulations in the event of a ward fire.* (score: 8 – Amber). The Education, Learning and Development team in partnership with the Fire Officer and Estates team have launched the new e-learning programme and Fire Panel training, compliance will continue to

be monitored via monthly Trustwide mandatory training reports. Ongoing monthly compliance reports are also provided to Care Groups.

Amended Scores
None

Archived risks
None

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors are asked to **note** and **approve** the process outlined above and the progress made to date.

Who has approved this report for receipt at the above meeting?	
Contributing authors:	Suzanne Christopher, Head of Corporate Affairs

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Quality Committee	04.05.22
2	Operational Committee	18.05.22

Appendices provided for reference and to give supporting/ contextual information:

Appendix No.	Appendix title
1	Board Assurance Framework (incorporating strategic risk register)

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STANDARDISED HIGHLIGHT/ EXCEPTION REPORT

REPORT DETAILS	
Subject matter of report:	Report against Strategic Objectives – May 2022
Report provided by:	James Partington, Quality Surveillance Specialist
Date of report:	25/05/2022

SUBJECT MATTER
What is this report about? Summarise why this report requires the attention of the Committee.

Summarise the purpose of the report:

In mid-2019 the Board of Directors requested the development of a new product through which the Trust could report against its strategic objectives. This was based on metrics identified by the Board in December 2018. The new report was launched in September 2019. A further Activity Appendix was added in Spring 2020 to enable the Trust to monitor some key aspects of the impact of the pandemic.

There is an intention to review and potentially recast the metrics to better align with the new Strategic Objectives. Until that work takes place, the report is structured around the old Strategic Objectives.

There has been an interruption in the flow of data following the move to SystmOne. Information on admissions via the dynamic support database is not available and the activity appendix has not been updated this month. There is only partial information on mortality reviews, and the low figures for EI performance reported to NHSi reflect known SystmOne input issues.

ESCALATION
What do you need to escalate to the Committee?

Quality, clinical, care, other risks that require escalation:

Despite the Trust providing additional beds at Riverwood ward, the pressures on acute mental health beds have continued with the result that bed occupancy including leave continues to be over 100% (slide 3) and that more people have been cared for out of area (slide 4).

Appraisal rates have fallen again (slide 11). This further drop is due to the end of the third window for colleagues in bands 1-4 at the end of March 2022.

Sickness absence remains high (slide 14).

Turnover remains high (slide 15).

The vacancy rate remains above average at around 7% (slide 16).

ASSURANCE
What assurance or evidence of improvements are you providing to the Committee?

Other key matters to highlight:

Staff feedback reported to the quarterly pulse surveys has been stable despite the significant pressures that the workforce has been facing (slides 8 and 9).

For those services where there is a reliable information flow, the percentage of deaths reviewed through either a case record review of a Datix/Steis review remans high at 100% (slide 18).

Report Against Strategic Objectives

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

May 2022

Quality Surveillance Analysis Team

Helping people to be
the best they can be

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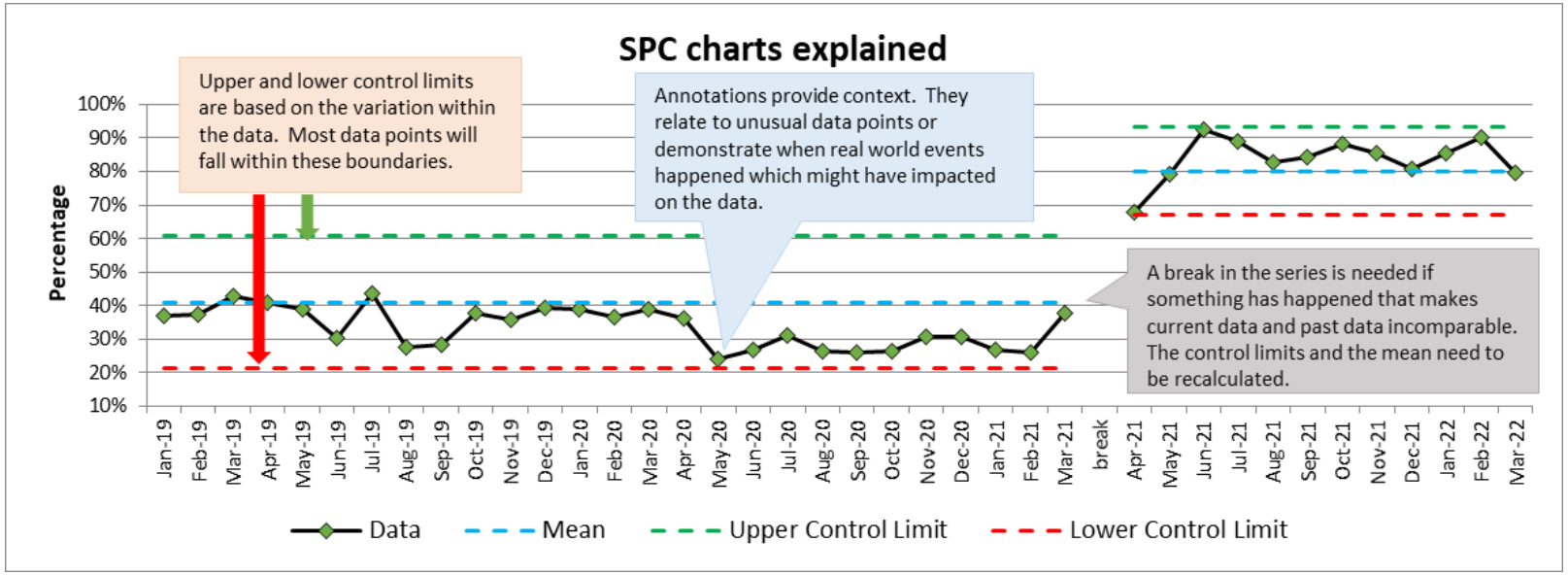
SPC Charts

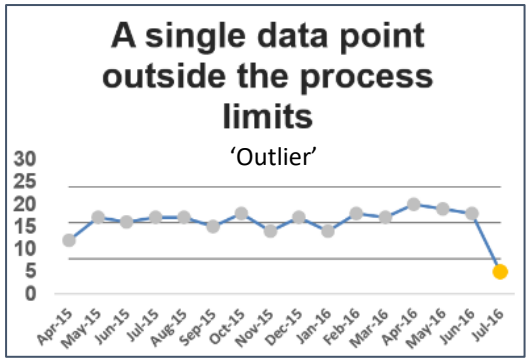
SPC stands for Statistical Process Control. SPC Charts were first developed in 1928. They help to highlight unusual data, prompting further investigation and hopefully better understanding. Their use has continued to grow, first in manufacturing and more recently in the health sector.

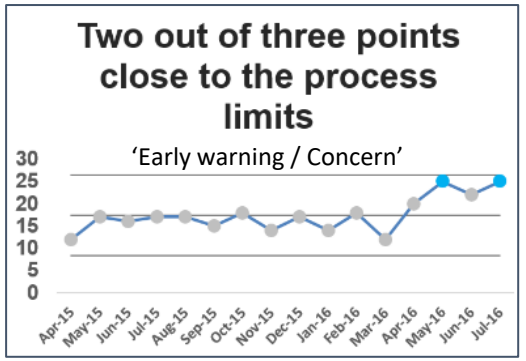
The graphic on the right shows the basic features of an SPC chart.

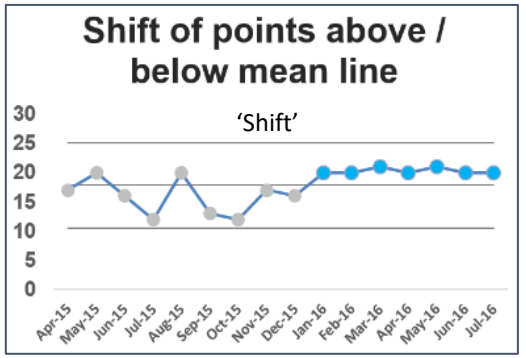


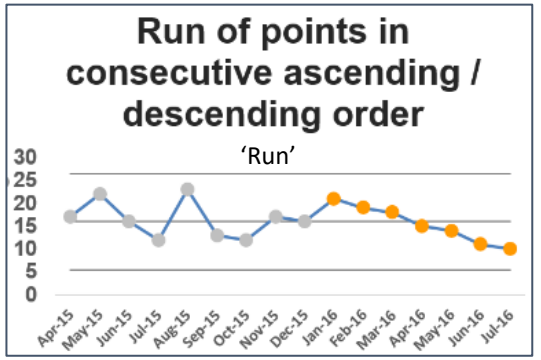
What to watch out for when reading an SPC chart

Most of the data points will fall within the control limits. Even where they do, there might be some patterns that would warrant further investigation. The following images are taken from NHS Improvement's 'Making Data Count' resources. All four types of case warrant further investigation or explanation. Note that the SPC chart can't give you the explanations for the movements, that information needs to come from the people who know the data.

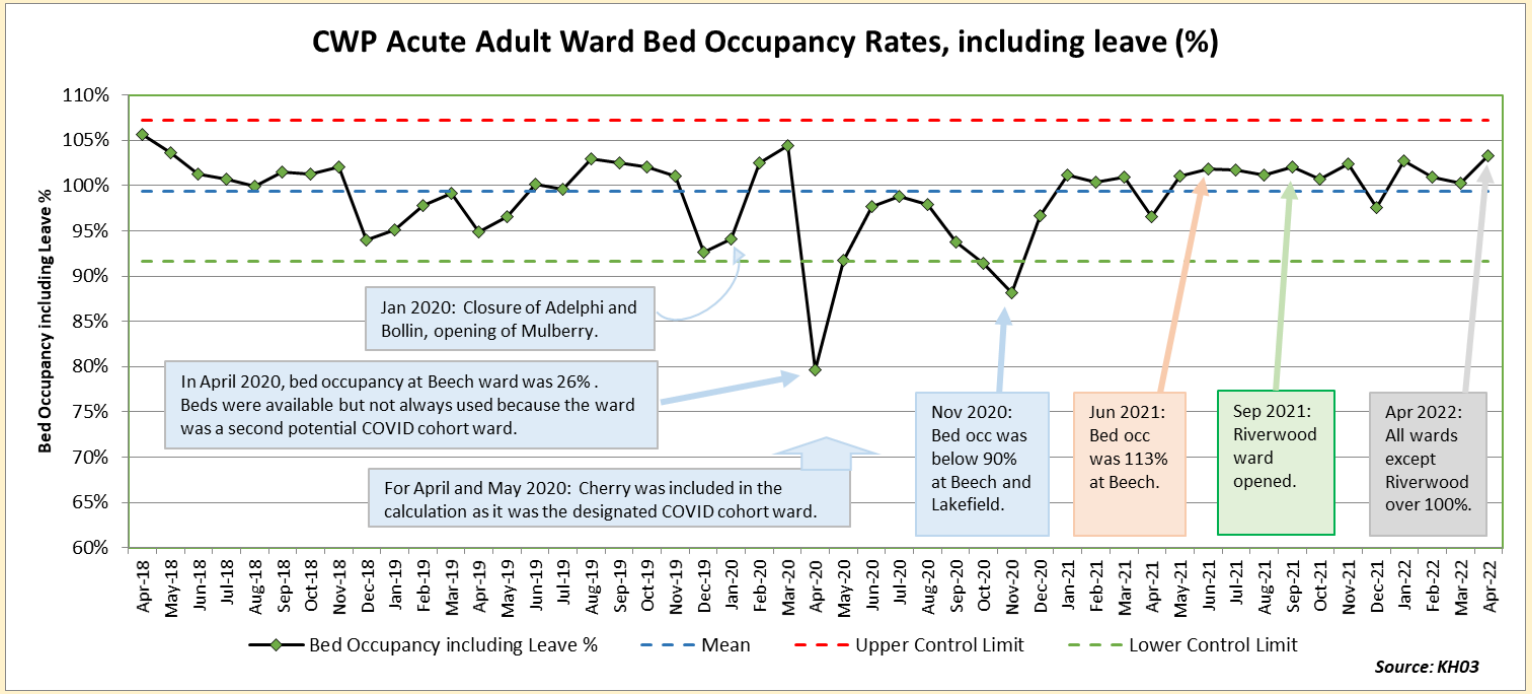






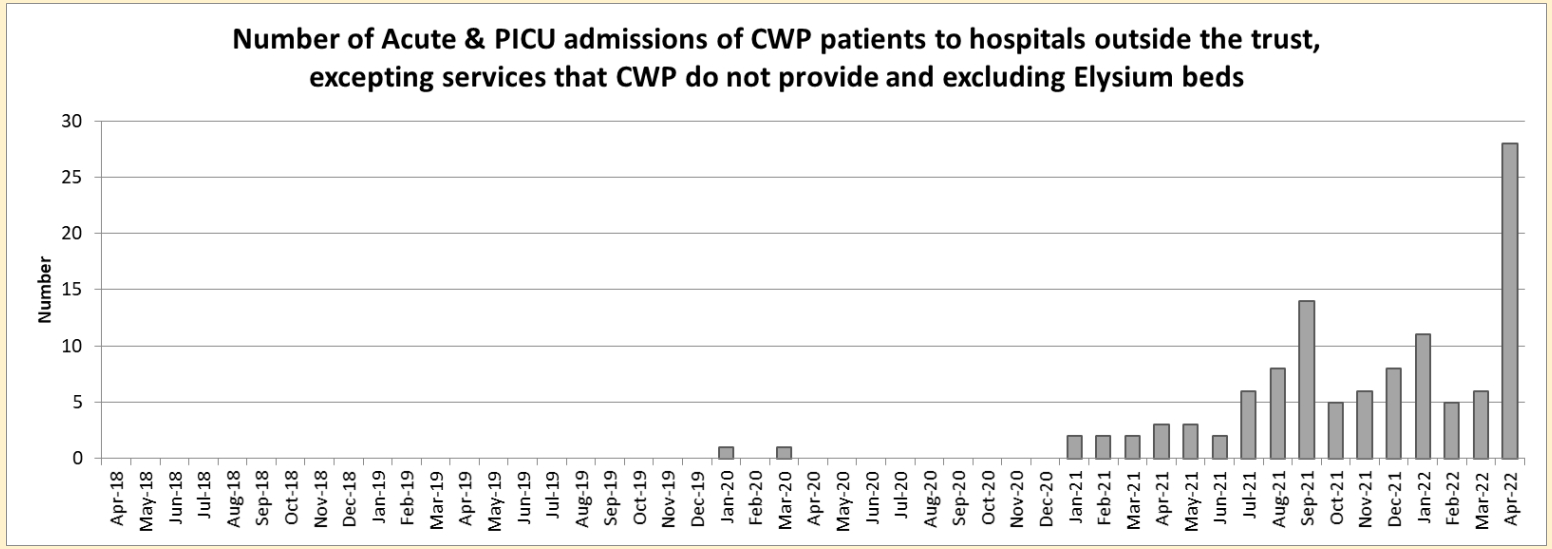


Deliver high quality, integrated and innovative services that improve outcomes

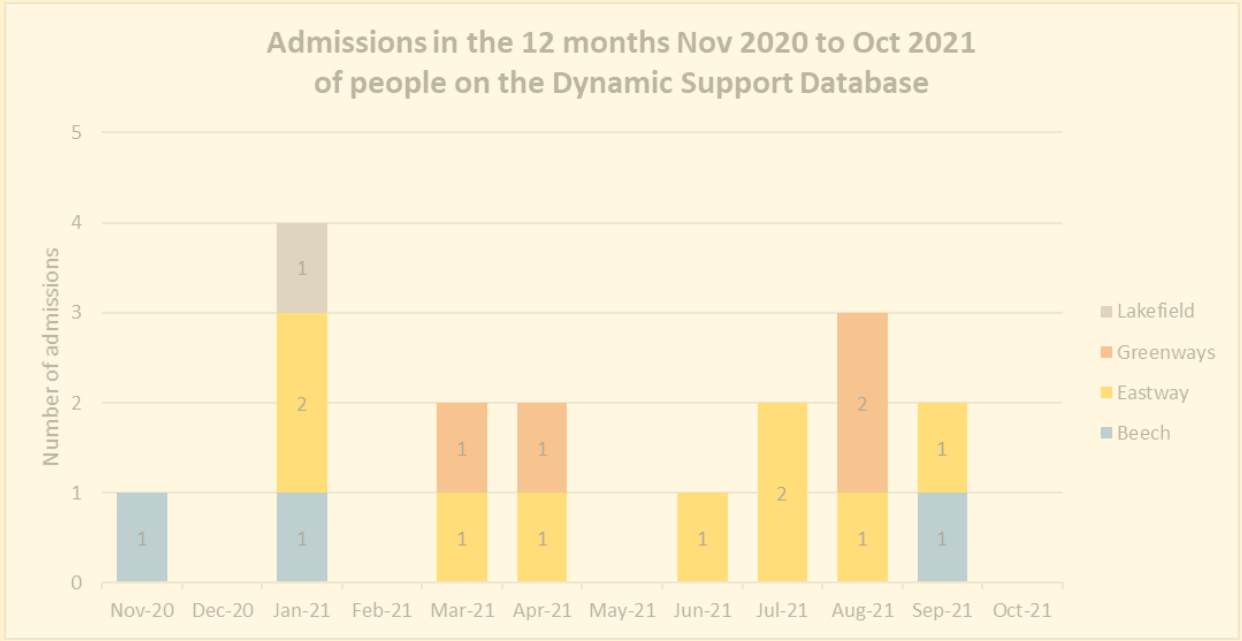
Metric	Data	Further Explanation
Bed Occupancy - Adult Acute wards		Metric owner: Suzanne Edwards / Anushta Sivananthan Monitored at: SMH Care Group Data sources: KH03 file provided by the Information Team.

Comment: Bed occupancy including leave has been over 100% for 14 of the last 16 months, reflecting the challenges and pressure facing our inpatient services and explaining the need for out of area/Elysium beds as shown on the next slide.

Deliver high quality, integrated and innovative services that improve outcomes

Metric	Data	Further Explanation
Out of Area Acute Admissions	 Comment: There has been further need for patients to be placed out of area in the most recent months, adding to a pattern which has developed since January 2021, after a long period with only minimal out of area placements prior to the start of 2020. This has been as a result of high levels of acuity in acute care impacting on flow and discharges, bed availability due to covid outbreaks and staffing challenges. To mitigate out of area bed usage, CWP have agreed continuation of 9 Elysium and 6 local out of area beds through the North West bed bureau. There are also an additional 6 acute beds open within Riverwood Ward, CWP, whilst a full review of our Acute Care System is undertaken.	Metric owner: Suzanne Edwards Monitored at: Operational Committee Data source: CWP Bed Hub The definition has been changed since previous versions of the report. Each month's data now includes people who have been discharged or repatriated before the end of the month whereas previously the data were an end-of-month count. CWP patients looked after in Elysium beds are not counted as they are receiving continuity of care.

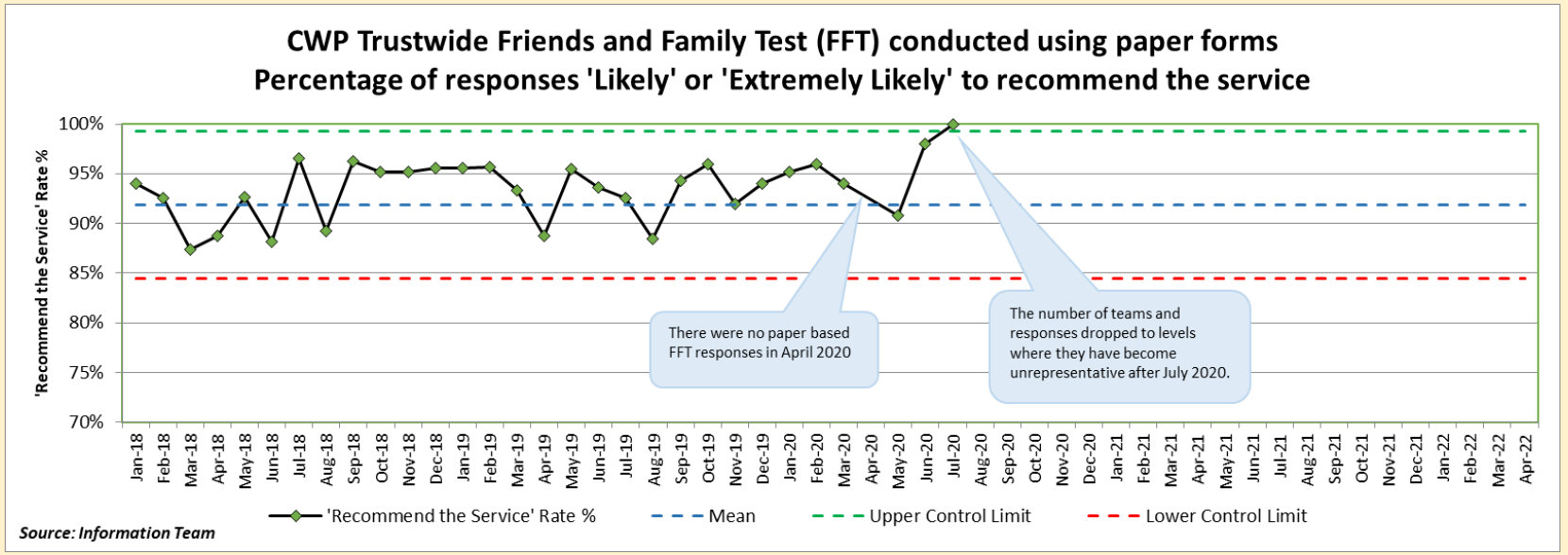
Deliver high quality, integrated and innovative services that improve outcomes

Metric	Data	Further Explanation
Admission to hospital for those on the Dynamic Support Database	 This information is not yet available following the EPR migration from Carenotes to SystmOne. The chart will be updated once the information flow is reinstated.	Metric owner: Maddy Lowry Monitored at: LD, NDD & ABI Care Group Data source: 'LD Risk Register Report for QS' Report Manager report

Deliver high quality, integrated and innovative services that improve outcomes

Metric	Data	Further Explanation
CWP performance against NHSi targets **(Exceptions only)**	The Trust reports a number of operational metrics to NHSi. These cover: Early Intervention in Psychosis (one metric), Improving Access to Psychological Therapies (3 metrics), Out of Area admissions (monitored on slide 4 of this pack), and a data quality measure which is provided with a three month lag. This means that the most recent two data points, reported in March and April 2022, are for December 2021 and January 2022. The following metrics were below target performance as set out in the NHS Oversight Framework for March and April 2022: • Out of Area Admissions which had 6 instances in March and 28 in April • The data quality measure, where the data for the most recent months were 66.6% in March and 77.2% in April against a target of 95%. • EI % in 2 weeks (completed) which was reporting 4.35% in March and 0.00% in April against a target of 60%. *This is caused by the SystmOne input problems*	Metric owner: Tim Welch Monitored by: Ops Committee by exception from Care Groups Data source: CWP Business and Value

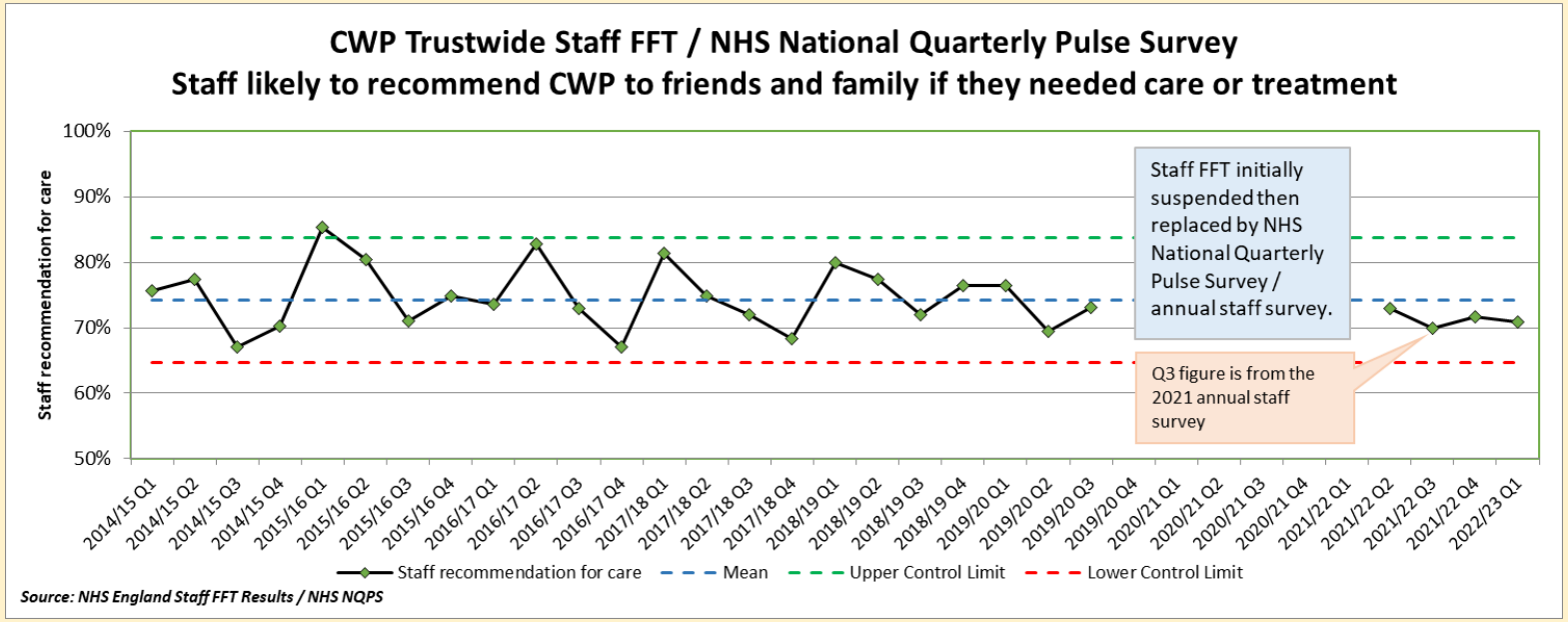
Ensure meaningful involvement of service users, carers, staff and the wider community

Metric	Data	Further Explanation
Friends and Family Test – responses from users of our services		Metric owner: Gary Flockhart Monitored through: Quality Committee and PACE Data source: 'FFTalldatatodate' file from the Information Team

Comment: Following the onset of Covid-19, there was a national pause on the reporting of FFT. The volume of paper based FFT forms diminished after July 2020 to a point where they are not representative of all CWP services, so results are not shown after that date. Work is still outstanding to re-link data extracts in the Data Warehouse since the move to SystmOne. Data input issues are affecting the information required for creating external data flows to Healthcare Communications in order to enable the text messages seeking feedback.

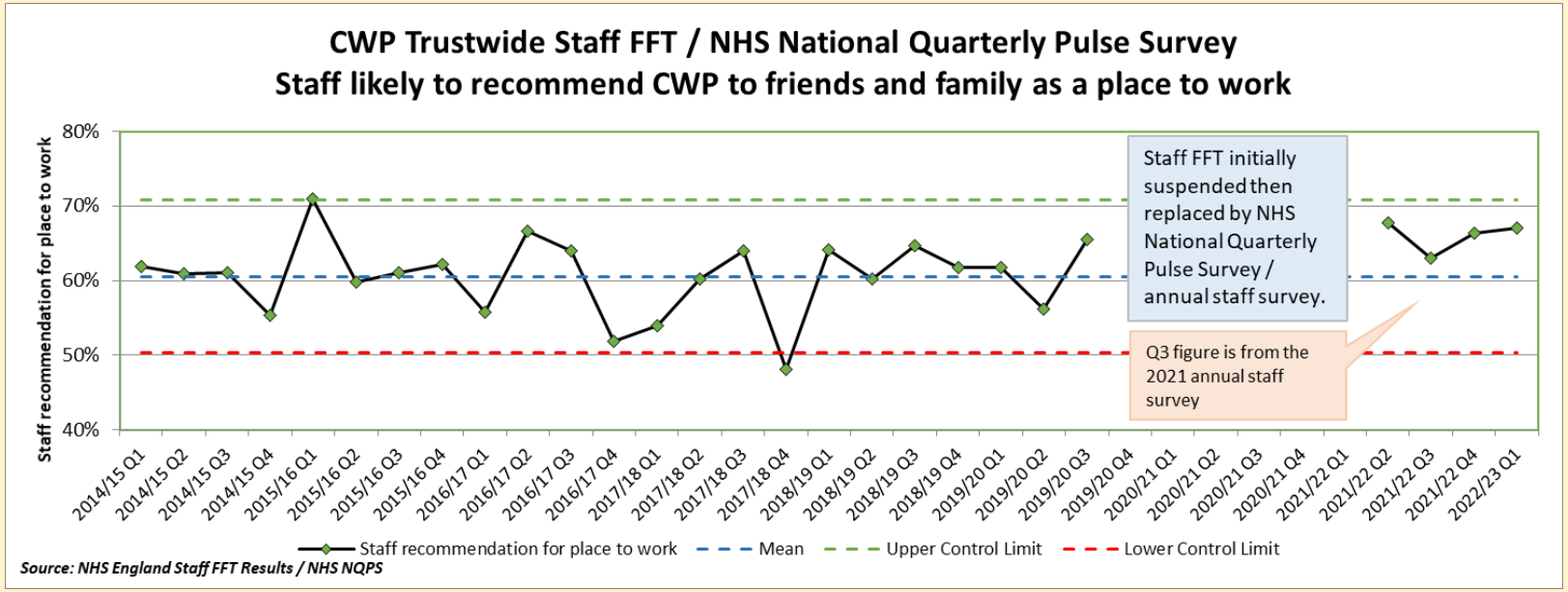
Although there has been a pick-up in the use of the paper forms in recent months, the redirection of resources to support SystmOne has precluded the development work that is needed to update this chart.

Ensure meaningful involvement of service users, carers, staff and the wider community

Metric	Data	Further Explanation
NHS National Quarterly Pulse Survey – about CWP as a care provider		Metric owner: David Harris, delegated to Simon Platt Monitored at: POD Sub Committee Data source: People Information

Comment: The Staff Friends and Family Test was paused during the COVID pandemic and this was replaced in July 2021 with the NQPS which expands on the two previous questions to include the 9 engagement questions from the Annual NHS Staff Survey. For Q1 2022/2023, CWP scored 70.86% although it is a slight decrease (0.8%) from Q4 2021/2022, it is still 6% higher than the average score of other Trusts who also utilised our external partner (Picker). For comparison, the score in Q4 2022/2023 is in line with the results of the 2021 NHS Annual Staff Survey where 70% of colleagues indicated that they would be happy with the standard of care provided by the organisation. Results from the Annual Staff Survey and NQPS are currently being incorporated into staff engagement plans for Care Groups/Teams.

Ensure meaningful involvement of service users, carers, staff and the wider community

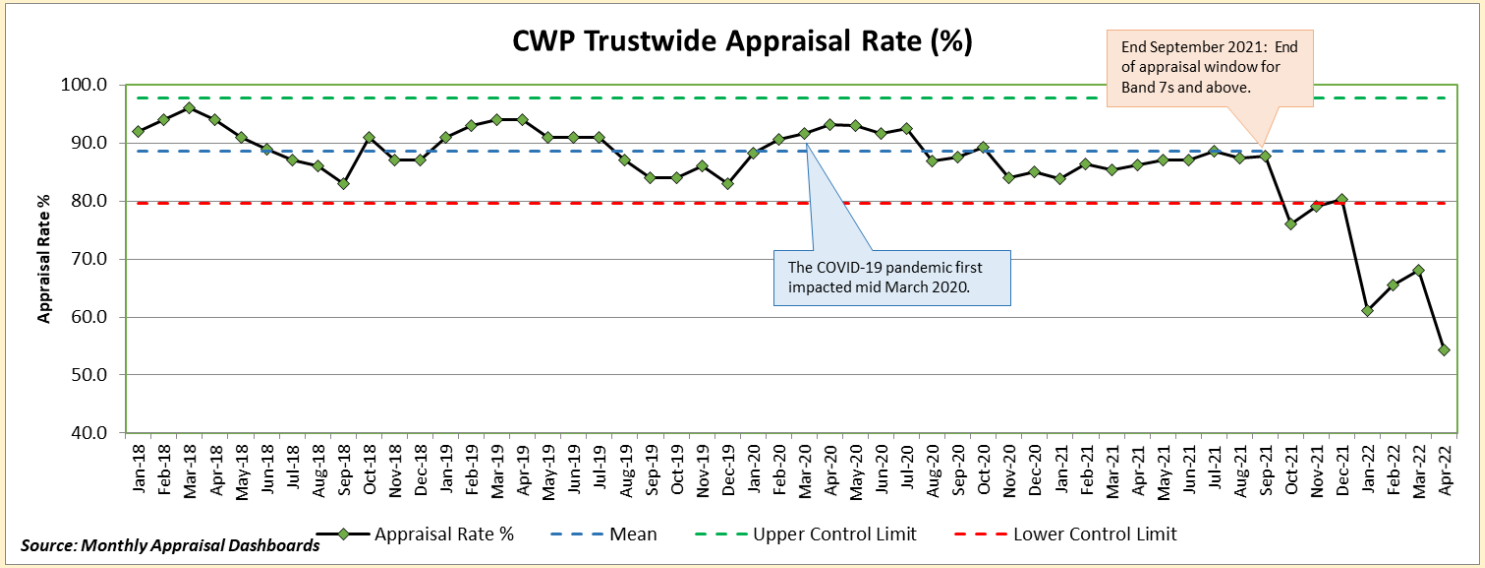
Metric	Data	Further Explanation
NHS National Quarterly Pulse Survey – about CWP as a place to work		Metric owner: David Harris, delegated to Simon Platt Monitored at: POD Sub Committee Data source: People Information

Comment: The Staff Friends and Family Test was paused during the COVID pandemic and this was replaced in July 2021 with the NQPS which expands on the two previous questions to now include the 9 engagement questions from the Annual NHS Staff Survey. For Q1 2022/2023, CWP scored 67.1% which is a slight increase (0.7%) from Q4 2021/2022. Additionally, it is 9.1% higher than the average score of other Trusts who also utilised our external partner (Picker). For comparison, the score in Q4 2022/2023 is 4.1% higher than the 2021 NHS Annual Staff Survey where 63% of colleagues indicated that they would recommend the Trust as a place to work. Results from the Annual Staff Survey and NQPS are currently being incorporated into staff engagement plans for Care Groups/Teams.

Ensure meaningful involvement of service users, carers, staff and the wider community

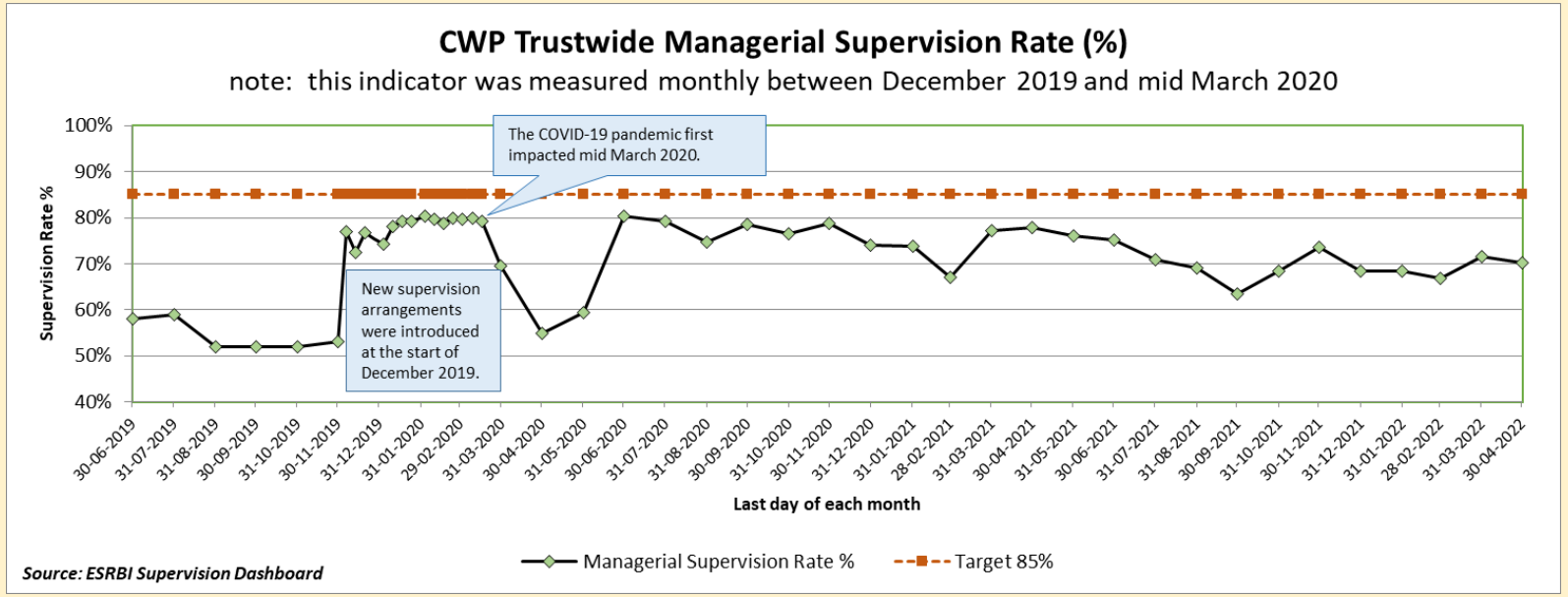
Metric	Data	
Effectiveness of working with the wider community	Comment: As a result of Covid-19 restrictions and limited ability to meet people we have developed our connecting virtually offer with members and public, we have utilised other methods of ensuring that we listen to the voice of people who access our services. We have involved people in the steering groups of various research and improvement projects. People with lived experience continue to be involved in numerous projects such as the review of our Lived Experience Connector® programme and our Volunteering and Involvement processes. People continue to work with us to create their Digital Stories, our participation and engagement groups continue their work to ensure that people voices are heard, and they are involved. Despite no identified specific listen and learn events, the PACE team have been involved in gaining feedback and making improvements in many of our processes so that people receive a person-centred experience.	Metric owner: Cathy Walsh Monitored at: PACE Sub Committee Information Source: PALS team

Be a model employer and have a caring, competent and motivated workforce

Metric	Data	Further Explanation
Appraisal		Metric owner: David Harris, delegated to Simon Platt Monitored at: POD Sub Committee and Ops Committee Data source: People Information

Comment: As reported last time, the sudden drop in performance is due to the windows for completion now closing. Also, in considering the "reducing the burden" instructions from NHSE/I the Trust considered extending these windows further. This would have kept performance at a higher level but it was decided that the Trust would stick with the current window, accept the inevitable drop in performance and then make it a priority to improve (alongside supervision). Please note that the further drop is due to the closure of the window for Band 1-4s at the end of March 2022. This issue was discussed further at April Operational Committee and will remain a focus of escalation. Furthermore, colleagues from Organisational Development are due to submit an options paper regarding the future of both Appraisal and Management Supervision by 10/6/22. This will include any researched opportunities to meet best-practice alongside other Northwest Organisations, improving the digital recording mechanism and simplifying the overall process for Supervisor/Supervisee.

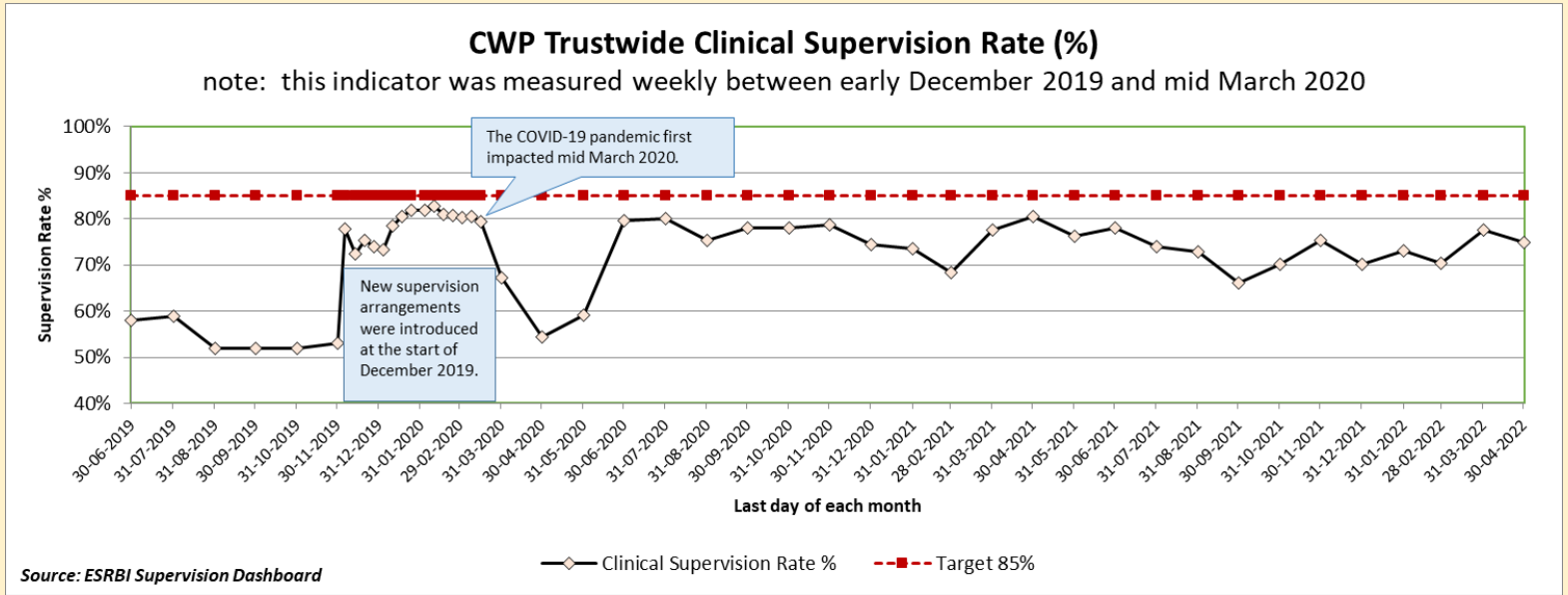
Be a model employer and have a caring, competent and motivated workforce

Metric	Data	Further Explanation
Managerial Supervision		Metric owner: David Harris, delegated to Simon Platt Monitored at: POD Sub Committee and Ops Committee Data source: People Information

Comment: Supervision has remained a focus of scrutiny at Operational Committee and People and OD Sub Committee. At the former, Care Groups provided details of the rapid improvement projects that they were carrying out with specific, targeted teams and this seemed to be leading to improved performance in November. However, in December and January a number of services were in business continuity mode with very high levels of absence. This led to a cessation of the improvement work (the focus was on keeping services running) and has had a negative impact on recorded supervision levels. At Operational Committee in January Care Groups were asked to give assurance that supervision was taking place. This was given verbally but it was acknowledged that this was not being reflected in the reported figures in all areas. Care Groups intend to restart the improvement projects that they had to stop over Dec/Jan but high level of absence and redeployment of staff continues to hinder this work. Furthermore, colleagues from Organisational Development are due to submit an options paper regarding the future of both Appraisal and Management Supervision by 10/6/22. This will include any researched opportunities to meet best-practice alongside other Northwest Organisations, improving the digital recording mechanism and simplifying the overall process for Supervisor/Supervisee.

Note: Separate managerial and clinical supervision competencies were introduced at the start of December 2019. For months up to and including November 2019, the time series reflects compliance with the previous 'all supervision' competence.

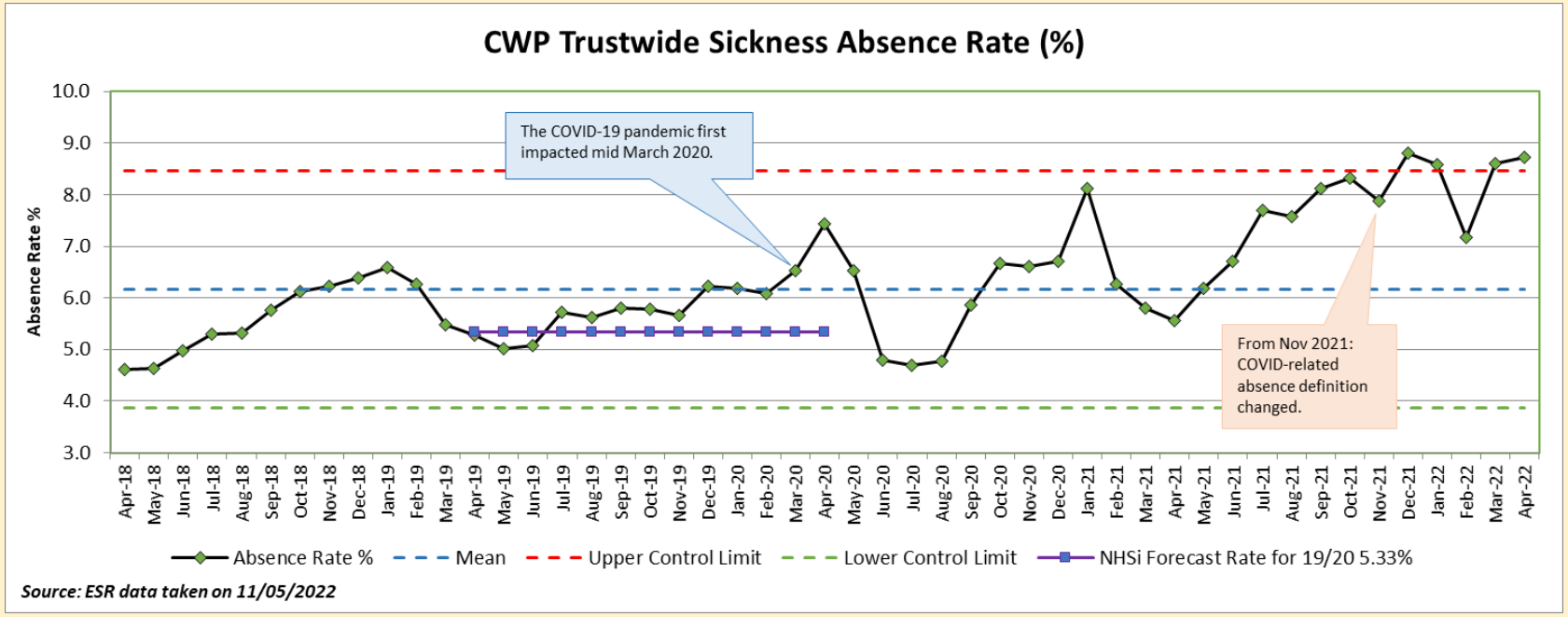
Be a model employer and have a caring, competent and motivated workforce

Metric	Data	Further Explanation
Clinical Supervision		Metric owner: Victoria Peach Monitored at: Care Group and Ops Committee Data source: People Information

Comment: The COVID-19 pandemic had a marked impact on the recording of clinical supervision over the period March to May 2020.
See comments on managerial supervision.
The clinical supervision compliance measure does not include medical supervision compliance.

Note: In December 2019 separate managerial and clinical supervision competencies were introduced. For months up to and including November 2019, the time series reflects compliance with the previous 'all supervision' competence.

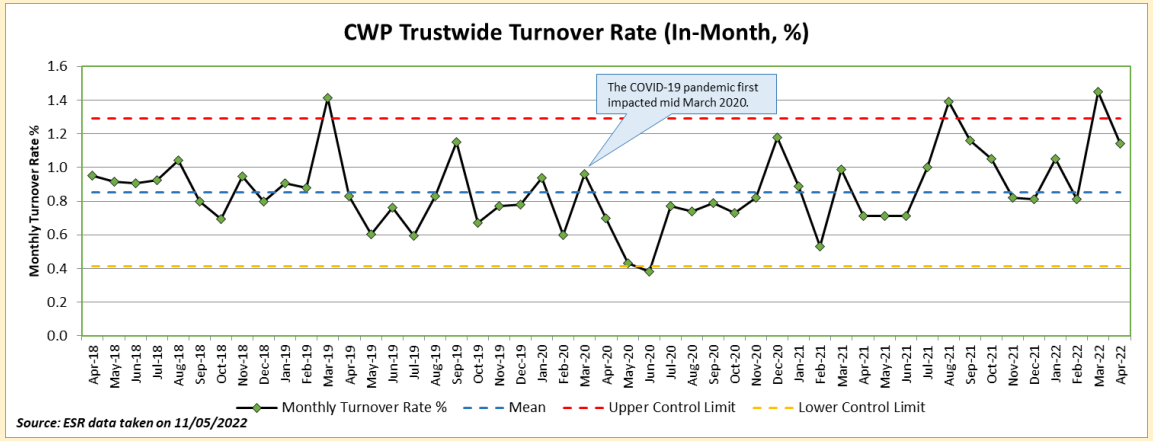
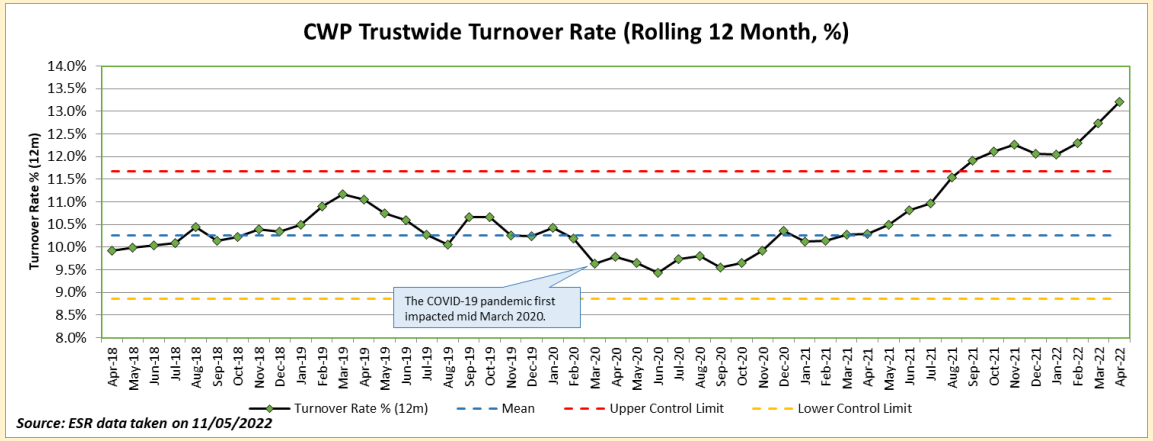
Be a model employer and have a caring, competent and motivated workforce

Metric	Data	Further Explanation
Sickness Absence (in-month)		Metric owners: David Harris, delegated to Carmel Hopkins Monitored at: POD Sub Committee Data source: People Information

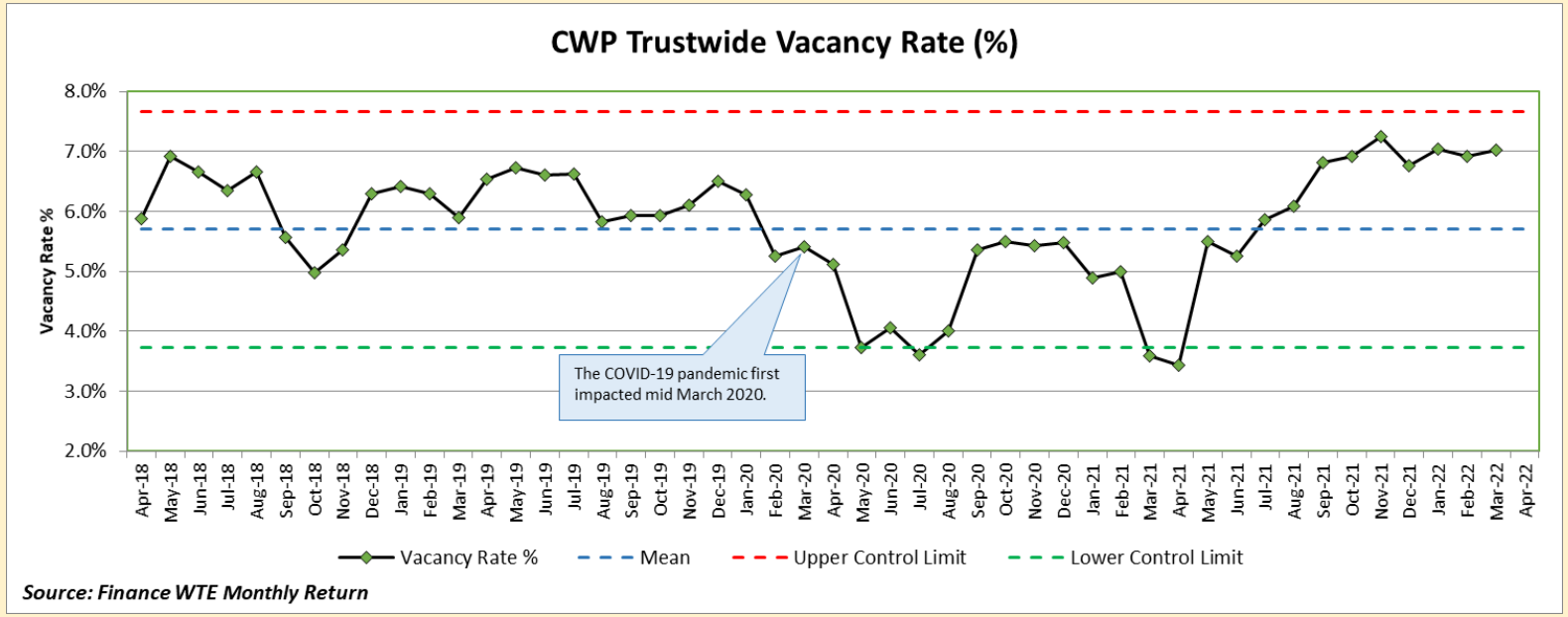
Current position: There has been a slight trajectory reduction in long term sickness absence but an increase in short term absence. 33.4% of overall absences for April 22 was due to infectious diseases (Covid) with the majority of sickness absence occurrences being from Nursing and Midwifery and Additional Clinical Services staff groups. The demands on services remain high and complex with staff continuing to feedback that they are tired which, together with recruitment and retention challenges, impacts on sickness. HR Ops continue to support and work with managers to ensure cases are effectively managed together with an extensive range of wellbeing interventions available to support staff. There is a commitment to look at how Covid absence figures have impacted on general absence pre and post pandemic.

The data presented here are in-month sickness absence rates. A rolling 12 month rate is shown in the Operational Committee Performance Dashboard.

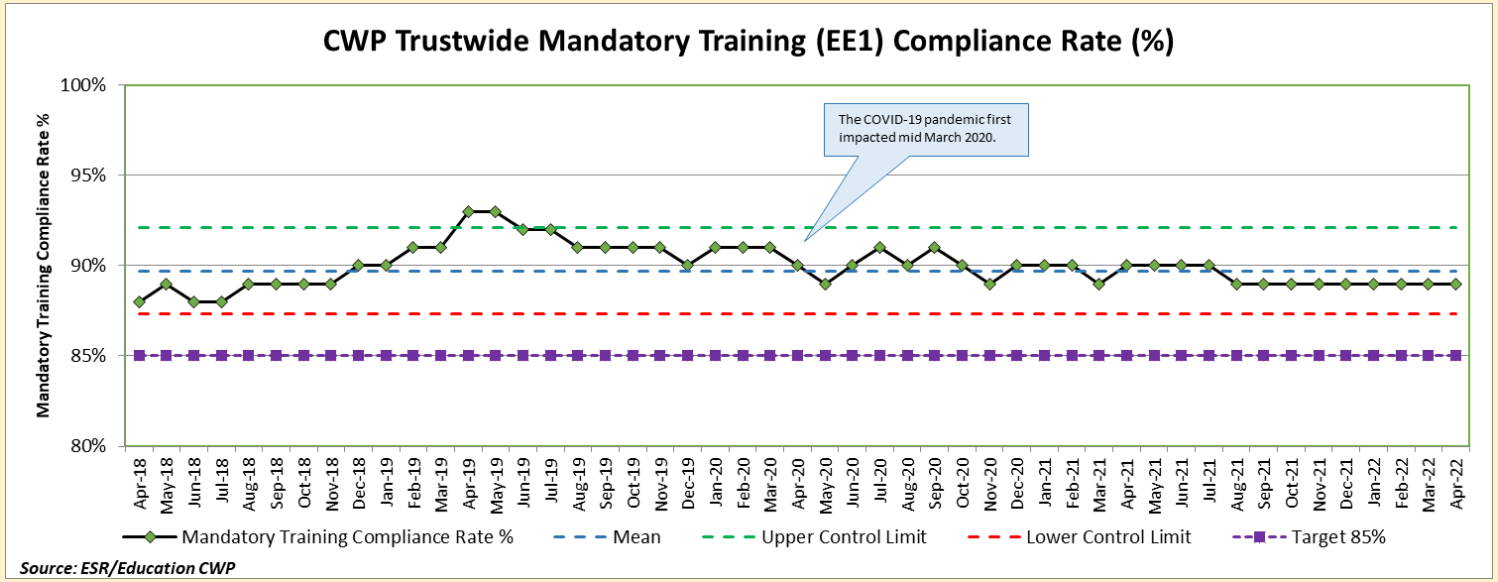
Be a model employer and have a caring, competent and motivated workforce

Metric	Data	Further Explanation
Staff Turnover	 *Source: ESR data taken on 11/05/2022*  *Source: ESR data taken on 11/05/2022*	Comment: The latest rolling 12 month data continues to exceed the upper threshold. This is not what we would expect from normal variation but is representative of the national picture. As per previous updates the turnover and vacancy rate challenge has been captured in Strategic Risk 2, which has been reviewed by Quality Committee. The mitigating actions are being addressed through a number of task and finish groups together with further work to understand the detail of turnover data and collate feedback from exit interviews. Stay interviews are also being trialled.	Metric owner: David Harris, delegated to Viv Williamson Monitored at: POD Sub Committee Data source: People Information

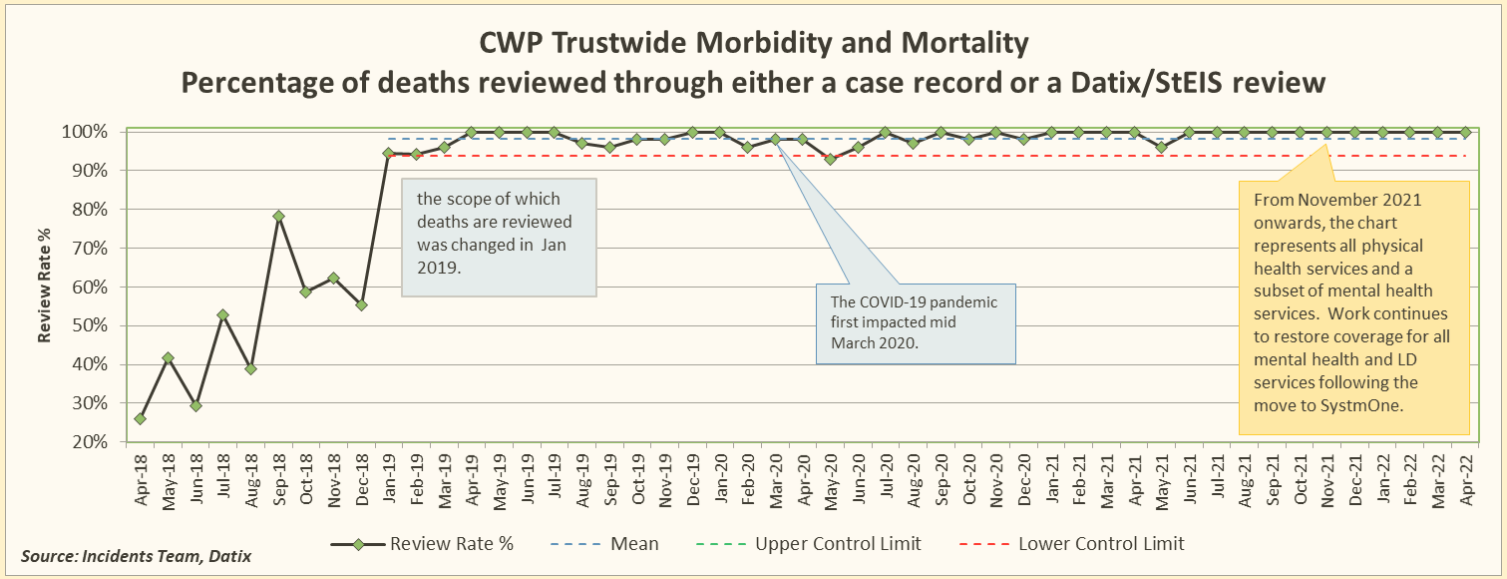
Be a model employer and have a caring, competent and motivated workforce

Metric	Data	Further Explanation
Vacancy Rate	 ***Source: Finance WTE Monthly Return*** Comment: Phase one of the attraction campaign has been completed and recruitment and retention initiatives continue. Phase 2 of the attraction campaign will focus on hard to fill roles and widening participation. Number of offers for April 22 were 183 FTE with a total of 343 FTE in recruitment excluding authorisation and advert stages. Data for starters/leavers shows a net increase of 212 FTE between Mar 21 and Apr 22, however this will also include new roles not yet included in establishment and vacancy figures.	Metric owner: David Harris, delegated to Joanne Wing Monitored at: POD Sub Committee Data source: Business and Value Note: data for April 2022 were not available at the point when this report was being compiled.

Be a model employer and have a caring, competent and motivated workforce

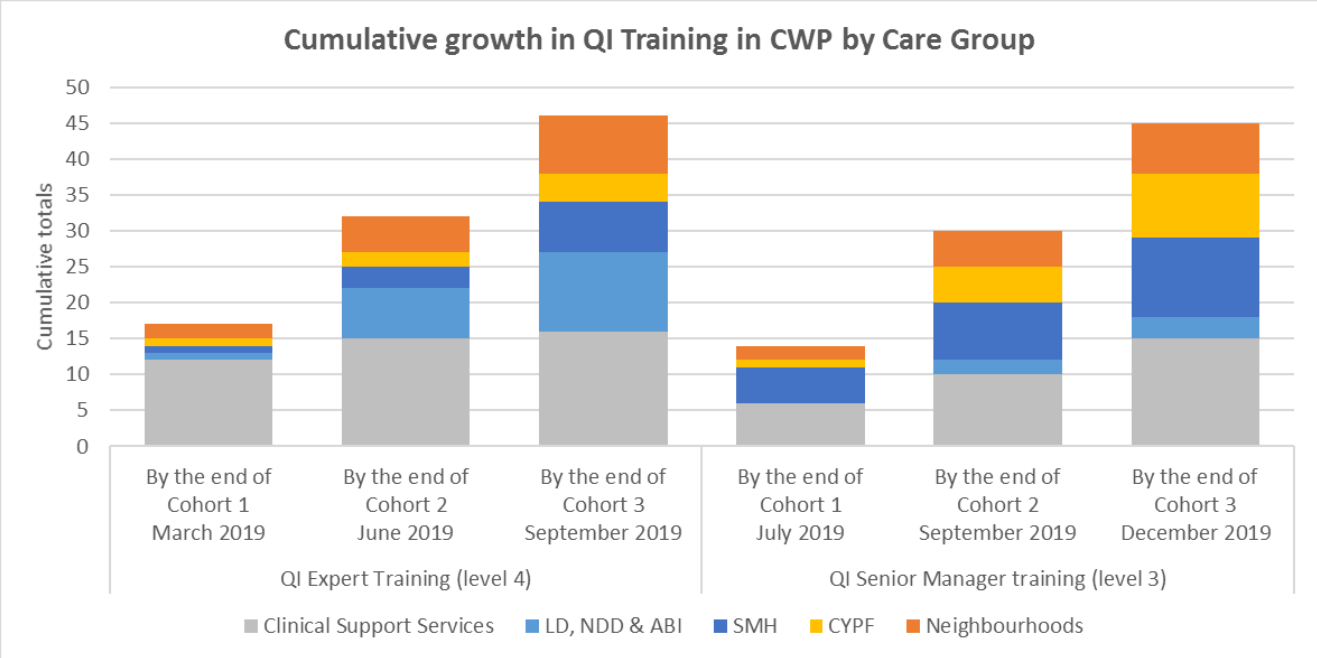
Metric	Data	Further Explanation
Mandatory Training	 Comment: The Trust mandatory compliance figure is currently 89%, just below the long term average, however we are still above the 85% target. As part of the Trust's People Strategy and Plan a review of our mandatory training programme in underway, to ensure it maximises capacity and best meets need.	Metric owner: David Harris Monitored at: POD Sub Committee and Ops Committee Data source: Education CWP Definition: Excludes staff on Maternity Leave, Career Break, External Secondments, Long Term Sick (>92 days) and new starters < 3 months. Also excludes any new course competences added to the Training Needs Analysis for 12 months, to allow staff time to complete

Improve the quality of information to improve service delivery, evaluation and planning

Metric	Data	Further Explanation
Morbidity and Mortality		Metric owner: Gary Flockhart Monitored by: Quality Committee Data source: CWP Incidents team

From November 2021 onwards, the chart shows the percentage for all physical health services but only a subset of mental health services. Work is underway to restore coverage for mental health and LD services following the move to SystmOne.

Improve the quality of information to improve service delivery, evaluation and planning

Metric	Data	Further Explanation
Level 3 and 4 QI Training		Metric owner: Anushta Sivananthan Monitored by: Quality Committee Data provider: Quality Assurance and Improvement team

Comment: Since the last update there has been no further progress regarding level 2, level 3 and level 4 training. This training is instructor led and until the COVID situation is resolved rollout of all instructor led training has been halted. Latest figures show that 91% of staff members have completed the level 1 QI training.

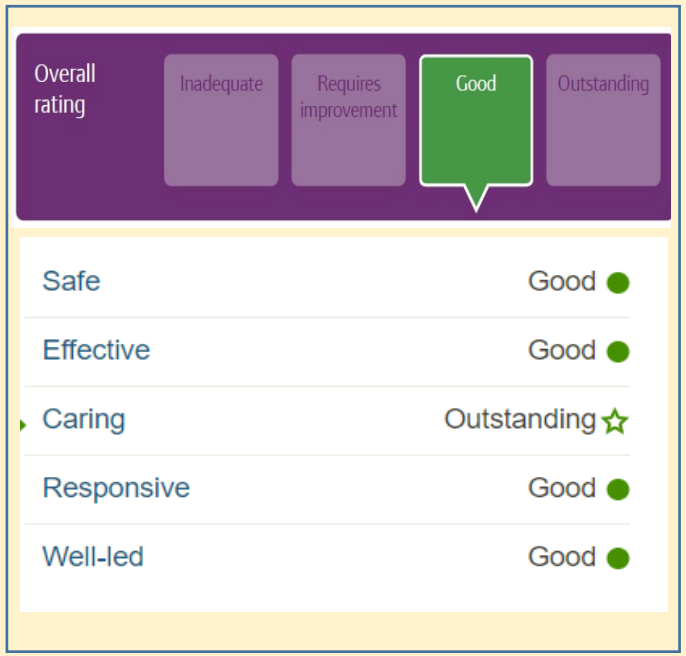
Work to develop further measures for this strategic objective is as follows:

Improve the quality of information to improve service delivery, evaluation and planning	
Metric	**Development Plans**
Dashboard development	Development work on the Operational Committee Performance Report has been continuing and the following improvements have been made: • Rationalisation of measures so they are only reported into a single committee, leading to addition of new measures and others being reported elsewhere • Overhaul of visualisation within the report • Separate section created for Oversight Framework Performance Indicators • Inclusion of Indicator definition and how RAG ratings are calculated • Local targets agreed with Care Groups (which is still in progress) • Separation of Specialist Mental Health into three localities • Collaborative work continues between Clinical Support Services and the Specialist Mental Health Care Group to develop a care group specific performance framework. • Demonstration of performance framework measures to Exec's who suggested holding a Clinical Engagement and Leadership Forum (CELF) session to outline suggested approach • Measures being built in-line with named priority areas and linking into what is available within SystmOne data flows. Metric owner: Tim Welch Monitored by: Operational Committee

Work to develop further measures for this strategic objective is as follows:

Sustain financial viability and deliver value for money	
Metric	**Development Plans**
Delivery of Value for Money	Temporary financial arrangements put in place at the height of the pandemic have now been replaced by a financial regime based system working within individual Integrated Care Boards. The expectation is that each system will achieve at least a breakeven position with each provider organisation working to achieve this common goal. Included within this is the expectation that organisations will deliver on national tariff efficiencies (1.1%), a convergence efficiency (0.9%), and a significant reduction in Covid expenditure in line with reduced income levels. The Business & Value team will continue to work with colleagues to support them to maximise the use of resources. Metric owner: Andy Harland Monitored through: Ops Committee

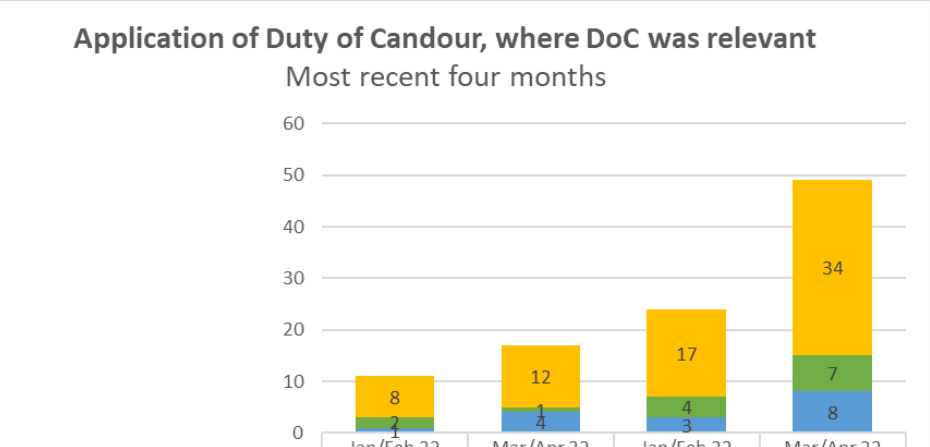
Be recognised as an open, progressive organisation that is about care, well-being and partnership

Metric	Data	Further Explanation
CQC Rating		Metric owner: Anushta Sivananthan delegated to Stephanie Bailey Monitored at: Quality Committee Data source: CQC website

Comments:
The most recent Well led inspection took place between 9 and 11 March 2020 and showed improvement over the previous inspection.

At the time of writing, there are 5 regulatory actions open in relation to ADHD services and Rosewood ward. As per March 2022 Quality Committee Chair's report, the CQC have advised that CWP are required to continue to provide progress against the ongoing actions in relation to ADHD, whilst for Rosewood, the CQC have agreed to an extension so that the improvement actions address the regulatory action on a sustained basis. This extension request was submitted to the CQC and has since been formally agreed until September 2022. There is no change to report to the current CQC rating for the Trust.

Be recognised as an open, progressive organisation that is about care, well-being and partnership

Metric	Data	Further Explanation
Duty of Candour		Comment: The Duty of Candour field is now a mandatory field within Datix, staff are signposted to consider the duty and its relevance to an incident. Duty of Candour twice weekly alert to care groups to commence. Duty of Candour is monitored weekly at ISAF. Training is included within the incident module. CWP is looking to make the training a standalone module. Duty of Candour features regularly within the ISAF Learning from Incidents Bulletin. The Trusts Solicitors are due to deliver training in June 2022. A staff experience Podcast is planned for July 2022 / hosted by NHS Resolution.	Metric owner: Gary Flockhart Monitored at: Quality Committee Data source: CWP Incidents Team

	Incidents involving serious harm		Incidents involving moderate harm	
	Jan/Feb 22	Mar/Apr 22	Jan/Feb 22	Mar/Apr 22
Duty of Candour was not applied in line with regulatory requirements - reasons either not given or not satisfactory	0	0	0	0
Duty of Candour was not fully applied in line with regulatory requirements - for acceptable clinical reasons *	8	12	17	34
Duty of Candour was applied in line with regulatory requirements	2	1	4	7
In progress	1	4	3	8

** All patients/families have been contacted, however letters not sent as the offer of a letter has been declined*

Report Against Strategic Objectives

End Sheet

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Guardian of Safe Working Quarterly Report
Agenda ref. number:	22.23.02 e
Report to (meeting):	Trust Board of Directors
Action required:	Information and noting
Date of meeting:	25/05/2022
Presented by:	Dr F Alam – Medical Director

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes

Which NHSI Single Oversight Framework themes this report reflects:		CWP Quality Framework:		
Quality	Yes	Patient Safety	Safe	Yes
Finance and use of resources	Yes	Clinical Effectiveness	Effective	Yes
Operational performance	Yes		Affordable	Yes
Strategic change	Yes		Sustainable	Yes
Leadership and improvement capability	Yes	Patient Experience	Acceptable	Yes
			Accessible	Yes
		http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	Yes/ No

Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	Yes/ No

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

This report is to update the trust on the issues regarding junior doctors, their working conditions and locum use due to vacancies, during the period of January 2022 to April 2022. Consideration has been given for any current and future risk.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The 2016 contract for Doctors in training created the postt of Guardian of Safe Working in order to monitor and provide reassurance of Safe Workjing practice related to hours worked. This is an independent post and requires a resposibilty of providing reports.

Assessment – *analysis and considerations of the options and risks*

There have been no concerns raised regarding safe practice or access to education and training experiences.
There have been no fines levied against the Trust

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board is asked to approve the report.

Who has approved this report for receipt at the above meeting?	Dr F Alam – Medical Director
Contributing authors:	

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
	Junior Doctor Forum Mark Cadwallder Jon Ruffler	

Appendices provided for reference and to give supporting/ contextual information:

Appendix No.	Appendix title
1	Guardian of Safe working report

Guardian of Safe working Hours Report to the Trust Board for the period

January 2022 to April 2022

Report Author: **Dr Faouzi Alam**

This report was prepared by Faouzi Alam as the Guardian of safe working hours stepped down due to other clinical leadership commitments. A new Guardian will be appointed by the end of May 2022

There has been no report of exception, during this period. There have been no highlighted areas of concern regarding safe working or access to educational and training opportunities.

Introduction

The introduction of the 2016 Junior Doctor created the role of the Guardian of Safe Working Hours and ended the previous hours monitoring system, replacing it with a continuous system of reporting exceptions occurring from a previously agreed work schedule aiming to ensure rotas and working hours are safe for Doctors and patients. The Guardian is bound by the terms and conditions of the contract to provide reports to the Trust Board regarding the safety of Doctor's working hours and areas and plans for improvement.

Exception reports

There were no exception reports for this time.

Work schedule reviews

There have been no work schedule reviews requested or completed.

Summary

There have been no concerns raised regarding safe practice or access to education and training experiences. There have been no fines levied against the Trust

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Statutory Registers: Directors and Governors 2021/22
Agenda ref. number:	22/23/03 a
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	25/05/2022
Presented by:	Chair

Which strategic objectives this report provides information about:	
Improving Care, Health and Wellbeing	Yes
Working within Communities	Yes
Working in Partnership	Yes
Delivering, Planning and Commissioning Services	Yes
Making Best Value	Yes
Reducing Inequalities	Yes
Enabling our People	Yes
Improving and Innovating	Yes

Which NHSI Single Oversight Framework themes this report reflects:		CWP Quality Framework:		
Quality	Yes	Patient Safety	Safe	Yes
Finance and use of resources	Yes	Clinical Effectiveness	Effective	Yes
Operational performance	Yes		Affordable	Yes
Strategic change	Yes		Sustainable	Yes
Leadership and improvement capability	Yes	Patient Experience	Acceptable	Yes
			Accessible	Yes
		http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Any matters that will impact on the CWP Green Plan?	
	No

Equality, Diversity, and Inclusion	
Does this report present any equality related impacts / risks in relation to any of the following protected characteristics; age, disability, ethnicity/race, gender reassignment, marriage & civil partnership, pregnancy & maternity, religion & belief, sex or sexual orientation ?	
No	**Comments** *(please explain which protected characteristics this impacts on and how).*

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No
All strategic risks	

Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

To present to the Board of Directors the Director register of interests, Director gifts and hospitality register and the Governors register of interests 2021/22 to provide assurance regarding compliance with the national and local conflicts of interest policies.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The NHS as a public sector organisation must be impartial and honest in the conduct of its business.

Guidance on Managing Conflicts of Interest in the NHS came into force from 1 June 2017. The guidance introduces common principles and rules for managing conflicts of interests, provides simple advice to staff and organisations about what to do in common situations, supports good judgement about how interests should be approached and managed and sets out the issues and rationale behind the policy.

The guidance is applicable to CCGs, NHS Trusts, NHS Foundation Trusts and NHS England. NHS Trusts and NHS Foundation Trusts must have regard to this guidance through its incorporation into the NHS Standard Contract pursuant to General Condition 27.

The requirements for Governors and Directors to identify and declare interests are set out in the Trust's Constitution and the Corporate Governance Manual.

Assessment – *analysis and considerations of the options and risks*

As an NHS Foundation Trust and in accordance with the Trust's Corporate Governance Manual the Trust shall have a register of interests of Directors and Governors. Furthermore, the Corporate Governance Manual states that the Trust shall make the registers available for inspection by members of the public.

This information is held to ensure the Trust conducts business honestly and impartially and employees remain beyond suspicion. As a public sector employer the Trust must operate systems which allow public accountability and openness maintaining the highest standards of integrity and probity while supporting and engaging in collaboration and partnership working.

In order to assist with the identification and declaration of interests, Directors and Governors are requested to declare their interests upon initial appointment and annually thereafter. Where Directors and Governors have no declaration of interest, they are asked to provide a NIL response.

Directors and members of staff are also required to register any sponsorship, gifts and hospitality, whether offered or accepted. These declarations are normally submitted on an ad-hoc basis throughout the year following which the register is updated accordingly.

The updated registers are attached in the appendices of this report and are also made available on the Trust's website and will be reported in the Trust's Annual Report. In addition, at each meeting of the Board of Directors, the Council of Governors and their respective Sub-Committees, members are asked to declare any further interests since the date of the last declaration and to notify the Chair of any conflicts of interest in relation to the agenda items for discussion (for which they may need to abstain). Any such declaration is recorded in the minutes.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors are recommended to **note**:

- The Directors Register of Interests 2021/22
- The Directors Register of Gifts and Hospitality 2021/22
- The Governors Register of Interest 2021/22

Who has approved this report for receipt at the above meeting?	Tim Welch, Director of Business and Value
Contributing authors:	Suzanne Christopher, Head of Corporate Affairs

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Audit Committee	10.05.2022

Appendices provided for reference and to give supporting/ contextual information:

Appendix No.	Appendix title
1	Director - register of interests - Click Here
2	Director – gifts and hospitality - Click Here
3	Governors – register of interests - Click Here

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Fit and Proper Persons policy and process review 2021/22
Agenda ref. number:	22.23.03 b
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	25/05/2022
Presented by:	Chair

Which strategic objectives this report provides information about:	
Improving Care, Health and Wellbeing	Yes
Working within Communities	Yes
Working in Partnership	Yes
Delivering, Planning and Commissioning Services	Yes
Making Best Value	Yes
Reducing Inequalities	Yes
Enabling our People	Yes
Improving and Innovating	Yes

Which NHSI Single Oversight Framework themes this report reflects:		CWP Quality Framework:		
Quality	Yes	Patient Safety	Safe	Yes
Finance and use of resources	No	Clinical Effectiveness	Effective	Yes
Operational performance	No		Affordable	No
Strategic change	No		Sustainable	No
Leadership and improvement capability	Yes	Patient Experience	Acceptable	No
			Accessible	No

http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf

Any matters that will impact on the CWP Green Plan?	
	No

Equality, Diversity, and Inclusion	
Does this report present any equality related impacts / risks in relation to any of the following protected characteristics; age, disability, ethnicity/race, gender reassignment, marriage & civil partnership, pregnancy & maternity, religion & belief, sex or sexual orientation ?	
No	**Comments** *(please explain which protected characteristics this impacts on and how).*

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No
All strategic risks	

Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

The purpose of this report is to provide assurance to the Board of Directors that the trust is compliant with the Fit and Proper Persons (FPPR) requirements as outlined within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires that all trusts ensure that all executive and non-executive director posts (or anyone performing similar or equivalent functions) are filled by people that meet the requirements of the FPPR. These regulations were introduced in 2014 and the fundamental standards came into force in April 2015.

The regulations place a duty on trusts to ensure that their directors are compliant with the FPPR. It is the trust's duty to ensure that they have fit and proper directors in post. The CQC has the power to take enforcement action against the trust if it considers that the trust has not complied with the requirements of the FPPR.

In accordance with the trust policy, the trust is expected to undertake a number of pre-employment checks on appointment as well as a number of on-going checks on a yearly basis.

Assessment – *analysis and considerations of the options and risks*

Below is an outline of the evidence for the reporting year 2021/22 and to present day.

Annual FPPR Checks

- Self- declaration forms have been renewed and completed and are held by the Corporate Affairs Team for the full Board for the reporting year
- The Register of Disqualified Directors was checked for 2021/22 and is held in a central register.
- The Insolvency/ bankruptcy Service Register (IIR) was checked for 2021/22 and is held in a central register.
- A general google search is undertaken on each Director and the output from this is held in a central register.
- DBS Checks are carried out every three years. DBS checks for three Directors are currently being renewed.
- Two new Non-Executive Directors, Roderick Thompson and Julie Higgins were appointed to the Board of Directors with start dates of April 2022 and July 2022 respectively. All pre-employment checks were undertaken.
- Appraisals for all Directors were undertaken between June and October 2021. The appraisals reviewed performance during 20/21 and considered objectives for 2021/22. Each appraisal also includes consideration of the fit and proper persons test for Executive Directors, by the Chief Executive Officer, and for Non-Executive Directors by the Chair on an annual basis. Final copies of appraisals are held by the Corporate Affairs Team.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors are recommended to **note** the report.

Who has approved this report for receipt at the above meeting?	David Harris, Director of People and OD.
Contributing authors:	Suzanne Christopher, Head of Corporate Affairs Jo Wing, Head of Recruitment

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Audit Committee	10.05.2022

Appendices provided for reference and to give supporting/ contextual information:

Appendix No.	Appendix title
1	Register

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	CWP Provider Licence – annual self-assessment and Licence declarations
Agenda ref. number:	22/23/03 c
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	25/05/2022
Presented by:	Tim Welch, Chief Executive Officer

Which strategic objectives this report provides information about:	
Improving Care, Health and Wellbeing	Yes
Working within Communities	Yes
Working in Partnership	Yes
Delivering, Planning and Commissioning Services	Yes
Making Best Value	Yes
Reducing Inequalities	Yes
Enabling our People	Yes
Improving and Innovating	Yes

Which NHSI Single Oversight Framework themes this report reflects:		CWP Quality Framework:		
Quality	Yes	Patient Safety	Safe	Yes
Finance and use of resources	Yes	Clinical Effectiveness	Effective	Yes
Operational performance	Yes		Affordable	Yes
Strategic change	Yes		Sustainable	Yes
Leadership and improvement capability	Yes	Patient Experience	Acceptable	Yes
			Accessible	Yes
		http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Any matters that will impact on the CWP Green Plan?	
	No

Equality, Diversity, and Inclusion	
Does this report present any equality related impacts / risks in relation to any of the following protected characteristics; age, disability, ethnicity/race, gender reassignment, marriage & civil partnership, pregnancy & maternity, religion & belief, sex or sexual orientation ?	
No	**Comments** *(please explain which protected characteristics this impacts on and how).*

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No
All strategic risks	

Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

The licence requirement for health care providers came into effect from April 2013.

Compliance with the licence is routinely monitored through the NHS System Oversight Framework (formally the NHSI Oversight Framework), however on an annual basis, the licence requires NHS providers to self-certify as to whether they have effective systems, governance and resources in place to meet their obligations. Other key

components within the licence criteria are reviewed on an annual basis. The annual self-certification provides assurance that NHS providers remain cognisant of and are compliant with the conditions of their NHS provider licence.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

This report details the NHS provider licence criteria self-assessment for year ending 2021/22. The licence contains obligations for the Trust and this assessment aims to help the Audit Committee members in confirming the accuracy of requirements that CWP is required to comply with as a licence holder.

Assessment – *analysis and considerations of the options and risks*

Appendix 1 contains the high level excerpts from the full licence document and enables Audit Committee members to consider the key licence conditions and any risks to compliance. All conditions are now rated as Green (compliant).

The Board of Directors is also required to make an annual declaration under General Condition 6 of the Licence to confirm the Trust's ongoing compliance with the Licence and confirm the availability of resources in accordance with Continuity of Services Condition 7. In addition, the Board are also required to confirm compliance under Section 6 (Foundation Trust Condition 4) with a number of Corporate Governance Statements. With regard to the declarations required under General Condition 6 and Continuity of Service Condition 7, the Board is required to confirm or otherwise, systems in place for compliance with the licence conditions. The declarations are set out at appendix 2. The above are required to be completed by 31st May 2022.

With regard to the declarations required under section 6, condition FT4 – NHS FT governance systems, the Board is recommended to confirm the corporate governance statements and confirmation for governance systems where major joint ventures or Allied Health Science Networks are in place. The Board are also required to confirm provision of appropriate Governor training opportunities which the Board are recommended to confirm evidenced by the ongoing governor training programme in place, providing a range of internal and externally facilitated training opportunities. The corporate governance statement (licence condition FT4) is required to be completed by 30th June 2022.

While declarations are no longer required for submission to NHSE/I, Boards must ensure they review the declarations, that documents are available for audit and that some declarations (G6) are published.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors are asked to note the 2021/22 year end Licence position and approve the declarations in accordance with General Condition 6, CoS 7 and Condition FT4 of the Licence and for publication on the Trust website.

Who has approved this report for receipt at the above meeting?	Tim Welch, Chief Executive Officer
Contributing authors:	Suzanne Christopher, Head of Corporate Affairs

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued

Appendices provided for reference and to give supporting/ contextual information:

Appendix No.	Appendix title
1	Key Provider licence conditions as at end 2020/21
2	Licence Declarations FT4 and G6, CoS7

NHS
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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Register of Seals 2021/22
Agenda ref. number:	22/23/02
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	25/05/2022
Presented by:	Andy Harland, Director of Business and Value (Interim)

Which strategic objectives this report provides information about:	
Improving Care, Health and Wellbeing	Yes
Working within Communities	Yes
Working in Partnership	Yes
Delivering, Planning and Commissioning Services	Yes
Making Best Value	Yes
Reducing Inequalities	Yes
Enabling our People	Yes
Improving and Innovating	Yes

Which NHSI Single Oversight Framework themes this report reflects:		CWP Quality Framework:		
Quality	Yes	Patient Safety	Safe	Yes
Finance and use of resources	Yes	Clinical Effectiveness	Effective	Yes
Operational performance	Yes		Affordable	Yes
Strategic change	Yes		Sustainable	Yes
Leadership and improvement capability	Yes	Patient Experience	Acceptable	Yes
			Accessible	Yes
		http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Any matters that will impact on the CWP Green Plan?	
	No

Equality, Diversity, and Inclusion	
Does this report present any equality related impacts / risks in relation to any of the following protected characteristics; age, disability, ethnicity/race, gender reassignment, marriage & civil partnership, pregnancy & maternity, religion & belief, sex or sexual orientation ?	
No	**Comments** *(please explain which protected characteristics this impacts on and how).*

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No
All strategic risks	

Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

The use of the corporate seal formally signifies the Trust's act of entering into the transactions evidenced by the documents to which it is fixed. The Board of Directors is invited to note Register of Sealing which demonstrates the documents (and the underlying transactions) to which the Trust's corporate seal has been affixed for the period April 2021 – March 2022.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The use of the corporate seal is regulated by Board of Directors' Standing Orders. In accordance with the NHS Constitution, the affairs of NHS organisations should be managed with excellence and professionalism.

Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Business and Value / Director of Finance (or an officer nominated by them) and authorised and countersigned by the Chief Executive (or an officer nominated by them who shall not be within the originating division or department).

The Chief Executive keeps a register in which they, or the Head of Corporate Affairs as authorised by them, enters a record of the sealing of every document.

Assessment – *analysis and considerations of the options and risks*

The Sealing Report for the period April 2021 – March 2022 is set out below (appendix 1) for review by the Board of Directors.

The Register of Sealing is required to be noted by the Board of Directors on an annual basis.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors is invited to note the Register of Sealing.

Who has approved this report for receipt at the above meeting?	Andy Harland, Director of Business and Value (Interim)
Contributing authors:	Suzanne Christopher, Head of Corporate Affairs

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued

Appendices provided for reference and to give supporting/ contextual information:

Appendix No.	Appendix title
1	Register of Seals 2021/22

NHS
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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Chair and Chief Executive - Division of Responsibilities
Agenda ref. number:	22.23.02
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	25/05/2022
Presented by:	Chair

Which strategic objectives this report provides information about:	
Improving Care, Health and Wellbeing	Yes
Working within Communities	Yes
Working in Partnership	Yes
Delivering, Planning and Commissioning Services	Yes
Making Best Value	Yes
Reducing Inequalities	Yes
Enabling our People	Yes
Improving and Innovating	Yes

Which NHSI Single Oversight Framework themes this report reflects:		CWP Quality Framework:		
Quality	No	Patient Safety	Safe	No
Finance and use of resources	No	Clinical Effectiveness	Effective	No
Operational performance	No		Affordable	No
Strategic change	No		Sustainable	No
Leadership and improvement capability	Yes	Patient Experience	Acceptable	No
			Accessible	No
		http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Any matters that will impact on the CWP Green Plan?	
	No

Equality, Diversity, and Inclusion	
Does this report present any equality related impacts / risks in relation to any of the following protected characteristics; age, disability, ethnicity/race, gender reassignment, marriage & civil partnership, pregnancy & maternity, religion & belief, sex or sexual orientation ?	
No	**Comments** *(please explain which protected characteristics this impacts on and how).*

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No
All strategic risks	

Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

To inform the Board of the requirements in the NHS Foundation Trust Code of Governance regarding the division of responsibilities between the Chair and the Chief Executive.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The division of responsibilities between the Chairperson and Chief Executive should be clearly established and used to inform objectives for the Chair and Chief Executive.

Section A.2.1 of the NHS Foundation Trust Code of Governance states, the division of responsibilities between the Chairperson and Chief Executive should be clearly established, set out in writing and agreed by the Board of Directors. The above is also stated within section 7.11.7 of the Corporate Governance Manual.

Assessment – *analysis and considerations of the options and risks*

As set out in the NHS Foundation Trust Code of Governance, every NHS foundation trust should be headed by an effective Board of Directors. The Board is collectively responsible for the performance of the NHS foundation trust.

The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the trust as a whole and for the public.

The Chairperson is responsible for leadership of the Board of Directors and the Council of Governors, ensuring their effectiveness on all aspects of their role and leading on setting the agenda for meetings.

The Chief Executive, as the Accounting Officer, should follow the procedure set out by NHSI (formally Monitor) for advising the Board of Directors and the Council of Governors and for recording and submitting objections to decisions considered or taken by the Board of Directors in matters of propriety or regularity, and on issues relating to the wider responsibilities of the accounting officer for economy, efficiency and effectiveness.

The responsibilities of the Chair and Chief Executive are set out at appendix 2.

The NHS Foundation Trust Code of Governance is available at
https://www.gov.uk/government/publications/nhs-foundation-trusts-code-of-governance

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors is recommended to **approve** the division of responsibilities as set out in the NHS Foundation Trust Code of Governance and to be reviewed annually.

Who has approved this report for receipt at the above meeting?	Isla Wilson, Chair Tim Welch, Chief Executive Officer
Contributing authors:	Suzanne Christopher, Head of Corporate Affairs

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued

Appendices provided for reference and to give supporting/ contextual information:

Appendix No.	Appendix title
1	CEO and Chair division of responsibilities

Appendix 1

The responsibilities of the Chair are as follows:

- To ensure the effective operation of the Board of Directors and the Council of Governors
- To promote the highest standards of integrity, probity and corporate governance throughout the organisation and particularly at the Board of Director level
- To ensure that the Board of Directors as a whole plays a full part in the development and determination of the Foundation Trust's strategy and overall objectives, having regard to the Council of Governors
- To lead the Board of Directors, to preside and lead the Council of Governors and to be the guardian of the Board of Directors decision making processes
- To ensure that the Board of Directors and the Council of Governors work together effectively
- To set clear expectations concerning the Trust's culture, values and behaviours including setting the style and tone of discussions at Board meetings
- To ensure the Board of Directors and Council of Governors agendas take full account of the important issues facing the Trust
- To ensure compliance with the Board of Directors approved procedures including schedule of matters, terms of reference and other Board policies and procedures
- To facilitate the effective contribution of all members of the Board of Directors and the Council of Governors ensuring that constructive relationships exist between Directors, between Governors and between Governors and Directors themselves
- To ensure that the Non-Executive Directors understand their accountability, individually and collectively to the Council for Governors for the performance of the Board
- To preside over the Council of Governors in holding the Non-Executive Directors to account
- Ensure the provision of appropriate development and training for the council of governors
- To ensure that accountability processes work effectively
- To Chair the Nomination and Remuneration Committees
- To initiate succession planning at Board level with the Nominations Committee to ensure appropriate Board composition and refreshment
- To ensure effective communication on the part of the foundation trust with patients, members, staff and other stakeholders
- To lead an induction programme for new Non-Executive Directors
- Working with the Chief Executive, to lead in updating the skills and knowledge and in meeting the development needs of individual Directors and the Board of Directors as a whole
- To ensure that the Governors have the skills, knowledge and familiarity within the Foundation Trust to fulfil their role
- To ensure that the performance of the Board of Directors and the Council of Governors as a whole, including an externally led assessment at least once in every three / five years

- To ensure a good flow of information each way between the Board of Directors, committees, the Council of Governors, Non-Executive Directors and management

The responsibilities of the Chief Executive are as follows:

- To report to the Chair and the Board of Directors and lead the Executive Team ensuring high standards of performance.
- Conduct the affairs of the Foundation Trust in compliance with the highest standards of integrity, probity and corporate governance and promote continuing compliance across the organisation.
- To lead and be responsible for proposing and developing, in consultation with the Board, the Foundation Trust's strategy and overall objectives, and to lead the implementation of these, ensuring appropriate resources and control and risk management systems are in place
- As the Accountable Officer to maintain a sound system of internal control that supports the organisation's policies, aims and objectives and manages risks to a reasonable level, including responsibility for safeguarding the public funds and organisations assets ensuring the efficient and effective use of all the resources in their charge to ensure the quality of services delivered.
- To ensure the appropriate and timely flow of information to the Board that enables an assessment of risk and a level of assurance in internal control.
- To ensure the provision of information and support with the Board of Directors and the Council of Governors
- To facilitate and support effective joint working between the Board of Directors and the Council of Governors
- To communicate the expectations of the Board, concerning culture, values and behaviours to all employees
- To ensure the Chair is aware of any important issues facing the Foundation Trust and to ensure the provision of reports to the Board containing accurate, timely and clear information
- To ensure the compliance of the Executive Team with the Board of Directors procedures
- To support the Chair in facilitating effective contributions and sustaining constructive relations between Executive and Non-Executive directors of the Board. Between governors and between the Board of Directors and Council of Governors
- To provide, with Executive team, support to the Non-Executive Directors in order to facilitate the accountability relationship
- To support the Chair in delivering an effective accountability process
- To support with Board succession planning, particularly in respect of executive directors
- Lead the communication programme with members and stakeholders including staff, particularly around Trust strategy, vision and values
- Ensure that the development needs of the Executive Directors and other senior management are identified and are met
- Ensure that performance reviews are carried out at least annually for each of the Executive Directors and provide input to the wider Board of Directors and Council of Governors evaluation process

Reviewed: May 2022
Next review: May 2023

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Trust Autism Strategy
Agenda ref. number:	22.23.04
Report to (meeting):	Trust Board
Action required:	Discussion and Approval
Date of meeting:	25/05/2022
Presented by:	Andrea Campbell

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes

Which NHSI Single Oversight Framework themes this report reflects:		CWP Quality Framework:		
Quality	Yes	Patient Safety	Safe	Yes
Finance and use of resources	Yes	Clinical Effectiveness	Effective	Yes
Operational performance	Yes		Affordable	Yes
Strategic change	Yes		Sustainable	Yes
Leadership and improvement capability	Yes	Patient Experience	Acceptable	Yes
			Accessible	Yes
		http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No

Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
.	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

Following publication of the *National Strategy for autistic children, young people and adults: 2021 to 2026* by the government, the Trust has undertaken a co-produced review of its Autism Strategy. The accompanying document is a revised and updated Autism Strategy for consideration and approval.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

In February 2020, the Trust produced its first Autism Strategy, co-produced with Cheshire East Parent/ Carer Forum. An Autism Strategy Implementation Group (ASIG) was set up in 2020 to drive delivery of the Trust's vision.

The publication of the *National Strategy* in 2021, together with both the impact and learning from the Covid-19 pandemic, has prompted the Trust to review its Autism Strategy so that the Trust's work is directly aligned to the themes within the *National Strategy*.

Assessment – *analysis and considerations of the options and risks*

This revised Autism Strategy has followed a co-produced review in which autistic people were involved in the design and delivery of the engagement process.

The co-produced engagement process identified three core groups:

- Autistic People, Families and Carers
- Wider Key Stakeholders and Partners
- CWP Staff

There were flexible options to engage with the review including:

- A short survey, with co-produced questions
- A longer survey, with co-produced questions
- Options to engage directly via email, phone or face to face individually or as part of a group

Following the review, feedback was collated and informed the draft Strategy document. This draft version was approved at Trust Quality Committee in May 2022 (apart from Appendix 3 which has been added to demonstrate alignment with the Trust strategic objectives).

Quality Committee approved the draft with an awareness that concurrent feedback was also being obtained from commissioners, providers, staff and autistic people who uses services or are interested in service provision. Final comments on this version are being collated up to 20th May, with some face-to-face meetings with autistic people held in w/c 16th May.

To 16th May, feedback on the draft Strategy has indicated broad support with people appreciating the vision around improved experience and the aims which link directly to the *National Strategy.* Once the feedback opportunity has closed, there may be some small changes to take into account, which will be highlighted verbally at Trust Board.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

It is recommended, that, following presentation and identification of any small changes, the Autism Strategy be approved.

Who has approved this report for receipt at the above meeting?	Maddy Lowry
Contributing authors:	Sujeet Jaydeokar, Sharon Vernon

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued

Appendices provided for reference and to give supporting/ contextual information:

Appendix No.	Appendix title
1	Autism Strategy

NHS
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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Strategic Update 7 – briefing and background reading
Agenda ref. number:	22.23.05 a
Report to (meeting):	Trust Board
Action required:	Information and noting
Date of meeting:	25/05/2022
Presented by:	David Harris – Director of People and OD

Which strategic objectives this report provides information about:	
Improving Care, Health and Wellbeing	Yes
Working within Communities	Yes
Working in Partnership	Yes
Delivering, Planning and Commissioning Services	Yes
Making Best Value	Yes
Reducing Inequalities	Yes
Enabling our People	Yes
Improving and Innovating	Yes

Which NHSI Single Oversight Framework themes this report reflects:		CWP Quality Framework:		
Quality	Yes	Patient Safety	Safe	Yes
Finance and use of resources	Yes	Clinical Effectiveness	Effective	Yes
Operational performance	Yes		Affordable	Yes
Strategic change	Yes		Sustainable	Yes
Leadership and improvement capability	Yes	Patient Experience	Acceptable	Yes
			Accessible	Yes

http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf

Any matters that will impact on the CWP Green Plan?	
	Yes/ No

Equality, Diversity, and Inclusion	
Does this report present any equality related impacts / risks in relation to any of the following protected characteristics; age, disability, ethnicity/race, gender reassignment, marriage & civil partnership, pregnancy & maternity, religion & belief, sex or sexual orientation ?	
No	**Comments** *(please explain which protected characteristics this impacts on and how)*

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No
All strategic risks	

Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

The purpose of this report is to introduce the hyperlinked pack of slides that provide briefing and background reading for the Board Workshop in June 2022.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

Board has previously asked for more detailed briefing information on the following areas linked to Strategic Objective 7 – Enabling our People:

1. Staff Engagement / Staff Survey
2. Cost of Living – risk in scope
3. Strategic Risk 2 (including Attraction Campaign)

Additionally, a Board workshop is planned for June 2022 to discuss four enabling strategies (People, Communications, Digital and Estates).

Assessment – *analysis and considerations of the options and risks*

The linked slides provide detailed information on the following areas:

1. Staff Engagement / Staff Survey
2. Cost of Living – risk in scope
3. Strategic Risk 2 (including Attraction Campaign)

This information is provided by way of background briefing in preparation for a more detailed discussion at the Board workshop in June. Board members are asked to review the documentation and consider:

- **What strikes you as most important in these slides**
- **What is missing or you would like to know more about**

These insights will then be used to shape the content and agenda for the Board June workshop

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

Ahead of the Board Workshop in June, Board is asked to:

1) Review the briefing pack and consider the points raised above.

2) To provide comments to David Harris, Director of People and Organisational Development, by close of 10th June 2022.

Who has approved this report for receipt at the above meeting?	
Contributing authors:	

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued

Appendices provided for reference and to give supporting/ contextual information:

Appendix No.	Appendix title
1	Briefing Pack