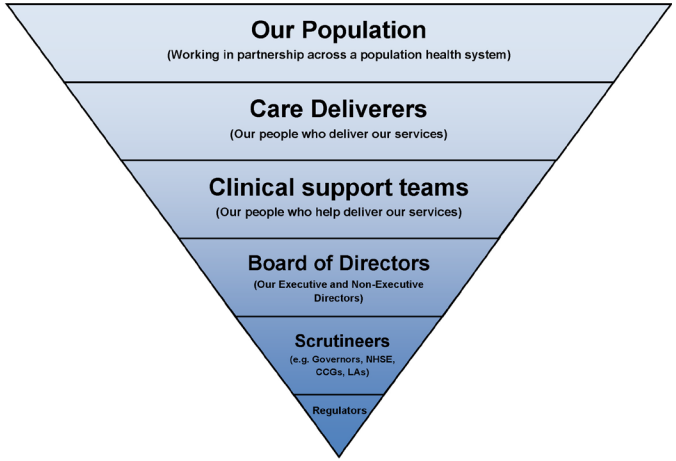
W1 Leadership	W2 Vision	W3 Culture	W4 Governance
W5 Risk	W6 Information	W7 Engagement	W8 Learning



NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

#cwpQI

Board of Directors *(held in Public)*

At 1:30pm on Wednesday 26 May 2021
Held Via Video Conferencing

Ref	Title of item	Well-led theme	Format	Presented by	Time
	ASSURANCE				
21/22/01 - Meeting Governance					
21/22/01 a	Welcome, apologies and quoracy		Verbal	Chair	1:30 (5 mins)
21/22/01 b	Declarations of interest		Verbal		
21/22/01 c	Minutes of the previous meetings held 31 March 2021		Paper		
21/22/01 d	Matters arising and action schedule		Paper		
21/22/01 e	2021/22 Business cycle		Paper		
21/22/01 f	Chair's Announcements		Verbal		1:35 (10 mins)
21/22/01 g	Chief Executive's Announcements		Verbal	Chief Executive	1:45 (15 mins)
21/22/02 - Internal reporting from committees; matters of escalation and assurance					
21/22/02 a	**Operational Committee** • Chair's report from Operational Committee – 19 May 2021 • To Include the following Highlight Reports:- ○ CQC Patient Survey and Response 2020 ○ Inpatient Survey 2021		Paper *(to follow)*	Operational Committee Chair	2:00 (15 mins)
21/22/02 b	**Quality Committee** • Chair's report from Quality Committee – 5th May 2021	W4 Governance W5 Risk	Paper	Quality Committee Chair	2:15 (5 mins)

Ref	Title of item	Well-led theme	Format	Presented by	Time
	• To include the following Highlight Reports:- ○ Learning from Experience Report Inc. Learning From Deaths.				
21/22/02 c	**Audit Committee** • Chair's report from Audit Committee 11 May 2021	W4 Governance W5 Risk	Paper	Audit Committee Chair	2:20 (5 mins)
21/22/02 d	**Monthly Safer Staffing Report**	W1 Leadership W4 Governance W5 Risk	Paper	Director of Nursing, Therapies and Patient Partnership	2:25 (10 mins)
21/22/02 e	**Board Assurance Framework** **To Include :-** ○ Report Against Strategic Objectives	W4 Governance W5 Risk W6 Information	Paper	Medical Director / Director of Business and Value	2:35 (20 mins)
BREAK – 2:55 – 3:05 (10 mins)					
21/22/03 - Effective Systems of Governance					
21/22/03 a	**Register of Interests (Directors and Governors)** *(Considered at Audit Committee – 11th May 2021)*	W4 Governance	Paper	Chair	3:05 (5 mins)
21/22/03 b	**Fit and Proper Persons Annual Assurance** *(Considered at Audit Committee – 11th May 2021)*	W4 Governance	Paper	Director of People and OD	3:10 (5 mins)
21/22/03 c	**CEO / Chair Division of Responsibilities**	W3 Culture W4 Governance W5 Risk	Paper	Chair	3:15 (5 mins)
21/22/03 d	**Register of Sealings** *(Considered at Audit Committee – 11th May 2021)*	W4 Governance	Paper	Director of Business and Value	3:20 (5 mins)
21/22/03 e	**Annual Provider Licence Compliance and Self-Certification Statements** *(Considered at Audit Committee – 11th May 2021)*	W4 Governance	Paper	Director of Business and Value	3:25 (5 mins)
BREAK – 3:30 – 3:40 (10 mins)					

Ref	Title of item	Well-led theme	Format	Presented by	Time
21/22/05 - Strategic Objective 7 – Enabling our People					
21/22/05 a	**Equality and Diversity Responsibilities Inc. WRES, WDES and Staff Networks**	W7 Engagement	Paper	Director of Nursing, Therapies and Patient Partnership	3:40 (5 mins)
21/22/05 b	**Guardian of Safe Working – Quarterly Report**	W4 Governance W5 Risk W3 Culture W7 Engagement	Paper	Medical Director	3:45 (5 mins)
21/22/05 c	**NHS Staff Survey** • Themes and improvement plan	W3 Culture W7 Engagement	Paper	Director of People and OD	3:50 (5 mins)
21/22/05 d	**Strategic Objective 7 – Enabling our People** • In depth discussion – in light of papers above	W1 Leadership W2 Vision W3 Culture W5 Risk	Verbal	Director of People and OD / Director of Nursing, Therapies and Patient Partnership / Medical Director	3:55 (30 mins)
21/22/06 - Any other business					
21/22/06 a	Any other business		Verbal	Chair/ All	4:25 (5 mins)
21/22/06 b	Matters for referral to any other groups				
21/22/06 c	Matters impacting on policy and/ or practice				
21/22/06 d	Review risk impact of items discussed				
21/22/06 e	Three things to communicate				
21/22/06 f	Review the effectiveness of today's meeting https://www.smartsurvey.co.uk/s/meetingeffectivenesssurvey/				
CLOSE [4:30]					
Date, time and venue of the next meeting: 28 July 2021 at 13:00					

Version No	1	Date issued	20.05.2021

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

At 1:30pm on Wednesday 31 March 2021
Via Video Conferencing

Present	Mike Maier	Chairman
	Farhad Ahmed	Non-Executive Director
	Paul Bowen	Non-Executive Director
	Andrea Campbell	Non-Executive Director
	Rebecca Burke-Sharples	Non-Executive Director
	Elizabeth Harrison	Non-Executive Director
	Edward Jenner	Non-Executive Director
	Sheena Cumiskey	Chief Executive
	Dr Faouzi Alam	Joint Medical Director, Effectiveness, Medical Education, and Medical Workforce & Caldicott Guardian
	Suzanne Edwards	Director of Operations
	David Harris	Director of People and Organisational Development
	Dr Anushta Sivananthan	Joint Medical Director, Quality, Compliance and Assurance
	Andy Styring	Director of Strategy and Partnerships
	Tim Welch	Director of Business and Value and Deputy Chief Executive
In attendance	Suzanne Christopher	Acting Company Secretary
	Victoria Peach (on behalf of Gary Flockhart)	Associate Director, Nursing and Therapies & Director of Infection Prevention & Control
	Samantha Scholes	Governance Officer (minutes)
	Peter Ashley-Mudie	Service User/Carer Governor
	Lisa Hulmes	Staff Governor
	Rob Robertson	Service User/Carer Governor
	Celia Jones	Member of the Public
	Chris Lynch	Member of the Public
	Steve McMahon	Member of the Public
Apologies	Gary Flockhart	Director of Nursing, Therapies and Patient Partnership

Ref	Title of item	Action
	Meeting governance	
20/21/106	**Welcome, apologies and quoracy** The Chair welcomed all to the meeting and confirmed the meeting as quorate. Apologies had been received from Gary Flockhart, Director of Nursing, Therapies and Patient Partnership and Victoria Peach, Associate Director, Nursing and Therapies & Director of Infection Prevention & Control would represent him and present item 20.21.117.	

Ref	Title of item	Action
	The Chair stated that for the public's benefit, Board members would introduce themselves at the first opportunity and invited Members of the public to introduce themselves at this point. Steve McMahon stated he was a member of the public who had lived in Cheshire half of his life and was committed to supporting the NHS. Chris Lynch introduced himself as a former Service User and Governor who now ran small groups concerned with health.	
20/21/107	**Declarations of interest** None were declared.	
20/21/108	**Minutes of the previous meeting held 27 January 2021** The minutes were **approved** as a true and accurate record of the meeting which took place on 27 January 2021 subject to minor typography amendments for items 20.21.85 and 20.21.86: 20.21.85: *L Harrison should be E Harrison* 20.21.86: *paragraph two: 'ton' should be 'to'*	
20/21/109	**Matters arising and action points** The action log was reviewed.	
20/21/110	**2020/21 business cycle** The business cycle for 2020/21 was **noted**.	
20/21/111	**Chair's announcements** M Maier updated the Board of Directors on the following: <u>Mass Vaccination Centre</u> At the previous Public Meeting of the Board of Directors on 27 January 2021 the Board was notified that Chester Racecourse would be used as a Mass Vaccination Centre with the Trust leading delivery of the centre. This had been approved using Emergency Powers which included the Chair, Mike Maier, Chief Executive, Sheena Cumiskey and two Non-Executive Directors, Andrea Campbell, Deputy Chair and Non-Executive Director and Rebecca Burke-Sharples, Senior Independent Non-Executive Director which was now ratified. <u>Provider licence consultation</u> Consultation on one condition had taken place. No concerns were raised by Board members. No changes to the provider licence had yet been confirmed. <u>23 March 2021 One Minute Silence</u> A year had passed since the national stay at home order on 23 March 2020 and a day of reflection took place across the UK on 23 March 2021. The whole Trust was invited to reflect and remember those who have suffered illness or lost lives during this period. The Union Jack was flown at half-mast and the Chair had shared his thoughts in a blog, which was available on the Trust website. <u>MP Visit</u> On 15 February 2021, Chris Matheson, MP for Chester visited the Mass Vaccination Site at Chester Racecourse and saw the collaborative work which included Cheshire Fire & Rescue and St John Ambulance to deliver	

Ref	Title of item	Action
	up to 2,000 vaccines per day. Mr Matheson had commented on the enthusiasm and commitment of everyone involved. Staff Survey Results The results of the Staff Survey were available on the Trust website. S Cumiskey had commended the outstanding efforts of our people and their response to the pandemic. The Chair was particularly pleased to note that the survey had demonstrated that the Trust was a highly recommended place to work. JourneyMEN In June 2020 Wirral had introduced JourneyMEN, a community interest group to improve the mental health of men in the area. As the service shared the same person-centred values as the Trust, Wirral teams would refer men in this area to the service. Building Partnerships Access to Healthbox and Improving Access to Psychological Therapies (IAPT) was being provided to key workers across Cheshire & Wirral. This included an emotional support line, manned 8am-10pm, 7 days per week, plus counselling services for those in acute settings. 26 March 2021 CANDDID Conference The Trust hosted the conference virtually after a hiatus in 2020. The focus had been on Attention Deficit Hyperactivity Disorder (ADHD) and had included a host of expert speakers. The event was well attended, and thanks were given to the organisers. The Board of Directors **noted** the above updates.	
20/21/112	**Chief Executive's announcements** S Cumiskey introduced herself and stated her pronouns were 'she' and 'hers'. Patient Stories She stated that the Private Board, held earlier in the day, had begun with listening to two inspirational Patient Stories which on this occasion related to patients who subsequently decided to work for the Trust. The Board take time to consider these fabulous patient stories, which provides an opportunity to reflect on the care provided by CWP and how we can look to continually improve and learn. Update on response to COVID. It had been impressive to see staff working in partnership alongside other public services and with those who access the Trust's services. A detailed briefing on the COVID vaccination programme and Chester Racecourse would be provided later in the Board. All staff and those who worked alongside them had access to the vaccination. Thanks were given to everyone who had contributed to such a great effort. Operational Committee Escalation on items from the Committee had focused on ADHD service provision and the role of the Trust as the Lead Provider for regulatory requirements. She also reported that the Trust remained on track to achieve financial balance for 2020/21	

Ref	Title of item	Action
	National Planning Guidance Guidance was issued during the week commencing 15 March 2021 and identified the priorities, including supporting the health and wellbeing of staff plus recruitment and retention, COVID-19 response and care of those infected plus infection prevention and control, cancer care, mental health care, outcomes and re-design of emergency pathways. The Trust would continue to work collaboratively and act as one across health and social care to provide the best care for the population we serve. Development of Integrated Care System Consideration about what this meant, its impact and how this would further develop took place. It was recognised that Place based work would increase even further over the coming year. S Cumiskey concluded by thanking all staff for their fantastic response to COVID-19 on behalf of Board, which was echoed by Chair who acknowledged the resilience of staff and the changes achieved. The Board of Directors **noted** the summary.	
	Internal reporting from committees, matters of governance and assurance	
20/21/113	**Quality Committee: Chair's report of the Quality Committee held 3 March 2021** A Campbell introduced herself as Chair of the Quality Committee and Non-Executive Director (NED). **Escalation** The Trust had not undertaken any remote inpatient detention assessments however a number of renewal of detentions had taken place, in line with guidance. No further remote assessments would take place until the challenge to the guidance was decided nationally. When this was available, this would be communicated to the Committee and subsequently the Board. **Assurance** The Committee assured the Board that the Care Quality Commission (CQC) Action Plan was on track and provided assurance on ADHD which the Board was aware of and had been escalated to Operations Committee with proposed actions. **Improvement** The reduction of restrictive practices for those in our care to significantly lessen these with the goal of eradication was being carefully examined by Care Groups and significant improvement was being demonstrated. The Eating Disorder Service set out quality approaches to treating patients in the community through integrating physical and psychological care; evaluating staff training on emotionally unstable personality disorder and that innovative ways of changing pathways in response to the impact of COVID-19 had taken place. The Chair commented that the quality of care had continued to be of the highest standard despite the challenges of COVID-19. The Board of Directors **noted** the Chair's report.	
20/21/114	**Audit Committee: Chair's Report of the Audit Committee held 9 March 2021**	

Ref	Title of item	Action
	E Jenner introduced himself as Chair of the Audit Committee and NED. **Escalation** The Internal Audit report on Estates Maintenance Strategy had provided substantial assurance and the Estates department review of its structure would be considered alongside the Trust Strategy refresh. Plans to meet the 15 June 2021 year-end schedule deadline were in place. The Chair was pleased to see the improvement in the present style of Board Assurance Framework (BAF) which now included time graphs with target risks. **Assurance** The MIAA Progress Report included assurance that the Internal Audit plan was on track, that the Trust complied with Public Sector Internal Audit Standards and that in addition to the Estates reviews, work was in progress for audit of HR/Payroll systems, Conflicts of Interest, Assurance Framework and the Data Protection Security Toolkit. **Improvement** Following review of the programme for Internal Audit for 2020/21, the Auditors had been directed to build more quality reviews into the programme. Further, in planning for the year end examination of how the Auditors could be more efficient was requested, including insight into a Value for Money (VfM) approach. The quarterly Anti-Fraud update had been presented and the draft plan approved by the Committee. D Harris introduced himself as the Director of People and Organisational Development and commented that ongoing conversations had been taking place with the Associate Director of Estates and Infrastructure to carefully consider the interrelationships of Estates, Information Communications Technology (ICT) and the People Strategy which was scheduled to be considered in July 2021 by the Board. A Styring introduced himself as Director of Strategy and Partnerships and added that Estates and Facilities had produced great work to ensure safe and effective patient care during the pandemic. This had included maintaining a high level of available acute and specialist mental health beds. This achievement was due to providing and maintaining good estates. The Board of Directors **noted** the Chair's report.	
20/21/115	**Report against Strategic Objectives** T Welch introduced himself as Director of Business and Value and presented the report which detailed performance against Key Performance Indicators (KPIs) which identified the progress made in relation to the previous Strategic Objectives and would be updated to reflect the new Strategic Objectives for the next Board of Directors meeting held in Public. In summary, the information and escalation reflected the circumstances at the time particularly in relation to the third wave of the pandemic.	

Ref	Title of item	Action
	Out of Area placements for the Trust remained very rare and where this was seen, it reflected the pressures seen on services. Demand at this time continued to be evident. Sickness and absence plus supervision rates had showed deterioration and D Harris commented that the challenge of supervision had been considered in some detail in the day's earlier Private Board. A new reporting regime had been implemented, along with changing the policy and process which made it clear who was responsible to provide and document supervision. As a result, an improvement of up to 85% had been seen, however in the first wave of the pandemic, a deterioration had been evidenced. As this was potentially attributable to staff being unable to access the mechanism to report this, support was provided which improved rates. Over the past few months, deterioration had been seen. It was acknowledged that this was as a result of the second wave of the pandemic and during winter months which resulted in capacity being stretched. It was clear that there was a link between increased pressures and a reduction in reporting of supervision. Discussion took place on the multi-faceted and complex challenge. The target had been met 18 months ago and had then been impacted by COVID-19. Whilst the Operations Committee feedback to the Board was that supervision was occurring, it was not always being recorded or recorded with sufficient quality for the purpose of assurance. The People and Organisation Development team were carefully considering how reporting could be made as easy as possible to support teams in this function. This would be incorporated as part of the Imagining Future Refresh and it was acknowledged that it was also a professional responsibility for certain roles. E Jenner commented on how well colleagues had performed throughout the pandemic. F Ahmed, (NED), added that from a wellbeing perspective, supervision was critical alongside managerial relationships which would further enhance the Trust being a learning organisation. D Harris responded that staff wellbeing and development was at the heart of supervision and appraisal. Engagement scores from the Staff Survey were very positive and it was vital that the focus was on staff experience, which influenced the care provided. Work in this area would continue to be supported by the People and Organisational Development Team to support Care Groups as required. T Welch concluded the report by commenting that the discussion had been a good example of looking at KPIs against the new Strategic Objectives. The KPIs for the Board and its sub-committees needed to demonstrate that progress was being achieved and that learning and continuous improvement was evidenced. The Board of Directors **noted** the report.	
20/21/116	**Board Assurance Framework** A Sivananthan introduced herself as one of the Medical Directors and reported that the previous Board Assurance Framework (BAF) had been carefully reviewed and the previous process mapped to align with the new Strategic Objectives. In addition, historical risks had been examined, updated and amended where appropriate. The process had considered the development of what the Board wanted	

Ref	Title of item	Action
	to measure to demonstrate delivery of the Strategic Objectives and monitoring risks changing over time. The final version would be presented to the Quality Committee at its meeting in May 2021 and its sub-committees would undertake deep dives into individual risks and mitigations. It was noted that the Quality Committee, at its March 2021 meeting, had considered the Infection Prevention & Control Risk following COVID-19 in detail and no questions had arisen. The Board of Directors **noted** the report.	
20/21/117	**Monthly Ward Staffing Update** V Peach, Associate Director, Nursing and Therapies & Director of Infection Prevention & Control introduced the report for January and February 2021. During January 2021 the Trust achieved average staffing levels of 93.7% for registered nurses and 98.7% for clinical support workers on day shifts and 93.6% and 103.7% respectively on night shifts. A similar picture had been evidenced during February 2021 and the Trust had achieved average staffing levels of 94.7% for registered nurses and 102.6% for clinical support workers on day shifts and 92.5% and 105.6% respectively on night shifts. She reported that challenges had occurred due to COVID-19 related staff absence which had caused pressures mitigated appropriately by redeployment of staff and the wider multi-disciplinary team supporting activity. The Board noted the hard work and flexibility staff had demonstrated and thanked them for maintaining safe and effective staffing levels to achieve the high levels of care. The Board of Directors **noted** the report.	
S Cumiskey left the Board and T Welch assumed the role of Chief Executive		
20/21/118	**CWP Strategy Refresh – Imagining the Future update** D Harris presented the update which had resulted in the development of eight new strategic objectives. Steps would now be taken to embed and deliver these incorporating alignment, consistency, and clarity plus recognition of the different contributions required, available resources, expectations and experience. Further consideration was required to align the People, Digital, Estates, Quality, Research and Communications Strategies. Initiatives would be aligned strategically, operationally and culturally and would be measured and evaluated to identify success. In addition, the language used would be consistent. Simplification and alignment of the current procedures and processes would enable managers to have the confidence and the tools to deliver what was required in a measured way and to required timescales. A planned Board Workshop would consider issues including, how could the Board operate effectively; how effective was it now and what do we need to do better.	

Ref	Title of item	Action
	A Styring commented that this would encompass how key strategic objectives would be enacted, reduce inequalities, and provide clarity on the role of the Trust as a commissioner. Work with third sector partners, supporting carers and assisted housing would take place. In addition, improving the delivery of the Tier 4 Children and Adolescent Mental Health Service (CAMHS) and adult eating disorders (AED) was scheduled to effectively and safely go live in October 2021, through the Provider Collaboratives work. This would result in the transformation of some services and look to deliver services closer to home. It would also encompass those communities who had not been previously served well. At the 26 March 2021 CANDDID conference, Autism and ADHD stories had been heard and carefully considered. A redesign of services would include Alder Hey, Prospect Partnership, MerseyCare and the Trust along with adolescents. Local Authority colleagues have also expressed their interest A Campbell observed that the Trust's role as a commissioner was vital as NHS structure was rapidly changing. A more detailed discussion on what this meant was suggested to provide a strategic perspective on this. She added that work remained to address current inequalities. Along with the Local Authority, the NHS acute sector, Primary Care and others needed to be included in the discussion, agreement and implementation of the redesign of service. T Welch commented that this work would continue to take place in a complicated environment and added that it was exciting that the digital strategy was now brought together as a coherent whole. F Ahmed added that this was a dynamic environment and Central Government's plan for growth, known as 'Build Back Better' provided opportunities to be innovative and address inequalities. The strategies discussed would give optimal outcomes and enable the organisation to be the best we can be. The Board of Directors **noted** the report.	
20/21/119	**Mental Health Act Reform** A Sivananthan, Medical Director, presented the Trust's response to the Consultation on the White Paper: Reform of the Mental Health Act. To provide context she stated that the Mental Health Act was being reviewed by Government after findings that people were being disadvantaged by it in its current form. There were some ways it had been used nationally which had perpetuated inequalities which resulted in the White paper and consultation taking place. Responses to this could be individually or collectively and the White Paper had been circulated Trustwide to inform the collective response. Consultation responses so far had been requested for, but not limited to, the requirement for Advance Choice documents, treatments offered, greater scrutiny and more advocacy, plus a change in detention criteria to make it more proportionate and necessary. R Burke-Sharples, stated that there was concern that the proposal for a	

Ref	Title of item	Action
	first-tier tribunal could be decided by a judge sitting alone with no clinical expert to support them, which did not reflect the care and compassion expected. A Sivananthan agreed and that this point would be incorporated within the response on behalf of the Trust. The Board of Directors **noted** the report.	
20/21/120	**Quality Improvement Report** A Sivananthan presented the report which included learning and provided assurance against the priority framework. She commented that due to COVID-19, Quality Accounts had not been as visible and were not required to be audited for 19/20. The work undertaken and achieved by clinical and support services demonstrated how quality improvement priorities for 2020/21 were on track. Excellent improvements on mental and physical health to improve care for the population were evidenced and the report included great stories which all teams had contributed to. A Styring added that he had recently spent half a day with the Healthy Child Programme Team, and acknowledged the tremendous achievement of meeting all vaccination targets during the pandemic, plus support of the Mass Vaccination Centre. The Board of Directors **noted** the report.	
	Closing Business	
20/21/121	**Any other business** There was no other formal business from the Board members The Chair thanked Governors and Members of the Public for joining the meeting and provided the opportunity to raise questions relating to the Board. Peter Ashley-Mudie, Service User/Carer Governor praised staff for making it easy to access treatment during the pandemic.	
20/21/122	**Matters for referral to any other groups** There were no matters to refer or escalate to other groups from the meeting.	
20/21/123	**Matters impacting on policy and/ or practice** There were no matters identified impacting on policy and/or practice.	
20/21/124	**Review risk impact of items discussed**	
20/21/125	**Three things to communicate**	
20/21/126	**Review of meeting performance** Board members were encouraged to review the meeting via Smart survey in order to continuously improve the meeting.	
	CLOSE	
Date, time and venue of the next meeting:		

Ref	Title of item	Action
26 May 2021 at 13:00		

Cheshire and Wirral Partnership NHS Foundation Trust
Open Actions Action Schedule

		Board of Directors: Open meeting action schedule: May 2021			

Meeting date	Group/ Ref	Action	By Whom	By when	Status
25.11.20	20.21.70	**Report against strategic objectives:** Additional Staff sickness data to be included with a comparison between the live information and historical norms to be included	TW	27.1.21	Deferred whilst new reporting is developed (delayed due to pandemic) **Propose Close - RaSO's now reviewed in light of new SO's.**

NHS
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NHS Foundation Trust

DRAFT - Board of Directors
Business Cycle 2021/22
(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* ***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	✓ 6	✓ 1	✓ 5	✓ 2	✓ 4&3	✓
	Audit Committee Chairs Report	AC Chair	Review Chair's Report and any matters for note/ escalation	W4 W5	✓	✓	✓	✓	✓	✓
	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	✓ 1&2	✓ 1&3	✓ 1&4	✓ 1&5	✓ 1

	Place Based reports / updates including ICP Board/s (minutes)	SC	To note system developments	W6	✓	✓	✓	✓	✓	✓
	BOD draft Business Cycle 2022/2023	MM/SC	Ensure matters reported to the Board in a timely fashion	W4						✓
	Review risk impacts of items	MM/SC	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	ASiv / TW	Review performance and risk – and note for assurance	W4 W5 W6	✓	✓	✓	✓	✓	✓
Effective Systems of Governance	Annual Provider Licence Compliance and self-certification statements	TW	Review and note for assurance/ regulatory requirement	W4	✓					
	Annual Report, Accounts and Quality Account	TW	Statutory requirement	W4 W6	✓					
	CQC Statement of Purpose	ASiv	Regulatory requirement	W4	✓					
	Corporate Governance Manual	TW	Best practice annual review	W4	✓					
	Integrated Governance Framework – annual review	ASiv	Best practice annual review	W4	✓					

	CEO/Chair Division of Responsibilities	MM/SC	Governance requirement	W3 W4 W6	✓					
	Register of Interests (Directors and Governors)	MM	Governance requirement	W4	✓					
	Fit and Proper Persons annual assurance	DH	Regulatory and Licence requirement	W4	✓					
	Register of Sealings	TW	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.	GF	Review and note for assurance	W7	✓	✓		✓	✓	
	Freedom to speak up six monthly report	GF	Review and note for assurance	W3 W5 W7 W8		✓			✓	
	Medical Appraisal Annual Report and annual declaration of Medical revalidation	FA	Review and note for assurance	W4 W5		✓				
	Guardian of Safe Working quarterly report	FA	Review and note for assurance	W4 W5 W3 W7	✓	✓		✓	✓	
	People and OD strategy delivery	DH	Review and note for assurance	W2 W3 W7		✓		✓		✓
	NHS Staff Survey (themes and improvement plan)	DH	Review and note for assurance	W3 W7	✓					

	Digital Strategy	TW	Review and note for assurance	W2 W3 W8		✓				✓
	Estates Strategy	SE	Review and note for assurance	W2 W3 W8		✓				✓
	Research Strategy	FA	Review and note for assurance	W2 W3 W8		✓				✓
	Communication and Engagement Strategy	SC	Review and note for assurance	W2 W3 W8		✓				✓
Quality of Care	Quality Improvement report/ strategy implementation	ASiv	Review and note for assurance	W2 W3 W8		✓		✓		✓
	Learning from Experience report, Inc. Learning from Deaths	GF	Review and note for assurance	W4 W5 W6	✓		✓		✓	
	LEVEN Report	GF	Review and note for assurance	W2 W3 W7 W8						

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

Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED CHAIR'S REPORT

CHAIR'S REPORT DETAILS	
Name of meeting:	Operational Committee
Chair of meeting:	Sheena Cumiskey
Date of meeting:	19/05/2021

ESCALATION

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

Continuous Improvement Performance Report:
NHS Oversight Framework Targets:

- Data Quality Maturity Index (DQMI) – 86.8% against a target of 95%. The performance for January is slightly lower than that reported in the previous month.
- Out of Area placements – there were 3 in month.
- EI: Percentage in 2 weeks – 57.8% against a target of 60%

Ethnicity Data recording – all areas apart from Neighbourhoods were reporting a similar position to the previous month. Operational pressures as a result of the pandemic had prevented more detailed reviews taking place. This would be picked up again with the Data Quality group to accelerate progress.
Safeguarding 3 yearly training was below the 95% target but performance had improved slightly in month to 86.4% from the previous month's figure of 85.3%, reflecting continuous improvement over several months.
Waiting times (Community) – overall CWP was reporting 90.4% seen within 18 weeks (target 95%) which was a small deterioration on the previous month's figures. Care groups reported continuing work in this area.
72 hour follow up target (95%) had been missed at 78.8%. This was a deterioration on the previous month's figure of 86.7% following a steady improvement. Focused work in this area to address data quality issues continues to take place.

ASSURANCE

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

Review of Operational Committee Terms of Reference & Annual Review of Effectiveness
Committee reviewed and approved its Terms of Reference and members were asked to input to the annual review of its effectiveness.

Other matters discussed that provide assurance:

Continuous Improvement Report: Supervision – significant work had been done by Care Groups in the last two months. Rates for clinical supervision had increased again from last month (77.6%) to 80.4%, and management supervision numbers had also increased on the figures reported last month (77.3%) to 77.8%.

COVID 19 (Coronavirus Update): The Trust continued to have no active outbreaks and no positive cases in its inpatient units. Staff vaccination rate at 10/05/21 was 91% and a working group has been formed to agree risk mitigations for CWP staff that have yet to receive a Covid-19 vaccination. CWP has received approval to administer the Pfizer vaccine as well as the Oxford vaccine at the vaccination centre at the Racecourse, which is moving to Ellesmere Port in mid-June.

ADHD Update: The Committee received an update on the approach to waiting lists for new referrals. Needs stratification work is underway and third sector support is being sought.

COVID Restoration and Recovery Principles: Care Groups had been piloting a template, with feedback informing an updated version. A full update report would be brought back to Operational Committee in July.

North West Adult Eating Disorders LPC: The Committee were advised of the risks associated with the project and given assurance that further discussions were being held with NHSE/I and other LPC colleagues to mitigate these risks and ensure consistency with commissioning plans.

SMH Bed Capacity: The Committee received an update on the actions taken by the Specialist Mental Health Care Group in response to the increasing demand for mental health inpatient beds. Agreement had been given to increase bed capacity on a medium term until May 2022.

Operational Planning Update: The Committee received an overview and gained assurance of the work being undertaken by Care Groups to meet the requirements of the 2021/22 Mental Health, Learning Disabilities & Autism and Community services planning round, in response to the Operational Planning Guidance March 2021.

	Summary of Changes for the NHS Standard Contract: The Committee received an overview of the changes to the NHS Standard Contract for 2021/22, including changes to the 2021/21 contract which had not previously been highlighted due to COVID19. **Strategic Risk Register / Care Group Risk Registers:** The Committee received the strategic risk register to increase operational awareness of strategic risks and strengthen integrated governance in terms of the synergy between it and care group risk registers, which were also reviewed at the meeting together with assurances and mitigations in place to address risks.
IMPROVEMENT	**Developments/ achievements:** **Surveys:** The Committee received three reports on surveys identifying areas of improvement, together with areas for further development which will inform the People Strategy and care group workstreams: Staff Survey Update: The Committee received an overview of the results from the annual staff survey, including areas for improvement. Out of the 26 organisations (surveyed via Picker), CWP scored above average on 50 out of the 78 questions. Community Mental Health Trusts (CMHT) survey: CWP performed at a similar level to other organisations, receiving a slightly higher score for 'organising care'. Inpatients Survey: consisted of 38 questions answered by 11 other organisations. CWP did better than the national average on 32 questions and had one of the highest response rates. **Care group improvement projects round-up:** • SMH put forward by Rethink for best practice engagement example in King's Fund report; • Neighbourhoods have developed a quality visit template; • LD receive positive feedback from a Royal College visit to Greenways; • CYP had achieved a successful bid for two further mental health support teams in Cheshire schools.

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STANDARDISED CHAIR'S REPORT

CHAIR'S REPORT DETAILS	
Name of meeting:	Quality Committee
Chair of meeting:	Andrea Campbell, Non-Executive Director
Date of meeting:	05/05/2021

ESCALATION

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

- The residual score for the strategic risk of "increasing demand for ADHD services exceeding current contract values and commissioned capacity resulting in increasing waiting times and complaints from people who have not accessed services due to gaps in commissioning" was considered by the Quality Committee, in line with the provisions in the Trust's integrated governance framework, with an increase in the score from 16 to 20 agreed.
- Directions have been provided to all NHS trusts required a Quality Account to be published by the end of June 2021. The safe services team has mobilised an emergency response to this and will escalate any concerns in being able to meet this newly announced timeframe.
- The Serious Incident Review Meeting has highlighted that there is a backlog in the completion of serious incident investigation reports. The delay, causation, and impact on learning, quality improvement and the duty of candour will be taken forward in discussion with the Director of Nursing (from a clinical support services [incidents team] perspective) and the Director of Operations (from the Care Groups' perspective) and report to Operational Committee meeting and by exception to the Quality Committee. Post meeting note, in agreement with the Audit Committee – an internal audit to review the robustness of existing systems will be including in the internal audit plan for quarter one.

ASSURANCE

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

- Approval of the following for discussion and endorsement by the Board of Directors:
  - Quality Improvement report (January – April 2021).
  - Learning from Experience report (December 2020 – March 2021).
- Approval of a Hospital Manager panel (now known as the Independent Review Panel) to strengthen the capability of the panel and those providing evidence to the panel so that the panel's power are enacted as effectively as possible through the delivery of an exemplar review process.
- Approval of a new quality standard requiring a clinical peer review for those people who have been on a Community Treatment Order for three years or more.

Other matters discussed that provide assurance:

- A consultation draft of the Quality Improvement strategy (phase 2, covering 2021/23) was considered, with comments and feedback provided and continuing to be sought until approval at the July 2021 meetings of Quality Committee and the Board of Directors.
- Assurance was provided against Care Group self-assessments of the Green Light Toolkit (GLT) 'basic' audit standards. Trustwide and Care Group improvement areas were agreed, to be taken forward by GLT Leads in the Care Groups, followed by self-assessment against the 'better' audit standards.

IMPROVEMENT

Developments/ achievements:

- The Providing High Quality Care dashboard report is strengthening oversight of CWP's Strategy/ NHS Long Term Plan (LTP) delivery, with good performance in the most recent month around the Early Intervention two week access target and the IAPT access rate target being demonstrated.
- Two presentations were received around the "accessibility" domain of the CWP quality framework, both providing insight into Insight into how CWP currently provides services for different communities. They discussed what the quantitative and qualitative data tells us about how we currently deliver accessible care across CWP, so that we can identify improvements and in doing so reduce unwarranted health inequalities in access as one of the Trust's new Strategic Objectives. Follow-up at the Clinical Engagement and Leadership Forum was agreed to ask further questions of the data to try and understand it. Further, service development work was agreed, with people who access services, to map out "ideal" ("to be") pathways across all ages so that CWP can understand what the "true" gaps are currently and what is required to reduce the gaps.

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STANDARDISED HIGHLIGHT/ EXCEPTION REPORT

REPORT DETAILS	
Subject matter of report:	Learning from Experience Report - Trimester 3 2020/21
Report provided by:	Hayley McGowan, Associate Director of Nursing and Therapies (MH & LD)
Date of report:	24/05/2021

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 December 2020 to the end of March 2021. The report aggregates qualitative and quantitative analysis from a variety of sources, and includes learning gained from undertaking patient safety incident reviews, case reviews, complaint investigations and learning from inquests. The 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.
- This highlight report provides the board with an overview of the key learning themes identified over the reporting period and the actions agreed to take forward areas identified for improvement in order to provide assurance of the Trust's approach to Learning from Experience.

ESCALATION
What do you need to escalate to the Committee?

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

- Incidents of self-harm continued to be the highest reported category of incidents during the reporting period but the trust has seen a decrease in the overall numbers of self-harm incidents reported compared to the previous two trimesters. SMH and CYP care groups are undertaking projects in line with the regional Self Harm work streams that are being facilitated by NHSE/I and supported by CHAMPS. The work streams are enabling shared pathways to be developed across providers and training to be commissioned for professionals to be able to effectively support individuals who self-harm through provision of assessment and a range of interventions.
- There has been a decrease in the number of complaints received during the reporting period compared to the previous trimester with a number of concerns addressed successfully through local resolution enabling the corresponding formal complaints to be closed.
- The trust continues to have a backlog of comprehensive serious incident reviews that have not been concluded, a position that was further compounded during the Covid pandemic. Work is currently being undertaken to support the respective care groups to work through this backlog including increasing the number of staff who have completed training to undertake patient safety reviews and reducing the number of newly commissioned reviews which should start to address the backlog in the forthcoming trimester.

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

Other key matters to highlight:

- The quality of safety reviews across the trust is improving, which is resulting in improvement in the quality of information and assurance provided on the StEIS system and to CCG's. As a consequence, the number of comprehensive serious incident investigations which CWP have commissioned following the completion of an immediate safety review in 2020/21 has reduced by nearly 50% compared to 2019/20 and enabled thematic reviews to be commissioned which is in alignment with the NHS Patient Safety Strategy.
- Training on a system-based approach to patient safety investigations has been provided for a range of staff to enable them to undertake serious incident investigations and reviews. Training has also been provided to senior managers and clinical directors to support quality assurance of serious incident investigations.
- The NHS Complaint Standards were published by the PHSO on 30th March 2021. The NHS Complaint Standards set out how organisations providing NHS services should approach complaint handling. The Patient and Carer Experience and Complaints team to review the standards in collaboration with the Clinical Care Groups to identify required actions to enable the right support to be provided in order for the standards to be met by 2022.

STANDARDISED CHAIR'S REPORT

Cheshire and Wirral Partnership NHS Foundation Trust

CHAIR'S REPORT DETAILS	
Name of meeting:	Audit Committee
Chair of meeting:	Edward Jenner
Date of meeting:	11th May 2021

(ESCALATION) Quality, clinical care, other risks identified that require escalation

Items to be escalated to Board of Directors

Assurance Framework Review

The Committee noted the recent Assurance Framework review led by internal Audit, MIAA. It was commented that the recent improvements now provided greater clarity & assurance against the Trust's Strategic Objectives. It was recommended that Board minutes should more fully reflect the level of challenge and discussion on this topic. The Committee have sought advice from MIAA to confirm how this may be improved. Directors are encouraged to ensure that the draft minutes fully reflect the debate.

Conflicts of Interest

The Committee noted the recent Conflicts of Interest review led by Internal Audit, MIAA. Committee members commented that the assurance against declarations for medical staff had been rated amber for three consecutive years. Assurance was provided that this has been explored in detail and a plan was being put in place to rectify the matter for the end of year audit 21/22.

Serious Incident Review Process

The Serious Incident Review Process was discussed. The delays in the process were noted by the committee as a concern. It was recommended to undertake a review of processes and procedures to support improvement in this area. The recommendation will be put to SIRM and Quality Committee.

Year-End Schedule

Committee members noted that in line with current guidance the 2020/21 Annual Report and Accounts would be approved by the 15th June 2021 deadline. To highlight to Board of Directors the closure of the Year End Process.

(ASSURANCE) Matters discussed/decision:

Internal Audit Plan

The MIAA Progress Report Included:

- Progress Report
- Assurance Framework Opinion
- MIAA Charter for 2021-2022
- Conflicts of Interest Report
- DPST Progress Review
- ESR/Payroll Briefing
- Head of Internal Audit Opinion
- Draft Internal Audit Plan

Internal Audit Plan includes core assurances, national and regional risk areas, strategic risks from the Board Assurance Framework and management requests, MIAA insight, including benchmarking, briefings and events which will be integral to the Plan.

External Audit

Progress Report and Sector Update:

- External Auditors have now completed their planning processes for the 2020/21 Audit.
- To deliver their Final Audit Opinion by the target date of the 15th June 2021.

2021-2022 Audit Plan:

- The document provides an overview of the planned scope and timing of the statutory audit of Cheshire & Wirral Partnership NHS Foundation Trust.

Anti-Fraud

- The Anti-Fraud Services Annual Report was presented to highlight work undertaken during the

period from April 2020 to March 2021.

- The Draft Self-Assessment was discussed, this will be approved by Tim Welch and Edward Jenner before submission. Approval was noted with no challenges reported.

The following items were discussed and noted by Audit Committee members:

- NHS Code of Governance Annual Assurance Report
- NHS Provider Licence
- Fit & Proper Persons Annual Report
- Register of Sealing 2020-2021
- Register of Directors and Governors
- Interim Governance Note
- Internal Audit Self-Assessment including Terms of Reference

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Ward Daily Staffing Levels March and April 2021
Agenda ref. number:	21.22.02
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	26/05/2021
Presented by:	Gary Flockhart, Director of Nursing, Therapies and Patient Partnerships

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	No
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
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:	
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	No
	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

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*

This report details the ward daily staffing levels during the months of March and April 2021 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 how patient safety is being maintained in the continued context of the COVID-19 response and recovery.

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 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 recovery planning and continued development of alternative ways of working.

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

During March 2021 the trust achieved average staffing levels of 96.5% for registered nurses and 99.1% for clinical support workers on day shifts and 95.0% and 105.3% respectively on night shifts. During April 2021 the trust achieved average staffing levels of 99.4% for registered nurses and 96.8% for clinical support workers on day shifts and 96.3% and 100.6% respectively on night shifts.

During March and April Willow Ward experienced staffing challenges for registered nurses on nights due to sickness absence. The Ward manager was able to work twilight shifts to provide support during the early part of the night shifts and additional support was provided from across the unit as required.

Throughout March and April Maple and Rosewood continued to experience staffing challenges, particularly in relation to registered nurse fill rates across the 24-hour shift cycle on Rosewood and on nights on Maple. This was due to vacancies and sickness absence. Safer staffing levels were maintained during this period by the ward manger working flexibly across the different shifts, redeploying staff from other wards in Bowmere on a shift by shift basis and increasing the numbers of clinical support workers on night shifts on both units. Both units worked on reduced registered nurse staffing numbers at night with the registered nurses providing mutual support to both adjoining units.

Throughout March and April Cherry Ward has been able to work on lower staffing numbers than their planned establishment due to a temporary change to the function of the ward from supporting older people with organic needs to supporting older people with functional needs. This has led to a reduction in acuity on the ward and reduced the requirement for one to one support with personal care tasks. Cherry Ward have been able to redeploy staff on an as required basis to support other wards across the unit whilst maintaining safe staffing levels to meet the patient needs on the ward.

Within Bowmere all the ward managers now undertake twilight shifts on a weekly rotational basis, enabling the twilight ward manager to support any areas that may be short staffed until midnight. Generally, after midnight the wards can work safely on reduced staffing levels.

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 recommended 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:	Hayley McGowan Associate Director of Nursing and Therapies (Mental Health and Learning Disabilities)

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 March and April 2021

		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	1001.00	965.70	1234.75	1177.25	678.50	678.50	713.00	705.50	99.5%	97.2%	98.4%	99.7%
	Greenways A&T	1201.25	1149.25	1426.50	1273.25	747.50	786.00	1299.50	1168.50	89.0%	95.7%	98.4%	100.0%
	Mulberry	1349.50	1262.00	2145.00	1897.60	713.00	678.50	2113.85	2006.00	94.8%	92.2%	98.4%	97.4%
	Silk	1117.00	1105.50	2167.00	1921.50	670.00	670.00	2403.50	2211.00	98.6%	94.6%	97.1%	96.2%
	Saddlebridge	1123.50	1099.00	1115.50	1087.50	701.50	701.50	678.50	678.50	92.3%	99.3%	100.0%	100.0%
Wirral	Brackendale	1177.50	1205.50	1219.00	1338.50	759.00	806.00	885.50	839.50	100.3%	106.8%	98.5%	106.6%
	Brooklands	1194.50	1052.50	1489.50	1561.00	660.00	487.50	943.00	816.50	102.9%	112.7%	105.3%	119.3%
	Lakefield	1144.50	1113.00	1184.50	1231.50	724.50	802.00	949.50	731.00	95.1%	106.4%	98.5%	111.4%
	Meadowbank	1500.00	1350.25	1479.00	1482.00	701.50	725.50	1012.00	1058.00	99.5%	98.6%	97.0%	125.6%
	Oaktrees	1243.50	1198.00	1397.50	1545.20	793.50	682.50	828.00	897.00	101.0%	106.8%	90.8%	108.8%
West	Willow PICU	949.40	869.00	1372.00	1257.00	701.50	655.50	1322.50	1138.50	110.4%	89.2%	82.1%	124.3%
	Beech	1118.00	1093.00	1405.50	1365.00	575.00	575.00	1266.50	1232.00	97.6%	100.0%	100.0%	97.4%
	Cherry	1163.20	1164.90	1220.50	1277.50	537.50	548.40	1193.90	1254.80	82.9%	71.2%	87.0%	84.8%
	Coral	1672.00	1390.50	1851.50	1741.50	1065.00	867.50	1196.00	1877.00	101.1%	107.6%	93.7%	113.1%
	Eastway A&T	1327.80	990.35	1464.80	1338.10	669.80	594.20	1032.00	961.60	97.0%	95.5%	100.9%	98.8%
	Indigo	411.00	380.50	526.00	560.50	313.50	290.50	379.50	517.50	94.8%	94.0%	95.6%	99.1%
	Juniper	1088.50	1057.00	1278.50	1255.50	584.00	584.00	1027.50	1004.50	98.5%	97.4%	98.6%	99.0%
	Rosewood Unit	1174.50	760.50	1460.50	1748.00	713.00	517.50	1104.00	1460.50	81.2%	115.3%	79.6%	125.8%
	Maple Unit	761.00	934.50	1426.00	1184.30	713.00	482.80	713.00	850.00	97.0%	103.0%	85.5%	93.5%
	Trustwide	20956.65	19206.45	25437.55	25058.40	12308.30	11650.60	20348.25	20557.90	96.5%	99.1%	95.0%	105.3%

		Day				Night				Fill Rate			
		Registered		Care Staff		Registered		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	809.50	801.80	1304.00	1254.50	678.50	678.50	609.50	602.50	97.5%	90.7%	95.0%	96.6%
	Greenways A&T	1108.25	951.75	1124.50	1076.50	644.00	552.00	1114.60	1183.60	92.8%	96.4%	107.5%	87.9%
	Mulberry	1343.50	1213.50	1776.00	1670.50	644.00	639.00	1886.00	1771.00	92.1%	91.7%	100.0%	94.4%
	Silk	1095.00	1080.00	2345.50	2232.00	708.50	708.50	2080.00	2025.50	100.9%	90.6%	92.8%	96.1%
	Saddlebridge	1009.00	1002.50	1012.00	1000.50	678.50	678.50	655.50	655.50	99.3%	99.0%	98.4%	100.0%
Wirral	Brackendale	1040.50	1068.50	1035.00	1092.50	638.50	626.00	874.00	920.04	100.1%	103.4%	99.1%	101.3%
	Brooklands	963.00	953.00	1380.00	1442.00	667.00	634.00	1000.50	1058.50	107.3%	105.5%	91.5%	101.2%
	Lakefield	1169.50	1185.00	1145.00	1214.50	783.50	800.00	949.50	1169.00	96.9%	103.9%	93.2%	94.4%
	Meadowbank	1307.00	1241.00	1133.50	1242.00	713.00	675.50	1069.50	1232.50	98.4%	102.1%	100.6%	102.1%
	Oaktrees	1349.00	1207.00	1276.50	1584.50	609.50	577.00	816.50	872.50	100.4%	103.0%	100.9%	105.1%
West	Willow PICU	888.50	877.00	1031.50	1020.00	644.00	575.00	736.00	747.50	101.0%	96.8%	86.7%	125.0%
	Beech	1180.50	1134.50	1207.50	1196.00	546.50	523.50	1127.00	1107.50	95.4%	99.2%	95.8%	95.9%
	Cherry	927.30	878.60	1429.40	1317.12	320.20	320.20	764.70	799.90	104.4%	77.4%	100.0%	92.1%
	Coral	1123.50	1143.00	1447.00	1458.50	678.50	678.50	1166.00	1166.00	100.0%	100.0%	100.0%	100.0%
	Eastway A&T	1082.20	877.55	1320.30	1250.20	607.70	480.20	859.10	836.10	95.7%	96.7%	101.2%	97.2%
	Indigo	898.50	905.50	1104.00	1104.00	517.50	517.50	1046.50	1046.50	100.0%	100.0%	100.0%	100.0%
	Juniper	932.50	915.50	1129.00	1138.50	501.50	498.50	908.50	885.50	100.0%	92.9%	100.0%	98.3%
	Rosewood Unit	1093.50	886.50	1288.00	1591.75	644.00	333.50	966.00	1322.50	90.2%	97.1%	85.0%	125.1%
	Maple Unit	1063.50	919.75	966.00	1051.09	644.00	471.30	644.00	759.00	115.9%	92.4%	81.7%	98.3%
	Trustwide	19320.75	18322.20	23488.70	23885.57	11224.90	10495.90	18629.40	19402.14	99.4%	96.8%	96.3%	100.6%

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Board Assurance Framework and Strategic Risk Register
Agenda ref. number:	21.22.02
Report to (meeting):	Board of Directors (meeting in public)
Action required:	Discussion and Approval
Date of meeting:	26/05/2021
Presented by:	Dr Anushta Sivananthan, Medical Director (Executive Lead for Quality)

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:	
Quality	Yes
Finance and use of resources	Yes
Operational performance	Yes
Strategic change	Yes
Leadership and improvement capability	Yes

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.	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	No
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 (May 2021) the Trust has nine strategic risks – three are rated red and six are rated amber. There is one risk in scope.

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*

Newly Agreed Strategic Objectives

The Trust recently reviewed its strategic objectives as part of the 'Imagining the Future' CWP Strategy refresh. The strategic risks have been mapped against the new strategic objectives and further refinement of the BAF has taken place. This has been reviewed at the 5 May 2021 Quality Committee and the 19 May 2021 Operational Committee.

New risks/ risks in-scope

There are no new risks.

One risk remains in scope: ***Risk of failure to deliver full scale of transformation projects across Care Groups.*** This risk previously related to the transformation projects within the Specialist Mental Health Care Group. Discussion with Executive risk owners has resulted in a broader risk description to encompass Trustwide transformation programmes. Work will be therefore be taken forwards to deliberate the re-modelling of this risk. Risk appetite, controls, assurances and gaps will now be considered against that wider context.

Current risks

Strategic risk positions have been reviewed and updated.

Risk 1 – *Risk of supervision compliance rates falling below the Trust target of 85%.* Work has taken place to better understand the impact of COVID-19 on compliance. The Operational Committee had provided assurance that supervision is being treated as a priority and undertaken at Care Group; however, there continue to be issues with ease of recording. Further to the review of the Trust's overall SOs, Trust enabling strategies and associated risks will now be aligned to those objectives. Work on the Digital and People Strategies will be considered in partnership and will give consideration to a new frontline digital approach to support the recording of supervision. In the short term, a helpline has been established to support the recording and the findings of a pilot exercise are being pulled together to enable a targeted improvement approach.

Risk 11 – *Failure to achieve Trust (and system) control totals.* Interim arrangements are in place due to COVID-19 to support the NHS response. The risk will be reviewed in light of planning guidance for 2021/22.

Risk 12 – *Shortfalls in data capture.* This risk underpins a number of the newly agreed SOs. Going forwards, the risk will be considered as part of the Digital Strategy, which will support better articulation of the risk, possible causes and effects. The review is also likely to result in refreshed staff training and development.

Amended risk scores

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.* Regular updates are provided by the TCG to the Board of Directors meetings to ensure Board members remain fully informed of the current situation and the actions taken by the Trust. The risk target score has been increased to 12 to better reflect the current circumstances. In response to the National Incident level, the frequency of TCG meetings are reviewed/ amended as appropriate to ensure an effective response and co-ordination of activities. Measures are continually reviewed to support the delivery of safe and effective care and the well-being and safety of staff. The current risk score has reduced to 16, in light of the work which has taken place to mitigate all risks.

Risk 5 – *Failure to achieve compliance levels for Fire Evacuation training for inpatient services.* Assurances have been provided in relation to staff who are out of compliance with formal training being equipped with the knowledge required to safely respond in the event of a fire incident occurring on an inpatient unit therefore reducing the risk associated with non-compliance with the formal training requirement. Scores and assurances have been reviewed and the risk score reduced from 16 to 9 as a consequence.

Risk 9 – *Demand for ADHD services which exceeds current contract values and commissioned capacity.* The risk appetite for this risk has been reviewed and amended from 2 to 3. An update to the regulatory action plan was presented to March 2021 Operational Committee. An options paper was presented to the March 2021 Board for approval and oversight. Option 3 was agreed; to close to new referrals and provide internal resource to address needs stratification for up to 12 months whilst continuing to pursue an increase in commissioned capacity. The situation will continue to be monitored via the Operational Committee and the Board. The risk score was recently increased at the May Quality Committee from 16 to 20, in line with the Trust's integrated governance framework.

Risk 10 – *People requiring admission, may have to wait longer than 4 hours for a bed to be allocated.* A surge in demand for inpatient beds is likely linked to the impact of the pandemic. The Care Group has been operating at the highest Opel levels (3 and 4) for the last 3 to 4 months. Demand has exceeded capacity which has resulted in delayed admissions. The bed hub is prioritising patients for admission based on risk factors and working closely with A&E departments to keep patients safe. The Care Group are proposing the opening of Riverwood ward to create an additional 9 adult acute beds with effect from August 2021. The risk will be re-modelled to ensure impact on out of area (OOA) placements is captured. Although OOA placements remain low in comparison to other trusts, there has been an increase. The target score has been reviewed and increased from 8 to 12. Alongside this, the risk appetite score has been increased from 3 to 4.

Archived risks

Risk 3 – *Risk of cyber-attack.* The risk treatment plan has reached a point of completion where a review of cyber risk can be undertaken. The target score has been achieved and the risk has remained static for some considerable time. A review was led by the Executive Director of Business & Value in February and March 2021. Based on the controls and assurances provided on the SRR and a review of V87 of the ICT Services Risk Register and assurances provided by the ICT Head of Operations, the Executive Director of Business & Value has proposed the archiving of this risk from the SRR. The risk will remain on the ICT Services Risk Register whilst further mitigations are undertaken, however, the rating on the local risk register will be reduced. The ICT Services Risk Register is reviewed as a standing agenda item at the Infrastructure Sub Committee and escalations going forwards will be via the Chair of the sub committee, the Associate Director for Infrastructure.

Risk 8 – *Risk of deficiencies and end of life pathway in ICT infrastructure.* The risk treatment plan has reached a point of completion where a review can be undertaken. This risk has remained static for some considerable time. A review was led by the Executive Director of Business & Value in February and March 2021. Based on the controls and assurances provided on the SRR and a review of V87 of the ICT Services Risk Register and assurances provided by the ICT Head of Operations, the Executive Director of Business & Value has proposed the achieving of this risk from the SRR. The ICT Services Risk Register is reviewed as a standing agenda item at the Infrastructure Sub Committee and escalations going forwards will be via the Chair of the sub committee, the Associate Director for Infrastructure.

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?	K Wright, AD of Communications, Engagement and Corporate Affairs
Contributing authors:	Suzanne Christopher, Head of Corporate Affairs

Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Quality Committee	05.05.21
2	Operational Committee	19.05.21

Appendices provided for reference and to give supporting/ contextual information:	
Appendix No.	Appendix title
1	Board Assurance Framework (incorporating strategic risk register)

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Report against Strategic Objectives – May 2021
Agenda ref. number:	21.22.02
Report to (meeting):	Board of Directors (meeting in public)
Action required:	Discussion and Approval
Date of meeting:	26/05/2021
Presented by:	Tim Welch, Director of Business and Value

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*

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 and the May 2021 edition presented today is the eleventh iteration.

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

The format of the Report has been stable since the first couple of editions. However, a number of changes are in the pipeline. The first relates to the format of the report. An alternative format, based on a good practice template promoted by NHS Improvement, has been adopted for the providing High Quality Care Report taken to Quality Committee. This has been well received and the same format will be adopted for the RaSO from July 2021. The second relates to the Strategic Objectives. The May RaSO is still structured around the metrics that were agreed in December 2018 linked to the strategic objectives in place at that time. Work has commenced to map the current metrics onto the new strategic objectives and a piece of work is being considered for late summer to look again at the extent to which the current metrics provide coverage of performance against the new strategic objectives and what further developments are needed.

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

Coverage and completeness

The data behind a quarter of the indicators are not being updated as a result of suspensions due to the pandemic. This particularly affects the charts showing patient and staff feedback: patient FFT, staff FFT, Listen and Learn events; but it also affects QI Training metrics. The Use of Resources metric has been removed from the report until reporting resumes. Commentaries within the Report give details.

Current performance

Performance against the metrics is detailed in the Report attached. Particular points to note are:

- There was a further cluster of out of area placements in March and April 2021 following a cluster in January / early February 2021.
- There were two recent admissions of people with learning disabilities rated amber in the Dynamic Support Database, both to support rapidly developing emergency situations
- Absence due to sickness was higher in January 2021 than at the start of the pandemic in April 2020 but has since fallen to more typical levels;
- Significant work had been done by Care Groups in the last month to increase rates for both clinical and management supervision and two Care Groups were now above the target of 85% and one was above 80%. Care groups will now share good practice to help continue to drive improvement forwards.

The activity data, provided in a separate appendix and not part of the public papers, show a clear impact at the point of the outbreak. With the passage of time we have been able to more confidently assess whether the features seen immediately after the initial outbreak were blips or the start of fundamental shifts in patterns of behaviour. Where we are confident that the data are showing fundamental shifts we have introduced breaks in the SPC charts. Notable points include:

- A fundamental shift downwards in referrals to the Neighbourhood based physical health services;
- The growth in the use of video technologies appeared to reach a peak in February 2021 and has fallen back since;
- Notable improvement in the proportion of planned appointments that have been attended, driven particularly by what appears to have been a fundamental shift in the proportion of appointments cancelled by the patient to a new lower level since the start of the pandemic.

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

The Board of Directors is invited to **comment** on this edition of the Report and **confirm** any direction they would like future editions to take.

Who has approved this report for receipt at the above meeting?	Board business cycle requirement
Contributing authors:	For the SBAR: James Partington, Tim Welch For the Report: all metric owners who are listed in the Report

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	19/05/2021

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

Appendix No.	Appendix title
1	Report against CWP Strategic Objectives May 2021 - Final (powerpoint file)
2	Report against CWP Strategic Objectives May 2021 Appendix (powerpoint file)

Report Against Strategic Objectives

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

May 2021

Quality Surveillance Analysis Team

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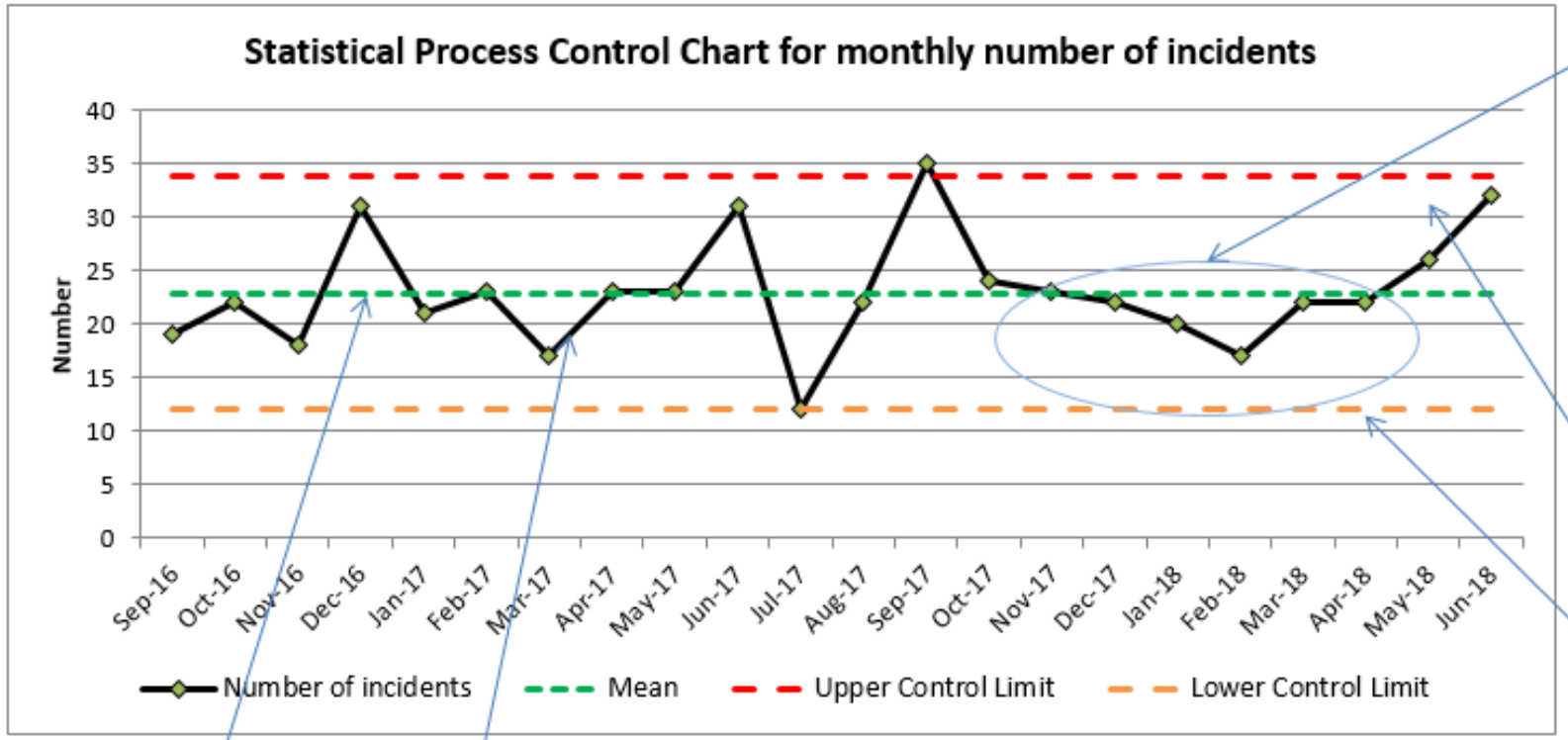
Interpreting Statistical Process Control charts



A run of consecutive data points in the same direction (up or down), or a run of data points all of which are below or above the mean, may be an indicator of a shift in the long term underlying trajectory. The SPC chart allows this to be assessed.

Upper Control Limit - the maximum expected variation above the mean. Set at 2 standard deviations above the mean.

Lower Control Limit - the maximum expected variation below the mean. Set at 2 standard deviations below the mean.

Mean - the arithmetic mean of the source data.

Source data - in this case, the "Number of Incidents". The variation in the data drives where the Upper and Lower control limits are plotted - the greater the variation, the further apart the control limits will be.

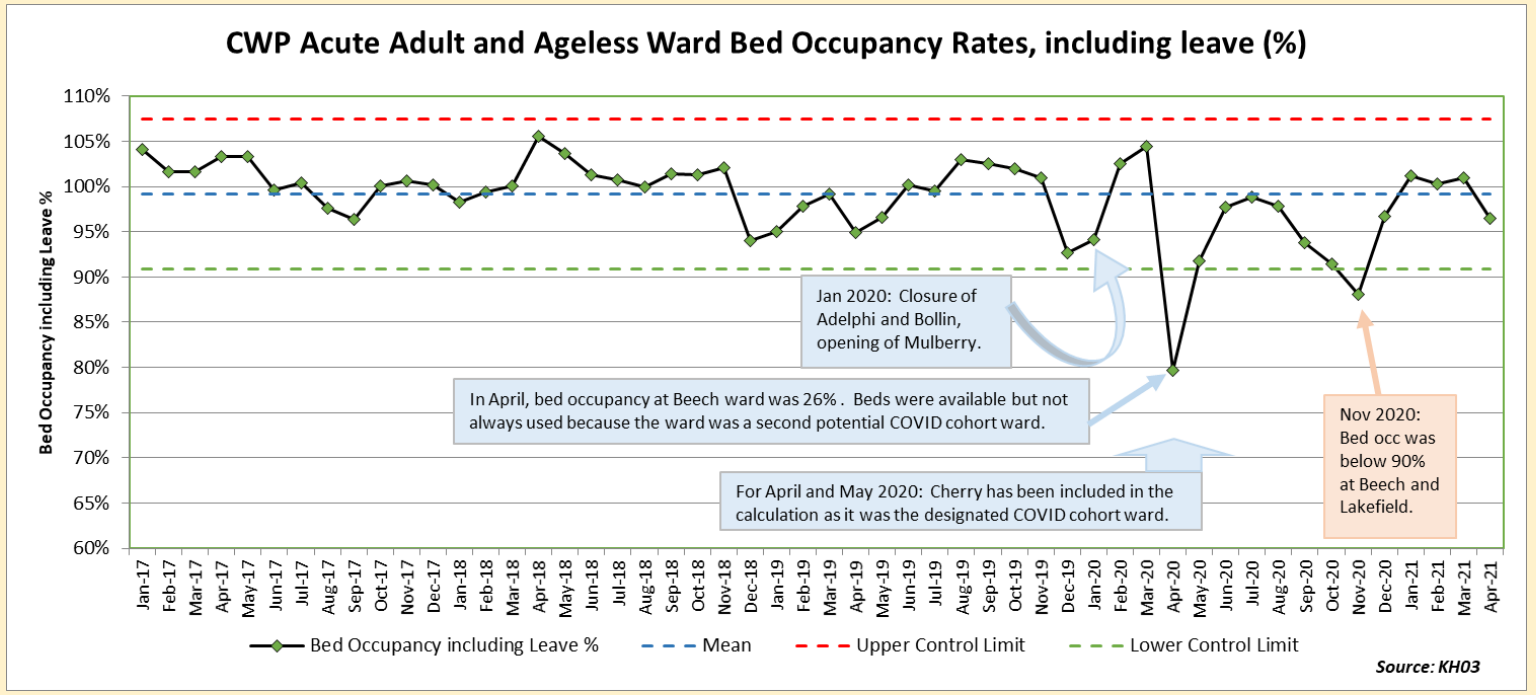
What does the SPC tell us?

The SPC tells us whether a series is "in control". This is a statistical term equivalent to being predictable or stable. That's not to say there won't be variation, but the SPC shows what kind of variation can be expected. In the example above, the latest two months have shown increases, but we know from the rest of the data that this is within the bounds of expectation.

What's the science behind setting the control limits at two standard deviations from the mean?

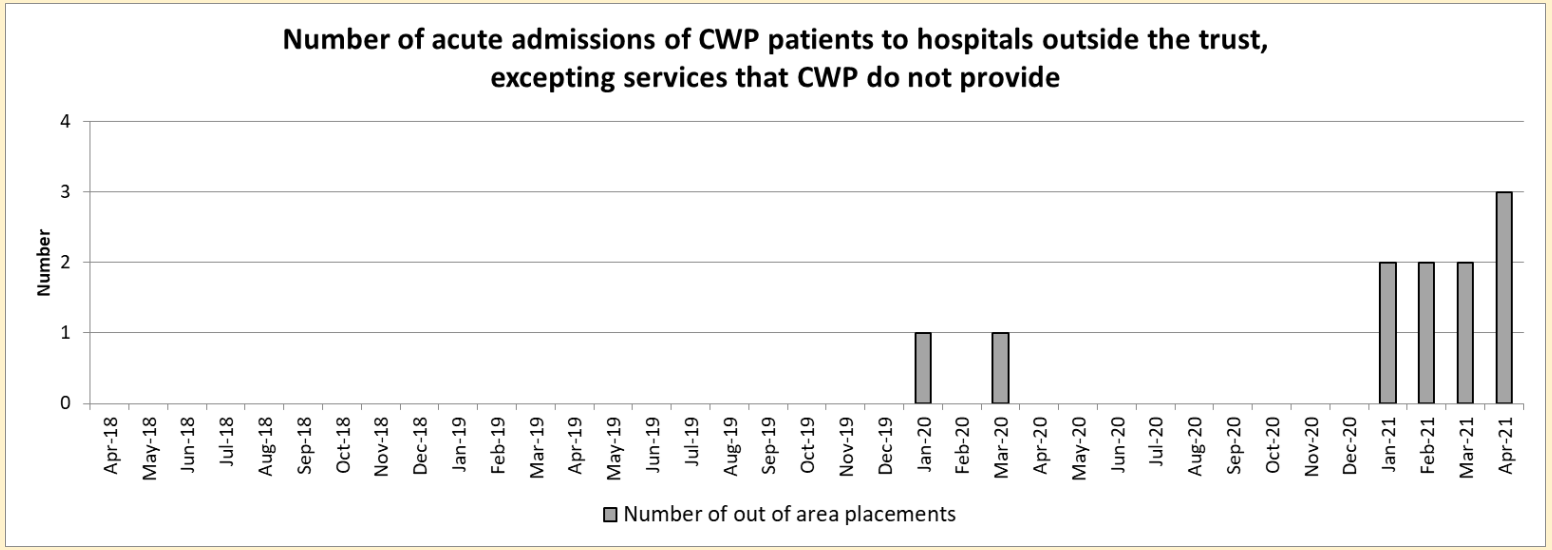
One of the properties of what is known as "the normal distribution" is that 95% of the data are within 2 standard deviations either side of the mean. The remaining 5% of the data are further away from the mean than that, in either direction. 95% is equivalent to one in 20. So we would expect, when looking at a SPC based on data that are distributed normally, that 19 out of 20 data items will be within the control limits, and one in 20 of the data items will exceed the control limits.

Deliver high quality, integrated and innovative services that improve outcomes

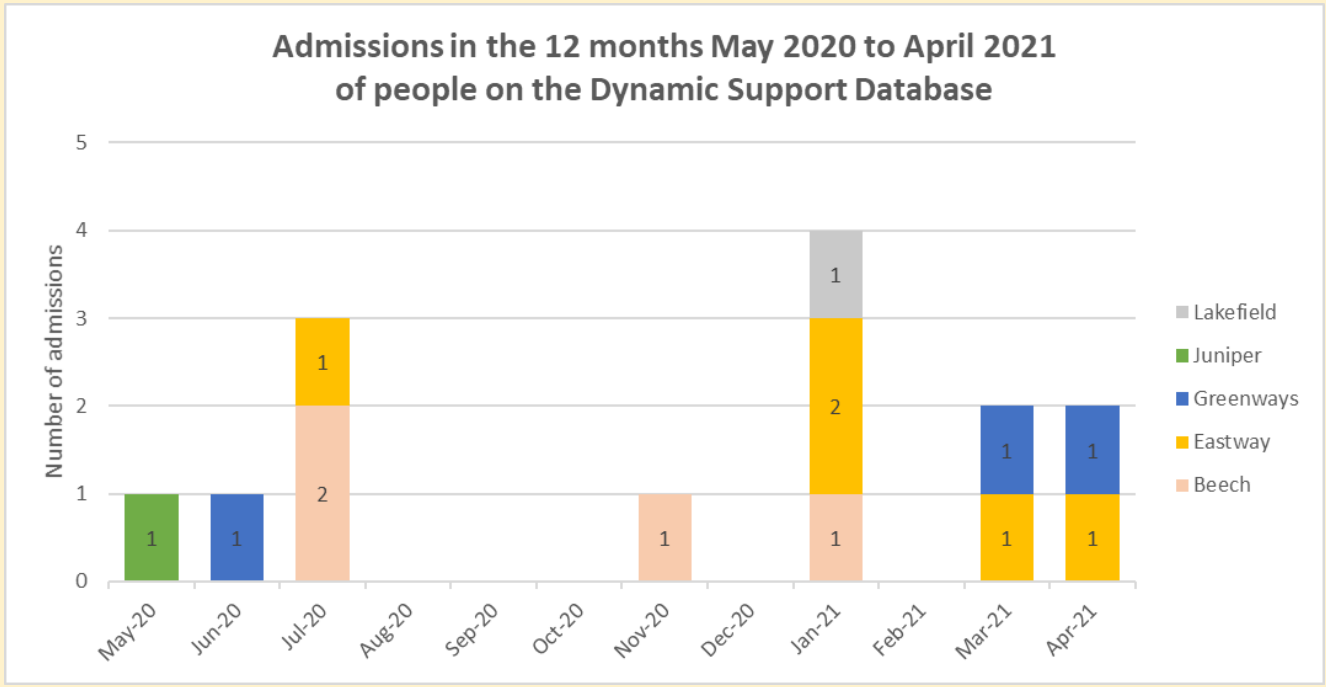
Metric	Data	Further Explanation
Bed Occupancy - Adult Acute and Ageless wards		Metric owner: Suzanne Edwards / Anushta Sivananthan Monitored at: SMH Care Group Data sources: KH03 file provided by the Information Team.

Comment: The usual definition includes adult and ageless wards. Cherry ward, normally an older person's ward, was used as the COVID-19 cohorting ward during April and May 2020 and has been added to the calculation for those months. Bed occupancy was low in November across a number of our acute wards due to both a lower rate of admissions and COVID outbreaks resulting in bed closures for periods of time. Bed occupancy rates have been back to more typical levels since then.

Deliver high quality, integrated and innovative services that improve outcomes

Metric	Data	Further Explanation
Out of Area Acute Admissions	 Note: There has been a cluster of out of area placements in the early part of 2021 as a result of no adult acute availability related to the COVID-19 pandemic.	Metric owner: Suzanne Edwards Monitored at: Operational Committee Data source: CWP Bed Hub

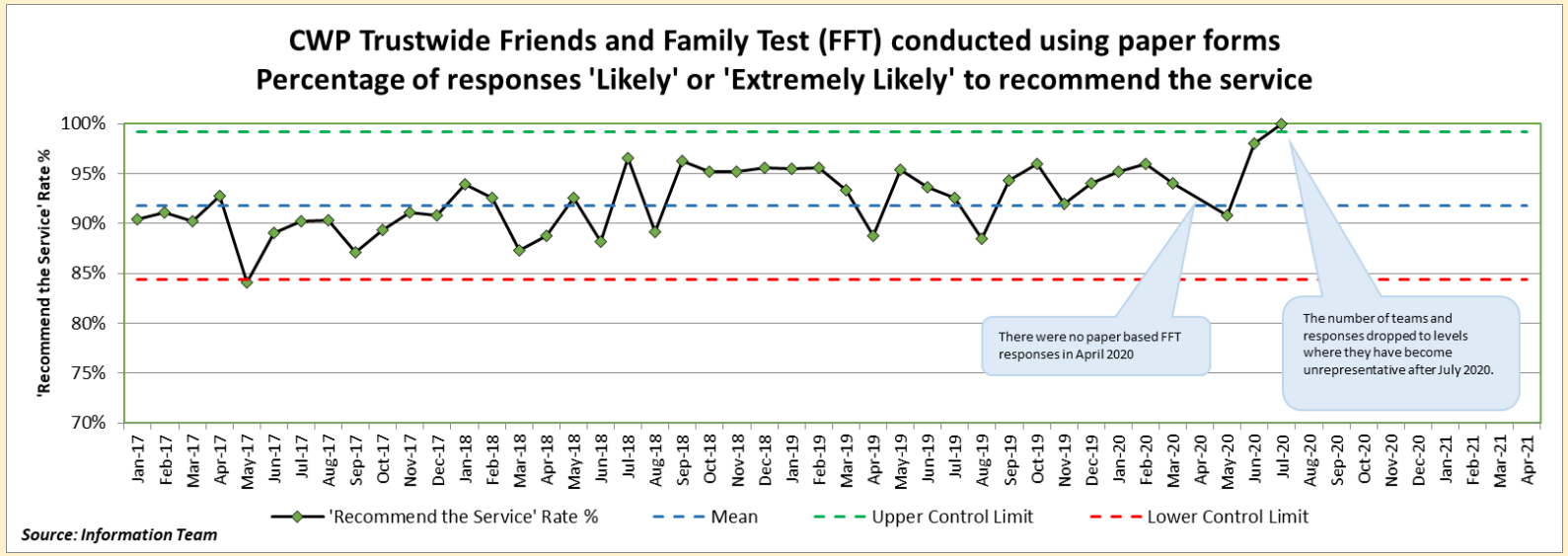
Deliver high quality, integrated and innovative services that improve outcomes

Metric	Data	Further Explanation
Admission to hospital for those on the Dynamic Support Database	 Comment: Of the four people who have been admitted in the most recent two months, two were rated 'red' and two 'amber'. The two amber admissions were both in response to emergency situations. Three were under the care of the Cheshire West and Chester CLDT and one under the care of East CLDT. Three remain in hospital at mid May.	Metric owner: Maddy Lowry Monitored at: LD, NDD & ABI Care Group Data source: 'LD Risk Register Report for QS' Report Manager report

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

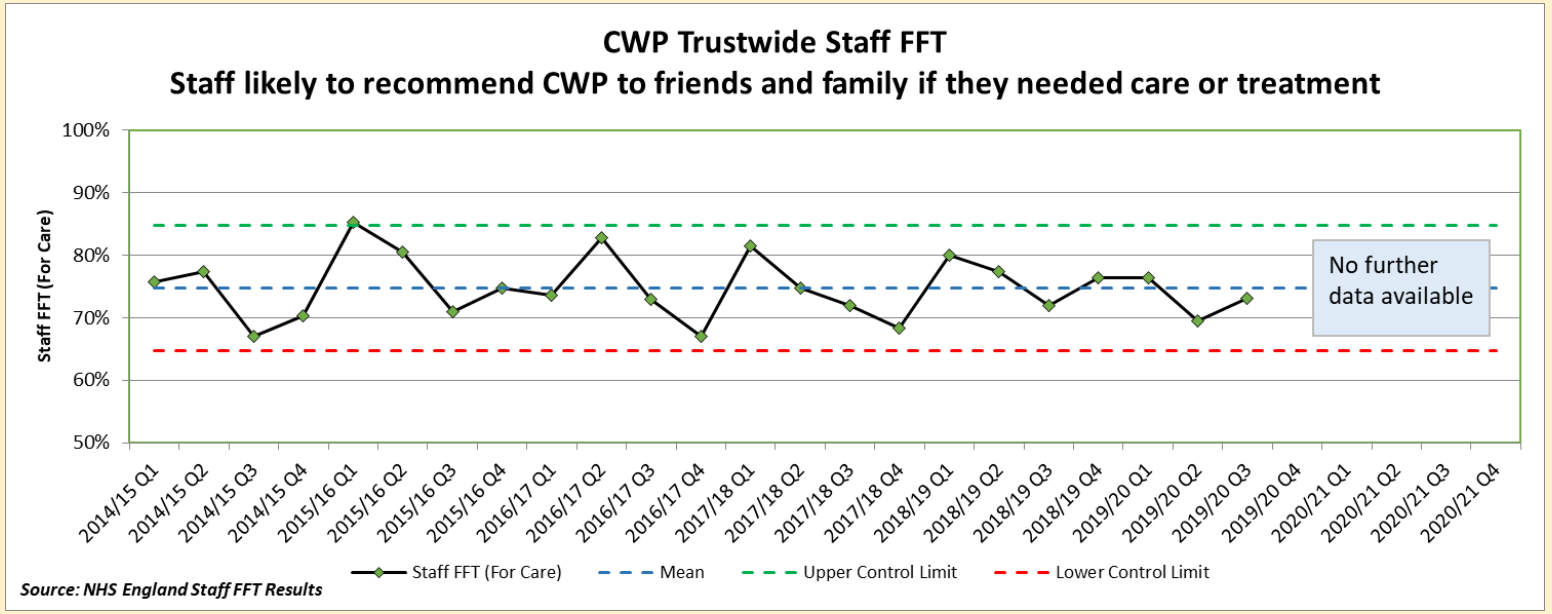
Deliver high quality, integrated and innovative services that improve outcomes		
Metric	**Data**	**Further Explanation**
CWP performance against NHSi targets **(Exceptions only)**	The Trust reports a number of operational metrics to NHSi. These cover: Early Intervention in Psychosis (one metric), Improving Access to Psychological Therapies (3 metrics), Out of Area acute admissions (monitored on slide 5 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 2021, are for December 2020 and January 2021. The following metrics were below target performance as set out in the NHS Oversight Framework for January and February 2021: • Out of Area Acute Admissions which had 2 instances in March and 3 in April. • The data quality measure, where the most recent months were 87.3% for December 2020 and 86.8% for January 2021 against a target of 95%. • EI – percentage completed in two weeks which was 57.9% for April against a target of 60%.	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

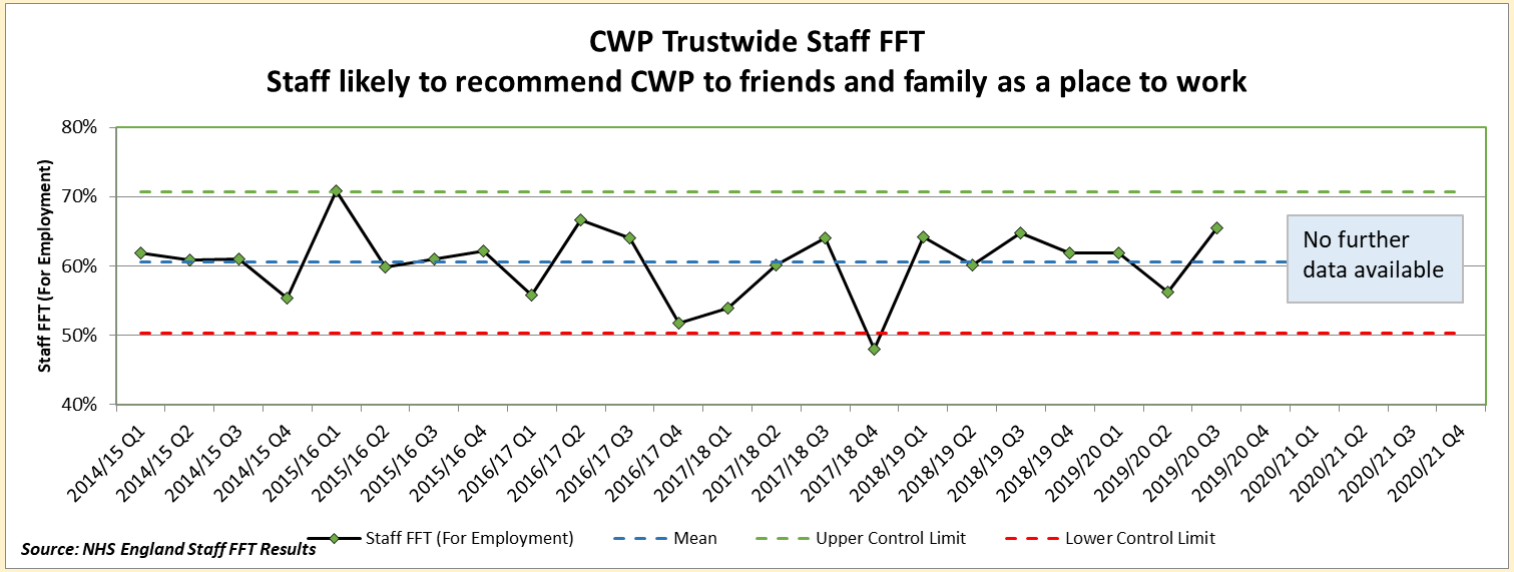
Comment: Following the onset of Covid-19, there was a national pause on the reporting of FFT. The volume of paper based FFT forms diminished after July 2020 to a point where they are not representative of all CWP services so results are not shown after that date. The revised national FFT guidance offers providers greater flexibility than the original model and we are developing new processes including QR codes, new forms and refreshed secure methods of collection. Updated collection procedures should also ensure more complete recording of patient details including the person's protected characteristics. We are also revising our reporting mechanisms and looking to provide a more up to date chart once the data begins to flow. We are also working on merging the paper based and the automated data into one information system.

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

Metric	Data	Further Explanation
Friends and Family Test responses from our staff – about CWP as a care provider		Metric owner: David Harris, delegated to Simon Platt Monitored at: POD Sub Committee Data source: People Information

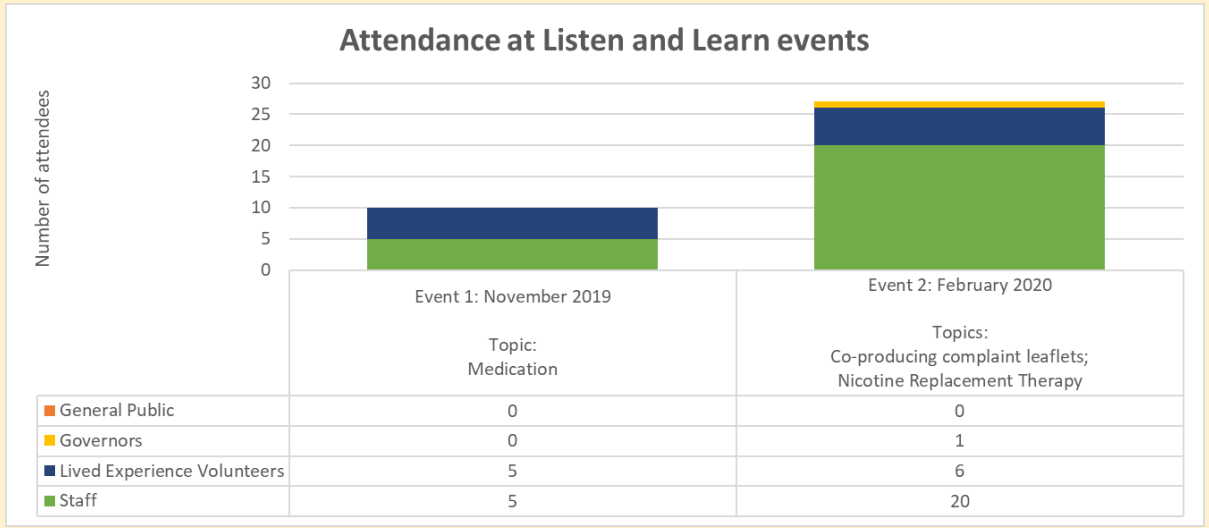
Comment: Due to the national agreement to suspend certain data collection activities as a result of the COVID-19 pandemic, there has been no further data to add to this chart since the edition reported in March 2020. However, as well as the 2020 NHS Staff Survey, the Trust has also participated in the NHS People Pulse survey. While this does not replicate the questions from within the NHS FFT, it has given staff the option to participate and indicate how they are feeling and what support they have utilised through the pandemic as well as anything else that would further assist them.

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

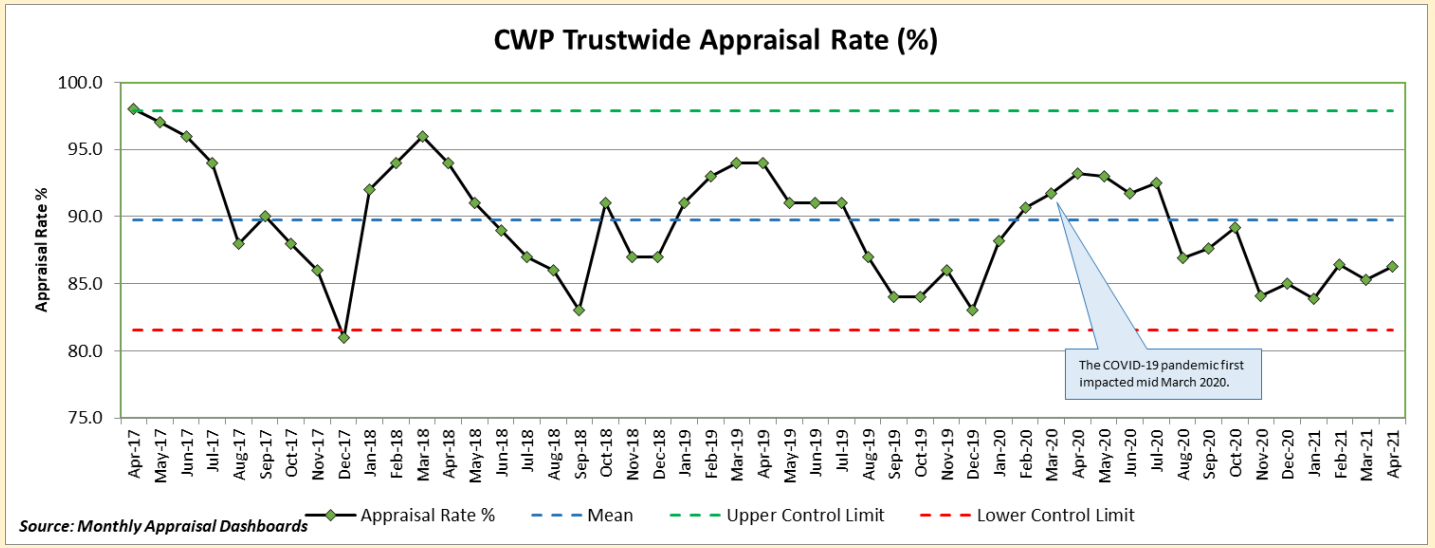
Metric	Data	Further Explanation
Friends and Family Test responses from our staff – about CWP as a place to work		Metric owner: David Harris, delegated to Simon Platt Monitored at: POD Sub Committee Data source: People Information

Comment: Due to the national agreement to suspend certain data collection activities as a result of the COVID-19 pandemic, there has been no further data to add to this chart since the edition reported in March 2020. However, as well as the 2020 NHS Staff Survey, the Trust has also participated in the NHS People Pulse survey. While this does not replicate the questions from within the NHS FFT, it has given staff the option to participate and indicate how they are feeling and what support they have utilised through the pandemic as well as anything else that would further assist them.

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

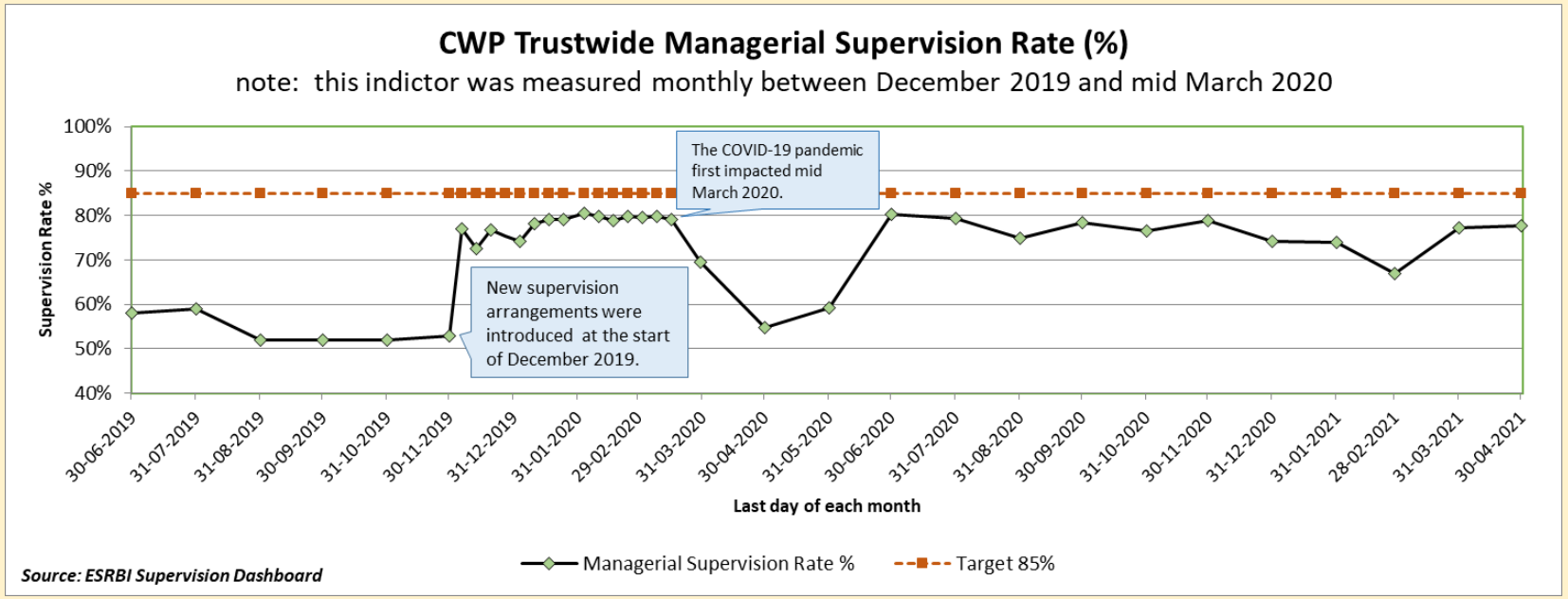
Metric	Data	
Effectiveness of working with the wider community	 Comment: Due to Covid-19 restrictions and limited ability to connect virtually with members and public, we have utilised other methods of ensuring that we listen to the voice of people who access our services. We have involved people in the steering groups of various research and improvement projects. People with lived experience have been involved in data analysis of surveys. Our participation and engagement groups have been working within care groups to ensure that people voices are heard and they are involved.	Metric owner: Cathy Walsh Monitored at: PACE Sub Committee Data Source: PALS team

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

Metric	Data	Further Explanation
Appraisal		Metric owner: David Harris Monitored at: POD Sub Committee and Ops Committee Data source: People Information

Comment: In previous years, peaks in compliance have tended to be at March/ April whereas dips in compliance occurred during Aug and Dec. Work to understand this has taken place and is attributed to peak leave period. The impact of the COVID-19 pandemic on appraisal rates has been marginal in the data reported so far and a 90 day extension has been applied since April 2020. Hotspot Compliance reports are issued to line managers via the Care Groups' Business and Governance Managers, making them aware of where action needs to be taken. Appraisal compliance remains an important indicator for Care Group governance meetings.

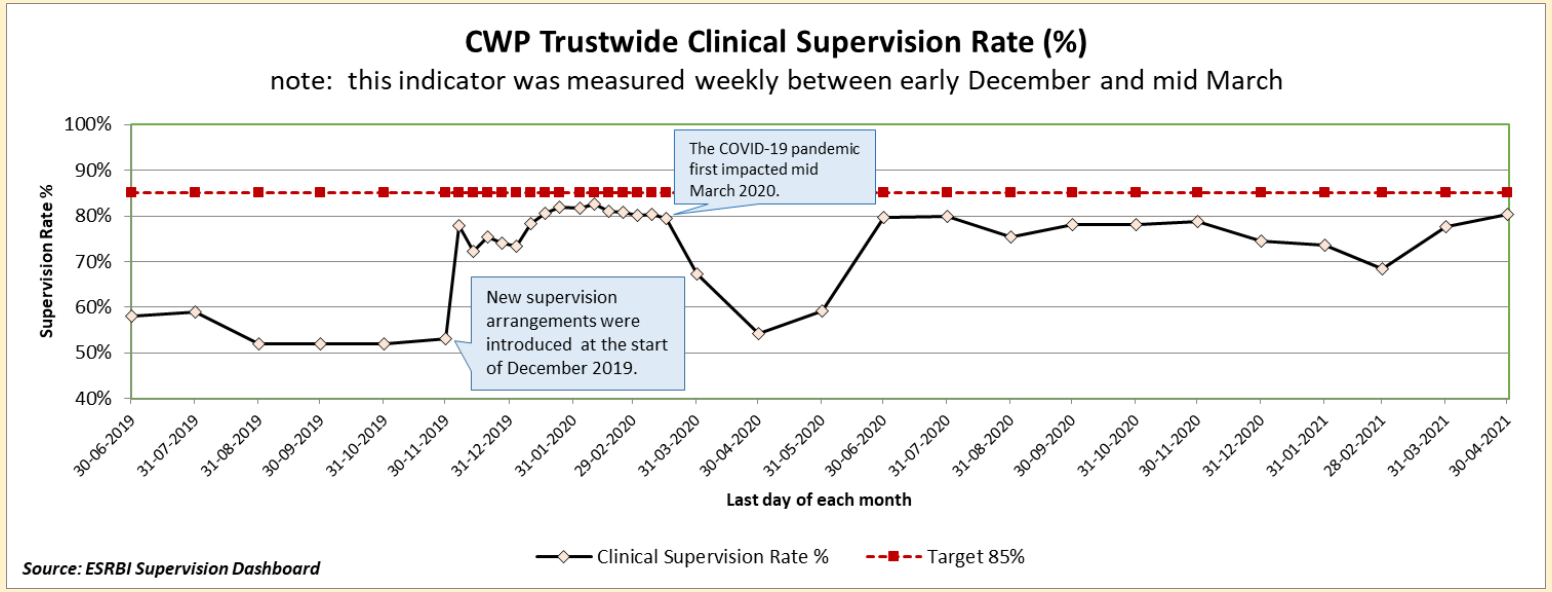
Be a model employer and have a caring, competent and motivated workforce

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: The COVID-19 pandemic had a marked impact on the recording of Managerial Supervision between March and May 2020. Since then, figures had shown a steady trend, recovering to give an approx. average of 77% compliance between July and December. However, January and February 2021 saw a tailing off. Discussions with Care Groups indicate that there is an issue with how hotspot compliance reports are generated and interpreted differently within the Trust. In response to this a focussed pilot took place during January with 23 of the Trust's teams with low compliance for Management Supervision. As a result of the pilot 56% of the teams showed a marked increase in their compliance. A full report on the pilot is being compiled for Operational Committee to consider the findings and next steps. Furthermore the Organisational Development team is working with the People Information service to resolve the perceived issues with the Compliance reports. A proposed solution has been found and the next steps will be to discuss this approach with Care Group Business & Governance Managers. Significant work has been done by Care Groups in the last month to increase rates for both clinical and management supervision and two Care Groups were now above the target of 85% and one was above 80%. Care groups will now share good practice to help continue to drive improvement forwards.

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.

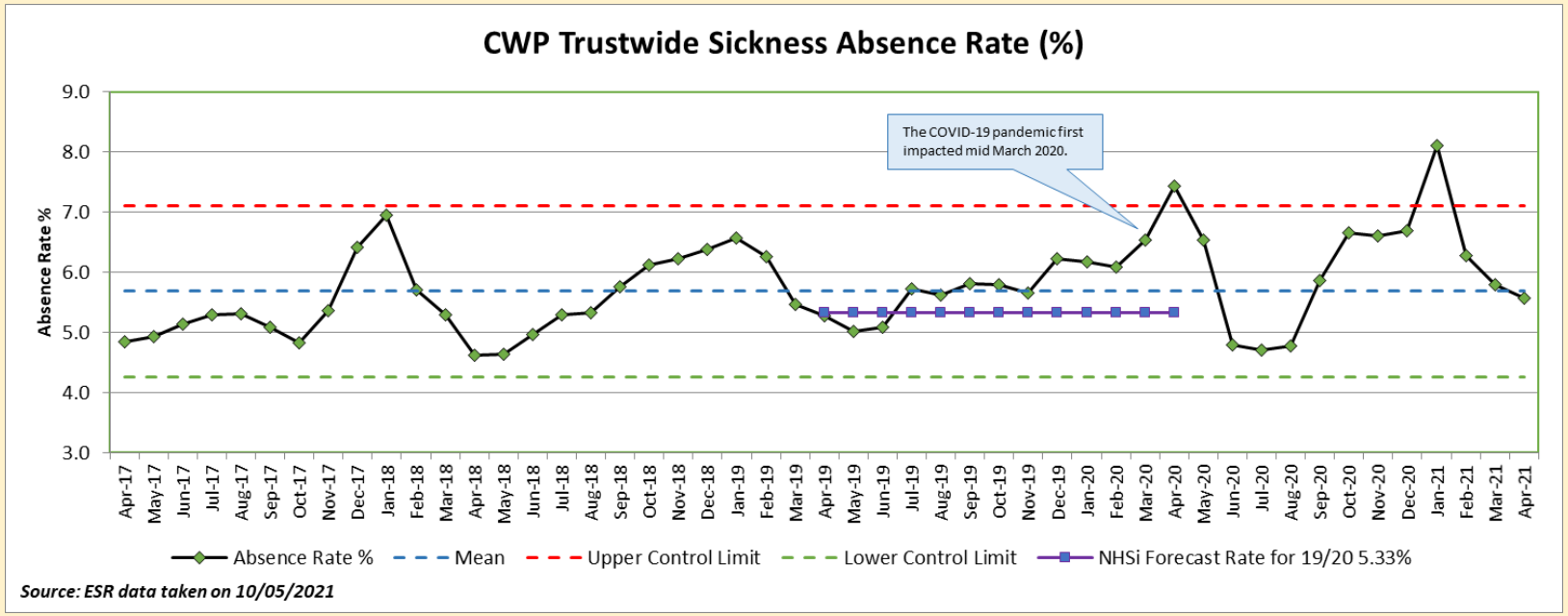
Be a model employer and have a caring, competent and motivated workforce

Metric	Data	Further Explanation
Clinical Supervision		Metric owner: Gary Flockhart, delegated to 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. Significant work has been done by Care Groups in the last month to increase rates for both clinical and management supervision and two Care Groups were now above the target of 85% and one was above 80%. Care groups will now share good practice to help continue to drive improvement forwards.
The clinical supervision compliance measure does not include medical supervision compliance.

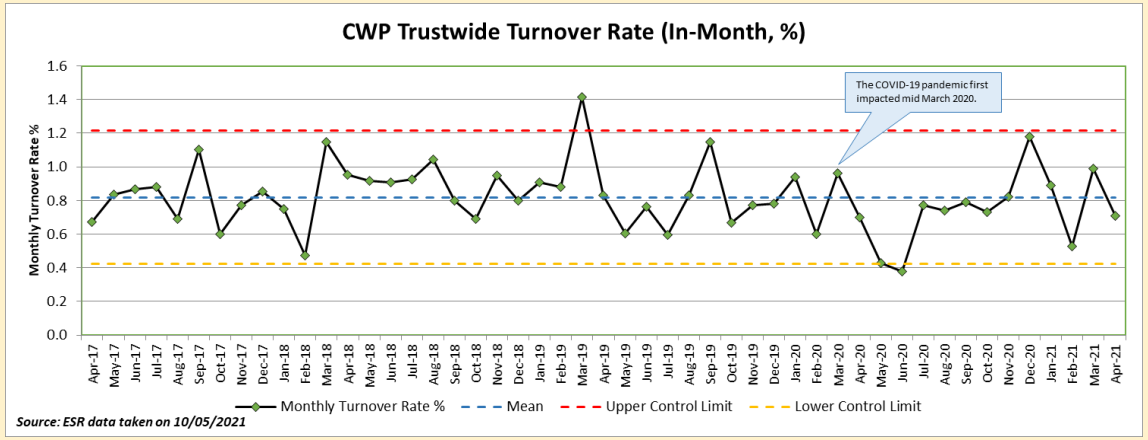
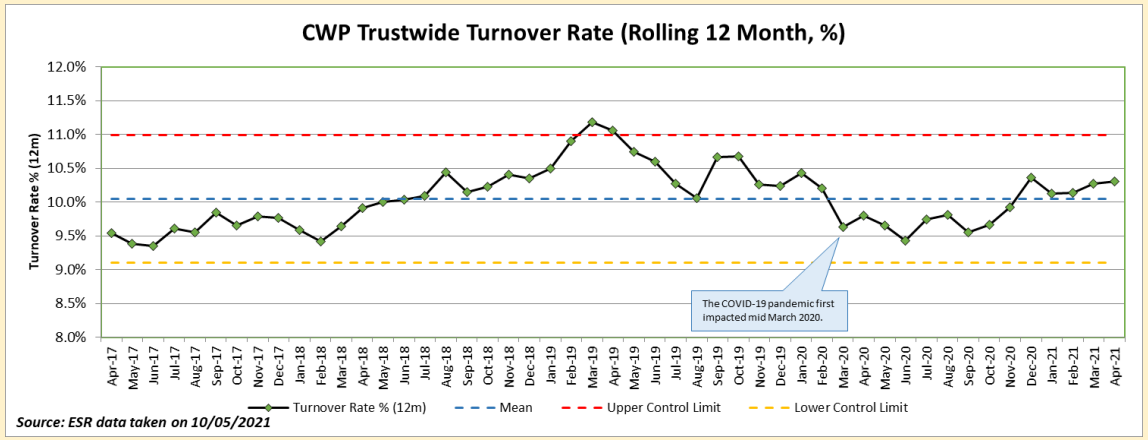
Note: In December 2019 separate managerial and clinical supervision competencies were introduced. For months up to and including November 2019, the time series reflects compliance with the previous 'all supervision' competence.

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

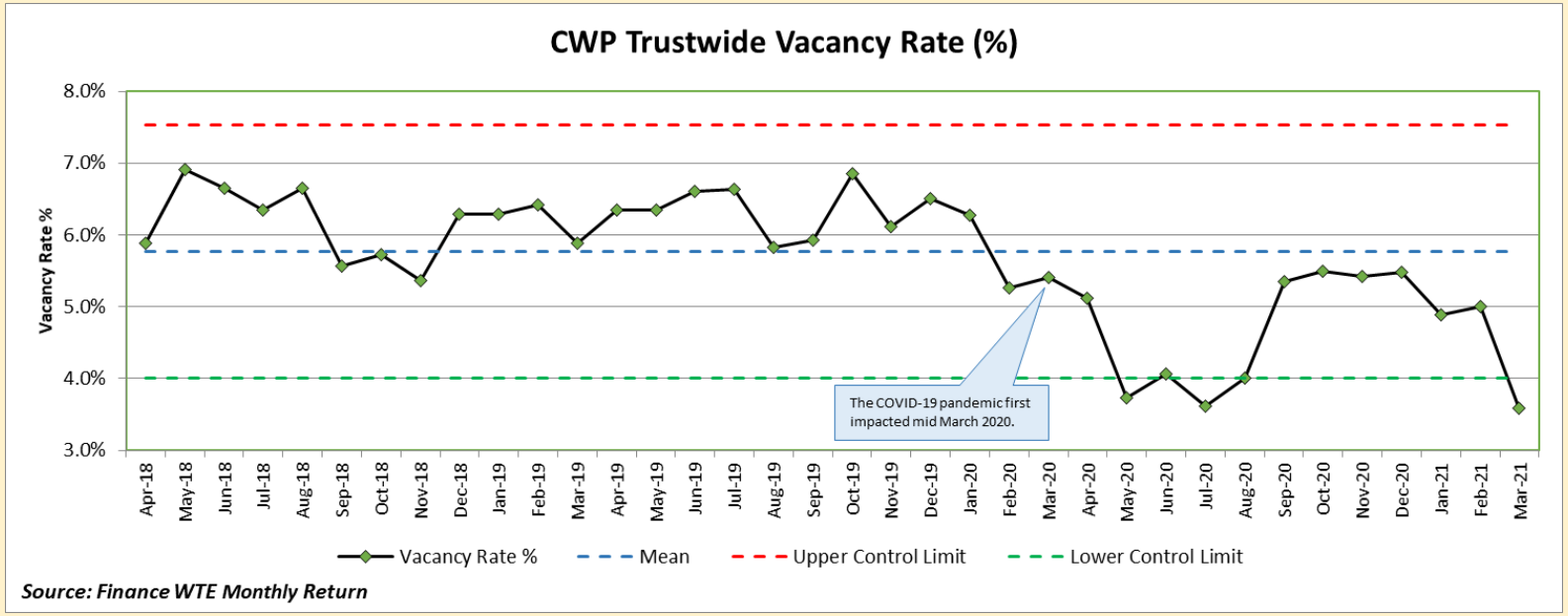
Metric	Data	Further Explanation
Sickness Absence		Metric owners: David Harris Monitored at: POD Sub Committee Data source: People Information

Comment: The peak at January 2021 was higher than the peak in April 2020. It is difficult to provide conclusive evidence why that might be although it is possible that this is due to the combination of a seasonal peak with covid outbreaks and general lower resilience amongst our people. Absence levels will continue to be monitored and a more detailed analysis will take place once capacity is released from supporting the Covid workforce cell.

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

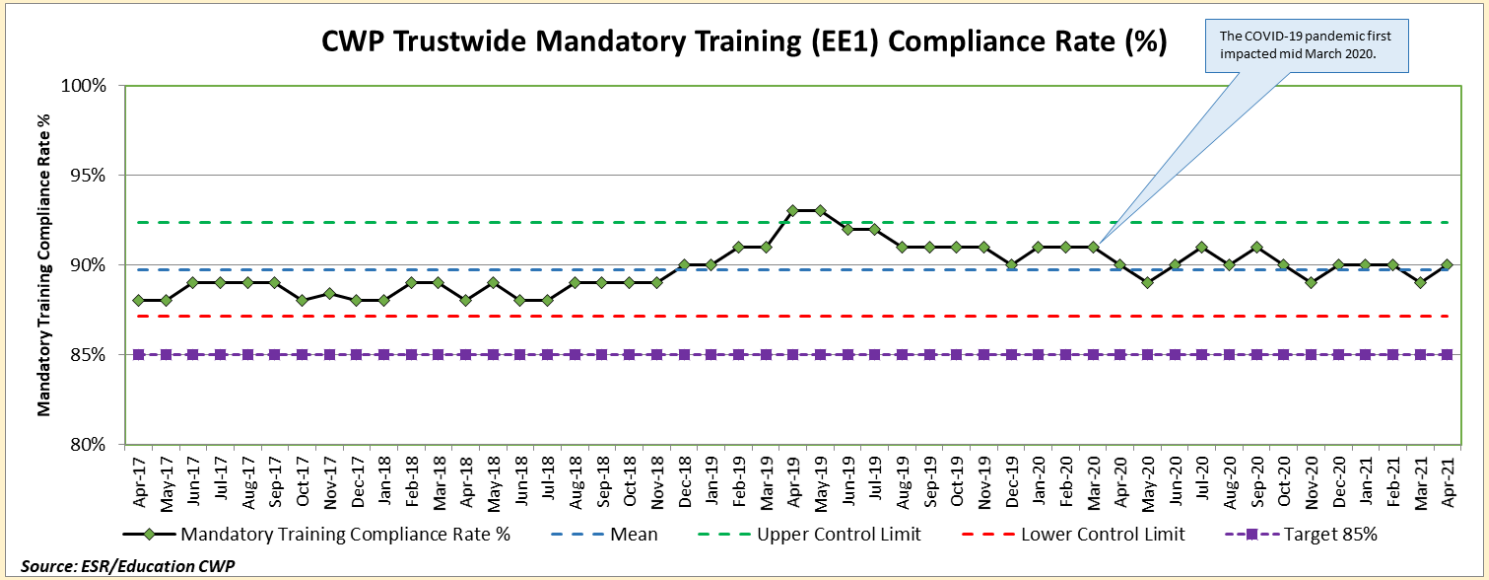
Metric	Data	Further Explanation
Staff Turnover	 *Source: ESR data taken on 10/05/2021*  *Source: ESR data taken on 10/05/2021*	Comment: The latest rolling 12 month data are just above the long term average after a period of nine months March to November 2020 when they were below the long term average.	Metric owner: David Harris Monitored at: POD Sub Committee Data source: People Information

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

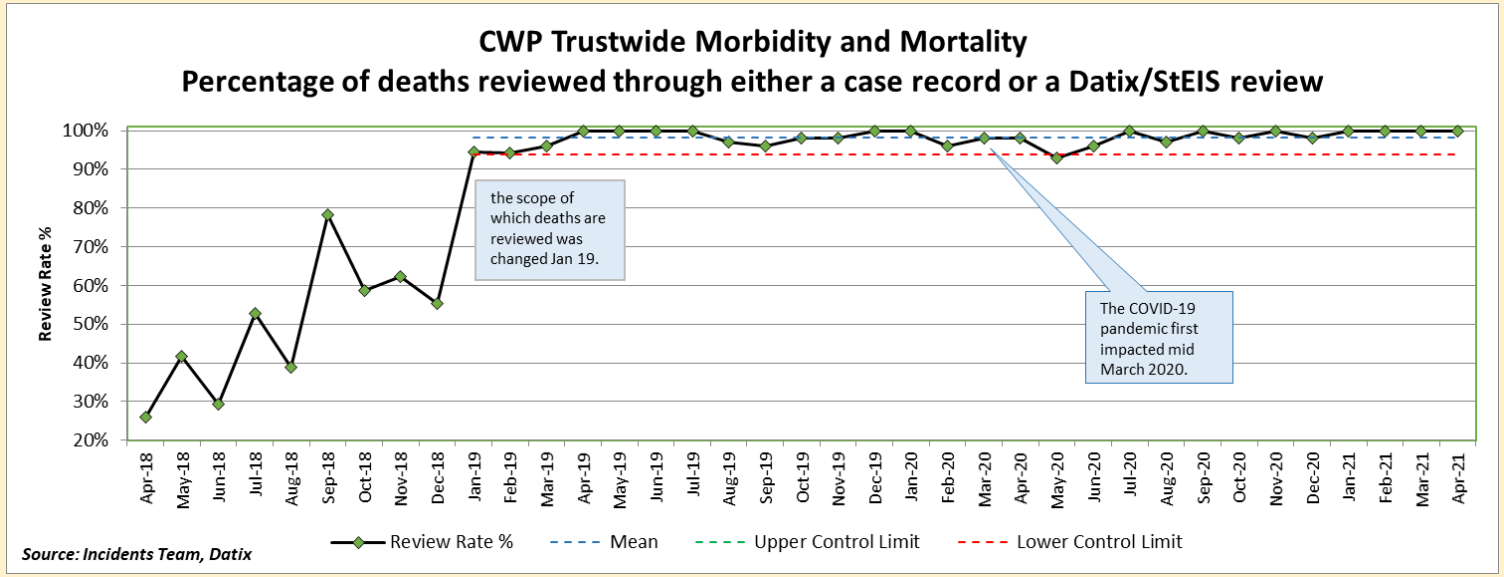
Metric	Data	Further Explanation
Vacancy Rate		Metric owner: David Harris Monitored at: POD Sub Committee Data source: People Information

Comment: The vacancy rate was on or below the lower control limit between May and August 2020, and below the long term average for the last 13 months. The lower vacancy rate at that time was consistent with low staff turnover which has been noted elsewhere in this Report. At the time this report was compiled in mid May, data for April 2021 were not available.

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

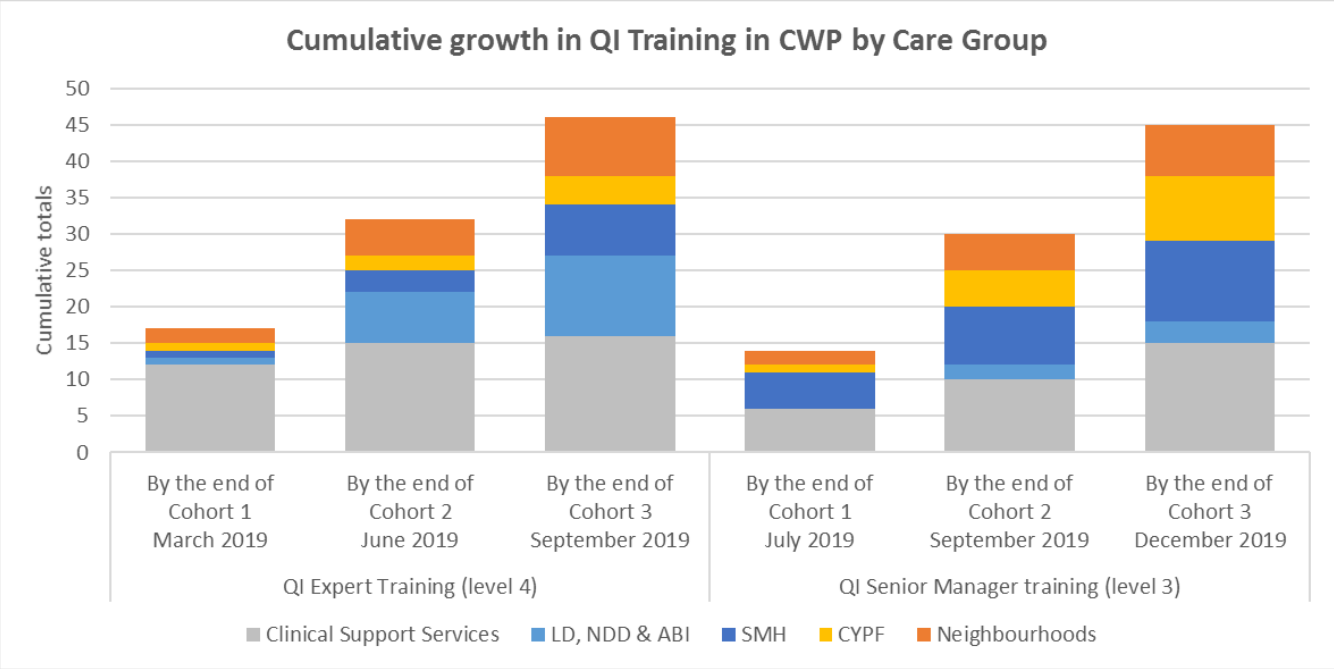
Metric	Data	Further Explanation
Mandatory Training	 Comment: The Trust mandatory compliance figure is currently 90%, matching the long term average. Definition: Excludes staff on Maternity Leave, Career Break, External Secondments, Long Term Sick (>92 days) and new starters < 3 months. Also excludes any new course competences added to the Training Needs Analysis for 12 months, to allow staff time to complete.	Metric owner: David Harris Monitored at: POD Sub Committee and Ops Committee Data source: Education CWP

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

Comment: The requirement to undertake mortality case record reviews was paused during the COVID-19 response. At CWP we continued to undertake mortality case record reviews during this period as good practice. However, prioritisation was given to case reviews where it was considered there may be some learning to support ongoing service development during the easing of this requirement. This is the reason for the dip in the percentage in May 2020.

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 is upwards of 4 hours per level. Due to the COVID situation further rollout of this training has been halted. As of mid May 2021, **3,207** out of **5,673** have completed the level 1 QI training. This is an increase of just over **1,000** since the end of August 2020.

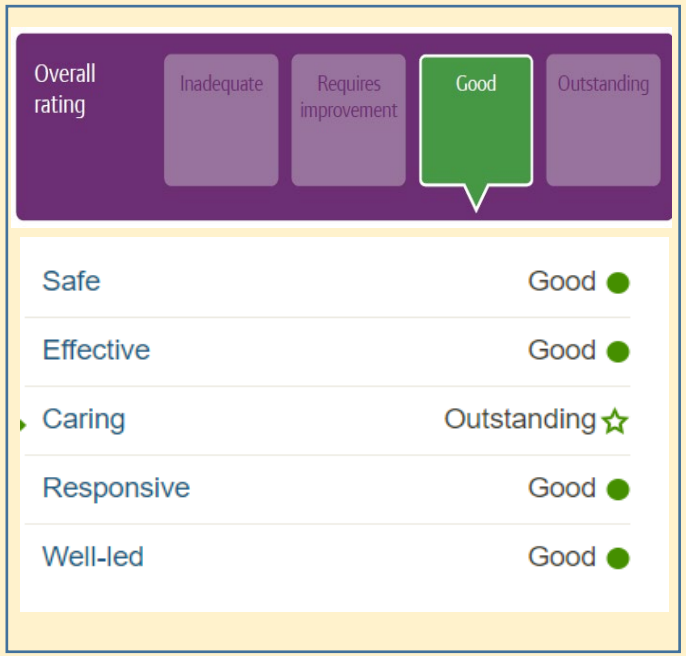
Work to develop further measures for this strategic objective is as follows:

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. 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	Whilst the Covid-19 response has removed the requirement to deliver efficiency savings in 2020/21, the Business & Value team have continued to work with colleagues to support the various new ways of working that have developed as part of the response and help maximise the use of resource. For example the rapid take up of working from home and deployment of digital tools has reduced the travel costs of the Trust and increased the available productive time. Metric owner: Tim Welch Monitored through: Ops Committee

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

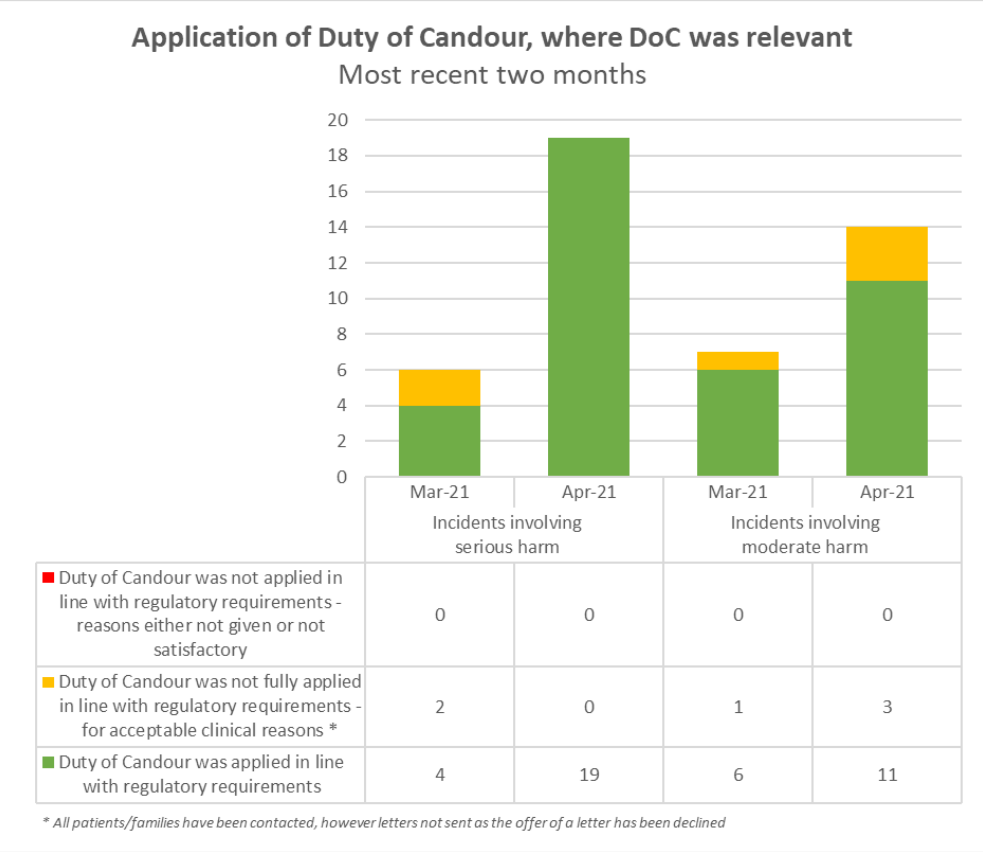
Metric	Data	Further Explanation
CQC Rating		Metric owner: Anushta Sivananthan delegated to Stephanie Bailey Monitored at: Quality Committee Data source: CQC website

Comments:
The most recent Well Led inspection took place between 9 and 11 March 2020. The results were reported in June 2020 and showed improvement over the previous inspection.

Key changes for the overall CQC domains are:
Safe - Good overall ↑
Effective -Good overall →
Caring - Outstanding overall→
Responsive - Good overall→
Well-Led - Good overall→

At the time of writing, there are 2 regulatory and 2 improvement actions open. Outstanding regulatory action has been agreed as an extension with the CQC and will be monitored weekly by the executive team to ensure all touchpoints as part of that extension are met or can be effectively escalated.

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

Metric	Data	Further Explanation
Duty of Candour		Metric owner: Gary Flockhart delegated to Hayley McGowan Monitored at: Quality Committee Data source: CWP Incidents Team

Comment: Following the introduction of the electronic Immediate Safety Review process in April, the members of the ISAF are able to review whether Duty of Candour (DoC) has been applied appropriately for every serious incident and take corrective action as required in a timely manner. This has also enabled increased consistency in the recording of DoC to facilitate effective monitoring and reporting.

Report Against Strategic Objectives

End Sheet

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Statutory Registers: Directors and Governors 2020/21
Agenda ref. number:	21.22.03
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	26/05/2021
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:	
Quality	Yes
Finance and use of resources	Yes
Operational performance	Yes
Strategic change	Yes
Leadership and improvement capability	Yes

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

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 present to the Board of Directors the Director register of interests, Director gifts and hospitality register and the Governors register of interests 2020/21 to provide assurance regarding compliance with the national and local conflicts of interest policies.

The detail of this paper was considered by the Audit Committee on the 11th May 2021.

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 Audit Committee recommend the Board of Directors to **note**:

- The Directors Register of Interests 2020/21
- The Directors Register of Gifts and Hospitality 2020/21
- The Governors Register of Interest 2020/21

Who has approved this report for receipt at the above meeting?	Katherine Wright, Associate Director of Communications, Engagement and Corporate Affairs
Contributing authors:	Suzanne Christopher, Acting Company Secretary

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Audit Committee	11.05.2021

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

Appendix No.	Appendix title
1	Director - register of interests - https://webstore.cwp.nhs.uk/board/interest/DirectorsRegisterInterestMarch2021.pdf
2	Director – gifts and hospitality - https://webstore.cwp.nhs.uk/board/giftsandhospitality/2020-21giftsandhospitalityregister.pdf
3	Governors – register of interests - https://webstore.cwp.nhs.uk/governors/DOIgovernors24Feb2021v5.pdf

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Fit and Proper Persons policy and process review 2020/21
Agenda ref. number:	21.22.03
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	26/05/2021
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:	
Quality	Yes
Finance and use of resources	No
Operational performance	No
Strategic change	No
Leadership and improvement capability	Yes

CWP Quality Framework:		
Patient Safety	Safe	Yes
Clinical Effectiveness	Effective	Yes
	Affordable	No
	Sustainable	No
Patient Experience	Acceptable	No
	Accessible	No

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*

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.

The detail of this report was considered at the recent Audit Committee held on 11th May 2021.

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*

It is worth noting that the last report presented to the Audit Committee and to the Board of Directors was in November 2020 and considered compliance against the financial year 2019/20. The report is now being presented in May 21 for the financial year 20/21 to support the revised business cycle of the Board of Directors.

Below is an outline of the evidence for the reporting year 2020/21 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 2020/21 and is held in a central register.
- The Insolvency/ bankruptcy Service Register (IIR) was checked for 2020/21 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 – all are up to date. The DBS check for Dr Faouzi Alam is due to expire on the 20th May 2021. The renewal of this information is currently being processed.
- Two new Non-Executive Directors, Farhad Ahmed and Elizabeth Harrison were appointed to the Board of Directors in October 2020. All pre-employment checks were undertaken. This was confirmed to the Audit Committee in November 2020.
- Appraisals for all Directors were undertaken during October and November 2020. The appraisals reviewed performance during 19/20 and considered objectives for 20/21. Final copies of all appraisals are held by the Corporate Affairs Team. The timetable for the completion of appraisals this year was adjusted in view of COVID-19.

It is also worth noting the CQC Well Led inspection in 2020 made no recommendations for improvement in relation to the Fit and Proper Person arrangements within CWP.

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

The Audit Committee recommend the report to the Board of Directors for noting.

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	11/05/2021

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

Appendix No.	Appendix title

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Chair and Chief Executive - Division of Responsibilities
Agenda ref. number:	21.22.03
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	26/05/2021
Presented by:	Mike Maier, Chairman

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

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

CWP Quality Framework:		
Patient Safety	Safe	No
Clinical Effectiveness	Effective	No
	Affordable	No
	Sustainable	No
Patient Experience	Acceptable	No
	Accessible	No

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 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?	Mike Maier, Chairman Sheena Cumiskey, Chief Executive
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

Last reviewed: July 2020
Next review: May 2021

NHS
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NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Register of Seals 2020/21
Agenda ref. number:	21.22.03
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	26/05/2021
Presented by:	Tim Welch, Director of Business and Value

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		

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*

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 are invited to note the 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 2020 – March 2021.

The detail of this report was considered at the Audit Committee on the 11th May 2021.

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 2020 – March 2021 is set out below for review by the Board of Directors.

The Audit Committee queried the approval process regarding the required signatures. It was confirmed that signatures are added prior to the document being sealed and added to the register.

The Register of Sealing is required to be approved by the Board of Directors on an annual basis.

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

The Audit Committee recommend to the Board of Directors, the approval of the Register of Sealing.

Who has approved this report for receipt at the above meeting?	Katherine Wright, Associate Director of Communications, Engagement and Corporate Affairs
Contributing authors:	Suzanne Christopher, Head of Corporate Affairs

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Audit Committee	11.05.2021

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

Appendix No.	Appendix title
1	Register of Seals 2020/21

Cheshire and Wirral Partnership NHS Foundation Trust

Register of Seals April 2020 – March 2021

Cheshire & Wirral Partnership NHS Foundation Trust (CWP)

April 2020 – March 2021

Entry No	Details	Value	Date of Sealing
01	Reversionary Lease by Reference, Sycamore House – Annual Rent	£65,826.00	04/11/2020
02	The Christie NHS FT Lease	N/A	24/02/2021

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NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	CWP Provider Licence – annual self-assessment and Licence declarations
Agenda ref. number:	21.22.03
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	26/05/2021
Presented by:	Tim Welch, Director of Business & Value

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:	
Quality	Yes
Finance and use of resources	Yes
Operational performance	Yes
Strategic change	Yes
Leadership and improvement capability	Yes

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

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*

The licence requirement for health care providers came into effect from April 2013.

Compliance with the licence is routinely monitored through 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 2020/21. The licence contains obligations for the Trust and this assessment aims to help the Board of Directors in confirming the accuracy of requirements that CWP is required to comply with as a licence holder.

The detail of this report was considered by the Audit Committee on the 11th May 2021.

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

Appendix 1 contains the high level excerpts from the full licence document and enables the Board of Directors 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 2021.

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 2021.

While declarations are no longer required for submission to NHS I, Boards must ensure they review the declarations, that documents are available for audit and that some declarations (G6) are published.

The detail of the appendices were considered by the Audit Committee at their meeting held on the 11th May 2021.

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

The Audit Committee recommend to the Board of Directors the approval of the 2020/21 year end Licence position and declarations in accordance with General Condition 6, CoS 7 and Condition FT4 of the Licence for publication on the Trust website

Who has approved this report for receipt at the above meeting?	Tim Welch, Director of Business & Value Katherine Wright, Associate Director of Communications, Engagement and Corporate Affairs
Contributing authors:	Suzanne Christopher, Head of Corporate Affairs

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Audit Committee	11.05.2021

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

Appendix 1: Self-assessment evidence against NHS provider licence key criteria as at end Q4 2020/21

RAG		Definition
GREEN		Meets or exceeds expectations. Many elements of good practice. No major omissions.
AMBER/	GREEN	Partially meets expectations but confident in management's capacity to deliver green performance within reasonable timeframe.
AMBER/	RED	Partially meets expectations but some concerns on capacity to deliver within a reasonable timeframe.
RED		Does not meet expectations.

Licence reference	Licence provision	Self assessment	End quarter 4 2019/20 position	Comments/ Further actions for completion
1. General provisions				
G2	Has NHSI given any direction regarding setting or limiting conditions within the Provider Licence?	**GREEN**	Compliant	No issues identified.
G4(1)	Is the Trust aware of any reason why a newly appointed Governor or an appointed Governor is unfit to be a Governor?	**GREEN**	Compliant	No issues identified.
G4(2)	Is the Trust aware of any reason why a newly appointed Director or a Director in post is unfit to be a Director?	**GREEN**	Compliant	No issues identified – policy and processes in place in accordance with the licence and CQC Fit and Proper Persons regulations. Assessed during the 2020 CQC well-led inspection and were found to meet Regulation 5 requirements. CQC final report published June 2020.
G5	Has NHSI issued new guidance relating to the provider licence in the last 12 months	**GREEN**	Compliant	No new guidance issued. Consultation process currently underway.
G6	Executive to consider any new licencing risks identified in the quarter – update of Board Assurance Framework for Board approval?	**GREEN**	Compliant	No risks recorded on the board assurance framework concerning licence impacts.

Licence reference	Licence provision	Self assessment	End quarter 4 2019/20 position	Comments/ Further actions for completion
G6(3)	Publication of Annual Governance Statement (AGS)?	**GREEN**	Compliant	2020/21 Statement drafted. This will be considered at the May 2021 Audit Committee and Board of Directors meeting. This will be published as part of Annual Report and Accounts following completion of Parliamentary requirements.
G7	Consider CQC registration status in 2020/21 – note cancellations and registrations (G7(2))?	**GREEN**	Compliant	CQC Statement of Purpose including registrations and cancellations was last reviewed by the Board in January 2021. The Statement of Purpose has been updated in conjunction with the Care Group business and governance teams, who have updated, confirmed, and approved the services provided and service contacts detailed in the statement. Locations and addresses have been reviewed and updated accordingly. In addition, the description of services provided by the Trust has also been updated in line with the services we currently provide. Specific in-year amendments include: • Transfer of services from Stanney Lane Clinic to Hope Farm Clinic. • Transfer of the Wirral Continuing Health Care service to CWP. • Update of our strategic objectives. NHS England have designated Churton Resource Centre as a COVID vaccination site. This does not amend our regulated activity, but all trusts supporting the 'coronavirus vaccination programme' are required to send a statutory notification to the CQC, which we have completed and submitted.
G8	Consider if all information on range of services and information on who can access them is published	**GREEN**	Compliant	Details of all services including eligibility (age range/ conditions) and referral routes are within each service listed on the CWP website.
G9	Consider whether Commissioner Requested Services have been amended?	**GREEN**	Compliant	Commissioner Requested Services with NHS England, Specialised Services for the following services: CAMHS Tier 4, Adult Eating Disorders, Secure and Mental Health Services (adult) and Learning Disabilities. No changes in the last year.

Licence reference	Licence provision	Self assessment	End quarter 4 2019/20 position	Comments/ Further actions for completion
G9(12)	Have the contractual requirements to activities or any mandatory services been amended?	**GREEN**	Compliant	No material changes that would impact on licence conditions.
2. Pricing				
P1(4)	Have any services been sub contracted?	**GREEN**	Compliant	No new sub-contracts in year.
3. Choice and competition				
C1(3)	Are clear systems in place for notifying individual patients about choice?	**GREEN**	Compliant	Patient choice information on CWP website in applicable service areas.
4. Integrated care				
IC1	Are there any service changes that require staff/ public consultation (need to be cognisant of Public Interest)?	**GREEN**	Compliant	No public consultation in 2020/21.
5. Continuity of services				
CoS1	Have any contract variations been completed to service specifications	**GREEN**	Compliant	Yes –there have been contract variations to service specifications within this time period but not of a material nature requiring notification.
CoS2	Have any assets been disposed of that would impact on the ability to provide 'Commissioner Requested Services'?	**GREEN**	Compliant	No assets have been disposed of during 2020/21
6. NHS Foundation Trust conditions				
FT1	Has the Constitution been amended? Amended constitution should be submitted to NHSI with 28 days of	**GREEN**	Compliant	Work commenced in 20/21 to review the Trust Constitution with close involvement of the Council of Governors. However, this work was interrupted by the COVID-19 pandemic and the need for Trusts to focus efforts on the response. This work will re-commence as soon as is practically possible to do so.

Licence reference	Licence provision	Self assessment	End quarter 4 2019/20 position	Comments/ Further actions for completion
	amendment.			
FT4(8)	Submit to NHSI Corporate Governance Statement following Board approval in Q1 by 30 June.	**GREEN**	Compliant	Statements are due for approval at the May 2021 meeting of the Board of Directors.

Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED HIGHLIGHT/ EXCEPTION REPORT

REPORT DETAILS	
Subject matter of report:	Equality, Diversity & Inclusion Networks; Workforce Disability Equality Standard (WDES); Workforce Race Equality Standard (WRES) Update
Report provided by:	Gary Flockhart, Director of Nursing, Therapies and Patient Partnership
Date of report:	17/05/2021

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

Summarise the purpose of the report:

In terms of Equality, Diversity & Inclusion Networks, we have a Disability Network, an LGBT+ Network (lesbian, gay, bisexual, transgender, the + simply means that we are inclusive of all identities, regardless of how people define themselves) and a BAME+ Network (Black, Asian and Minority Ethnic, the + is for all ethnicities both visible and non-visible). Recent Cabinet Office guidance regarding the latter suggests that terminology be reviewed and our group is considering this. All groups now have Board Champions and have agreed Terms of Reference. Our BAME+ and Disability Networks have each appointed a Chair and a Vice Chair.

We are contracted to publish our annual WDES and WRES reports in September. Whilst the data as at 31st March 2021 from the People and OD Team is awaited, we have done some preparatory work and have populated elements which are based on feedback from the November 2020 Staff Opinion Survey. This was shared at the February Board Workshop and has been included as Appendices A and B.

ESCALATION
What do you need to escalate to the Committee?

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

Our network groups have celebrated events such as Black History Month, Virtual Pride, LGBT+ History Month, Disability History Month and International Day for Persons With Disabilities so as to involve people, share experiences and raise awareness. We have coproduced a Reasonable Adjustments Guide, worked together to renew our 'Disability Confident Employer' award, continue to promote the NHS Rainbow Badge initiative and recently held a 'Safe Space' event for colleagues from ethnic minority backgrounds to engage with Board members.

We are working with our networks to coproduce action plans to respond to our WDES, our WRES and, despite it being neither a contractual nor a statutory obligation, we are also looking to formulate our own Workforce Sexual Orientation Equality Standard and an associated action plan.

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

Other key matters to highlight:

Trust Board members are asked to note ways in which our Equality, Diversity & Inclusion Networks support and involve colleagues covered by protected characteristics.

Trust Board members are also asked to note work in relation to Workforce Disability Equality Standard and Workforce Race Equality Standard (WRES) reports and action plans.

Appendices

Appendix A – Workforce Disability Equality Standard 20-21
Appendix B – Workforce Race Equality Standard 20-21

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Guardian of Safe Working Quarterly Report
Agenda ref. number:	21.22.05
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	26/05/2021
Presented by:	Faouzi 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 February 2020-April 2021. 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 post of Guardian of Safe Working in order to monitor and provide reassurance of Safe Working practice related to hours worked. This is an independent post and requires a responsibility of providing reports.

Assessment – *analysis and considerations of the options and risks*
Exception reporting: This has been discussed through the Junior Doctor Forum on how and when to do exception reporting. There have been 8 exception reports during this period, all of which were resolved through time in lieu. There have been no fines levied against the Trust **Junior Doctor Forum** It is part of the role of the Guardian of Safe Working to chair a Junior Doctor Forum. This is currently established as a monthly forum to discuss issues.

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

Who has approved this report for receipt at the above meeting?	Dr Sumita Prabhakaran
Contributing authors:	Sumita Prabhakaran, GOSW

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 Report – May 2021

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

Feb 2021 to Apr 2021

Report Author: **Dr Sumita Prabhakaran**
Guardian of Safe Working Hours

Executive summary

The following report is the second of the quarterly reports to the Trust board and details the months from Feb 2021 to April2021.

There have been eight reports of exceptions from agreed work schedules during the report period all of which were resolved with time in lieu. There have been no highlighted areas of concern regarding safe working or access to educational and training opportunities. There was a new set of trainees starting in February 2021.

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.

Background Data

Number of doctors in training (total):	60
Number of vacancy:	9
Amount of time available in job plan for guardian to do the role:	0.5 PAs per week
Admin support provided to the guardian (if any):	No admin support
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

Exception reports

There were 8 exception reports for this time, all of which were resolved through giving time in lieu.

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

Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED HIGHLIGHT/ EXCEPTION REPORT

REPORT DETAILS	
Subject matter of report:	Staff Survey 2020
Report provided by:	Simon Platt, Head of Organisational Development
Date of report:	17/05/2021

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

Summarise the purpose of the report:

The purpose of this report is to provide an update to Trust Board on the NHS Staff Survey 2020 findings, highlighting proposed priority areas for improvement and monitoring arrangements.

Board comments are sought in relation to the findings of the survey and then (alongside the other two related papers on the meeting agenda) on strategic people priorities for Strategic Objective 7 (Enabling our People) and the related Trust People Strategy.

ESCALATION
What do you need to escalate to the Committee?

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

- The Executive Summary Report (see Appendix 1) was presented to CWP's Operational Committee on the 19th of May for discussion and approval of the proposed priorities. A verbal update on this discussion will be provided to Board.

- The Executive Summary report sets out at a high level the main areas of:
  - Improvement and deterioration in relation to the Trust's Survey results last year
  - How the Trust compares to similar organisations
  - Progress on last year's priorities
  - Proposed priorities for action for 2021

- Based on experience from previous years, the most impactful way of achieving improvements is by ensuring local ownership of the data and any associated action plans and this will be the basis of the approach for 2021.

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

Other key matters to highlight:

The following actions have been and will be taken to ensure that improvement action is taken as a result of the findings of the Staff Survey:

- March 21 – Organisational Development shared bespoke Care Group/Clinical Support Service Data Packs with all Associate Directors (ADs) (for Care Groups) and Heads of Service (HoS) (for Clinical Support Services). The packs were issued with a request that all recipients consider how the insights could be used to make improvements to staff experience in their local area.
- April 21 – Organisational Development reviewed progress with ADs and HoS. Early responses from AD's and HoS were that they are hosting engagement activities internally with their staff, seeking feedback to the insights provided in the data packs and forming an understanding of how they can make the biggest difference to staff experience.
- Over the next quarter, Organisational Development will liaise with AD's/HoS to confirm the local staff experience improvement initiatives. These will be monitored locally but also by the People and OD Sub-Committee, which is due to recommence in July.
- Work will recommence (following a pause due to the pandemic) on producing a regular staff experience report which will triangulate a range of quantitative and qualitative data, the latter to include the NHS People Pulse Survey and the NHS Staff 'Friends & Family' Survey (which relaunches in July).

Appendix 1 NHS Staff Survey – Executive Summary Trust-wide Report 2020/21

Response Rate

The response rate to the 2020 survey among Trust staff was 51% - A decrease of 3% from 2019's 54%. The average response rate for similar organisations is 52%. While it cannot be said definitively, this decrease in participation could be attributed to our COVID 19 experience where staff absence increased through the months of the survey's campaign in comparison to the previous year. In addition, out of the 3751 members of staff invited to participate, 55 complete responses were deemed ineligible and 32 completed responses were from people who then left the organisation. Bank Staff were not invited to participate as was nationally advised. However, the lessons learned here are that Bank Staff should have been included and the national view now is that this will be advised moving forward.

Staff Engagement

The overall staff engagement score is an average of the scores for questions on advocacy, involvement and motivation.

Overall staff engagement					
	2018	**2019**	**2020**		**Trust improvement/ deterioration over previous year**
	Trust	Trust	Trust	Benchmarking group (Combined MH/LD and community trusts) average	
Staff engagement score	7.2	7.1	7.2	7.1	+0.1

NHS Staff Survey Comparisons to Similar Organisations

As Picker also provided the same survey to 26 other Mental Health & Learning Disability/Mental Health/Learning Disability & Community Trusts, we are able to compare our results against their combined average score. Overall, we place 8th out of the 26 organisations.

Out of the 78 questions fielded to staff in 2019:

- CWP scored better than the combined average score on 50 of the questions. Notably for:

If friend/relative needed treatment would be happy with standard of care provided by organisation	+8%
Organisation acts fairly: career progression	+ 7%
Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	+ 6%

Satisfied with level of pay	+ 5%
Not experienced discrimination from patients/service users, their relatives or other members of the public	+ 5%

- CWP matched the combined average score on 9 of the questions

- CWP scored worse than the combined average score on 19 of the questions. Notably for:

Team members often meet to discuss the team's effectiveness	- 7%
Senior managers try to involve staff in important decisions	- 6%
Senior managers act on staff feedback	- 6%
Communication between senior management and staff is effective	- 5%
Satisfied with opportunities for flexible working patterns	- 4%

Areas of Improvement from Previous Year (CWP to CWP)

The following results are taken from our internal report comparing this year's results with the previous year.

Most improved from last survey		
2020	**+/- Since 2019**	**Question**
58%	+14%	Q11d. In last 3 months, have not come to work when not feeling well enough to perform duties
62%	+14%	Q4f. Have adequate materials, supplies and equipment to do my work
42%	+7%	Q9b. Communication between senior management and staff is effective
67%	+6%	Q16d. Staff given feedback about changes made in response to reported errors/near misses/incidents
37%	+6%	Q4g. Enough staff at organisation to do my job properly

Areas of Deterioration from Previous Year (CWP to CWP)

The following results are taken from our internal report comparing this year's results with the previous year.

Least improved from last survey		
2019	**+/- Since 2018**	**Question**

59%	-3%	Q11c. In last 12 months, have not felt unwell due to work related stress
91%	-3%	Q12d. Last experience of physical violence reported
62%	-3%	Q4i. Team members often meet to discuss the team's effectiveness
75%	-3%	Q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities
75%	-3%	Q4j. I receive the respect I deserve from my colleagues at work

Our Local Questions

For 2020, CWP's OD Team raised 7 additional local questions for staff to respond to. The questions were devised to specifically target key matters, identified throughout 2020, knowing that the answers would provide valuable local insights for the Trust to act upon. The questions and results are as follows:

If you witnessed discrimination in any form, how would you respond?	
a) I would feel comfortable to both challenge it appropriately and report it	59.4%
b) I would report it	29.8%
c) I would want to challenge/report it, but I'm not sure how	7.0%
d) I would keep out of it	0.9%
e) I'd rather not say	2.8%

CWP defines Person-centeredness as 'connecting with people as unique individuals with their own strengths, abilities, needs and goals in mind'. It is our aspiration to apply person-centred principles in everything we do. To what extent do you believe CWP works with a person-centred approach in everything we do?	
I strongly agree there is a Person-centred approach in everything CWP does	22.8%
I agree there is a Person-centred approach in most of what CWP does with room for improvement	59.5%
I am not sure what Person-centeredness means and would like to know more	2.6%
I disagree that CWP is Person-centred in everything it does, it doesn't apply to everything	12.9%
I strongly disagree that CWP is Person-Centred	2.1%

Based on your personal experience over the last 12 months, do you agree that CWP promotes a positive and supportive culture?	
Strongly disagree	4.0%
Disagree	7.1%
Neither agree nor disagree	27.2%
Agree	49.2%
Strongly Agree	12.6%

Are you aware that the Trust actively supports you to support your own health and wellbeing?	
Yes	91.0%
No	9.0%

Which of the following services/offers have you accessed in the last 12 months? Please select all that apply.	
CWP Coaching	2.8%
Annual Health & Wellbeing Events such as Mental Health Week, Know your Numbers	2.4%
Childcare voucher scheme	5.1%
Occupational Health Pathway via Workforce Wellbeing Service	14.7%
Fast track interim physiotherapy service via the MSK Pathway	6.1%
Psychological Wellbeing Pathway via Workforce Wellbeing Service (was formerly known as Staff Support)	11.5%
Freedom to Speak Up Guardians	1.4%
Mediation	1.1%
Healthy food provision	0.3%
Reduced gym memberships for NHS staff	7.7%
Free Flu Vaccination	74.4%
CWP Mentoring	3.1%
'Working Longer Living Life to the Full' 2 day course	4.2%
Cycle 2 Work Scheme	3.3%
Eyetest voucher scheme	10.1%
Staff Health Checks	5.2%
Display Screen Equipment Checks (Cardinus Assessments)	7.7%
Workforce Wellbeing Intranet Pages	14.4%
Resilience Workshops	1.7%
On-site Gym	3.0%
Recovery College Courses	1.4%

Based on your personal experience over the last 12 months, what are the 3 things that have significantly helped you to be the best you can be?
Approx. 2850 text responses entered by all participants – Currently being themed by OD Team and will be added as an appendix shortly

Based on your personal experience over the last 12 months, what are the 3 things that have significantly hindered you from being the best you can be?
Approx. 2850 text responses entered by all participants – Currently being themed by OD Team and will be added as an appendix shortly

Last Year's Agreed Trust-wide Priorities

The findings from the Staff Survey 2019 highlighted a number of priority areas that were to be focused on by the Trust throughout 2020. These were:

1. Improve senior manager visibility and engagement of staff in decision making and shaping service plans

2. Improve team effectiveness with a focus on relationships

3. Make better use of feedback from our people and those who use our services to inform decision making

4. Improve quality of appraisals and supervision

5. Support staff wellbeing, including capacity (time, energy and attention) and opportunities for flexible working

6. Build managerial capability (capacity, competence and confidence)

NOTE: While Organisational Development had worked to create an improved Care Group/Service Group Action Plan that would be implemented by each area of the Trust during 2020/21, the arrival of the COVID Pandemic and its longevity meant that the action plans were paused. Instead the Executive Team decided to implement 'Recovery & Restoration' plans as the Trust navigated its way through Business Continuity Plans and back into Business As Usual status.

However, initiatives were still developed throughout 2020 by Clinical Support Services that still addressed some of the Trust-wide Priorities.

Below shows the Trust-wide Priorities with their respective 2019 and 2020 Staff Survey results and where an improvement or deterioration has been observed. The average score from all the organisations Picker delivers the survey to have also been included to help us understand how we compare.

NOTE: Questions 22b, 22c, 19b, 19c, 19d, 19e were removed from the NHS Staff Survey by NHSE/I and therefore, we are not able to draw comparison as planned. This decision was apparently made in order to try and streamline the survey and make it quick and supportive for NHS staff as they confronted the COVID Pandemic.

2020 Trust-wide Priorities with attributing staff survey questions	2019	2020	CWP Variation +/-	2020 Picker Average
Improve senior manager visibility and engagement of staff in decision making and shaping service plans				
9 b) Communication between senior management and staff is effective	35%	42%	+7	47%
9 c) Senior Managers try to involve staff in important decisions	31%	34%	+3	41%
9 d) Senior managers act on staff feedback	30%	33%	+3	39%
Improve team effectiveness with a focus on relationships				
6 c) Relationships at work are unstrained	53%	54%	+1	53%
Make better use of feedback from our people and those who use our services to inform decision making				
22 b) Receive regular updates on patient/service user feedback in my directorate/department	54%	**Question Withdrawn By NHSE**	N/A	N/A
22 c) Feedback from patients/service users is used to make informed decisions within directorate/department	52%	**Question Withdrawn By NHSE**	N/A	N/A
Improve quality of appraisals and supervision				
19 b) Appraisals/review definitely helped me improve how I do my job	20%	**Question Withdrawn By NHSE**	N/A	N/A
19 c) Appraisals/performance review: Clear work objectives definitely agreed	31%	**Question Withdrawn By NHSE**	N/A	N/A
19 d) Appraisals/Performance review: Definitely left feeling work is valued	31%	**Question Withdrawn By NHSE**	N/A	N/A
19 e) Appraisals/Performance review: Organisational values definitely discussed	35%	**Question Withdrawn By NHSE**	N/A	N/A
Support staff wellbeing, including capacity (time, energy and attention) and opportunities for flexible working				
4 g) Enough staff at organisation to do my job properly	31%	37%	+6	39%
6 a) I have realistic time pressures	24%	28%	+4	25%
10 c) Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	42%	41%	-1	37%
11 a) Organisation definitely takes positive	35%	39%	+4	37%

action on health and Well-being				
11 g) Put myself under pressure to come to work when not feeling well enough	5%	6%	+1	6%
Build managerial capability (capacity, competence and confidence)				
8 c) Immediate manager gives clear feedback on my work	67%	68%	+1	70%
8 d) Immediate manager asks for my opinion before making decisions that affect my work	61%	63%	+2%	63%

2021 Trust Priority Areas

At the time of this report's creation, the Trust is yet to make a decision on how it will implement a set of Trust-wide Priorities based on the NHS Staff Survey and if it will utilise the Care/Service Group Action Plans (as was intended for 2020). In addition, the following large-scale Change Initiatives are also either planned for 2021 commencement or already in progress:

- NHS People Plan
- CWP Strategy and enabling strategies refresh
- Clinical Support Service Review Care Group Transformation Programmes

The findings of the Staff Survey will be used to inform the above initiatives.

From looking at the 2020 Staff Survey results, it is recommended that the following areas should be addressed in order to improve the current position and ultimately make CWP a better place to work, where staff feel a noticeable difference in their day-to-day experiences.

Priority and Associated Staff Survey Questions	**CWP 2020 Trust-wide Score %**	**Comparators Average %**
Be proactive and proud to continuously improve		
4 i) Team members often meet to discuss the team's effectiveness	62%	69%
6 a) I have realistic time pressures	28%	25%
Being 'Satisfied' is the minimum standard for our colleagues' experience at CWP		
5 a) Satisfied with recognition for good work	61%	63%
5 f) Satisfied with extent organisation values my work	51%	52%
18 c) Would recommend organisation as place to work	69%	66%
19 a) I don't often think about leaving this organisation	52%	49%

All our Managers are inclusive in how they engage with colleagues – Two-way communication is recognised as one of our essential standards		
8 d) Immediate manager asks for my opinion before making decisions that affect my work	63%	63%
9 b) Communication between senior management and staff is effective	42%	47%
9 c) Senior managers try to involve staff in important decisions	34%	40%
9 d) Senior managers act on staff feedback	33%	38%
We recognise our Wellbeing as our most precious resource and our Trust proactively supports its maintenance and growth too		
11 a) Organisation definitely takes positive action on health and well-being	39%	36%
11 c) In last 12 months, have not felt unwell due to work related stress	59%	56%
11 d) In last 3 months, have not come to work when not feeling well enough to perform duties	58%	54%
We will continue to develop a Culture that supports the right behaviours and offers a safe space for colleagues to be their best. We will seek to understand our differences and learn from our mistakes. We will challenge bad behaviour and offer zero tolerance toward discrimination and/or abuse anywhere it is found		
13 d) Last experience of harassment/bullying/abuse reported	62%	59%
16 a) Organisation treats staff involved in errors/near misses/incidents fairly	60%	59%
17 c) Would feel confident that organisation would address concerns about unsafe clinical practice	66%	63%

Monitoring arrangements

Based on the context described above under '2021 Trust Priority Areas', the Staff Survey 2020 results have been shared with Care Group and Clinical Support Services Associate Directors and Heads of Service via focused Data Packs. These packs demonstrate how the Clinical Support Services and Care Group's scores compare with newly identified Trust-wide Priorities and will also highlight areas of the Staff Survey that the Clinical Service and Care Group should consider acting upon as they move forward with their local restoration and recovery plans.

In addition to the above, and further drawing on the findings of the survey, a Trust-wide engagement programme is being planned under the banner of "Imaging the Future". This will focus on creating 'pen pictures' of the experience people can expect working or volunteering for CWP in various roles. These, in turn, will inform the development of the enabling strategies and a benchmark for future monitoring via the People and Organisational Development Sub-Committee with updates provided to Operational Committee and Trust Board.