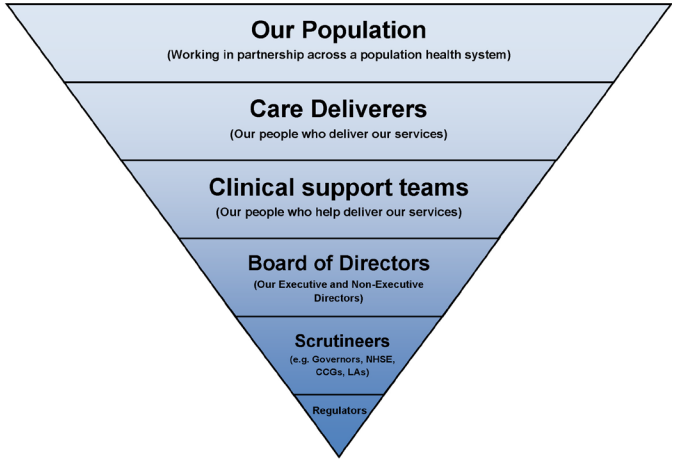
W1 Leadership	W2 Vision	W3 Culture	W4 Governance
W5 Risk	W6 Information	W7 Engagement	W8 Learning



NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

#cwpQI

Board of Directors *(held in Public)*

At 1:00pm on Wednesday 26th January 2022
Held Via Video Conferencing

Ref	Title of item	Well-led theme	Format	Presented by	Time
ASSURANCE					
21/22/23 - Meeting Governance					
21/22/23 a	Welcome, apologies and quoracy		Verbal	Chair	1:00 (5 mins)
21/22/23 b	Declarations of interest		Verbal		
21/22/23 c	Minutes of the previous meetings held 24th November 2021		Paper		
21/22/23 d	Matters arising and action schedule		Paper		
21/22/23 e	2021/22 Business cycle		Paper		
21/22/23 f	Chair's Announcements		Verbal		1:05 (10 mins)
21/22/23 g	Chief Executive's Announcements		Verbal	Chief Executive	1:15 (15 mins)
21/22/24 - Internal reporting from committees; matters of escalation and assurance					
21/22/24 a	**Operational Committee** • Chair's report from Operational Committee – December 2021 & January 2022 • To Include the following Highlight Reports:- o Monthly Safer Staffing Report o Safer Staffing – Six monthly report o Operational Committee Terms of Reference	W4 Governance W5 Risk	Paper	Director of Business and Value	1:30 (10 mins)

Ref	Title of item	Well-led theme	Format	Presented by	Time
21/22/24 b	**Quality Committee –** 5th January 2022 Committee - reducded meeting agenda. • Learning From Experience Report • Quality Improvement Report – E3 Sept-Dec 21	W4 Governance W5 Risk	Paper	Quality Committee Chair	1:40 (5 mins)
21/22/24 c	**Audit Committee** • Audit Committee Chairs Report - 11th January 2022 - Bribery Act Board Statement	W4 Governance W5 Risk	Paper	Audit Committee Chair	1:45 (10 mins)
21/22/24 d	**Board Assurance Framework & Report Against Strategic Objectives**	W4 Governance W5 Risk W6 Information	Paper	Chief Executive / Director of Business and Value	1:55 (10 mins)
Break – 2:05 – 2:15 (10 mins)					
21/22/25 – Enabling Our People					
21/22/25 a	**Freedom to Speak Up – six monthly report**	W3 Culture W5 Risk W7 Engagement W8 Learning	Paper	Director of Nursing, Therapies and Patient Partnerships	2:15 (15 mins)
21/22/25 b	**Guardian of Safe Working quarterly report**	W4 Governance W5 Risk	Paper	Medical Director	
21/22/26 - Any other business					
21/22/26 a	Any other business		Verbal	Chair/ All	2:30 (5 mins)
21/22/26 b	Matters for referral to any other groups				
21/22/26 c	Matters impacting on policy and/ or practice				
21/22/26 d	Review risk impact of items discussed				
21/22/26 e	Three things to communicate				
21/22/26 f	Review the effectiveness of today's meeting https://www.smartsurvey.co.uk/s/meetingeffectivenesssurvey/				
CLOSE [2:35pm]					
Date, time and venue of the next meeting: 30th March 2022. Time - TBC					

Version No	1	Date issued	

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

#cwpQI

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

At 1:00pm on Wednesday 24 November 2021
Via Video Conferencing

Present	Mike Maier	Chairman
	Andrea Campbell	Deputy Chair
	Rebecca Burke-Sharples	Non-Executive Director
	Farhad Ahmed	Non-Executive Director
	Elizabeth Harrison	Non-Executive Director
	Tim Welch	Chief Executive (Interim)
	David Harris	Director of People and OD (*for item 21.22.39a only)*
	Andy Styring	Director of Strategy and Partnerships
	Andy Harland	Director of Business and Value (Interim)
	Gary Flockhart	Director of Nursing, Therapies and Patient Partnership
	Suzanne Edwards	Director of Operations
	Dr Faouzi Alam	Joint Medical Director, Effectiveness, Medical Education and Medical Workforce & Caldicott Guardian
	Dr Anushta Sivananthan	Joint Medical Director, Quality, Compliance and Assurance
In attendance	Suzanne Christopher	Head of Corporate Affairs
	Katherine Wright	Associate Director of Communications, Engagement and Corporate Affairs
	Justin Pidcock	Associate Director Operations, Infrastructure
	Raj Purewa	Member of the Public
	Tim Seabrooke	Governor
	Isla Wilson	Incoming Chair
Apologies	Edward Jenner	Non-Executive Director

Ref	Title of item	Action
	Meeting governance	
21/22/17a	**Welcome, apologies and quoracy** The Chair welcomed all to the meeting. Apologies were noted as above. The meeting was confirmed as quorate. The Chair welcomed all those attending to observe the meeting, as detailed above.	
21/22/17b	**Declarations of interest** None	
21/22/17c	**Minutes of the previous meeting held 29 September 2021** The minutes of the meeting held on the 29 September 2021 were reviewed and **approved**.	
21/22/17d	**Matters arising and action points** None to review.	
21/22/17e	**2021/22 business cycle** The business cycle for 2021/22 was **noted**.	
21/22/17f	**Chair's announcements** M Maier provided the following updates;	

Ref	Title of item	Action
	Incoming Chair It was noted that Cheshire and Wirral Partnership NHS Foundation Trust had announced the appointment of a new chairperson at the Annual Members meeting held virtually on the 11th November 2021. Isla Wilson, current vice chair of the Lancashire and South Cumbria Integrated Care System, had been appointed and will take up her new position as Chair of CWP on 3rd January 2022, following the end of current Chair Mike Maier's term of office. Black History Month Through October, and in line with the Trust's commitment to Equality, Diversion and Inclusion, it was noted that CWP colleagues had supported Black History Month. To this end, Clifford Mukumbira, shared his story in a digital narrative entitled "Proud to be black and working at CWP". In the story he detailed some of the work taking place at CWP to ensure greater equality and diversity. In addition, Non-Executive Director, Farhad Ahmed had shared his thoughts on Black History Month in a special guest blog. Both the digital story and the blog are available on the CWP website. The Board of Directors **noted** the above updates.	
21/22/17g	**Chief Executive's announcements** T Welch introduced the item as the Interim Chief Executive Officer, stating that his pronouns are he, him and his. T Welch provided a summary of the items discussed within the private session of the Board of Directors: Patient Story The private Board of Directors commenced with a patient story that focused on Equality, Diversity and Inclusion. An informal session for Board members will be held on the 10th December 2021, to further reflect on Equality, Diversity and Inclusion matters, to consider CWP's approach and how best to support colleagues. Increased Pressures Current pressures on services were considered. It was noted that the needs of our populations are increasing. CWP needs to be able to respond accordingly to ensure continued quality service provision both in the community and within our bed-based services. Vaccination Programme An update was provided to Board members, acknowledging CWP as a lead orgnaisation to ensure the delivery of flu and covid booster vaccinations to the wider population. Supervision Compliance Compliance rates for supervision were reviewed to ensure support to our front-line staff and across the organisation was being provided as effectively as possible. Financial Performance A Harland as the Interim Director of Business and Value provided a presentation to Board members outlining financial performance for the	

Ref	Title of item	Action
	previous month and the financial plans for the second half of the financial year. Lead Provider Collaboratives Board members had received two presentations regarding the Tier 4 CAMHS and the Adult Eating Disorder LPC's. Board members considered how best to support both projects moving forwards. Equality, Diversity and Inclusion Annual Report It was noted that Board members had received the report at their previous meeting (October 2021). T Welch confirmed that the report was now published and available on the Trust website. The Board of Directors **noted** the summary.	
	Internal reporting from committees, matters of governance and assurance	
21/22/18a	**Operational Committee: Chair's Report of the Operational Committee held October & November 2021** T Welch introduced the item. It was noted that the chairs reports from both the October and November meetings had been included in the Board packs. These were accompanied by the monthly safer staffing report. T Welch reflected that the Committee had noted that data presented to the November Operational Committee appeared to reflect the current pressures on staff and teams. The Committee also took time to discuss and consider the Trusts Green Plan, which would be considered in more detail as part of this agenda. R Burke-Sharples queried the 72 hour follow up target. The report suggested that the current performance may not be fully reflected due to capacity to record the information. Further assurance was sought. S Edwards confirmed that a discussion took place at Operational Committee to further understand the underlying issues. It was noted that the follow-up forms part of the discharge process, and sufficient staff have been available to undertake this work, which is a priority for the Home Treatment Team. Operational Committee considered the current data issues and will continue to follow this through. A Sivananthan commented that the process for reporting such data will be improved by the implementation of the new patient records system, SystmOne. Staff training has been delivered and random record sampling is being undertaken by way of assurance. Thanks was offered to all those who had ensured the successful implementation of the system whilst also responding to the continued pandemic. Monthly Safer Staffing G Flockhart presented the reports to Board members. It was noted that staffing of inpatient wards had been significantly challenging during the pandemic. G Flockhart offered thanks on behalf of the Board of Directors for their continued support and commitment. It was noted how accommodating, supportive and flexible staff had been. The Board of Directors **noted** the Chair's reports.	
21/22/18b	**Quality Committee: Chair's Report of the Quality Committee held November 2021**	

Ref	Title of item	Action
	A Campbell presented the November Chairs report, which provided assurance to the Board of Directors regarding issues of quality, management of risk and progress against quality improvement targets. It was noted that the Quality Committee agendas had been restructured to take a thematic approach. Items for escalation would be considered as part of the Board Assurance Framework later on the agenda, concerning fire training compliance and workforce concerns. The recent inspection of Rosewood Ward was noted, and assurance was provided that the matter will be closely monitored by the Quality Committee. The Committee also received a presentation concerning the developing framework for clinical effectiveness. The framework is anticipated to significantly contribute to the level of assurance received by the Board of Directors on clinical effectiveness. The model will be presented to the Board of Directors at a future meeting once it is further developed. Community Treatment Orders were also considered at the recent Quality Committee. The challenges to continue such orders in the best interests of the patient were noted. Two research papers were presented that reflected the situation from two different perspectives. The Quality Committee chair noted that a number of presentations had been received at the November meeting that were inspiring and demonstrated the positive contribution that CWP continues to make to enhance the experience of its local communities. M Maier commented on the LEVEN report, noting its quality and positiveness. A Campbell noted that its position on the Quality Committee agenda had been reviewed, to ensure appropriate time could be dedicated to its review. Thanks was offered to Cathy Walsh and her team who had continued to provide services to the Trust throughout the pandemic. G Flockhart also recognised the participation of volunteers during the pandemic, who have continued to support activities such as our recruitment processes. It was noted that the approach to volunteering is currently under review and updates will be provided to the Quality Committee. The Board of Directors **noted** the Chair's report.	
21/22/18c	**Audit Committee: Minutes from the meetings held 9 November 2021** R Burke-Sharples introduced the item as the Deputy Chair of Audit Committee. It was noted that the Chairs report outlined the meeting held on the 11th November 2021. The following items were highlighted for escalation. The Committee considered future audit methods. It was noted that other trusts are now considering face to face audits once again. Audit Committee requested that consideration be given to site visits as part of the audit programme moving forwards. It was noted that Committee members had considered the current governance process to review and agree internal audit reports and	

Ref	Title of item	Action
	management responses. The terms of reference for Audit and Operational Committee will now be considered to ensure the process is as streamlined as possible. Consideration was given to the two risks currently in scope and the request from Quality Committee for these to be reviewed against each other was noted. Audit Committee considered the management of current risks and their place on the heat map. It was acknowledged that the response to the pandemic continues to impact across all risks. The Committee will seek further assurance of risk mitigation and progress. The Tender Waiver Update Report was noted by Committee members. It was reported that there had been an increase in the volume of Tender Waivers during the reporting period. This would continue to be monitored accordingly. The Board of Directors **noted** the Chair's report.	
21/22/18d	**Board assurance Framework & Report Against Strategic Objectives** A Sivananthan introduced the item, confirming that there were currently three red risks and six amber risks included on the strategic risk register. It was reported that a focus is now required on the two risks in scope, that both have a workforce element and impact on patient care. These risks also relate to the recent reports to the Operational Committee, including the monthly safer staffing report. The synergies between the second risk in scope and risk two were also noted, relating to capability and the delivery of service change. Quality Committee had suggested that the above risks be remodelled and requested that Board members note and approve this request. A discussion took place regarding people matters. The need for the Board of Directors to reflect on all of these matters as a whole to ensure colleagues were supported was noted. Board members recognised that this was an area of challenge for trusts across the sector. It was noted that alternative, more creative solutions would be required to move forwards. Embracing partnership working would also be paramount. Assurance was provided that the People Strategy, as part of the enabling strategies work, will provide a response to the Trusts Strategic Objectives regarding our People and will provide a framework within which to have structured conversations as a Board. As part of the enabling strategies work, CWP people will be involved to ensure the key areas are covered and well-being is supported. Advice and support is also being shared nationally to ensure trusts across the system are supported. Recent guidance is currently being reviewed. It was recognised that whilst indicators are pointing in the wrong direction, the current demand on people needs to be addressed. T Welch noted the need to combine all the strands of the people agenda to provide the organisation with a full understanding of how this work is progressing. The Board of Directors **approved** the Board Assurance Framework. <u>Report Against Strategic Objectives</u>	

Ref	Title of item	Action
	A Harland introduced the item. D Harris commented on the sickness absence data. It was noted that whilst CWP had recorded COVID related absence from the beginning of the pandemic, other trusts had not followed the same process. CWP continued to consider how best to assist and support people. R Burke-Sharples outlined the context of Duty of Candour and how this is undertaken when members of the family do not wish to be contacted by the organisation. G Flockhart agreed, and noted the efforts taken by CWP in the past to go over and above what is expected. G Flockhart agreed to consider the definition to ensure clarity moving forwards. T Welch noted that the report against strategic objectives was currently under review to ensure that the indicators aligned to the Trust's new strategic objectives. The above would be considered as part of that review and considered via Quality Committee. F Ahmed questioned current appraisal processes. D Harris clarified the appraisal cycles in place across the Trust, allowing a flow through of the strategic objectives, which had also been considered as part of the recent Operational Committee. The Board of Directors **noted** the reports and identified actions.	
	In Depth Discussion	
21/22/19a	**In Depth Discussion – Reducing inequalities** *A Harland left the meeting for this item due to an urgent matter.* *Justin Pidcock (Associate Director Operations, Infrastructure) joined the meeting.* S Edwards introduced the item that would consider the Trust's Green Plan. J Pidcock then provided a presentation to Board that set out the journey to date, outlining CWP's sustainability and transformation plan that had spanned the previous five years, and the Draft Green Plan that would now be taken forward. The presentation set out the plan against the NHS Long Term Plan and CWP's vision, values and strategic objectives. The plan outlined the Trust's goals and ambitions and the progress to be made. A report accompanied the presentation, and asked Board Members to discuss and approve the Green Plan as recommended by the Operational Committee. Further to the above, Board members held an in-depth discussion to consider the plans moving forwards. Board members considered a range of matters including, the thirteen areas of focus, the proposed addition of a sustainability manger, the impact of COVID, ease of access to improvements such as electric cars, our impact on our local communities, and central point care delivery. J Pidcock outlined the importance of investing in a sustainability lead to assist the organisation to continually review, update and evolve the plans moving forwards. It was also noted that reviewing governance arrangements to consider the addition of a sustainability committee, would also enable a clear focus and drive on this area of work. Board members considered how CWP may look to reduce car admissions, such as COVID secure care sharing, the introduction of electric cars as part of the CWP fleet of vehicles, how colleagues may be	

Ref	Title of item	Action
	supported to access electric cars to support their work, and facilitating access to charging points. Board members recognised the impact on our Communities in light of this work and acknowledged the overlap with the Enabling Strategies work through the Estates and Digital Strategies. A Campbell commented on the need to link with sustainability committees across the system to avoid duplication of work and ensure partners were closely linked to the achievement of this work. R Burke-Sharples queried how achievable the plans were against the backdrop of current advise to encourage NHS staff to return to their work base and future plans to consider new builds. It was suggested that consideration be given to new green ways of building, community interest groups, where and how food for the Trust is produced, and reviewing methods of identification to move away from plastic badges. A Sivananthan commented on the importance of the sustainability lead and the need to link into Place. It was noted that internally, matters of risk need to be appropriately escalated, with consideration of amending Trust templates to capture Green impact of proposals put forward, and considering Green Impact Assessments. It was also suggested how CWP estate could be used to create green energy through the use of windmills, solar panels etc., using the estate to refresh and renew. F Ahmed noted the links to well-being but recommend this be enhanced within the report (access to green areas, stress releasing benefits of nature for example). It was suggested that consideration be given to how CWP links with urban agricultural plans and food plans, collaborating with the local community. Procurement processes were also considered, and how this could be considered as part of our social impact and embedded into existing practices. Communication was recognised as key, to ensure the message across CWP and support reporting processes. T Welch thanked J Pidcock and his team for all their work to date, noting the importance of working with others to achieve success. T Welch also recognised the need for CWP to ensure the right emphasis, progress, energy and drive was maintained as part of this work. It was noted that Operational Committee had started to consider where this may fit within the current governance structure to ensure its correct profile and appropriate reporting mechanism to Board. The responsibilities were both organisational and personal, and the role of Board members is to set the conditions to allow this work to be successful. It was noted that CWP people need to feel a part of the plans to enable their full engagement. S Edwards thanked the Board of Directors for their comments, thoughts and ideas. It was noted that time would now be taken to reflect on those, consider internal governance arrangements and how CWP would also link with Place. It was agreed that further consideration would be given to governance and reporting arrangements and presented back to the Board of Directors at a later date. M Maier commented that the focus may change from costs to environmental costs / impacts. It was noted that this was the beginning	

Ref	Title of item	Action
	of something different that will become part of everything that we do. M Maier offered his thanks to all involved. The Board of Directors **noted** the discussion and **approved** the Green Plan and the introduction of a sustainability lead.	
	Enabling Our People	
21/22/20a	**Guardian of Safe Working quarterly report** F Alam introduced the quarterly report to the Board of Directors. It was noted that no concerns regarding safe practice or access to training and education had been raised during the reporting period and no fines had been levied against the Trust. Board of Directors **approved** the report.	
	Closing Business	
21/22/20a	**Any other business** None. The Chair invited questions or comments, in relation to the agenda items discussed, from the members of the public observing the meeting. Raj Purewa stated that he was a former colleague and had retired from the Trust a couple of years ago. Raj Purewa commented that he was very proud of what the Trust was doing and stated that the meeting had been excellent and effective, thanking the Board for their work. Tim Seabrooke noted the importance of maintaining momentum with the Green Plan proposals, with the right resources and energy to support its progress. Isla Wilson thanked the Board for an inspiring meeting and looked forward to joining them in the new year.	
21/22/20b	**Matters for referral to any other groups** None	
21/22/20c	**Matters impacting on policy and/ or practice** None	
21/22/20d	**Review risk impact of items discussed** None	
21/22/20e	**Three things to communicate** None	
21/22/20f	**Review of meeting performance**	
CLOSE		
Date, time and venue of the next meeting: 26 January 2021 at 13:00 / 13:30 - TBC		

Cheshire and Wirral Partnership NHS Foundation Trust
Open Actions Action Schedule

		Board of Directors: Open meeting action schedule: January 2022			
Meeting date	**Group/ Ref**	**Action**	**By Whom**	**By when**	**Status**

NHS
Cheshire and Wirral Partnership
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* 7. *Learning from Experience Report, incl. learning from deaths* ***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 &7	✓ 1	✓ 5&7	✓ 2	✓ 4&3&7	✓
	Audit Committee Chairs Report 1. *Bribery Act – Board Statement – annual review*	AC Chair	Review Chair's Report and any matters for note/ escalation	W4 W5	✓	✓	✓	✓	✓ 1	✓

	Operational Committee Chairs Report To include:- *1. Monthly safer staffing* *2. Health and Safety and Fire annual report (and LINK Certification)* *3. PLACE* *4. DPST/GDPR* *5. Capital Plan* ***All above reports to be accompanied by a Highlight report.***	OC Chair	Review Chair's Report and any matters for note/ escalation	W4 W5	✓ 1&4	✓ 1&2	✓ 1&3	✓ 1	✓ 1&5	✓ 1
	Place Based reports / updates including ICP Board/s (minutes)	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. – including Annual Equality, Diversity, and Inclusion Monitoring Report.	GF	Review and note for assurance	W7			✓ (Annual Report)			✓
	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		✓		✓		✓
	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**

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED CHAIR'S REPORT

CHAIR'S REPORT DETAILS	
Name of meeting:	Operational Committee
Chair of meeting:	Tim Welch
Date of meeting:	14/12/2021

ESCALATION

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

Continuous Improvement Performance Report

Due to the requirement to close CareNotes at the end of October to enable the migration of data to CWP's new electronic patient record, this month's report did not include patient activity details.

Supervision – rates for clinical supervision had improved from last month (70.2%) to 75.3%, as had management supervision rates which were 73.5% compared to those reported last month (68.3%). Both remained below the 85% target. Care groups gave assurance that teams were prioritising supervision for staff returning to the workplace and specific service areas are being identified for rapid improvement work.Staff appraisal – the Trust wide position had improved in month to 79.1% compared to 76% last month.

72 hour review – the SMH care group reported that performance had dropped to 72% (from 85%) which was under the compliance target of 95%. Heads of Clinical Services had identified a number of data validation errors that would significantly have improved performance. The SMH Business & Governance Group scheduled for January 2022 will receive an update and a recovery plan will be continuously monitored.

ASSURANCE

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

Other matters discussed that provide assurance

COVID 19 (Coronavirus Update): CWP's vaccination team continued to support the national mission to vaccinate as many people as possible. 95% of CWP staff had received their first vaccination, 92.1% had received there second vaccination, and 78.9% had received their third booster. The flu vaccination rate stood at 56.5%.

Fire evacuation training ward compliance – care groups reported on progress in this area and gave assurances around mitigations, in line with discussion at November Operational Committee.

Ward Staffing Monthly Update: The Committee received an update in relation to monthly ward staffing. Staffing levels continued to be a challenge across Care Groups due to the impact of the pandemic, but assurance was given that work was ongoing in relation to recruitment and retention.

Equality Act Compliance; the Committee received an update on the ongoing work around the Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES). A number of action plans were in place.

MIAA Report: Key Financial Systems: The Operational Committee received an internal audit report that gave 'high assurance'.

IMPROVEMENT

Developments/ achievements

• CANDDID has been approached to take on the editorial lead for the journal "Advances in Mental Health and Intellectual Disabilities".

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED CHAIR'S REPORT

CHAIR'S REPORT DETAILS	
Name of meeting:	Operational Committee
Chair of meeting:	Tim Welch
Date of meeting:	18/01/2022

ESCALATION

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

Continuous Improvement Performance Report - due to the migration of data to the new electronic patient record SystmOne, a temporary Cut Over Record system was put in place to record patient activity. The transfer of this data is not yet complete and therefore this report does not include patient activity detail:

- NHS Oversight Framework Targets – 2 fails in month
- Data Quality Maturity Index (DQMI) – 86.7% against a target of 95%. This is a data set score within MHSDS which is reported quarterly in arrears. This performance is for the month of September.
- Out of Area placements – there were 12 in month.
- Supervision – rates for clinical supervision have deteriorated from last month (75.3%) to 70.2%, as have management supervision rates which are 68.4% compared to those reported last month (73.5%). Both remain below the 85% target. All care groups reported on the impact of return to Business Continuity Planning Mode (BCP) in addressing improvements in this area. Assurance was given that regular forms of 'supervision' are taking place, often on a daily basis, as part of the Covid response but that further work is required to establish formal supervision sessions and reporting to achieve compliance.
- Staff appraisal – the Trust wide position has improved in month to 80.2% compared to 79.1% last month.
- Safeguarding 3 yearly training is below the 95% target. Performance for the month has declined to 88.5% from 89.9% reported last month.

72-hour review: Until SystmOne can capture this data, focused work is taking place to validate data locally including a targeted audit and linking with the Trust quality surveillance analysts.

ADHD Update: Needs stratification work continues, however the target completion date of February 2022 will need review in light of the operational impact of the Covid-19 pandemic / omicron variant.

Six monthly/monthly ward staffing report: Significant workforce challenges due to the operational impact of the Covid-19 pandemic / omicron variant, but also noted key areas of success with recruitment exercises.

Strategic risk register: Noted the nine strategic risks and discussed reviewing the scores for risks 2, 4 and 6.

ASSURANCE

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

Operational Committee Terms of Reference: Approved a change to the terms of reference to clarify the role of Operational Committee in relation to receiving audit reports, prior to approval at Audit/Quality Committee.

Other matters discussed that provide assurance

COVID 19 (Coronavirus Update): An update on the ongoing Trust response to the Covid-19 pandemic / omicron variant, including response to operational pressures and the booster vaccination/flu programme. Churton House became public facing to help increase capacity. The vaccination team continue to support with under-served communities such as the homeless population. Following the announcement of the national requirement for front line staff to be fully vaccinated by April 2022, a Task & Finish Group has been established.

Continuous Improvement Performance Report: Operational budget performance – overall CWP is reporting a £209k surplus against a £45k plan deficit position.

Capital Plan: Received assurance on the Trust's capital plan and supported ongoing monitoring of the programme within 21/22.

	MIAA report: stocks and stores management: Received the audit report which provided 'substantial assurance' and endorsed it going to Audit Committee. **People & OD:** Received assurance on a range of people forums that are continuing to ensure focus on people issues, despite the People and OD Sub-Committee meeting being postponed following the national 'reducing burden' guidance.

IMPROVEMENT	**Developments/ achievements**
	Developments: • Proposed that a paper on UNBRA (a tool used by LD to map inpatient staffing resource) is taken to a CELF session and then CPS/ Ops as a proposal if appropriate. **Achievements:** • Ancora House has achieved autism accreditation. • Specialist Mental Health Care Group has commenced engagement session with service users, carers and partners regarding the specialist mental health community redesign with positive feedback received. • The neighbourhood care group has successfully launched the new Neutralising Monoclonal Antibodies Service in West Cheshire. • LD care group colleagues are presenting this month at a national conference on *Improving the Quality of Care for Patients with Learning Disabilities in Healthcare Settings.*

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED HIGHLIGHT/ EXCEPTION REPORT

REPORT DETAILS	
Subject matter of report:	Inpatient Daily Staffing Levels November 2021
Report provided by:	Hayley McGowan, Associate Director of Nursing and Therapies
Date of report:	18/01/2022

SUBJECT MATTER

Summarise the purpose of the report:

This report details the ward daily staffing levels during November 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 the actions that are being taken to try to ensure patient safety is being maintained in the continued context of the impact of COVID-19.

The monthly reporting of daily staffing levels is a requirement of NHS England/Improvement and the National Quality Board in order to appraise the Board and the public of staffing levels within inpatient units.

The recommendations made within the latest six monthly reports are being taken forward in line with the ongoing COVID-19 response and continued development of the Transformation plans and new models of care being implemented across all care groups that provide inpatient services.

ESCALATION

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

Greenways continued to experience significant staffing challenges in relation to registered nurses and clinical support workers and continued to operate within their Business Continuity Plans, remaining closed to admissions. Staff from Eastway and Community Learning Disability Teams continued to be redeployed to support the unit and staff from other inpatient units in the locality have provided support as required. Temporary staff have also been utilised where available. Members of the wider multidisciplinary team, including psychology staff and the matron continue to work within the staffing numbers as required to support the maintenance of core clinical interventions. As part of the Business Continuity Plan both Greenways and Eastway continued to be closed to admissions to ensure the available staffing resource can support the level of acuity and dependency of the individuals currently admitted to the units.

Coral and Indigo also continued to experience significant staffing challenges due to reduced staffing capacity resulting from vacancies that have been filled but are awaiting staff to commence in post and unplanned absence. As part of the Business Continuity Plan for the unit 4 beds remained closed to admission. Staff were redeployed across the unit to support maintenance of minimum staffing levels on a shift by shift basis with staff from the care group and wider multidisciplinary teams providing support as required. A high number of temporary staff were utilised throughout the month to maintain minimum safe staffing

The Specialist Mental Health Care Group continued to enact elements of their Business Continuity Plan throughout November in response to challenges relating to reduced staffing capacity resulting from vacancies and sickness absence. Willow Ward at Bowmere re-opened part way through the month which is reflected in the partial fill rates reported for this period. Bowmere continued to experience significant staffing challenges, with staff from other inpatient services in the locality redeployed on a shift by shift basis and members of the leadership team and the wider multidisciplinary team providing support to the wards to cover core clinical interventions. In the East and Wirral localities cross cover was provided between wards on a shift by shift basis. The registered nursing numbers on some units continued to be reduced to a minimum of one at night and support was provided from other inpatient areas across the unit/locality with additional clinical support worker resources deployed where available. Riverwood ward at Springview continued to be supported by redeployment of staff from other wards within the unit to provide support whilst recruitment into vacant posts continued. A high number of temporary bank and agency staff were also utilised across all localities during this period.

ASSURANCE

Other key matters to highlight:

During November 2021 the trust achieved average staffing levels of 95.8% for registered nurses and 93.7% for clinical support workers on day shifts and 94.9% and 98.2% respectively on night shifts, which was an increase overall in comparison to October. All inpatient areas continued to experience significant challenges in order to ensure minimum safe staffing levels could be maintained and relied on staff from clinical and non clinical areas being redeployed to support this.

#cwpQI

		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	841.50	796.50	1661.00	1531.00	688.50	688.50	701.50	701.50	94.7%	92.2%	100.0%	100.0%
	Greenways A&T	1162.25	1169.75	1726.00	1372.25	690.00	714.00	1380.00	1108.25	100.6%	79.5%	103.5%	80.3%
	Mulberry	1360.50	1251.50	2047.00	1946.00	690.00	681.00	2081.50	1989.50	92.0%	95.1%	98.7%	95.6%
	Silk	1257.50	1246.00	2069.45	1942.45	690.00	690.00	2282.50	2144.50	99.1%	93.9%	100.0%	94.0%
	Saddlebridge	1050.50	949.00	1542.00	1510.50	690.00	655.50	736.00	770.50	90.3%	98.0%	95.0%	104.7%
Wirral	Brackendale	886.00	948.00	1190.50	1090.50	559.50	544.00	931.50	881.00	107.0%	91.6%	97.2%	94.6%
	Brooklands	724.00	756.50	1723.00	1586.50	597.50	606.00	1379.00	1432.50	104.5%	92.1%	101.4%	103.9%
	Lakefield	881.00	912.50	1128.50	1153.00	570.50	593.00	933.50	996.30	103.6%	102.2%	103.9%	106.7%
	Meadowbank	862.00	843.50	1573.00	1544.00	471.50	457.50	989.00	1033.50	97.9%	98.2%	97.0%	104.5%
	Riverwood	835.00	933.50	952.60	999.50	311.00	323.50	1023.50	989.00	111.8%	104.9%	104.0%	96.6%
	Oaktrees	1112.00	1107.35	1509.50	1455.00	563.50	514.50	428.50	465.50	99.6%	96.4%	91.3%	108.6%
West	Willow PICU	492.50	349.50	552.00	368.00	368.00	172.50	368.00	368.00	71.0%	66.7%	46.9%	100.0%
	Beech	1198.50	1118.00	1502.90	1482.90	770.50	716.50	1035.00	943.00	93.3%	98.7%	93.0%	91.1%
	Cherry	937.50	921.00	1462.50	1351.50	448.50	454.00	1031.50	1021.00	98.2%	92.4%	101.2%	99.0%
	Coral	1230.00	1034.50	1943.50	1949.00	832.00	726.50	1932.00	1890.50	84.1%	100.3%	87.3%	97.9%
	Eastway A&T	1247.50	1197.60	1582.60	1462.50	860.30	868.40	1157.30	1109.85	96.0%	92.4%	100.9%	95.9%
	Indigo	975.50	810.50	1601.50	1604.00	690.00	574.00	1460.50	1420.50	83.1%	100.2%	83.2%	97.3%
	Juniper	766.50	743.50	1359.50	1325.00	539.50	516.50	908.00	862.00	97.0%	97.5%	95.7%	94.9%
	Rosewood Unit	1110.50	1038.00	1702.00	1485.00	552.00	565.90	1053.50	1007.00	93.5%	87.3%	102.5%	95.6%
	Maple Unit	1006.00	986.00	1123.50	1074.50	425.50	408.50	793.50	820.50	98.0%	95.6%	96.0%	103.4%
	Trustwide	19936.75	19112.70	29952.55	28233.10	12008.30	11470.30	22605.80	21954.40	95.8%	93.7%	94.9%	98.2%

STANDARDISED HIGHLIGHT/ EXCEPTION REPORT

NHS Cheshire and Wirral Partnership NHS Foundation Trust

REPORT DETAILS	
Subject matter of report:	Safer staffing six monthly report June 2021 to November 2021
Report provided by:	Hayley McGowan, Associate Director of Nursing and Therapies
Date of report:	19/01/2022

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

Summarise the purpose of the report:

This report provides an overview of the work undertaken to maintain safer staffing by all services within the Trust during the reporting period. This is in addition to monthly fill rates for inpatient services that are reported to the Trust Board. The report focuses on how services continue to work towards having the right staff, with the right skills, at the right time and place in order to provide evidence regarding the Trust's capacity and capability to provide high quality care via safer staffing during the implementation of business continuity plans in the ongoing context of Covid-19. Link to full report.

ESCALATION
What do you need to escalate to the Committee?

All services have continued to work flexibly and creatively in order to respond to the ongoing challenges associated with Covid-19 and maintain minimum safe staffing levels to continue to provide accessible services and respond to increasing demands.

All services have continued to be impacted by recruitment challenges and the effects of covid related absence which continues to affect staff wellbeing and morale. This has impacted on staffing fill rates across inpatient services throughout the reporting period which has resulted in all care groups invoking Business Continuity Plans during this period in order to ensure safe inpatient service provision could be maintained.

The MHOST has been completed for the second time across mental health and children and young people's inpatient services during this reporting period to review staffing requirements for each area against funded establishments based on dependency levels of the people supported within inpatient settings during the data collection period. The results of the MHOST will be reviewed as part of the transformation programmes being undertaken within the care groups to inform future workforce plans for inpatient services. The review of funded headroom continues to be progressed for all inpatient services.

Recruitment of registered mental health and learning disability nurses and health visitors continues to be a particular challenge across care groups which is reflective of the national position.

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

Other key matters to highlight:

In addition to continuing to respond to the challenges of Covid-19 all care groups continue to progress with transformation and service development programmes in order to support the development of a sustainable service offer for the future based upon national and local drivers.

Care Groups are working in partnership with Higher Education Institutes to develop education programmes to support continuing professional development (CPD) in line with the skill requirements of the emerging models of care.

Health Education England CPD funding is being utilised to enable practitioners to access a range of opportunities to consolidate and expand their skills and knowledge to improve their practice.

New roles continue to be developed across Care Groups in order to support delivery of different models of care and provide opportunities for career progression for staff from a range of professional backgrounds.

Workforce wellbeing continues to be a priority across all teams with a range of approaches being utilised to ensure staff are able to access effective support.

Ancora House has successfully achieved Autism Accreditation during this reporting period

During this period the People Planning Group has been re-established in response to the workforce challenges that are being experienced across the Trust reflecting the regional and national position. As part of this group a number of workstreams have been established including Recruitment, Retention and Workforce Planning in order to take forward initiatives and improvements at scale and pace. All of the workstreams are being mobilised by both Corporate Support and Operational Services linking in to regional and national work streams where appropriate.

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

OPERATIONAL COMMITTEE

TERMS OF REFERENCE

1. Constitution

The Board of Directors hereby resolves to establish a committee to be known as the Operational Committee.

2. Duties

The Operational Committee is responsible for ensuring that governance, assurance and improvement systems operate effectively and thereby underpin clinical care:

Assurance
Receiving assurance on performance through the lens of:

- People
- Clinical services
- Clinical support services
- Finance

Improvement
Overseeing delivery of strategic priorities as described in the CWP Forward View, in order to assure the Board of Directors that there is sustainable leadership, governance and improvement capability to deliver better outcomes for populations the Trust serves.

Operational Committee is the formal route to support the Chief Executive in effectively discharging their responsibilities as Accountable Officer.

The agenda for Operational Committee meetings will be structured to allow time for strategic debate and discussion of current and future issues affecting the Trust and the wider health care system.

The Operational Committee's duties can be categorised as:

Assurance

a) Oversight of the development of Trust strategy and delivery of strategic change through the development, completion, and delivery of the Operational Plan and Strategic Plan, in accordance with regulatory requirements and to respond to the external context. This includes:
   - Ensuring that staff are kept up to date on Trustwide issues.
   - Advice on the early development of strategy and business case proposals.
   - Development of risk mitigation plans to strategic delivery

b) Receiving assurance on:
   - organisational strategic change
   - finance and use of resources
   - operational performance, and
   - leadership and improvement capability (well-led) – aligned to the national "NHS Oversight Framework". This will include monitoring of the Trust's performance against key targets, business plans, Care Quality Commission and other corporate objectives.

c) Oversight of Care Group operational (including clinical and financial) risks in line with the integrated governance framework.

d) Receiving recommendations from Care Groups for Operational Committee approval regarding investment decisions.

e) Reviewing financial plans (including the capital plan) and to monitor the financial performance and efficiency of the Trust.

f) Ensuring that equality and diversity issues are continually considered and addressed throughout the work of the Operational Committee (seeking advice and expertise from the People & Organisational Development Sub-Committee and the Patient and Carer Experience Sub-Committee, as necessary).

g) Ensuring that decisions of the Board of Directors associated with the business of the Operational Committee are communicated and implemented.

h) Approving the terms of reference and membership of its reporting sub committees and overseeing the work of those sub committees, receiving reports from them for consideration and action as necessary and routinely receiving Chair's reports of their meetings. These meetings are:

- Contract Management and Development Sub Committee
- Infrastructure Sub Committee
- Information Governance & Data Protection Sub Committee
- Health & Safety Sub Committee
- Emergency Planning Sub Committee
- People & Organisational Development Sub Committee

Improvement

i) Debate and discussion of strategic issues affecting the Trust and the wider health economy, identifying improvement plans to facilitate delivery of the CWP Forward View.

j) Sustaining and improving the operational performance of the Trust through receipt and monitoring of improvement plans in response to exceptions highlighted in the performance dashboard and through review of the Programme Support Office monthly report.

k) Receiving risks referred from the Quality Committee relating to serious incident management processes and putting in place mitigation plans/ quality improvement initiatives.

l) Monitoring and ensuring delivery of the Trust efficiency plans.

m) Receiving internal audit reports for review of the findings and the management responses identified in relation to areas requiring improvement, referring the ~~approved~~ reports to the Audit and Quality Committees.

n) Advising on planning and change management initiatives.

o) Consideration of issues arising from the Clinical Engagement & Leadership Forum.

3. Membership

Membership will be appointed by the Board of Directors and will consist of the following:

i. Chief Executive (Chair)
ii. Executive Directors (one of whom shall be Vice Chair)
iii. Strategic Clinical Directors
iv. Associate Directors of Operations
v. Heads of Operations
vi. Associate Directors
vii. Staff Side Representative

The Board of Directors will appoint the Chief Executive as Chair of the Operational Committee and the Deputy Chief Executive as its Vice Chair. The Vice Chair will automatically assume the authority of the Chair should the former be absent. Should both the Chair and the Vice Chair be absent, the role of Chair will be undertaken by a nominated Executive Director.

a. Quorum
A quorum shall be two Executive Directors and at least one representative of each Care Group.

b. Voting
Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary, a decision will be determined by a simple majority.

c. Attendance by members
Committee members will be required to attend a minimum of 50% of all meetings in-year, this is in addition to the requirement to ensure that a nominated deputy attends.

d. Attendance by officers
Officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.

4. Accountability and Reporting Arrangements

The Operational Committee will be accountable to the Board of Directors.

The Chair's report of the Operational Committee will be submitted to the Board of Directors. The Chair of the Operational Committee shall draw to the attention of the Board of Directors any issues that require disclosure to it, or require executive action.

The Chair's report will also be circulated to the Audit Committee and Quality Committee for information.

Members of the Operational Committee will provide reports to the Audit Committee on assurances relating to the effective operation of controls and in the event of a significant risk arising, the risk will be reported as per the Trust's integrated governance framework and risk management processes.

5. Frequency

Meetings shall be held monthly (with the exception of August) and additional meetings may be arranged from time to time, as and when required, to support the effective functioning of the Trust.

6. Authority

The Operational Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any reasonable request made by the Operational Committee.

The Operational Committee is authorised to obtain legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

7. Monitoring effectiveness

The Operational Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.

8. Administration

The Committee shall be supported administratively by a member of the Corporate Affairs / Board Support Team, whose duties in this respect will include:

- Agreement of the agenda with the Chair
- Collation and review of reports
- Distribution of agenda and reports to members in accordance with the Trust's corporate governance standards
- Taking the minutes of the meeting
- Preparing a record of actions
- Advising the Committee on pertinent areas

9. Review

These Terms of Reference will be reviewed at least annually.

Date reviewed by Operational Committee	May 2020
Review date	May 2021

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED CHAIR'S REPORT

CHAIR'S REPORT DETAILS	
Name of meeting:	Quality Committee (assurance meeting)
Chair of meeting:	Andrea Campbell, Non-Executive Director
Date of meeting:	05/01/2022

Due to escalation in operational pressures, this meeting was held in the absence of the usual quorum and was a focussed meeting to seek assurance around quality critical matters from the executive leads for the patient safety, clinical effective and patient experience domains of quality and the associate director of safe services.

ESCALATION

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

- A second extension to the timeline for completing the regulatory actions concerning the provision of ADHD services will be required, due to operational pressures (and the capacity/ time required) impacting on the completion of needs stratification for all people on the wait list. The CQC will need to apply their judgement framework to determine next steps, given the progress made has not met that which was planned. The Board should be aware of the potential risk for re-inspection and consequent action. However, it is anticipated, in line their commitment to taking an appropriate and proportionate approach, that the most likely action is that the CQC will request progress assurance, noting the volatile impacts of the pandemic.
- In reviewing the strategic risk register, it was recommended (and endorsed by the executive leads present) that the risk scores for strategic risks #2 (transformation agenda) and #4 (impact of the COVID-19 pandemic) be amended, with strategic risk #2 being scored Red (20) with a reduced likelihood score of 4, and strategic risk #4 being scored Red (20) with an increased consequence score of 5.

ASSURANCE

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

Review of the following reports, with the assurance meeting recommending approval by the Board of the:

- Quality Improvement report (Edition 3; September – December 2021)
- Learning from Experience report (August – November 2021)

Review of the Providing High Quality Care dashboard report, providing assurance that, as per the request at the last Quality Committee, subject matter experts have reviewed the relevance of the measures and added appropriate benchmarks; this is to ensure future quality assurance can identify outliers where this is less clear by looking only at CWP's longitudinal performance. In terms of outliers, assurance was provided around:

- Review of the ambition for prone position restraint – the executive lead and subject matter expert will review the measures 'to reduce the number of prone position restraints' and 'to have zero incidents of prolonged prone position restraint' to ensure that it is clear that, overall, there is a zero aspiration concerning this restrictive practice. For the next report, assurance will also be sought that post restraint reviews (for all physical restraints) are taking place in order to identify learning and improvement.
- Seeking to understand the atypical October 2021 dip in performance to 50% (target 60%) around those with first episode psychosis accessing treatment within two weeks – led by the Medical Director for Effectiveness.

Other matters discussed that provide assurance:

The Rosewood improvement plan, in response to identified themes/ concerns/ incidents and the CQC lines of enquiry from their unannounced inspection of Rosewood on 17 August 2021, is progressing. Lead Patient Safety Specialist from Safe Services has visited the ward to review the plan and provided assurance around progress with the regulatory actions. The Board is asked to note that the regulatory action plan has been submitted to the CQC with a timeframe for completion of 25 March 2022. The Board is also asked to take assurance around progress being made; routine reports and escalation will continue to be provided to Operational Committee via the Care Group risk register.

IMPROVEMENT

Developments/ achievements:

- Each Care Group has identified leads to co-ordinate their submissions of the Green Light Toolkit (GLT) audit; progress with demonstrating performance against the 'Better' and 'Best' audit standards, through improvement activities, has been demonstrated. The Learning Disability Improvement Standards are being mapped to the GLT to strengthen implementation of both, and to streamline the work to help reduce the burden for Care Groups; implementation of these standards is a contractual requirement across all Care Groups. NHS Benchmarking has moved the data collection period for this requirement to 7 March 2022.
- Highlighted in the Quality Improvement report, the Board is asked to commend the continuing demonstration of co-delivery with people accessing CWP's services, improved outcomes, and the high numbers and quality of compliments received during and despite the challenging times posed by the response to the pandemic. Taken together as a suite, the Quality Improvement, Learning from Experience and Providing High Quality Care dashboard reports are providing robust assurance around care and quality impacts and delivery.

Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED HIGHLIGHT/ EXCEPTION REPORT

REPORT DETAILS	
Subject matter of report:	Learning From Experience
Report provided by:	Gary Flockhart Director of Nursing, Therapies and Patient Partnerships
Date of report:	13/01/2022

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

Summarise the purpose of the report:

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

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

ESCALATION
What do you need to escalate to the Committee?

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

Quality Committee approved all recommendations in the Learning From Trimester 2 report.

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

Other key matters to highlight:

The report highlights that self-harm continues to be the category with the highest number of incidents reported overall, however, the reduction of self-harm incidents reported in trimester 3 20/21 and trimester 1 21/22 has been maintained during this trimester.

1608 incidents were uploaded onto NRLS. This is a 19% increase on last Trimester. It was identified that not all patient safety incidents were being recognised as a patient safety incident (historical practice) and therefore not uploaded onto the NRLS system. This has been rectified and submission is being monitored on a fortnightly basis by the Patient Safety Incident Lead.

The trust has successfully reduced the number of reviews that have not been concluded within 60 days and as at the end of December this has been reduced to 14 reviews as not concluding

A Regulation 28, was issued to the trust and partner organisations. A letter of response has been sent to the HM Coroner and was shared with the Clinical Commissioning Group.

101 complaints closed. The complaints team offer support to people to help resolve their concerns with the clinical service or PALS before commencing a complaints investigation. This trimester

there were 37 out of 101 (37%) closed complaints which were withdrawn following local resolution with clinical services and PALS. Complaint investigations have concluded for the remaining 68 closed complaints: 10 were upheld, 23 were partially upheld and 30 were not upheld.

The Learning from Deaths Group has established the Mortality Review Working Group and work has commenced. The Trust had completed 100% of case record review during this trimester.

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 January 2022

(ESCALATION)

Quality, clinical care, other risks identified that require escalation

Items to be noted/escalated to Board of Directors

Bribery Act Compliance Review
Committee members reviewed the Bribery Act Compliance Report and noted the refreshed training that will be provided to the Board of Directors via a workshop.

Anti-Fraud & Bribery Update
Committee members received an update report and sought assurance regarding the oversight and management of fraud and bribery at a system level as the Structure of the NHS evolved and develops.

Serious Incident Review Audit
Committee members discussed the report and noted the steps taken since the report was finalised. Welcomed feedback was given from the Chair of the SIRM.

(ASSURANCE)

Matters discussed/decision:

Internal Audit Plan
The MIAA Progress Report Included:

- 2021 Audit Reviews
- Details of forthcoming events and Collaborative Masterclass Event
- The final copy of the Serious Incident Review was discussed by Audit Committee members

External Audit
Draft External Audit Plan
A verbal discussion took place regarding the timeline of the Draft External Audit Plan. Expecting the Draft Plan to be brought to the March 2022 Audit Committee meeting.

Progress Report and Sector Update:

- The Progress Report provided the Audit Committee with an update on progress in delivering their responsibilities
- Sector Update included invites to workshops that are available for Finance Teams to join

Anti-Fraud Progress Report

- The Progress Report noted the work that has been undertaken in the last quarter.

To:	Trust Board
From:	Tim Welch, Director of Business and Value
Date:	26.01.2022
Re:	Bribery Act 2010 & Trust Anti-Bribery Strategy

1. Introduction and Background

1.1. The Bribery Act 2010, which came into force on the 1st July 2011, reformed the criminal law of bribery, making it easier to tackle this offence proactively in the public and private sectors. In addition to the main offences under Sections 1, 2 and 6 of the Act, which carry custodial sentences of up to 10 years and potentially unlimited fines, it introduced a corporate offence (under Section 7), exposing commercial organisations to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

1.2. Any organisation that is incorporated under the law in the United Kingdom falls under Section 7 of the Act. NHS bodies such as CCGs, NHS trusts, foundation trusts, and special health authorities are all deemed to be relevant corporate bodies. Applicable organisations must ensure 'adequate preventative procedures' are in place for acts of bribery and corruption committed by 'persons associated' with them, in the course of their work, or else the organisation will become liable.

1.3. 'Persons associated' can mean employees, temporary and agency personnel, contractors, agents, suppliers, partners and Joint Ventures, as well as other individuals or organisations (whether incorporated or not) that may provide a service.

1.4. For the purposes of the Bribery Act, a 'trade' or 'profession' is considered a business. This means that, whether individually or in partnership, GPs, pharmacists, dental practitioners, opticians, finance professionals etc. will also be subject to, and personally liable under, the Bribery Act.

2. Definition

2.1. Bribery is generally defined as an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage, on behalf of oneself or another.

3. Risks of Non-Compliance

3.1. There are a number of risks entailed in breaching the Bribery Act. These include:

3.1.1. Criminal justice sanctions against directors, board members and other senior staff (under Section 14);

3.1.2. Damage to the organisation's reputation;

3.1.3. Conviction of bribery or corruption may lead to the organisation being precluded from future public procurement contracts. *[Under the Public Contracts Regulations 2006, a company is automatically and perpetually debarred from competing for public contracts where it is convicted of a corruption offence. There are no current plans to amend the 2006 Regulations for this to include the crime of failure to prevent bribery. Organisations which are convicted of failing to prevent bribery are not automatically barred from participating in tenders for public contracts; however, there is discretion to exclude organisations convicted of this offence if it is deemed appropriate.]*

3.1.4. Potential diversion and/or loss of resources;

3.1.5. Unforeseen and unbudgeted costs of investigations and/or defence of any legal action;

3.1.6. Negative impact on patient/stakeholder perceptions.

4. Bribery Act Offences

4.1. In summary, there are four key offences under the Act:

4.1.1. **Section 1** - Offering, promising, or giving a bribe to another person to perform a relevant 'function or activity' improperly, or to reward a person for the improper performance of such a function or activity.

4.1.2. **Section 2** - Requesting, agreeing to receive or accepting a bribe to perform a function or activity improperly, irrespective of whether the recipient of the bribe requests or receives it directly or through a third party, and irrespective of whether it is for the recipient's benefit.

4.1.3. **Section 6** - Bribing a foreign public official (probably of limited applicability to most NHS organisations/ staff).

4.1.4. **Section 7** - Failure of a commercial organisation to prevent bribery (the corporate offence). This is a 'strict liability'* offence and an organisation can be found guilty of 'attempted' or 'actual' bribery on the organisation's behalf, even if the organisation and its officers were not aware of the bribery itself. It should be noted that a corresponding Section 1 or Section 6 offence needs to be proven for a section 7 offence to apply.

** Strict liability offences do not require proof of intention or recklessness – in other words, it is not necessary for the prosecution to show that the organisation intended to make the bribe in bad faith, or that it was negligent as to whether any bribery activity took place.*

4.2. An organisation has a defence to the corporate offence if it can show that it had in place 'adequate procedures' as part of a cohesive and integrated corporate Anti-Bribery Strategy designed to prevent bribery by, or of, persons associated with the organisation.

5. Adequate Procedures

5.1. The Act is not prescriptive as to what constitutes 'adequate procedures', although both the Ministry of Justice (MoJ) and the NHS Counter Fraud Authority have provided guidance as to what form these procedures might take, depending on the nature, size and type of organisation. Adequate procedures need to be applied proportionally, based on the level of risk of bribery across the organisation, and form part of an NHS body's overall governance arrangements.

5.2. Adequate procedures relate to relevant compliance protocols and transparent procedures and measures which an organisation can put in place to prevent bribery by individuals associated with it. These might include training, briefings or new internal controls and procedures. Whether the procedures are adequate will ultimately be a matter for the courts to decide on a case-by-case basis.

5.3. The MoJ suggests that an effective Anti-Bribery Strategy framework could be informed by six principles:

5.3.1. **Principle 1 - Proportionate Procedures.** An organisation's procedures to prevent bribery by persons associated with it are proportionate to the bribery risks it faces and to the nature, scale and complexity of the organisation's activities. They are also clear, practical, accessible, effectively implemented and enforced.

5.3.2. **Principle 2 - Top-Level Commitment.** The top-level management of an organisation (be it a board of directors, the owners or any other equivalent body or person) are committed to preventing bribery by persons associated with it. They foster a culture within the organisation in which bribery is never acceptable.

5.3.3. **Principle 3 - Risk Assessment.** The organisation assesses the nature and extent of its exposure to potential external and internal risks of bribery on its behalf by persons associated with it. The assessment is periodic, informed and documented.

5.3.4. **Principle 4 - Due Diligence.** The organisation applies due diligence procedures, taking a proportionate and risk-based approach, in respect of persons who perform or will perform services for or on behalf of the organisation, in order to mitigate identified bribery risks.

5.3.5. **Principle 5 - Communication (inc. Training).** The organisation seeks to ensure that its bribery prevention policies and procedures are embedded and understood throughout the organisation via internal and external communication, including training, which is proportionate to the risks faced

5.3.6. **Principle 6 - Monitoring & Review.** The organisation monitors and reviews procedures designed to prevent bribery by persons associated with it and makes improvements where necessary. It considers independent assessment and/or certification of its arrangements.

6. Existing Counter Measures & Action Required

6.1. Bribery should be seen as another business risk to the organisation and should be treated accordingly. It is the responsibility of everyone in the organisation playing their part to ensure both the likelihood of bribery occurring, and its adverse impact if it does, are kept to an absolute minimum. However, as with the anti-fraud strategy, the implementation of an anti-bribery agenda backed by a zero-tolerance culture should be driven from the very top of the organisation, at Board level.

6.2. MIAA's Internal Audit (IA) and Anti-Fraud (AF) Services directly assist and support the Trust and its senior management with maintaining adequate procedures on an ongoing basis, primarily through existing IA and AF plans.

6.3. However, changes to the environment in which the Trust operates, such as the introduction of new legislation and global pandemics, as well as organisational and operational changes for the Trust over time, can result in alterations to risk exposure.

6.4. The most significant change to the Trust's operating environment in recent times is the COVID-19 global pandemic, which has affected all organisations, and the NHS in particular. It is therefore timely for the Trust to reflect on whether changes in recent years, particularly the response to the COVID-19 pandemic, have had any impact on the Trust's bribery risks, such as procuring PPE from non-typical sources and restricted procurement processes. Minimal changes to internal controls and working practices in key risk areas have occurred because of the pandemic and, consequently, no specific bribery issues have been identified. MIAA will continue to work with the Trust to manage bribery risks.

6.5. A key step in this process is ensuring that the Anti-Bribery Strategy is driven from the very top of the organisation.

7. Recommendations

7.1. That the Board note this paper and continue to support the Trust's Top-Level Commitment with respect to adopting and applying bribery counter measures on an organisation-wide basis.

7.2. That the Board reaffirm that the Trust adopts a 'zero-tolerance' attitude towards bribery and corruption and does not, and will not, pay or accept bribes or offers of inducement to or from anyone, for any purpose.

7.3. That the Board reaffirm its commitment to the Bribery Act Statement, to then be updated and published on the Trust website and intranet (see Appendix 1).

Appendix 1

Statement on the Bribery Act 2010

From the Chief Executive and the Executive Director of Business and Value

The Bribery Act 2010 was enacted on the 1st of July 2011 to reform the criminal law of bribery and corruption and make it easier to tackle these offences proactively.

Bribery can be defined as: ***"an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage."***

Bribery is a criminal offence. The Trust does not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor do we, or will we, accept bribes or improper inducements. This approach applies to **everyone** who works for us, or with us. To use a third party as a conduit to channel bribes to others is a criminal offence. We do not, and will not, engage indirectly in, or otherwise encourage, bribery.

The Bribery Act creates specific criminal offences which carry custodial sentences of up to 10 years and potentially unlimited fines. It also introduces a corporate offence which means that if Cheshire and Wirral Partnership NHS Foundation Trust ['the Trust'] is exposed to criminal liability, it is punishable by an unlimited fine, for failing to prevent bribery.

To limit its exposure and to combat bribery, the Trust has a number of suitable measures in place, including an Anti-Fraud, Bribery and Corruption Policy, a Corporate Governance Manual, and a Conflicts of Interests Policy, with details around managing conflicts of interests and declaring gifts and hospitality. These apply to all staff and to all individuals and organisations who act on behalf of the Trust. The Trust also has in place a nominated Anti-Fraud Specialist who will investigate, as appropriate, any allegations received. The Trust will seek the most stringent sanctions available against anyone seeking to commit bribery.

The success of the Trust's anti-bribery approach depends on its staff playing their part in helping to detect and eradicate bribery. The Trust therefore encourages all staff, service users and others associated with it to report any suspicions of bribery. In addition, the Trust holds a register of interests for directors, staff and governors and asks staff not to accept gifts, hospitality or sponsorship that will compromise them or the Trust.

As an organisation, the Trust has a zero-tolerance attitude towards bribery and aims to maintain anti-bribery compliance as 'business as usual', rather than as a one-off exercise. The Trust Board of Directors carries out its business in an open and transparent way. The Trust is committed to the prevention, deterrence and detection of bribery, as well as combatting fraud in the NHS, and expects any organisation it works with to do the same. Doing business in this way enables the Trust to reassure its patients, members and stakeholders that public funds are properly safeguarded.

To find out more about the Bribery Act and how it might affect your department or area of responsibility, please contact the Head of Corporate Affairs Suzanne Christopher - suzanne.christopher@nhs.net.

Signed: ……	Signed: ……
Sheena Cumiskey Chief Executive	Tim Welch Executive Director of Business and Value

Reporting Concerns

If you have any concerns or suspicions regarding bribery, corruption or fraud, please contact:

- Phillip Leong, Anti-Fraud Specialist
  Tel - 07721 237352
  Email - phillip.leong@miaa.nhs.uk or phillip.leong@nhs.net
- Tim Welch, Executive Director of Business and Value
  Email – tim.welch@nhs.net
- NHS Fraud and Corruption Reporting Line
  Tel - 0800 028 40 60 (freephone)
- NHS Fraud & Corruption Online Reporting Form
  https://cfa.nhs.uk/reportfraud

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Board Assurance Framework and Strategic Risk Register
Agenda ref. number:	21.22.24
Report to (meeting):	Board of Directors (meeting held in public)
Action required:	Discussion and Approval
Date of meeting:	26/01/2022
Presented by:	A Sivananthan, Medical Director

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

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

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 (December 2021) the Trust has nine strategic risks – four are rated red and five are rated amber. There are no risks 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*

The Strategic Risk Register was recently reviewed by the Quality Committee at its meeting on the 5th January 2022 (which was a reduced meeting in light of current operational pressures) and by the Operational Committee at its meeting on the 18th January 2022.

New risks/ risks in-scope

There are no risks in scope.

Current risks

Risk 1 – *Risk of supervision compliance rates falling below the Trust target of 85%.* (Score: 12 - Amber)
Work in this area continues to be a priority and is regularly discussed at Operational Committee, Board and Executive Team meetings. Through various reviews it has been reported that a significant amount of supervision is taking place. However, these sessions are not consistently recorded. ESR is also reported to be non-user friendly, leading to an under-representation of the level of supervision taking place. To support an improvement in this area, revised monthly reporting is being implemented with a revised single compliance report. A short-term Supervision Support service has been agreed to enable Managers/Supervisors to send their supervision dates and staff details to a central resource who will upload the data on their behalf. The digital solution continues to be progressed. Following discussions at Operational Committee in November each of the Care Groups identified a small number of teams to carry out rapid improvement activity in relation to supervision. At the December Operational Committee it was noted that a) supervision levels have improved and b) the rapid improvement activity had started in some teams. While it was too early to show a direct causation, the Care Groups had clearly identified a number of local issues that had been hindering the recording of supervision and these were now being addressed. The aim, once this initial round of improvements is completed, is for the Care Groups to move onto the next set of teams with the aim that the improvements are spread in a sustainable way.

Risk 12 – *Shortfalls in data capture.* (Score: 12 - Amber) This risk underpins a number of the newly agreed Strategic Objectives and will be considered as part of the Trust Digital Strategy. In part the introduction of the new EPR (SystmOne) will support improved recoding and has now been launched. The launch has seen the development of standardised data dictionaries / SOP's across services and system users. This should support enhanced reporting enabling better oversight of team capacity and demands for line managers. Audit reporting will be created to ensure consistent processes for recording new referrals are being followed. A quality data maturity matrix, management framework and weekly data quality reviews will be established by 31st March 2022. Further to the implementation of SystmOne, some initial data concerns were reported to the January 2022 Operational Committee. These will be considered by the next EPR Board meeting.

Risk 11 – *Failure to achieve Trust (and system) control totals.* (Score: 9 - Amber) Interim arrangements are in place due to COVID-19 to support the NHS response. The revised financial regime is now in place until the end of H2, and the expectation is that all organisations within the Cheshire and Merseyside HCP will breakeven by the end of the 21/22 financial year. Care Groups are considering how to meet efficiency targets against a background of acuity and demand, with a requirement to increase capacity and meet this through bank/ agency. Mechanisms are in place to monitor new investment schemes in terms of mobilisation progress. All current vacancies are also being reviewed to understand the challenges to recruitment and mitigate slippage for spend plans. Weekly Mental Health planning and implementation meetings are attended by the Business & Value team and the Associate Directors of Operations. The approach to efficiency delivery during H2 will be further assessed, leading to further discussion with the Care Groups on the approach to be adopted. It is likely that the 1.1% recurrent element that relates to national tariff will be levied across services , with the remaining balance managed centrally in recognition that this additional element would be challenging to achieve against given the timescales and the current Covid environment.

Risk 6 - Risk of adverse impact on patient care and operational effectiveness due to the implementation of SystmOne electronic patient record for MH, LD and CYP services. (Score: 8 – Amber)
SystmOne has been successfully rolled out trust wide. Floorwalkers were present daily for two weeks within inpatient units and CWP staff were trained to floor walk within the community teams to support with any immediate system queries. Both IT and the ePR team provided 24/7 support within that two week timeframe. Emergency Planning coordinated and chaired situation report meetings to ensure a route for updates and escalations to IT, ePR team, on call managers and the Executive board. Due to the success of the project these meetings were stood down from Tuesday 30th November 2021.

A cutover record system (COR) was employed during the Care Notes read only period of the ePR Programme prior to the SystmOne Go Live date (15.11.2021). Available data as of Wednesday 24th November 2021 shows approximately 44,600 records saved into the COR system. The COR system since that date has remained read only for users in readiness for migration. An external provider, Ideal, will be coordinating and completing the migration of the COR system records onto SystmOne. This migration is expected to take approximately 4 weeks and will commence once the appropriate CWP and system specific training can be provided to the external staff.

Further to the implementation of SystmOne, some initial data concerns were reported to the January 2022 Operational Committee. These will be considered by the next EPR Board meeting and the risk score reviewed accordingly.

Risk 5 – ***Failure to achieve compliance levels for Fire Evacuation training for inpatient services.*** **(Score: 8 - Amber)** A significant number of additional fire Ward evacuation training sessions have been arranged between November and February that are being delivered by the approved external training provider in venues across the 3 localities in order to support the improvement in compliance for this competency. Informal face to face (on location) ward-based fire response training sessions continue to be delivered, provided by either the Trust's fire officer or experienced staff from within the units. This ensures that staff know how to respond in the event of a fire and are familiar with the specific fire evacuation approach on site (which the formal training is unable to provide as it is not location specific). A structured programme for delivering these on-site sessions has been scoped to ensure sufficient capacity is available for registered practitioners across inpatient services to achieve compliance with this element of the core competency. The amendments to the e-learning programme that are required to enable inpatient staff to achieve compliance with the national core standards have been completed and the revised e-learning programme will be launched in the new year. It was noted at the December 21 Operational Committee that engagement between Fire Officers and Care Groups had enhanced and compliance against the target had increased. It was noted that further work is required to continue to build on the progress made to date.

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.*** **(Score: currently 16. Quality Committee have suggested that risk score be increased to 20 - Red)** This risk has been reviewed against the previous risk in scope A. The two risks are now combined. In response to the National Incident level, the frequency of TCG meetings and associated measures remain continually under review to support the delivery of safe and effective care and the well-being and safety of staff. Flexibility exists to increase the frequency at short notice in response to demands. The EPRR process is being utilised as the single point of contact and lead to enable the Trust to fulfil its obligations into the announced national Covid inquiry which will be held in 2022. A robust communication strategy utilising a number of platforms exists and is implemented to support staff with current advice and guidance and to encourage staff to receive vaccinations and boosters. Operational pressures are constantly monitored and decision making supports operational delivery to ensure the safe delivery of care. Following new winter planning guidance issued in August 2021, the CWP EPRR framework and methodology will continue until March 2022. Intelligence and data indicate that Covid together with a significant rise in flu cases will lead to serious pressures within health and care settings during winter 21/22. It was noted at the December 21 Board of Directors that the National Incident level had now increased to level 4. The TCG and SEG will respond accordingly and guidance is being considered to support our continued response to the pandemic and involvement in the delivery of the vaccination programme. In light of the recent National Incident level announced before Christmas, the Quality Committee have proposed that the risk score now be reviewed and increased to 20.

Risk 2 - ***CWP may not have sufficient capability (capacity, confidence and competence) to deliver, or support delivery of, safe and effective person-centred care or to enable the transformation of services and contribute to system working.*** **(score: currently 25. Quality Committee have suggested that risk score be reduced to 20 – Red).** The above was previously listed as risk in scope B and has been reviewed against the previous risk 2. The two risks have now been combined and the risk description revised accordingly. It is recognised that supply and retention has been negatively impacted nationally by the pandemic, impacting on a number of areas and creating significant pressures. Work has taken place to recruit to temporary roles, utilise agency staff as appropriate and ensure staff well-being is supported. The People Planning Oversight Group (PPOG) has also been established and TOR approved. Four Task and Finish groups have been established for Attraction, Recruitment, Retention and Workforce Planning to take forward the actions identified during the People Summit held in September 2021. The recruitment campaign commenced with effect from 29th November 2021, with staff volunteering to be the 'faces' of the campaign. The response to the COVID-19 pandemic has adversely impacted on the ability to release capacity to progress work relating to the transformation projects. Sufficient

capability to manage and deliver the programme, and support the impact, needs to be identified. A Programme Monitoring Group has now also been established that will report directly to the Operational Committee. This will support the Committee's oversight of strategic priorities. At the recent Quality Committee meeting held on the 5th January 2022, it was proposed that consideration be given to reducing the risk score to 20.

Archived risks
None

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

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

Who has approved this report for receipt at the above meeting?	Katherine 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	05.01.22
2	Operational Committee	18.01.22

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 HIGHLIGHT/ EXCEPTION REPORT

REPORT DETAILS	
Subject matter of report:	Report against Strategic Objectives – January 2022
Report provided by:	James Partington, Quality Surveillance Specialist
Date of report:	26/01/2022

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

Summarise the purpose of the report:

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

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

There has been an interruption in the flow of data following the move to SystmOne. Bed occupancy rates, admissions via the dynamic support database, EI performance, information on mortality reviews and the activity appendix cannot be updated this month.

ESCALATION
What do you need to escalate to the Committee?

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

Sickness absence has continued to rise and peaked again in December 2021 (slide 14).

Despite the Trust providing additional beds at Riverwood ward, the pressures on acute mental health beds have continued to grow such that more people have been cared for out of area (slide 4).

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

Other key matters to highlight:

In-month turnover has levelled off (slide 15) and there has been a slight fall in the vacancy rate in the latest month after a series of monthly rises (slide 16).

There has been a slight climb in appraisal compliance (slide 11).

Report Against Strategic Objectives

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

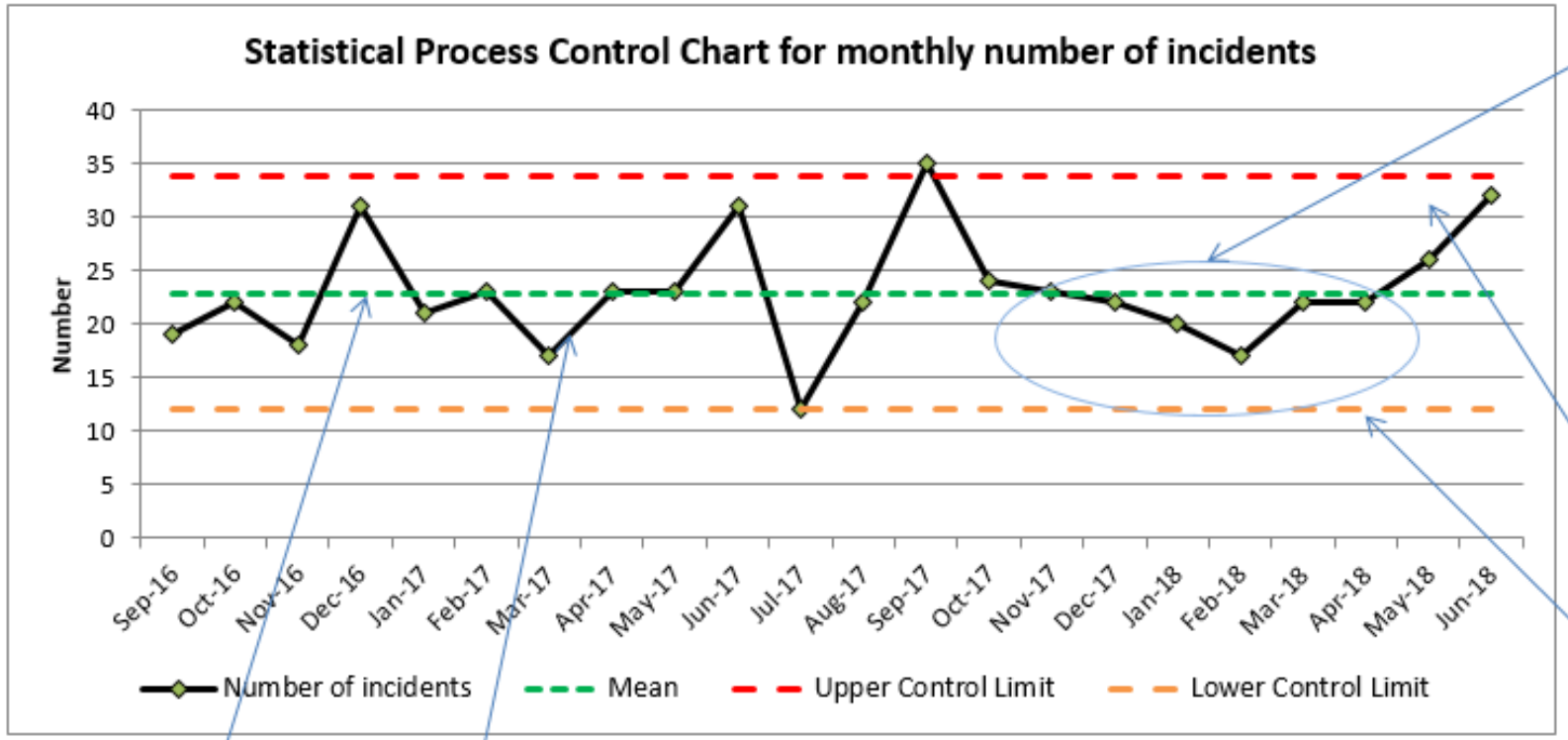
January 2022

Quality Surveillance Analysis Team

Helping people to be
the best they can be

@cwpnhs
www.cwp.nhs.uk

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.

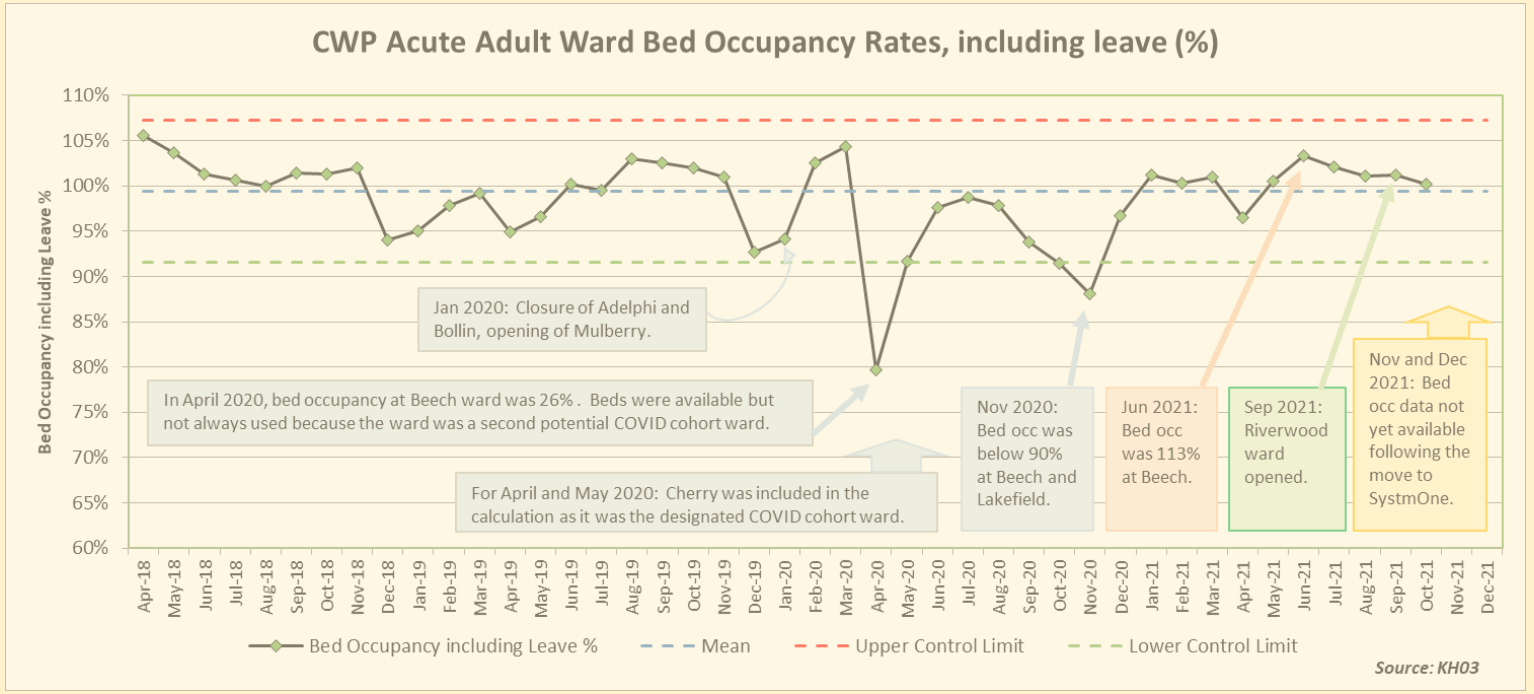
What does the SPC tell us?

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?

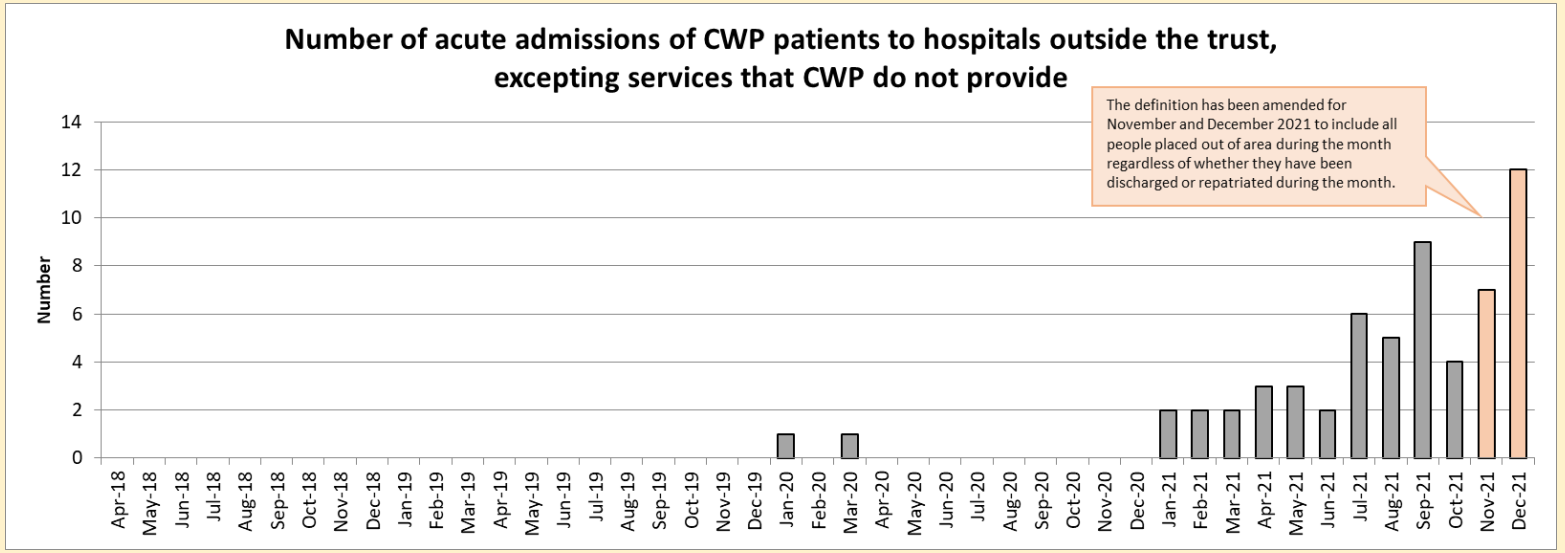
One of the properties of what is known as "the normal distribution" is that 95% of the data are within 2 standard deviations either side of the mean. The remaining 5% of the data are further away from the mean than that, in either direction. 95% is equivalent to one in 20. So we would expect, when looking 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

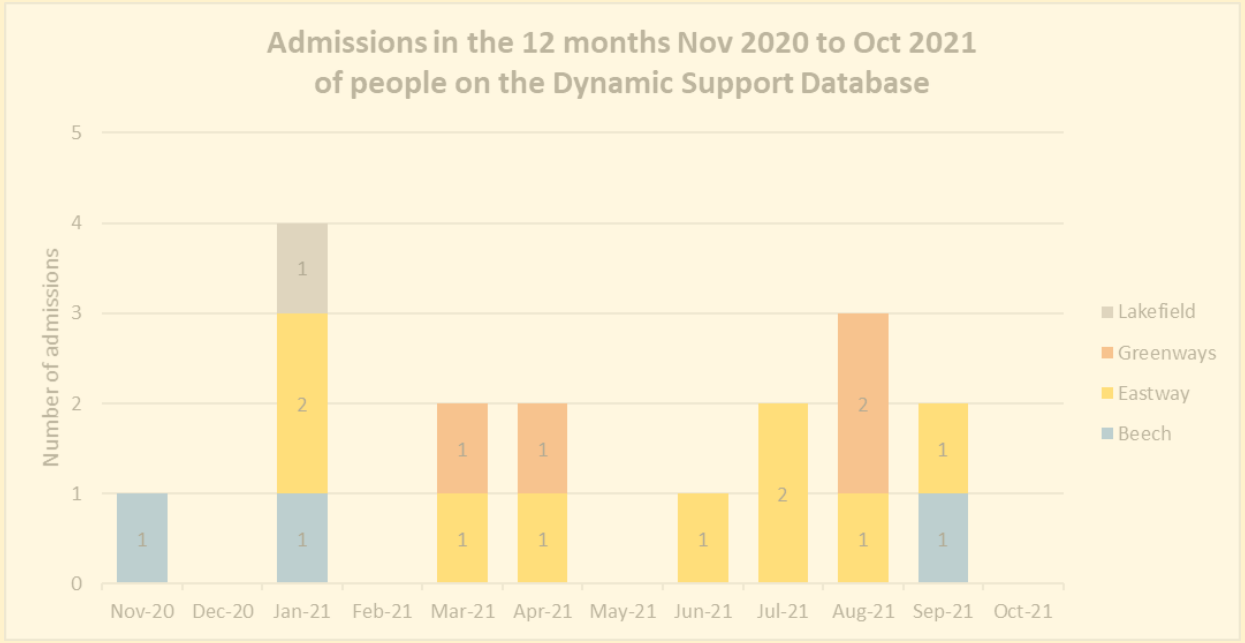
Metric	Data	Further Explanation
Bed Occupancy - Adult Acute wards		Metric owner: Suzanne Edwards / Anushta Sivananthan Monitored at: SMH Care Group Data sources: KH03 file provided by the Information Team.

This information is not yet available following the EPR migration from Carenotes to SystmOne.
The chart will be updated once the information flow is reinstated.

Deliver high quality, integrated and innovative services that improve outcomes

Metric	Data	Further Explanation
Out of Area Acute Admissions	 Comment: There have been further cases of patients placed out of area in the most recent months, adding to a pattern which has developed since January 2021, after a long period with only minimal out of area placements prior to the start of this calendar year. This has been as a result of high levels of acuity in acute care impacting on flow and discharges, bed availability due to covid outbreaks and staffing challenges. The definition has been changed for November and December 2021 based on updated guidance from NHS Digital to include people who may have been discharged or repatriated by the end of the month. Earlier months do not currently include such patients and will be reworked to provide a consistent series.	Metric owner: Suzanne Edwards Monitored at: Operational Committee Data source: CWP Bed Hub

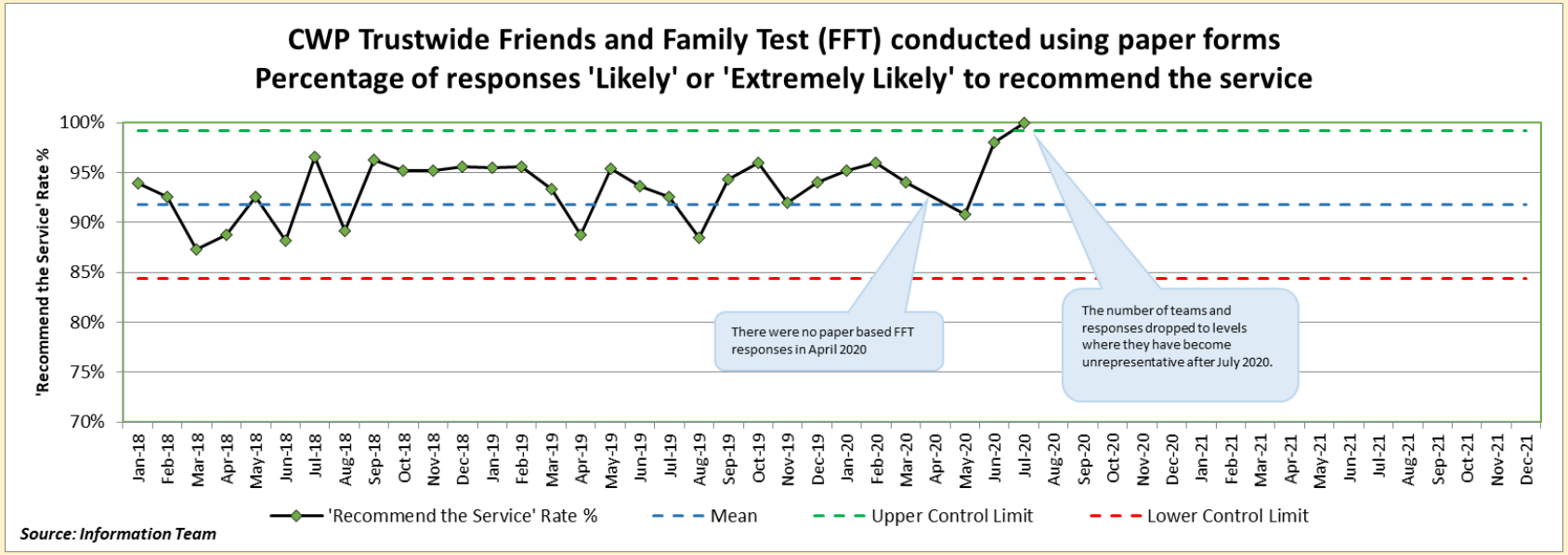
Deliver high quality, integrated and innovative services that improve outcomes

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

Deliver high quality, integrated and innovative services that improve outcomes

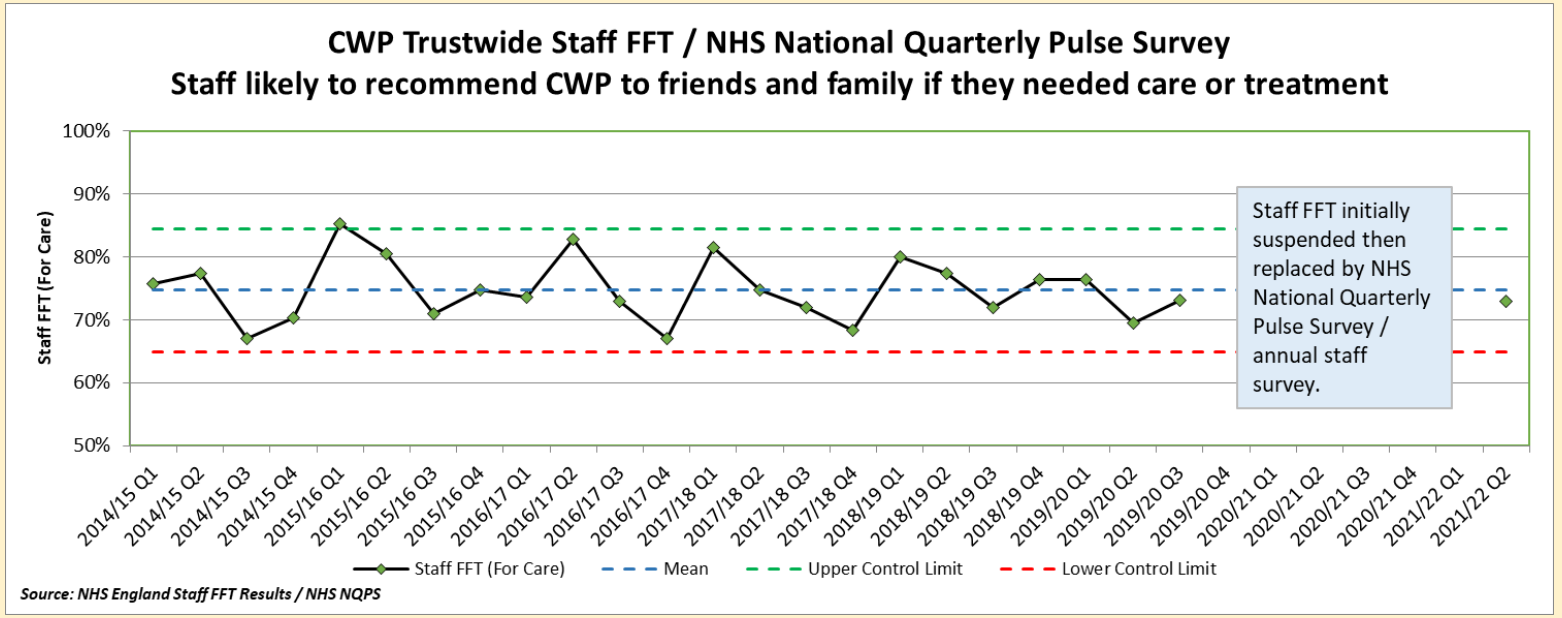
Metric	Data	Further Explanation
CWP performance against NHSi targets **(Exceptions only)**	The Trust regularly reports a number of operational metrics to NHSi. These cover: Early Intervention in Psychosis (one metric), Improving Access to Psychological Therapies (3 metrics), Out of Area admissions (monitored on slide 4 of this pack), and a data quality measure which is provided with a three month lag. This means that the most recent two data points, reported in November and December 2021, are for August and September 2021. The following metrics were below target performance as set out in the NHS Oversight Framework for November and December 2021: • Out of Area Admissions which had 7 instances in November and 12 in December. • IAPT: % in 18 weeks was 87.73% against a target of 95% • The data quality measure, where the data for the most recent months was 87.1% in November and 86.7% in December against a target of 95%. EI performance could not be reported due to the unavailability of data following the move to SystmOne.	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

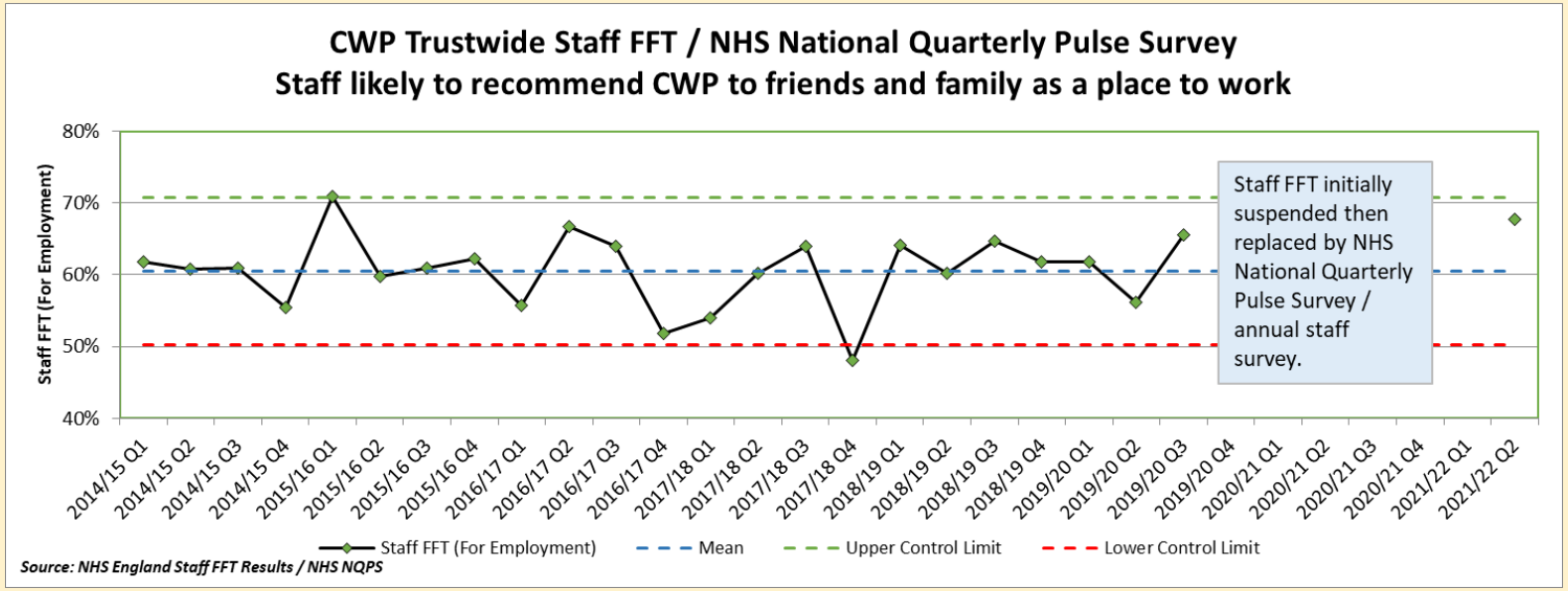
Comment: Following the onset of Covid-19, there was a national pause on the reporting of FFT. The volume of paper based FFT forms diminished after July 2020 to a point where they are not representative of all CWP services, so results are not shown after that date. The revised national FFT guidance offers 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
NHS National Quarterly Pulse Survey – about CWP as a care provider		Metric owner: David Harris, delegated to Simon Platt Monitored at: POD Sub Committee Data source: People Information

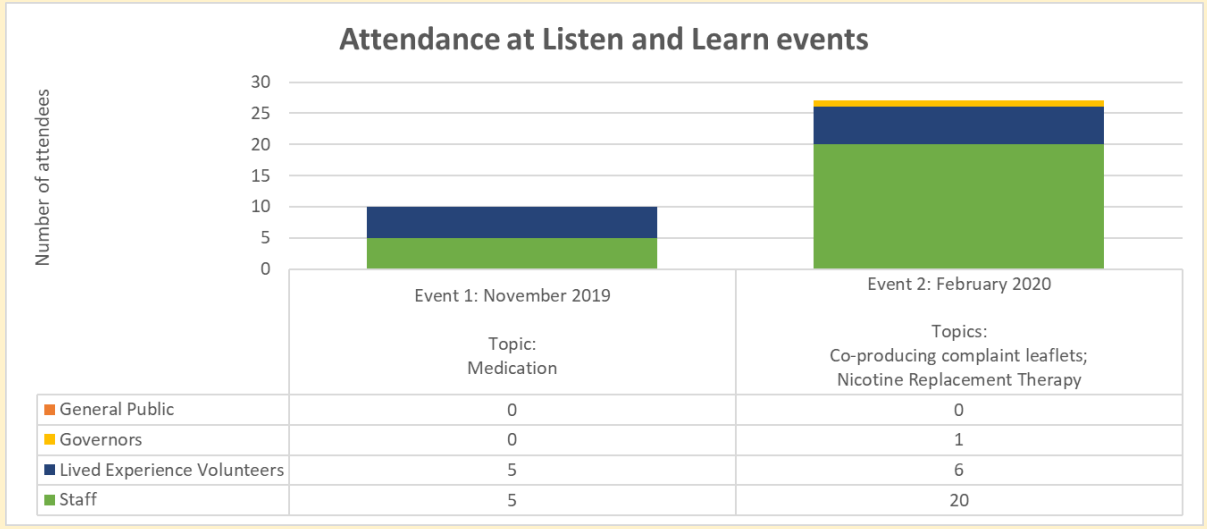
Comment: The NQPS has adopted the 9 engagement questions from the NHS Annual Staff Survey, meaning it is still possible to compare the original FFT questions to the new NQPS responses. For Q2 2021, CWP scored 72.9%. This is 2.8 percentage points higher than the average score of other Trusts who also utilised our external partner and approx. the same score as the old FFT survey back in Q3 2019/20. The Q4 NQPS is currently live across CWP and results of this will become available within the next two months. The National Annual Staff Survey ran through Q3 and these results are currently being analysed separately due to the richer content and need to work them into formal action plans.

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

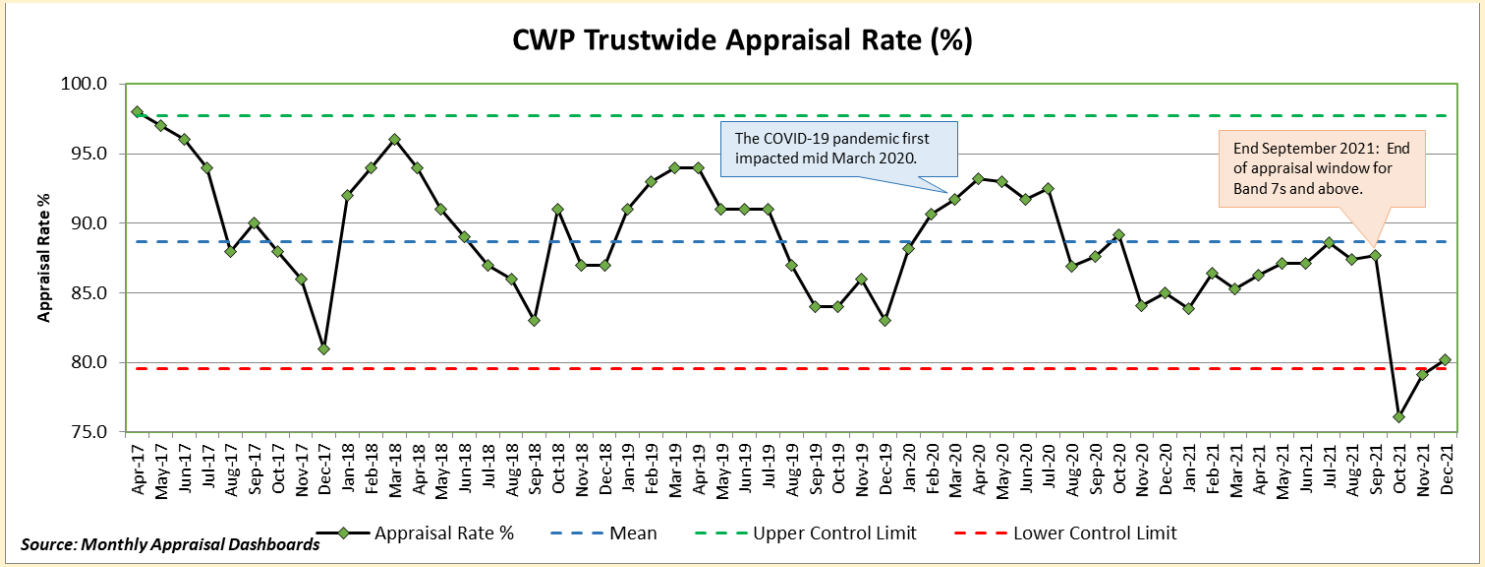
Metric	Data	Further Explanation
NHS National Quarterly Pulse Survey – about CWP as a place to work		Metric owner: David Harris, delegated to Simon Platt Monitored at: POD Sub Committee Data source: People Information

Comment: The NQPS has adopted the 9 engagement questions from the NHS Annual Staff Survey, meaning it is still possible to compare the original FFT questions to the new NQPS responses. For Q2 2021, CWP scored 67.7%. This is 6.4 percentage points higher than the average score of other Trusts who also utilised our external partner. It is also a relatively high score when set against the previous dataset, and the second highest score over the last seven years, albeit with a measurement gap for some of that period. The Q4 NQPS is currently live across CWP and results of this will become available within the next two months. The National Annual Staff Survey ran through Q3 and these results are currently being analysed separately due to the richer content and need to work them into formal action plans.

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

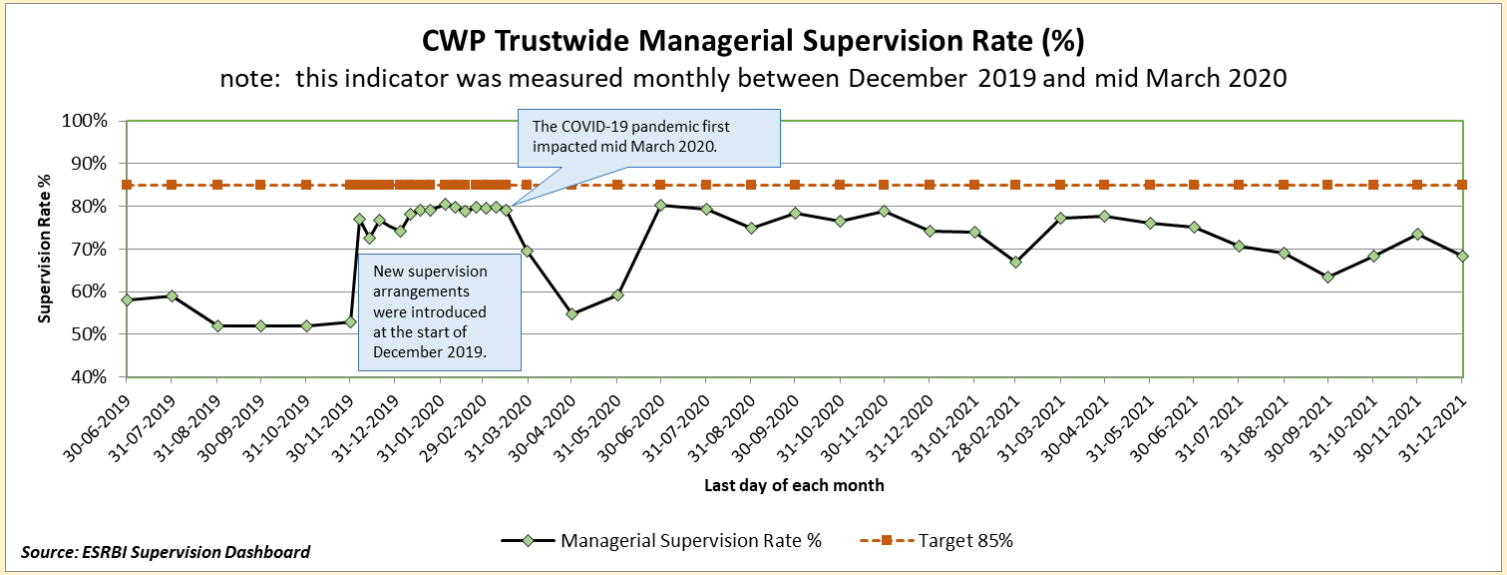
Metric	Data	
Effectiveness of working with the wider community	 Comment: Due to Covid-19 restrictions and limited ability to connect virtually with members and public, we have utilised other methods of ensuring that we listen to the voice of people who access our services. We have involved people in 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. Despite no identified specific listen and learn events, the PACE team have been involved in the Imagining the Future consultation events and consulted with various groups and communities.	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: The impact of the COVID-19 pandemic on appraisal rates has been marginal in the data reported so far. However, recent increases in both Staff Absence and Turnover may be impacting the compliance against Appraisals, as the workforce flexes to cope with capacity/demand challenges. 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. For December/January, the Executive Team acknowledged that Appraisal and Supervision may experience a decline due to the increased pressures brought on by the arrival of the Omicron variant. That said, December saw a continued improvement in compliance taking the Trust above the 80% threshold.

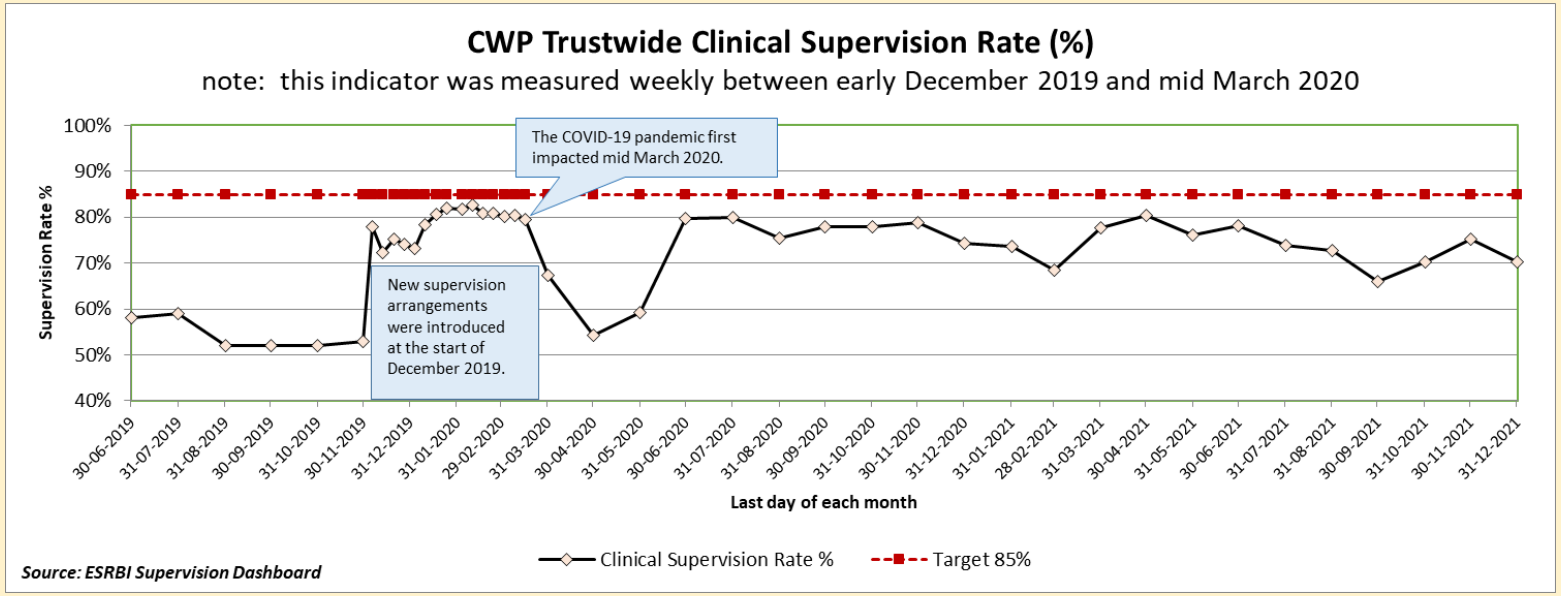
Be a model employer and have a caring, competent and motivated workforce

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

Comment: Supervision has remained a focus of scrutiny at Operational Committee and People and OD Sub Committee. At the former, Care Groups provided details of the rapid improvement projects that they were carrying out with specific, targeted teams and this seemed to be leading to improved performance in November. However, in December and January a number of services were in business continuity mode with very high levels of absence. This led to a cessation of the improvement work (the focus was on keeping services running) and has had a negative impact on recorded supervision levels. At Operational Committee in January Care Groups were asked to give assurance that supervision was taking place. This was given verbally but it was acknowledged that this was not being reflected in the reported figures in all areas. Care Groups intend to restart the improvement projects that they had to stop over Dec/Jan and an improvement is expected.

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.

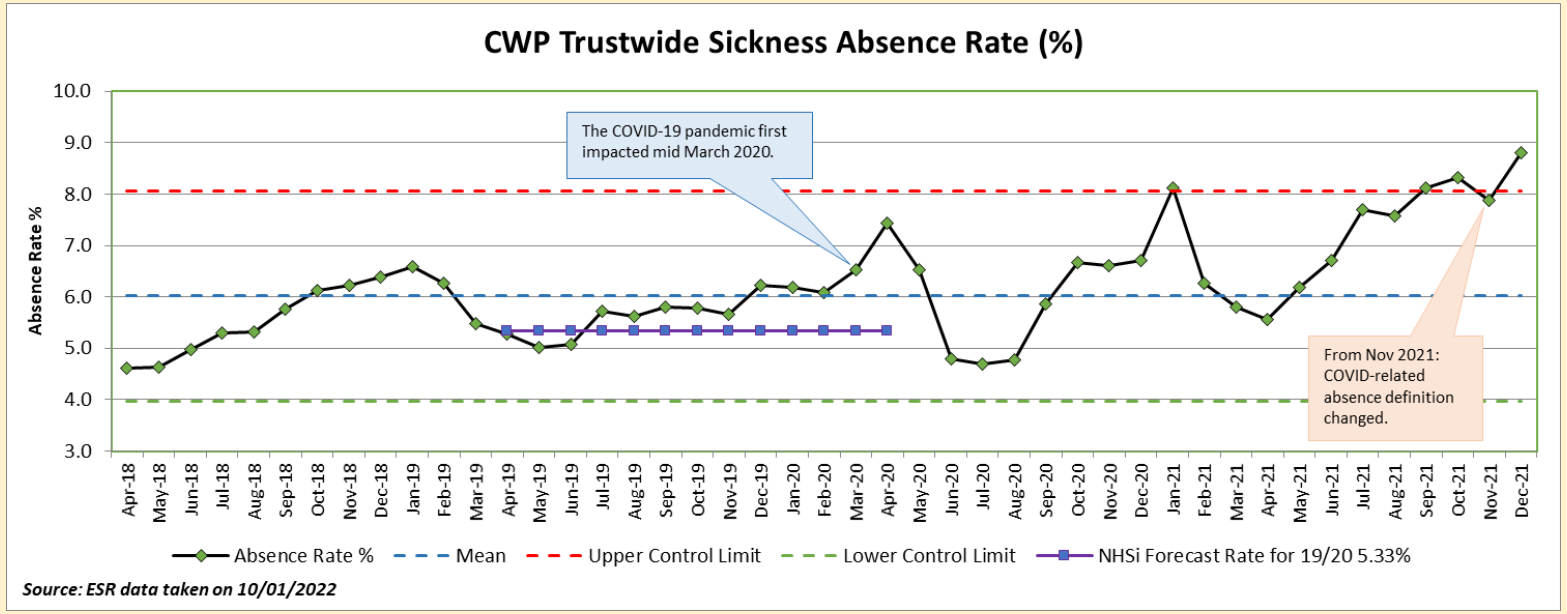
Be a model employer and have a caring, competent and motivated workforce

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

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

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

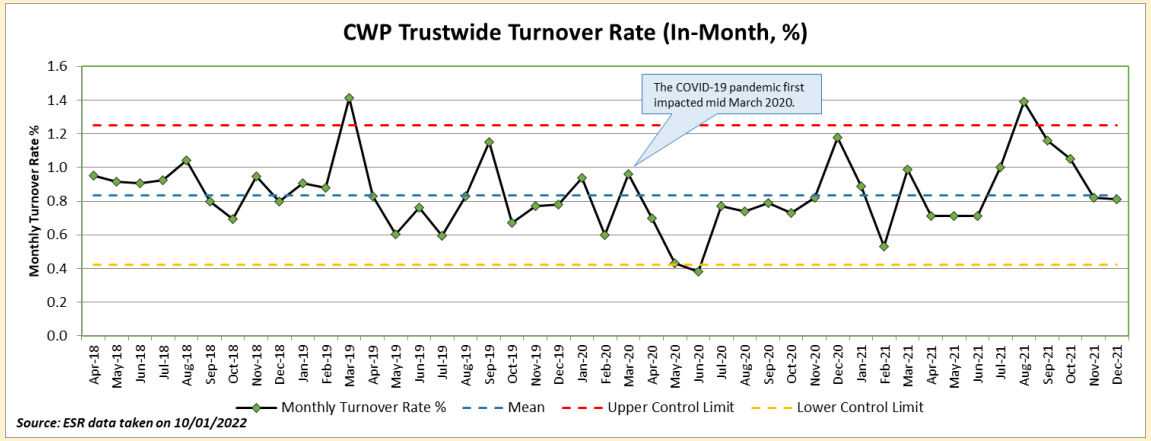
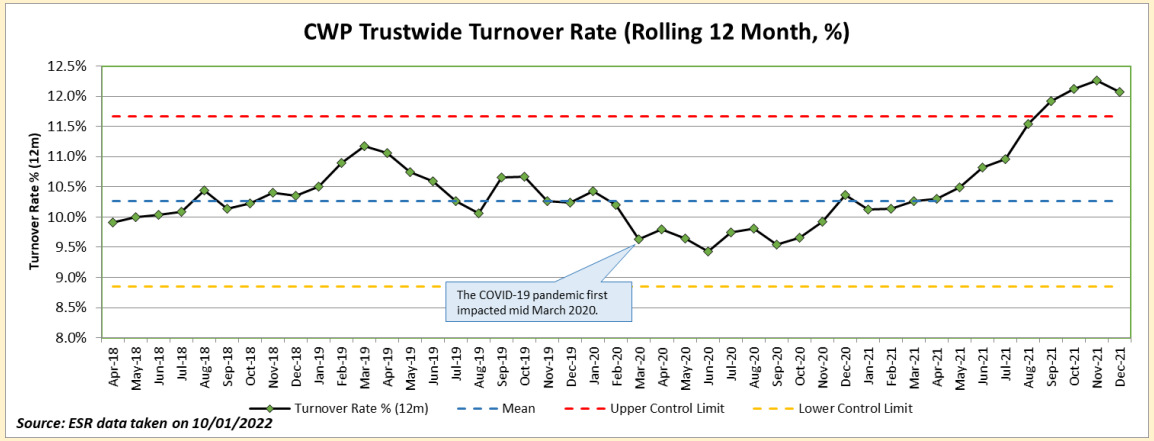
Be a model employer and have a caring, competent and motivated workforce

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

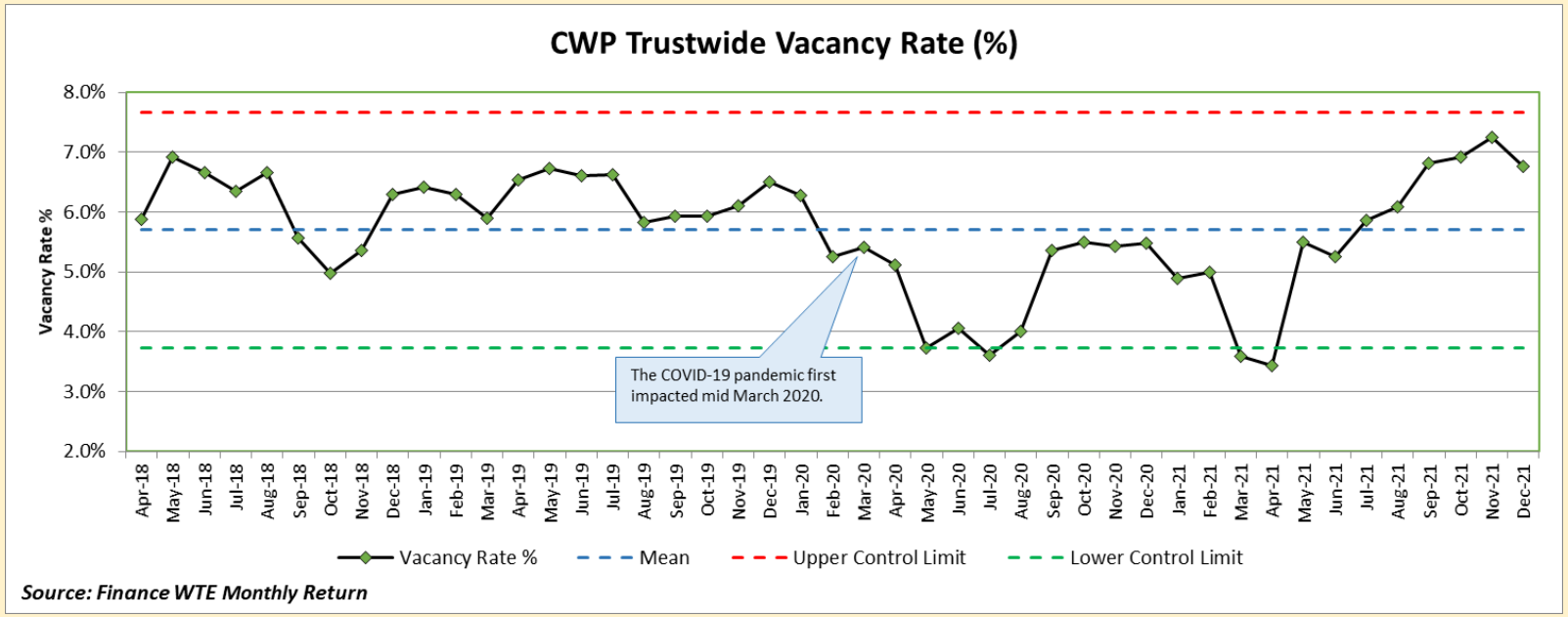
Comment: The rise of recent months continues , this despite an extensive range of wellbeing interventions and regular scrutiny via Operations Committee, People and OD Sub- Committee and the ongoing support of the Trust Wellbeing Guardian. The main challenges remain as stated - the demands on services are growing in number and complexity, and we know from staff feedback that they are tired. This combined with challenges in recruitment and retention all make for a harder working environment which leads to increased sickness. The national trend in Dec/Jan of a significant increase in people testing positive with the Omicron variant of Covid was mirrored within CWP with absence rising to the highest ever level. In addition to the established wellbeing offer, a group of wellbeing champions were mobilised to attend ward settings to offer in situ wellbeing coaching support. This was well received. The HR Ops team continue to work with managers to ensure that all absence cases are being effectively managed and recorded.

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

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

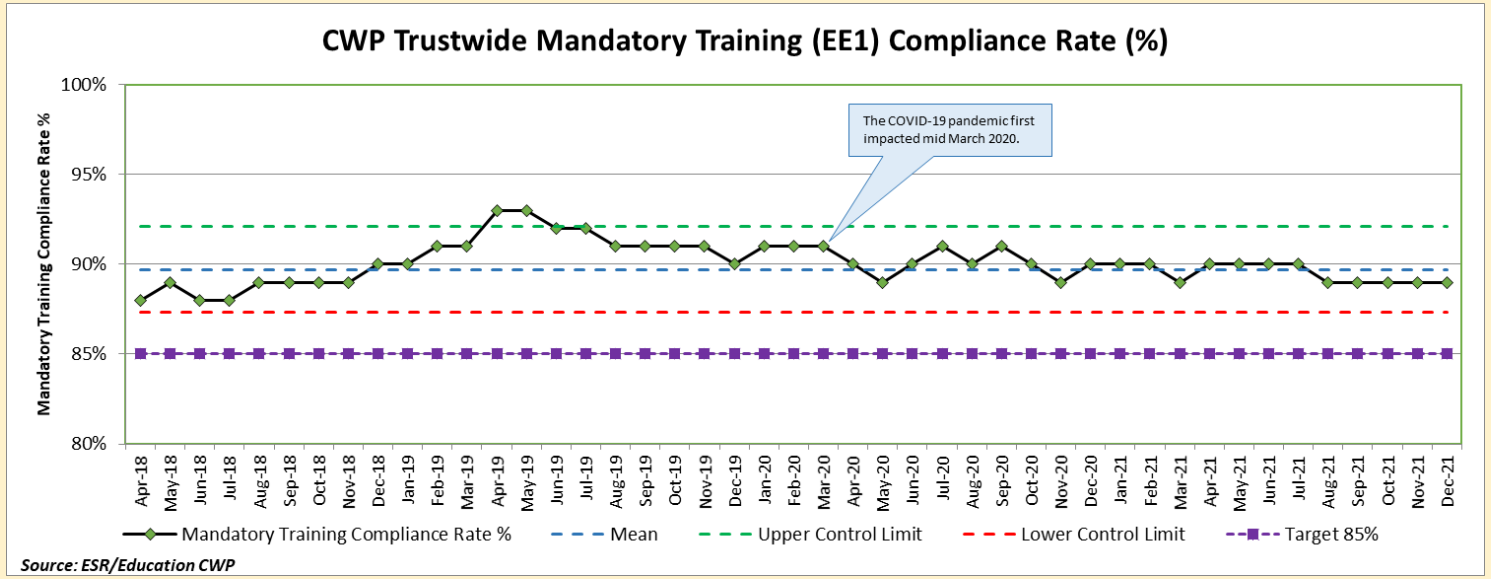
Metric	Data	Further Explanation
Staff Turnover	 *Source: ESR data taken on 10/01/2022*  *Source: ESR data taken on 10/01/2022*	Comment: The latest rolling 12 month data continues to exceed the upper threshold despite dropping back slightly in the latest month. This is not what we would expect from normal variation but is representative of the national picture. As per previous updates the turnover and vacancy rate challenge has been captured in Strategic Risk 2, which has been reviewed by Quality Committee. The mitigating actions are being addressed through a number of task and finish groups and overseen by the reinstituted People Planning Group and People and OD Sub Committee.	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

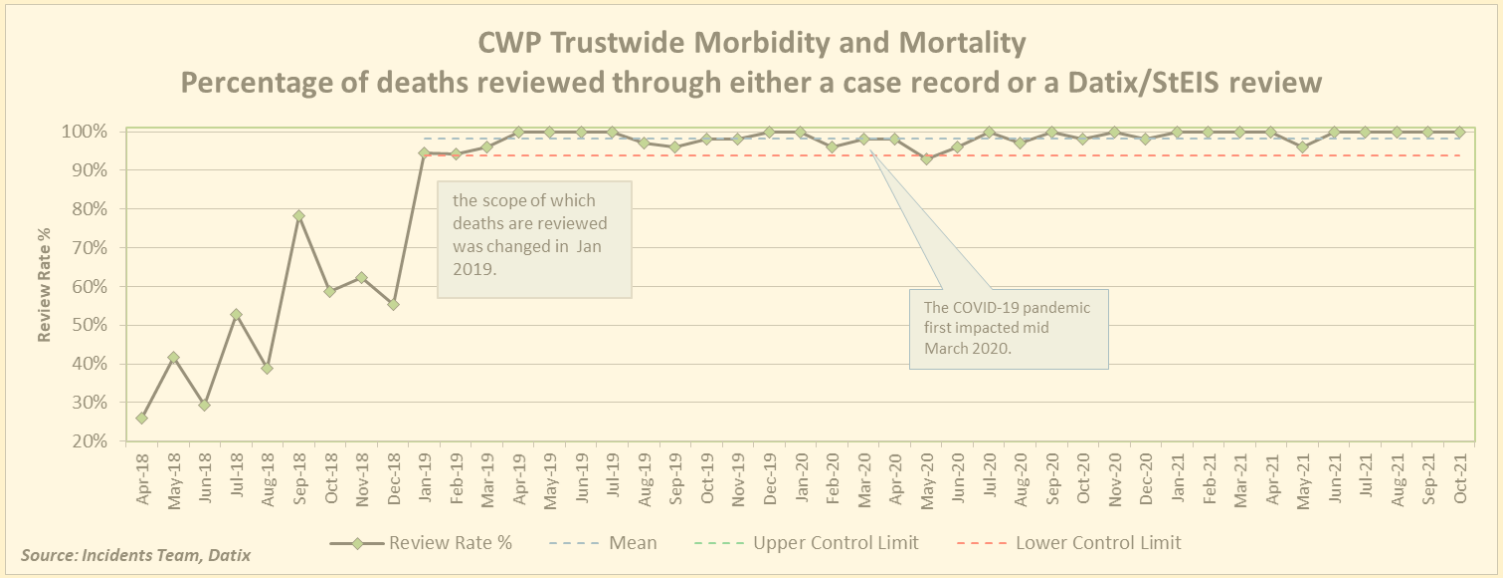
Metric	Data	Further Explanation
Vacancy Rate		Metric owner: David Harris Monitored at: POD Sub Committee Data source: People Information

Comment: The national shortage of suitable people for posts remains. The rate for November 2021 was the highest in the last four years. It is too soon to tell if the drop in December is a trend, however, the dedicated CWP recruitment campaign launched in January and as per mid- January we currently have 575 FTE at various stages of recruitment- more than double the recruitment activity at this stage last year. See also previous comments on Turnover for the action being take to address these associated indicators.

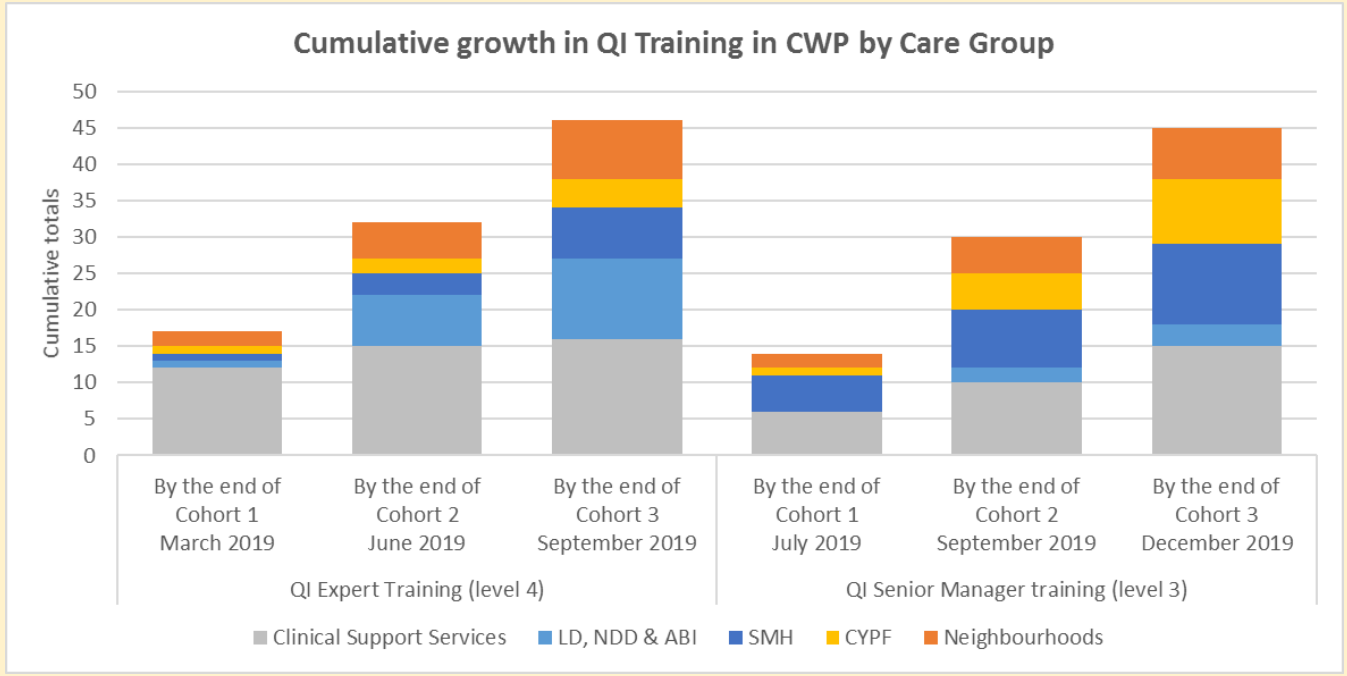
Be a model employer and have a caring, competent and motivated workforce

Metric	Data	Further Explanation
Mandatory Training	 Comment: The Trust mandatory compliance figure is currently 89%, just below the long term average, however we are still above the 85% target. As part of the Trust's People Strategy and Plan a review will be carried out of our mandatory training programme to ensure it maximises capacity and best meets need. A timetable for this review is being produced. The recent declaration of a critical incident, teams being in Business Continuity mode and Education CWP releasing staff to provide support to the wards are likely to mean that mandatory training compliance rates will dip further before they recover.	Metric owner: David Harris Monitored at: POD Sub Committee and Ops Committee Data source: Education CWP Definition: Excludes staff on Maternity Leave, Career Break, External Secondments, Long Term Sick (>92 days) and new starters < 3 months. Also excludes any new course competences added to the Training Needs Analysis for 12 months, to allow staff time to complete

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

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

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. Latest figures show over **3,800** people have completed the level 1 QI training.

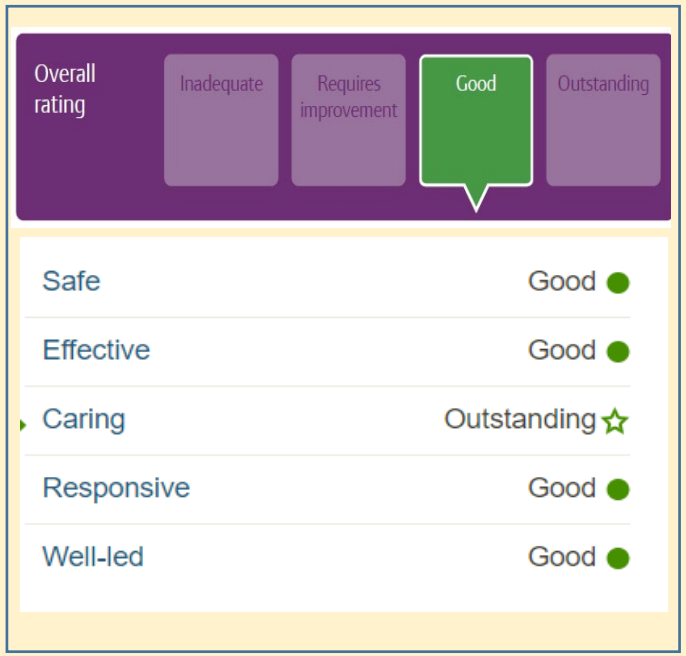
Work to develop further measures for this strategic objective is as follows:

Improve the quality of information to improve service delivery, evaluation and planning	
Metric	**Development Plans**
Dashboard development	Development work on the Operational Committee Performance Report has been continuing and the following improvements have been made: • Rationalisation of measures so they are only reported into a single committee, leading to addition of new measures and others being reported elsewhere • Overhaul of visualisation within the report • Separate section created for Oversight Framework Performance Indicators • Inclusion of Indicator definition and how RAG ratings are calculated • Local targets agreed with Care Groups (which is still in progress) • Separation of Specialist Mental Health into three localities Collaborative work continues between Clinical Support Services and the Specialist Mental Health Care Group to develop a care group specific performance framework. Metric owner: Tim Welch Monitored by: Operational Committee

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

Sustain financial viability and deliver value for money	
Metric	**Development Plans**
Delivery of Value for Money	Temporary financial arrangements are again in place for 2021/22 with a limited efficiency requirement in the first half of the year, but this is expected to increase significantly from October. The Business & Value team will continue to work with colleagues to support them to maximise the use of resources. Metric owner: Tim Welch Monitored through: Ops Committee

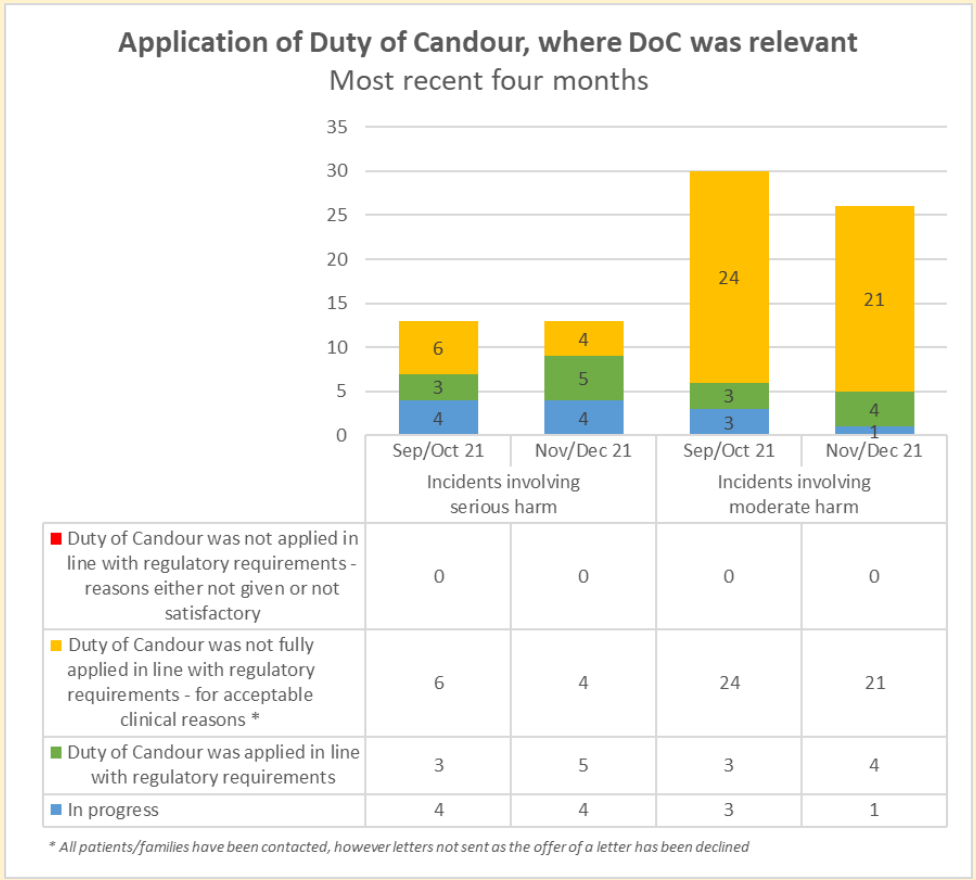
Be recognised as an open, progressive organisation that is about care, well-being and partnership

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 and showed improvement over the previous inspection.

At the time of writing, there are 5 regulatory actions, and 3 improvement actions open in relation to ADHD services and Rosewood Ward. Outstanding regulatory action has been agreed as a second extension until February 2022 with the CQC and will be monitored by the executive team to ensure all touchpoints as part of that extension are met or can be effectively escalated. The Rosewood inspection report was published on the 17/11/21 following their inspection on the 19/08/21. The ward were "inspected not rated" overall - therefore there is no impact or change to CWP or the core service rating, but the Safe rating specifically for Rosewood decreased from Good to Requires Improvement considering the regulatory breaches.

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

Metric	Data	Further Explanation
Duty of Candour		Comment: The Immediate Safety Assurance Forum scrutinise all the serious incidents and have identified the cases where the Duty of Candour has not been applied as required and requested immediate action with assurance being given to the Patient Safety incident Lead that this has been completed. A learning bulletin on Duty of Candour and when it is applied was issued last October explaining the updated regulation and is going out again in January 2022 as a reminder.	Metric owner: Gary Flockhart delegated to Hayley McGowan Monitored at: Quality Committee Data source: CWP Incidents Team

Report Against Strategic Objectives

End Sheet

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Helping people to be
the best they can be

@cwpnhs
www.cwp.nhs.uk

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED HIGHLIGHT/ EXCEPTION REPORT

REPORT DETAILS	
Subject matter of report:	Freedom to Speak Up Bi-annual report Q1 and Q2 2021/22
Report provided by:	Hayley McGowan, Associate Director of Nursing and Therapies
Date of report:	18/01/2022

SUBJECT MATTER

Summarise the purpose of the report:

CWP are committed to having effective speaking up arrangements for any employee to raise a concern that they may have.

This commitment aligns to the national Freedom to Speak Up (FTSU) programme led by the National Guardian Office, to make the NHS a 'better place to work and a safer place for patients' and is recognised as vitally important to help protect patients and improve the experience of our people.

This bi annual Speak Up and Raising Concerns report provides assurance to the Trust Board that a 'speak up' culture is continually being strengthened throughout the organisation.

ESCALATION

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

The number of concerns reported during this period is significantly lower than the number of concerns reported in the same periods in 2019/20 and 2020/21. It is considered likely that the continued availability of helplines for the Covid-19 Tactical Command Group, the Infection Prevention and Control Team and the Workforce Cell that have been available as part of the Covid-19 response since April 2020, in addition to the support structures in place in the care groups, has provided staff with a range of other routes to raise any queries or concerns in relation to both the ongoing impact of Covid-19 and other work related issues and receive a timely and effective resolution which has negated the need to access the Speak Up pathway.

There has been a marked increase in the proportion of people (5) speaking up who consider their concern to be associated with staff safety compared to previous periods. This is reflective of the staffing challenges that services have experienced as a result of the ongoing impact of covid, other unplanned absences and vacancies and the subsequent implementation of business continuity plans across multiple service areas during this reporting period. The concerns that were raised related to staff safety all identified corresponding patient safety concerns and appropriate action was taken to address concerns in a timely manner.

ASSURANCE

Other key matters to highlight:

The Trust's 'Raising and escalating concerns at work' policy (HR3.8) and speak up processes have been refreshed during this reporting period to reflect updates in national guidance.

All speak up communication routes remain active including the dedicated FTSU email address and telephone number, mailing addresses and telephone numbers of the FTSU Guardian and Associate Guardians. Additionally, staff can raise concerns face to face with any member of the team

An Ambassador workshop was held which provided a refresher of the Freedom to Speak Up Process and the Ambassador role, an overview of themes from the last 12 months of FTSU cases and an opportunity to share ideas for promoting FTSU including FTSU month activities.

Systems are in place to record and monitor the FTSU activity across the organisation and the FTSU Guardian reports this information to the National Guardians Office each quarter as required.

Cheshire and Wirral Partnership
NHS Foundation Trust

Report to Board:	Trust Board
Date of Meeting:	
Title of Report:	Bi-annual update of Speak Up and Raising Concerns (Quarter 1 and Quarter 2)
Action sought:	Receive Assurance / Approval
Author:	Hayley McGowan
Presented by:	Hayley McGowan

Strategic Objective(s) that this report covers *(delete as appropriate):*
SO1 - Deliver high quality, integrated and innovative services that improve outcomes
SO2 - Ensure meaningful involvement of service users, carers, staff and the wider community
SO3 - Be a model employer and have a caring, competent and motivated workforce
SO5 - Improve quality of information to improve service delivery, evaluation and planning
SO7 - Be recognised as a progressive organisation that is about care, well-being and partnership

Distribution

Version	Name(s)/Group(s)	Date Issued
1	Gary Flockhart	17th February 2022
1	David Harris Chair of People and Organisational Development Sub Committee	17th February 2022

Executive director sign-off

Executive director (name and title)	Date signed-off
Gary Flockhart, Director of Nursing, Therapies and Patient Partnership	18th February 2022

Cheshire and Wirral Partnership
NHS Foundation Trust

Speaking Up and Raising Concerns

Biannual Report

April 2021 – September 2021

Board of Directors' Speaking Up Declaration

Cheshire and Wirral Partnership NHS Foundation Trust (the Trust) are committed to create an open and honest learning culture that is responsive to feedback to continually improve, and as such take the responsibility for Speaking Up very seriously. The following declaration of compliance with Speaking Up and Raising Concerns practice is made:

- The Trust meets the statutory requirement of NHS England by having a Freedom to Speak Up Guardian available to support any employee to raise a concern that they may have.

- Speaking up policy and processes are up to date and in line with recommendations of the National Guardian's Office. All associated polices are reviewed on an annual basis or as guidance develops that requires change.

- Associate Freedom to Speak Up Guardians and Freedom to Speak Up Guardians have a clear understanding of their roles and responsibilities and are able to access support as and when required.

Executive Director of Nursing, Therapies and Patient Experience, namely Gary Flockhart, is the Director Lead for Speaking Up. The Trust has a Non-Executive Director Freedom to Speak Up Champion, Rebecca Burke-Sharples, who provides alternative support to the Freedom to Speak Up Guardians, scrutinises and is able to robustly challenge Speak Up governance.

The Board receives regular reports in relation to Speak Up, a biannual and annual report. Reports contain details on the number of concerns raised, lessons learned and recommendations for any further necessary action. The Board is assured that the Trust adheres to good practice and that appropriate Speak Up arrangements are in place.

If any further information is required, please contact the Chief Executive Officer at Trust Headquarters.

Contents

Introduction

Cheshire and Wirral Partnership NHS Foundation Trust (thereafter referred to as the Trust) are committed to have effective speaking up arrangements for any employee to raise a concern that they may have.

This commitment aligns to the national Freedom to Speak Up (FTSU) programme led by the National Guardian Office, to make the NHS a 'better place to work and a safer place for patients' and is recognised as vitally important to help protect patients and improve the experience of our people.

This biannual Speak Up and Raising Concerns report provides assurance to the Trust Board that a 'speak up' culture is continually being strengthened throughout the organisation.

Commitment

Our person-centred commitment to Freedom to Speak Up is that:

> "We will have the courage to speak up and voice our views. We will always try to improve things to make a lasting difference".

Speaking Up April 2021 – September 2021

Quality Improvement

The 2021 staff survey was undertaken during the reporting period and the results will be available in March 2022. Only one of the four questions within the staff survey related to Speaking Up that have previously been utilised to calculate the FTSU index scores was retained in the staff survey this year. Further information on how this will be taken forward will be provided by the National Guardian's Office following the publication of the 2021 staff survey results.

The FTSU Guardian role has been undertaken by the Associate Director of Nursing and Therapies for Mental Health and Learning Disabilities from August 2021 following the secondment of the Associate Director of Nursing and Therapies for Physical Health, supported by the four Associate FTSU Guardians. The Associate roles were developed to provide additional capacity to respond to concerns raised by staff in recognition of the significant challenges that the Covid-19 response continues to present for everyone working within the organisation. The Associate FTSU Guardians are all experienced FTSU Ambassadors and undertake senior clinical roles across the Trust. The four posts provide a dedicated role in each locality and an additional role for Trust wide and corporate support services. All Guardians and Associates are available to respond to concerns from individuals in any area of the organisation as required. Developing a shared approach has enabled increased access to a member of the FTSU team, providing choice for people, and quality assurance process to be implemented without compromise to individuals' confidentiality. Each Speak Up case has been quality reviewed and learning from cases has been extracted.

The FTSU Guardian is well supported to carry out the role. The FTSU Guardian has had regular meetings with the Executive Director lead for Speaking Up and has access to the Non-Executive Director FTSU Champion, as well as the Chief Executive and Chair to discuss Speaking Up strategy and any associated matters. This continues to raise the profile of Speaking Up and ensure senior leaders are aware of the Speaking Up strategy, enabling them to continue to promote a Speak Up culture during quality visits and engagement with people.

Building Confidence and Capability

The Trust's 'Raising and escalating concerns at work' policy (HR3.8) and Speak Up processes are in place and available on the Trust intranet and have been refreshed during this reporting period to reflect updates in national guidance. The importance of Speaking Up and Speaking Up processes continue to be shared with people in a variety of ways including distribution of written information and posters; through the Trust's communication bulletins; social media platforms, inclusive of Facebook and Twitter; Board member quality visits and face to face by FTSU Guardians, Associate Guardians and Ambassadors.

The Trust requires all staff to complete the Freedom to Speak Up e-learning modules that have been developed by the National Guardian's Office in association with Health Education England for everyone in the health sector. They explain in a clear and consistent way what Speaking Up is and its importance in creating an environment in which people are supported to deliver their best. The first module – Speak Up – is for everybody and is an essential requirement for all staff working across CWP to complete. The second module, Listen Up, for managers, builds upon the first and focuses on listening and understanding the barriers to speaking up. A final module – Follow Up – for senior leaders, will be launched in the future to support the development of Freedom to Speak Up as part of the strategic vision for organisations and systems.

The Trust has a cohort of Speak Up Ambassadors from a wide range of services across the Trust. The Speak Up Ambassadors are self-nominated people working in any role within the Trust who are able to provide support for colleagues in raising concerns. There has been limited engagement with Ambassadors that has resulted in individuals formally raising concerns through the Speak Up pathway during this reporting period.

During this period we held an Ambassador workshop and invited all Ambassadors to attend. The purpose of the workshop was to provide a refresher of the Freedom to Speak Up Process and the Ambassador role, provide an overview of themes from the last 12 months of FTSU cases and to share ideas for promoting FTSU, including FTSU month activities. The workshop was also used to promote the Rainbow Badge Scheme amongst the Ambassadors supported by the Trust's Equality and Diversity Lead. Following the workshop the Ambassador directory was reviewed in response to changes in individual roles and responsibilities. A Microsoft Teams channel has now been developed for Ambassadors to share information and to facilitate peer support and joint learning.

The Freedom to Speak Up Associate Guardians have been supported by the Guardian to continue to promote their roles within the localities and areas of work, and have been supported to undertake direct case work with individuals who have raised concerns. The Guardian has been able to provide advice and guidance through a buddy approach, to enable the Associate Guardians to consolidate their skills and confidence in undertaking their extended role.

Feedback mechanisms continue to be utilised to enable individuals who have raised concerns to evaluate their experience of the process, as well as the outcome that was achieved. Staff are requested to provide feedback in line with National Guardian Office requirements.

Measuring Progress

One of the ongoing challenges for the Trust is ensuring all staff are aware of the role of FTSU Guardian and how to access Speak Up pathways to enable them to raise any issues or concerns, or challenge any wrongdoing, through this route. The FTSU Guardian has

continued to work closely with the Equality and Diversity Lead to ensure that the importance of Speak Up is recognised in all staff networks with the aim of recruiting more Ambassadors from each network to provide staff from these groups with the opportunity to access support to Speak Up from a broad range of individuals, including people that they trust and feel a connection with.

All speak up communication routes remain active including the dedicated FTSU email address and telephone number, mailing addresses and telephone numbers of the FTSU Guardian and Associate Guardians. Additionally, staff can raise concerns face to face with any member of the team. The most common method of contacting the FTSU Guardian from individuals raising concerns remains through the dedicated Raising Concerns email account and phone line.

The FTSU Guardian will continue to work collaboratively with organisational development and others to link access to Speaking Up with other Trust staff initiatives. The FTSU Guardian will continue to work with organisational development to scrutinise the findings of the staff survey and understand the opportunities for further development and improvement.

Analysis of Activity

Systems are in place to record and monitor the FTSU activity across the organisation and the FTSU Guardians report this information to the National Guardian's Office each quarter as required. However, success should not be measured by the number of concerns and issues being raised. It is recognised that the trends of activity can be useful to triangulate with wider data and can support the identification of early warning, enabling prompt and appropriate intervention and support.

A limited number of people have spoken up and raised concerns through the FTSU Guardian route during this reporting period; the number of recorded Speak Up concerns in quarters 1 and 2 of 2021/2022 in comparison to previous years are below:

Table 1 – Total numbers of Speak Up concerns reported from 2018/2019 to date.

Locality	**TOTAL 2018-2019**	**TOTAL 2019-2020**	Q1	Q2	Q3	Q4	**TOTAL 2020-2021**	Q1	Q2	**TOTAL 2021-2022**
Central and East	**12**	**9**	2	1	0	0	**3**	0	0	**0**
Wirral	**4**	**9**	1	6	4	1	**12**	1	1	**2**
West	**11**	**13**	0	4	3	5	**12**	0	3	**3**
Trust wide/ Anonymous	**1**	**3**	0	0	0	0	**0**	0	1	**1**
TOTAL	**28**	**34**	3	11	7	6	**27**	1	5	**6**

The number of concerns reported this financial year is significantly lower than the number of concerns reported in the same periods in 2019/20 and 2020/21. It has not been possible to evidence the reason why there has been this level of reduction in Speak Up concerns during this period, however it is considered likely that the continued availability of helplines for the Covid-19 Tactical Command Group, the Infection Prevention and Control Team and the Workforce Cell that have been available as part of the Covid-19 response since April 2020, in

addition to the support structures in place in the care groups, has provided staff with a range of other routes to raise any queries or concerns in relation to both the ongoing impact of Covid-19 and other work related issues, and receive a timely and effective resolution which has negated the need to access the Speak Up pathway.

Table 2 – Comparison of percentage of concerns raised by locality

	18-19		19-20		20-21		Q1 & Q2 21-22	
TOTAL	**28**		**34**		**27**		**6**	
East	**12**	43%	**9**	27%	**3**	12%	**0**	0%
Wirral	**4**	14%	**9**	27%	**12**	44%	**2**	34%
West	**11**	39%	**13**	38%	**12**	44%	**3**	50%
Trust Wide/ Anonymous	**1**	4%	**3**	8%	**0**	0%	**1**	16%

The highest number of concerns raised during this reporting period were raised by individuals who work within West and Wirral localities, with no concerns raised by individuals within the East locality; this is a sustained reduction on previous reporting periods for this locality. The concerns have been raised by individuals within a variety of teams across the localities and have not highlighted any specific themes or trends that indicate targeted actions are required.

All concerns raised during this period were followed up by a FTSU Guardian or Associate Guardian. The FTSU pathway is being promoted to encourage staff to report via this route, however, in keeping with our Raising and Escalating Concerns policy, staff will continue to be able to raise concerns externally with the CQC should they feel this is the most appropriate method.

People are able to raise concerns to the FTSU Guardian on an anonymous basis; such concerns are considered and investigated accordingly. However, personal evidence and clarification from individuals can be essential to enable a comprehensive response and outcome. In order to continue to improve the culture regarding raising concerns, staff are encouraged to be open with the confidence that the FTSU Guardian will provide confidential support and only use the anonymous route when necessary. We have received one anonymous concern in Quarter 2.

All the concerns raised have been investigated and responded to in a proportionate way by a variety of methods, inclusive of supporting people with specific concerns that could be addressed at supervision or through the line management processes and formal independent investigations.

Table 3 – Breakdown of concerns raised in Quarter 1 and 2 2021 - 2022 per Care Group.

Care Group	Quarter 1	Quarter 2	Total
SMH	1	2	**3**
NBC	0	0	**0**
LD / ABI	0	0	**0**
CYP	0	2	**2**
AAD	0	0	**0**
Corporate/Anonymous	0	1	**1**
Total	**1**	**5**	**6**

The FTSU process is accessible to all people working within the Trust, or previously employed by the Trust, regardless of their role. Concerns have been received from a variety of people working across a range of services and from a variety of roles inclusive of nurses,

health visitors, administrators and allied health professionals. There have not been any concerns received from individuals working in corporate services during this reporting period.

The FTSU Guardians will continue to review opportunities for promoting Speak Up to individuals who are working remotely as a result of the ongoing utilisation of different ways of working that were initiated in response to the Covid-19 pandemic, as this has reduced the opportunity for individuals to raise concerns face to face with a member of the Speak Up team. We continue to emphasise the importance of Speaking Up across our services and work with the Equality and Diversity Lead to ensure options for considering harder to reach areas are taken into account.

There have been a range of concerns raised to the FTSU Guardian; the concerns have been categorised in line with the NGO guidance. Some concerns have been included within multiple categories therefore the total number does not equate to year-end total as above.

Table 4 – Number of concerns raised from 2019 / 2020 to 2020 / 2021 per NGO category

*A Speaking Up concern can be assigned more than one category; the number of categories exceeds total concerns.

	2019 – 2020					2020 - 2021					2021 - 2022		
	Qtr 1	Qtr 2	Qtr 3	Qtr 4	**TOTAL**	Qtr 1	Qtr 2	Qtr 3	Qtr 4	**TOTAL**	Qtr 1	Qtr 2	**TOTAL**
Bullying / Harassment	8	1	4	0	13 (26%)	0	3	3	1	7 (25%)	0	0	0
Patient Safety / Quality	4	1	1	2	8 (15%)	0	2	0	3	5 (18%)	1	4	5 (50%)
System / Process	1	1	0	1	3 (6%)	0	2	2	0	4 (14%)	0	0	0
Staff Safety	0	0	0	0	0 (0%)	0	1	0	0	1 (3%)	0	4	4 (40%)
Leadership / Management Issue	8	6	10	5	29 (55%)	3	7	1	0	11 (40%)	0	0	0
Other	0	0	0	0	0%	0	0	0	0	0%	0	1	1 (10%)

Analysis of the categories of concerns raised by people during this reporting period identifies that there has been a marked increase in the proportion of people speaking up who consider their concern to be associated with staff safety compared to previous periods. This is reflective of the staffing challenges that services have experienced as a result of the ongoing impact of Covid, other unplanned absences and vacancies, and the subsequent implementation of business continuity plans across multiple service areas during this reporting period. The concerns that were raised related to staff safety all identified corresponding patient safety concerns.

The learning that has been extracted from cases is congruent with previous years; the importance of developing effective communication between individuals, managers and teams and supporting people to raise concerns as and when they arise.

There have been no concerns raised regarding bullying and harassment, and leadership and management, during the period which have previously been the two categories associated with the highest number of concerns. This is a positive reduction.
A total of 10 concerns were closed in quarters 1 and 2 2021 – 2022.

Speaking Up in Quarter 3 and 4 2021 – 2022

The FTSU Guardians are working alongside senior leaders to continue to strengthen, and achieve, a healthy speaking up culture throughout the Trust.

The following priority areas for action during the next reporting period are as follows:

- To complete the Freedom to Speak Up Board Self Assessment.
- To review the role of the Freedom to Speak Up Guardian and explore future options for provision of this role across the Trust aligned to the development of professional leadership capacity with a view to increasing capacity to drive forward this agenda.
- To make a decision on the longer-term requirement for the Freedom to Speak Up Associate Guardian roles.
- To improve awareness of Speaking Up within Corporate Services.
- To continue to explore alternative options for expanding access to routes to Speak Up for individuals who continue to work remotely.
- FTSU Guardians to support the work of organisational development to understand the matters which contribute to related areas of the 2021 staff survey.

Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Guardian of Safe Working Quarterly Report
Agenda ref. number:	21.22.25
Report to (meeting):	Trust Board of Directors
Action required:	Information and noting
Date of meeting:	26/01/2022
Presented by:	Dr F Alam – Medical Director

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

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

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

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

REPORT BRIEFING

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

This report is to update the trust on the issues regarding junior doctors, their working conditions and locum use due to vacancies, during the period of November 2021 to January 2022. Consideration has been given for any current and future risk.

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

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

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

Exception reporting:. This has been discussed through the Junior Doctor Forum on how and when to do exception reporting. There was no exception report during this period.

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

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

The Board is asked to approve the report.

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

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

November 2021 to January 2022

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

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

Introduction

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

Background Data

Number of doctors in training (total):	67
Number of vacancies:	7
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 no exception reports for this time. Trainees were encouraged at last Junior doctor forum to report this.

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