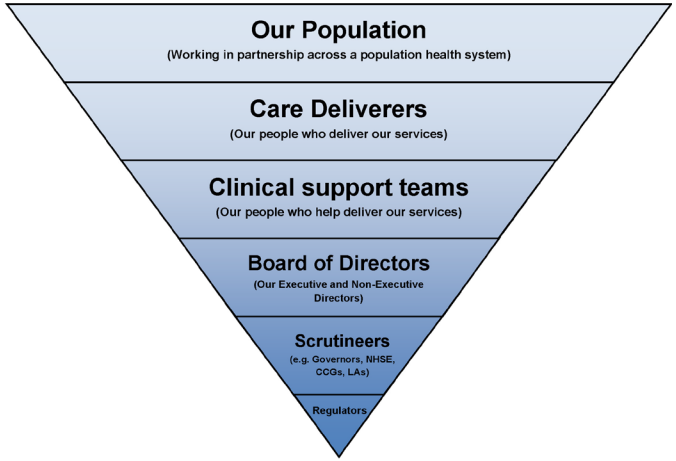
W1 Leadership	W2 Vision	W3 Culture	W4 Governance
W5 Risk	W6 Information	W7 Engagement	W8 Learning



NHS
Cheshire and Wirral Partnership
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Board of Directors *(held in Public)*

At 1:00pm on Wednesday 30 September 2020
Held Via WebEx

Ref	Title of item	Well-led theme	Format	Presented by	Time
	ASSURANCE				
	Committee governance				
20/21/32	Welcome, apologies and quoracy		Verbal	Chair	13:00 (5 mins)
20/21/33	Declarations of interest		Verbal		
20/21/34	Minutes of the previous meetings held July 2020		Paper		
20/21/35	Matters arising and action schedule		Paper		
20/21/36	2020/21 Business cycle		Paper		
20/21/37	Chair's Announcements		Verbal		13:05 (10 mins)
20/21/38	Chief Executive's Announcements		Verbal	Chief Executive	13:15 (30 mins)
	Internal reporting from committees, matters of governance and assurance				
20/21/39	**Quality Committee** • Chairs report from Quality Committee – 9th September 2020	W4 Governance W5 Risk	Paper	Quality Committee Chair	13:45 (5 mins)

Ref	Title of item	Well-led theme	Format	Presented by	Time
20/21/40	**Audit Committee** • Chairs report from Audit Committee – 8th September 2020	W4 Governance W5 Risk	Paper	Audit Committee Chair	13:50 (5 mins)
20/21/41	Board Assurance Framework *(Reported to Quality Committee and Operational Committee – Sept 20 - Board to Discuss and Note)*	W4 Governance W5 Risk W6 Information	Paper	Medical Director	13:55 (10 mins)
20/21/42	Provider Collaborative • Prospect Leadership Collaborative update *(Board to Note and Approve)*	W2 Vision W3 Culture W7 Engagement	Paper	Director of Strategy and Partnerships	14:05 (10 mins)
20/21/43	Data Protection MIAA Checklist – Compliance Review • MIAA Checklist – (Click Here) *(Reported to Operational Committee – September 2020 Board to Discuss and Note)*	W4 Governance W6 Information	Paper	Director of Business and Value	14:15 (5 mins)
20/21/44	Information Governance and Data Protection Sub-Committee – Terms of Reference *(Reported to the Information and Governance Data Protection Sub-Committee G sub-committee August 2020 & Operational Committee – September 2020 – Board to Note)*	W4 Governance W6 Information	Paper	Medical Director	14:20 (5 mins)
Break 14:25 – 14:35 (10 mins)					
	Quality of Care				
20/21/45	Report against strategic objectives *(Board to Discuss and Note)*	W4 Governance W5 Risk W6 Information	Paper	Director of Business and Value	14:35 (10 mins)
20/21/46	Safer Staffing: • Ward Staffing: July and August 2020 *(Board to Discuss and Note)*	W4 Governance W5 Risk	Paper	Associate Director of Nursing and Therapies (Mental Health and Learning Disabilities)	14:45 (10 mins)
20/21/47	Learning from Experience Report (April to July) *(Board to Discuss and Note)*	W4 Governance W5 Risk W6 Information	Paper	Associate Director of Nursing and Therapies (Mental Health and Learning Disabilities)	14:55 (10 mins)
20/21/48	CWP's Response to COVID-19 *(Board to Discuss and Note)*	W1 Leadership W4 Governance	Presentation (to follow)	Director of Operations	15:05 (25 mins)

Ref	Title of item	Well-led theme	Format	Presented by	Time
20/21/49	Safeguarding Annual Report – *(Click Here)* *(Reported to Trust Wide Safeguarding meeting - Board to Note)*	W4 Governance W8 Learning	Paper	Associate Director of Nursing and Therapies (Physical Health)	15:30 (10 mins)
	Any other business				
20/21/50	Any other business		Verbal	Chair/ All	15:40 (5 mins)
20/21/51	Matters for referral to any other groups				
20/21/52	Matters impacting on policy and/ or practice				
20/21/53	Review risk impact of items discussed				
20/21/54	Three things to communicate				
20/21/55	Review the effectiveness of today's meeting https://www.smartsurvey.co.uk/s/meetingeffectivenesssurvey/				
CLOSE [15:45]					
Date, time and venue of the next meeting: Wednesday 30 September 2020, 1:00pm (TBC)					

Version No	1	Date issued	24.09.2020

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

At 1:00pm on Wednesday 29 July 2020
At Boardroom, Redesmere

Present	Mike Maier	Chairman
	Dr Paul Bowen	Non-Executive Director
	Andrea Campbell	Non-Executive Director
	Dr Jim O'Connor	Non-Executive Director
	Rebecca Burke-Sharples	Non-Executive Director
	Sheena Cumiskey	Chief Executive
	Suzanne Edwards	Director of Operations
	Gary Flockhart	Director of Nursing, Therapies and Patient Partnership
	David Harris	Director of People and OD
	Tim Welch	Director of Business and Value
	Dr Anushta Sivananthan	Joint Medical Director, Quality, Compliance and Assurance
	Andy Styring	Director of Strategy
In attendance	Suzanne Christopher	Acting Company Secretary
	Katherine Wright	Associate Director of Communications, Engagement and Corporate Affairs
	Hayley McGowan	Associate Director, Nursing and Therapies (MH &LD) – *for items 20.21.16 & 20.21.17*
	Victoria Peach	Associate Director, Nursing and Therapies / Director of IPC – *for items 20.21.18 & 20.21.19*
Apologies	Dr Faouzi Alam	Joint Medical Director, Effectiveness, Medical Education and Medical Workforce & Caldicott Guardian
	Edward Jenner	Non-Executive Director

Ref	Title of item	Action
	Meeting governance	
20/21/1	**Welcome, apologies and quoracy** The Chair welcomed all to the meeting and confirmed the meeting as quorate. Tim Seabrooke (Service User and Carer Governor) was also welcomed to the meeting.	
20/21/2	**Declarations of interest** None were declared.	
20/21/3	**Minutes of the previous meeting held January 2020** The minutes had previously been approved at the Board of Directors meeting held in May 2020 (in private). The minutes were provided for completeness and noted.	
20/21/4	**Matters arising and action points** The action log was reviewed. There were no open actions.	

Ref	Title of item	Action
20/21/5	**2020/21 Cycle of business** The business cycle for 2020/21 was **noted**.	
20/21/6	**Chair's announcements** Mike Maier updated the Board of Directors on the following: **Safety measures update** Over recent months CWP have made fantastic progress in establishing appropriate safety measures across our wards, community services and clinical support areas. As we see lockdown measures gradually reduce nationally, CWP is making sure that colleagues remain as vigilant as ever to the risks of COVID-19. Expectations regarding the importance of following appropriate safety measures such as wearing the correct PPE, maintaining 2m social distancing and regular hand hygiene continue to be emphatically shared across our services and networks. **COVID-19 evaluation project** Our COVID-19 evaluation project continues at pace and we have had well over 1,000 responses from colleagues telling us about improvements and innovative practice that have put in place since the pandemic began. The project also seeks to understand any challenges or obstacles people have experienced to help us learn moving forward, and provides an opportunity for people to talk about their experiences throughout this period. This work is being led by a number of senior colleagues within the Trust. How this work links with the Board's Strategy refresh will also be discussed later on this agenda. **24/7 Urgent Mental Health Helpline** CWP's 24/7 All Age Urgent Mental Health Helpline was launched earlier this year. To date, our service has helped over 12,000 people in Cheshire West, Cheshire East and Wirral be supported in accessing the help they need. This is a testament to the incredible hard work of all those involved in the service. To further improve the helpline, CWP has launched a new Freephone number for the service, to ensure that access to urgent mental health support is available to all those who require it in our area. The new number for the service is 0800 145 6485 and all those who feel they require urgent support are encouraged to use the number and access appropriate support. **Lived Experience Connectors share their stories with HEE** Lived Experience Connectors (LECs) have been strengthening person-centred care at CWP for a number of years now. Due to the enormous success of this partnership between services and people, CWP recently teamed up with Health Education England (HEE), who asked for our help to support other Trusts in this area. HEE are almost ready to launch their campaign which will focus heavily on CWP's LEC story. **Virtual launch of #TeamCWP Choir** In response to the challenges experienced by so many during the COVID-19 pandemic, staff from across the Trust came together to perform a (virtual) rendition of the classic hit 'Over the Rainbow' to highlight the importance of staying in touch and looking out for one another. The performance can be viewed on the Trust's YouTube channel (www.youtube.com/CWPnhsft).	

Ref	Title of item	Action
	Creating a welcoming space for adults with autism CWP has helped the brand-new West Cheshire Autism Hub get ready for its virtual launch. The Autism Hub will be a welcoming space for autistic people to visit and access services, such as post-diagnostic support, supported volunteering and internship opportunities, social and community group activities and much more. While the Autism Hub will eventually be based at The Bluecoat in Chester, it has had to launch virtually for the time being because of the coronavirus (COVID-19) pandemic. The Board of Directors **noted** the above updates.	
20/21/7	**Chief Executive's announcements** Sheena Cumiskey updated Board members and those in attendance of proceedings at the private Board of Directors' meeting. This included: • Reflections on two staff stories relating to LGBT experiences. • Updates from the ICP's in regards to collaborative working, taking a population based approach and addressing inequalities. • CWP's response to COVID-19 with acknowledgement of staff's commitment to providing safe and effective care and our plans going forward. • Financial performance of the Trust to date, and the new financial regime that we are now operating in. • Receipt of the Trust's Equality, Diversity and Inclusion report. • Update in regards to CWP's strategy refresh along with the outcomes of the COVID evaluation project. The Board of Directors **noted** the above summary.	
	Internal reporting from committees, matters of governance and assurance	
20/21/8	**Quality Committee: Chair's report of the Quality Committee held on 1 July 2020** A Campbell introduced the item. The following areas were escalated to Board members: Restrictive practices were considered by the Committee who will be undertaking further work in this area, as a key priority for the trust. The work will take a continuous improvement approach. This will be a detailed piece of work to consider a different approach and a different way of thinking to allow progress to be assessed. An update was provided in regards to the COVID evaluation project and the lessons to be learnt (also introduced above by the Chair). The majority of the meeting focused on COVID, which was considered in great detail. The activities undertaken by the Trust to support the response to COVID provided assurance to the Committee. The Quality Improvement report was also received. In the context of a great deal of work responding to the current crisis, it was encouraging to see the continued work to ensure staff and service users are fully supported. The Board of Directors **noted** the Chair's report.	

Ref	Title of item	Action
20/21/9	**Audit Committee: Chair's Report of the Quality Committee held 8 July 2020** R Burke-Sharples introduced the item as vice chair of the Committee and on behalf of Edward Jenner (Chair of Audit Committee). It was noted that COVID had resulted in a number of delays for both the internal and external audit work. The meeting of the 8th July, therefore, combined the regular Audit Committee meeting and end of year annual reports and annual accounts. An extraordinary Board meeting was then held to formally approve the Annual Report and Accounts. Given the challenges that COVID 19 has presented, it was agreed that the internal audit plan for 20/21 required a review. A separate meeting has been scheduled for the 5th August to consider that along with our internal auditors. The Board of Directors **noted** the Chair's report.	
20/21/10	**Chair and Chief Executive: Division of Responsibilities** The Chair introduced the item, advising that the report provided a statement of responsibilities for the Chair and the Chief Executive. Board members were invited to comment or raise questions. The Board of Directors **approved** the statement of responsibilities.	
20/21/11	**Corporate Governance Manual** T Welch advised that the Corporate Governance Manual (CGM) sets out the Trust's system of regulations and this year, the review had been led by Mersey Internal Audit. Their review included a benchmarking exercise against other Trusts to compare areas such as delegation of limits etc. All proposed changes were set out in the SBAR and were considered by the Audit Committee, who endorsed the amended policy to the Board of Directors. The Board of Directors **approved** the revised Corporate Governance Manual.	
20/21/12	**Register of Seals** T Welch introduced the item, advising of the requirement within the standing orders for the organisation to affix a seal in regards to transactions. The register is required to be presented to and noted by the Board of Directors each year. The document provided is the register for the preceding 12 months (April 2019 to March 2020). The Board of Directors **noted** the report.	
20/21/13	**Flu Campaign** D Harris introduced the item. The report provided an overview of the learning from last year's processes and the proposed plans moving forward. It was noted that this year there will be an even higher expectation that every member of the NHS will have the vaccination unless exempt for clinical reasons. It is not yet confirmed if this will be a mandatory	

Ref	Title of item	Action
	requirement. The request to Board members is to approve the establishment of a project team to take the programme forward, which will also include closer involvement from Lloyds Pharmacy. A further report will follow to provide the detail of the work to date and the plans moving forward. J O'Connor queried access to the vaccination of those shielding. It was confirmed that this has been taken into consideration and is being worked into the plans. The Board of Directors **noted** the report and **approved** the establishment of a project team.	
	Quality of Care	
20/21/14	**Report against strategic objectives** T Welch introduced the item and noted the progress made in regards to the format of this report. As acknowledged at the May meeting, the report also included five additional metrics to provide further insight into how the trust has responded to COVID-19. The report was taken as read and provided for noting. Board members commented on the following areas. Vacancy and Turnover rates. The report reflected low numbers for both vacancies and turnover rates. Staff were thanked for their efforts to ensure recruitment activity continued, despite the challenges that now presented. Sickness absence. The report included an additional metrics to differentiate between COVID related and non-COVID related absence. As this is worked through, the potential impact on staff well-being needs to be supported. Referrals. Referral numbers had seen a decline, which is in part was due to COVID. The Trust is now seeing a steady increase in referral numbers and consideration needs to be given to how individuals are encouraged to return to service and any additional support they may require. The number of face to face contacts was noted, in particular for one care group who appeared to maintain a high level of face to face activity. It was suggested that learning is shared between care groups to consider different forums that may be utilised going forward. It was noted that the Neighbourhood's Care Group did make use of alternative platforms, such as telephone appointments and video facilities; however, much of their work also requires hands on assessment of patients. S Cumiskey noted her thanks to the team for the inclusion of the new metrics to allow Board members to be better sighted on CWP's response to COVID. It was requested that future reports also show the rating for each of the domains overall, as well as additional context to better understand the support provided to patients who were identified as high risk. A Campbell noted the importance of the report in regards to triangulating the assurances to Board, noting the reports also provided to Quality	

Ref	Title of item	Action
	Committee and other sub-committees. This report provides a further layer of assurance. It also allows Board members to compare outcomes both pre and post COVID. A Styring raised a query in relation to hospital admissions and if there is a potential for confusion in regards to this data including those admitted to acute wards as well as those admitted to assessment and treatment units. A Styring and S Edwards will consider this further outside of the Board meeting and ensure the data is clear for future reports. The Board of Directors **noted** the report.	
20/21/15	**Guardian of Safe working Q1 Report** A Sivananthan introduced the item on behalf of Dr F Alam. Board members were reminded that the report was a nationally mandated quarterly report to successfully monitor the working hours of doctors. The report provided assurance that hours and training requirements were being manged correctly for the period reported. **ACTION** – Doctors to be contacted to thank them for their efforts during the COVID response period. The Board of Directors **noted** the report.	KW
20/21/16	**Safer Staffing: May and June & Six monthly report** *H McGowan (Associate Director, Nursing and Therapies - MH &LD) joined the meeting.* The item was introduced by H McGowan. The report covered the period May 2020 to June 2020 and provided assurance that despite the challenges in regards to staffing establishments and staff absence, healthy fill rates have been maintained. Some staff remain redeployed to support the response to COVID. Additional support has also been received from Pre-Registered nursing students as part of the national response to COVID 19. The Chair commented on the detail of the report and the assurance this provides to Board members. Thanks was offered to all those who support the co-ordination of staff to ensure safe delivery of care. Six Monthly Report Board members were advised that during the COVID response period, the statutory requirement to provide this report has been suspended. However, CWP has continued to provide the report for Board members by way of assurance, to outline the work undertaken and highlight areas of good practice that have been implemented. Staff have embraced new ways of working and have maintained the safe delivery of services to our populations. Data for the All Age Disability Service has now also been included in this report. It was noted that the report highlighted the flexibility of staff. It was also apparent that there had been a clear reduction in staff sickness absence. Board members commented on the positive response from students to support the NHS during the pandemic.	

Ref	Title of item	Action
	R Burke-Sharples declared an interest in this item, in that her Daughter supports the placement of students currently and commented that students have put themselves forward so readily to support the NHS at this time. S Edwards advised that CWP was working alongside the 'Think Ahead' programme for the first time. The programme supports students as part of a fast track process to achieve their qualification. To date the feedback has been positive. CWP will consider engaging with this programme again in the future. G Flockhart advised Board members that the report has been developed over time and now has a greater emphasis on assurance, rather than data reporting. S Cumiskey thanked H McGown and her team for their work to ensure the trust has the right skills in the right place at the right time. The report provided Board members with a very detailed view of the work that has been undertaken to ensure the needs of people in our communities are met. The flexibility of staff and dedication of staff is clearly demonstrated as part of this report and reiterates our achievement of outstanding for Care, as it is evident that staff at CWP really do care. A Styring commented that there are a number of achievements that CWP has managed to implement whilst also supporting the pandemic. It was suggested that time is taken at the next Board meeting to consider that further. ***ACTION*** – Achievements of CWP during the pandemic to be presented to September Board. The Board of Directors **noted** the report.	KW / SE
20/21/17	**Learning from Experience** H McGowan introduced the item, advising that the report focused on Trimester 3 for 2019-20. The following key points were highlighted from the report;- • The number of incidents had reduced. However, work continues with Care Groups to ensure reporting continues in line with policy, along with support to staff to ensure they remain confident with reporting processes. Information and learning is also being captured and shared to support these processes. • The number of incidents being reported on StEIS has also reduced. This is in part due to more of a collaborative approach to meeting the StEIS reporting criteria. The trust has also utilised enhanced safety reviews where we are confident that no further learning would be identified, rather than level 1 investigation processes. • Electronic processes have now been embedded to ensure that safety reviews are undertaken in a timely manner. The process remains under review and feedback is being tracked from a number of people. Duty of candour is also being monitored and is reviewed via the weekly meetings.	

Ref	Title of item	Action
	• A recent survey was also issued to inform the development of learning processes. Dr J O'Connor confirmed that the report had also been submitted to the Quality Committee, who scrutinised the report and approved the recommendations. The Board of Directors **noted** the report. *H McGowan left the meeting.*	
20/21/18	**Freedom to Speak up Guardian 2019/20 Annual report** *V Peach (Associate Director, Nursing and Therapies / Director of IPC) joined the meeting.* V Peach introduced the item. Board members were advised that the report included the Freedom to Speak Up declaration, which is recognised as good practice and gives assurance of Board oversight. The report demonstrated that CWP have embedded and continued to improve its Freedom to Speak Up culture. A greater number of concerns have been raised within the last 12 months, and these appear to be evenly distributed across localities. No concerns have been raised by LD or All Age Disability Services. Contact has been made with these services to seek assurance that staff are aware of the processes and how to use them. There has been a noticeable increase in leadership and management issues. Regular meetings are held with HR colleagues to work through areas for improvement. This year's report also includes information in regards to the responsiveness of Freedom to Speak Up Guardians. It is reported that Guardians responded to concerns within a 72 hour period. The longest length of time that a case has remained open is 45 days. However, it is noted that a case will remain open as long as required. V Peach confirmed that commitments for 20/21 are all being progressed. A discussion followed in regards to the links between the staff survey results and the Freedom to Speak Up role. In particular, the staff survey has identified that staff do not always feel they will be treated fairly should they make a mistake. This could in turn impact on Freedom to Speak Up. V Peach confirmed that the team work closely with HR Colleagues to ensure a person centred approach to managing people through capability and disciplinary processes. S Cumiskey commented that this area is something that she often seeks feedback from during 'Breakfast with Sheena' sessions to better understand perceptions and consider how our approach to this can be improved. It was noted that the Trust emphasises a culture of learning and developing. Language is also an important area to be considered. A discussion also took place in regards to the leadership and management category of the data and potential trends concerning two particular Care Groups. V Peach advised that the national categories can cause an issue, and so the leadership and management category then becomes quite	

Ref	Title of item	Action
	broad and is usually the 'best fit' for a number of issues. Often the concerns relate to staff who are involved in capability or disciplinary processes, which is often a very sensitive issue to consider. Staff are encouraged to raise concerns as soon as possible, with the aim of resolving issues at an early stage. D Harris reiterated the importance of confident conversations with staff as well as mediation. It is important that managers have timely conversations to avoid matters escalating unnecessarily. A Campbell confirmed that the paper had also been presented to Quality Committee. However, given the staff stories presented ahead of the private Board of Directors meeting earlier today, questioned how the Freedom to Speak Up role supports concerns raised by those staff with protected characteristics and if we are aware of any underlying issues in relation to this. V Peach advised that regular meetings are also held with the Equality and Diversity Officer and that her and her colleague also have a presence at the Networks. The Board of Directors **noted** the report.	
20/21/19	**Infection, Prevention and Control 2019/20 Annual Report** V Peach introduced the item confirming this as the annual report for Infection, Prevention and Control (IPC) 2019/20. It was also noted that the previous Board meeting received the IPC Board Assurance framework, which has now been accepted by the CQC further to its submission and a recent engagement call. A number of achievements were highlighted to the Board from the report, including the following; • Work continues to ensure that all necessary training is accessible to all staff. • The Trust was successful in gaining the Cheshire East contract. • All ICP audits have been conducted with 93% compliance or above. • Cleaning assurance processes are now in place further to the feedback from CQC. Board members noted the detail of the report and the assurance provided. The work and commitment of the team was acknowledged and staff were thanked for their efforts. The Board of Directors **noted** the report. *V Peach left the meeting.*	
20/21/20	**Medicines Management 2019/20 Annual Report** A Sivanthan introduced the item. It was noted that the Medicines Management Annual Report had also been sighted at Quality Committee. A huge amount of work had taken place in year in regards to the use of medication and new models of care. The Board of Directors **noted** the report.	
20/21/21	**Medical Appraisal 2019/20 Annual Report** A Sivananthan introduced the item.	

Ref	Title of item	Action
	It was reported that Dr F Alam is the responsible officer for Medical Appraisal. Dr Alam supports 108 Doctors to ensure that they are providing care in line with GMC guidance. The report includes all Doctors, with the exception of those in training. Outcomes are reported to NHS England and Sheena Cumiskey is also required to formally sign off the process. The revalidation of Doctors has paused for 12 months and appraisal of Medial Staff will restart in September. Board members were asked to approve the annual report, further to which S Cumiskey will then formally sign off. Board members noted how comprehensive the report was. Assurance of due process was requested for those GP's who now fall under CWP, but all of whom have their own accountable officer. It was confirmed that although it is not a requirement to include them in this report, Dr F Alam works closely with their Accountable Officers to ensure appropriate approval. It was confirmed that this information could be added to the report going forward. The Board of Directors **noted** the report.	
20/21/22	**Health and Safety Annual Report** G Flockhart introduced the item. It was noted that the annual report had also been presented to the Health and Safety Sub-Committee and the Operational Committee. The following was highlighted; • Reduction in RIDDOR, mainly in relation to violence and aggression. • Slight increase in unwanted fire signals. Appropriate action has been taken to address this. • Work is on-going to support staff working remotely (self-help assessments). • The approach to the health and safety sub-committee has been reviewed along with its terms of reference. • Board are asked to note the report and the recommendations for 20/21. Thanks was offered to Lyn Ellis for her work on the Health and Safety agenda. The Board of Directors **noted** the report and the recommendations for 20/21.	
20/21/23	**GDPR Compliance Annual Review** T Welch introduced the item advising that the report outlines the trusts compliance with data protection regulations. It was noted that the toolkit is subject to review by internal audit and forms part of the supporting evidence that informs the Annual Governance Statement included in the Trust's Annual Report and Accounts. The work is overseen by the Governance and Data Protection sub-committee. The report has been submitted to the Operational Committee	

Ref	Title of item	Action
	for consideration and is now presented to Board for noting. The Board of Directors **noted** the report.	
	Strategy	
20/21/24	**Quality Improvement Report** A Sivananthan introduced the item. Board members were reminded that the trust agreed three quality priorities. Progress against those priorities is provided in the report. The information contained in this report, would normally form part of the Quality Report to be included in the Annual Report and Accounts. As Board members are aware, there was not requirement to submit a quality report this year as part of our statutory return. The three priorities set for 19/20 have been achieved. The report goes on to outline the priorities set for 20/21. Board noted the number of positive improvements that had been implemented during the year, and in light of the additional challenges of the pandemic. P Bowen commented on the quality of the report and how the information proves the value of CWP, and congratulated all on their efforts. The Board of Directors **noted** the report.	
20/21/25	**People and OD Strategy** D Harris introduced the item. It was noted, that due to staff supporting the response to COVID-19, the report had been slightly delayed. A number of key achievements were highlighted, including; • Coaching and mentoring activity has increased across the trust. • The virtual CWP academy has been launched. This now includes a lot of staff training and it is already being put to great use. • Recruitment activity has been maintained during the pandemic, due to the efforts of the recruitment team and the time dedicated to this by managers. It is proposed that this work is now paused whilst the Board take further the work on the trust strategy. The People and OD Strategy can then be aligned to that accordingly. It was noted that a number of the work areas had also been accelerated due to COVID, such as digital solutions and moving to an on-line approach. As part of the Trust strategy refresh, it is important to consider within that people's well-being. CWP has achieved a great deal in recent months, but this will also have an impact on staff. How we work more flexibly and address inequalities are important areas that the Board are focusing on as part of the strategy review, as well as influencing others across Cheshire and Wirral to support the best possible outcomes for our local communities.	

Ref	Title of item	Action
	S Cumiskey reflected the value of the report and how CWP continues to consider its people who are fundamental to the provision of high quality care experiences for our local communities. The workforce cell has ensured staff continue to be supported through this period of challenge, and have undertaken significant work whilst also being flexible in their approach. Thanks was offered to D Harris and his team. The Board of Directors **noted** the key achievements outlined in the report and **agreed** the proposal to refresh the People and OD Strategy following further work on the trust strategy.	
	Closing Business	
20/21/26	**Any other business** **Equality and Diversity Inclusion report** G Flockhart advised that during the private session of the Board of Directors, an update had been presented in relation to CWP's staff network groups. The work of the groups was helping the trust to further develop in regards to Disability, LGBT and BAME issues for example. S Cumiskey advised that the Board will take time to consider these matters in greater depth to ensure that everyone is treated with respect and dignity and is supported to be the best they can be as an employee of CWP. **Governor Attendance** Thanks was offered to Tim Seabrooke for his attendance to the session and he was invited to ask questions of the Board members. T Seabrooke commented on the amount of work that is taking place within CWP and how hard people have worked in what are very strange times. T Seabrooke advised that he found the meeting very interesting and thanked the Board members.	
20/21/27	**Matters for referral to any other groups** There were no matters to refer or escalate to other groups from the meeting.	
20/21/28	**Matters impacting on policy and/ or practice** There were no matters identified impacting on policy and/or practice.	
20/21/29	**Review risk impact of items discussed** It was acknowledged that the board assurance report and risk register reflected all risks discussed.	
20/21/30	**Key messages for communication** • Messages of thanks to staff for their efforts, commitment and flexibility during recent months.	
20/21/31	**Review of meeting performance** Board members were encouraged to review the meeting via the smart survey in order to continuously improve the meeting.	
	CLOSE	
Date, time and venue of the next meeting: **Wednesday 30 September 2020, 1:00pm (TBC)**		

Cheshire and Wirral Partnership NHS Foundation Trust
Open Actions Action Schedule

		Board of Directors: Open meeting action schedule: September 2020			

Meeting date	Group/ Ref	Action	By Whom	By when	Status
29.07.2020	20.21.15	Guarding of Safe Working Q1 Report : Doctors to be contacted to thank them for their efforts during the COVID response period.	KW	Sept 2020	Open
29.07.2020	20.21.16	Safer Staffing: May and June & Six monthly report : Achievements of CWP during the pandemic to be presented to September Board.	KW / SE	Sept 2020	Propose Close - Included on agenda

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Board of Directors
Business Cycle 2020/21 (Public Meeting)

	Item	Lead	Scope	Well-led domain	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Assurance	Chair and CEO report and Announcements	MM/SC	To update on developments not on agenda	W1 W6		✓		✓	✓		✓		✓		✓
	Review minutes of the previous meeting	MM	To approve minutes	W4 W5		✓		✓	✓		✓		✓		✓
	Place Based reports/ updates including ICP Board/s (minutes)	SC	To note system developments	W6		✓		✓	✓		✓		✓		✓
	Receive Chair's Report of the Quality Committee	JOC	Review Chair's Report and any matters for note/ escalation	W4 W5		✓		✓	✓		✓		✓		✓
	Receive Chair's Report of the Audit Committee	EJ	Review Chair's Report and any matters for note/ escalation	W4 W5		✓		✓	✓		✓		✓		✓
	Freedom to speak up six monthly report	AD	Review and note for assurance	W3 W5 W7 W8				✓					✓		
	People and OD strategy delivery	DH	Review and note for assurance	W2 W3 W7							✓		✓		✓
	Six monthly Infection Prevention Control Report	Director of IPC	Review and note for assurance	W4 W5									✓		

Item	Lead	Scope	Well-led domain	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Director of Infection Prevention and Control Annual Report Inc. PLACE	Director of IPC	Review and note for assurance	W4 W5				✓							
Safeguarding Adults and Children Annual Report and six monthly report	AD	Review and note for assurance	W4 W5				✓					✓		
Accountable Officer Annual report Inc. Medicines Management	AS	Review and note for assurance	W4 W5				✓							
Monthly Ward Staffing update (monthly and six monthly reporting)	AD	Review and note for assurance	W4 W5		✓		✓	✓		✓		✓		✓
Research Annual Report	FA	Review and note for assurance	W2 W8					✓						
Medical Appraisal Annual Report and annual declaration of Medical revalidation	FA	Review and note for assurance	W4 W5				✓							
Performance report against strategic objectives	TW	Review performance and risk	W4 W5 W6		✓		✓	✓		✓		✓		✓
Annual Report, Accounts and Quality Account	TW	Statutory requirement	W4 W6		✓									
Annual SIRO report	TW	Review and note for assurance	W4 W5				✓							
Health and Safety Annual Report and Fire and Link Certification	AD	Review and note for assurance	W4 W5				✓							
Board Assurance Framework	AS	Review and note for assurance	W4 W5 W6		✓			✓				✓		✓

Item	Lead	Scope	Well-led domain	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Learning from Experience report, Inc. Learning from Deaths	AD	Review and note for assurance	W4 W5 W6		✓			✓				✓		
Integrated Governance Framework – annual review	AS	Best practice annual review	W4									✓		
Equality and Diversity responsibilities inc. WRES and WDES	AD	Review and note for assurance	W7					✓						
Guardian of Safe Working quarterly report	FA	Review and note for assurance	W4 W5 W3 W7		✓		✓			✓		✓		
Annual Provider Licence Compliance and self-certification statements	TW	Review and note for assurance/ regulatory requirement	W4		✓									
CQC Statement of Purpose	AS	Regulatory requirement	W4									✓		
Data Protection and Security toolkit	FA	Review and note for assurance	W4 W5 W6											✓
GDPR compliance annual review	FA	Review and note for assurance	W4 W5 W6				✓							
Register of Sealings	TW	Governance requirement	W4					✓						
Register of Interests (Directors and Governors)	MM	Governance requirement	W4		✓									
Corporate Governance Manual	TW	Best practice annual review	W4									✓		

	Item	Lead	Scope	Well-led domain	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Fit and Proper Persons annual assurance	DH	Regulatory and Licence requirement	W4					✓						
	Terms of Reference and effectiveness reviews: • Quality Committee • Audit Committee • Operational Committee	JOC/SC	Governance requirement	W4		✓		✓							
	Review risk impacts of items	MM/SC	Identify any new risk impacts	W4		✓		✓	✓		✓		✓		✓
	CEO/Chair Division of Responsibilities	MM/SC	Governance requirement	W3 W4 W6		✓									
	BOD draft Business Cycle 2021/222	MM/SC	Ensure matters reported to the Board in a timely fashion	W4											✓
IMPROVEMENT	Quality Improvement report/ strategy implementation	AS	Review and note for assurance	W2 W3 W8				✓			✓				✓
	CQC Community Patient Survey Report (themes and improvement plan)	AD	Review and note for assurance	W3 W7							✓				
	NHS Staff Survey (themes and improvement plan)	DH	Review and note for assurance	W3 W7											✓
	People and OD strategy inc. workforce planning)	DH	Review and note for assurance	W3 W7		✓					✓				

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

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STANDARDISED CHAIR'S REPORT

CHAIR'S REPORT DETAILS	
Name of meeting:	Quality Committee
Chair of meeting:	Andrea Campbell, Non Executive Director
Date of meeting:	09/09/2020

(ESCALATION)

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

The Thorn Heys Short Breaks Service remains suspended, pending further review w/c 14 September 2020. A quality and equality impact assessment has been undertaken to mitigate the impact of this suspension, with assurance received that any matters requiring escalation will be escalated to the Tactical Command Group and Senior Executive Group.

The regulatory action plan around the ADHD strategic risk has been reviewed following points of clarification requested by the CQC. Progress with risk treatment will be taken at each meeting to ensure matters requiring escalation, including action plan timeframes, can be supported and overseen.

To support the emerging Trust strategy refresh, in October 2020, the Board will be asked to approve the output of a review of our corporate governance structures to take on board learning from the emergency response to the COVID-19 pandemic regarding lean decision making.

(ASSURANCE)

Matters discussed:

A report on the impact of the COVID-19 pandemic on the use of the Mental Health Act was received, with assurance taken that the Trust is ensuring the protection of people's liberty/ rights, and that information is being monitored and evaluated to ensure oversight of actions to reduce health inequalities. Access to advocacy in Cheshire has returned to a face to face offer, with Wirral soon to follow suit.

The IPC Board Assurance Framework was received and provided assurance of the measures being taken in line with current pandemic guidance. The CQC had assessed this via an engagement call held on 24/07/2020 and found that the Board is assured that the Trust has effective measures in place. A small number of minor gaps in assurance were noted by the CQC, with the Quality Committee being assured of actions and interventions being taken to improve on these. The CQC will continue to monitor progress through routine and ongoing monthly engagement with the Trust.

Detailed assurance was received against the supervision strategic risk treatment plan, with improvement actions noted as returning the residual risk score to its pre-pandemic level.

(IMPROVEMENT)

Achievements:

Numerous quality improvement achievements were presented in the Quality Improvement report and Lived Experience, Volunteering & Engagement Network report.

The 'Quality Assurance dashboard' has been redesigned as a 'Providing High Quality Care' report. As part of our evolving strategy, it will include wider measures which reflect population outcome measures and our aspiration to reduce health inequalities. The measures proposed are those which are already collected so as not to add burden to clinicians. The measures proposed are from the Long Term Plan and the Centre for Mental Health's recent report on inequalities in mental health. Feedback on the measures is being sought and this improvement work is being highlighted to the Board as one method of ensuring quality is aligned to strategy.

Following on from the success of the Clinical Ethics Forum (CEF) set up temporarily during the emergency response to the COVID-19 pandemic, Quality Committee approved the establishment of a permanent structure for a CEF. Further comments and recommendations are currently being sought.

The Trust has received the outcome of the reviews/ visits it has been involved in as part of the Getting It Right First Time (GIRFT) NHS improvement programme. To ensure Quality Committee oversight, Care Groups will bring their improvement plans and progress every six months to the meeting; they may also need to take relevant operational challenges and escalation to Operational Committee.

STANDARDISED CHAIR'S REPORT

NHS Cheshire and Wirral Partnership

CHAIR'S REPORT DETAILS	
Name of meeting:	Audit Committee
Chair of meeting:	Edward Jenner
Date of meeting:	8th September 2020

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

Internal Audit Plan

- Some delays in the commencement of the Internal Audit plan for 20/21 have been evident as a result of COVID-19. Assurance is provided that a revised Plan has been considered in detail by the Audit Committee with amended timescales to ensure all necessary work is undertaken within the financial calendar year. MIAA reported to the Audit Committee on the 8th September, that projects are now underway and thanked CWP colleagues for their co-operation in this area to ensure projects are now on track.

Improved Assurance to Quality Committee

- Further to a recent audit undertaken by MIAA, it was recommended that the identified Sub-Committee with oversight of each risk included on the BAF be reviewed. It was noted, that for some risks, greater oversight is required by the Quality Committee. The terms of reference for this committee are currently under review and the Chair and MIAA will link to consider this further.

External Audit – New Code of Practice

- The Committee were informed of a new code of practice that will come into force in 2021. The new code, will introduce additional responsibilities on external auditors when reviewing the Value for Money Statement. This will significantly impact on the work required to be undertaken by external auditors. Grant Thornton will provide further details once the full documentation is available. Board members will be kept informed accordingly.

Matters discussed/decision: (ASSURANCE)

Internal Audit
Progress report

- A refreshed audit plan has been approved and priorities have been agreed.
- It was confirmed that work is now on track. Outcomes will be reported to future Audit Committees.
- Reference was made regarding Clinical Supervision and a notable drop in the data during the pandemic. It was confirmed that this related to data entry only. This has recently been reviewed by the Associate Director of Nursing and a detailed report will be provided to the Quality Committee for consideration and assurance.

Key priority projects review

- Work in this area is on-going, further to the audit and feedback from CQC. This work will also be further reviewed alongside the trust's Strategy Refresh currently underway.

External Audit

- External Audit provided the annual audit letter to Committee members, which confirmed the no concerns have been raised as part of the audit process and an unqualified opinion has been awarded to CWP in regards to the financial statements.
-

Anti-fraud

- The Anti-fraud Annual Report was presented to the Committee providing an overview of work undertaken for this period.
- It was confirmed that no fraud referrals had been received during the reporting period.
- One live criminal case had been cancelled due to Covid-19 and has been re-scheduled for March 2021.

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Board assurance framework and strategic risk register
Agenda ref. number:	20.21.41
Report to (meeting):	Board of Directors (meeting in public)
Action required:	Discussion and Approval
Date of meeting:	30/09/2020
Presented by:	Dr Anushta Sivananthan, Medical Director (Executive Lead for Quality)

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
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 strategic risk register to inform discussion of the current risks to the delivery of the organisational strategic objectives, and as per the requirements outlined within the Trust's integrated governance framework. The report indicates progress against the mitigating actions identified against the Trust's strategic risks and the controls and assurances in place that act as mitigations against each strategic risk.

As at 17 September the Trust has the Trust has 9 strategic risks – three are rated red and six are rated amber.

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

The Medical Director (Executive Lead for Quality) and the Quality Committee are the designated officer and committee respectively for risk management. The Quality Committee reviews the strategic risk register. The Board of Directors reviews the corporate 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. Commencing in July 2020, Operational Committee also receives the strategic risk register to increase operational awareness of strategic risks and to respond to CQC feedback around ensuring differentiation between strategic and operational risks.

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

New strategic risks

There are no new risks or new risks in-scope.

Operational Committee noted that, in light of the CWP forward strategy review, risks around new objectives are in the process of being considered.

Current strategic risks

Strategic risk #4 – *Risk that the impact of COVID-19 will adversely affect services provided by CWP* has been updated in light of the dynamic nature of the risk. Quality Committee noted operational updates on this risk via the TCG collective risk logs and updates from Care Group representatives, with further updates recieved at Operational Committee on 23 September 2020.

Strategic risk #9 – *Risk of increasing demand for ADHD services which exceeds current contract values and commissioned capacity, resulting in increasing waiting times and complaints from people who have not accessed services due to gaps in commissioning* has been updated in response to additional clarification sought by the CQC following submission of the Trust's regulatory action plan. At the CQC relationship management meeting on 2 September 2020, the CQC were satisfied with the Trust's updated action plan and agreed to monitor progress with this on a monthly basis; this is also monitored within the Trust via Quality Committee and Operational Committee.

All other strategic risk positions have been updated as per Appendix 1.

Amended risk scores

The score for strategic risk #1 – *Supervision compliance rates are below Trust target of 85%* has been has been decreased from 16 to 12 to reflect the improved position (a return to approx. ~80% for both clinical and management supervision, i.e. to pre-pandemic levels when this risk was scored 12, as reported in the July 2020 Operational Committee dashboard). Quality Committee noted additional assurance in relation to the continuous improvement plans for this risk and sustainability of target performance.

Operational Committee noted a slight dip in Truswide performance in relation to supervision in the September Continuous Improvement Report (August 2020 data). This will continue to be monitored and reflected in future risk scoring and treatment plans as required.

Exception reporting

There are no exceptions to report against overdue risk treatment plan actions – all are on track.

Enhancements to reporting

An addition has been included in the Board Assurance Framework, tracking strategic risk ratings from May 2020. See the "risk over time" tab within Appendix 1. This addresses a recommendation made by the CQC following their inspection (published June 2020) that CWP "should fully track and measure the risk ratings over time to see if remedial work to mitigate risk was effective." As can be seen from the graphs showing risk score over time, with the exception of strategic risk 1 as referenced above, all strategic risk scores have remained static. Whilst this might usually be an indicator that currently identified risk treatment plans for some risks are not effective in reducing the residual risk, there are no overdue risk treatment actions (risk mitigation progress is on track) and as previously reported, without exception, every strategic risk has been affected by the emergency response to the COVID-19 pandemic. As the NHS returns to "near normal" responses as part of the ongoing Phase 3 COVID-19 response, the next report to Quality Committee in November 2020 will revisit the rigour of current risk treatment plans, supported by the risk score tracker. The same will apply to Care Group risk treatment plans overseen by the Operational Committee.

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

The Board of Directors is asked to **review**, **discuss** and **approve** the amendments made to the corporate assurance framework as recommended by the Quality Committee.

Who has approved this report?	K Wright, AD of Communications, Engagement and Corporate Affairs
Contributing authors:	Elspeth Fergusson, Business and Governance Lead

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	

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

Appendix No.	Appendix title
1	Board assurance framework and strategic risk register

Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Progress update on establishment of Provider Collaboratives in CWP
Agenda ref. number:	20.21.42
Report to (meeting):	Board of Directors Meeting
Action required:	Discussion and Approval
Date of meeting:	25/09/2020
Presented by:	Andy Styring, Director of Strategy and Partnerships

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

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

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

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

REPORT BRIEFING

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

- A full position statement on the establishment of the Provider Collaboratives (PCs) for CAMHS Tier 4 in Cheshire and Merseyside and Adult Eating Disorders in the North West was presented at the Executive Directors meeting held on 30th July 2020. This report provides an updated position on progress since that meeting, including the appointment of additional programme management capacity.
- The timescale for completion of the two detailed Lead Provider business cases has been informally notified by NHSE/I as December 2020 when the Approval Panels for the business cases will be held in order that, once approved, each Provider Collaborative will be operational by April 2021.

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

- The establishment of Lead Provider arrangements within the 2 Provider Collaboratives by April 2021 will be highly challenging as the Programme was suspended for a period of time due to the COVID -19 pandemic restrictions.
- Learning from the former New Care Models Mental Health initiatives and other fast track Provider Collaboratives (Mersey care) will be secured.
- The clinical delivery models for both AED and CAMHS Tier 4 are well developed and a recent Getting it Right First Time (GIRFT) assessment highlighted the best practice already in place across CWP

CAMHS Tier 4 services.

- The PC programme not only requires confirmation of the clinical delivery models but also assurance to NHSE/I on the safety, sustainability and compliance of the PC in meeting national standards. The transfer of commissioning responsibilities to the PCs will require detailed discussion in order to provide that assurance. The NHSE/I Quality Maturity Framework will be used to assess progress.
- There are significant operational challenges of insufficient resources, organisational resistance to change and the need for agreed governance processes which must be managed.

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

The core deliverables on the PC Programme aim to secure operational Lead Providers within PCs by April 2021 and are:

1. Establishment of a Partnership Board within each service area with detailed Terms of Reference.
2. Preparation of Full Business Cases for both CAMHS Tier 4 in C&M and Adult Eating Disorders in the North West to present at the NHSE Approval Panels. If approved, operational plans to establish the PCs.

Programme Enablers

In securing these core deliverables, there are a number of structures and processes that will be established:

Programme Management Structure

A part time Programme Manager has been appointed to develop the CWP Local Delivery Plans in support of the Lead Provider Full Business Cases in each service area. The Programme Manager will report on a weekly basis to the Director of Strategy and Partnerships and Associate Director of Effective Services.

Local Delivery Plans

The Programme Manager will work with each service team to develop a detailed Local Delivery Plan with actions, timescales and deliverables. A Draft Business Case for CAMHS Tier 4 and Adult Eating Disorders will be presented to the Board of Directors in October 2020 with the final Business Case being presented in November 2020.

Quality Maturity Framework

The delineation of provider and commissioning roles within each PC will be guided by assessment against the NHSE/I Quality Maturity Framework

Stakeholder Communications and Engagement Plans

A plan for full engagement and involvement of all key stakeholders in each PC will form part of each Local Delivery Plan. Critical to any change programme is the effective communication of progress and it is considered essential that dedicated communications resource is allocated to the programme.

Risk Assessment

There are a number of risks facing the CWP PC programme. A detailed Risk and Issues log will be established as part of each Local Delivery Plan and will be presented at the Board of Directors in Oct 2020 and Nov 2020 alongside the business cases. The Board can then assess the risk mitigation plans and consider the impact on the Trust. In summary, the risks are:

Programme Delivery – the timescale for securing agreement across the partner organisations in order to present the final business cases to the Approvals Panel in December 2020 is extremely challenging.
Financial Risk – securing sufficient financial resources to mitigate any risk facing CWP as lead provider within these PCs. In addition to this, reaching agreement on the financial risk and gain share across partner organisations.
Clinical Risk – due to the large number of organisations involved in delivering care across the CAMHS and Eating Disorder pathways, there are risks of lack of cohesion, alignment and synergy.
Operational Risk – there are a number of operational delivery risks in the programme including workforce, particularly with reference to the transfer of commissioning responsibilities from NHSE/I. Also need to agree how decision making on strategic service priorities and investments will be made.
Reputational Risk – the potential consequence of the key risks not being sufficiently mitigated is a reputational impact on CWP.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors is asked to: • Note the progress with the Provider Collaboratives in CWP and the proposed programme management processes to secure delivery of the business cases by December 2020. • Approve the allocation of CWP Communications Team resource to the Programme

Who has approved this report for receipt at the above meeting?	Andy Styring, Director of Strategy & Partnerships
Contributing authors:	Claire James, Associate Director of Effective Services

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Claire James, Associate Director of Effective Services	17/09/2020
2	Claire James & Andy Styring	18/09/2020

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

Appendix No.	Appendix title

NHS
Cheshire and Wirral Partnership
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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	PROSPECT Lead Provider Collaborative Update
Agenda ref. number:	20.21.42
Report to (meeting):	Trust Board
Action required:	Information and noting
Date of meeting:	09/09/2020
Presented by:	Andy Styring, Director of Strategy and Partnerships, CWP

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	No
Sustain financial viability and deliver value for money	No
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes

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

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

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

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

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

REPORT BRIEFING

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

In July 2020 Mersey Care, with support of the PROSPECT Partners, applied to be the Lead Provider in the Lead Provider Collaborative (LPC) process in respect of secure Mental Illness and Personality Disorder services across Cheshire and Merseyside (the current PROSPECT Partnership). The application was subsequently fast tracked with a go live date of the 1st April 2020.

Following negotiations with other Lead Providers across the North West (Greater Manchester Mental Health and Lancashire & South Cumbria NHS Foundation Trust), it was agreed that Mersey Care would also be the Lead Provider for Learning Disability and Autism services across the North West area.

On 25th March 2020, following the outbreak of Covid-19, the NHSE/I national team advised that the LPC process was paused for a period of at least six months to allow providers to focus on their response to the pandemic. The programme has now resumed with an ambition that fast tracked LPCs will go live on 1st October 2020.

For the PROSPECT New Care Model, a number of financial risks had been identified and subsequently mitigated by way of caveat agreement with NHSE/I regional team. For the LPC, that agreement no longer applies but the risks remain in place. Negotiations are taking place at both regional and national level in order to seek satisfactory mitigations.

On 31st July 2020 the Mersey Care advised NHSE that as these issues have not been resolved, it would not be able to achieve the required levels of assurance to meet a go live date of 1st October 2020 and the PROSPECT LPC would therefore be working towards a go live on 1st April 2021.

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

In July 2019 Mersey Care applied to be Lead Provider for adult low and medium secure Mental Illness and Personality Disorder services across Cheshire and Merseyside (the existing PROPSECT New Care Model partnership) and the application was subsequently fast tracked, with a go live date of 1st April 2020.

On 7th February 2020, agreement was reached with Greater Manchester Mental Health, Lancashire and South Cumbria NHS FT and NHSE/I that Mersey Care would also be the Lead Provider for Learning Disability and Autism secure services across the North West.

A number of financial risks have been identified and negotiations are ongoing with NHSE/I regional and national colleagues to seek mitigation, in line with caveats that are currently in place for the PROSPECT New Care Model. In addition, further information is awaited in respect of the LDA patient cohort in order to complete due diligence. The business case cannot be finalised until this is completed.

An update was provided to PROSPECT Partnership Board on 20th July 2020 and on 31st July 2020 NHSE/I were formally advised that, due to these ongoing negotiations, Mersey Care could not complete the required due diligence and governance processes to achieve a go live date of 1st October 2020. In effect, PROSPECT is now working to the timescales of the development tracks with a go live date of 1st April 2021.

Regular updates will be provided to Partners and it is envisaged that the business case will be presented to Boards in January 2021 for approval, with sub-contracts agreed prior to the go live date of 1st April 2021.

Whilst the financial negotiations are ongoing Mersey Care is in the process of agreeing the governance arrangements for the NW LDA LPC with Greater Manchester Mental Health and Lancashire Care and the PROPSECT Partnership Board provides ongoing governance of the New Care Model.

LPCs allow local clinicians greater control over decision making and financial flows which will have a positive impact across all CQC domains (Safe, Effective, Caring, Responsive, Well-Led).

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

Ongoing negotiations continue to mitigate financial risks with regular updates provided to all Partners. CWP is well integrated into this work.

Business case will be presented to Boards in January 2021 and sub-contracts agreed prior to 1st April 2021.

This paper does not involve significant change(s) to service delivery and as such no engagement took place with service users, carers or staff.

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

The Board are asked to note the contents of this paper for information, including the delay in the go-live date from 1 April 2020 to 1 April 2021.

Who has approved this report for receipt at the above meeting?	Andy Styring, Director of Strategy and Partnerships, CWP
Contributing authors:	Louise Edwards, Director of Strategy and Planning, Mersey Care NHS Foundation Trust on behalf of PROSPECT

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued

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

Appendix No.	Appendix title

NHS
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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Covid-19 Data Protection Checklist
Agenda ref. number:	20.21.43
Report to (meeting):	Board of Directors
Action required:	Note
Date of meeting:	30/09/2020
Presented by:	Dr Faouzi Alam, Medical Director, Effectiveness, Medical Education and Medical Workforce/Caldicott Guardian

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

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

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

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

REPORT BRIEFING

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

The purpose of the report is to provide assurance in relation to Covid-19 Data Protection considerations. The checklist was submitted to the Operational Committee in September for review and scrutiny. The Board of Directors are requested to note the Covid-19 Data Protection Checklist.

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

A Covid-19 data protection checklist was provided to the Trust for optional use by Mersey Internal Audit Agency. The checklist reflects guidance issued by the Information Commissioner and NHS Digital (NHSX). It provides:

- Structured approach to assessing the robustness of internal control, governance and risk management arrangements, specifically in relation to data security and protection in the context of Covid-19.
- Vehicle for checking and demonstrating that measures, established at pace, were implemented in accordance with legal and NHS requirements.
- Supplement statutory documentation of processing activities, which can be used to support future assurance.
- Referencing and planning tool for data protection in the recovery phase, working towards a return to

`business as usual'.

Information Governance & Data Protection Sub-Committee (IG & DP SC) reviewed the completed checklist on 24/08/2020.

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

- Accountability arrangements:
  At the beginning of the pandemic the IG & DP SC was deferred and then streamlined appropriately to include items for approval and relevant Covid-19 updates. Accountability arrangements in relation to data protection were unaffected.

- Staying connected (video conferencing/tablets/mobile devices – staff and patients):
  Daily Covid-19 staff briefings were issued which included all information governance related issues. All wards have portable laptops and/or tablet devices, which can be used for patients to keep in touch with relatives.

- Data protection impact assessments:
  Normal DPIA processes have continued during the pandemic e.g. video conferencing platforms and business as usual DPIAs.

- New processing of personal data:
  New processing has been reviewed by the DPO and approved by the Caldicott Guardian. Data flows have been documented in the information asset register.

- Lawful basis/data protection/privacy notices and data subject rights considerations:
  An additional Covid-19 privacy notice was published on the Trust website alongside the existing privacy notice. Information in relation to COPI notices was disseminated to staff. Privacy information has been disseminated to staff alongside information in relation testing.

- Access to NHS data sets:
  The Trust is making use of NHS data sets where possible.

- Risk considerations:
  The COPI notices have been extended and are in effect until 31 March 2021, when they will either be extended further or expire. When the COPI notices expire, Covid-19 related information sharing will either cease or another legal basis will need to be found for sharing to continue. The IGDP SC will continue to monitor guidance from NHSx in relation to COPI notices. The IGDP SC reviewed the completed checklist and agreed that there were no current risks in relation to Covid-19 and data protection.

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

The Board of Directors are asked to note the Covid-19 Data Protection Checklist.

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Information Governance & Data Protection Sub-Committee	24/08/2020
2	Operational Committee	23/09/2020

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

Appendix No.	Appendix title
1	Covid-19 Data Protection Checklist

Cheshire and Wirral Partnership
NHS Foundation Trust

Information Governance & Data Protection Sub Committee

Terms of Reference

1. Constitution

The Operational Committee hereby resolves to establish a committee to be known as the Information Governance and Data Protection Sub-Committee.

2. Duties

The Information Governance and Data Protection Sub-Committee is responsible for:

- Supporting the trusts strategic goals contractual and regulatory requirements, specifically through compliance with the annual Data Security and Protection Toolkit (DSPT) assessment which encompasses the National Data Guardian review's 10 data security standards. The requirements of the DSPT also support key requirements under the General Data Protection Regulation (GDPR) and the Data Protection Act 2018.

Assurance
The sub-committee will provide assurance on Information Governance and Data Protection requirements and the Data Security & Protection Toolkit standards.

Improvement
The sub-committee will ensure that assessments/audits of records and information governance policies and arrangements include improvement plans with clear timescales and accountability arrangements.

The Information Governance and Data Protection Sub-Committee has delegated responsibility from the Operational Committee for agreeing and monitoring progress against the data security and protection toolkit and data protection work plans, ensuring that the Trust has effective policies and management arrangements covering all aspects of information governance (IG), records management and clinical systems.

The Information Governance and Data Protection Sub- Committee's duties can be categorised as:

Assurance

- Implementing the information governance framework and monitoring performance against the data security and protection toolkit and data protection work plans identifying any associated risks the requirements outlined above ensuring that risks/issues associated with duties of the sub-committee are escalated (where appropriate) and mitigating actions are in place.

- Reviewing and approving IG related policies.

- Reviewing evidence for final submission of DS&P toolkit and make recommendations to Board in respect of the annual information governance and data protection reports.

- Receiving and considering reports into records incidents, breaches of confidentiality and information security, availability of paper records, subject access requests compliance with timescales, FOI requests and compliance with timescales.

- Reviewing data privacy impact assessments and information sharing agreements for any new processing which is likely to result in a high risk to the rights and freedoms of data subjects.

- Ensuring a log of records/information governance and Caldicott queries is maintained on the information governance page of the intranet.

Improvement

- Where appropriate undertaking or recommending remedial action in relation to records incidents, breaches of confidentiality, information and cyber security, availability of paper records, subject access requests compliance with timescales, FOI requests and compliance with timescales.

- Ensuring that the Trust undertakes annual assessments/audits of its records and information governance policies and arrangements including improvement plans with clear timescales and accountability arrangements.

- Undertaking an education programme to include records management, information governance, data protection and Caldicott.

- Liaising with other Trust committees and working groups in order to promote records and information governance work plan.

3. Membership

Membership will be appointed by the Operational Committee and will consist of the following:

- Medical Director - Effectiveness/Caldicott Guardian(Chair)
- ~~Information Governance~~ Lead~~/Data Protection Officer~~ (Vice chair)
- Clinical Lead for Informatics/ Chief Clinical Information Officer (CCIO)
- Head of Clinical Governance
- Head of Information Management & Business Intelligence
- Head of Corporate Affairs (for FOI)
- Head of ICT
- Research and Effectiveness Manager
- Chief Pharmacist
- Head of Operations, or the deputy, for each Care Group*
- Clinical representative for each Care Group*
- Clinical Audit (Healthcare Quality Improvement) representative
- System Managers
- People Information representative

- Representatives of other organisations may be invited when appropriate
- Key staff to attend by invitation

* Care Group represented will be:

- Specialist Mental Health
- Neighbourhood Based Services
- Children, Young People and Families
- Transforming Care for People with LD and NDD

If core members cannot attend meetings, they must ensure that a nominated deputy attends.

The following individuals may be in attendance at meetings:
Committee Secretary

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum.

The Board of Directors will appoint one of the members to be Chair and another Vice Chair from the outset. The Vice Chair will automatically assume the authority of the Chair should the former be absent.

a. Quorum
A quorum shall be 50% of core membership including the Chair or Vice Chair, and also 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
Core members identified above 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 Information Governance and Data Protection Sub-Committee will be accountable to the Operational Committee.

The minutes of the Information Governance and Data Protection Sub-Committee will be formally recorded and submitted to the Operational Committee. The Chair of the Information Governance and Data Protection Sub-Committee shall draw to the attention of the Board of Directors any issues that require disclosure to it, or require executive action, via a Chair's report.

The Chair's report will also be circulated to the Operational Committee for information.

Members of the Information Governance and Data Protection Sub-Committee will provide reports to the Operational 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 every two months, with at least 5 meetings per year, and additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.

6. Authority

The Information Governance and Data Protection Sub-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 request made by the Information Governance and Data Protection Sub-Committee.

The Information Governance and Data Protection Sub-Committee is authorised to obtain legal or other independent professional advice and to secure the attendance of other parties with relevant experience and expertise to facilitate its understanding of the issues if it considers necessary.

7. Monitoring effectiveness

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

8. Administration

The Sub-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 by the Sub-Committee.

Date reviewed by Sub-Committee	06/07/2020
Date approved by Quality/ Operational Committee	
Review date	As per 2020/21 business cycle

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Report against Strategic Objectives – September 2020
Agenda ref. number:	20.21.45
Report to (meeting):	Board of Directors (meeting in public)
Action required:	Discussion and Approval
Date of meeting:	30/09/2020
Presented by:	James Partington, Quality Surveillance Specialist

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

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

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

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

REPORT BRIEFING

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

In mid-2019 the Board of Directors requested the development of a new product through which the Trust could report against its strategic objectives. This was based on metrics identified by the Board in December 2018. The new report was launched in September 2019 and the September 2020 edition presented today is the seventh iteration.

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

Feedback since the early versions of this Report has centred on the following: continuing to add more commentary/ annotations so that the annotated time series form part of our corporate memory; named owners for each metric to take responsibility for content and sign off; the addition of targets/ benchmarks where appropriate and to provide further context; and the inclusion of further metrics to continually improve the Report's relevance. Regarding the latter point, five metrics were added in May and again in July to give insight into how the Trust has responded to the COVID-19 pandemic. These have been provided again in September, but in an appendix separate from the main Report. Links to the Trust's strategic risks have not been shown this month pending further consideration of how best these relationships can be represented. A chart has been developed to show a visual, rather than narrative, summary of Duty of Candour information.

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

Current performance

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

A number of metrics including patient engagement/feedback and use of resources have ceased to be available during the pandemic. The Report makes it clear where data have not been updated. However, even though national reporting requirements were eased during the pandemic, the Trust has still monitored exceptions against NHSi targets and, following good performance in June, performed well again in September with only one breach.

The supervision charts show recovery to pre-pandemic levels.

The sickness absence chart shows recovery following high levels during the pandemic. Absence in each of the most recent three months has been below the long term average.

CWP's vacancy rate remains low.

The additional activity charts show that telephone contact continues to run much higher than before the start of the pandemic in mental health services, and they also show some slowing down of referrals into mental health services in recent weeks.

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

The Board of Directors are asked to discuss and note the report.

Who has approved this report for receipt at the above meeting?	Board business cycle requirement
Contributing authors:	James Partington, Tim Welch, Andy Harland, David Harris, Simon Platt, Cathy Walsh, Anushta Sivananthan, Hayley McGowan, Maddy Lowry, Gary Flockhart

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	18/09/2020

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

Appendix No.	Appendix title
1	Report against CWP Strategic Objectives September 2020 final (powerpoint file)
2	Report against CWP Strategic Objectives September 2020 Appendix (powerpoint file)

Report Against Strategic Objectives

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

September 2020

Quality Surveillance Analysis Team

Helping people to be
the best they can be

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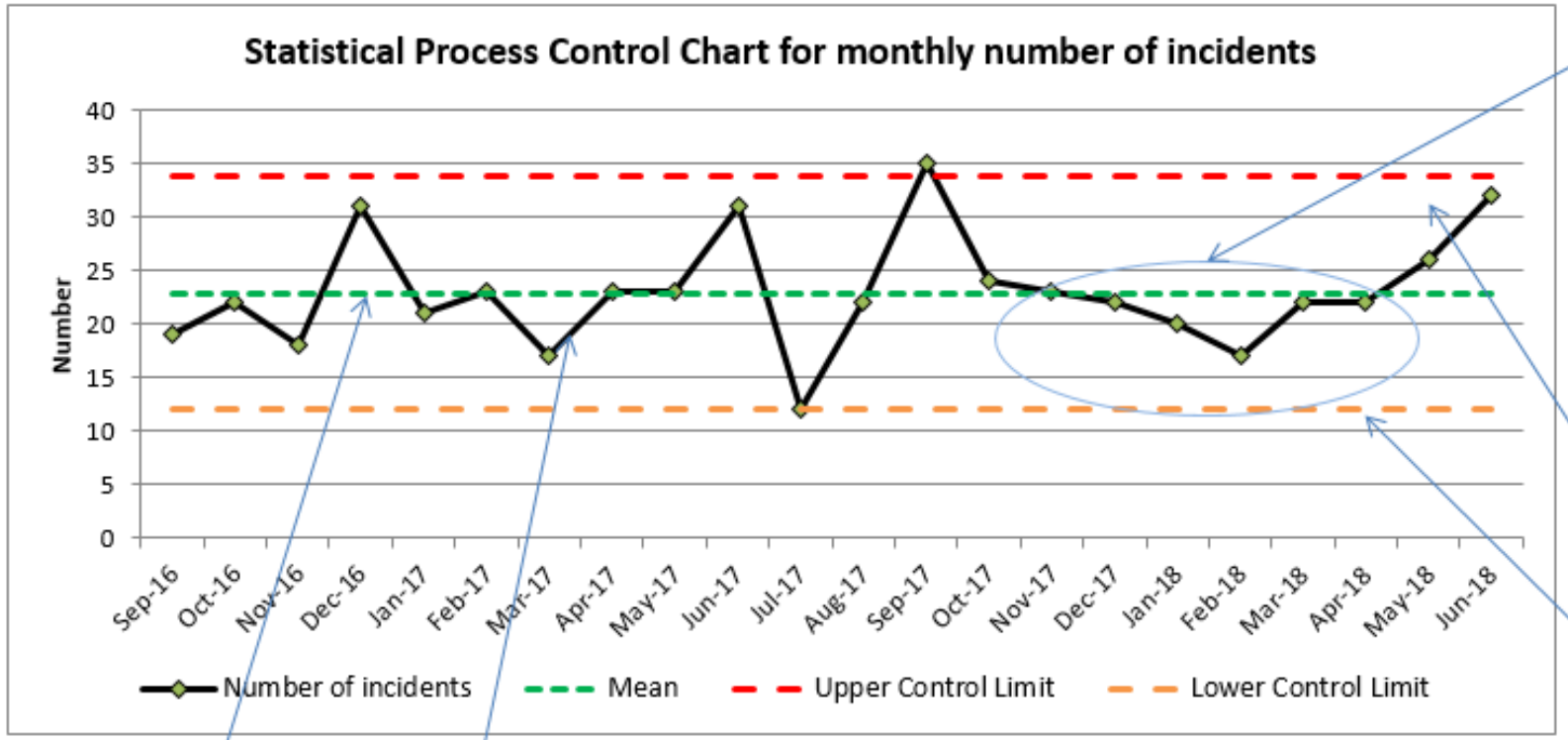
www.cwp.nhs.uk

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.

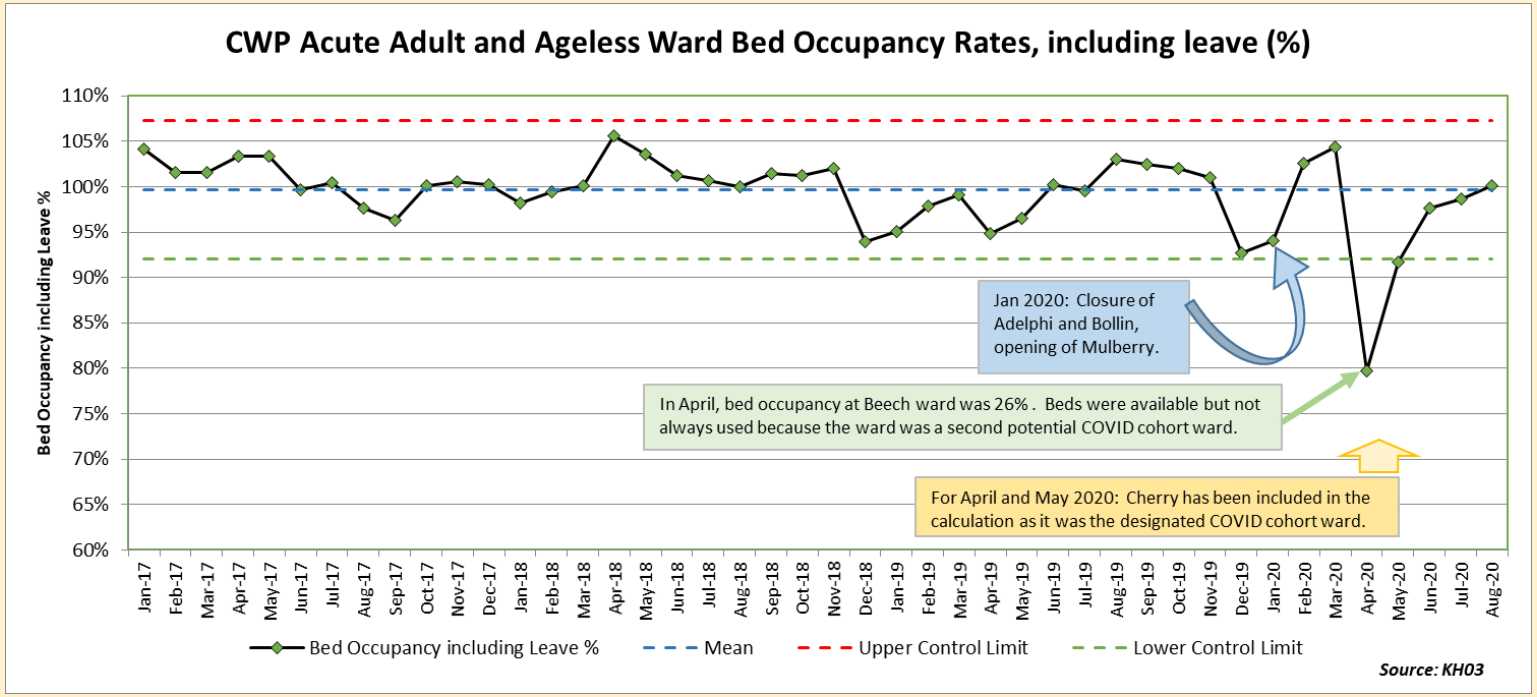
What does the SPC tell us?

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?

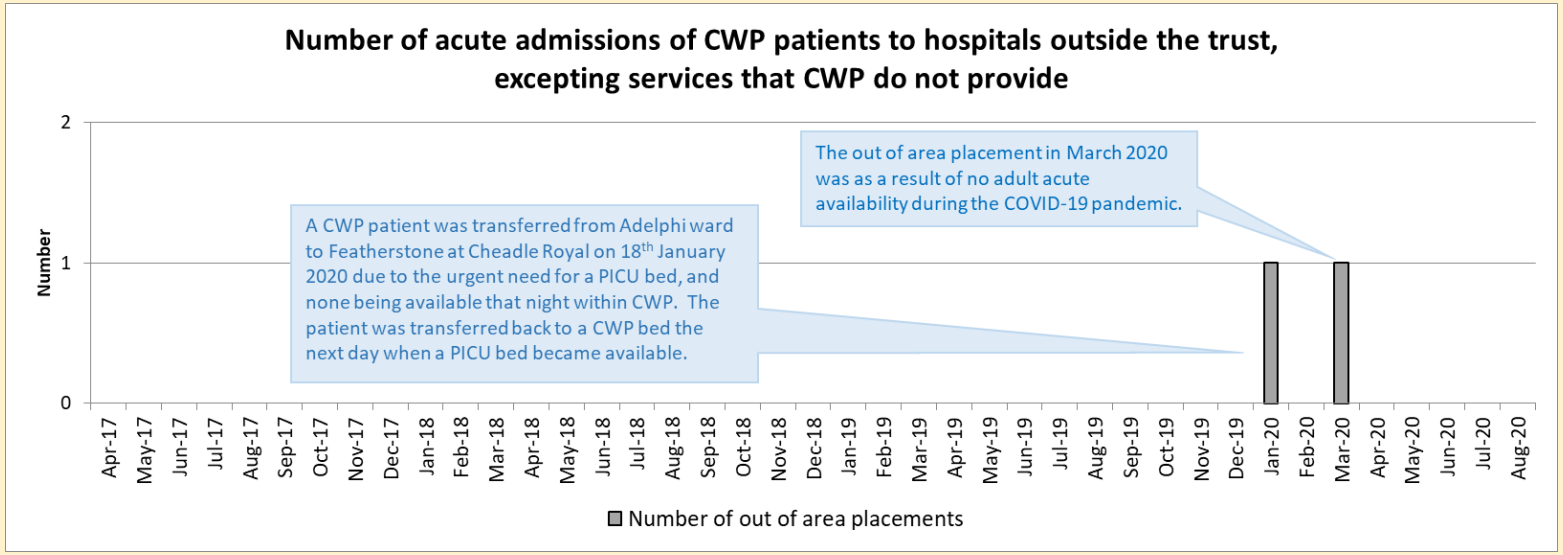
One of the properties of what is known as "the normal distribution" is that 95% of the data are within 2 standard deviations either side of the mean. The remaining 5% of the data are further away from the mean than that, in either direction. 95% is equivalent to one in 20. So we would expect, when looking 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 and Ageless wards		Metric owner: Suzanne Edwards / Anushta Sivananthan Monitored at: SMH Care Group Data sources: KH03 file provided by the Information Team.

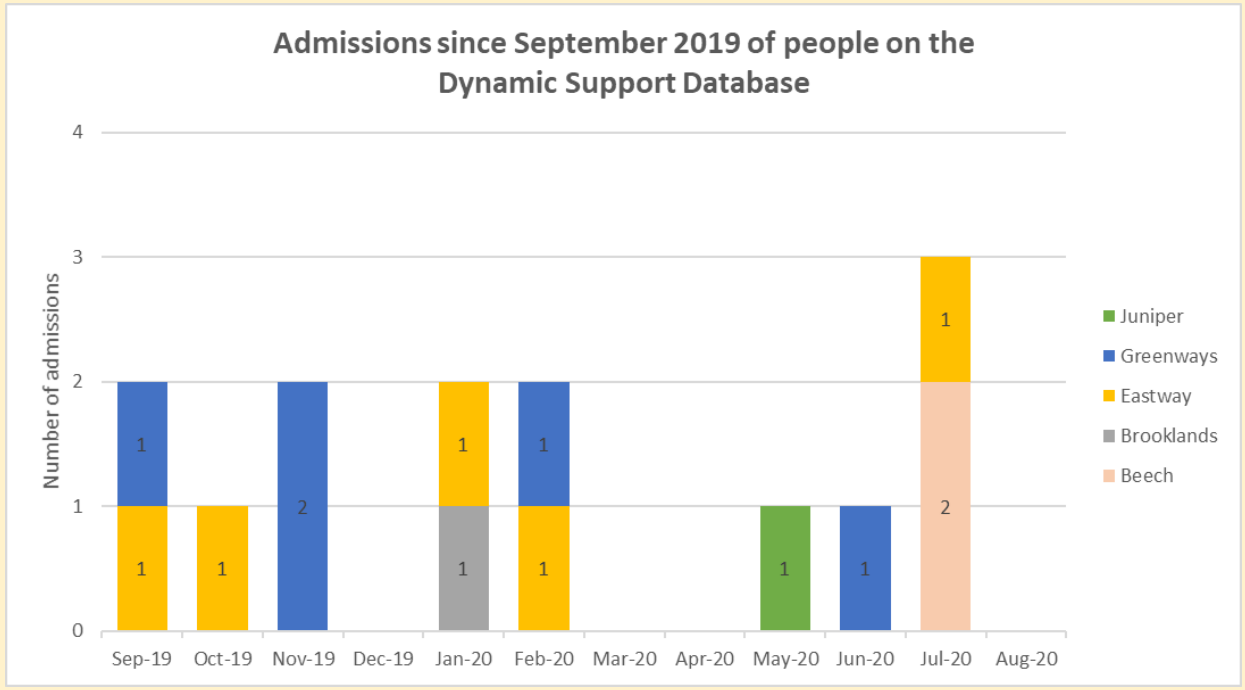
Comment: The usual definition includes adult and ageless wards. Cherry ward, normally an older person's ward, was used as the COVID-19 cohorting ward during April and May and has been added to the calculation for those months. During that time, Beech ward was the second designated COVID cohort ward if needed, with beds available but for most of the time not used; this drives the downward spike in bed occupancy in April 2020.

Deliver high quality, integrated and innovative services that improve outcomes

Metric	Data	Further Explanation
Out of Area Acute Admissions		Metric owner: Suzanne Edwards Monitored at: Operational Committee Data source: CWP Bed Hub

Note:
There have been no out of area placements since March 2020.

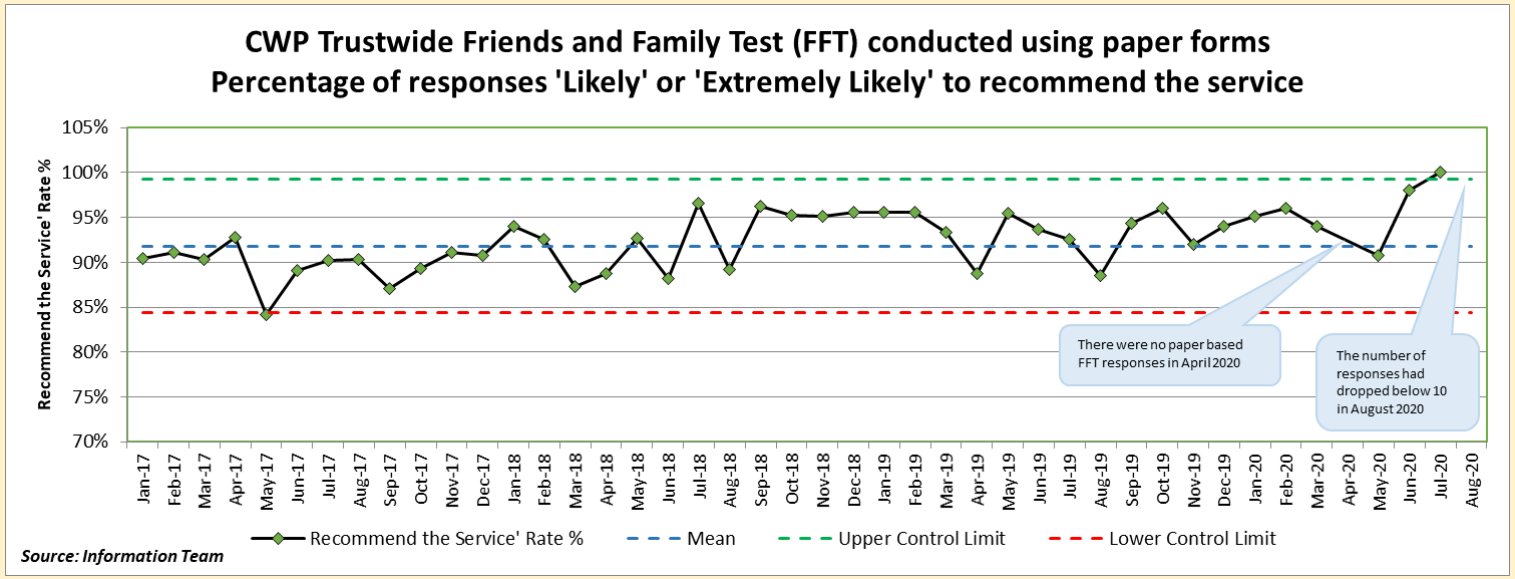
Deliver high quality, integrated and innovative services that improve outcomes

Metric	Data	Further Explanation
Admission to hospital for those on the Dynamic Support Database	 Comment: Of the five people who have been admitted in the current financial year, four have been 'red' rated and one has been 'amber' rated.	Metric owner: Maddy Lowry Monitored at: LD, NDD & ABI Care Group Data source: 'LD Risk Register Report for QS' Report Manager report

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

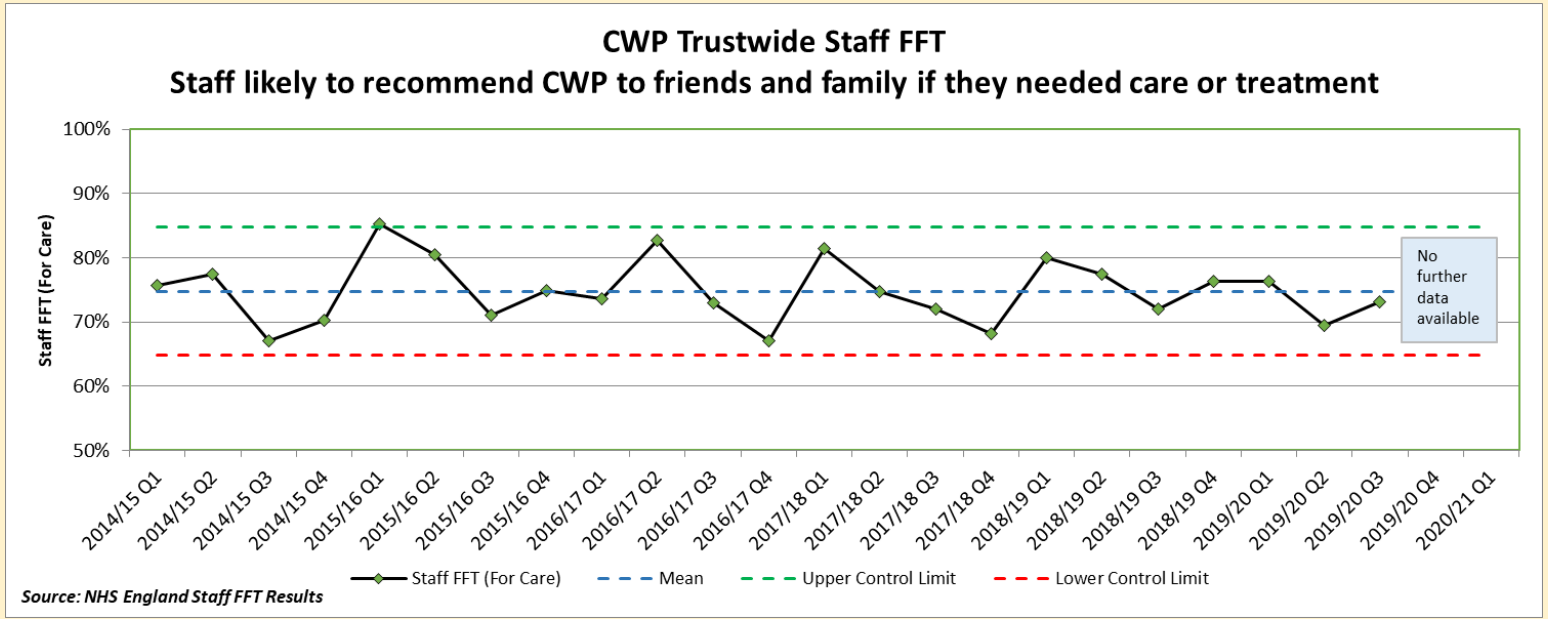
Deliver high quality, integrated and innovative services that improve outcomes		
Metric	**Data**	**Further Explanation**
CWP performance against NHSi targets **(Exceptions only)**	The Trust reports a number of operational metrics to NHSi. These cover: Early Intervention in Psychosis (one metric), Improving Access to Psychological Therapies (3 metrics), Out of Area admissions (monitored on slide 5 of this pack), and a data quality measure which is provided with a three month lag, so the most recent two data points are for April and May 2020. Only one metric was below target performance as set out in the NHS Oversight Framework for July and August 2020: • The data quality measure, where the data for April 2020 are 89.7% and for May 2020 89.5% against a target of 95%.	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

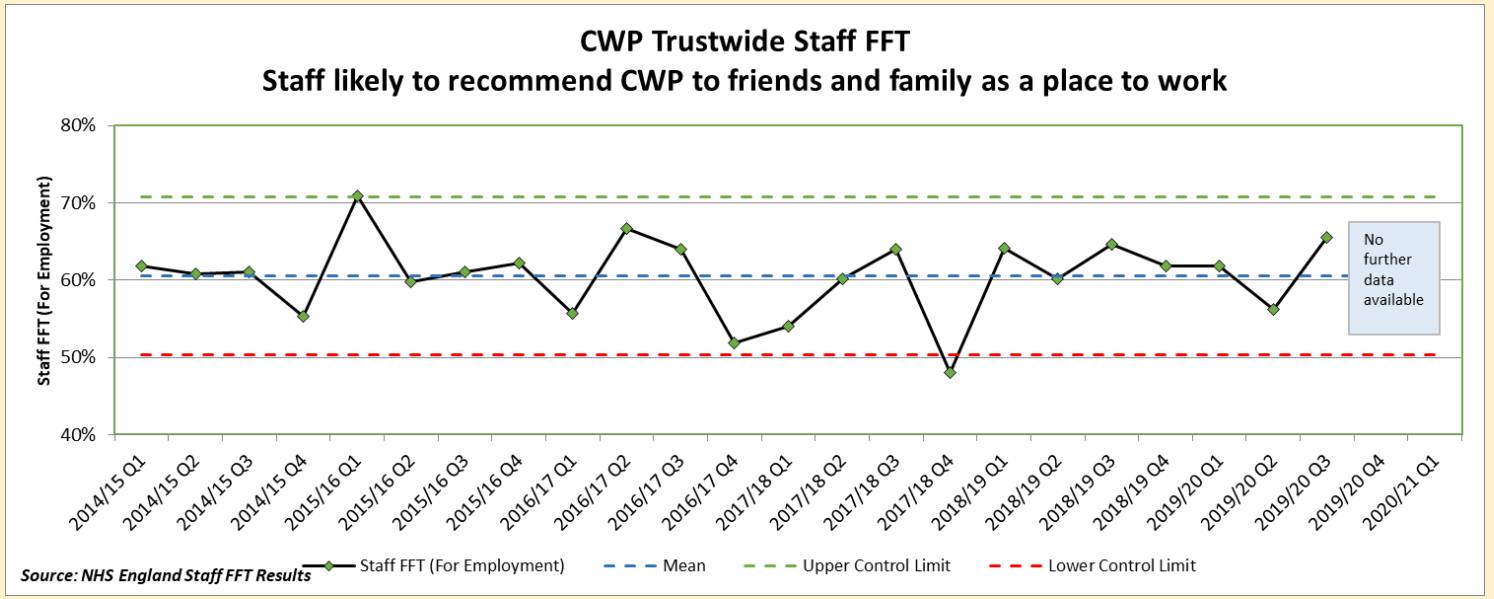
Comment: Following the onset of Covid-19, there was a national pause on the reporting of FFT. Since then, only a handful of CWP services have continued to use paper FFT forms and the number of responses diminished to a negligible number by August 2020. Looking ahead, the Trust is working to resume FFT collection from 1 December 2020 with a view to publishing again in February 2021. The revised national FFT guidance offers providers greater flexibility than the original model. We should ensure that all patients and people that use services are able to give feedback if they want to, and we are required to use that feedback to identify good practice and opportunities to improve. Because safety of patients is paramount, we are working with Infection Prevention and Control colleagues to ensure that any collection process avoids risk of spreading infection, so initially we may only be using text messaging.

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

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

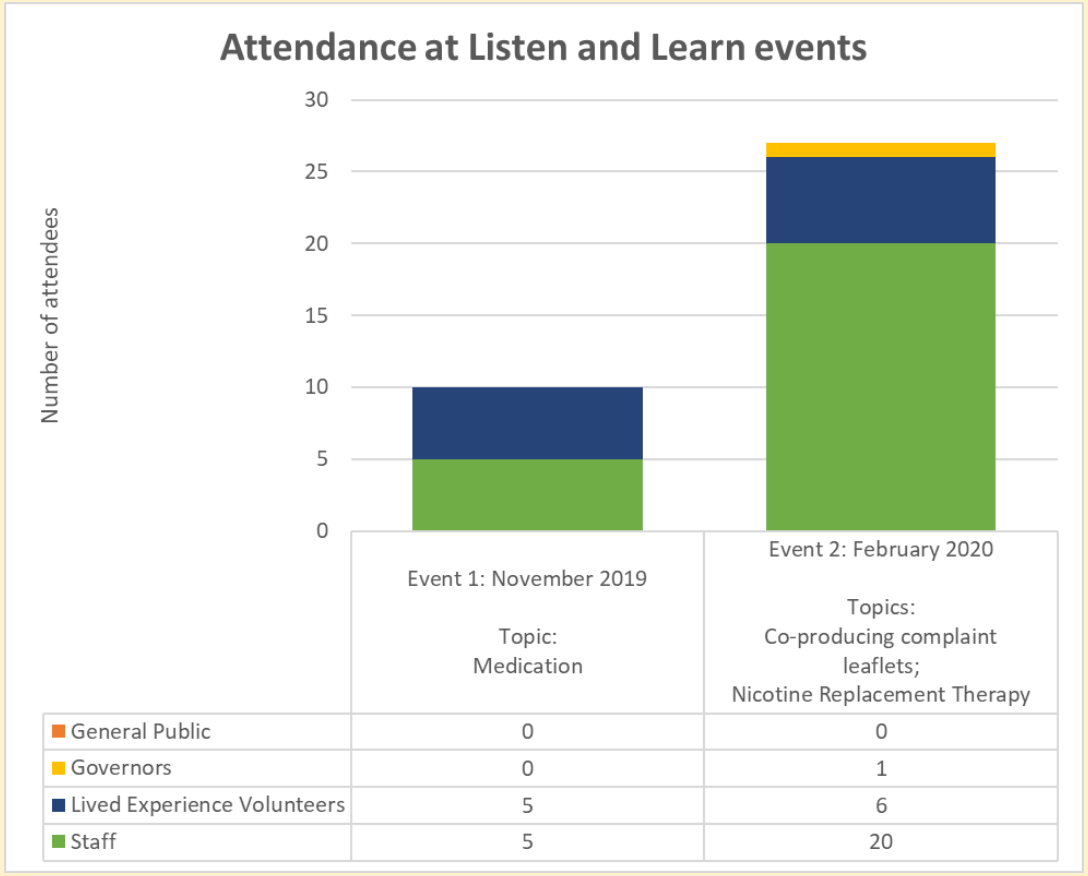
Comment: Due to the national agreement to suspend certain data collection activities as a result of the COVID-19 pandemic, there has been no further data to add to this chart since the edition reported in March 2020. However, ahead of the 2020 NHS Staff Survey, the Trust has also participated in the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

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

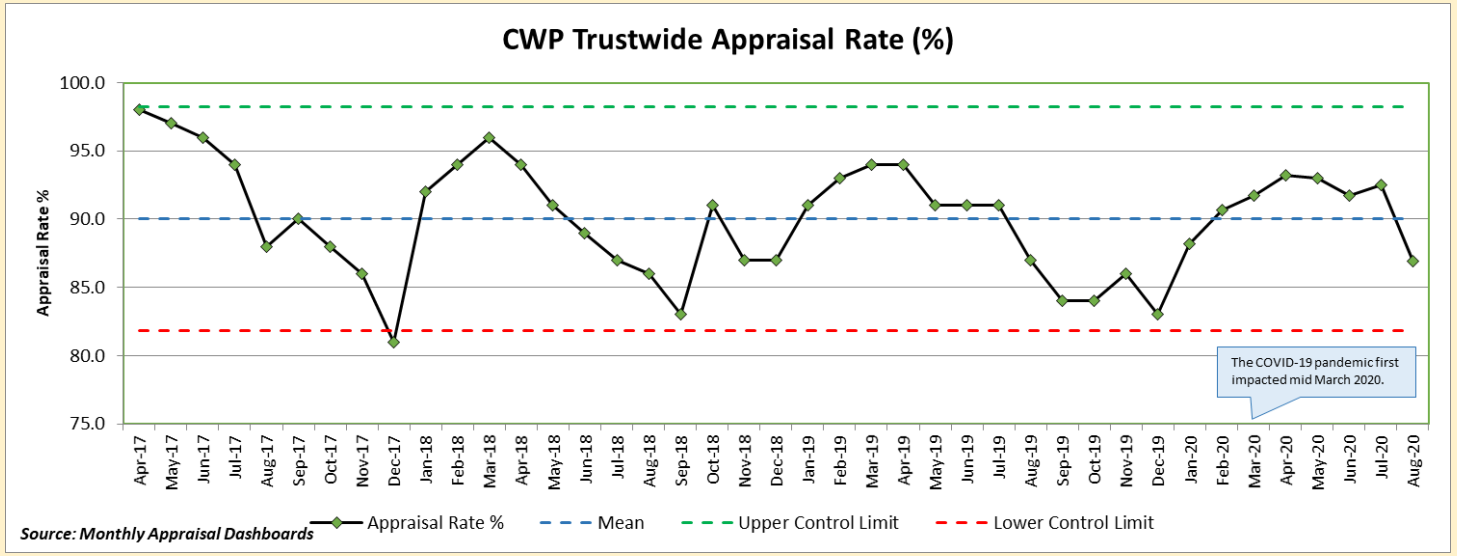
Metric	Data	Further Explanation
Friends and Family Test responses from our staff – about CWP as a place to work		Metric owner: David Harris, delegated to Simon Platt Monitored at: POD Sub Committee Data source: People Information

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

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

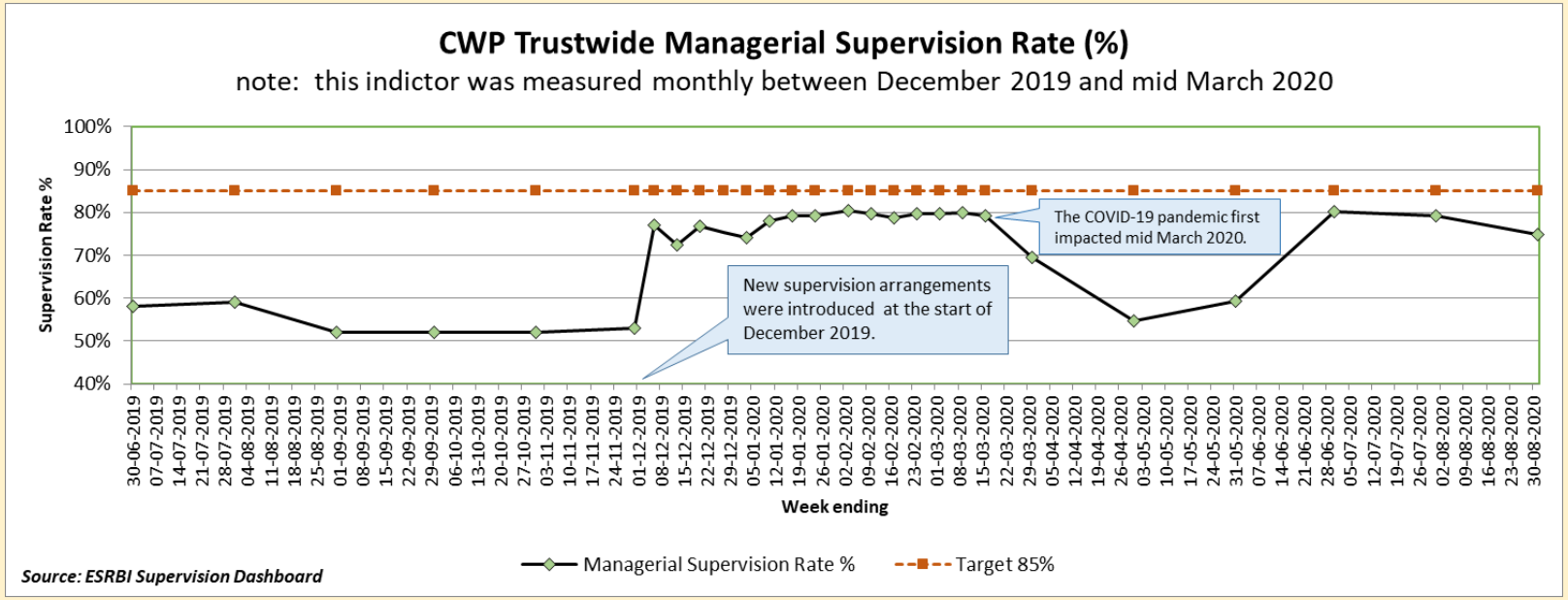
Metric	Data		
Effectiveness of working with the wider community		Comment: No additional listen and learn events have been held since February 2020.	Metric owner: Cathy Walsh Monitored at: PACE Sub Committee Data Source: PALS team

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: Peaks have tended to be at March/ April. Following three years of implementation, a dip in compliance rates during Aug – Sept has become a trend. Work to understand this has taken place and is attributed to peak leave period. The impact of the COVID-19 pandemic on appraisal rates has been marginal in the data reported so far and a 90 day extension has been applied since April 2020. While the current reduction in compliance appears to follow previous trends, the Trust continues to promote the importance of 2020/21 appraisals, recognising their importance as another form of support and development for staff as we navigate the Pandemic.

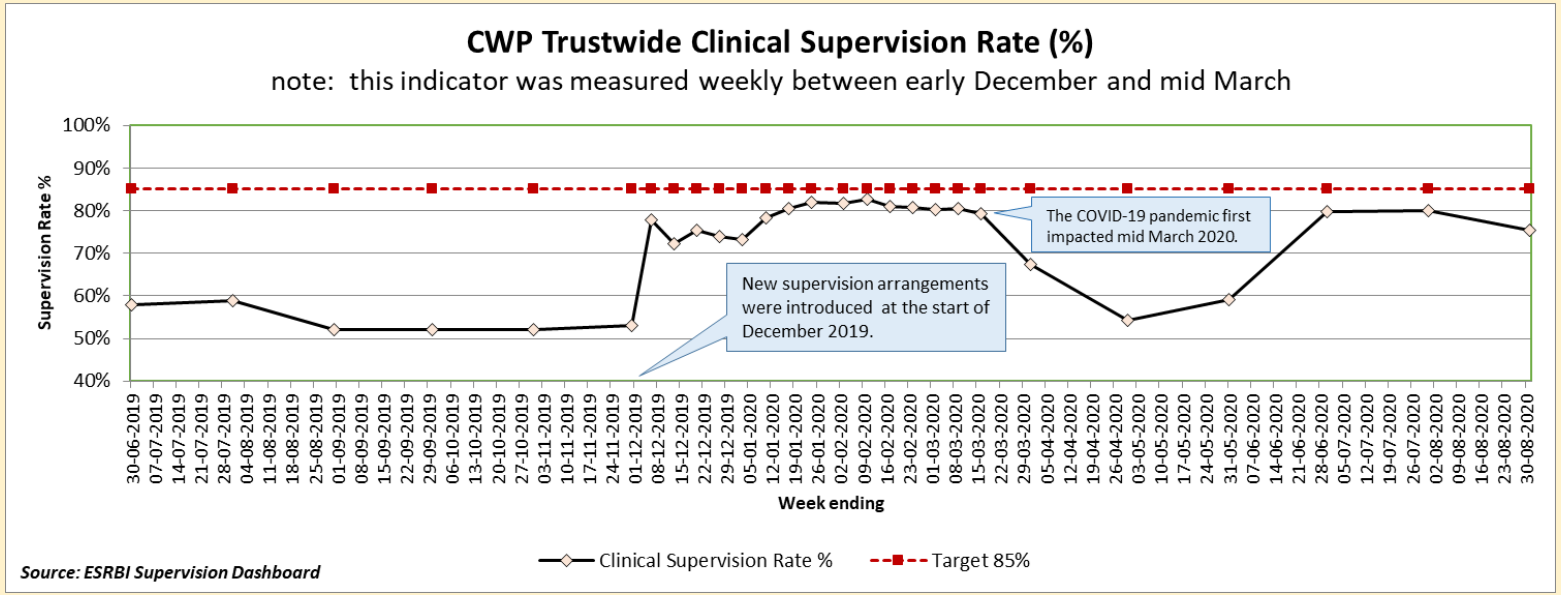
Be a model employer and have a caring, competent and motivated workforce

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: 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.

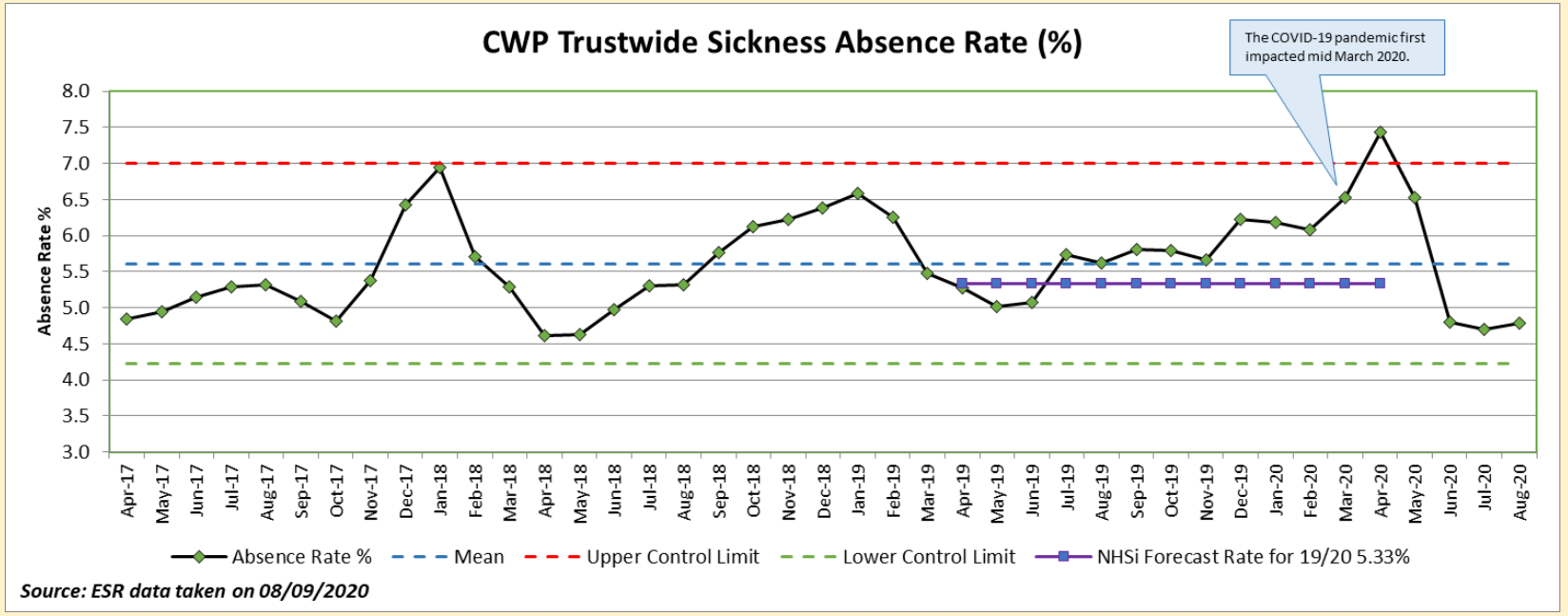
The COVID-19 pandemic had a marked impact on the recording of Managerial Supervision. However, since then, figures have shown a strong recovery back up as high as 80% for both Managerial and Clinical Supervision. The Organisational Development (OD) Team have conducted a Trust-wide diagnostic to understand how CWP can further support staff to achieve best practice supervision and the desired compliance target. OD has worked alongside the People & Information Team and Education Team to plan the necessary changes and this was documented in an improvement plan that was presented at our September Quality Committee.

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

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

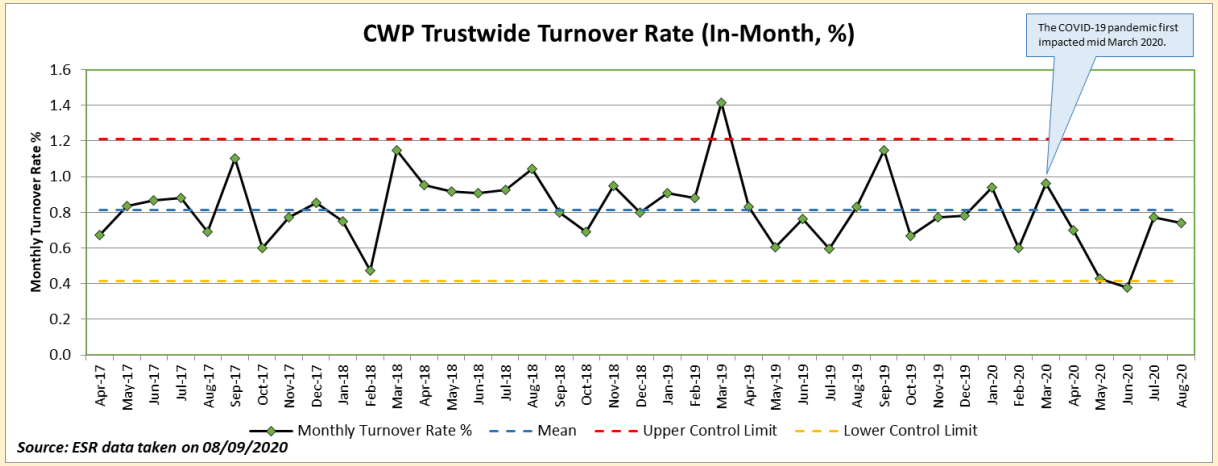
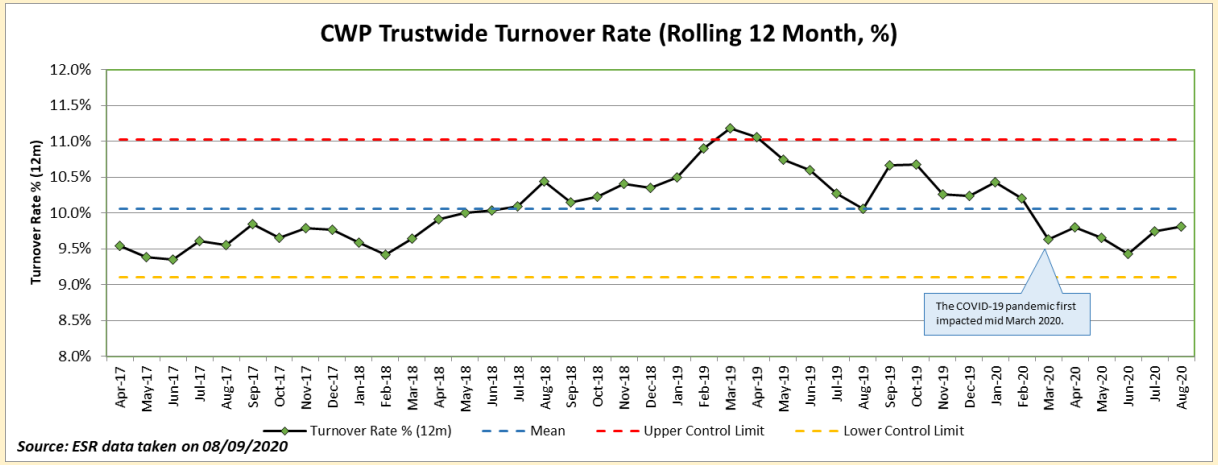
Comment: In December 2019 separate managerial and clinical supervision competencies were introduced. For months up to and including November 2019, the time series reflects compliance with the previous 'all supervision' competence.
The COVID-19 pandemic had a marked impact on the recording of clinical supervision over the period March to May 2020.
The clinical supervision compliance measure does not include medical supervision compliance.

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

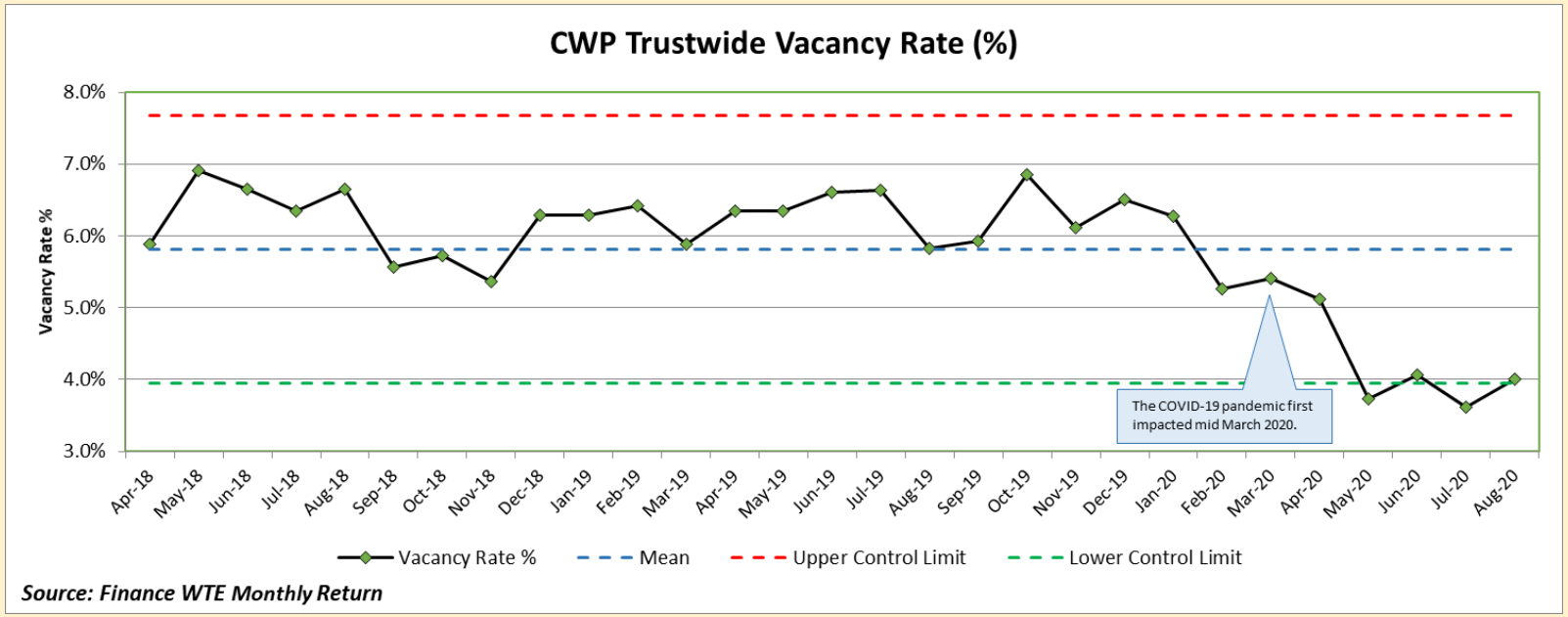
Metric	Data	Further Explanation
Sickness Absence		Metric owners: David Harris Monitored at: POD Sub Committee Data source: People Information

Comment: The COVID-19 pandemic had a notable impact on sickness absence in March, April and May, but the absence rate has dropped below the long term average in June, July and August for the first time since mid 2019.

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

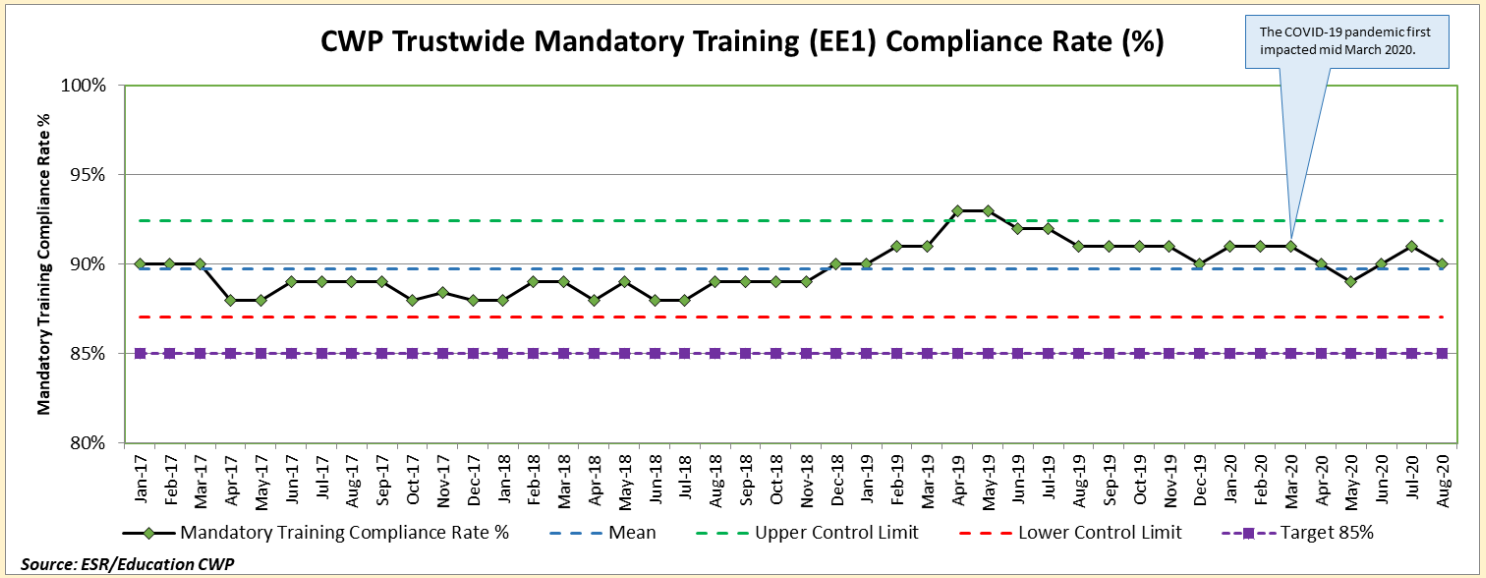
Metric	Data	Further Explanation
Staff Turnover	 *Source: ESR data taken on 08/09/2020*  *Source: ESR data taken on 08/09/2020*	Comment: The monthly turnover rate was close to the lower control limit in June 2020, indicating lower turnover (people leaving the Trust) than would be expected given the natural variation in the data. This may be explained by economic uncertainties following the COVID-19 pandemic. The turnover rate has been more typical in the most recent two months.	Metric owner: David Harris Monitored at: POD Sub Committee Data source: People Information

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

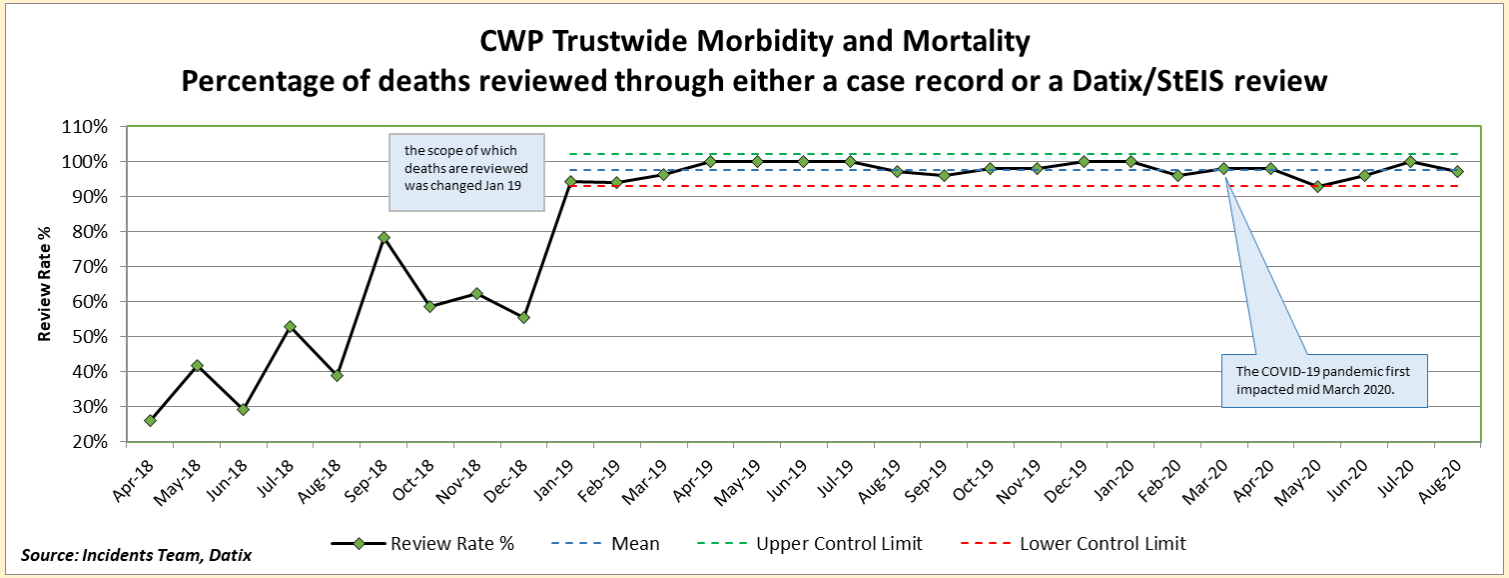
Metric	Data	Further Explanation
Vacancy Rate		Metric owner: David Harris Monitored at: POD Sub Committee Data source: People Information

Comment: The vacancy rate has been on or below the lower control limit since May 2020. A lower vacancy rate is consistent with low staff turnover which has been seen elsewhere in this Report.

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

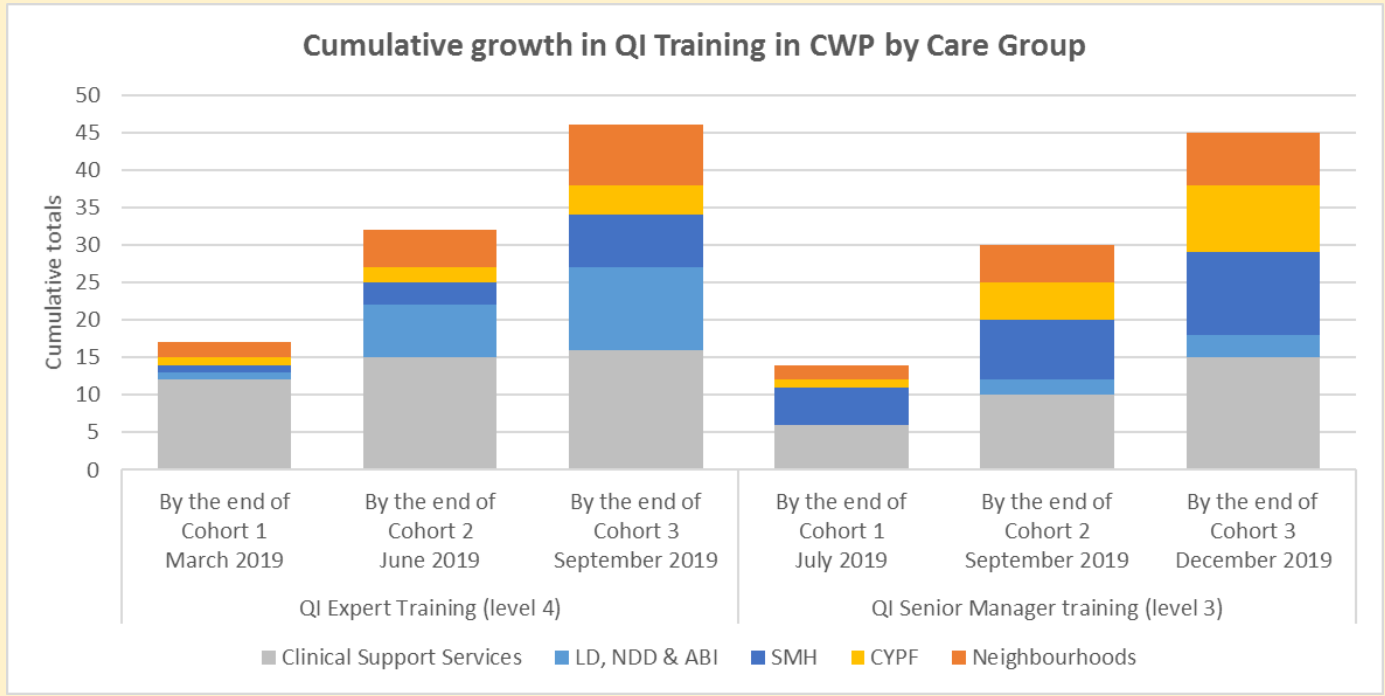
Metric	Data	Further Explanation
Mandatory Training	 Comment: The Trust mandatory compliance figure is currently 90%, matching the long term average. Definition: Excludes staff on Maternity Leave, Career Break, External Secondments, Long Term Sick (>92 days) and new starters < 3 months. Also excludes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

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

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

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

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

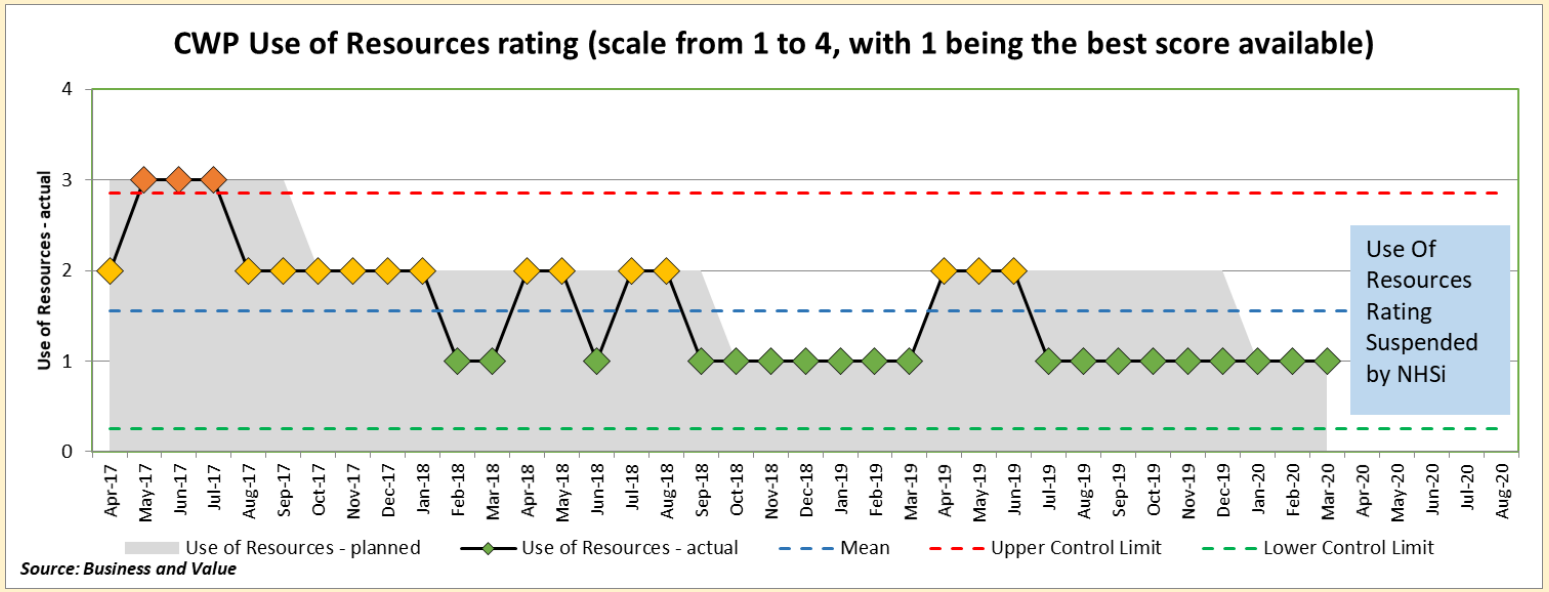
Metric	Data	Further Explanation
Level 3 and 4 QI Training		Metric owner: Anushta Sivananthan Monitored by: Quality Committee Data provider: Quality Assurance and Improvement team

Comment: Plans are being developed to re-launch the QI training programme from Autumn 2020, with events to be delivered using a combination of remote technology and COVID-secure facilities.

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 Development work on the Care Group dashboards will take place in 2020. Metric owner: Tim Welch Monitored by: Operational Committee

Sustain financial viability and deliver value for money

Metric	Data	Further Explanation
Use of Resources Rating		Metric owner: Tim Welch Monitored by: Trust Board Data source: Business and Value

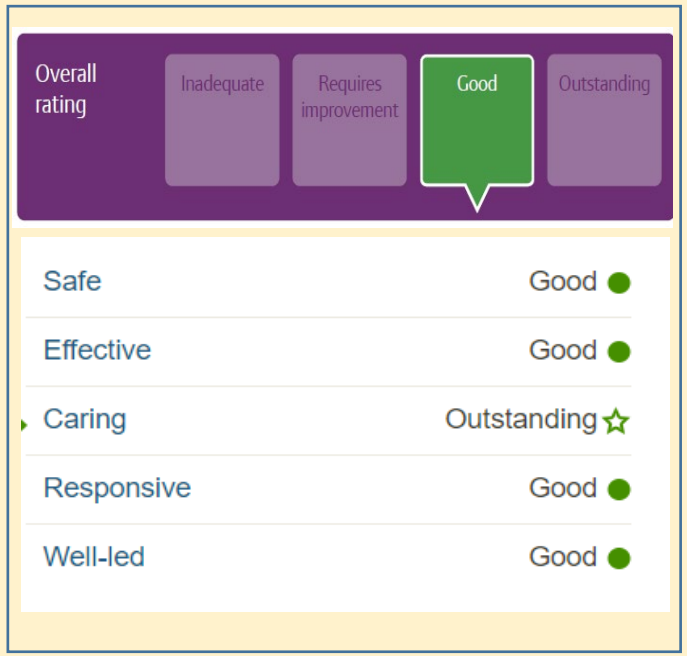
Comment: The overall Use of Resources metric is a summary of 5 separate financial metrics. A score of '1' reflects the lowest financial risk rating and a '4' the highest level of risk. The chart shows the actual rating against the planned rating; in no cases since April 2017 has the actual rating been higher (worse) than the planned rating.

At the time of preparing this report, the Use of Resource rating process has been suspended and the details of the regime for the 2020/21 financial year have not been finalised.

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

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

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

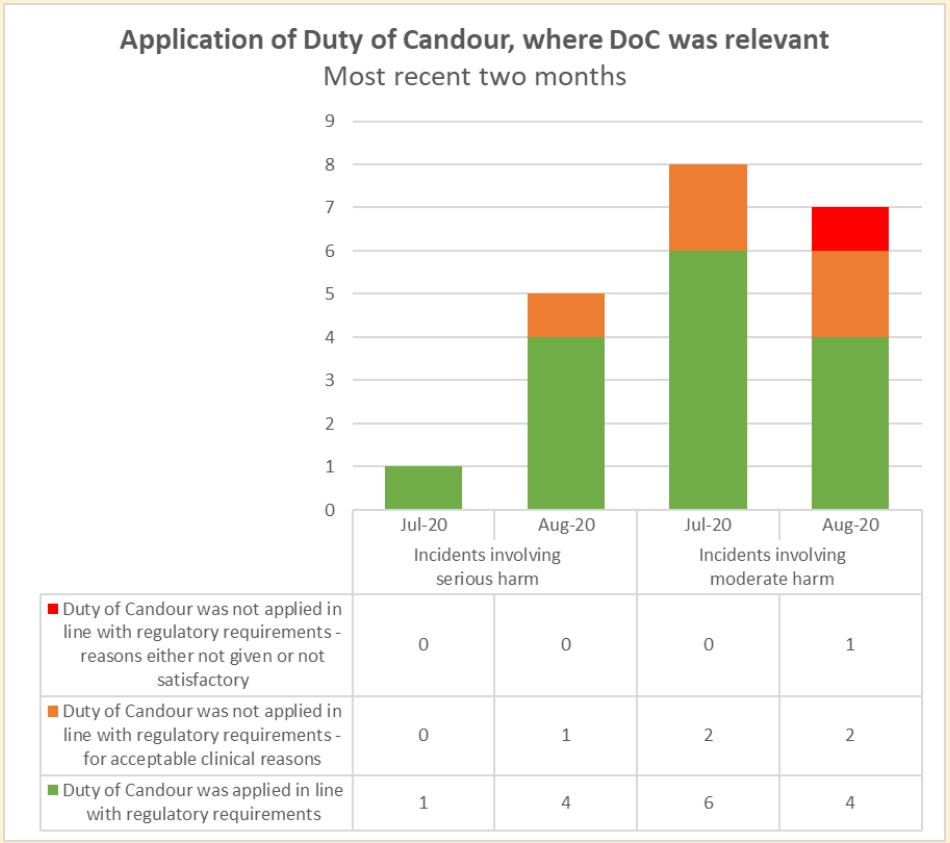
Metric	Data	Further Explanation
CQC Rating		Metric owner: Anushta Sivananthan Monitored at: Quality Committee Data source: CQC website

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

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

Quality Committee is monitoring the 4 regulatory and 16 improvement actions identified.

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

Metric	Data	Further Explanation
Duty of Candour		Comment: Following the introduction of the electronic Immediate Safety Review process in April, the members of the ISAF are able to review whether Duty of Candour (DoC) has been applied appropriately for every serious incident and take corrective action as required in a timely manner. This has also enable increased consistency in the recording of DoC to facilitate effective monitoring and reporting.	Metric owner: Gary Flockhart delegated to Hayley McGowan Monitored at: Quality Committee Data source: CWP Incidents Team

Report Against Strategic Objectives

End Sheet

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Ward Daily Staffing Levels July and August 2020
Agenda ref. number:	20.21.46
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	30/09/2020
Presented by:	Gary Flockhart, Director of Nursing, Therapies and Patient Partnerships

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes

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

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

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

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

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

REPORT BRIEFING

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

This report details the ward daily staffing levels during the months of July and August 2020 following the submission of the planned and actual hours of both registered nurses (RN) and clinical support workers (CSWs) to UNIFY (appendix 1 and 2). The themes arising within these monthly submissions identify how patient safety is being maintained in the continued context of the COVID-19 response.

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

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

The recommendations made within the latest six monthly reports are being taken forward in line with the COVID-19 recovery planning and continued development of alternative ways of working.

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

During July 2020 the trust achieved staffing levels of 98.6% for registered nurses and 97.4% for clinical support workers on day shifts and 96.3% and 100.1% respectively on nights. During August 2020 the trust achieved staffing levels of 100.8% for registered nurses and 97.9% for clinical support workers on day shifts and 97.7% and 100.7% respectively on nights.

Throughout July and August Rosewood ward experienced some staffing challenges due to sickness absence and leave. Safer staffing levels were maintained during this period by utilising staff from other wards in Bowmere. Cherry Ward was not fully operational with reduced bed capacity and substantive staff from Cherry were able to support Rosewood. During this period Maple ward also experienced pressures in relation to the availability of registered nurses to provide cover on night shifts due to sickness absence and leave. In line with the response to the challenges experienced on Rosewood safer staffing levels were maintained during this period by utilising staff from other wards in Bowmere and by increasing the numbers of Clinical Support Workers on night shifts.

During August Greenways experienced pressures in relation to the availability of clinical support workers to provide cover on day shifts and this was mitigated by the utilisation of additional registered nursing staff. In addition the Matron, Ward Manager, Psychologist and Occupational Therapy Technical Instructor also supported the team by working on the ward as required.

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

Appendix 1 details the fill rates for all inpatient services.

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

The Board of Directors are recommended to note the report.

Who has approved this report for receipt at the above meeting?	Gary Flockhart, Director of Nursing, Therapies and Patient Partnerships
Contributing authors:	Hayley McGowan, Associate Director of Nursing and Therapies (Mental Health and Learning Disabilities)

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued

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

Appendix No.	Appendix title
1	Ward Daily Staffing July and August 2020

		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	873.75	866.25	1740.25	1566.10	713.00	713.00	713.00	701.50	99.1%	90.0%	100.0%	98.4%
	Greenways A&T	840.50	881.50	1624.00	1458.50	713.00	682.00	1265.00	1221.00	104.9%	89.8%	95.7%	96.5%
	Maple	966.50	888.00	1339.50	1305.00	632.50	506.00	753.00	741.50	91.9%	97.4%	80.0%	98.5%
	Mulberry	1220.00	1220.00	2150.50	1986.00	713.00	713.00	1782.50	1748.00	100.0%	92.4%	100.0%	98.1%
	Silk	1511.00	1499.40	2253.00	2167.00	747.50	747.50	2435.50	2411.50	99.2%	96.2%	100.0%	99.0%
	Saddlebridge	920.00	843.50	1472.00	1449.00	701.50	678.50	713.00	713.00	91.7%	98.4%	96.7%	100.0%
Wirral	Brackendale	1144.00	1144.00	1405.50	1405.50	736.00	736.00	1150.00	1150.00	100.0%	100.0%	100.0%	100.0%
	Brooklands	1177.25	1177.25	1893.50	1893.50	702.50	702.50	1285.50	1285.50	100.0%	100.0%	100.0%	100.0%
	Lakefield	1384.00	1384.00	1602.00	1602.00	783.00	783.00	1012.00	1012.00	100.0%	100.0%	100.0%	100.0%
	Meadowbank	1447.50	1447.50	1803.50	1803.50	604.00	604.00	1403.00	1403.00	100.0%	100.0%	100.0%	100.0%
	Oaktrees	1247.75	1247.75	1573.50	1573.50	691.00	691.00	747.50	747.50	100.0%	100.0%	100.0%	100.0%
West	Willow PICU	952.00	952.00	1520.50	1520.50	646.00	646.00	1168.50	1168.50	100.0%	100.0%	100.0%	100.0%
	Beech	1194.00	1171.00	1412.00	1330.00	661.50	661.50	982.00	982.00	98.1%	94.2%	100.0%	100.0%
	Cherry	631.90	620.20	458.40	470.10	458.40	466.40	619.40	619.60	98.1%	102.6%	101.7%	100.0%
	Coral	1092.00	1092.00	1495.00	1495.00	747.50	736.00	977.50	977.50	100.0%	100.0%	98.5%	100.0%
	Eastway A&T	1763.25	1705.75	1533.25	1452.75	770.50	740.00	1391.50	1334.00	96.7%	94.7%	96.0%	95.9%
	Indigo	1040.00	1030.50	992.00	980.50	713.00	668.00	977.50	963.50	99.1%	98.8%	93.7%	98.6%
	Juniper	1276.00	1251.00	1200.00	1168.50	743.00	703.50	878.00	866.50	98.0%	97.4%	94.7%	98.7%
	Rosewood Unit	1070.00	1032.50	1610.00	1598.50	667.00	483.00	1069.50	1265.00	96.5%	99.3%	72.4%	118.3%
	Trustwide	21751.40	21454.10	29078.40	28225.45	13143.90	12660.90	21323.90	21311.10	98.6%	97.4%	96.3%	100.1%

	Ward	Day				Night				Fill Rate				Safe Staffing was maintained by:
		Registered		Care Staff		Registered		Care Staff		Day		Night		
		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	856.75	786.70	1787.25	1590.25	713.00	713.00	713.00	649.00	91.8%	89.0%	100.0%	91.0%	
	Greenways A&T	810.50	966.00	1955.00	1594.33	713.00	690.50	1311.00	1360.00	119.2%	81.6%	96.8%	103.7%	
	Maple	810.00	840.50	1403.00	1369.50	690.00	506.00	713.00	782.00	103.8%	97.6%	73.3%	109.7%	
	Mulberry	1150.50	1093.00	2140.00	2056.50	713.00	713.00	1541.50	1500.00	95.0%	96.1%	100.0%	97.3%	
	Silk	1374.00	1328.00	2096.00	1950.50	874.00	874.00	2058.00	1982.50	96.7%	93.1%	100.0%	96.3%	
	Saddlebridge	951.00	938.95	1483.50	1469.50	724.50	724.50	874.00	851.00	98.7%	99.1%	100.0%	97.4%	
Wirral	Brackendale	1132.50	1126.00	1265.50	1417.50	724.50	704.00	736.00	782.00	99.4%	112.0%	97.2%	106.3%	
	Brooklands	1012.00	1075.00	1555.00	1909.50	678.50	690.00	874.00	1130.00	106.2%	122.8%	101.7%	129.3%	Additional staffing utilised due to levels of acuity and numbers of increased levels of observation.
	Lakefield	1136.00	1348.85	1449.00	1271.50	713.00	783.00	1046.50	908.50	118.7%	87.8%	109.8%	86.8%	
	Meadowbank	1127.00	1175.45	1654.50	1730.50	770.50	762.00	1196.00	1198.50	104.3%	104.6%	98.9%	100.2%	
	Oaktrees	1197.50	1181.75	1594.50	1726.00	713.00	701.50	644.00	759.00	98.7%	108.2%	98.4%	117.9%	
West	Willow PICU	900.00	900.00	1483.50	1483.50	713.50	713.50	1428.30	1428.30	100.0%	100.0%	100.0%	100.0%	
	Beech	1185.00	1183.50	1241.00	1206.50	642.50	642.50	931.50	931.50	99.9%	97.2%	100.0%	100.0%	
	Cherry	823.40	800.70	768.70	711.00	607.30	595.60	848.20	794.90	97.2%	92.5%	98.1%	93.7%	
	Coral	1071.50	1108.00	1299.50	1276.50	724.50	713.00	1012.50	1001.00	103.4%	98.2%	98.4%	98.9%	
	Eastway A&T	1477.00	1476.40	1403.00	1352.25	724.50	713.00	1283.90	1249.40	100.0%	96.4%	98.4%	97.3%	
	Indigo	943.15	885.65	989.00	989.00	644.00	632.50	759.00	759.00	93.9%	100.0%	98.2%	100.0%	
	Juniper	1190.00	1135.00	1219.50	1190.50	502.50	491.00	928.00	928.00	95.4%	97.6%	97.7%	100.0%	
	Rosewood Unit	1063.50	982.00	2024.00	1753.50	713.00	632.50	1575.50	1391.35	92.3%	86.6%	88.7%	88.3%	
	Trustwide	20211.30	20331.45	28811.45	28048.33	13298.80	12995.10	20473.90	20385.95	100.8%	97.9%	97.7%	100.7%	

Report subject:	Learning from Experience report – trimester 1 20/21 (incorporating an update on Learning from Deaths)
Agenda ref. no:	20.21.47
Report to (meeting):	Board of Directors
Action required:	Discussion and approval
Date of meeting:	30.09.2020
Presented by:	Gary Flockhart, Director of Nursing, Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	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	No
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Services that are responsive to people's needs	Yes
Well-led services	Yes
Which NHSI quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
N/A	
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	

1.0 Situation

This Learning from Experience report aggregates qualitative and quantitative analysis from key sources of feedback from people who access and deliver the Trust services and other sources of learning including learning gained from undertaking safety reviews / case reviews. The report covers the period from April 2020 to July 2020, trimester 1 of 2020/21. The report compares current performance across a four trimester time series to mitigate seasonal variations, whilst also facilitating the identification of potential triggers to detect and prevent incidents by comparing current performance with the previous trimester. The in-depth Learning from Experience report received by the Quality Committee uses Statically Process Control (SPC) charts to help with more effective and visual depiction of learning from experience and identification of recommendations as well as to alert as part of an early warning framework, any emerging trends.

2.0 Background- Key Performance Indicators

2.1 Performance indicators

Performance indicator			2019/20 T1	2019/20 T2	2019/20 T3	2020/21 T1	RAG rating – do this last
Number of safety incidents reported			3730	3496	2956	**3085**	↑
Number of safety incidents by care group	*Specialist MH - Bed Based*		1823	1766	1527	**1770**	↑
	Neighbourhoods		686	723	547	**547**	=
	Children, Young People & Families		582	419	326	**256**	↓
	LD, NDD & ABI		245	299	211	**211**	=
	Specialist MH - Place Based		310	209	268	**244**	↓
	All Age Disability		45	49	46	**27**	↓
	Corporate Support Services		39	31	31	**30**	↓
Mortality monitoring *as a minimum subject to a case record review	Inpatient deaths (including deaths 30 days after discharge)		*1/ 100%	*4/ 100%	*6/ 100%	***5/ 100%**	=
	Deaths reported to the Trust/case record review completed		*205/ 100%	*226/ 97%	*275/ 99%	***331/ 97%**	↓
	Deaths reported as a serious incident/subject to a serious incident investigation		*20/ 100%	*20/ 100%	*16/ 100%	4/ 100%	=
Reports to external agencies	StEIS		40	33	27	**12**	↓
	National Reporting Learning System		1681	957	1243	**1376**	↑
	NHSR	Non clinical	4	5	9	**0**	↓
		Clinical	1	3	1	**1**	↓
Number of complaints			94	113	46	**60**	
Number of compliments			1162	1093	877	**622**	

Note: All numbers represent a snapshot as at the time of publication of the report and are subject to change over time, for example: re-categorisation of incidents following receipt of further information since the previous report, receipt of compliments retrospectively.

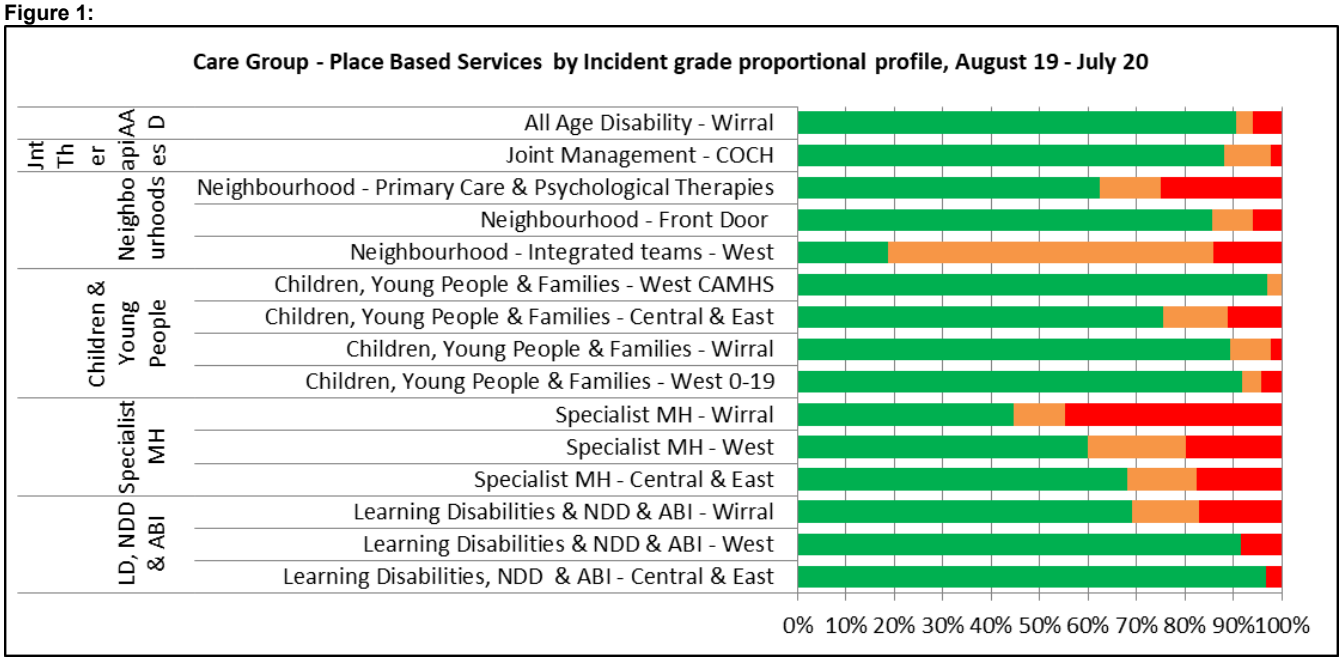
It is important to note that trimester 1, includes the period when the Trust was responding to the height of the Covid-19 pandemic and the Trust was is in buisness contitinuity.

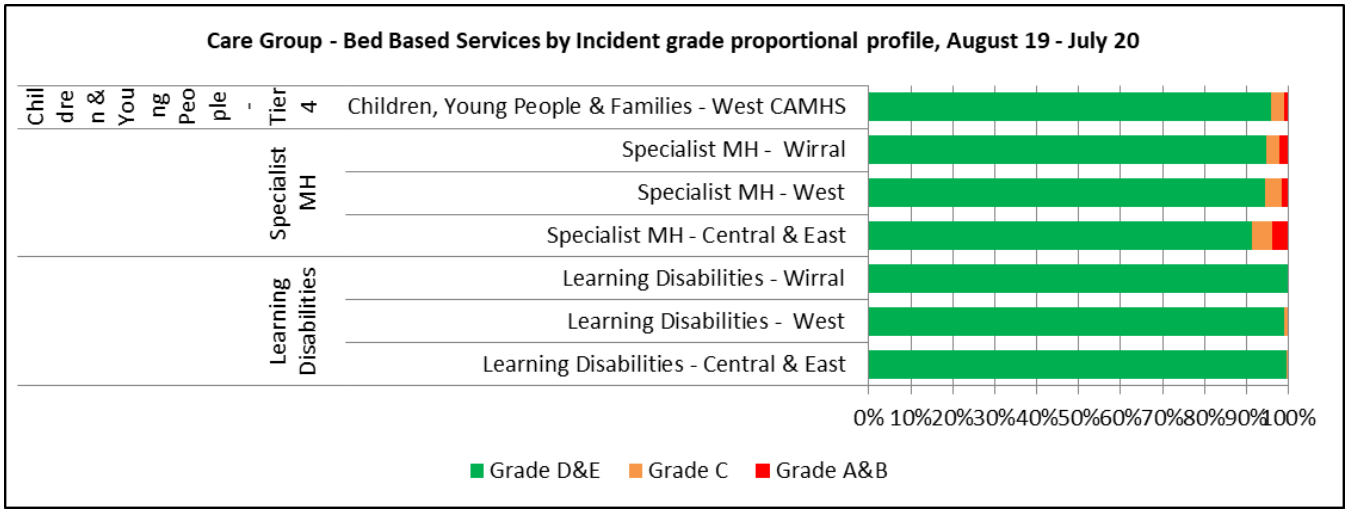
2.2 Proportional reporting performance indicators – Incident reporting

Proportional reporting of incidents measures incidents against the care group. This approach was taken following a Quality Account aspiration to develop how CWP measures incident reporting profiles, for example Neighbourhood – integrated teams' reporting profiles are influenced by pressure ulcer incident reporting because of the way they required to be reported nationally by NHS Improvement. By presenting the incident reporting profiles in this way, the charts reveal differences between the care groups that can be used to identify where the focus is needed. It also helps to reinforce the need for reporting no or lower harm incidents to promote learning to enable potential to mitigate future actual or significant harm incidents.

Figure 1 illustrates the proportional split of incident grades per care group. This illustrates the differences in severity of incident occurrence. It can also further inform potential opportunities for both service improvement and quality improvement activity.

Figure 1:





3.0 Analysis.

3.1 Incident Reporting

This trimester the number of safety incidents reported has increased compared to trimester 3 and therefore provide evidence that patient safety continues to be an organisational priority.. The number of incidents

reported on STEIS reduced within this reporting period. The decrease in the numbers of incidents being reported on STEIS is due to numerous factors as follows:

- Clarifying the facts prior to reporting the incident. This has resulted in the Trust reducing the number of incidents that are undeclared. This is also providing assurance to the Clinical Commissioning Groups.
- During the month of April and May 2020, there was a delay of notification of deaths from the coroner's office. This was due to the COVID-19 pandemic.
- Unexpected death where COVID-19 was confirmed or suspected due to COVID-19 was not reportable on STEIS in line with NHS England guidance.

There has been a significant increase in the number of self harm incidents reported this trimester which has resulted in this moving to the highest reported incident category. Further analysis will be undertaken by the Specialist Mental Health Care Group and Children & Young People Care Group to understand this increase, as the previous 3 trimester had shown a sustained reduction.

The number of incidents reported relating to pressure damage that developed whilst under the care of Trust services has increased in trimester T1 20/21 within the Neighbourhood Care Group. Work therefore continues to be undertaken by the care group to understand the factors influencing the increase in pressure damage incidents being reported to establish if this is as a result of increased awareness, care delivery or patient related factors. The number of incidents reported within the transfer issue category had also increased over the past two trimester's further analysis needs to be undertaken by the care group to understand the increase in number of transfer issues being reported upon to determine next steps.

Key learning has been shared across the Trust following safety reviews undertaken when serious incidents have occurred during this trimester. The first area of learning followed a ligature incident. A shared learning bulletin was disseminated to all clinical services and was also raised at the weekly Immediate Safety Assurance Forum.

A second shared learning bulletin was distributed following another ligature incident concerning estates. The bulletin was immediately disseminated advising clinical staff of the risk.

During April, there were a number of Mental Health Act Administrative errors noted by the Immediate Safety Assurance Forum, the majority relating to errors made by AMHP's. The learning from these incidents were shared by the Mental Health Act administrator with the respective Local Authorities. To strengthen the Immediate Safety Assurance Forum, the Mental Health Act Administrator has joined as a member of this forum.

Learning from an incident whereby prescriptions lost in the post highlighted that not all teams were aware of the policy that the option of posting prescriptions should only be used in exceptional circumstances. The 'FP10 Prescriptions: collection and posting to patients/carers- a reminder' was shared to all teams as part of a series of medicines information provided during COVID-19

Box 1 illustrates examples of improvement to services provided following learning from complaints which can be shared across the Trust.

Specialist Mental Health - IAPT

- Complaint raised regarding the lack of support in helping a person access therapy and that distress was caused by the use of language recorded in clinical notes as 'person declined therapy'. The outcome of the complaint was that reasonable adjustments were made and the person is engaged with treatment.

  Learning Identified

  -Reasonable adjustments are made to help people engage with therapy
  -Clinical notes are written in a person centred way.
  -Language utilised by investigating managers within reports and letters should support a person centred approach

Neighbourhoods - Integrated care

- A concern rasied regarding a delayed Continuing Health Care fast track assessment. The clinical lead was not informed resulting in the delayed assessment.

  Learning Identified

  -An end of life checklist has been developed to support clinicians to follow the correct procedure

Specialist Mental Health – bed based and place based

- Concerns were raised regarding a person subject to standard Deprivation of Liberty authorisation and their discharge to supported accommodation. The clinical team facilitated a series of meetings to help explain the complex care needs.

  Learning Identified

  -Family/Carer's should be informed and involved in the decision making at the earliest opportunity.

The learning identified to achieve a locally resolved complaint included the following:

- Early contact being made with the person who has raised concerns
- People feel they have been listened to and given the opportunity for ongoing communication
- An apology provided in line with Duty of Candour
- Senior staff that are accountable for providing assurance that action will be taken with their oversight or involvement.

3.2 NHS Patent Safety Strategy.

The current serious incident framework 2015 is due to be replaced, by the introduction of a **Patient Safety Incident Response Framework** to improve the response to the investigation of incidents. CWP, sponsored by Clinical Commissioning Groups, have begun to respond to the strategy by launching a quality improvement initiative 'Serious incident investigations – Learning for Improvement' to reduce risk and improve safety through effective investigations of serious incidents that maximises the learning and the integration of learning.

CWP have a contractual obligation to undertake a patient safety review within 72 hours of being notified of a serious incident. The information collated from the review must be uploaded onto the NHS England serious incident database (StEIS) in line with national reporting guidance.

During trimester 1, saw the commencement of immediate safety reviews being completed electronically utilising the DATIX system. The use of DATIX has had a positive review from clinical teams with the Heads of Clinical Services' reporting that this has resulted in them being informed of serious incidents immediately and ensuring safety reviews are being completed promptly. The process will be reviewed within Trimester 2 by the Interim Head of Clinical Governance in conjunction with Heads of Clinical Services.

3.3 Learning From Deaths.

Mortality monitoring *For serious incidents, investigatory performance is 100%	2019/20			2020/21
	T1	T2	T3	T1
Inpatient deaths*	1/ 100%	4/ 100%	6/ 100%	**5/ 100***
Deaths reported to the Trust/ subject to a Case Record Review	205/ 100%	226/ 97%	275/ 99%	**331/ 97%**
Deaths reported as a serious incident/ subject to a serious incident investigation	20/ 100%	20/ 100%	16/ 100%	**4/ 100%**

During the height of the Covid- 19 pandemic, there was no requirement for the Trust to complete case record reviews. However, the Trust continued to maintain a high level of compliance of Case Record Reviews during that time as the practice to undertake case record reviews was deeply embedded by services

3.4 Learning From Inquests

During this trimester, the trust has not received any Preventing Future Death Reports (regulation 28)

3.5 Learning from External Reviews/ Investigations

There has been no external reviews published during this trimester.

4.0 Recommendations

4.1 Recommendations From Trimester 1 Analysis

The recommendations below have been identified from the detailed analysis of Learning from Experience report that is received by the Quality Committee. Updates and assurances received against these recommendations will be presented in the next report to the Board of Directors.

- Review the increase in self-harm incidents with respective care groups where this increase has been noted to understand the factors for the increase.

- Head of Clinical Governance and Heads of Clinical Services to review the immediate safety review process.

4.2 Recommendation To The Board of Directors

The Board of Directors is asked to note the report and the recommendations contained within.

Who/ which group has approved this report for receipt at the above meeting?		Gary Flockhart, Director of Nursing, Therapies & Patient Partnership
Contributing authors:		Satwinder Lotay, Interim Head of Clinical Governance Hayley McGowan, Associate Director of Nursing and Therapies (MH & LD)
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Board of Directors	

Appendices provided for reference and to give supporting/ contextual information:	
Appendix number	Appendix title
1	Updates and assurances received against trimester 3 2019/20 recommendations

Appendix 1 – Updates and assurances received against trimester 3's (T3 2019/20) recommendations

The following recommendations were made in the LfE Trimester 3 report:

1 The complaint process will be reviewed by the Head of Clinical Governance, Associate Director of Nursing and Therapies (Mental Health) and the Associate Director of Patient and Carer Experience in line with learning form the Collaboration at Scale programme being undertaken across the partnership.

2 The Clinical Governance team to re issue the Shared Learning Bulletin (SL70) reminding staff the importance of reporting 'low level 'incidents

3 Care groups to work with the respective governance/ incident teams to determine if any teams are outliers with the reporting of incidents

Recommendation 1 has been completed. A proposal was presented and approved at Quality Committee in May 2020.

Recommendation 2 has been completed with a shared learning Bulletin SL 70 being reissued in May 2020.

Recommendation 3 has commenced and respective care groups are working with the quality analysts to determine if any teams are outliers.