Cheshire and Wirral Partnership
NHS Foundation Trust

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

At 1:30pm on Wednesday 29 January 2020
At Boardroom, Redesmere

Present	Mike Maier	Chairman
	Dr Faouzi Alam	Joint Medical Director, Effectiveness, Medical Education and Medical Workforce & Caldicott Guardian
	Dr Paul Bowen	Non-Executive Director
	Andrea Campbell	Non-Executive Director
	Dr Jim O'Connor	Non-Executive Director
	Sheena Cumiskey	Chief Executive
	Suzanne Edwards	Acting Director of Operations
	Gary Flockhart	Director of Nursing, Therapies and Patient Partnership
	David Harris	Director of People and OD
	Edward Jenner	Non-Executive Director
	Rebecca Burke-Sharples	Non-Executive Director
	Tim Welch	Director of Business and Value
In attendance	Louise Brereton	Head of Corporate Affairs
	Hayley McGowan	Associate Director, Nursing and Therapies (for items 19.20.125, 130,131 and 132)
	Andy Styring	Interim Director of Strategy
	David Wood	Associate Director, Safe Services (for items 19.20.126, 127 and 135)
	Cathy Walsh	Associate Director, Patient Experience (for item 19.20.136)
	Katherine Wright	Associate Director, Communications and Engagement
	Ceri Morris-Williams	Care Quality Commission (CQC)
Apologies	Anne Boyd	Non-Executive Director
	Dr Anushta Sivananthan	Joint Medical Director, Quality, Compliance and Assurance

Ref	Title of item	Action
	Meeting governance	
19/20/116	**Welcome, apologies and quoracy** The Chair welcomed all to the meeting. The meeting was confirmed as quorate. Apologies received from Dr Anushta Sivananthan and Anne Boyd. A welcome was extended to Ceri Morris-Williams (CQC) observing the meeting as part of their well-led inspection.	
19/20/117	**Declarations of interest** None was declared.	

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Ref	Title of item	Action
19/20/118	**Minutes of the previous meeting held 27 November 2019.** The minutes of the meeting held 27 November 2019 were reviewed and **approved** as a correct record.	
19/20/119	**Matters arising and action points** The action log was reviewed. There were no further updates required.	
19/20/120	**2019/20 Cycle of business** The business cycle for 2019/20 was **noted**.	
19/20/121	**Chair's announcements** Mike Maier updated the Board of Directors on the following: **Care Quality Commission Well-led Inspection** CWP is pleased to have received notification from the CQC that they will conduct their 'Well-led' inspection of CWP on 9 – 11 March 2020. Visits to services have been ongoing in the last few weeks. **NHS Rainbow Pin Badge – CWP launch** The Trust will be joining the NHS Rainbow Pin Badge Scheme in February to tie in with LGBT History Month. The Rainbow Badge initiative gives healthcare staff a way to show that their place of work offers open, non-judgemental and inclusive care for all who identify as LGBT+. **Social Value Charter** CWP recently signed the Cheshire and Merseyside Social Value Charter. Led by the Cheshire and Merseyside Health and Care Partnership, this seeks commitment to the principles of social value and CWP will seek, where possible, to do this when we design, shape and deliver our services. **Partnership with Liverpool Philharmonic** CWP recently established a new partnership with Liverpool Philharmonic as part of its music and mental health programme. As part of this, musicians from the company have led a number of music sessions and performances for people living with dementia, their families and carers and members of staff at Springview Hospital. **CWP wishes farewell to Julia Cottier** Earlier this month we wished farewell to Julia Cottier, Associate Director of Operations for Children, Young People and Families, who has retired after 25 years with CWP. On behalf of the Board, the Chair extended thanks to Julia for everything she has given to CWP over the years and wish her all the best for the future. **State-of-the-art mental health facilities for East Cheshire unveiled** The two new mental health wards in Macclesfield have been opened. The wards are the result of a £4.5 million investment programme to modernise inpatient services for people who require a hospital stay, as part of wider improvements to local mental health services. **Lived Experience Connectors** This week the Trust has welcomed colleagues from Health Education England (HEE) to film ahead of a joint collaboration to promote new roles in mental health with CWP's Lived Experience Connectors. Lived Experience Connectors partner with people working in services to provide	

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	continuous support and feedback in their journey of person centred practice. The roles will be championed by HEE nationally at two events in London and Leeds later this year. The Board of Directors **noted** the above updates.	
19/20/122	**Chief Executive's announcements** Sheena Cumiskey updated Board members and those in attendance of proceedings at the private Board of Directors' meeting. This included: • Board reflections on the patient story that was presented to members with particular focus on the support from services for people with Learning Disabilities (LD) and autism. Thanks were extended to the PACE team for support with co-production. • Progress with the CQC well-led inspection. • Feedback from the recent 'Breakfast with Sheena' session held in East Cheshire. • Updates from the Cheshire and Merseyside Health and Care Partnership and the process to appoint to the Senior Responsible Officer position. • Escalation and assurance from Operational Committee which included an update on the current position with ADHD services. • Approval of the 2018/19 Charitable Fund accounts in line with Charity Commission requirements. • Month 9 financial position and assurance regarding likely achievement of the 2019/20 control total. • Improvement work on process for serious incidents and the wider clinical governance agenda. • A review of current and forthcoming business and development opportunities • Consideration of a proposal for the future provision of Wirral Continuing Healthcare (CHC) • A review of the current partnership work at 'place'. The Board of Directors **noted** the above summary.	
	Internal reporting from committees, matters of governance and assurance	
19/20/123	**Quality Committee: Chair's report of the Quality Committee held on 8 January 2020** Dr Jim O'Connor, Chair of the Quality Committee presented the Chair's report and highlighted the following issues: • The Learning from Experience report was circulated following the meeting and comments received to inform the summary version on the Board agenda later today. • The quality assurance dashboard in relation restraint incidents. This was referred back to Care Groups for further review. • A review of the risk register approved the archive of Risk 4.	

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	• The Mental Health Law activity report was reviewed and areas for improvement noted. The Board of Directors **noted** the Chair's report.	
19/20/124	**Audit Committee: Chair's Report of the Quality Committee held 14 January 2020** Edward Jenner, Chair of Audit Committee provided an overview of the report and highlighted the following issues: • The proposal for the quality spot checks audit was agreed. • An update was provided on progress with the recommendations from the health roster audit with a further update due at the March meeting. • The Committee were reassured by the outcome from the clinical supervision supportive audit, in particularly the progress already made and the commitment to ensure a focus on quality. • Preparations for external audit were reviewed with the pre-audit due to commence in February 2020. • An update on data quality improvement work was also received providing assurance on progress in this area. The Board of Directors **noted** the Chair's report.	
19/20/125	**2019/20 six monthly reports** Hayley McGowan drew attention to the six-monthly reports provided to the Board of Directors for noting. It was confirmed that all three reports had been received by their respective sub-committee. **a. Infection, Prevention and Control (IPC)six monthly report** Compliance with all regulatory requirements was confirmed. The IPC team's support with the flu campaign was noted. A discussion followed with queries raised around treatment of C.diff cases and antibiotic stewardship. It was requested that these queries be passed to Victoria Peach, Director of Infection, Prevention and Control who was unable to attend the meeting today. **Action**: Queries regarding C.diff and antibiotic stewardship in GP surgeries be passed to Victoria Peach for a response outside the meeting. The Board of Directors **noted** the report. **b. Safeguarding adults and children six monthly report** Hayley McGowan highlighted the key issues within the report including updating the level three training plan reflecting on the intercollegiate guidance regarding training requirements. This is on track to be achieved by September 2020. A discussion followed. Board members expressed their thanks to the Safeguarding team for the significant amount of work they support, in particular with adult safeguarding **Freedom to Speak Up Guardian (FTSU) six monthly report**	**GF/ HM**

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	Hayley McGowan highlighted the key issues within the report. • The Trust's Freedom to Speak Up Guardian role is undertaken jointly by Hayley McGowan and Victoria Peach • The number of FTSU ambassadors continues to increase. • FTSU concerns are increasing but there are no specific trends arising suggesting any specific concerns. Themes include management and leadership and disciplinary processes. • There have been no concerns raised in this period by the LD Care Group or the ADD Care Group. Raising awareness work will be targeted at this group to ensure ongoing awareness of the FTSU facility. • The FTSU app has been discontinued following agreement by the Operational Committee. No concerns were raised by this method and feedback indicates that when staff wish to raise a concern, they prefer to do this on a face to face basis. A discussion followed. Mike Maier commented on the increasing number of concerns as an indicator of increased awareness of the facility. Thanks were extended to Rebecca Burke-Sharples who undertakes the NED FTSU Champion role. It was noted that FTSU is discussed at new staff induction and a six monthly review of new staff and their initial experiences of CWP has been initiated. It was also noted that the FTSU report is received by both the Quality Committee and the Audit Committee from a quality and internal control perspective respectively. The Board of Directors **noted** the report. (David Wood joined the meeting)	
19/20/126	**Board assurance framework and strategic risk register** The Chair welcomed David Wood, Associate Director, Safe Services to the meeting. David Wood reminded Board members of the requirements of the integrated governance framework and the respective roles of the Quality Committee, Audit Committee and Board of Directors in risk management. Attention was drawn to the 'heat-map' tab which sets out the Board's capacity to deal and mitigate the risks it holds. This indicated that the Board have capacity for this. It was also noted that MIAA are currently undertaking their annual review of the assurance framework. David Wood provided an overview of current risks. The ADHD risk remains in-scope reflecting the dynamic situation with this risk. Board members were reminded that this risk had been escalated to the Quality Committee from the LD Care Group. Following consideration by the Operational Committee, the team are making plans to implement option 3 – to provide a commissioned service based on funding. Patient needs remain paramount as this risk is mitigated. The emerging risk around flu vaccinations has been escalated to the strategic risk register (risk 6). A strong risk treatment plan has been devised. This risk current scores 12 (amber)	

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	A risk treatment plan has also been developed for the finance/ efficiency risk (risk 11). This previously archived risk has been re-escalated reflecting the emerging risks around reliance on non-recurrent efficiency schemes. Reporting on archived risks, David Wood advised Board members that Risk 4 *(risk of not providing effective electronic transfer of inpatient discharge summaries within 24 hours and outpatient clinic letters within 7 days, potentially impacting on the quality of clinical information and potentially increasing the likelihood of contractual and regulatory breaches)* was agreed for archive by the Quality Committee. It was confirmed that all risk treatment plans are on track with no overdue actions. A discussion followed. Board members discussed the ADHD risk and the need for close scrutiny of this to ensure appropriate CCG ownership of elements of the risk. The Board of Directors **approved** the report and the amendments made to the board assurance framework as recommended by the Quality Committee.	
19/20/127	**CQC statement of purpose** David Wood presented the report. As set out in the business cycle, the Board review the CQC statement of purpose on an annual basis. This document sets out the services provided by the Trust and where they are provided. This supports CQC regulation of activity and they are duly notified of any changes as and when they arise in-year. It was noted that the statement of purpose is being updated to reflect the opening of Silk and Mulberrry wards and the closure of Bolin, Croft and Limewalk House. It also reflects the re-designation of Maple Ward and the acquisition of Old Hall Surgery and the All Age Disability Service. Non-Executive Directors commented on the statement of purpose being an accurate reflection of the significant scale of Trust operations. The Board of Directors **noted** the report.	
19/20/128	**Report against Strategic Objectives** Tim Welch presented the report and highlighted the following issues: • IAPT recovery rate reported marginal underperformance in November 2019. Care Groups have been asked to keep this metric under close review. • Data quality measure is reporting under-performance. The most recent data (September 2019) indicated a position of 82% against a target of 95%. Plan in progress to further improve this position. • The dashboard continues to develop including further community physical health metrics as agreed by the Neighbourhood Care Group. • Out of Area acute admissions continue to be sustained at zero which is testament to the planning and operational management of services.	

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	It was noted that initial discussions on the evolving board dashboard commenced 12 months ago. This is being kept under review to ensure continuous improvement. Board seminar time will be arranged to further review progress. **Action:** Board seminar/ development time to be scheduled in Board development plan to review developments with board dashboard and to inform future developments. The Board of Directors **noted** the report.	**LB/ TW**
19/20/129	**Guardian of Safe working: Q3** Dr Faouzi Alam presented the report. The following issues were highlighted: • This report represents the third report to the Board in 2019/20, covering four month period (September – December 2019). • One exception has been raised from a Junior Doctor in the reporting period, who had worked one hour overtime. Time off in lieu had been awarded in response. • There have been no concerns raised regarding safety or access to education and training opportunities. • To date no fines have been levied against the Trust. Board members were advised of the Health Education England visit to the Trust today. Initial feedback has been very positive with HEE citing no safety concerns and commending good governance, supportive education, culture and environments promoting multi provider learning. A discussion followed. Board members commended the feedback from HEE. It was agreed the formal feedback when received by HEE should inform future planning, working with partners and visibility across services. The Board of Directors **noted** the report	
19/20/130	**Safer Staffing: November and December 2019** Hayley McGowan presented the report and confirmed that staffing levels were maintained to required standards during November and December 2019. Pressures increased in the East Cheshire wards through the transition period to the new wards, however gaps were mitigated and pressures should now reduce now the wards are fully open. Staffing at Greenways remains challenging and recruitment of LD nurses is underway but this is a national challenge. Pressures in staffing levels here were mitigated to ensure patient safety. It was noted that CWP remains the only LD trust in the North-West which is open to inpatient referrals which reflects the complexities of patients and services. It was confirmed that there are plans in place locally to provide a greater substantive staffing base but national shortages are having an impact. Gary Flockhart reminded Board members that the report only reflects nurse staffing in accordance with National Quality Board requirements and consequently does not reflect the wider MDT support provided in teams. It was noted that the report also includes the cleansed data on fill rates for	

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	Ancora House wards for September and October 2019, with no issues identified. The Board of Directors **noted** the report.	
	Quality of Care	
19/20/131	**Safer Staffing: six monthly report** Hayley McGowan presented the six monthly Safer Staffing report and highlighted the following issues: • Registered nursing levels on Bollin were on occasion lower than planned, mitigated by wider team support. • The LD Care Group have launched a nursing recruitment programme which is hoped to yield results though in the face of national shortages. • Two new Psychology posts have been created to support in-patient wards. • Inpatient recruitment in advance of need continues, including a student nurse recruitment event. • CWP holds a 5% vacancy rate for nurses at the moment. This is lower than comparable trusts and is a position the Trust hopes to sustain. • Staffing establishments in LD assessment and treatment units are under review in line with contract negotiations and national drivers. Spot purchase arrangements are planned to reduce and bank supply is currently good, however this reduces when staffing appointments become substantive. • The new leadership structure in Starting Well services is beginning to embed positively. • The ongoing recruitment challenge demands various approaches to mitigate risks. The team continue to try and be innovative and creative to support recruitment challenges across the Care Groups. A discussion followed. Non-Executive Directors commended the comprehensiveness of the report and the assurance therein. Hayley McGovern noted that the All Age Disability Service will be included in the future reports. This was welcomed by Board members as it would include the opportunity to connect and collaborate with other providers and include social work staff and their contribution to the staffing mix. Board members reflected on the development of the report over the last four years and the growing emphasis the report has on quality and assurance. Next steps were noted around involving care communities and assessing the skills needed to support defined populations. The Board of Directors **noted** the report.	
	Strategy / Strategic Development	
19/20/132	**Learning from Experience** Hayley McGowan presented the report and highlighted the following	

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	issues; • There has been an overall reduction of incident reporting in the period including a significant reduction in incidents of self-harm. This potentially suggests the positive impact of QI projects but remains under review. • The Neighbourhood Care Group has reported an increase in the number of category C pressure ulcer incidents. Work is being taken forward in the Care Group Governance group to understand the drivers to this trend. • Working is continuing to align clinical governance processes and policies with the national patient safety strategy. The Patient Incident Response framework is still awaited. Board members welcomed the review of clinical governance processes and Non-Executive Directors expressed their support for this. The Board of Directors **noted** the report. (Hayley McGowan left the meeting)	
19/20/133	**People and OD strategy – Q3 report** David Harris presented the Q3 report detailing progress with the implementation of the People and OD strategy. Board members were reminded that the strategy is monitored on a monthly basis by the People and OD sub-committee, reporting into the Operational Committee. A discussion followed regarding the level of assurance offered by the report. Non-Executive Directors welcomed the report and the assurance provided, however commented on the need for future reports to provide more analysis of the risks to strategy delivery. It was agreed that this would be built into future reports. The Board of Directors **noted** the report.	
19/20/134	**Central and East Cheshire redesign** Suzanne Edwards provided a presentation to the Board of Directors on the progress with the Central and East Cheshire redesign. The presentation set out the journey from the engagement and public consultation up to the present day and the recent transition to the new wards, Mulberry and Silk and increase in community services.. The design and functionality of the new wards were highlighted. Attention was drawn to the level of consultation and intensive partnership to achieve the redesign, including with local mental health forums and local MPs. A discussion followed. Thanks were extended to Suzanne Edwards and her team and to Katherine Wright and the Communications team for their input and support to the programme. It was noted that the PALS team will be having an extended presence on the new wards to understand how patients are receiving the changes. Other metrics such as bed occupancy will be kept under review to monitor responses to the changes.	

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	Dr Faouzi Alam expressed thanks to Dr Anushta Sivananthan and Suzanne Edwards for the diligence in keeping the momentum with the programme. The impacts have been well-monitored via the QIA process. The Clinical Practice and Standards sub-committee will be receiving a paper setting out the quality outcomes for the programme which will report to the Quality Committee. Board members were advised that an event is planned to celebrate the project completion. It was agreed that the project was a good example of a very challenging programme which was achieved though good leadership, teamwork, communication and courage. An evaluation is also planned and the project has also been entered for the HSJ Value Awards. The Board of Directors **noted** the report.	
19/20/135	**Quality Improvement report** David Wood presented the Quality Improvement Report and drew attention to the following issues: • Capability building for senior managers through QI projects is improving through a structured approach to embedding QI. • Quality Account improvement priorities are all on track. The patient safety priority has been achieved following the reduction in self-harm incidents and the improved comparable position with peer mental health trusts. This will now require sustaining and monitoring. The Coral ward project on this was a particularly good example of reducing self-harm incidents by a significant margin of 22% • A DBT skills group has resulted in a significant reduction in harmful behaviours for young people. • Within the effective domain, the complex-needs service has resulted in a reduction in bed days. • Within the experience domain, an improved self-care programme for those expiring osteoarthritis has been implemented. Board members noted that all projects have a sustainable plan for delivery with the potential to roll out elsewhere and are owned by staff delivering the service. The Board of Directors **noted** the report. (Rebecca Burke-Sharples left the meeting, David Wood left the meeting Cathy Walsh joined the meeting)	
19/20/136	**CQC Community Mental Health team survey** The Chair welcomed Cathy Walsh to the meeting. Cathy Walsh advised Board members that the CQC community mental health survey had recently been issued and provided an overview of the results. These included: • Positive process made in the 'support and well-being' domains and in 'therapies', partly around support with medications and access to wider services such as financial advice. • Areas to improve were around the domains of 'organising your	

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	care,' and support for physical health needs. • The SMH Care Group has taken the results and developed an action plan which will report progress to the Quality Committee. A discussion followed. Andrea Campbell commented on the need to focus on the improvements required to support people with their physical health needs, particularly given the expertise that the Trust has through delivering community physical health services in West Cheshire. It was noted that this could be addressed in part through care communities. Board members agreed that progress with implementing the recommendations required close oversight but that this would be monitored by the Quality Committee, reporting into the Board of Directors. The Board of Directors **noted** the report. (Cathy Walsh left the meeting).	
	Closing Business	
19/20/137	**Any other business** There were no further items of business.	
19/20/138	**Matters for referral to any other groups** There were no matters to refer or escalate to other groups from the meeting.	
19/20/139	**Matters impacting on policy and/ or practice** There were no matters identified impacting on policy and/or practice.	
19/20/140	**Review risk impact of items discussed** It was acknowledged that the board assurance report and risk register reflected all risks discussed.	
19/20/141	**Key messages for communication** The Chair invited Katherine Wright to provide an overview of the key messages from the meeting. These included: • Positive progress through the implementation of the QI strategy as reflected in the QI report. • The positive reflection on the journey to deliver the Central and East redesign project. • The positive feedback from the HEE inspection.	
19/20/142	**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 26 February 2020, 9.30am (seminar session)**	

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Cheshire and Wirral Partnership NHS Foundation Trust
Open Actions Action Schedule

Meeting date	Group/ Ref	Action	By Whom	By when	Status
29.01.2020	19.20.128	**Report against Strategic Objectives**: Board seminar/ development time to be scheduled in Board development plan to review developments with board dashboard and to inform future developments.	TW/LB	Feb 2020	Noted as an addition for the board development/ seminar time. Action closed

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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		✓		✓	✓		✓		✓		✓
Assurance	Review minutes of the previous meeting	MM	To approve minutes	W4 W5		✓		✓	✓		✓		✓		✓
Assurance	Place Based reports/ updates including ICP Board/s (minutes)	SC	To note system developments	W6		✓		✓	✓		✓		✓		✓
Assurance	Receive Chair's Report of the Quality Committee	JOC	Review Chair's Report and any matters for note/ escalation	W4 W5		✓		✓	✓		✓		✓		✓
Assurance	Receive Chair's Report of the Audit Committee	EJ	Review Chair's Report and any matters for note/ escalation	W4 W5		✓		✓	✓		✓		✓		✓
Assurance	Freedom to speak up six monthly report	AD	Review and note for assurance	W3 W5 W7 W8				✓					✓		
Assurance	People and OD strategy delivery	DH	Review and note for assurance	W2 W3 W7							✓		✓		✓
Assurance	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											✓
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		✓					✓				

IMPROVEMENT

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:	06/05/2020

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

CQC regulatory updates and addendums to the Statement of Purpose were escalated to the Quality Committee, specifically COVID-19 related changes to service provision. As of 24 March 2020, the CQC agreed a new, temporary process with the Trust's Compliance team when considering any regulatory updates that should be made to the Statement of Purpose, allowing the Trust to keep the CQC fully updated on a weekly basis regarding any temporary regulatory changes and without permanently affecting the Statement of Purpose or requiring constant changes to it.

A continuing reduction in staff reporting no and low harm incidents was noted via the quality assurance dashboard. This has been impacted on as a consequence of the COVID-19 pandemic response at a time when clinical prioritisation takes precedence, however the longitudinal incidents data shows a reduction prior. The Trust has periodically reminded all staff of the value of recording these incidents as opportunities to learn lessons which may prevent a more serious incident from occurring – the Quality Committee agreed to re-issue the share learning bulletin in relation to this topic as a priority task once the Trust enters recovery mode from the response to the COVID-19 pandemic response.

(ASSURANCE) Matters discussed:

Detailed assurance was received on treatment of the strategic risk associated with COVID-19 by reviewing the collective risk logs overseen by the Tactical Command Group. In particular, assurance was received around the sufficient availability of Personal Protective Equipment.

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 was both ensuring the protection of people's liberty and that the Trust's operational response was robust.

Assurance around the Trust's response was received in relation to incidents and complaints management during the COVID-19 pandemic. The Trust's current operational response follows national guidance and has been agreed with regulators and commissioners. Learning from experience themes are being captured. For incidents the top two themes since March 2020 are self-harm and physical violence, though the numbers have reduced. For complaints, one has related staff members not social distancing outside of work. The other complaints received have been around accessing services, poor communication with patients and families, and the MHA – they do not relate to the COVID-19 emergency response and the latter does not relate to any unlawful detention.

The Care Groups provided assurance of their response to changes in activity detailed in the weekly clinical prioritisation SitReps, including assurance of capability to provide appropriate responses to escalating clinical need, specifically safe and effective systems for face-to-face access to services.

(IMPROVEMENT) Achievements:

A project has commenced to evaluate the changes in service provision and utilisation across CWP's services in response to COVID-19. This will help to understand the impact on clinical practice and people's experience of accessing services, in order to inform future practice, service provision and redesign. The project will include the following elements: data collation and analysis; qualitative and quantitative surveys with people who access and deliver the Trust's services; capacity and demand modelling. The report will be presented to the Clinical Practice & Standards Sub Committee and Quality Committee and the key findings, recommendations and lessons learned shared widely across Care Groups in order to inform future practice. An abstract for conference presentations will also be developed, followed by a comprehensive research paper for publication.

#cwpQI

Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	CWP Provider Licence – annual self-assessment and Licence declarations
Agenda ref. number:	20.21.36
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	27/05/2020
Presented by:	Tim Welch, Director of Finance

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	No
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	No

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

Compliance with the licence is routinely monitored through the NHSI Oversight Framework, however on an annual basis, the licence requires NHS providers to self-certify as to whether they have effective systems, governance and resources in place to meet their obligations. Other key components within the licence criteria are reviewed on an annual basis. The annual self-certification provides assurance that NHS providers remain cognisant of and are compliant with the conditions of their NHS provider licence.

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

This report details the NHS provider licence criteria self-assessment for year ending 2019/20. The licence contains obligations for the Trust and this assessment aims to help the Audit Committee/ Board members in confirming the accuracy of requirements that CWP is required to comply with as a licence holder.

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

Appendix 1 contains the high level excerpts from the full licence document and enables Board members to consider the key licence conditions and any risks to compliance. All conditions are now rated as Green (compliant).

The Board of Directors is also required to make an annual declaration under General Condition 6 of the Licence to confirm the Trust's ongoing compliance with the Licence and confirm the availability of resources in accordance with Continuity of Services Condition 7. In addition, the Board are also required to confirm compliance under Section 6 (Foundation Trust Condition 4) with a number of Corporate Governance Statements. With regard to the declarations required under General Condition 6 and Continuity of Service Condition 7, the Board is required to confirm or otherwise, systems in place for compliance with the licence conditions. The Board are recommended to confirm this declaration. These are set out at appendix 2. The above are required to be completed by 31st May 2020.

With regard to the declarations required under section 6, condition FT4 – NHS FT governance systems, the Board is recommended to confirm the corporate governance statements and confirmation for governance systems where major joint ventures or Allied Health Science Networks are in place. The Board are also required to confirm provision of appropriate Governor training opportunities which the Board are recommended to confirm evidenced by the ongoing governor training programme in place, providing a range of internal and externally facilitated training opportunities. The corporate governance statement (licence condition FT4) is required to be completed by 30th June 2020.

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

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

The Board of Directors are **recommended** to note the 2019/20 year end Licence position and approve the confirmation of the declarations in accordance with General Condition 6, CoS 7 and Condition FT4 of the Licence and for publication on the Trust website

Who has approved this report for receipt at the above meeting?	Tim Welch, Director of Business & Value
Contributing authors:	Louise Brereton, Head of Corporate Affairs

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued

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

Appendix No.	Appendix title
1	Key Provider licence conditions as at end 2019/20
2	Licence Declarations FT4 and G6, CoS7

Appendix 1: Self-assessment evidence against NHS provider licence key criteria as at end Q4 2019/20

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

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

Licence reference	Licence provision	Self assessment	End quarter 4 2019/20 position	Comments/ Further actions for completion
G6(3)	Publication of Annual Governance Statement (AGS)?	GREEN	Compliant	20/19/20 AGS currently in developed, produced later than usual in accordance with later annual reporting timescale which was, extended as part of response to COVID- 19 pandemic. This will be published as part of Annual Report and Accounts following completion of Parliamentary requirements which have been deferred until the autumn.
G7	Consider CQC registration status in 2019/20 – note cancellations and registrations	GREEN	Compliant	CQC Statement of Purpose including registrations and cancellations was last reviewed by the Board in January 2020. In-year amendments included: • Addition of Old Hall Surgery as a registered location following the acquisition of the service. • Transfer of All Age Disability services to CWP. • As a result of changes to services as part of the redesign within Central & Eastern Cheshire • Closure of Limewalk House and opening of Maple ward as a rehabilitation unit • Closure of Adelphi, Bollin and Croft wards and opening of Mulberry and Silk wards.
G8	Consider if all information on range of services and information on who can access them is published	GREEN	Compliant	Details of all services including eligibility (age range/ conditions) and referral routes are within each service listed on the CWP website.
G9	Consider whether Commissioner Requested Services have been amended?	GREEN	Compliant	Commissioner Requested Services with NHS England, Specialised Services for the following services: CAMHS Tier 4, Adult Eating Disorders, Secure and Mental Health Services (adult) and Learning Disabilities. No changes in the last six months.

Licence reference	Licence provision	Self assessment	End quarter 4 2019/20 position	Comments/ Further actions for completion
G9(12)	Have the contractual requirements to activities or any mandatory services been amended?	GREEN	Compliant	No material changes that would impact on licence conditions.
2. Pricing				
P1(4)	Have any services been sub contracted?	GREEN	Compliant	Various sub-contractors to support the Emotional Healthy Children and Young People service commissioned by Cheshire East Council; Spider Project to support Community Crisis Provision commissioned by West Cheshire CCG.
3. Choice and competition				
C1(3)	Are clear systems in place for notifying individual patients about choice?	GREEN	Compliant	Patient choice information on CWP website in applicable service areas.
4. Integrated care				
IC1	Are there any service changes that require staff/ public consultation (need to be cognisant of Public Interest)?	GREEN	Compliant	No public consultation in 2019/20.
5. Continuity of services				
CoS1	Have any contract variations been completed to service specifications	GREEN	Compliant	Yes –there have been contract variations to service specifications within this time period but not of a material nature requiring notification.
CoS2	Have any assets been disposed of that would impact on the ability to provide 'Commissioner Requested Services'?	GREEN	Compliant	Assets disposed of in the period have not impacted on the delivery of commissioner requested services.
6. NHS Foundation Trust conditions				
FT1	Has the Constitution been amended? Amended constitution should be submitted to	GREEN	Compliant	No changes in 2019/20 however it is recognised that the Constitution requires a full review. This work has commenced, working closely with Governors, however requires further impetus which is planned for 2020/21

Licence reference	Licence provision	Self assessment	End quarter 4 2019/20 position	Comments/ Further actions for completion
	NHSI with 28 days of amendment.			
FT4(8)	Submit to NHSI Corporate Governance Statement following Board approval in Q1 by 30 June.	**GREEN**	Compliant	Statements are due for approval at the May 2020 meeting of the Board of Directors.

You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Insert name of organisation

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7" Financial Year to which self-certification relates: 2019-20 — Please complete the explanatory information in cell

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

	Statement	Response	
1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

	Statement	Response	
3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

OR

	Statement	Response	
3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

	Statement	Response	
3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Mike Maier	**Name**	Sheena Cumiskey
Capacity	Chairman	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Cheshire and Wirral Partnership NHS Foundation Trust *Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration" Financial Year to which self-certification relates: 2019/20

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	No risks identified. Good practice review of the Corporate Governance Manual commenced in February 2020 by MIAA . MIAA also facilitating the annual (2019/20) reflective reviews of committee effectiveness as part of audit plan; this work has commenced but has been delayed by the COVID 19 pandemic. Recent CQC inspection reviewed approach to integrated governance and standards.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	No risks identified. All guidance issued by NHS Improvement is duly implemented and is discussed with NHS Improvement, as required, at regular relationship meetings.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	No risks identified. The Trust continues to have a robust governance (meetings and reporting/ accountability) structure in place. Assurance of effectiveness of the integrated governance framework is also confirmed via the annual governance statement and also via the feedback received to date from the CQC arising from their most recent well-led inspection of the Trust in March 2020.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	No risks identified. The Board has implemented and has oversight of systems and processes in place to ensure ongoing compliance with the requirements of the Licence, confirmed in the Annual Report and Annual Governance Statement. This includes: • Annual review of compliance with the Licence via self-assessment supported on ongoing monitoring of the Oversight Framework across the year. • Established planning cycle, including early oversight of financial projections. • Monthly Board reporting against performance against the Trust's strategic objectives. • Substantial internal audit assurance opinion on the Board Assurance Framework. • Internal audit plan driven by strategic and local risk registers and Board Assurance Framework. • Full compliance with CQC registration conditions.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Board business cycle in place providing a mixture of formal open (meeting in public) and closed (meetings in private) meetings and developmental seminar sessions. Annually updated Board development programme in place. Three times yearly reporting on quality improvement and learning from experience to the Board. Reporting on Board performance (financial and operational). Assurance and escalation framework in place from Quality Committee, Audit Committee and Operational Committee to Board of Directors.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	All Directors have the appropriate skills, qualifications and experience to undertake their roles on the Board and to ensure compliance with its NHS provider licence, confirmed annually through appraisal and annual assurance review by the Chair. Also confirmed as part of well-led inspection by CQC in March 2020.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		Signature	
	____________		____________
Name		Name	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Worksheet "Training of governors"

Financial Year to which self-certification relates: 2019/20

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

NHS Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Board of Directors: Register of Declared Interest and Register of Gifts and Hospitality
Agenda ref. number:	20.21.37
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	27/05/2020
Presented by:	Louise Brereton, Head of Corporate Affairs

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

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 Directors Register of Interests and Gifts and Hospitality 2019/20 are presented to the Audit Committee to provide assurance regarding compliance with the national and local conflicts of interest policies.

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

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

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

The guidance is applicable to CCGs, NHS Trusts, NHS Foundation Trusts and NHS England. NHS Trusts and NHS Foundation Trusts must have regard to this guidance through its incorporation into the NHS

Standard Contract pursuant to General Condition 27.

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

As an NHS Trust and in accordance with the Trust's Corporate Governance Manual requires that "the Trust shall have a register of interests of the directors". Furthermore, it states that "the Trust shall make the registers available for inspection by members of the public. This information is held to ensure the Trust conducts business honestly and impartially and employees remain beyond suspicion. As a public sector employer the Trust must operate systems which allow public accountability and openness maintaining the highest standards of integrity and probity while supporting and engaging in collaboration and partnership working.

The final register of directors' interests for 2019/20 is included at Appendix 1 and these details are made available on the Trust's website and will also be reported in the Trust's Annual Report. In addition to the annual review, at each meeting of the Board of Directors, and its Committees, members are asked to declare any further interests since the date of the last declaration and to notify the Chair of any conflicts of interest in relation to the agenda items for discussion (for which they may need to withdraw). Any such declaration is recorded in the minutes.

Directors and members of staff are now also required to register any sponsorship, gifts and hospitality, whether offered or accepted. The current register is included as Appendix 2. These declarations are normally submitted on an ad-hoc basis throughout the year following which the register is updated accordingly.

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

The Board of Directors are recommended to note:

- The Directors Register of Interests 2019/20
- The Directors Register of Gifts and Hospitality 2019/20

Who has approved this report for receipt at the above meeting?	
Contributing authors:	N/A

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
Click here to enter text.	Audit Committee	March 2020

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

Appendix No.	Appendix title
1.	Directors Register of Interests 2019/20
2.	Directors Register of Gifts and Hospitality 2019/20

DIRECTOR REGISTER OF INTERESTS 2019/20
(updated February 2020)

(As per section 7.23 of the Corporate Governance Manual, an annual review of the register should detail any changes to interests declared during the preceding twelve months)

NAME, DESIGNATION/ BOARD DIRECTORSHIP	NOTHING TO DECLARE	TITLE OF INTEREST	DETAILS OF RELEVANT ORGANISATION	COMMENCEMENT OF INTEREST	LENGTH OF APPOINTMENT
Dr Faouzi ALAM Joint Medical Director and Caldicott Guardian	✓				
Dr Paul BOWEN Non-Executive Director		Non-Executive Director	GP partner, Middlewood Partnership *(Non-financial professional interest)*	April 2019	On-going
		Non-Executive Director	The above practice is a shareholder in Vernova CIC. *(Non-financial professional interest)*	April 2019	On-going
		Non-Executive Director	The above practice is a member of NHS Eastern Cheshire CCG *(Non-financial professional interest)*	April 2019	On-going

Anne BOYD (Turpin) Non-Executive Director		Non-Executive Director	A family member has accessed CWP services in the past	January 2014	On-going
		Member	Cheshire and Warrington LEP	January 2016	On-going
		CEO	Active Cheshire	January 2012	On-going
Andrea CAMPBELL Non-Executive Director		Director	A.Campbell Consultancy – Health/ Social Care Consultancy	December 2004	On-going
		Non-Executive Director	Belong – Social Care Provider	January 2016	On-going
		Chair	Aspire CIC, Salford – Social Care Provider	October 2016	On-going
Dr James O'CONNOR Non-Executive Director/ Chair of Quality Committee		Chairman	General Council – Eastham Lodge, Golf Club.	20/12/2018	On-going
Sheena CUMISKEY Chief Executive		Chair	Board of the NHS North West Leadership Academy	22 February 2010	Ongoing
		Member	NHS Employers policy Board	2016	Ongoing

Gary FLOCKHART Director of Nursing, Therapies and Patient Partnership	✓				
Suzanne EDWARDS Acting Director of Operations	✓				
David HARRIS Director of People and OD		Associate Teaching Fellow	University of Lancaster Bailrigg Lancaster. LA1 4YW	November 2017	On-going-assignments on an ad-hoc basis. Any wages received for the role are paid into CWP charitable funds
Edward JENNER Non-Executive Director	✓				
Mike MAIER CHAIR	✓				

Rebecca BURKE-SHARPLES Non-Executive Director/ Senior Independent Director		Spouse (Alan Sharples) is a Vice Chair and lay member Governance South Sefton CCG.	South Sefton CCG	August 2019	Minimum of 2 years
		Volunteer restorative justice practitioner working exclusively in Wirral		January 2020	On-Going
Dr Anushta SIVANANTHAN Joint Medical Director	✓				
Andy STYRING Director of Operations		Director	Nevexia Ltd, Redesmere, Countess of Chester Health Park. (non-remunerated)	January 2017	On-going

		Governor of Ancora School	Ancora House, Countess of Chester Health Park, Chester. (non-remunerated)	December 2016	On-going
Tim WELCH Director of Finance/ Deputy Chief Executive		Director	Nevexia Ltd, Redesmere, Countess of Chester Health Park.	January 2017	On-going
		Director	Villicare, Limited Liability Partnership	November 2013	On-going
Previous Directors (within the preceding 12 months)					
NAME, DESIGNATION/ BOARD DIRECTORSHIP	**NOTHING TO DECLARE**	**TITLE OF INTEREST**	**DETAILS OF RELEVANT ORGANISATION**	**COMMENCEMENT OF INTEREST**	**LENGTH OF APPOINTMENT**
Lucy CRUMPLIN Non-Executive Director		Director	Tiger Bright Ltd (consultancy)	May 2012	On-going
Avril Devaney		Trustee Of Jamie Devaney Memorial Fund	Charity supporting mental health care in Uganda	March 2013	Ongoing

Director of Nursing		Chair	Mental Health and Learning Disabilities Nurse Directors and leads' Forum	March 2016	March 2019
		Visiting Professor at University Of Chester	University of Chester, Parkgate Road, Chester	December 2016	Three Years

Cheshire and Wirral Partnership
NHS Foundation Trust

DIRECTOR DECLARATION OF GIFTS AND HOSPITALITY REGISTER

2019-20

Name	Designation	Department	Date of Declaration	Details of Gift and/or Hospitality
Dr Faouzi Alam	Medical Director	Trust Board		NIL
Paul Bowen	Non-Executive Director	Trust Board		NIL
Anne Boyd	Non-Executive Director	Trust Board		NIL
Andrea Campbell	Non-Executive Director	Trust Board		NIL
Dr James O'Connor	Non-Executive Director	Trust Board		NIL
Sheena Cumiskey	Chief Executive	Trust Board	9.3.2020	HSJ conference meal and overnight accommodation on 28/11/19. Total value £100
Suzanne Edwards	Acting Director of Operations	Trust Board		NIL

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Name	Designation	Department	Date of Declaration	Details of Gift and/or Hospitality
Gary Flockhart	Director of Nursing, Therapies and Patient Partnership	Trust Board	NIL	
David Harris	Director of HR and OD	Trust Board	NIL	
Edward Jenner	Non-Executive Director	Trust Board	NIL	
Mike Maier	Chair	Trust Board	14.10.2019	Attendance at 'Unsung Heroes' dinner hosted by Active Cheshire at Chester Racecourse ON 25.09.2019. Total cost £37+ VAT
Rebecca Burke Sharples	Non-Executive Director	Trust Board	NIL	
Dr Anushta Sivananthan	Medical Director	Trust Board	NIL	
Andy Styring	Interim Director of Strategy	Trust Board	NIL	
Tim Welch	Director of Finance	Trust Board	NIL	

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Name	Designation	Department	Date of Declaration	Details of Gift and/or Hospitality
Lucy Crumplin	Non-Executive Director	Trust Board	NIL (tenure ended 31.8.19)	
Avril Devaney	Director of Nursing, Therapies and Patient Partnership	Trust Board	NIL (Retired 6.9.19)	

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Modern Slavery Act 20 15 – Proposed Statement 2020
Agenda ref. number:	20.21.38
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	27/05/2020
Presented by:	David Harris, Director of People and OD

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	No
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	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:		**CWP Quality Framework:**		
Quality	No	Patient Safety	Safe	No
Finance and use of resources	No	Clinical Effectiveness	Effective	No
Operational performance	No		Affordable	No
Strategic change	No		Sustainable	No
Leadership and improvement capability	Yes	Patient Experience	Acceptable	No
			Accessible	No
		http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

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 provides a revised statement on Modern Slavery for publication on the Trust's website for approval by the Board following consideration at People and OD Sub Committee held on 6th March 2020.

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

The UK Modern Slavery Act came into force in 2015 and requires all businesses with commercial operations in the UK and a turnover in excess of £36m to publish an annual statement setting out the steps that they have taken to ensure that slavery and human trafficking do not exist in their business or supply chains. Whilst there is no obligation on NHS Trusts to provide a statement it is considered that providing one will uphold the values of the Trust. The proposed statement is attached as Appendix 1.

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

The revised statement sets out the Trust's approach to minimising the potential for modern slavery and human trafficking.

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

The Board is requested to approve the revised statement on Modern Slavery.

Who has approved this report for receipt at the above meeting?	David Harris, Director of People and OD
Contributing authors:	Chris Dyson, Head of Safeguarding, Darren Henderson, Head of Procurement, Andy Harland, Deputy Director of Business and Value

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	People and OD Sub-Committee	17 February 2020

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

Appendix No.	Appendix title
1	Modern Slavery Act 2 015 Statement 2020

#cwpQI

Appendix 1

Modern Slavery Act 2015 Annual Statement 2020

Introduction

Cheshire and Wirral Partnership NHS Foundation Trust offers the following statement regarding its efforts to prevent slavery and human trafficking in its supply chains, and in any part of its own business.

CWP provide specialist mental health, learning disabilities, neuro developmental and acquired brain injury services, community physical health and services for children, young people and families. These are provided in partnership with commissioners, local authorities, voluntary and independent organisations, people who use our services and their carers. We also provide services across a wide geographic footprint including Sefton, Bolton, Warrington, Halton and Trafford.

We serve a population of over a million people and employ more than 3,400 staff across 65 sites. Our annual turnover for 2019/20 was £188.09m.

Our vision is 'working in partnership to improve health and well-being by providing high quality care'. We are committed to the safeguarding agenda which encompasses a safeguarding strategy that ensures that all those who use CWP are appropriately protected.

We are also committed to the highest level of ethical standards and sound governance arrangements and fully support the government's objectives to eradicate modern slavery and human trafficking.

Supply chain policy

The Trust has internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery and human trafficking. The top 80% of suppliers nationally, affirm their own compliance with the Modern Slavery Act within their own organisation, sub-contracting arrangements and supply chain.

We expect our delivery partners, organisations within our frameworks and other companies we engage with to ensure their goods, materials and labour-related supply chains:

- Fully comply with the Modern Slavery Act 2015; and are
- Transparent, accountable and auditable; and are
- Free from ethical ambiguities.

Assessment of risk

The Trust has evaluated the principal risks related to slavery and human trafficking and identifies them as:

- Reputational
- Lack of assurances from suppliers

- Lack of anti-slavery clauses in contracts

Mitigation of risks

- Tender documentation includes the mandatory exclusion of any bidder who has been convicted of an offence under section 1, 2 or 4 of the Modern Slavery Act 2015.
- Impose in new contracts that we enter into provisions for termination in the event of a modern slavery or human trafficking breach by the supplier.
- Act promptly where a compliance breach has been identified or flagged.
- Train relevant staff in relation to the Act and to support them to maintain the trust's position around its requirements. Safeguarding polices and training references the action to be taken where slavery is suspected or identified.
- The Trust will raise awareness of this published statement by notifying organisations in our framework, delivery partnerships and other companies with which we regularly engage.

The Board has considered and approved this statement and will continue to support the requirements of the legislation.

Signed

Chief Executive and Chair

Date – 27.05.2020

NHS Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Guardian of Safe Working Quarterly Report
Agenda ref. number:	20.21.40
Report to (meeting):	Trust Board of Directors
Action required:	Information and noting
Date of meeting:	15/05/2020
Presented by:	Dr Faouzi Alam

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

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

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

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

REPORT BRIEFING

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

This report is to update the trust on the issues regarding junior doctors, their working conditions and locum use due to vacancies, during the period of January-April 2020. Consideration has been given for any current and future risk.

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

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

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

Exception reporting:. This has been discussed through the Junior Doctor Forum on how and when to do exception reporting. There was one exception report during this period. The last one was also resolved with time off after discussion with supervisor. There have been no fines levied against the Trust

Junior Doctor Forum It is part of the role of the Guardian of Safe Working to chair a Junior Doctor Forum. This is currently established as a monthly forum to discuss issues. The last one was held on 29.04.20 via teleconference

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

The Board of Directors is recommended to note the report

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

Distribution to other people/ groups/ meetings:

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

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

Appendix No.	Appendix title

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

January 2020 to April 2020

Report Author: **Dr Sumita Prabhakaran**

Guardian of Safe Working Hours

Executive summary

The following report is the first of the quarterly reports to the Trust board and details the months from January 2020 to April 2020.

There has been one report of exceptions from agreed work schedules during the report period. There have been no highlighted areas of concern regarding safe working or access to educational and training opportunities.

Introduction

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

Background Data

Number of doctors in training (total):	50
Number of vacancy:	16
Amount of time available in job plan for guardian to do the role:	0.5 PAs per week
Admin support provided to the guardian (if any):	No admin support
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

Exception reports

There was one exception report for this time which was addressed with the clinical supervisor and time off.

Work schedule reviews

There have been no work schedule reviews requested or completed.

CURRENT SCHEDULE FOR 1ST TIER AND HIGHER TRAINEES DEPENDENT ON AREA including step down by Higher trainee into 1st tier, consultant into higher trainee and 1st tier:

East rota is a 1 in 12 rota
Wirral and Chester rota was a 1 in 21
Since the introduction of the 'Covid' rota 7 doctors agreed to join the Covid wards rota and their gaps on the original rota have been covered by locums

During the reporting period there were the following gaps on the on-call rotas –

Wirral and Chester

1st tier – 22 locum shifts

Step down (HT/Cons to CT) – 4

2nd tier – 18 locum shifts

Step down (Cons to HT) - 3

Central and East –

1st tier – 17 locum shifts

Step down (HT/Cons to CT) – 3

2nd tier – as Chester and Wirral

1. MEDICAL BANK/FINANCE: £21,892.50 was spent on locum cover and £10,220 on step down payments in this period

Summary

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

Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED 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:	27/05/2020
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:	
Quality	Yes
Finance and use of resources	Yes
Operational performance	Yes
Strategic change	Yes
Leadership and improvement capability	Yes

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

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

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

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

REPORT BRIEFING

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

To apprise the Board of Directors of the current status of the 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 19 May 2020, the Trust has 10 strategic risks – two are rated red and eight are rated amber. Two additional risks are in-scope, both 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 Board of Directors monitors and 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.

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

New risks/ risks in-scope

The *risk of inability to support the transfer of the Continuing Healthcare Service due to capacity constraints, potentially resulting in lack of understanding of risk profile, service demands, financial implications and any reputational considerations* remains in-scope. In light of the COVID-19 pandemic emergency response, the transfer has been delayed; however work is continuing to progress the transfer and mitigate the risks associated. A full risk treatment plan will be developed.

The *risk of reducing ability to provide safe and effective care and services due to staffing levels (all professional groups) primarily as a result of impacts of the COVID-19 pandemic* is being scoped as a specific strategic risk in addition to risk 4 (discussed below). An initial risk treatment plan has been developed, detailed on the BAF, but it is a rapidly changing risk and continues to be monitored at TCG/ SEG level.

COVID-19 emergency response

A verbal update will be provided to the Board of Directors on risk 4 – *Risk that the impact of COVID-19 will adversely affect services provided by CWP, potentially resulting in a risk to the delivery of safe, effective care to the population of Cheshire and Wirral* as part of this report and other associated reports. The Board of Directors should also note that without exception, all of the other strategic risk updates for this period reflect the impact of the COVID-19 emergency response. Further, a supplementary IPC board assurance framework has been designed nationally and following Board review, information from this will additionally supplement the CWP board assurance framework.

Amended risk scores – no risks have been re-scored.

Archived risks

Risk 5 – *Risk of breach of legislation and CQC regulation in respect of adherence to the Mental Health Act* is scheduled for review at Quality Committee in July 2020 with a decision made on it being archived dependent on the assurance level provided in the publication of the CQC's inspection report.

Risk 7 – *Gaps in consultant staffing in both inpatient and the community setting resulting in a potential risk to patient safety, service continuity and increasing waiting times* has been reviewed by the Medical Director (Workforce) and the Quality Committee has recommended it be archived. The residual risk issues concerning future consultant staffing levels in children and young people's services is captured on the Care Group risk register and is reviewed through Care Group governance and at the Medical Staffing Group, reporting to the People and OD Sub Committee and Operational Committee. The risk will be re-escalated to the strategic risk register if the residual risk score increases.

Exception reporting

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

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 and since the Quality Committee meeting on 06/05/2020.

Who has approved this report?	David Wood, Associate Director of Safe Services	
Contributing authors:	Louise Brereton, Head of Corporate Affairs	
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Board of Directors	20/05/2020
Appendices provided for reference and to give supporting/ contextual information:		
Appendix No.	Appendix title	
1	Board assurance framework and strategic risk register	

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NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Report against Strategic Objectives – May 2020
Agenda ref. number:	20.21.42
Report to (meeting):	Board of Directors (meeting in public)
Action required:	Discussion and Approval
Date of meeting:	27/05/2020
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*

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

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

Feedback since the early versions of this Report remains pertinent and has centred on the following: 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; clearer information on the links between these metrics and the Trust's strategic risks so that it is easier to see how these metrics provide assurance or where there may be assurance gaps; and the inclusion of further metrics to continually improve the Report's relevance. Regarding the latter point, five metrics have been added this month to give insight into how the Trust has responded to the COVID-19 pandemic.

Assessment – *analysis and considerations of the options and risks*
Current performance Performance against the metrics presently included in the strategic objective data set is detailed in the charts attached. Some of the commentaries are not as well developed as previous iterations, due to time and resource constraints. It is recognised that this particular production round has fallen at a time when resources at all levels have been stretched and colleagues are thanked for their efforts in ensuring the Report has reached a satisfactory level of completeness.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors is invited to **comment** on this iteration of the dashboard and **confirm** any direction they would like future iterations to take.

Who has approved this report for receipt at the above meeting?	Board business cycle requirement
Contributing authors:	James Partington, Tim Welch

Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Board of Directors	19/05/2020

Appendices provided for reference and to give supporting/ contextual information:	
Appendix No.	Appendix title
1	Report against CWP Strategic Objectives May 2020 final (powerpoint file)

#cwpQI

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NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Staff Survey 2019
Agenda ref. number:	20.21.44
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	27/05/2020
Presented by:	David Harris, Director of People and OD

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:	
Quality	No
Finance and use of resources	No
Operational performance	No
Strategic change	No
Leadership and improvement capability	Yes

CWP Quality Framework:		
Patient Safety	Safe	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 provides a summary of the 2019 Staff Survey, actions taken to date and proposed priorities for addressing the findings of the survey.

Important note: while most Care/Service Groups had been able to submit their Local Staff Survey Action Plans, a few were either still in draft and/or not yet available. As the Pandemic and other Trust priorities took precedence, it was agreed by the Director of People and OD that further refinement of this plan and outstanding local responses would be required once the Trust returned to Business As Usual.

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

The NHS Staff Survey provides data to monitor staff satisfaction and opinion annually across a range of measures and enables the Trust to benchmark against other similar NHS organisations, of which there is a total of 31 across England.

The annual staff survey continues to be one of the key ways to engage with staff and as in previous years, the Trust has opted to survey all staff rather than a representative sample. The response rate to the 2019 survey among trust

staff was 54% - An improvement of 6% from 48% in 2018. The average response rate for similar organisations is 51%

This year's survey was accessible to all employees in the last quarter of 2019 and the results were collated by the approved external contractor - Picker. This year, the vast majority of surveys were emailed to staff; the third time the Staff Survey has been conducted in this way. Those in roles with limited access to emails could also opt for a paper based version of the survey. Picker collected and translated our questionnaire data into anonymised information ensuring its confidentiality and impartiality. This information was made available in phases throughout January to March 2020.

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

The NHS Staff Survey is run yearly to gauge staff experience of scenarios involving their Job, Colleagues, Managers and the Trust as a whole. Though not exclusively, the survey raises questions on:

- Appraisal and development
- Health and wellbeing
- Staff engagement and involvement
- Raising concerns.

Please see Appendix 1 for a detailed breakdown of the survey findings. (Given these findings were discussed and addressed at length at CELF this report focuses on the actions being taken in response.)

On receipt of the Trust's results, the Organisational Development team looked to analyse the data and form a set of Trust-wide insights and priorities to address during 2020/21. The six priorities for 2020/21 are as follows:

1. Improve senior manager visibility and engagement of staff in decision making and shaping service plans
2. Improve team effectiveness with a focus on relationships
3. Make better use of feedback from our people and those who use our services to inform decision making
4. Improve quality of appraisals and supervision
5. Support staff wellbeing, including capacity (time, energy and attention) and opportunities for flexible working
6. Build managerial capability (capacity, competence and confidence)

CELF Local Action Plan Design Session

As with previous years, the results from our NHS Staff Survey were collated and grouped into either Care Group or Clinical Support Service level and presented at the Trust's Clinical Engagement and Leadership Forum. This allows each Group to take a closer look at their results and determine how best they can improve their staff's experience, Group Culture and Service Delivery respectively.

The Groups were split as follows:

- Neighbourhoods
- Children, Young People & Families
- All Age Disability
- Clinical Support Services
- Estates & Facilities
- Learning Disabilities; Neurodevelopmental Disorders and Acquired Brain Injury
- Specialist Mental Health – Bed Based
- Specialist Mental Health – Place Based

In 2018/19 The Groups were given access to their specific data in its entirety and did not get chance to review the information ahead of the design session. This meant much time of the CELF design session was spent analysing the results and not focusing how best each group could implement its own action plan.

For 2019/20's CELF Action Plan Design session, a number of improvements were made to the process to support all concerned and the overall resulting Action Plans:

- A new template was created to help Groups work through their results and create their bespoke Action Plans. The template demonstrated how the Group performed against each of the identified six 2019/20 priorities. If Groups felt that they performed well against the six priorities (or that they could not resonate with them locally), then they were given an additional five 'Areas of Focus' from their Staff Survey results. This allowed them to focus on issues that truly reflected the opinions of their staff locally.

- Each Group's data had been refined by the facilitation team in advance of the design session, allowing the Groups to focus on key insights rather than having to 'mine' through all the data within the CELF session itself
- Each Group was given sight of the refined data two weeks in advance of the Design Session to allow them time to digest it and discuss with line managers.
- CELF Facilitators were given two briefing sessions and crib sheets to help them facilitate focussed discussions during the CELF Design Session
- Each Care Group Lead had an assigned HR Manager they could seek support from and was offered additional time with a member of the OD team if they wanted. (COVID-19 interrupted the process at this stage)

CELF Design Session Outcomes & Action Plans

Appendix 2 contains a summary of all generated Improvement Priorities and each Group's Action Plan.

- Of the original 8 Groups tasked with completing their own Staff Survey Action Plan, 6 have submitted first drafts. It is to be noted that CQC inspections and Financial Year-end led almost seamlessly into the beginning of the COVID-19 Pandemic, meaning some Groups did not have capacity to get their drafts to the OD team in time. This work will recommence again when it is safe and meaningful to do so.
- It became clear quickly that it would not be possible to do a single Action Plan for the entirety of the Clinical Support Services. Individual services within this unit had started to work on their own Action Plans – Namely HR, Effectives Services and Education.
- The new Action Plan Template has been well received and, thus far, it is demonstrating that most Groups do feel able to connect with the 6 Trust-Wide Priorities. In addition some of the Groups have also decided to act upon the 'Areas of Local Focus'.
- To date, the Groups' Action Plans have generated 27 unique Improvement Priorities.

Next Steps

- The OD Team will look to continue the completion of outstanding Action Plans with Groups as soon as the COVID-19 Pandemic ends and Business As Usual is reinstated. Original reporting timelines will need to be reassessed and signed off with the Director of People and OD.
- Support will be offered to reconnect Groups with the original ask and Staff Survey data.
- For those who did complete a draft of their Action Plan, further refinement will take place. In light of the Pandemic, chosen Improvement Priorities will be sense-checked to see if they are still accurate or required. Indeed it is possible recent experiences may well have moved some Groups beyond the challenges of their Improvement priorities and they may wish to take account of their lessons learned.

The above was discussed and agreed at Operational Committee on 20th May 2020. In addition, the committee agreed that the output of the evaluation project, which is part of Imaging the Future programme, will be fed back to Care Groups and Clinical Support Services to allow their local action plans to also take account of recent learning from the Coronavirus pandemic.

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

- The Board of Directors is asked to note the content of this report and to approve the proposed next steps.

Who has approved this report for receipt at the above meeting?	David Harris, Director of People and OD	
Contributing authors:		
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued

Appendices provided for reference and to give supporting/ contextual information:	
Appendix No.	Appendix title
1	Summary of Staff Survey Findings 2019
2	Summary of Improvement Priorities and Group Action Plans

#cwpQI

NHS Staff Survey – Executive Summary Trust-wide Report 2019/20

Response Rate

The response rate to the 2019 survey among trust staff was 54% - An improvement of 6% from 2018's 48%. The average response rate for similar organisations is 51%

Staff Engagement

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

	Overall staff engagement				
	2017	**2018**	**2019**		**Trust improvement/ deterioration over previous year**
	Trust	Trust	Trust	Benchmarking group (Combined MH/LD and community trusts) average	
Staff engagement score	7.1	7.2	7.1	7.1	-0.1

NHS Staff Survey Comparisons to Similar Organisations

As Picker also provided the same survey to 12 other similar organisations to CWP, we are able to compare our results against their combined average score. Overall, we place 7th out of the 12 organisations.

Out of the 90 questions fielded to staff in 2019:

- CWP scored better than the combined average score on 48 of the questions. Notably for:

Last experience of physical violence reported	+ 6%
Last experience of harassment/bullying/abuse reported	+ 6%
Organisation acts fairly: Career Progression	+ 5%
In last month, have not seen errors/near misses/incidents that could hurt patients/service users	+ 5%
If friend/relative needed treatment, would be happy with standard of care provided by organisation	+ 5%

- CWP matched the combined average score on 11 of the questions

- CWP scored worse than the combined average score on 31 of the questions. Notably for:

Receive regular updates on patient/service user feedback in my	- 10%

directorate/department	
Have adequate materials, supplies and equipment to do my work	- 9%
Communication between senior management and staff is effective	- 7%
Senior managers try to involve staff in important decisions	- 7%
Senior managers act on staff feedback	- 6%
Appraisal/performance review: Organisational values definitely discussed	- 6%
Feedback from patients/service users is used to make informed decisions within directorate/department	- 6%

Areas of Improvement from Previous Year

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

Most improved from last survey		
2019	**+/- Since 2018**	**Question**
63%	+9%	Q13d. Reported last experience of harassment/bullying/abuse
54%	+6%	Q22b. Receive regular updates on patient/service user feedback in my directorate/department
94%	+5%	Q12d. Reported last experience of physical violence
52%	+4%	Q22c. Feedback from patients/service users is used to make informed decisions within directorate/department
83%	+2	Q8e. Immediate manager supportive in personal crisis

Areas of Deterioration from Previous Year

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

Least improved from last survey		
2019	**+/- Since 2018**	**Question**
82%	-4%	Q12a. Not experienced physical violence from patients/service users, their relatives or other members of the public

67%	-4%	Q20. Had training, learning or development in the last 12 months
72%	-4%	Q13a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public
48%	-4%	Q4f. Have adequate materials, supplies and equipment to do my work
51%	-3%	Q4c. Involved in deciding changes that affect work

Last Year's Agreed Priority Areas

The findings from the Staff Survey 2018 highlighted a number of priority areas that were to be focused on throughout 2019. These were:

1. Improvements in senior manager visibility and engagement
2. Senior managers to engage staff in decision making and shaping service plans
3. Teams to receive feedback from people who use our services to inform decision making
4. Improvements in team effectiveness
5. Improved access to resources and materials to support staff in undertaking work
6. Increased awareness in reporting incidents for staff
7. Improve appraisal take up and access to training for non-clinical staff
8. Create more opportunities for flexible working

Below shows the individual priorities with their respective 2018 and 2019 Staff Survey results and where an improvement or deterioration has been observed. For 2019, the average score of similar organisations has also been included to help us understand how we compare.

2019 Priority Area with attributing staff survey questions	**2018**	**2019**	**Variation +/-**	**2019 Similar Orgs. Average**
Improvements in senior manager visibility and engagement				
9 a) I know who my senior managers are	82%	80%	-2%	83%
9 b) Communication between senior management and staff is effective	37%	35%	-2%	42%
9 d) Senior managers act on staff feedback	29%	30%	+1%	36%
Senior managers to engage staff in decision				

making and shaping service plans				
9 c) Senior managers try to involve staff in important decisions	30%	31%	+1%	38%
Teams to receive feedback from people who use our services to inform decision making				
22 a) Patient/service user feedback collected within directorate/department	94%	93%	-1%	95%
22 b) Receive regular updates on patient/service user feedback in my directorate/department	48%	54%	+6%	64%
22 c) Feedback from patients/service users is used to make informed decisions within directorate/department	48%	52%	+4%	58%
Improvements in team effectiveness				
4 b) Able to make suggestions to improve the work of my team/dept	79%	78%	-1%	77%
4 c) Involved in deciding changes that affect work	54%	51%	-3%	54%
4 d) Able to make improvements happen in my area of work	57%	55%	-2%	59%
4 e) Able to meet conflicting demands on my time at work	44%	45%	+1%	45%
4 g) Enough staff at organisation to do my job properly	32%	31%	-1%	32%
4 h) Team members have a set of shared objectives	74%	74%	Even	74%
4 i) Team members often meet to discuss the team's effectiveness	67%	65%	-2%	70%
4 j) I receive the respect I deserve from my colleagues at work	78%	78%	Even	76%
5 c) Satisfied with support from colleagues	87%	85%	-2%	84%
Improved access to resources and materials to support staff in undertaking work				
4 f) Have adequate materials, supplies and equipment to do my work	52%	48%	-4%	57%
Increased awareness in reporting incidents for staff				
17b) Organisation encourages reporting of errors/near misses/incidents	89%	89%	Even	90%
18 a) Know how to report unsafe clinical practice	97%	97%	Even	96%
18 b) Would feel secure raising concerns about unsafe clinical practice	75%	76%	+1%	75%
Improve appraisal take up and access to training for non-clinical staff				
19 a) Had appraisal/KSF review in last 12 months	87%	90%	+3%	N/A
19 f) Appraisal/performance review: training, learning or development needs identified	61%	67%	+6%	N/A
19 g) Definitely supported by manager to receive training, learning or development identified in appraisal	71%	69%	-2%	N/A
20 Had training, learning or development in the last 12 months	61%	67%	+6%	N/A
Create more opportunities for flexible working				
5 h) Satisfied with opportunities for flexible working patterns	57%	56%	-1%	60%

2020 Trust Priority Areas

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

2. Improve team effectiveness with a focus on relationships

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

4. Improve quality of appraisals and supervision

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

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

*Although lack of equipment has been raised as a concern again in this staff survey the current ITC refresh programme (which had not really become embedded at the time of the survey) is considered to be addressing this aspect and feedback is positive.

Monitoring arrangements

Staff Survey 2019 results will initially be shared at CELF in February with the intention of confirming Trust and Care Group priorities for action. This information will then be shared across CWP to all staff. Progress will be communicated via quarterly 'We said, we're doing' communications.

In addition, individual services will have responsibility for reviewing and addressing the findings. Once a Trustwide action plan has been developed it will be monitored as part of People and Organisational Development sub-committee with updates provided to Operational Committee; the findings will also be shared with Trust Board and Council of Governors.