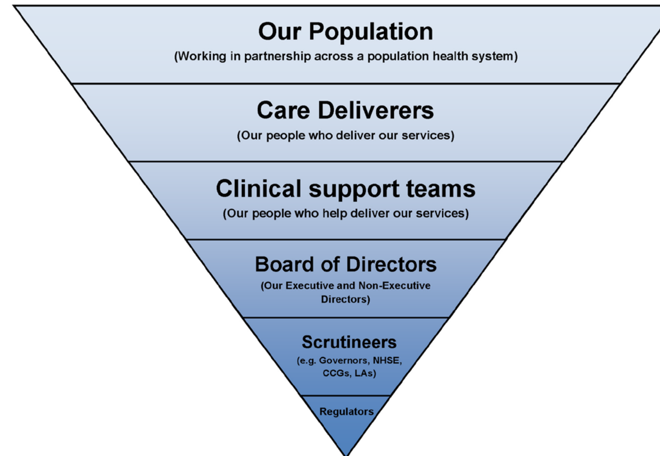
W1 Leadership	W2 Vision	W3 Culture	W4 Governance
W5 Risk	W6 Information	W7 Engagement	W8 Learning



NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Board of Directors *(held in Public)*

At 1:00pm on Wednesday 29 July 2020
Held Via WebEx

Ref	Title of item	Well-led theme	Format	Presented by	Time
Part 1: ASSURANCE					
Committee governance					
20/21/1	Welcome, apologies and quoracy		Verbal	Chair	13:00 (5 mins)
20/21/2	Declarations of interest		Verbal		
20/21/3	Minutes of the previous meetings held January 2020 *(Previously approved at the May 2020 meeting in a private forum. For noting only)*		Paper		
20/21/4	Matters arising and action schedule		Paper		
20/21/5	2020/21 Business cycle *(Previously approved at the May 2020 meeting in a private forum. For noting only)*		Paper		
20/21/6	Chair's Announcements		Verbal		13:05 (10 mins)
20/21/7	Chief Executive's Announcements		Verbal	Chief Executive	13:15 (30 mins)
Internal reporting from committees, matters of governance and assurance					
20/21/8	**Quality Committee** • Chairs report from Quality Committee – 1st July 2020	W4 Governance W5 Risk	Paper	Quality Committee Chair	13:45 (5 mins)

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

Ref	Title of item	Well-led theme	Format	Presented by	Time
20/21/9	**Audit Committee** • Chairs report from Audit Committee – 8th July 2020	W4 Governance W5 Risk	Verbal	Audit Committee Chair	13:50 (5 mins)
20/21/10	Chair and Chief Executive: Division of Responsibilities	W3 Culture W4 Governance W6 Information	Paper	Chair	13:55 (5 mins)
20/21/11	Corporate Governance Manual	W4 Governance	Paper	Director of Business and Value	14:00 (10 mins)
20/21/12	Register of Seals	W4 Governance	Paper	Director or Business and Value	14:10 (5 mins)
20/21/13	Flu Campaign	W3 Culture W5 Risk	Paper	Director of People and OD	14:15 (10 mins)
	Quality of Care				
20/21/14	Report against strategic objectives	W4 Governance W5 Risk W6 Information	Paper	Director of Business and Value	14:25 (10 mins)
20/21/15	Guardian of safe working – Q1 Report	W3 Culture W4 Governance W5 Risk W7 Engagement	Paper	Medical Director	14:35 (5 mins)
20/21/16	Safer Staffing: • A. Ward Staffing: May and June 2020 • B. Six monthly report	W4 Governance W5 Risk	Paper	Associate Director of Nursing and Therapies (Mental Health and Learning Disabilities)	14:40 (10 mins)
Break 14:50 – 15:00 (10 mins)					
20/21/17	Learning from Experience Report	W4 Governance W5 Risk W6 Information	Paper	Associate Director of Nursing and Therapies (Mental Health and Learning Disabilities)	15:00 (10 mins)
20/21/18	Freedom to Speak up Guardian 2019/20 Annual Report	W3 Culture W5 Risk	Paper	Associate Director of Nursing and Therapies	15:10 (10 mins)

Ref	Title of item	Well-led theme	Format	Presented by	Time
		W7 Engagement W8 Learning		(Physical Health)	
20/21/19	Infection, Prevention and Control 2019/20 Annual Report	W4 Governance W5 Risk	Paper	Associate Director of Nursing and Therapies (Physical Health) / Director of IPC	15:20 (5 mins)
20/21/20	Medicines Management 2019/20 Annual Report	W4 Governance W5 Risk	Paper	Medical Director	15:25 (5 mins)
20/21/21	Medical Appraisal 2019/20 Annual Report	W4 Governance W5 Risk	Paper	Medical Director	15:30 (5 mins)
20/21/22	Health and Safety Annual Report	W4 Governance W5 Risk	Paper	Director of Nursing, Therapies and Patient Partnership	15:35 (5 mins)
20/21/23	GDPR Compliance Annual Review	W4 Governance W5 Risk W6 Information	Paper	Medical Director	15:40 (5 mins)
Part 2: IMPROVEMENT					
	Strategy				
20/21/24	Quality Improvement Report	W3 Culture W4 Governance	Paper	Medical Director	15:45 (10 mins)
20/21/25	People and OD Strategy	W1 Leadership W2 Vision W3 Culture	Paper *(to Follow)*	Director of Strategy / Director of People and OD	15:55 (20 mins)
	Any other business				
20/21/26	Any other business		Verbal	Chair/ All	16:15 (5 mins)
20/21/27	Matters for referral to any other groups				
20/21/28	Matters impacting on policy and/ or practice				
20/21/29	Review risk impact of items discussed				
20/21/30	Three things to communicate				
20/21/31	Review the effectiveness of today’s meeting https://www.smartsurvey.co.uk/s/meetingeffectivenesssurvey/				
CLOSE [16:20]					
Date, time and venue of the next meeting: Wednesday 30 September 2020, 1:00pm (TBC)					

Version No	1	Date issued	22.07.2020

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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These minutes are an accurate record of the meeting subject to amendments agreed at the subsequent meeting

Ref	Title of item	Action
	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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Ref	Title of item	Action
	• 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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Ref	Title of item	Action
	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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DRAFT

Ref	Title of item	Action
	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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Ref	Title of item	Action
	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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Ref	Title of item	Action
	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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Ref	Title of item	Action
	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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Ref	Title of item	Action
	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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Ref	Title of item	Action
	• 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)**		

DRAFT

Cheshire and Wirral Partnership NHS Foundation Trust
Open Actions Action Schedule

Meeting date	Group/ Ref	Action	By Whom	By when	Status

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

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

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

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

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

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

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NHS Foundation Trust

STANDARDISED CHAIR'S REPORT

CHAIR'S REPORT DETAILS	
Name of meeting:	Quality Committee
Chair of meeting:	Andrea Campbell, Non Executive Director
Date of meeting:	01/07/2020

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

The increase in score against the supervision strategic risk was escalated and work to appreciatively inquire why was noted. The outputs of this work will be presented at the September 2020 meeting.

The full set of restrictive practices data within the quality assurance dashboard was reviewed. In relation to physical restraint, assurance was received that performance, in terms of incidents, is stable. However, to work towards a zero ambition, this target will be added to the dashboard, in addition to annotations to better understand exceptions for what is working and what is not in working.

Areas of non-compliance with antimicrobial prescribing were escalated in the medicines management annual report. Quality improvement work involving the medicines management and IPC teams, to improve engagement with prescribers in the Care Groups, has been identified to increase compliance.

Matters discussed: (ASSURANCE)

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.

A report on the impact of the COVID-19 pandemic on the use of the Mental Health Act was received, with assurance taken that the Trust is both ensuring the protection of people's liberty/ human rights, and that information is being monitored and evaluated to ensure oversight of actions to reduce health inequalities. Access to advocacy is being closely monitored and issues escalated as appropriate.

Assurance around the Trust's compliance with the patient safety COVID-19 update provided by the national patient safety team on 12 June was received, regarding the requirements related to patient safety incidents. From a secondary governance capacity, the CCGs receive assurance around this, further, the CQC are provided with assurance by exception. Further, the overarching Learning from Experience report for December 2019 – March 2020 was received and noted.

Assurance against the national patient safety team's requirement that respiratory protective equipment always fits correctly was provided. To-date, 400 staff have been fit tested to the FFP3 masks that the Trust has available in sufficient quantities. Fit testing of all inpatient staff remains an ongoing task, with this included in the induction for new staff also.

The Freedom to Speak Up and Medicines Management annual reports were approved.

Achievements: (IMPROVEMENT)

A presentation was received on the initial findings of the clinical prioritisation survey and staff focus groups, as part of the project to evaluate the changes in service provision and utilisation across CWP's services in response to COVID-19. Early findings are that there have been a large number of positive service changes made since the onset of the pandemic, which have progressed in a way that they may not have otherwise done and they have the potential to enable further progression. This work was complemented by receipt of numerous achievements in the special edition of the QI Report.

The QI strategy is continuing to be implemented, with phase 1 continuing to focus on building capability. Different levels of training, from universal training to expert training, are being re-evaluated (including in light of the requirement to ensure accessibility during COVID-19 restrictions). The Quality Committee noted the positive impact of phase 1 on the rating arising from the 2020 CQC inspection of the Trust's services and leadership.

A proposed new approach to responding to concerns, compliments and complaints was received, with an increased emphasis on the experience of people raising concerns through the provision of a combined PALS and complaints offer managed within the PACE team.

#cwpQI

Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED CHAIR'S REPORT

CHAIR'S REPORT DETAILS	
Name of meeting:	Audit Committee
Chair of meeting:	Edward Jenner
Date of meeting:	7th July 2020

(ESCALATION)

Quality, clinical care, other risks identified that require escalation

Draft Annual Governance Statement

- Sheena Cumiskey talked through the Annual Governance Statement for 2019/20. This was agreed by members of the committee and recommended for approval to the Board as part of the Annual Report and Accounts.

External Audit

- Grant Thornton presented the ISA260 Report for year ending 31st March 2020. It was acknowledged that there was a delay of two weeks in submitting the Report, this was partly due to COVID19 and associated challenges with resources. The ISA260 will be presented the Board meeting on the 9th July 2020 for final sign off.

Financial Accounts/Annual Report

- The Committee members noted the Financial Accounts / Annual Report. The Committee recommended the reports for approval to the Board.

(ASSURANCE)

Matters discussed/decision:

Internal Audit

- Committee members noted the Assurance Framework Briefing which confirmed that the Trust Assurance Framework is scripted to meet the NHS requirement in respect of defining objectives, risk, controls, assurances and gaps.
- The Internal Audit Annual Report & Head of Internal Audit Opinion shows the overall opinion for the period of 1st April 2019 to 31st March 2020. Substantial Assurances were given and it was discussed that there is a good system of internal control designed to meet CWP's objectives.
- The MIAA Progress Report included:
  - Assurance Framework and Risk Management Briefing
  - Data Security and Protection Toolkit Assurance Summary Report
  - Health Roster Follow-up
  - Internal Audit Plan – A separate meeting will be set up to discuss moving forward with the Audit Plan
  - Cyber Essentials Recommendations

Anti-fraud

- The Anti-fraud Annual Report for 2019/20 was presented to the Committee providing an overview of work undertaken for this period.

Conflicts of Interest Policy

- The Committee members were asked to consider and approved the suggested amendments to the Conflicts of Interest Policy in regards to the definition of decision-making staff and publication description. Approval was confirmed.

Corporate Governance Manual Review

- The Corporate Governance Manual was provided to Committee members with suggested amendments following an audit undertaken by MIAA.

Matters of Governance

- Committee members reviewed the Governor Declarations of Interests in line with business cycle requirements.
- Code of Governance Assurance was noted by the Committee members. Assurance on this occasion showed that we are compliant with the all domains under the Code of Governance.
- Register of Sealing's for 2019/20 was noted by Committee Members.

Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Chair and Chief Executive - Division of Responsibilities
Agenda ref. number:	20.21.10
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/07/2020
Presented by:	Mike Maier, Chairman

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	No
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	No

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	No

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

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

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

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

REPORT BRIEFING

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

To inform the Board of the requirements in the NHS Foundation Trust Code of Governance regarding the division of responsibilities between the Chair and the Chief Executive.

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

The division of responsibilities between the Chairperson and Chief Executive should be clearly established, set out in writing and agreed by the board of directors. They should be used to inform objectives for the Chair and Chief Executive.

Section 7.11.7 of The Corporate Governance Manual sets out that the division of responsibilities for the Chair and the Chief Executive to be set out in writing and approved by the Board of Directors on an annual basis.

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

The responsibilities of the Chair and Chief Executive are set out at appendix 2. The NHS Foundation Trust Code of Governance is available at https://www.gov.uk/government/publications/nhs-foundation-trusts-code-of-governance

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

The Board of Directors is recommended to **approve** the division of responsibilities as set out in the NHS Code of Governance for Foundation Trusts and that this is reviewed on an annual basis

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
N/A	N/A	N/A

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

Appendix No.	Appendix title
1.	CEO and Chair division of responsibilities

Appendix 1

The responsibilities of the Chair are as follows:

- To ensure the effective operation of the Board of Directors and the Council of Governors
- To promote the highest standards of integrity, probity and corporate governance throughout the organisation and particularly at the Board of Director level
- To ensure that the Board of Directors as a whole plays a full part in the development and determination of the Foundation Trust's strategy and overall objectives, having regard to the Council of Governors
- To lead the Board of Directors, to preside and lead the Council of Governors and to be the guardian of the Board of Directors decision making processes
- To ensure that the Board of Directors and the Council of Governors work together effectively
- To set clear expectations concerning the Trust's culture, values and behaviours including setting the style and tone of discussions at Board meetings
- To ensure the Board of Directors and Council of Governors agendas take full account of the important issues facing the Trust
- To ensure compliance with the Board of Directors approved procedures including schedule of matters, terms of reference and other Board policies and procedures
- To facilitate the effective contribution of all members of the Board of Directors and the Council of Governors ensuring that constructive relationships exist between Directors, between Governors and between Governors and Directors themselves
- To ensure that the Non-Executive Directors understand their accountability, individually and collectively to the Council for Governors for the performance of the Board
- To preside over the Council of Governors in holding the Non-Executive Directors to account
- Ensure the provision of appropriate development and training for the council of governors
- To ensure that accountability processes work effectively
- To Chair the Remuneration and Nominations Committees
- To initiate succession planning at Board level with the Nominations Committee to ensure appropriate Board composition and refreshment
- To ensure effective communication on the part of the foundation trust with patients, members, staff and other stakeholders
- To lead an induction programme for new Non-Executive Directors
- Working with the Chief Executive, to lead in updating the skills and knowledge and in meeting the development needs of individual Directors and the Board of Directors as a whole
- To ensure that the Governors have the skills, knowledge and familiarity within the Foundation Trust to fulfil their role
- To ensure that the performance of the Board of Directors and the Council of Governors as a whole, including an externally led assessment at least once in every three years

- To ensure a good flow of information each way between the Board of Directors, committees, the Council of Governors, Non-Executive Directors and management

The responsibilities of the Chief Executive are as follows:

- To report to the Chair and the Board of Directors and lead the Executive Team ensuring high standards of performance.
- Conduct the affairs of the Foundation Trust in compliance with the highest standards of integrity, probity and corporate governance and promote continuing compliance across the organisation.
- To lead and be responsible for proposing and developing, in consultation with the Board, the Foundation Trust's strategy and overall objectives, and to lead the implementation of these, ensuring appropriate resources and control and risk management systems are in place
- As the Accountable Officer to maintain a sound system of internal control that supports the organisation's policies, aims and objectives and manages risks to a reasonable level, including responsibility for safeguarding the public funds and organisations assets ensuring the efficient and effective use of all the resources in their charge to ensure the quality of services delivered.
- To ensure the appropriate and timely flow of information to the Board that enables an assessment of risk and a level of assurance in internal control.
- To ensure the provision of information and support with the Board of Directors and the Council of Governors
- To facilitate and support effective joint working between the Board of Directors and the Council of Governors
- To communicate the expectations of the Board, concerning culture, values and behaviours to all employees
- To ensure the Chair is aware of any important issues facing the Foundation Trust and to ensure the provision of reports to the Board containing accurate, timely and clear information
- To ensure the compliance of the Executive Team with the Board of Directors procedures
- To support the Chair in facilitating effective contributions and sustaining constructive relations between Executive and Non-Executive directors of the Board. Between governors and between the Board of Directors and Council of Governors
- To provide, with Executive team, support to the Non-Executive Directors in order to facilitate the accountability relationship
- To support the Chair in delivering an effective accountability process
- To support with Board succession planning, particularly in respect of executive directors
- Lead the communication programme with members and stakeholders including staff, particularly around Trust strategy, vision and values
- Ensure that the development needs of the Executive Directors and other senior management are identified and are met
- Ensure that performance reviews are carried out at least annually for each of the Executive Directors and provide input to the wider Board of Directors and Council of Governors evaluation process

Last reviewed: May 2020
Next review: May 2021

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Corporate Governance Manual – Refresh – July 2020
Agenda ref. number:	20/21/11
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/07/2020
Presented by:	Tim Welch, Director of Business and Value

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

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

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

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

REPORT BRIEFING

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

Cheshire and Wirral Partnership NHS Foundation Trust (the Trust) is a public benefit corporation that was established in accordance with the provisions of the National Health Service Act 2006. As a body corporate the Trust has specific powers to contract in its own name and to act as a corporate trustee.

Corporate governance is the system by which an organisation is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability and probity. Effective corporate governance, along with clinical governance, is essential for a Foundation Trust to achieve its clinical, quality and financial objectives. Fundamental to effective corporate governance is having the means to verify the effectiveness of this direction and control, which is achieved through independent review and assurance. This Corporate Governance Manual sets out the regulation of the Trust's governance system.

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

After an internal review of the Corporate Governance manual by the Head of Corporate Affairs and the Deputy Director of Business and Value an approach to MIAA was made to invite an independent review to include benchmarking against other organisations.

The principal objective of the project was to ensure the Trust's Corporate Governance Manual, which determines the regulation of members, officers and governors reflects current guidance and structures and provides clarity for users. As part of this review, comparison was made with equivalent NHS Organisation Corporate Governance Manuals, to identify any significant variances and best practice for insertion.

The final report from MIAA is attached in appendix 1.

The following amendments were discussed and considered during the Audit Committee meeting held on the 7th July 2020.

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

Amendments have been made as follows;

General Updates.
General updates to the manual have included a review of all job titles, numbering, formatting, and changes in operating processes e.g. Manager Self Service, Iproc procurement system etc.

Updated Wording
A number of amendments have been made to the wording of the Manual based on recommendations from MIAA. These are clearly outlined within section 2.4 of MIAA's final report.

Delegated Authorities and Delegated Limits
MIAA provided some benchmarking information and this has been considered as part of the review. A combination of this and local discussion with senior managers within CWP has resulted in the following changes:

Quotations and Tenders
Original:
- £5k to £20k - 3 quotations
- Over £20k – competitive tender

Revised:
- £5k to £10k - 2 quotations
- £10k to £30k - 3 quotations
- Over £30k – competitive tender

Non Pay Expenditure Limits
- Director of Business & Value increased from £150k to £164k in line with iproc hierarchy
- Reference to orders for capital works removed as this is no longer applicable following the move to iproc
- New limit up to £10k introduced for Associate Directors and Heads of Operations
- New category for management consultancy arrangements in line with requirements identified by NHSE/I

Investments section for exchequer funds
Reference to the Treasury Management policy has been removed as this is no longer applicable due to the utilisation of Government Banking Services.

Tender Waiver Process
The manual has been updated to reflect the tender waiver process agreed at September 2019 Audit Committee. Revised wording has been included in section 6.73 and the amended Waiver Request Form is included as Attachment 2.

The original Attachment 3 covered the recording of the receipt of tenders. This has been removed as this is all carried out electronically now via the Delta e-tendering system.

Trust Committees

Whilst the scope of the review did not include a review of the Trust sub-committee terms of reference, MIAA recommended including a statement to allow the holding of meetings 'electronically', in light of the ongoing COVID 19 pandemic. Whilst a statement already existed within a number of the sub-committee terms of reference, this was not consistent. The statement now appears in all sub-committee terms of reference and will be ratified at their next meeting.

Council of Governors

The standing orders for the Council of Governors has been updated to reflect the most recent version detailed in the Trust Constitution.

Additional information, in regards to Declarations of interest has been added to strengthen the expectations of Governors in this area.

Conflicts of Interest Policy

The policy has been updated in line with recent considerations by this committee.

The updated manual is attached in appendix 2.

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

The Audit Committee have endorsed the suggested changes and recommend these to the Board of Directors for approval.

Who has approved this report for receipt at the above meeting?	
Contributing authors:	Andy Harland, Deputy Director of Business and Value Suzanne Christopher, Acting Company Secretary

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Audit Committee	07.07.2020

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

Appendix No.	Appendix title
1	Corporate Governance Manual Update – MIAA final report 19/20
2	Corporate Governance Manual

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Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Register of Seals 2019/20
Agenda ref. number:	20/21/12
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/07/2020
Presented by:	Tim Welch, Director of Business and Value

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

Which NHSI Single Oversight Framework themes this report reflects:	
Quality	Yes
Finance and use of resources	Yes
Operational performance	Yes
Strategic change	Yes
Leadership and improvement capability	Yes

CWP Quality Framework:		
Patient Safety	Safe	Yes
Clinical Effectiveness	Effective	Yes
	Affordable	Yes
	Sustainable	Yes
Patient Experience	Acceptable	Yes
	Accessible	Yes
http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

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

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

REPORT BRIEFING

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

The use of the corporate seal formally signifies the Trust's act of entering into the transactions evidenced by the documents to which it is fixed. The Board of Directors is invited to note the Register of Sealing which demonstrates the documents (and the underlying transactions) to which the Trust's corporate seal has been affixed for the period April 2019 – March 2020.

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

The use of the corporate seal is regulated by Board of Directors' Standing Orders. In accordance with the NHS Constitution, the affairs of NHS organisations should be managed with excellence and professionalism.

Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Business and Value / Director of Finance (or an officer nominated by them) and authorised and countersigned by the Chief Executive (or an officer nominated by them who shall not be within the originating division or department).

The Chief Executive keeps a register in which they, or the Head of Corporate Affairs as authorised by them, enters a record of the sealing of every document.

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

The Sealing Report for the period April 2019 – March 2020 is attached in appendix 1 for review by the Board of Directors.

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

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

The Board of Directors is invited to note the Register of Sealing.

Who has approved this report for receipt at the above meeting?	
Contributing authors:	Suzanne Christopher, Acting Company Secretary

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Audit Committee	07.07.2020

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

Appendix No.	Appendix title
1	Register of Seals 2019/20

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Flu Campaign 2019/20 Evaluation and Plans for 2020/21 Campaign
Agenda ref. number:	20.21.13
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/07/2020
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	No
Improve quality of information to improve service delivery, evaluation and planning	No
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	No		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*

The purpose of this SBAR is to provide Trust Board with a brief summary of the Flu Campaign 2019/20 and proposals for the 2020/21 Flu Campaign.

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

The annual Flu Campaign is reviewed each year within the Flu Planning Group to evaluate successes and learn from any areas for improvement. The attached report provides detail of the 2019/20 Campaign and plans for the 2020/21 Campaign.

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

A detailed analysis of the 2019/20 Flu Campaign is attached at appendix 1 and proposals for the 2020/21 Campaign are set out. The report describes the costs of last year's campaign and proposals for this year including funding requirements.

The conclusions within the report are based on the review of the Campaign and feedback from the Flu Planning Group:

- Given the importance of reaching a "Herd Immunity" across the CWP workforce, it is imperative we approach the 2020/21 Campaign with a positive mind set, by engaging front-line staff through positive and accurate messaging about the Flu virus.

- The CQUIN target of 90% would have been critical and the money associated with achieving this target was predicted to be significant. However, the financial regime adopted during the covid-19 pandemic includes the suspension of all CQUIN targets in 2020/21.

- A paperless, electronic solution will be key to ensuring accurate data and more effective, streamlined Flu Clinics. However, because of the timescales now involved Business Intelligence have suggested an update and review of the existing database be looked at.

- Given the current Covid-19 Pandemic and news reports about the benefits of having a Flu vaccination it is anticipated that there will be an increased scrutiny on uptake this year.

The risks identified so far are as follows:

i) We do not achieve 90% uptake and therefore, do not reach a "Herd Immunity" (*Herd immunity is a form of immunity that occurs when the vaccination of a significant portion of a population provides a measure of protection for individuals who have not developed immunity).* In practice, this means people who access our services, patients and staff would be at greater risk of contracting Flu as the immunity would be low.

ii) Reputational damage to CWP - based on poor performance in the vaccination league tables (PHE have not published these as yet), the organisation may not be deemed attractive to work for, and the public may not be happy for loved ones to be cared for in an organisation where front-line staff do not see this as an important Healthcare priority.

iii) Another significant risk to this year's Flu Campaign the ability to maintain social distancing whilst offering the most effective and accessible Flu Clinics.

iv) If we have a second wave of Covid-19 during the Winter season in addition to the usual Winter pressures on the NHS infrastructure, the impacts could be severe.

v) Further impact on service delivery due to it being hard to distinguish between "flu like" and Covid-19 symptoms and, therefore, having to adhere to the ongoing guidance to self-isolate.

The following recommendations were submitted to Operational Committee on 22nd July 2020:

i) The Flu Campaign to be run as a Quality Improvement Project with a dedicated Project Manager in post from August 2020 to April 2021.

ii) A dedicated Project Team, led by a Project Manager with full time administration/coordination support to be appointed. The Project Team will be able to undertake duties currently carried out from within the Workforce Wellbeing Service, to reduce capacity pressures and ensure service delivery is sustained throughout the Flu Campaign period. This is even more crucial this year given the pressures from the demands of the Covid-19 Pandemic on all services.

iii) Members of the Project Team (formerly the Flu Planning Group) to be determined by the Project Manager, Exec Lead for Flu, Pharmacy Lead (currently Chair of flu planning group) and Operational Lead.

iv) A completely separate fully funded Flu Budget to be assigned to the Flu Project Manager.

v) The existing Flu Database Solution to be improved as much is possible to enable more accurate and timely capturing and recording of information.

vi) Director of Nursing, Therapies and Patient Partnership to be Clinical Lead Champion for Flu Campaign and there to be Clinical Champions in each Ward and Clinical Team with responsibility for monitoring peer vaccinators within their team including fridge monitors.

vii) Care Groups to be clinically accountable for the Flu Campaign via the Heads of Operations and Strategic Clinical Director.

viii) Consideration to be given to how we can deliver Flu Clinics safely given the current social distancing guidance: including possible use of mobile testing centres, investment in technology to be able to use QR codes, use of flu vouchers or a hybrid model of clinics and vouchers.

Recommendations

Board members are asked to note the contents of the report and to commit their support to the 2020/21 campaign.

Who has approved this report for receipt at the above meeting?	David Harris; Director of People and OD
Contributing authors:	Karen Phillips Fiona Couper

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Operational Committee	22.07.20

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

Appendix No.	Appendix title
1	2019/20 Flu Campaign Report

Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Report against Strategic Objectives – July 2020
Agenda ref. number:	20.21.14
Report to (meeting):	Board of Directors (meeting in public)
Action required:	Discussion and Approval
Date of meeting:	29/07/2020
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 July 2020 edition presented today is the sixth 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: continuing to add more commentary/ annotations so that the annotated time series form part of our corporate memory; named owners for each metric to take responsibility for content and sign off; the addition of targets/ benchmarks where appropriate and to provide further context; 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 were added in May to give insight into how the Trust has responded to the COVID-19 pandemic, and these additional five metrics have been included again with updated data.

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

Current performance

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

The impact of the COVID pandemic on our bed occupancy levels was a significant fall in the bed occupancy ratio in April. This is because beds were made available but not used on Beech ward, being kept in reserve in case a second COVID cohort ward was needed. Once the cohorting approach ceased and patients were nursed again on their usual ward, from mid-May, the bed occupancy ratio returned to typical levels.

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

The supervision charts show recovery to pre-pandemic levels, whereas staff turnover and vacancy rates are very low for the most recent month.

The Report has been updated to include the most recent CQC ratings.

The additional activity charts show the switch in most care groups from face to face to telephone contact from mid-March.

Once again, this 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 high level of completeness.

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

The Board of Directors is asked to note the content of the report.

Who has approved this report for receipt at the above meeting?	Board business cycle requirement
Contributing authors:	James Partington, Tim Welch, Andy Harland, David Harris, Simon Platt, Cathy Walsh, Anushta Sivananthan, Elspeth Fergusson, Amy Fraser, Suzanne Edwards, Satwinder Lotay.

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	22/07/2020

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

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

#cwpQI

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Guardian of Safe Working Quarterly Report
Agenda ref. number:	20.21.15
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	23/07/2020
Presented by:	Faouzi Alam, Medical Director

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

Which NHSI Single Oversight Framework themes this report reflects:	
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/ 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 April 2020-July 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 psot of Guardian of Safe Working in order to monitor and provide reassurance of Safe Workjing practice related to hours worked. This is an independent post and requires a resposibilty of providing reports.

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

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

Junior Doctor Forum It is part of the role of the Guardian of Safe Working to chair a Junior Doctor Forum. This is currently established as a monthly forum to discuss issues.

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

Board of Directors to note the report.

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

Distribution to other people/ groups/ meetings:

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

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

Appendix No.	Appendix title	
1	Guardian of Safe Working Report	

NHS Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Ward Daily Staffing Levels May and June 2020
Agenda ref. number:	20.21.16
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/07/2020
Presented by:	Gary Flockhart, Director of Nursing, Therapies and Patient Partnerships

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

Which NHSI Single Oversight Framework themes this report reflects:		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	No		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*

This report details the ward daily staffing levels during the months of May and June 2020 following the submission of the planned and actual hours of both registered nurses (RN) and clinical support workers (CSWs) (Appendix 1 and 2). The themes for this reporting period focus on the measures that have been taken to ensure safe staffing levels have been maintained during the COVID-19 response.

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

The monthly reporting of daily staffing levels is ordinarily a requirement of NHS England and the National Quality Board in order to appraise the Board and the public of staffing levels within in-patient units. This requirement has been temporarily suspended during the COVID-19 pandemic response, however for assurance purposes the information will continue to be provided to the Board

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

During May 2020 the trust achieved staffing levels of 100% for registered nurses and 98.7% for clinical support workers on day shifts and 100% and 99.5% respectively on nights. During June 2020 the trust achieved staffing levels of 99.0% for registered nurses and 98.0% for clinical support workers on day shifts and 99.3% and 99.5% respectively on nights.

Although absence levels have reduced since the previous reporting period, during May and June inpatient units continued to experience higher levels of absence than would usually be expected, as a direct result of the Covid-19 pandemic. Spring view and Bowmere were the most adversely affected areas during the reporting period.

Inpatient services were supported by 36 opt-in pre-registration nursing students throughout this period and the staff from the Learning Disability Respite Service continued to be temporarily redeployed to the Assessment and Treatment Units at Greenway and Eastway. This enabled safe staffing levels to be maintained across all inpatient areas in the absence of sufficient numbers of substantive staff. The staff that were originally redeployed from community to inpatient services within the SMH care group at the commencement of the Covid-19 response were able to return to their substantive posts as the absence levels across the wards reduced. Cherry ward was closed during the reporting period in response to reduced demand for organic inpatient capacity and the reduction in staffing availability due to absence at Bowmere Hospital. Beech ward was able to be re-opened as an acute admission ward during this period and Lakefield ward was able to increase capacity by 4 additional beds due to the improved staffing position since the last reporting period.

Appendix 1 details the fill rates for individual inpatient units across May and June 2020

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

The Board of Directors are asked to note the report and receive assurance that safe staffing levels were maintained throughout this period.

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued

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

Appendix No.	Appendix title
1	Monthly Safer Staffing Report – May to June 2020

		Day				Night				Fill Rate				
		Registered midmives/nurses		Care Staff		Registered midmives/nurses		Care Staff		Day		Night		
	Ward	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Safe Staffing was maintained by:
East	Alderley Unit	844.75	810.25	1496.50	1398.00	678.50	667.00	747.50	747.50	95.9%	93.4%	98.3%	100.0%	
East	Greenways A&T	713.00	821.00	1426.00	1398.45	713.00	766.00	1069.50	1081.00	115.1%	98.1%	107.4%	101.1%	
East	Maple	1148.50	1154.50	1268.00	1250.50	506.00	506.50	1069.50	1058.00	100.5%	98.6%	100.1%	98.9%	
East	Mulberry	1205.00	1187.00	2008.50	1970.00	713.00	713.00	1518.00	1518.00	98.5%	98.1%	100.0%	100.0%	
East	Silk	1186.50	1158.00	1635.50	1590.50	747.50	742.50	1411.00	1411.00	97.6%	97.2%	99.3%	100.0%	
East	Saddlebridge	1016.00	984.00	1380.00	1361.50	713.00	713.00	966.00	966.00	96.9%	98.7%	100.0%	100.0%	
Wirral	Brackendale	1335.50	1335.50	1308.50	1308.50	759.00	759.00	1138.50	1138.50	100.0%	100.0%	100.0%	100.0%	
Wirral	Brooklands	1515.00	1515.00	1734.00	1734.00	782.00	782.00	1702.00	1702.00	100.0%	100.0%	100.0%	100.0%	
Wirral	Lakefield	1168.00	1168.00	1643.00	1643.00	741.00	741.00	989.00	989.00	100.0%	100.0%	100.0%	100.0%	
Wirral	Meadowbank	1378.50	1378.50	2150.50	2150.50	785.00	785.00	1318.00	1318.00	100.0%	100.0%	100.0%	100.0%	
Wirral	Oaktrees	1210.00	1210.00	905.25	905.25	672.50	672.50	556.00	556.00	100.0%	100.0%	100.0%	100.0%	
West	Willow PICU	1123.50	1123.50	1302.50	1291.00	747.50	747.50	770.50	770.50	100.0%	99.1%	100.0%	100.0%	
West	Beech	718.00	706.50	766.00	754.50	471.50	460.00	655.50	644.00	98.4%	98.5%	97.6%	98.2%	
West	Cherry	845.50	845.50	575.00	575.00	540.50	540.50	460.00	460.00	100.0%	100.0%	100.0%	100.0%	
West	Coral	1181.00	1169.50	1253.50	1253.50	782.00	782.00	1012.00	1012.00	99.0%	100.0%	100.0%	100.0%	
West	Eastway A&T	1432.50	1433.00	1081.00	1046.50	747.50	747.50	954.50	954.50	100.0%	96.8%	100.0%	100.0%	
West	Indigo	926.50	915.00	1046.50	1046.50	743.50	732.00	724.50	724.50	98.8%	100.0%	98.5%	100.0%	
West	Juniper	1351.00	1319.00	1410.00	1374.00	717.00	705.50	1155.50	1074.00	97.6%	97.4%	98.4%	92.9%	
West	Rosewood Unit	1372.05	1395.05	1714.40	1697.00	609.50	609.50	1207.50	1207.50	101.7%	99.0%	100.0%	100.0%	
	Trustwide	21670.80	21628.80	26104.65	25748.20	13169.50	13172.00	19425.00	19332.00	100.0%	98.7%	100.0%	99.5%	

	Ward	Day				Night				Fill Rate				Safe Staffing was maintained by:
		Registered		Care Staff		Registered		Care Staff		Day		Night		
		Total monthly planned staff hours	**Total monthly actual staff hours**	**Total monthly planned staff hours**	**Total monthly actual staff hours**	**Total monthly planned staff hours**	**Total monthly actual staff hours**	**Total monthly planned staff hours**	**Total monthly actual staff hours**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	
East	Alderley Unit	852.00	842.00	1730.50	1597.50	655.50	655.50	724.50	690.00	98.8%	92.3%	100.0%	95.2%	
East	Greenways A&T	1001.00	1066.50	1460.50	1350.00	690.00	715.00	1265.00	1242.00	106.5%	92.4%	103.6%	98.2%	
East	Maple	1158.00	1119.50	1492.50	1413.00	575.00	563.50	773.50	773.50	96.7%	94.7%	98.0%	100.0%	
East	Mulberry	1215.50	1180.50	1889.00	1865.00	690.00	690.00	1449.00	1449.00	97.1%	98.7%	100.0%	100.0%	
East	Silk	1151.00	1151.00	1512.50	1508.00	701.50	687.50	1526.00	1522.50	100.0%	99.7%	98.0%	99.8%	
East	Saddlebridge	912.45	912.50	1311.00	1285.50	678.50	678.50	701.50	701.50	100.0%	98.1%	100.0%	100.0%	
Wirral	Brackendale	1169.00	1169.00	1441.50	1441.50	724.50	724.50	885.50	885.50	100.0%	100.0%	100.0%	100.0%	
Wirral	Brooklands	1065.25	1065.25	1824.00	1824.00	762.00	762.00	1437.00	1437.00	100.0%	100.0%	100.0%	100.0%	
Wirral	Lakefield	1352.50	1352.50	1588.04	1588.00	737.00	737.00	944.50	944.50	100.0%	100.0%	100.0%	100.0%	
Wirral	Meadowbank	1289.00	1289.00	1966.00	1936.00	747.50	747.50	1147.00	1147.00	100.0%	98.5%	100.0%	100.0%	
Wirral	Oaktrees	1348.25	1276.25	1557.25	1557.25	705.00	705.00	880.00	880.00	94.7%	100.0%	100.0%	100.0%	
West	Willow PICU	888.50	888.50	1408.50	1408.50	699.50	709.50	908.50	908.50	100.0%	100.0%	101.4%	100.0%	
West	Beech	1495.50	1468.50	1328.50	1265.50	770.50	747.50	950.00	882.50	98.2%	95.3%	97.0%	92.9%	
West	Cherry	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	Temporarily closed				
West	Coral	1277.50	1277.50	1306.50	1306.50	719.00	719.00	1166.00	1166.00	100.0%	100.0%	100.0%	100.0%	
West	Eastway A&T	1628.50	1576.50	1161.50	1092.50	701.50	701.50	1276.50	1253.50	96.8%	94.1%	100.0%	98.2%	
West	Indigo	1030.95	1030.95	954.50	954.50	724.50	724.50	839.50	839.50	100.0%	100.0%	100.0%	100.0%	
West	Juniper	1384.00	1372.50	1246.00	1234.50	770.50	770.50	1023.00	1021.50	99.2%	99.1%	100.0%	99.9%	
West	Rosewood Unit	1346.20	1259.00	1929.95	1955.25	586.50	529.00	1196.00	1288.00	93.5%	101.3%	90.2%	107.7%	
	Trustwide	21565.10	21297.45	27108.24	26583.00	12638.50	12567.50	19093.00	19032.00	99.0%	98.0%	99.3%	99.5%	

Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Safer Staffing Six Monthly Review
Agenda ref. number:	20.21.16
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/07/2020
Presented by:	Gary Flockhart Director of Nursing, Therapies and Patient Partnership

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

Which NHSI Single Oversight Framework themes this report reflects:		**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	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 presents the safer staffing review findings from November 2019 to May 2020 in line with NHS England and National Quality Board requirements. The aim is to provide a high level review across the reporting period with a specific focus on the first three months of the COVID-19 response.

The information included in this report is derived through various means including data analysis (for example fill rates), temporary staffing and agency use. Additionally, qualitative views are considered.

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

Since 2014 the Operational Committee and Board of Directors have received a six monthly safer staffing report to provide assurance that the Trust is fulfilling their safer staffing obligations.

Due to the COVID-19 response the contractual reporting requirements in relation to safer staffing have been temporarily suspended, however a summary report has been developed in order to provide assurance to the Operational Committee and the Trust Board regarding the operational approach to maintaining safer staffing throughout this period.

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

The safer staffing review highlights that there has been effective workforce planning and management to support the maintenance of the delivery of safe care during this reporting period including during the initial COVID-19 response . The scope of the review has continued to extend and includes approaches underway in relation to safer staffing in the following areas:

Section 1 - Inpatient services

Section 2 - Place Based Specialist Mental Health services

Section 3 - Children, Young People and Families including Starting Well and Community CAMHS

Section 4 - Improving Access to Psychological Therapies (IAPT) services

Section 5 – Learning Disability, Neuro Developmental and Acquired Brain Injury Services

Section 6 - Neighbourhood Care Community Teams and GP Services

Section 7 – All Age Disability Services

All service areas have demonstrated their ability to embrace new ways of working, work flexibly and provide mutual support across services and care groups during the enactment of the Business Continuity Plans in response to the COVID-19 pandemic. This has enabled safe staffing levels to be maintained across all areas in the context of very challenging circumstances.

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

The Board of Directors are asked to receive assurance that the NQB safer staffing standards have continued to be met throughout the COVID-19 response as detailed in Appendix 1: "Safer Staffing Review".

Who has approved this report for receipt at the above meeting?	Gary Flockhart, Director of Nursing, Therapies and Patient Partnership
Contributing authors:	Hayley McGowan Associate Director of Nursing and Therapies (MH &LD) and Heads of Clinical Services

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.	Safer Staffing Review

#cwpQI

Six Monthly Safer Staffing Report

Period of review: November 2019 – May 2020

Introduction

This report provides an overview of safer staffing for Cheshire and Wirral Partnership NHS Foundation Trust (thereafter referred to as the Trust) for the period November 2019 to May 2020 (inclusive). This is in addition to monthly fill rates for inpatient services that are reported to the Trust Board. The aim is to provide an high level review across the reporting period with a specific focus on the first three months of the COVID-19 response; including workforce planning, deployment of staff, skill mix and workforce challenges, in order to provide evidence regarding the Trust's capacity and capability to provide high quality care[1] via safer staffing during the implementation of business continuity plans.

The guidance for safer staffing is determined by the National Quality Board (NQB). The NQB standards require trusts to provide assurance that organisational practices, skills development and evidence based tools are in place. Primarily this is to assure the delivery of quality clinical care to patients across the range of specialisms in the Trust, including inpatient, community and specialist services. Specifics that are requested to be considered include:

- Evidence-based tools employed to inform nursing and care staff requirements.
- Fostering a professional and responsive culture where staff feel able to raise concerns.
- Employing a multi-professional approach when setting nursing, midwifery and care staff, staffing establishments.
- Providing sufficient time for care staff to fulfil responsibilities beyond direct care delivery.
- Communicating the daily staffing provision per shift.
- Securing staff in line with the workforce requirements.

The information included in this report is derived through various means including data analysis (for example fill rates), temporary staffing and agency use. Additionally, qualitative views are considered. Specific updates for each service area are detailed in the subsequent sections below.

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[1] The National Quality Board (2013) How to ensure the right people, with the right skills, are in the right place at the right time A guide to nursing, midwifery and care staffing capacity and capability https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

Recommendations:

The Trust Board are asked to receive assurance that the NQB safer staffing standards have continued to be met throughout the COVID-19 response.

Process:

The Trust contract requires that information is presented bi-annually to ensure that there is "sufficient appropriately registered, qualified and experienced staff to enable the services to be provided in all respects". The achievement of this is continuous across the year through various work streams, task and finish groups, data accumulation and analysis.

Due to the COVID-19 response the contractual reporting requirements in relation to safer staffing have been temporarily suspended, however a summary report has been developed in order to provide assurance to the Board regarding the Trust's approach to maintaining safer staffing throughout this period.

The safer staffing review has continued to extend and includes approaches underway in relation to safer staffing in the following areas:

Section 1 - Inpatient services

Section 2 - Place Based Specialist Mental Health services

Section 3 - Children, Young People and Families including Starting Well and Community CAMHS

Section 4 - Improving Access to Psychological Therapies (IAPT) services

Section 5 – Learning Disability, Neuro Developmental and Acquired Brain Injury Services

Section 6 - Neighbourhood Care Community Teams and GP Services

Section 7 – All Age Disability Services

Section 1: Inpatient Services

1. Effective Workforce Planning

Inpatient services roster staff utilising the Healthroster system, anticipating nursing staff requirements per shift, per week and monthly as required. The planned rostering facility offered within Healthroster permits nursing skill mix to be taken into account to enable the early identification of staffing deficits and also facilitates contingency planning. The ward establishments provide capacity to allow staff time to fulfil planned activities such as training requirements and planned leave. Staff may submit requests in relation to their allocated shifts to accommodate their individual needs and personal circumstances. Flexibility within rostering and determining the planned establishment per shift remains the responsibility of the ward manager which enables staff wellbeing needs to be met alongside the provision of safe and responsive staffing.

1.1 Aggregate Fill Rate by Bed Based Area (November 2019-May 2020):

Figure 1: Specialist Mental Health - Wirral Bed Based Services

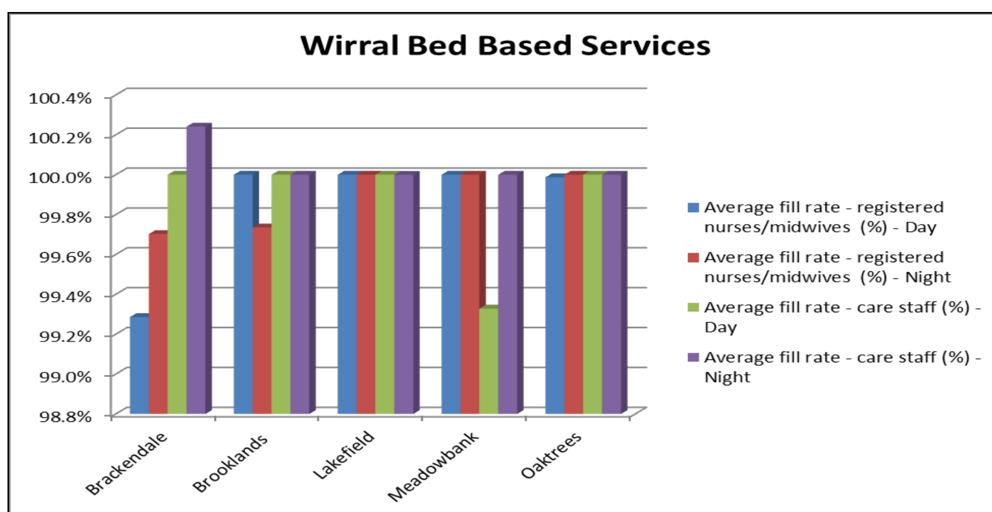
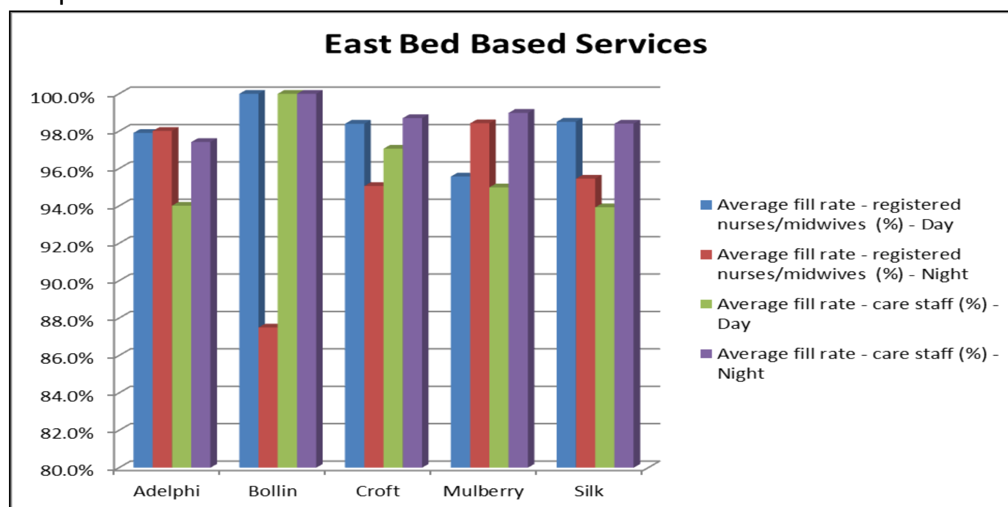


Figure 2: Specialist Mental Health- East Bed Based Services



NB. The figures in Table 2 provide the aggregate fill rates for Adelphi and Croft for November and December only and for Bollin for November only until their repsective closures as part of the East locality redesign.

Figure 3: Specialist Mental Health – West Bed Based Services

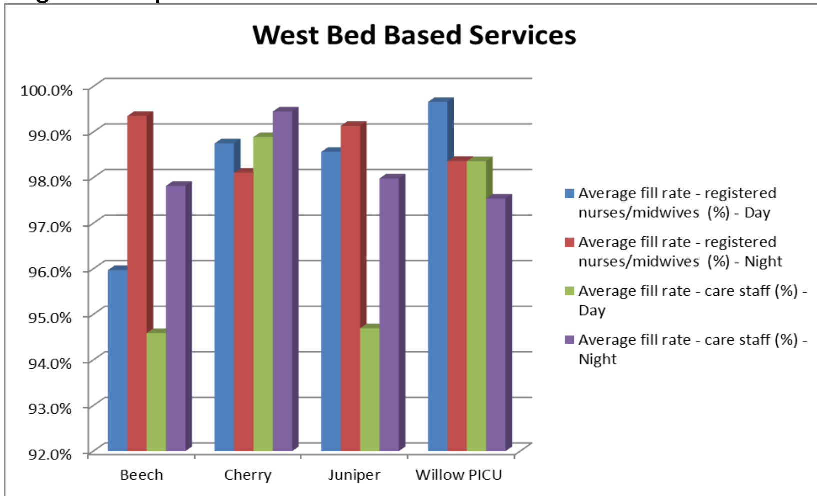
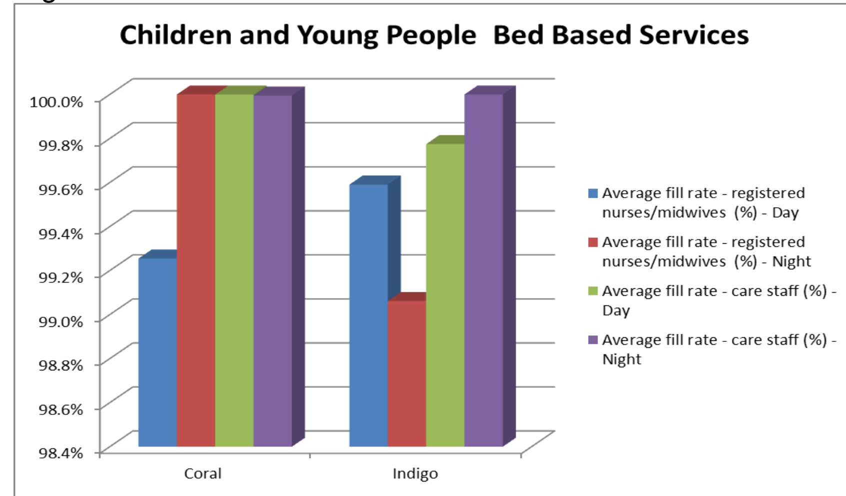


Figure 4: CYP- Bed Based Services



NB.The figures in Table 3 provide the aggregate fill rates for Beech from November to Februauary and May only due to the temporaray closure of the ward in March and April as part of the COVID-19 response. Fill rates for Cherry were not available for April and therefore are not included in the aggregated position.

Figure 5: Reabilitation and Secure – Bed Based Services

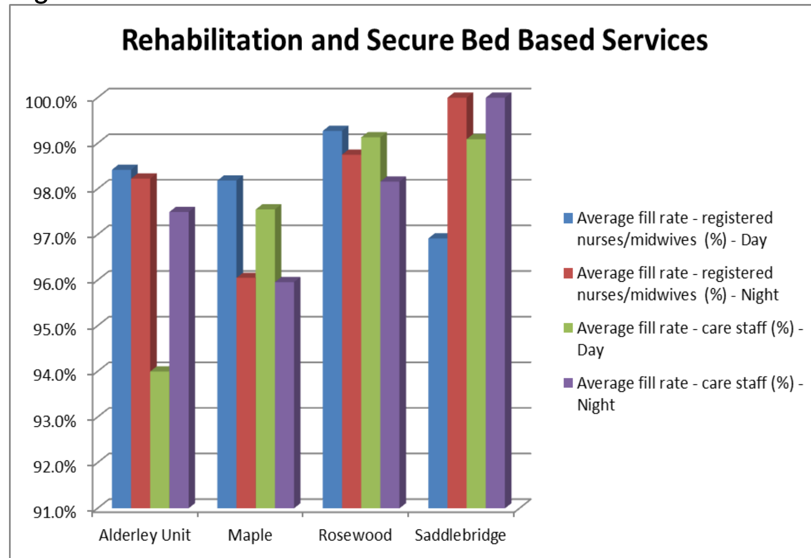
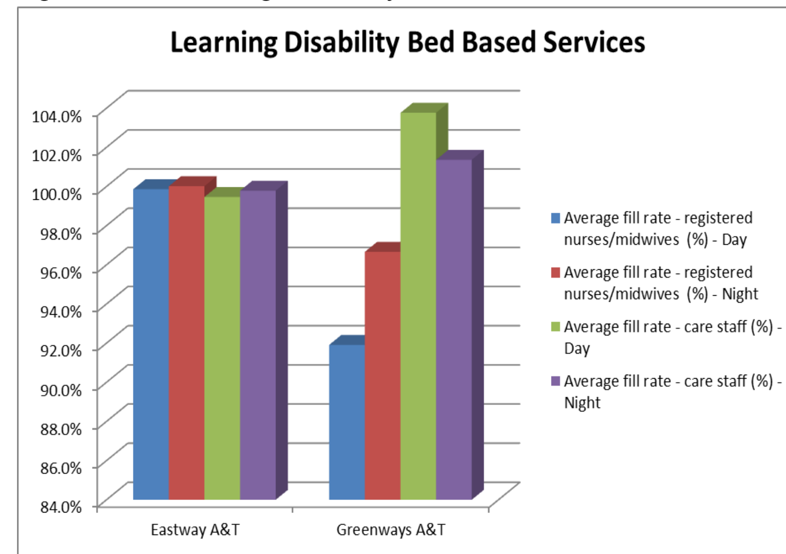


Figure 6 – Learning Disability – Bed Based Services



Overall the wards have managed to sustain sufficient fill rates to maintain safer staffing levels over the reporting period through a flexible approach to utilising staffing across localities in order to provide cover in response to fluctuating clinical needs. Fill rates include all registered and unregistered nursing staff who undertake full standard shifts but do not include staff from the wider multi-disciplinary teams who support the inpatient environments and are able to work into the staffing numbers as required.

2. Responding to workforce challenges during the COVID-19 response

2.1 Specialist Mental Health (SMH) Bed Based Services

The inpatient wards within Bowmere Hospital were operating with increased sickness levels prior to the onset of the pandemic which were then further exacerbated by the impact of COVID-19, with absence levels reaching a peak during April and May. This was managed through the temporary closure of Beech Ward during the peak period to enable minimum staffing levels to be maintained on the remaining wards. Bank and agency staff, overtime and redeployment of staff from SMH and Neighbourhood place based services was also utilised to maintain minimum safe staffing establishments and respond to increasing staffing capacity requirements in order to support individuals with suspected and confirmed COVID-19.

There was an unprecedented amount of change within Bowmere Hospital with temporary ward closures and wards being temporarily re-provisioned as COVID-19 cohort wards. The staff have risen to the challenge and worked flexibly across multiple specialities to be able to provide services in response to rapidly changing needs. Whilst this has been a significant challenge it has also provided opportunities for staff to experience working with individuals with a wide range of different needs and develop skills and knowledge in areas of practice that they may not have previously experienced. Sickness absence continues to be managed in line with policy and continues to reduce. Recruitment was initially paused during the emergency response but resumed throughout June, with some posts being successfully recruited to.

The inpatient wards at Spring View Hospital also experienced significant workforce challenges during the initial COVID-19 response with a significant number of staff being required to shield due to individual risk factors. COVID-19 related sickness was a particular concern for a number of weeks throughout April and May, with absence levels reaching a peak during this period. Bank and overtime, a number of agency staff block bookings and redeployment of staff from SMH and LD place based services was also utilised to maintain minimum safe staffing establishments and respond to increasing staffing capacity

requirements in order to support individuals with suspected and confirmed COVID-19. There were increased levels of stress and anxiety reported amongst the inpatient staff team in relation to the COVID-19 situation during this time, however staff remained in work and worked together as a team to be able to provide a flexible response across the unit and maintain minimum safe staffing levels whilst responding to the complex need of individuals who were accessing the service. Staff were fully supported during this period by the operational management teams and through direct access to the workforce wellbeing service where required. All service areas were kept up to date with changes to guidance and practice via daily trust wide communication updates and effective infrastructure support allowed access to the required PPE.

The new wards in the East Cheshire opened in January as part of the redesign project. Following an initial increase in COVID-19 related absence the inpatient services in East Cheshire, including the secure units at Soss Moss, have been able to safely support the majority of staff back to work in order to be able to support maintenance of safe staffing levels. A number of staff have been required to shield as a result of the COVID-19 response and where possible they have been supported to undertake work from home to support the administrative requirements for the inpatient units. Following the temporary suspension of the Learning Disability repsite services a number of staff from the Crook Lane service were temporarily redeployed to Silk Ward to support the maintenance of safe staffing levels during the COVID-19 response.

As part of the evaluation of the redesign project the staffing establishment for both Mulberry and Silk is currently being reviewed. A new ward manager has been recruited for Mulberry as part of succession planning with the current ward manager due to retire later in the year. A new ward manager has also been successfully recruited for Saddlebridge.

The support of the opt-in nursing students from April onwards has been invaluable to support safe staffing levels across all inpatient services.

Throughout the COVID-19 response clinical psychology services across SMH place based services have provided a range of interventions to support both staff and patients within inpatient services with the psychological impact of COVID-19. This has included provision of a staff telephone support service, group support sessions and development of tools to help staff support patients and families affected by COVID-19.

2.2 Learning Disability Bed Based Services

The Assessment and Treatment Units have continued to provide mutual support across the units and also to other inpatient units within their respective localities.

During the COVID-19 response, the respite unit provision has been temporarily suspended, resulting in the staff from the units being temporarily redeployed. The majority of the staff from Thorn Heys were redeployed to Eastway and two Registered Nurses' from Crook Lane were redeployed to Greenways, the other staff from Crook Lane have been redeployed into other areas within the Trust.

Recruitment of Registered Nurses continues to be a challenge for Greenways, in order to mitigate this Eastway have been able to support Greenways with Registered Nurse cover which has also provided an opportunity for staff to work across both units and share good practice. The addition of the opt-in student nurses working with the teams has also provided extra support during the COVID-19 response. Occupational therapy supervision has been provided by the lead OT and a Clinical Support worker has been redeployed into a technical instructor post in order to maintain occupational therapy provision during staff absence. These additional measures have limited the impact of the reduction in staffing capacity as a result of some staff having to shield in the context of COVID-19. Where possible, staff who are shielding have been supporting the units by undertaking administrative based tasks whilst working from home.

There is now one resource manager aligned to both of the units which in the long term should prove beneficial, working alongside the unit managers to ensure staffing levels are met and also having the ability to be able to cross cover if needed.

2.3 CAMHS

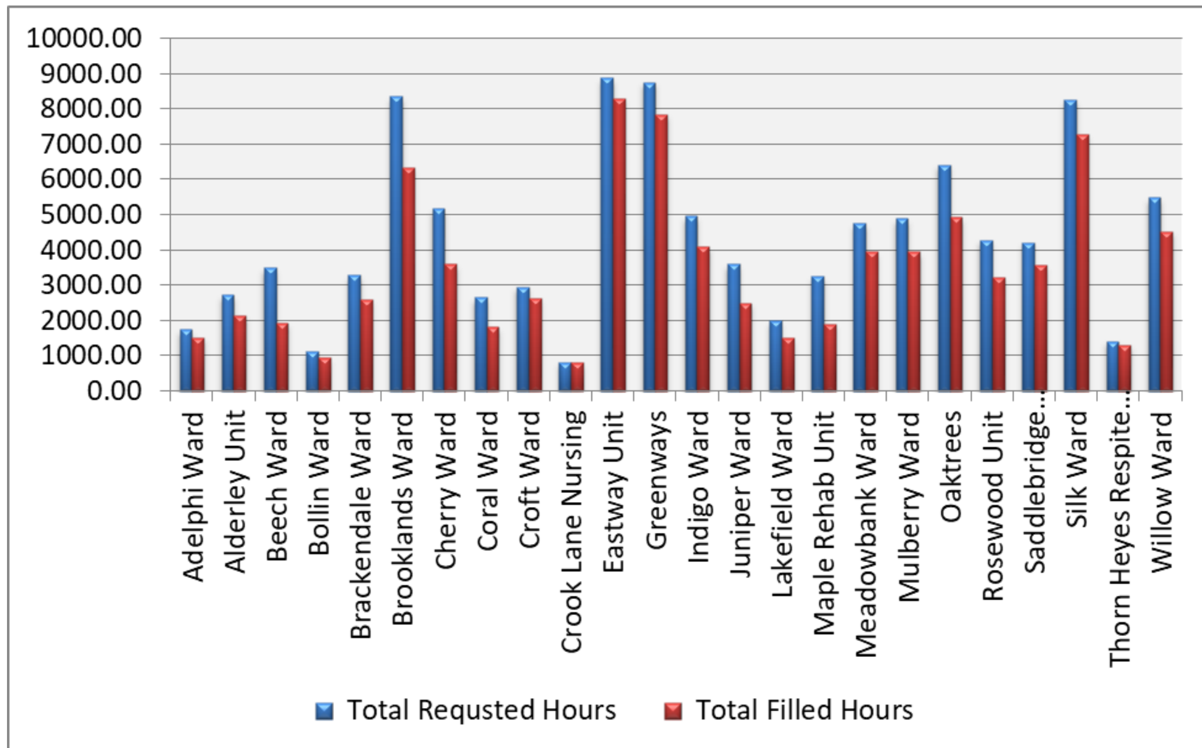
Both Coral and Indigo have continued to operate and safe staffing levels have been maintained throughout the COVID-19 response. Sickness and COVID-19 related absences have remained low during this period therefore utilisation of temporary staffing has remained low. Staff who have been unable to have face to face contact with patients due to being in higher risks groups in the context of COVID-19 have supported the wards by providing administrative support. The MDT have facilitated the provision of education for the children in the absence of Ancora House School being operational during this time. Coral and Indigo have continued to support Bowmere with the re-deployment of staff on a shift by shift basis when staffing levels allow

2.4 Temporary Staffing

The chart below shows the requests made to temporary staffing during the reporting period to meet safer staffing requirements due to both staff absences and increased clinical needs of patients. In total there were 8,000 less temporary staffing hours requested compared to the previous 6 monthly reporting period.

The highest number of requests were received from the Learning Disability Assessment and Treatment units which, due to their provision of externally commissioned spot purchased beds, rely on short term staffing solutions to support the service model. Silk ward also made a high number of requests due to a sustained period of utilisation of high numbers of one to one observations to support individuals with complex needs and risks. The number of requests made by Brooklands ward were in response to a number of vacancies, staff absence and increased levels of acuity.

Figure 7: Requests made to temporary staffing from 1st November 2019 until 31st April 2020



2.6 Recruitment

There are challenges in recruitment of registered nurses nationally; this is an area of priority for the Trust. A rolling quarterly programme of recruitment targets inpatient Band 5 nurses and Band 3 Clinical Support Workers with agreement to recruit in advance of need.

Understanding the turnover rate has enabled the determination of recruitment in advance of need and has helped reduce the impact of any recruitment attrition thus not resulting in longer term vacancy rates. During this period the recruitment in advance of need cap has been extended to enable the 36 opt-in pre-registration students who have supported inpatient services throughout the COVID-19 response to be offered an interview for a substantive post pending their successful completion of the nursing qualification.

The employment of newly registered nurses requires availability of a sufficient number of preceptors to provide and support effective learning opportunities. Facilitating learning

opportunities to enable experienced registered nurses to gain sign off preceptor status is a priority for Matrons, Ward Managers and Clinical Leads.

The vacancy position at April 20 within inpatient services across the Trust was as follows:

Trust Wards	WTE [budgeted establishment] as at Apr 20	WTE [Staff in post] as at Apr 20	Staffing differential	% of vacancies against establishment
Registered Nurses	273.60	262.57	-11.03	-4.03%
Clinical Support Workers	282.99	289.28	6.29	2.22%

2.7 Training and Supervision

Non safety critical face to face mandatory training was suspended during the COVID-19 response however a limited number of face to face training programmes continued to run during this period for specific groups of staff including new starters, students and redeployed staff. The safety critical programmes that were delivered during this time were included Basic Life Support, Management of Violence and Aggression and Fire Ward Evacuation.

A bespoke COVID-19 training programme was also developed and rolled out to over 330 inpatient staff across all care groups to improve knowledge, skills and confidence when supporting individuals with suspected or confirmed COVID-19.

A clinical skills refresher training programme was also developed on the Virtual Academy which was widely accessed by staff and included video tutorials, presentations and links to information that could be utilised to update knowledge and skills in the absence of attending face to face training courses.

3. Update on progress since the previous report

Psychological Therapies – Two newly established dedicated acute inpatient psychology posts have been successfully recruited to during this reporting period. All inpatient services across all care groups now have dedicated psychology provision as part of their Multi-Disciplinary Teams who are able to support the wider inpatient safer staffing requirements as and when needed.

Personality Disorder Hub – Further discussions have been held with the CCG's and Local Authorities regarding the proposed development of the Complex Needs and Community

Rehabilitation service and nominations have been provided by all partners to form a steering group to support the mobilisation of the project. The steering group will be supported by three working groups focussing on Finance/ Contracts and Data, Clinical pathways and Community development. There is a commitment from all to take the project forward at pace The Project Initiation Document is due to be refreshed following these discussions.

Medicine Administration Pharmacy technician- The role that is currently being utilised on Silk Ward is being reviewed to inform the future role requirements to ensure sustainability and consistency across the care group and to enable an increased focus on medicines management competency development across the inpatient registered nursing and nursing associate workforce.

Section 2: Specialist Mental Health- Placed Based Services

1. Overview

This report provides an overview of safer staffing within place based services that fall within the Specialist Mental Health (SMH) Care Group. It details the current position together with the steps being undertaken to ensure that services and the workforce are positioned to respond to the safer staffing agenda by ensuring the right staff, the right skills and the right place.

2. Responding to workforce challenges during the COVID-19 response

During the COVID-19 response period all SMH place based services experienced workforce challenges due to staff being required to shield and COVID and non-COVID related sickness absence. Both Wirral and West Cheshire Community Mental Health services redeployed staff to inpatient services during the peak of the pandemic and teams also redeployed staff to the Crisis Line that was developed as part of the COVOID-19 response. Wirral CMHT's experienced particular pressure as the staff redeployed from the CMHT were all nursing staff and the All Age Disability elements of the CMHT predominantly moved to working from home at the start of the enactment of the Business Continuity plan

In response to the workforce challenges and to ensure the maintenance of an effective service response a number of approaches were utilised in line with the Business Continuity plans for the services. The caseload was Red, Amber, Green (RAG) rated and the available resource was targeted towards the individuals identified as having the highest levels of need. In addition staff working from home were allocated work, including provision of 'Duty' functions and provision of telephone assessments, reviews and support. Demand was reviewed on a daily basis and re-prioritised accordingly. Enabling staff to work from home initially posed some challenges mainly through limited availability of agile working equipment however this has now been resolved.

The Liaison Psychiatry services also experienced staffing pressures as a result of COVID and non-COVID related sickness absence and the redeployment of staff from within the teams to the Crisis Line. The support that was previously provided by the Home Treatment Teams to the Liaison service was also diverted to the Crisis Line. The workload has been manageable as activity initially reduced; however, as the activity has increased the services have been supported by practitioners from the Single Point of Access (SPA) service.

The Complex Recovery Assessment and Consultation team have be challenged with vacancies due to absence and resignations with aid being requested from Forensic services and proactive recruitment being undertaken.
During this period some vacancies have been recruited to and new staff have commenced in post which has alleviated some pressures.

3. Update on progress since previous report

The CMHT transformation project continues to be progressed in line with the requirements within the NHS Long Term Plan. The purpose of this change is to break down the current barriers between (1) mental health and physical health, (2) health, social care, voluntary, community and social enterprise (VCSE) organisations and local communities, and (3) primary and secondary care, to deliver integrated, personalised, place-based and well-coordinated care.

A project board and implementation group have been identified with a number of defined work streams to support design, implementation and evaluation. A phased work plan is in the process of being finalised following extensive engagement to facilitate implementation of the new model by April 2022.

Section 3: Children, Young People and Families

1. Starting well

Starting Well services include the Starting Well 0-19 service, Speech and Language Therapy service and Paediatric Continence.

The integrated service provision includes delivery of the following specifications:

- Health Visiting 0-5
- Health and Well-being 5-19
- Family Nurse Partnership (FNP)
- Children's Centre Core offer
- Immunisation and Vaccination (commissioned separately by NHS England)

Responding to workforce challenges during the COVID-19 response

At the start of the COVID-19 response minimum safe staffing levels were scoped in order to provide capacity for surge planning and redeployment if required. This also enabled capacity to be monitored if sickness levels increased. Safe staffing levels have been maintained throughout the COVID-19 response period within Starting Well. Training requirements for staff working within the teams were also scoped and training undertaken in preparation for redeployment as required.

As part of the enactment of Business Continuity Plans (BCP) the service developed a robust communication process to ensure daily staff conference calls took place to maintain contact, share key messages and ensure staff felt confident with the leadership and planning of the service during the emergency response. Queries were promptly responded to with timely escalation on a daily basis and responses provided to staff.

Recruitment to vacancies has continued throughout the COVID-19 period within constraints. Staff have been actively promoting Starting Well as a service in which to work amongst colleagues who do not work within the services. This has supported the recovery against the 15% Health Visitor vacancy rate. New staff have been supported through a range of virtual approaches as part of their induction throughout this period to mitigate the reduced face to face support they would have ordinarily received.

Three Specialist Community Public Health Nursing students have been supported to complete their final placements to enable them to complete their qualification during the

COVID-19 response period. The service has subsequently recruited these students in advance of need to provide security for them and flexibility for the service.

Update on progress since the previous report

1. The leadership re-structure has been completed and the new model implemented in March 2020. The new model had been co-produced with team leaders. It has increased the Band 7 staffing establishment which has supported succession planning and confidence for staff in a more accessible career structure. The additional Starting Well Operational Lead capacity has been essential during the COVID-19 response
2. Scoping has been undertaken regarding the capacity required to re-align the roles of Public Health Nurses, Health Visitors and Starting Well nurses. This is an ongoing work stream that has been paused during Covid and will be picked up again from September 2020.
3. The service has supported two senior staff to undertake Masters in Business Administration using the apprenticeship levy and two more staff have secured places to commence in September 20. Three staff have also been supported to undertake apprenticeships for business support which has added social value and capacity to the teams.
4. The service has continued to pilot and develop new roles in response to service need and staff feedback including three temporary Team Around the Family practitioners and a Special Educational Needs and Disability lead role.
5. Training to support the Parenting offer was completed in March for Early Years workers who will now develop Incredible Years Parenting programme for 0-5 children. Wider ongoing training continues as part of the workforce development work stream
6. Development of Safeguarding Specialist Nurse Band 6 roles have been successfully recruited to. The roles will be evaluated as they embed and develop.
7. The demand and capacity tool for Health Visitor capacity is in the process of being reviewed to ensure reduction in unwarranted variation across the whole service
8. The clinical and managerial supervision model has been refreshed and implemented. An additional model to support Early Help and prevention is being developed and will be implemented in September to support Team Around the Family function.

2. Community Child and Adolescent Mental Health Service (CAMHS)

The requirement to respond to COVID-19 has enabled Community CAMHS to look closely at the skills within the service and to identify areas where less experienced staff could be placed to enhance their levels of skill. An example of this has been the acceleration of the development of the Placed Based Risk/Crisis offer which is now available 7 days per week from 8am-8pm and interfaces with the 24/7 All Age Crisis Line offer. The service provides risk assessment and interventions to Children and Young People who may otherwise have presented in a crisis to the Acute Trusts. Less experienced staff have had the opportunity to gain experience in this service on a rotational basis, whilst being supported by other members of the service who have more experience in the area of risk assessment. Staff have fed back that they have found this opportunity beneficial.

Due to the evolving nature of the pandemic and the rapid development of the Crisis functions the staff within the service have been required to work flexibly and adapt to multiple changes in order to ensure rota's could be covered 24/7 and a consistent response could be provided.

There have been some challenges encountered by the staff that have been working from home as part of the business continuity plan enactment, however due to a lower requirement for redeployment than had been anticipated, these staff have been able to provide a service to the children and young people who were on a waiting list prior to the pandemic. This work has been delivered virtually by the staff who have been working from home during the COVID-19 response and has reduced waiting times considerably, specifically in Wirral.

Update on progress since previous report

Community CAMHS model of care:

In 2019 the Children Young People and Families Care Group undertook a priority project for our community CAMHS model of care. The Clinical Directors for community CAMHS have been fully engaged and involved in the review of the model of care to ensure we demonstrate the clinical leadership aspect of the projects

The model of care work has now moved into Phase 2 which will be undertaken during 2020 with a planned implementation date of 1st October 2020. A series of workshops/sessions will be held with teams to help shape the future model of care with the purpose of the project being to reduce unwarranted variation in delivery of care across our Community CAMHS services in CWP. To achieve this, we explored and continue to explore efficiency,

effectiveness, experience and safety of current service delivery models to enable a common understanding of what provision is commissioned and operates across Cheshire and Wirral to inform quality improvement. The project is informing better ways of working for us to consider within community CAMHS with efficient and effective use of funding driven by best practice, learning from experience and service user feedback to increase engagement and performance.

An example of a change we have seen as a direct impact of the model of care project is the implementation of a number of essential standards for all teams to adopt in order to reduce the identified variation in terms of access, choice and partnership treatment. This has included the standard utilisation of outcome measurement tools, data inputting and the delivery of CHOICE (Choice appointments are the first contact the person has with the service). A further recommendation from the priority project was the development a single set of job descriptions for Community CAMHS based on roles required to deliver the service, underpinned by the principles of skill mix and partnership working. This work has progressed and we have completed the revision of the Band 6 job description with essential qualifications.

During phase 2 we will be working with teams to mobilise and implement the proposed model of care which will include:

- a review and alignment of the clinical pathways in use across all services
- developing and mobilising new and emerging service offers such as, Mental Health Support Teams
- development of a workforce strategy to deliver effective clinical care including the review of our structure, functions and job descriptions

Section 4 : Improving Access to Psychological Therapies (IAPT)

The Improving Access to Psychological Therapies (IAPT) programme supports the NHS in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people with depression and anxiety disorders.

NHS England recommend services employ IAPT trained staff or train their existing staff in the recognised therapy modalities to expand capacity and where services are employing non-IAPT trained staff those staff should be accredited, by the recognised body (i.e. BABCP for CBT therapists) for the modality of therapy they are offering.

The IAPT model is that steps 1 and 2 are provided by low intensity therapy workers trained in cognitive behavioural approaches for people with mild to moderate anxiety and depression. Moving up the stepped approach to level 3, provided by IAPT high intensity therapists trained in Cognitive Behavioural Therapy (CBT).

Right Staff:

	Trainee PWPs (WTE)	Qualified PWPs (WTE)	Senior PWP (WTE)	Trainee HITs (WTE)	Qualified HITs (WTE)	Qualified Counsellors (WTE)	Assistant PWPs/HCAs (WTE)	Total Staffing (WTE)	Variance from last six months
South Cheshire and Vale Royal	12	5.74	1	6	11.5	5.3	1	36.54	Increase 6 WTE
West Cheshire	9	10.4	1	10	10.9	7.6	1	39.9	Increase 10WTE
South Sefton, Southport & Formby	7	15.49	2	0	15	5.52	0	38.01	No change

The increase in staffing is linked to the Five Year Forward View & Long Term Plan investment, which has created additional posts within the service.

NHSE are recommending that the IAPT model reflects a 40% low intensity work force and a 60% high intensity workforce, with the long term conditions modelling reflecting 30% low intensity and 70% high intensity, as documented in the updated IAPT manual. The West Cheshire, South Cheshire & Vale Royal CCGs have invested in additional trainee IAPT staff this year: Collaborative work with the CCG's is underway to align local service provision with

the recommended model to meet the expected national targets. This is reflected within the above table.

Supervision:

There are sufficient numbers of supervisors for core Psychological Wellbeing Practitioners (PWPs), counsellors, and High Intensity Therapists (HITs) to meet the NHSE recommendations for IAPT. Within all localities it is identified that there are insufficient supervisors to provide supervision related to Eye Movement Desensitization and Reprocessing Therapy (EMDR). To address this EMDR consultant sessions across the IAPT sites has been purchased to provide the required supervision. An EMDR therapist will receive additional training to achieve accreditation as an EMDR consultant. By October 2020 the EMDR consultant will be able to provide internal supervision and develop a cascade approach to supervision across sites.

Internal supervision is being monitored monthly by the Clinical Leads within the service.

Sufficient number of supervisors to include supervision for counselling for depression is available as a result of the current trainees qualifying and accessing the Health Education England (HEE) commissioned supervisor course.

Right Skills

Locality	% of PWP Trainee on IAPT approved training	% of IAPT Qualified PWP	% of HIT Trainee on IAPT approved trainee	% of IAPT Qualified HIT	% of Qualified Counsellors with IAPT approved training or commencing training
South Cheshire & Vale Royal	100%	100%	100%	100%	100%
West Cheshire	100%	100%	100%	100%	100%
South Sefton, Southport & Formby	100%	100%	100%	100%	100%

We are assured by reaching 100% compliance for training in accordance with expected standards for all staff groups. It is not mandated that qualified counsellors have IAPT approved training but it is recognised good practice. This is an area of improvement and we

plan to enable our qualified counsellors to access this additional training by the end of the financial year 2019 - 2020.

Right Time / Place:

The discussions of individual clinical cases during supervision are prioritised according to clients' needs and a pre-determined schedule. All cases are reviewed within a 2- 4 week period of time; when assessed to be needed supervision is provided for individual clinical cases weekly.

High intensity activity is currently higher than the national model for step 3 across the IAPT services. Every service offers a stepped care model with all patients being offered a step 2 intervention initially. This enables staff to meet patient need effectively by identifying those with a greater need to continue onto a high intensity programme and enables capacity to be appropriately managed. To ensure we are offering the correct intervention at the right time therapist continually monitor patients improvement through psychometric measure and patients are stepped up to a higher intensity therapy if the patient isn't recovering as expected.

All IAPT services deliver treatment through a range of alternative delivery systems such as telephone, group therapy or 1-1 therapy which is delivered according to the IAPT guidance. All areas offer web based support which is a better use of staff resource to meet patient need.

Responding to workforce challenges during the COVID-19 response

Throughout the COVID-19 response the IAPT services have followed the national IAPT guidance and moved to remote therapy being delivered via video conferencing or over the telephone. NHSE have provided comprehensive training to all IAPT therapists to support with the delivery of remote therapy.

Supervision has continued either face to face with social distancing or via remote delivery. The IAPT trainees training programmes have been adapted by Chester University and Liverpool John Moores University for remote delivery. The trainees have also received regular supervision from the Universities via video link.

Section 5: Learning Disability, Neuro Developmental and Acquired Brain Injury- Place based services

1. **Responding to workforce challenges during the COVID-19 response**

During the COVID-9 response the Learning Disability (LD) community teams have actively utilised Dynamic Support Database and Dynamic Support Tool-physical health as tools to risk stratify their caseloads. This has provided a dynamic, proactive and responsive measure of the demand for the service. The teams have been able to utilise these tools to provide weekly reports regarding regarding the number of patients requiring support and the level of risk across the caseload in order to inform capacity requirements across the service. Where capacity pressures have been identified the care group has been able to redeploy staff to critical areas where demand has increased. The service maintained a comprehensive understanding of their workforce needs and risks which enabled safe staffing levels to be maintained.

A small number of staff have been redeployed from the respite service, following it's temporary suspension, to the LD community teams. Staff who have been required to shield have been supported to work from home where possible and other staff have been supported to work remotely to enable maintenance of social distancing and reduce unnecessary travel. Contact has been maintained with all staff who have been working remotely and the workforce risk assessment tool has been utilised with staff to support their well-being.

The teams have embraced the increased use of technology. Staff have been maintaining contact with each other and patients virtually by telephone and video. The service has been able to realise the benefits of utilising digital solutions during this period including improving service efficiency, e.g. expediting multi agency reviews when individuals are in crisis.

Regular feedback has been sought from staff, patients and carers regarding their support needs. This has allowed the service to respond promptly and make adjustments to service provision as required. The utilisation of proactive calls to patients and providers has supported the service to manage the flow of referrals to the service and prioritise provision based on demand and capacity.

During the COVID-19 response the service was able to secure additional physiotherapy capacity through the 'Return to Practice' initiative that was facilitated by Health Education England.

The service continues to experience challenges with recruitment overall, which have been compounded by the Covid -19 situation, leading to further recruitment delays.

2. Update on progress since previous report

The service has continued to support the Trainee Nursing Associate programme with 4 students currently undertaking their final placements. The Care Group has also committed to support the development of Registered Nursing Associates' through to Registered LD Nurses through provision of a number of apprenticeship secondments in response to the national shortage within this professional group.

The Care Group are continuing to develop opportunities for staff to undertake audit and research. This has been in response to the recognition of the need to promote academic pathways for practitioners allowing them to undertake role relevant training (through education) and develop the research base for the areas they work within (through partnership with universities) in order to provide career development opportunities. This initiative works alongside the quality improvement culture that has been developed.

The advanced practitioners in training have successfully continued in their courses and are due to complete this year.

Section 6: Neighbourhood Care Community Teams, Specialist Teams and GP Services

The focus of this report is to provide assurance regarding the safer staffing requirements within the Care Community Teams (CCT'S) and GP services that form the Neighbourhood Care Group during the COVID-19 response.

Responding to workforce challenges during the COVID-19 response

3. **Care Community Teams and Specialist Teams**

During the COVID-19 response staffing capacity has been impacted across the teams through staff either being required to shield or work from home due to Occupational Health guidance. This has affected the capacity within the teams to provide direct face to face care within community settings. In order to ensure staffing capacity could be utilised effectively new ways of working have been developed across all teams including caseload prioritisation, telephone triage/assessment and consultation and provision of training and skill development to enable cross cover to be provided by other teams within the service.

Ensuring staff had access to appropriate IT equipment was a challenge in enabling effective home working. The staff working from home have utilised new ways of working to support patients, carers and care home staff remotely which has enabled capacity to be released for staff who were able to continue to undertake direct patient care in the community. In addition, staff have been working through the various clinical audits, incident reporting, caseload cleansing etc. to ensure patient safety and accurate fluid caseloads.

The Tissue Viability, Physiotherapy and Continence teams have been able to utilise caseload prioritisation and new ways of working to release capacity and provide support to the CCT's This has been achieved through redeploying staff, providing interventions that the CCT's would have routinely provided, e.g. catheter care and venepuncture, and providing joint visits where more than practitioner was required to deliver care and treatment and meet the identified needs of an individual.

Self-management plans have been developed with patients, carers and care homes to reduce the number of face to face contacts that are required to maintain an individual's health and wellbeing. Virtual reviews have also been undertaken utilising photographs and videos to monitor progression and efficacy of treatment reducing the requirement for face to face contacts.

Chester Central CCT, Chester South and Ellesmere Port CCT have supported the Hospital Discharge service, the SMH COVID cohort ward and Rapid Response service through the

redeployment of staff from their teams. Physiotherapists received respiratory training and were FIT tested for PPE in preparation for redeployment to the acute services to provide additional respiratory physiotherapy capacity as required.

The Rural Alliance CCT utilised the opportunity created by reduced staffing capacity and limited face to face patient access to bring the Broxton & Tarporley CCT's together within the Tarporley Base. This has been very effective in furthering the rural alliance development and created opportunities for learning and sharing of skills across the caseload. It has enabled greater staff planning to be able to effectively manage the caseload in times of staff absence.

There have been ongoing issues with CCT's being required to fill the gaps as other elements of the health and social care pathway (e.g. social workers) have not been limited in the provision of face to face contacts. This is being addressed through the place based forums.

4. **GP Services**

During the COVID-19 response one of the biggest challenges for primary care was to ensure a clinical presence in each of the surgeries. Across the three practices, a significant number of GP's were deemed to be at moderate or high risk and therefore were unable to have direct close patient contact and were required to work from home. All three practices managed to maintain having one GP on site at all times with all other medical colleagues providing telephone consultations and administrative duties from home.

In the absence of clinical meetings, practice staff held (socially distanced) daily huddles to ensure key communication messages were cascaded and to check on staff wellbeing. Staff working from home have received telephone supervision to ensure they are feeling safe and supported.

Estates capacity has presented a challenge as not all practices have sufficient space available to enable practitioners to work in line with the 2m social distancing requirements. Whilst this has been difficult, it has also presented an opportunity and staff have developed their roles and have learned new skills in order to provide cross cover and to work from home on a rota basis.

During the COVID-19 response practitioners across the service have been required to develop and adjust to new and different ways of working, adapting and developing their skills to enable them to undertake different roles and provide additional services including dedicated COVID assessment and management services. Practitioners have also been required to utilise digital solutions to enable effective service provisions and have embraced a range of new technologies to support consultaaion, diagnosis and monitoriing. The service

has been able to realise the benefits of working in a more digitally enabled way and plan to continue to utilise the new technology moving forwards.

Attendance at regular team meetings has always been problematic for the GP Out of Hours Service as the majority of staff hold substantive posts elsewhere. At the beginning of the COVID-19 response weekly team meeting conference calls were initiated on Wednesday evenings to ensure staff were offered wellbeing support and were being kept informed during the fast pace of change. The meetings continue to be well-attended, although they have now reduced to fortnightly. The service intends to continue with this approach as feedback has been very positive.

Attendance overall has remained good across GP/primary care services. Staff have required a lot of advice and reassurance around the use/efficacy of PPE and support to use technology that was new to them but all services have worked cohesively and in partnership to continue to provide safe and effective care.

Section 7: All Age Disability Service

5. Overview

The All Age Disability (AAD) Service covers three areas of disability and mental health. This includes a Children with Disability Service (CWD), Integrated Disability Service – Adults (IDS) and a Community Mental Health Service- Adults (MH). All teams were brought together in early 2018 within Wirral Borough Councils Adult Services and were transferred to Cheshire and Wirral Partnership Trust under TUPE arrangements in August 2018. The All Age Disability Service is split over two sites. CWD and IDS are located at the Millennium Centre and the CMHT's are located at the Stein Centre.

6. Responding to workforce challenges during the COVID-19 response

In implementing the Care Group Pandemic Business Continuity Plan (BCP), differing staffing reduction levels were considered (25%, 50% and 75%) and the effect such reductions would have on services delivering the delegated statutory duties on behalf of the Local Authority in Wirral. Taking this approach enabled services to prioritise all key functions during this period and deliver safe and effective services.

As part of the Corona Bill there was the potential for the Director of Adult Social Services in Wirral, in conjunction with the Principal Social Worker, to enact Care Act Easements to support continued delivery of these core essential services. This would have enabled a further prioritisation of statutory duties. Within AAD & MH escalation procedures had to be developed both internally within CWP and externally to the Department of Adult Social Services.

Services have so far been able to manage capacity and demand within available staffing resource and have not had to escalate internally within CWP.

Right staff

Immediately prior to the implementation of the Covid-19 BCP response in both CWD and IDS there had been staff changes within some key leadership roles including Team Managers and Advanced Practitioners with four vacancies becoming available. Potential risk was mitigated and managed within the existing resource. During this period these posts have been recruited to and staff have commenced in post. Absence rates for both IDS and CWD have remained relatively low and stable

Absence within the Mental Health element of AAD escalated quickly and to mitigate risk around delivery of the Mental Health Act requirements of our delegated statutory duties an

AMHP hub was created that utilised dedicated staffing resource to undertake only the key functions associated with the Mental Health Act.

Right skills

The changed working arrangements that have been implemented during the COVID-19 response posed challenges for some of the newly qualified social workers within the service who are in their Assessed and Supported Year in Employment (ASYE) due to the limited access to face to face supervision and support. As part of the recovery plan for the service the ASYE's Practice Educators will evaluate and support staff to get back on track.

The Think Ahead Students who were on placement in the Mental Health service continued to support service delivery and this has enabled them to complete their programme of studies where elsewhere in the country the COVID-19 restrictions have affected other students' completion dates. This has enabled the service to recruit four newly qualified social workers to commence in September 2020 and undertake their ASYE.

To maintain compliance with the Care Act, three Senior Support Workers in the Mental Health element of the Care Group have been supporting with the assessment process. This is aligned to a Care Navigator Role within Adult Social Care and will be developed further going forward.

Right Time and Place

The care group has historically maintained high levels of staff retention. There have been four recent Social worker vacancies that have become available across IDS and CWD and these posts will be recruited to collectively.

In the Mental Health Service we were successful in recruiting to an AMHP post. We are also supporting and 2 practitioners from other Wirral CMHT's (1 x Nurse and 1 x Social Worker) to undertake their AMHP training via Chester University which will support stability and sustainability within this statutory function.

Cheshire and Wirral Partnership
NHS Foundation Trust

Report subject:	Learning from Experience report – trimester 3 2019/20 (incorporating an update on the national Learning from Deaths framework)
Agenda ref. no:	20.21.17
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and approval
Date of meeting:	29.07.2020
Presented by:	Gary Flockhart, Director of Nursing, Therapies & Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
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 CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Services that are responsive to people's needs	Yes
Well-led services	Yes
Which NHSI quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
N/A	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

1. Situation
This Learning from Experience report aggregates qualitative and quantitative analysis from key sources of feedback from people who access and deliver the Trust's services, and other relevant sources of learning, covering the period from December 2019 to March 2020, trimester 3 of 2019/20. The report compares current performance across a four trimester time series to mitigate seasonal variations, whilst also facilitating the identification of potential triggers to detect and prevent incidents by comparing current performance with the previous trimester. The in-depth Learning from Experience report received by the Quality Committee uses Statistical Process Control (SPC) charts to help with more effective and visual depiction of learning from experience and identification of recommendations, as well as to alert, as part of an early warning framework, any emerging trends.

2. Background – Key performance indicators

2.1 Performance indicators

<table>
<tr><th colspan="3" rowspan="2">Performance indicator</th><th>2018/19</th><th colspan="3">2019/20</th></tr>
<tr><th>T3</th><th>T1</th><th>T2</th><th>T3</th></tr>
<tr><td colspan="3">Number of safety incidents reported</td><td>3572</td><td>3730</td><td>3496</td><td>2956</td></tr>
<tr><td rowspan="7">Number of safety incidents by Care Group</td><td colspan="2">Specialist MH - Bed Based</td><td>1818</td><td>1823</td><td>1766</td><td>1527</td></tr>
<tr><td colspan="2">Neighbourhoods</td><td>653</td><td>686</td><td>723</td><td>547</td></tr>
<tr><td colspan="2">Children, Young People & Families</td><td>472</td><td>582</td><td>419</td><td>326</td></tr>
<tr><td colspan="2">LD, NDD & ABI</td><td>331</td><td>245</td><td>299</td><td>211</td></tr>
<tr><td colspan="2">Specialist MH - Place Based</td><td>202</td><td>310</td><td>209</td><td>268</td></tr>
<tr><td colspan="2">All Age Disability</td><td>57</td><td>45</td><td>49</td><td>46</td></tr>
<tr><td colspan="2">Corporate Support Services</td><td>39</td><td>39</td><td>31</td><td>31</td></tr>
<tr><td rowspan="4">Reports to external agencies</td><td colspan="2">StEIS</td><td>42</td><td>40</td><td>33</td><td>27</td></tr>
<tr><td colspan="2">National Reporting & Learning System</td><td>1698</td><td>1681</td><td>957</td><td>1243</td></tr>
<tr><td rowspan="2">NHSR</td><td>Non clinical</td><td>5</td><td>4</td><td>5</td><td>9</td></tr>
<tr><td>Clinical</td><td>2</td><td>1</td><td>3</td><td>1</td></tr>
<tr><td colspan="3">Number of complaints</td><td>97</td><td>59</td><td>96</td><td>47</td></tr>
<tr><td colspan="3">Number of compliments</td><td>1019</td><td>1155</td><td>1028</td><td>682</td></tr>
</table>

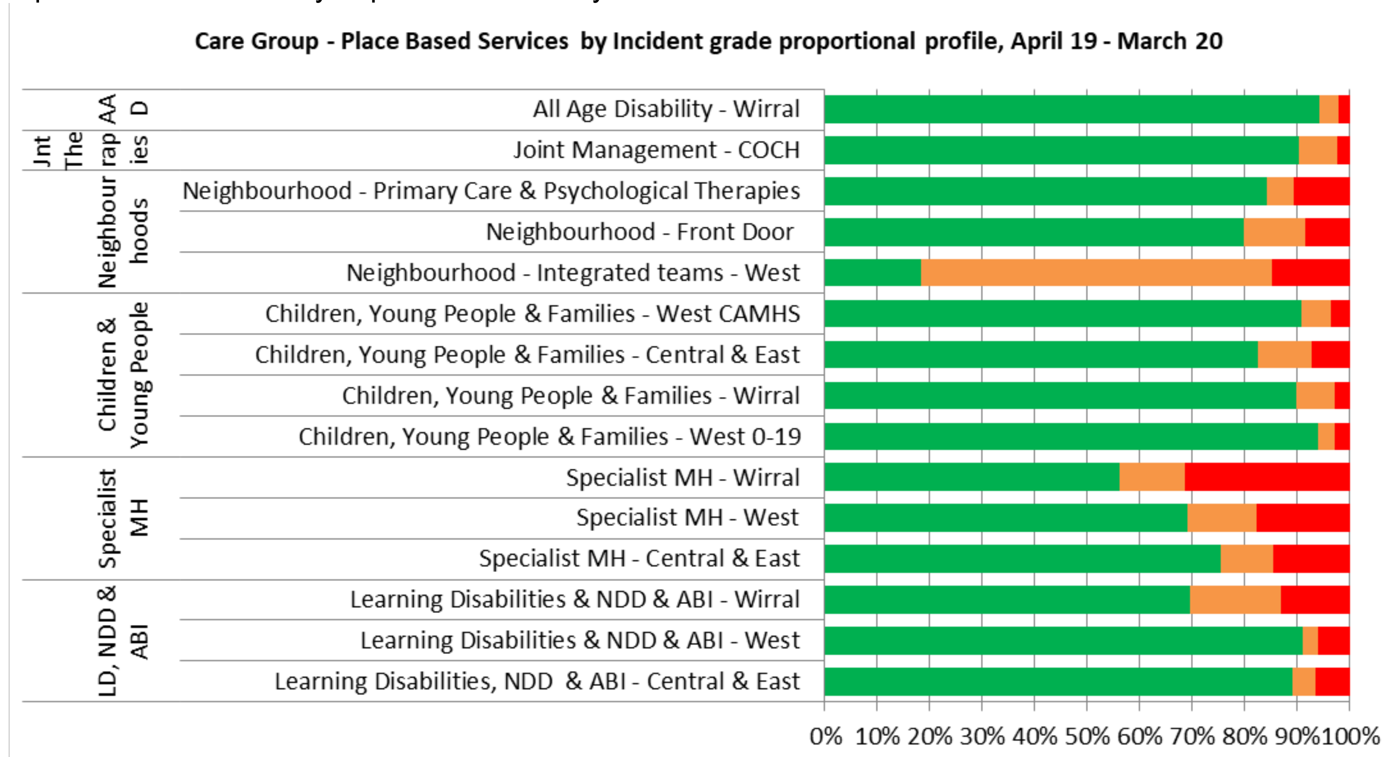
***Note:** All incident and compliment numbers represent a snapshot at the time of publication of the report and are subject to change over time, for example: re-categorisation of incidents following receipt of further information since the previous report, receipt of compliments retrospectively.*

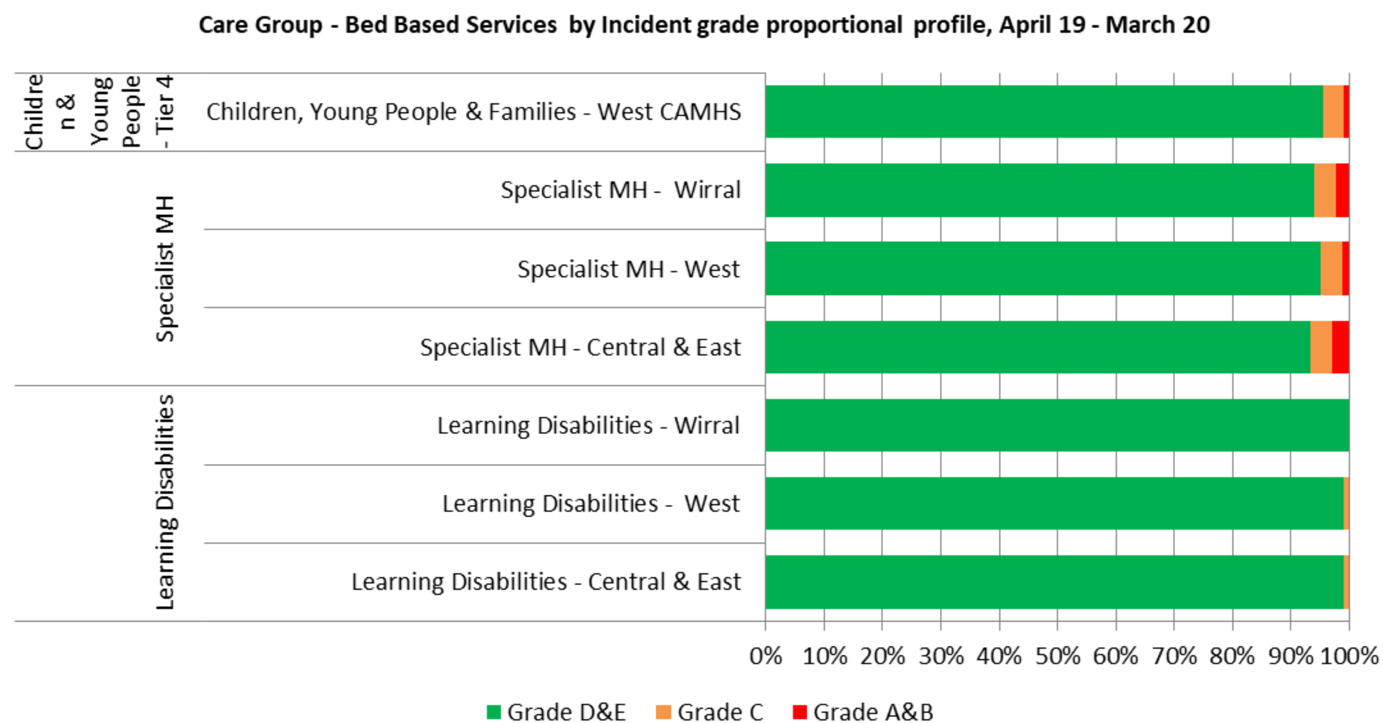
2.2 Proportional reporting performance indicators – Incident reporting
"Proportional reporting" of incidents measures incidents against the care group. This approach was taken following a Quality Account aspiration to develop how CWP measures incident reporting profiles – for example:

- Neighbourhood integrated care teams' reporting profiles (as evident in the chart below) are influenced by pressure ulcer incident reporting because of the way they are reported as (currently) required nationally.

By presenting the incident reporting profiles in this way, the charts reveal fundamental differences between the care groups that can be used to identify where focus is needed to reinforce that reporting no or lower harm incidents promotes learning to be able to potentially mitigate future actual or significant harm incidents.

The charts below show a proportional split of incident grade per care group. This illustrates the differences in severity of incident occurrence and can further inform potential opportunities for both Service Improvement and Quality Improvement activity.





3. Analysis

3.1 Incident reporting

Overall there has been a decrease in the number of reported incidents over the last 2 trimesters. A notable decrease has been seen within the Learning Disability, Neighbourhoods and Children, Young People and Families care groups. Further work to understand this decrease needs to be undertaken. Initial findings have highlighted a low number of low level incidents are being reported.

The number of incidents being reported on StEIS has shown a steady decrease across the last two trimesters. This reflects the work currently being undertaken to improve the quality of information required

to determine whether the incident meets the criteria for reporting on StEIS. This work has been supported by the respective Clinical Commissioning Groups across the footprint. This has also resulted in a reduction in the number of StEIS incidents that the trust has requested to be undeclared.

The category with the highest number of reported incidents continued to be physical violence and abuse/harassment for the second consecutive reporting period. The Learning from Experience group within the Specialist Mental Health Care Group will be reviewing the themes to understand the factors influencing the changes in incident category trends and consider whether any continuous improvement work needs to be undertaken.

Self-harm incidents were the second highest category of reported incidents during this period having increased this trimester following a reduction during trimester 2. This is partially due to work being undertaken to improve accuracy in reporting for this incident category. Within the Children, Young People and Families care group incidents of self-harm have significantly reduced during this trimester. Work continues within the care group to identify any learning from incidents in order to influence continuous service improvement.

The number of incidents reported relating to pressure damage that developed whilst under the care of Trust services has decreased this trimester having seen a steady increase over with the previous 3 trimesters within the Neighbourhood Care Group. This has been influenced by a change in the reporting requirements for foot ulcers during this period. Work has commenced to ensure the reporting requirements are clear for the staff and that the NHS Improvement reporting requirements are being achieved.

The incidents team are continuing to work with care groups and their governance teams to understand any factors that have influenced the overall reduction in incident reporting during this trimester including opportunities for reviewing incident reporting processes and sharing good practice. This is being supported through the development of resources and e-learning materials that will be available on the Virtual Academy. A share learning bulletin will also be re-issued reminding staff of the importance of reporting ‘low level’ incidents.

Within this trimester, a detailed share learning bulletin was issued to assist staff in reporting all restrictive interventions.

During Trimester 3 the Immediate Safety Review process has been reviewed and incorporated into Datix to reduce duplication and support the timely communication of information.

Significant work is currently being undertaken within the care groups to enable learning to be effectively captured and areas for quality improvement identified.

Key learning has been shared across the Trust following safety reviews undertaken when serious incidents have occurred during this trimester.

Following a number of serious incidents involving patients who were prescribed Clozapine, a Communications Bulletin was issued Trust Wide in February 2020 highlighting the importance of physical health monitoring which incorporated 7 key actions for Clinical Teams. The prescribing guidelines for Clozapine were also updated in January 2020 and the Clinical Pharmacy team have distributed Choice and Medication information leaflets regarding constipation and clozapine to every patient prescribed clozapine with a covering letter in March 2020. Additionally work continues with the community pharmacy services, the CCGs and GP practices to ensure that all patients prescribed clozapine are identified and supported appropriately. Immediate learning has been shared within the Specialist Mental Health care group and an action plan has been developed to address key issues. The Trust is currently undertaking a number of case reviews and once completed a thematic review will be undertaken led by the Executive Medical Director for Quality.

In January 2020, CWP co-hosted a joint learning event with the Countess of Chester Foundation NHS Hospital Trust. The event shared learning from a RCA investigation that both organisations had been involved with. It was an opportunity for practitioners and managers to discuss the learning and how this can impact on current practice. The evaluation of the event was positive and further events were planned for 2020.

3.2 NHS Patient Safety Strategy

NHS England and NHS Improvement published the NHS Patient Safety Strategy in July 2019. It is recognised that more can be done to share safety insight and empower people (patients and staff) with the skills, confidence and mechanisms to improve safety. Addressing these challenges will enable the NHS to achieve its safety vision; **to continuously improve patient safety**. To do this the NHS will build on two foundations: a **patient safety culture** and a **patient safety system**.

Three strategic aims will support the development of:
- Improving understanding of safety by drawing intelligence from multiple sources of patient safety information **(Insight)**
- Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system **(Involvement)**
- Designing and supporting programmes that deliver effective and sustainable change in the most important areas **(Improvement)**

The current serious incident framework 2015 is due to be replaced, by the introduction of a **Patient Safety Incident Response Framework** to improve the response to an investigation of incidents. The introductory version of the Patient Safety Incident Response Framework has been published in March 2020.

CWP have an obligation to undertake a patient safety review within 72 hours of being notified of a serious incident. The information collated from the review must be uploaded onto the NHS England serious incident database (StEIS) in line with national reporting guidance. Significant work has been undertaken between the clinical governance team and care groups to ensure immediate safety reviews are undertaken in line with required time scales and the quality and timeliness has significantly improved during trimester 3.

The Weekly Meeting of Harm was reviewed and relaunched as the Immediate Safety Assurance Forum (ISAF) and the terms of references revised to reflect the NHS Patient Safety Strategy and strengthening the process to focus on immediate patient safety and learning.

In addition, the Immediate Safety Assurance Forum ensures that the Duty of Candour is being applied appropriately and consistently. In order to support this the following actions were undertaken:
- GR1 incident policy was updated,
- A leaflet explaining Duty of Candour was co- produced to give to individuals and their families following an incident
- Shared learning Bulletin on Duty of Candour disseminated

3.3 Learning from deaths monitoring and engaging with bereaved families and carers

Mortality monitoring *For serious incidents, investigatory performance is 100%	**2018/19**	**2019/20**		
	T3	**T1**	**T2**	**T3**
Inpatient deaths*	4/ 100%	1/ 100%	**4/ 100%**	**6/ 100%**
Deaths reported to the Trust/ subject to a Case Record Review	302/ 80%	205/ 100%	**226/ 97%**	**275/ 99%**
Deaths reported as a serious incident/ subject to a serious incident investigation	25/ 100%	20/ 100%	**20/ 100%**	**16/ 100%**

The Trust continues to maintain a high level of compliance of Case Record Reviews and has undertaken reviews where a serious incident has been identified.

During this reporting period the Trust has undertaken one Level 3 internal review following the death of an individual who was admitted to inpatient services. Appropriate actions have been identified to address the areas of learning.

3.4 Learning from inquests

During this trimester, the Trust has not received or responded to any Preventing Future Deaths Reports (regulation 28).

3.5 Learning from external reviews and investigations

There have not been any external reviews published during this trimester.

4. Recommendation

4.1 Recommendations from Trimester 3 analysis

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

To continue to progress the recommendations as identified in Trimester 2 which are as follows:

- The Clinical Governance team to roll out the survey to ascertain how the Learning from Experience report can be developed further to support the sharing and integration of learning from complaints, incidents, inquests and compliments.

Recommendations from Trimester 3:

- The complaint process will be reviewed by the Head of Clinical Governance, Associate Director of Nursing and Therapies (Mental Health and Learning Disabilities) and the Associate Director of Patient and Carer Experience in line with learning from the Collaboration at Scale programme being undertaken across the region.
- The Clinical Governance team to re issue the Shared Learning Bulletin (SL70) reminding staff the importance of reporting 'low level 'incidents
- Care groups to work with the respective governance teams to determine if any teams are outliers with the reporting of incidents.

- **Recommendation to the Board of Directors**

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

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

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

Appendix 1 – Updates and assurances received against trimester 2's recommendations

The Clinical Governance team to review the GR1 incident reporting and management policy in preparation for the publication of the Patient Safety Incident Response Framework and to ensure alignment with the NHS patient safety strategy.
The GR1 incident reporting and management policy has been revised and published in March 2020. There has been a delay in the publication of the Patient Safety Incident Response Framework and the Serious incident Framework (2015) is the current framework the trust needs adhere to.
The Clinical Governance team should develop a survey to ascertain how the Learning from Experience report can be developed further to support the sharing and integration of learning from complaints, incidents, inquests and compliments.
The survey has been developed but was not rolled out due to the Trust needing to respond to Covid-19. This will be circulated in the near future once the recovery plans have been implemented by clinical services.
The Clinical Governance Team to develop systems to flag index learning from claims to be incorporated into ongoing QA work.
A system has been developed within CWP and the Head of Quality Assurance will be informed of any significant learning from claims

Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Freedom to Speak Up Annual Report 2019 -20
Agenda ref. number:	20.21.18
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/07/2020
Presented by:	Victoria Peach, Associate Director of Nursing and Therapies (Physical Health)

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	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
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	Yes	Patient Safety	Safe	Yes
Finance and use of resources	No	Clinical Effectiveness	Effective	Yes
Operational performance	No		Affordable	No
Strategic change	Yes		Sustainable	No
Leadership and improvement capability	Yes	Patient Experience	Acceptable	Yes
			Accessible	No
		http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

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

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

REPORT BRIEFING

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

The annual Freedom to Speak Up report presented provides assurance to the Trust Board that the creation of a Speak Up Culture, throughout the organisation is continually being strengthened.

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

The Trust is committed to have effective speaking up arrangements and for any employee to raise a concern that they may have.

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

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

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

The report provides an overview and analysis of the speak up concerns raised throughout 2019/20 2020; and provides comparatives to previous years where appropriate.

The Freedom to Speak Up commitments for 2020-21 are detailed within the annual report. The Board of Directors are asked to note the assurances that the Freedom to Speak Up processes are in place, are accessible to all people and that the commitments for 20-21 will continue to strengthen the development of a robust speak up culture

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

To receive assurance that Speak Up arrangements are in place and progress is being made to strengthen the Speak Up culture throughout the organisation.

Who has approved this report for receipt at the above meeting?	Gary Flockhart, Director of Nursing Therapies and Patient Partnerships
Contributing authors:	Victoria Peach, Associate Director of Nursing and Therapies (Physical Health)

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	FTSU Annual Report

#cwpQI

Cheshire and Wirral Partnership
NHS Foundation Trust

Document Reference (2018/19)

Report to Board:	Trust Board
Date of Meeting:	29.07.2020
Title of Report:	Annual update of Freedom to Speak Up 2019 - 2020
Action sought:	Approval
Author:	Victoria Peach
Presented by:	Victoria Peach

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

Distribution

Version	Name(s)/Group(s)	Date Issued
1	Quality Committee	24/06/2020
2	Board of Directors	29/07/2020

Executive director sign-off

Executive director (name and title)	Date signed-off
Gary Flockhart	24/06/2020

Cheshire and Wirral Partnership
NHS Foundation Trust

Speaking Up and Raising Concerns

Annual Report

April 2019 – March 2020

Board of Directors’ Speaking Up Declaration

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

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

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

Our Freedom to Speak Up Guardians have a clear understanding of their roles and responsibilities with sufficient time and support to undertake them.

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

The Board receives regular reports in relation to Speak Up; an annual report, six monthly reviews, exception report and through contributions to the Board Escalation report and Learning from Experience as appropriate. The annual report and six monthly reviews contain details on the number of concerns raised, lessons learned and recommendations for any further improvements to enable people to speak up. The Board is assured that Cheshire and Wirral Partnership NHS Foundation Trust adheres to good practice and that appropriate Speak Up arrangements are in place.

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

Contents

Introduction

Commitment

Speaking Up 2019 – 2020:

- Quality Improvement
- Building Confidence and Capability
- Measuring Progress
- Analysis of Activity

Speaking Up 2020 – 2021

Introduction

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

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

This annual FTSU report provides assurance to the Trust Board that the creation of a Speak Up Culture, throughout the organisation is continually being strengthened.

Commitment

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

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

Speaking Up 2019 – 2020

Quality Improvement

The FTSU Guardian role has been undertaken by the two Associate Directors of Nursing and Therapies; one being newly appointed in December 2019. The national requirement is for FTSU Guardians to have attended the formal Speaking Up training provided by the National Guardian Office and arrangments are in place for this to be achieved in relation to the new appointment. In the interim support is being provided to the newly appointed FTSU Guardian from the exisiting FTSU Guardian and the regional Guradian network. Developing a shared approach continues to enable improved access to a FTSU Guardian, provides choice for people and has enabled a quality assurance process to be implemented without compromise to individuals' confidentiality.

The FTSU Guardians are well supported to carry out the role: In addition to regular meetings with the Executive Director lead for Speaking Up, both Guardians have met with the Non-Executive Director FTSU Champion, as well as the Chief Executive and Chair to discuss Speaking Up strategy and any associated matters. This has enabled the FTSU Guardians to raise the profile of Speak Up and ensure that senior leaders are able to embrace the culture of speaking up and able to promote the importance of Speak Up during qualty visits and engagment with people. The FTSU Guardians report in person at board meetings.

During 2019 – 2020 the FTSU Guardians have reviewed the completed National Guardian Office self- assessment review tool that sets out the expectations of boards in relation to the Speak Up agenda. This process, in tandem with the details contained within this annual report, has enabled the Board to be assured that expectations are being met within the following areas:

- Leaders are knowledgeable about FTSU.
- Leaders have a structured approach to FTSU.

- Leaders actively shape the speaking up culture.
- Leaders are clear about their role and responsibilities.
- Leaders are confident that wider concerns are identified and managed.
- Leaders engage with all relevant stakeholders.
- Leaders are focused on learning and continual improvement.
- Individual responsibilities.

Building Confidence and Capability

Raising and Escalating Concerns at Work policy and processes are in place and are accesible to all employees on the Trust intranet. The importance of speaking up and speaking up processes continue to be shared with people in a variety ways; direct via distribution of leaflets; through Trusts communication bulletins; Chief Executive Officer drop in sessions and breakfast with the Chief Executive Officer; board member quality visits; and face to face by FTSU Guardians and ambassadors. Raising the profile of Speak Up has been in conjunction with an increased number of concerns being raised.

The Trust has recruited Speak Up Ambassadors from wide ranging services across the Trust. The Speak Up Ambassadors are self-nominated people working in any role within the trust who have demonstrated that they have the skills and qualities to provide support for colleagues in raising concerns, determine the best course of action and advise people of their options. All newly recruited Speak Up Ambassadors have received training and exisiting Speak Up Ambassadors are offered refresher training and have access to FTSU Guardians to offer support as necessary or to escalate, with consent, a persons concerns.

Feedback mechanisms have been developed to enable direct comment from concluded cases. Alongside the work of organisational development understanding the matters that contribute to related areas highlighted in the staff survey the information gained has informed the changes to policy and processes; and will continue to do so.

The FTSU Guardians have worked with the Equality and Diversity lead and meet regularly to maximise the opportunities for all people to raise concerns. Simiarly, joint working arrangments are in place with the Human Resources team.

Measuring Progress

One of the challenges for the Trust is reaching all staff, regardless of seniority or job role, with information regarding the access to FTSU Guardian to enable them to raise any issues or concerns, or challenge any wrongdoing, through this route. The development of a FTSU App, accessible to staff through a work or personal device, has been an approach to enhance accessibility to the FTSU Guardian for the previous three years. Within the previous 2 years no concerns have been raised through the FTSU App. All concerns have been via email directly to a FTSU Guardian or through the dedicated raising concerns email account, by telephone, escalated through the FTSU Ambassadors, through senior colleagues or face to face with the person. As a result a decision was reached not to renew the FTSU App.

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

Two concerns, relating to one service area, have been raised anonymously in 2019 – 2020. Both concerns were within the categories of leadership / management and bullying. The low levels of anonymity are a good indicator to suggest that workers feel confident to speak up. This is reinforced by the continued increase in the overall number of concerns being raised.

Learning from concerns is shared with team, service, care group and trust wide as appropriate. The Learning from Experience report provides assurance via the Quality Committee on a tri annual basis to trust board.

Systems are in place to record and monitor the FTSU activity and provisio of the FTSU Guardians report to the NGO each quarter as required. Success should not be measurable by the number of concerns and issues being raised. However, the trends of reporting can be useful when triangulated with wider data and can support the idenification of early warning that can enable prompt and appropriate intervention and support.

The results from the 2019 National Staff Survey are encouraging with staff responses to three out of four questions being higher than the national average. The FTSU Guardian will continue to work with organisational development to understand the opportunities for further development in those areas that have seen a slight reduction locally compared to 2018 response and for the one area that we did not exceed national average.

Table 1 – Staff Survey Results 2019

Question	National Response	Trust Response			
	2019	2019	2018	2017	2016
If you were concerned about unsafe clinical practice, would you know how to report it? (question 18a)		97%	97%	98%	97%
I would feel secure raising concerns about unsafe clinical practice.(question 18b)	71.7%	76%	75%	77%	76%
I am confident that my organisation would address my concern.(question 17b)	59.8%	65%	63%	64%	66%
My organisation treats staff who are involved in an error, near miss or incident fairly.(question 17a)	59.7%	56%	56%	53%	55%

The FTSU index has calculated the Trust to have a score of 80%; this is within the upper centile of the index of NHS Trusts.

Analysis of Activity

People are speaking up and raising concerns through the FTSU Guardian route which continues to be utilised across the Trust; the number of concerns raised in 2019 - 2020 has exceeded previous years. The increase in the total number of concerns reported to the FTSU Guardian this financial year demonstrates the increasing confidence of people to raise concerns and the strengthening of the Trust's culture to enable people to speak up. Further analysis provides assurance that people raising concerns are from across the trust; not limited to a particular locality, professional group, level of seniority, and gender or ethnicity.

A total of 34 concerns have been raised by a total of 30 people. Twenty four unrelated concerns were raised to the FTSU Guardian in 2019 -2020.

Table 2 – Total numbers of concerns raised from 2014 / 2015 – 2019 /2020

Year	Total number of FTSU concerns raised
2014 – 2015	7
2015 – 2016	20
2016 – 2017	12
2017 - 2018	23
2018 – 2019	28
2019 – 2020	34

Table 3 – Total numbers of concerns raised by locality from 2015 – 2016 to 2019 – 2020

Locality	**Total 2015 - 2016**	**Total 2016 - 2017**	**TOTAL 2017-2018**	Q1	Q2	Q3	Q4	**TOTAL 2018-2019**	Q1	Q2	Q3	Q4	**TOTAL 2019 - 2020**
Central and East	6	5	**15**	2	6	1	3	**12**	4	1	2	2	**9**
Wirral	4	2	**3**			3	1	**4**	1	0	5	1	**7**
West	8	4	**5**	3	2	3	3	**11**	3	4	5	3	**15**
Trust wide	2	1	**0**				1	**1**	3	0	0	0	**3**
TOTAL	20	12	**23**	5	8	7	8	**28**	11	5	12	6	**34**

Table 4 – Comparison of 2017 – 2018, 2018 – 2019 and 2019 - 2020 concerns raised by locality.

	2017 – 2018		**2018-2019**		**2019-2020**	
East	**14**	61%	**12**	43%	**9**	28%
Wirral	**3**	13%	**4**	14%	**7**	26%
West	**5**	22%	**11**	39%	**15**	43%
Trust Wide	**1**	4%	**1**	4%	**3**	3%
TOTAL	**23**		**28**		**34**	

Table 5 - The breakdown of concerns raised per Care Group is as follows:

Care Group	**Total**
Learning Disabilities and Acquired Brain Injury	0
Specialist Mental Health	13
Neighbourhood Based Care	5
All Age Disability	0
Clinical Support / Corporate Services	4

Children and Young People	12

Confirmation has been gained from All Age Disability and Learning Disabilities and Acquired Brain Injury Care Groups that people are aware of the Speak Up processes, with leaflets and communications being shared.

All the concerns raised have been investigated and responded to in a proportionate way by a variety of methods, inclusive of supporting people with specific concerns that could be addressed at supervision or through the line management processes through to commissioning an investigation under dignity at work policy. Scheduled and commissioned reviews have been undertaken to explore some concerns raised with any recommendations being shared with teams and services for further action.

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

Table 6 – Number of concerns raised 2018 – 2019 and 2019 - 2020

	2018-2019					**2019-2020**				
	Qtr 1	Qtr 2	Qtr 3	Qtr 4	**TOTAL**	Qtr 1	Qtr 2	Qtr 3	Qtr 4	**TOTAL**
Bullying / Harassment	3	6	1	4	14 (44%)	6	1	3		10 (20%)
Patient Safety / Quality			1	2	3 (9%)	4	1	1	3	8 (16%)
System / Process	2	1	3	2	8 (25%)	1	1	1	1	3 (6%)
Staff Safety			1		1 (3%)					
Leadership / Management Issue		1	4	1	6 (19%)	9	6	10	5	29 (58%)
TOTAL	5	8	10	9		20	9	15	9	

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

Analysis of the categories of concerns raised by people identifies that in 2019 – 2020 a higher proportion of people spoke up about their perception of leadership and management issues. The learning that has been extracted from cases is the importance of developing effective communication between individuals and teams and supporting people to raise concerns as and when they arise. Close working between FTSU Guardians and human resource team has enabled the themes and trends to inform conversations and support for line managers.

FTSU Guardians have been responsive to support people who raise concerns making first contact with people on most occasions within 72 hours. The mean average for the length of time for a case to be opened with the FTSU Guardian is 45 days. Of the feedback received one person felt a detriment of speaking up; feeling that colleagues treated them differently having raised a concern and did not consider sufficient feedback from the Speak Up process had been provided

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Table 7 – Number of cases closed.

2019 - 2020	Total cases	Cases closed	Feedback received
Quarter 1	11	11	1
Quarter 2	6	6	3
Quarter 3	12	7	3
Quarter 4	6	1	0

Raising Concerns and Responding to Concerns e-learning is available for all staff. Currently compliance is 95% for these programmes.

Speaking Up in 2020 – 2021

The FTSU Guardians will work alongside senior leaders to continue and where possible strengthen, and achieve, a healthy speaking up culture throughout the Trust. The following commitments for 2020 – 2021 are in place:

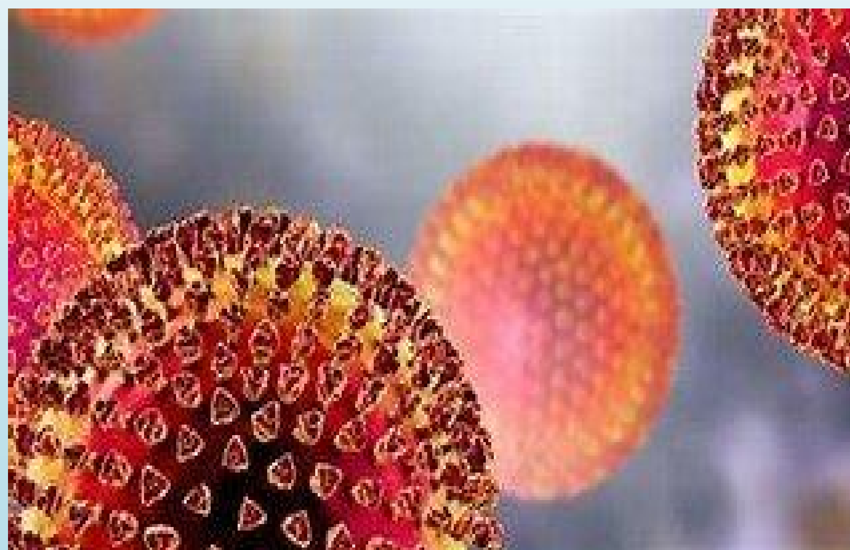
- The FTSU Guardians will support the Board of Directors to review the self-assessment review tool to reconsider any areas for further improvement.
- To promote the importance of strengthening a Speaking Up culture through a variety of methods supported by leaders across the organisation.
- To review the role of the Speak Up Ambassadors, gain feedback to understand if and how the role should be developed.
- To strengthen the work with the Equality Lead and continue to support the shared network approach to strengthen the voice of people with protected characteristics in relation to the Speak Up agenda.
- FTSU Guardians to support the work of organisational development to understand the matters which contribute to related areas highlighted in the staff survey.
- For the FTSU Guardian to regularly attend the staff side partnership group meetings.
- To review the processes to enhance the opportunity to gain feedback from people who have spoken up.

Cheshire and Wirral Partnership
NHS Foundation Trust

Infection Prevention and Control

ANNUAL REPORT

2019-20



Document Reference (2019 - 2020)

Report to: Board of Directors
Date of Meeting: 29.07.20
Title of Report: Infection Prevention and Control (IPC) Annual Report 2019-2020
Action sought: For Approval
Author: Helen Pilley, Nurse Consultant, Head of IPC
Contributing Authors: Helen Davies
Presented by: Victoria Peach, Director of IPC

Strategic Objective(s) that this report covers:

SO1 - Deliver high quality, integrated and innovative services that improve outcomes
SO2 - Ensure meaningful involvement of service users, carers, staff and the wider community
SO3 - Be a model employer and have a caring, competent and motivated workforce
SO4 - Maintain and develop robust partnerships with existing and potential new stakeholders
SO5 - Improve quality of information to improve service delivery, evaluation and planning
SO6 - Sustain financial viability and deliver value for money
SO7 - Be recognised as an open, progressive organisation that is about care, well-being and partnership

Distribution

Version	Name(s)/Group(s)	Date Issued
V1	Infection Prevention & Control Sub Committee	22nd July2020
Final	Board of Directors	29th July 2020

Executive director sign-off

Executive director (name and title)	Date signed-off
Gary Flockhart, Director of Nursing Therapies and Patient Partnership	21.07.2020

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1. Introduction

The purpose and content of this annual report is to provide an overview of the Infection Prevention and Control (IPC) activities from April 2019 to 31st March 2020. The report will highlight service achievements and demonstrate compliance and progress made against the priorities outlined in the Infection Prevention and Control Sub Committee (IPCSC) work programme. The Director of Infection Prevention and Control (DIPC) wishes to express thanks to all those who have made a positive contribution to the IPC work programme which is the cornerstone of delivering high quality and safe care.

High standards of infection prevention and control are crucial to reduce and help prevent infection and infection risks, in all health care facilities across Cheshire and Wirral Partnership NHS Foundation Trust (CWP). To support this, the IPC Integrated Service, which consists of the CWP Infection Prevention and Control Team (IPCT) and Cheshire West and Chester (CWaC) IPCT colleagues, continues to strive to prevent all avoidable infections and reduce the risk of resistant organisms across our Health & Social Care footprint. A separate annual report focusing on the IPC work undertaken for CWAC will be presented in the next six month DIPC report to the board.

The team use the CWP values in all areas of their work on a daily basis.

We encourage communication with our staff by being visible in the localities, having link practitioners, providing newsletters and attending key meetings.

We provide person – centred care.

We have the courage to challenge ANY behaviour that puts our services user, carers, visitors or staff at risk.

We are committed to maintaining our professional competence in relation to preventative IPC practice.

We are compassionate in all our contact with patients, carers, colleagues and stakeholders.

We are committed to preventing all avoidable infections.

Below is a brief summary of the IPCT highlights and achievements, and how we continue to raise the profile of both CWP and the IPC Integrated Service.

- **No** preventable Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections within our provider services
- **Collaborative** working with Public Health England (PHE) on health economy Public Health issues and antimicrobial stewardship.
- **Achieving** a zero number of identified cross infection cases in service users or staff (excluding small round structured virus outbreaks or influenza)
- **National** Education Professional and Development Committee secretary role for the Infection Prevention Society (IPS)
- **Active** members of the infection prevention IPS including Mental Health IPS Special Interest Group
- **North West** IPS Communications Officer role until May 2020.
- **North** West IPS and PHE meetings hosted at CWP, raising our profile for IPC
- **Ongoing** succession planning and developmental opportunities within the team including, tuberculosis, antimicrobial stewardship.

- **Collaborative** working across the Trust as Covid 19 emerged as a communicable disease in February 2020.
- **Collaborative** working with Children and Young People Services specifically supporting the Children Centres and improving compliance around Infection Prevention and Control
- **Supporting** national campaigns to raise awareness around, self-care and hydration, hand hygiene, Infection Prevention and Control, recognition of infection and Antibiotic usage.

2. Summary of Director of Infection Prevention and Control (DIPC) reports to the Board of Directors (BoD)

In addition to the annual report the DIPC delivered two half yearly reports produced by the Nurse Consultant and Lead Nurse. During 2019/20, the Board of Directors received these reports in accordance with the business cycle, which also highlighted areas of good practice and areas requiring development. The approval and any recommendations from the Board are communicated directly to the DIPC.

3. Care Quality Commission (CQC)

The CQC assess IPC standards against the Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance (Department of Health, 2015). During the CQC visit to the Trust in 2019 there were no major concerns identified in relation to IPC. The IPC assurance framework for 2019/20 demonstrates full compliance with the Code of Practice standards and this includes Water Safety and Antimicrobial Stewardship.

4. Infection Prevention and Control (IPC) governance

The IPCT continues to have a high profile within Clinical Services and Support Services across the CWP footprint.

4.1 Infection Prevention and Control subcommittee (IPCSC)

The IPCSC reports directly to the Quality Committee (QC), and is chaired by the DIPC or Nurse Consultant. Meetings take place four times per year. All care groups are members of the IPCSC are represented at these meetings. Assurance reports are provided bi-annually inclusive of this annual report.

4.2 The IPC Integrated Service

The structure of the IPC team enables an efficient service and response across the care groups and all CWP teams within mental health, learning disabilities and harm reduction services. The DIPC has overall accountability for the IPCT, which is led by the Nurse Consultant and supported by a lead nurse, a specialist nurse and two IPC nurses. In line with the Five Year Forward View, the team is working alongside the newly formed Care Groups. This will continue to evolve and include the Integrated Care Partnership during 2020-21.

During the period the IPCTunderwent a Management of Change process following the retirement of the the Nurse Consultant. This process ensured that a strong management structure remained in place whilst allowing for development and succession planning within the team.

The CWP IPCT have been commisioned to provide the IPC and tuberculosis nursing service (TBNS) across the Cheshire West and Chester health economy footprint since 2014.. The annual report for this service can be located in appendix 1. The DIPC is also pleased to report that during the period this report covers CWP were awarded the tender for the IPC and TBNS contract for the Cheshire East health economy by Cheshire East council. The service went line on April 1st 2020. CWP therefore now provide IPC services across the whole of Cheshire CCG. We look forward to developing a system wide proactive IPC service across the whole of Cheshire CCG .

5. CWP's commitment to IPC 2016 -2020

This document continues to be very much a working strategy until the close of 2020. The commitment outlined supports the person centred framework and the on-going IPC achievements to reduce and prevent avoidable healthcare-associated infections. The Board of Directors receives regular progress reports on the initiatives that are in place. The key objectives and plans for monitoring improvement are highlighted within the commitment and this is supported by the IPCSC work programme and assurance framework.

This commitment supports effective and meaningful infection prevention and control practice of all employees within CWP. It also ensures that effective measures for prevention and control of infection are integrated into the trust core business, planning and delivery.

5.1 IPC Link Groups

Matrons and IPC link practitioners throughout CWP are supported by the IPCT to deliver the IPC agenda locally. IPC link practitioner groups are well embedded in each locality. These groups meet on a quarterly basis and provide a forum to cascade and disseminate key IPC guidance and updates to operational staff. An education element is also incorporated to ensure continuing professional development (CPD). Updates, in between the quarterly meetings, are provided via monthly newsletters, newsfeeds, CWP communications and social media platforms such as Twitter.

5.2 Refurbishments and New Builds

The IPCT provide advice and support during refurbishments and new builds across the trust, including advice for primary care premises to ensure ongoing compliance with national guidance, statutory regulation and the audit programme. The IPCT continue to work in partnership with CWP Estates Department in relation to any plans and works carried out within CWP, thus demonstrating compliance with Hospital Building Note 00-09. This close collaboration ensure best use of Trust resources whilst ensuring our staff, service users and visitors have the best possible environment to work and have care provided in within the available resource.

5.3 Safe systems to prevent needle stick and exposure incidents

The IPCT review all incidents to reduce risk, strengthen good practice in relation to needle stick injuries (NSI) and learn from incidents and near misses. The IPCT have provided training and posters to all staff which are designed to inform and to support safer processes. This approach aims to protect both staff and patients from the risks of needle stick injuries.

5.4 Outbreaks

All IPC incidents and outbreaks are routinely reported to the IPCSC and the quality committee, ensuring relevant information and good practice is shared and action plans developed where required. A focus of the IPCT is to prevent outbreaks and if they do occur, to identify them promptly, thus reducing the impact of the outbreak on service users and staff and protecting their health and wellbeing. Below is a summary of outbreaks of potentially communicable disease in CWP inpatient areas during 2019/20. The DIPC is pleased to report that there were no occasions during these incidents where nosocomial transmission occurred.

	East	West	Wirral
Number of outbreaks	1	2	0
Outbreak cause	Diarrhoea and Vomiting	Norovirus Diarrhoea	NA
Average number of patients affected per	7	5	NA

ward			
Average number of staff affected per ward	4	7	NA
Average number of days ward closed	7	7	NA

In order to learn from experience in a timely manner, post-outbreak meetings are held for CWP inpatient areas within 5 working days of the end of an outbreak. These meetings include IPC Nurse, ward manager, modern matron, clinical lead and facilities manager where appropriate. Learning from these outbreaks is given as feedback to the teams and informs future outbreak management.

5.5 Hand Decontamination

Hand hygiene remains the cornerstone of the IPC practice. When optimally performed, hand hygiene reduces nosocomial transmission of infection and antimicrobial resistance. The IPCT continues to actively promote hand hygiene at all available opportunities including via observational activities in the workplace, Trust induction and at all other opportunities.

As the importance of hand hygiene has increased in profile the quality the sophistication of hand hygiene products has improved. The IPCT work alongside the Facilities Department and Procurement to ensure cost effective and fit for purpose hand hygiene facilities and products are accessible to all CWP staff, patients and visitors in all of our premises.

6. Education

6.1 Induction and Essential Learning (EE1)

The IPC team have facilitated 12 Induction sessions during 2019-2020 in addition to EE1 sessions (Essential Education). During 2019-20 the IPC team have been working in conjunction with Education CWP to ensure we are offering the right training to the right staff to improve overall compliance. As a result, from April 2019, non-clinical staff now complete e-learning triennially; as of September 2020 all patient facing clinical staff now undertake annual e-learning training in IPC, it is hoped this will make the training easier to access and help improve compliance.

The team strive to improve accessibility to training by providing targeted sessions in low compliance areas and attending key clinical meetings. Throughout the period of this report, the IPC sessions consistently scores “good” or “excellent” in feedback from participants.

6.2 Continuing Professional Development of the IPC team during 2019 - 2020

In addition to the completion of organisational training requirements, the IPC team attend relevant local, national workshops and conferences, including national and regional Infection Prevention Society (IPS) conferences.

Other than two new IPCT members the rest of the team hold recognised infection prevention and control qualifications at BSc level and the lead and nurses are working towards their MSc programmes. The new recruits are hoping to commence recognised IPC training programme during 2020/21

One member of the team has undertaken the CHALLENGE course in-house and one of the IPCT secretaries completed a NVQ in Business and Administration Management.

7. IPC Audits

During the period this report covers, the team carried out audits on all inpatient clinical areas, community based clinics across all localities, health centres, and three GP practices**.** All inpatient areas have achieved above the compliance score of 93% during 2019/20.

All Children Centres including both hub and link sites, were added to the audit programme in 2019/20 all are compliant as a result of an extensive support mechanism put in place in order to significantly improve compliance.

In Central and East three clinic settings in the community that are used for clozaril clinics did not achieve compliance predominantly down to environmental concerns that are being addressed with Facilities. The team are working with the services enabling access to spillage kits and appropriate use of sharps bins.

There has been a noted compliance improvement in some of the Trusts community settings including clinics, children centres and GP practices following an intensive IPC support mechanism being put in place. These areas are now compliant with the required IPC standards.

Following a CQC visit at the start of 2020 to one of the Trusts community clinics where dressing clinic takes place concerns were raised regarding cleanliness and cleaning schedules. CWP's facility department and IPC team worked closely with the external cleaning company to ensure cleaning was of a high standard. One of the IPC nurses is linking in with the services to ensure an appropriate cleaning schedule is now embedded in practice.

Results and action schedules are reported back to the ward manager, matron, service leads, estates and facilities managers. Where areas of good practice are noted and appropriate actions regarding areas of concern are highlighted, an update of feedback regarding progress of the actions is requested within one calendar month. Audit scores are reviewed and discussed at IPCSC and documented on the risk register if necessary. Improvement requirements will be reviewed within three months of the audit by the IPCT.

8. Health Care Associated Infection (HCAI)

MRSA - there were no cases of MRSA Blood Stream Infections assigned to CWP during the period this report covers.

Clostridium difficile - two cases were assigned to Westminster surgery and three to CWP inpatient services on Cherry and Juniper. A Root Cause Analysis (RCA) was completed for each case. Learning identified from the RCAs included protein pump inhibitor (PPI) prescribing and antibiotic exposure. This learning highlighted the ongoing need to work closely with staff around recognition of infection and appropriate antibiotic prescribing in line with the Trust's antimicrobial resistance work.

Quality Premium - Gram Negative Blood Stream Infections (GNBSI)

There is a national ambition to reduce healthcare associated gram-negative blood stream infections by 50% by March 2021. This is supported by the Quality Premium for Clinical Commissioning Groups (CCG), which has also set a reduction ambition of 10% in all E. Coli blood stream infections reported at CCG level, by 2019/20.

Following the implementation of an improvement plan, work has developed across key areas that could result in this type of infection, including;

- Catheter care
- Management and treatment of patients presenting with a urinary tract infection
- "To dip or not to dip" training across inpatient areas
- Appropriate antimicrobial prescribing

- PICC line management
- Chronic wound care management

This target remains a challenging ambition as it has been recognised that to achieve it a multi-agency response is required which includes public health initiatives such as encouraging hydration to prevent the occurrence of infection and promote health and well-being. During 2019 a Health Economy IPC group was created to bring practitioners together from across the health economy to address these complexities. The group has so far achieved improved communications between partner agencies such as domiciliary care as previous analysis of data evidenced that the majority of those affected by GNBSIs did not have any healthcare provider input.

9. Surveillance and Zero harm

The key items for CWP community services are the surveillance and identified risks associated with Pressure Ulcers, Wounds, Urinary Catheters, PICC and Hickman lines.

The Care Community Teams hold their own database of patients with Urinary and Suprapubic Catheters in the community, where patients are under the care of the Care Community Teams. The IPCT offers advice and guidance where appropriate and supports the teams to consider the suitability of the catheterisation and to consider a trial without catheter. The nursing teams are advised to use the 10 week catheter pathway, which has recently been updated in line with national guidance and support from the Community Continence & Urology Service.

Aseptic Technique training is provided via an e-learning package and the policy has recently been updated.

The IPC nurses continue to be visible across the Trust and work within the Care Groups to provide information and expert advice and guidance. The IPCT have had numerous face to face interactions with staff and service users throughout the year and including a large number of telephone contacts across the Trust.

For inpatient settings the IPCT continue to promote the adherence of MRSA screening of service users admitted to a CWP inpatient setting in accordance with national guidance this includes

- from another healthcare provider
- service users with an invasive device e.g. catheter or wound/breaks in the skin

Catheter Associated Urinary Tract Infection (CAUTI)

The IPCT continue to support the Trust response to the implementation of NICE guidance EPIC 3 (2014) and CQC requirements with regards to Catheter Associated Urinary Tract Infections. This has included the continuing monitoring of all catheterised patients in the community setting with CWP input, on average 250 patients, and offering support through, training, zero harm meetings, link meetings, communications (newsfeeds/newsletters), and updating the 10 week catheter pathway in line with new/updated guidance.

Skin-Tunnelled Central Catheter (Hickman) and Peripherally Inserted Central Line (PICCs)

The IPC service have worked collaboratively with other healthcare providers across the West Cheshire footprint on the development of guidance and competencies to support these devices, based on national guidance including NICE and EPIC 3. Patient information leaflets are available and in use, providing support and advice to both patients and carers. The IPCT continue to ensure best practice is in place in relation to these devices and the prevention of infection.

10. Sepsis

Sepsis is a life threatening medical emergency. It occurs when a patient's immune system over responds to an infection resulting to damage to the body's own tissues and organs. The UK Sepsis

Trust estimates that there are approximately 245,000 cases of sepsis on the UK per annum, resulting in around 48,000 deaths. CWP implemented a Sepsis Care Improvement Programme to improve the identification of sepsis in CWP inpatient and community services in 2018. This work was due to conclude in Quarter 4 of 2019/20, however, due to the emergency response to Covid 19 this piece of work will conclude in quarter 2 of 2020/21 with a roll out of the improvement programme to the Starting Well service and Health Facilitators.

11. Influenza Immunisation Activity

Members of the IPCT completed training to support the annual staff influenza vaccination campaign during 2019/20. The team has worked in partnership with the Workforce Wellbeing team to deliver the vaccine across all localities**.** CWP reached a total of 71% of face to face staff vaccinated.

For 2020/21, the national CQUIN targets for Health & Wellbeing of Staff in the NHS continue and the flu immunisation target for all Trusts will be 85% of all face to face staff to be vaccinated for flu by the end of February 2020. Planning for the 2020/2021 campaign has begun and the IPCT will continue to support the Workforce Wellbeing team in their delivery and will also support with the immunisation update training.

12. Antimicrobial Resistance (AMR) Strategy and CWP work

AMR has risen over the last 40 years and the inappropriate use of antimicrobials is a key contributor to this increase. The consequences of AMR include increased treatment failure for common infections and decreased treatment options where antibiotics are vital. Without effective antibiotics even minor surgery and routine procedures could potentially become high risk procedures. Antimicrobial stewardship is crucial in combating AMR and is an important element of newly published documents to include: The NHS Long Term Plan; Contained and controlled: The UK's 20 year vision for antimicrobial resistance published in January 2019 and Tackling antimicrobial resistance 2019-2024:The UK's five-year national action plan also published in January 2019.

By 2040, the government's vision is of a world in which antimicrobial resistance is effectively contained, controlled and mitigated. There are approximately 700,000 deaths around the world each year as a result of antimicrobial resistance. The UK's 20 years vision for antimicrobial resistance highlights that at least 20% of all antibiotic prescriptions in primary care are inappropriate and if no action is taken there will be 10 million deaths globally by 2050 attributed to AMR

The UK's five year national action plan focuses on 3 key areas:

- Reducing need for and unintentional exposure to antimicrobials
- Optimising use of antimicrobials
- Investing in innovation, supply and access to tackle AMR

The IPCT and CWP Pharmacy team have incorporated the principles of the UK's five year national plan into their AMR strategy to ensure that AMR remains a high priority within the Trust and antimicrobial stewardship represents an organisational and system-wide approach to promoting and monitoring the prudent use of antimicrobials by ensuring:

- Good infection prevention and control measures
- Quick and appropriate diagnosis of infection
- Appropriate use of antimicrobials
- Optimising therapy for individual patients;
- Minimising the development of resistance at patient and community levels

The IPCT are working collaboratively with the Trusts Pharmacy Department to ensure the Trusts prescribers are aware of local antibiotic guidelines and formulary and that they adhere to that formulary unless it is clinically indicated otherwise. During the period of 2019/20 there have been some areas of non-compliance to formulary. The IPC and Pharmacy teams are working collaboratively improve engagement with prescribers and increase compliance to antimicrobial prescribing during 2020/21.

Inpatient services antibiotic audits 2019/20
During 2019/20 antibiotic prescribing on the inpatient wards is audited for compliance with West Cheshire CCG (WCCCG) Antimicrobial Prescribing Guidelines which were reported quarterly at IPCSC and MMG with the exception of quarter 4 as the pharmacy department had invoked their business continuity plan in February. The most common infections treated on the CWP inpatient wards are urinary tract infections, respiratory infections and skin infections:

The quarterly audit was amended this year to a quarterly deep dive collecting one week of data in order to address the four key areas of adherence to formulary, appropriateness of the antibiotic, documentation of a stop date and the indication stated on the prescription. In general adherence is good in all areas and compliance with formulary was demonstrated.

GP OOHs and CWP GP practices antibiotic audits 2019/20
Similarly to the inpatient audits a week long deep dive audit was employed for each quarter to gain a better understanding of adherence to the formulary choices. This compromised reviewing the list of all medicines on *Adastra* issued by GP out of hours during a 7 day period. All antimicrobials were identified and each patient's notes were reviewed and the findings recorded on the audit tool. This demonstrated that there was 62% adherence to formulary in Q1 which rose to 70% adherence by Q2. Due to business continuity plan being enacted by the pharmacy team audits were not conducted during Q3 and Q4.

The Advisory Committee on Antimicrobial Prescribing, Resistance and Healthcare Associated Infection (APRHAI) has agreed antimicrobial prescribing quality measures for primary care. Two key prescribing comparators are available:

- Total number of antibiotics prescribed per STAR-PU (West Cheshire avg= 0.958)
- Co-amoxiclav, cephalosporins and quinolones as % all antibiotic items (target to be less than 10%)

Surgery	Total number of antibiotics prescribed per STAR-PU	Co-amoxiclav, cephalosporins and quinolones % items
Old Hall	1.492	9.1
Westminster	1.014	11.1 (12.88 previous year)
Willaston	1.012	9.2 (9.33 previous year)

Figure 4: table showing total number of antibiotics prescribed per STAR-PU and Co-amoxiclav, cephalosporins and quinolones as % all antibiotic items

All GP practices have a higher number of antibiotics prescribed per STAR-PU compared to the West Cheshire CCG average of 0.958. Westminster and Willaston have reduced the amount of co-amoxiclav, cephalosporins and quinolones prescribed although Westminster is still above the national target. Actions are being taken to address the prescribing at Westminster practice.

13. Estates Department Report

Estates department activity is essential in delivering the IPC agenda, and is delivered under the principles outlined in two main documents:

1. Health Building Note 00-09 and covers the importance of a clean, safe environment for all aspects of Healthcare.

2. The Department of Health (DH) Health Technical Memorandum (HTM) 04-01 (2016), Safe water in healthcare premises.

The Estates department manages Water Safety to HTM 04-01 with the implementation of a Water Safety Plan, Operations Manual, and a Water Safety Group.

For CWP this Water Safety Group is covered via our monthly Statutory Standards Departmental meetings where Legionella is discussed and reviewed and the quarterly Infection Prevention and Control Sub Committee meeting (IPCSC). Both meetings consist of a variety of personal with a range of competencies. We also engage with an independent Water Safety Authorising Engineer who gives expertise and guidance to our policies and procedures.

Legionella compliance with legislation

The control of legionella is covered by the legal requirements of the Health & Safety at Work Act 1974 concerning risks from exposure to legionella and guidance on compliance with the relevant parts of the Management of Health and Safety at Work Regulations 1999.

Legionella is managed and controlled by the estates department, which continues to employ the services of ZetaSafe Ltd, who provide professional monitoring software for statutory legionella temperature monitoring. The department also employs various contractors to undertake legionella risk assessments on Trust properties where required. There is a three monthly review of test results, control measures and procedures to ensure compliance with current legislation and these results are published at the Infection Prevention Control Sub Committee.

Estates Operational Service continually undertake statutory legionella temperature monitoring tests throughout the Trust estate, during April 19' – March 20' a total of 17,039 temperature tests were undertaken. The annual test result report records an overall compliance level of 97.05% which is above the department's target of 90%. Tests recorded not meeting the required standard was 2.95% and therefore automatically triggered remedial work to ensure compliance moving forward.

Capital programme Works

Whilst the capital programme only includes limited projects, specifically aimed at addressing IPC, all new build and major refurbishment projects are designed in full accordance with the latest Building Regulations, and British Standards together with the latest HTM guidance specifically in relation to Infection Prevention and Control and with consideration to the IPC audits.

All projects, both new builds and refurbishment, include advice from the IPC team which reflects the latest Health Building Note 00-09 (Department of Health, 2013) which states 'the infection prevention

and control (IPC) team should be consulted throughout every stage of a capital project and their views taken into account.'

14. Facilities Service and Waste Report

Facilities Service and Waste Report
CWP operational cleaning services are led via the Estates & Facilities services structure and the Facilities management team are responsible for implementing the trusts cleaning strategy.

The Facilities Management (FM) function has teams in each locality that report through a structure of managers and supervisory staff members, who are responsible for the co-ordination of services and monitoring of standards in all trust areas in line with National Standards of Cleanliness (2007).

We are awaiting the new guidance from NHS Improvement to align the trusts cleaning and decontamination policy to the 2020 standard. .

CWP Facilities services are predominantly provided in-house, this helps to ensure that services provided by the FM team are linked to the needs of Care Groups. There are a number of locations within CWP that are outsourced. This is only where operationally and commercially practical and there are robust monitoring systems in place to ensure the quality of service provided is the same as the in house team. There are a few buildings where FM services are provided by the landlord to the building and unfortunately we do not have control of the domestic services for these locations.

Monitoring Arrangements for CWP in house cleaning service
Within 2019 – 2020 the FM service have looked to improve the evidence based assurance on the standards of internal environment and cleanliness within CWP's inpatient areas and clinical areas - including community premises. As a result we have invested in an audit software MPRO5 to enable more effective assurance in real time.

Current systems for ensuring that CWP's internal environments continue to meet the required standards:

- Appropriately trained Domestic staff members supported that all receive a high level of internal training to meet the needs of the clinical services.

- CWP FM have invested in appropriate technology to support the department and provide assurance moving into 2020 – 2021

To monitor compliance in relation to cleaning standards, CWP operate a monitoring system that covers all current factors (49) as set out in the National Standards of Cleanliness 2007 approved code of practice.

The overall targets and achievements for cleanliness for all CWP areas for period 2018 - 2019 are listed below (again based on NSC risk ratings):

RISK LEVEL	TARGET RESULT (as set out by National Patient safety agency)	CWP Result
High Risk	95%	98.59%
Significant Risk	85%	91.80%
Low Risk	75%	99.41%

This information is taken from an average of all paper audits completed within 2019-2020

The Facilities management team cleanliness monitoring is supported by monthly Modern Matron walk-rounds that are attended by a senior member of the FM team to undertake a joined up approach with clinical services and address any issues patients or clinicians have with the Facilities services including the environment, this is then actioned by the relevant departments. We have amended these to include IPC nurses to every other visit to increase the support available ensuring the multi-disciplinary team are linking with key individuals within care group operational nursing teams.

CWP FM attends all inpatient IPC audits where possible. Areas for action are addressed mostly at the time of audit all other actions are done immediately following the inspection. The facilities team continue to have a good working relationship with all members of the IPC team, taking a collaborative approach to ensuring CWP's environments meet all required standards.

It is recognised that CWP have maintained assurance on cleaning standards using the current system however the push to implement the new technology MPRO5 is essential to provide a more robust real time assurance and remove unwarranted variation. .

Waste Management

The continued programme of central recycling points are situated in high concentration staff areas across CWP continues to be successful, working with CWP Estates project teams to ensure that these strategies are factored as part of redesign of buildings is helpful and ensures there success.

The Facilities team have reviewed all of our outsourced waste contracts within 2019 – 2020 and aligned these to the overall Cheshire and Merseyside HCP. This has also enabled more effective reporting on waste volumes as we have reduced our supplier base and ensured that the new contracts have reporting in a usable format to enable improvement to be made.

The green plan for Cheshire & Wirral Partnership is under review and will be completed within 2020, this plan will include a review of waste management to alignment with overall waste reduction strategies and investment in "green" projects to support the NHS targets.

Waste auditing

The CWP Waste audit system is designed to assess compliance with the requirements of Department of Health guidance document Safe Management of Healthcare Waste and to also ensure that waste segregation standards meet the requirements for waste handling and storage.

A programme of 6 monthly waste audits is undertaken twice yearly by Domestic community supervisors. The Waste audits submitted by Facilities domestic supervisors are underpinned by a Waste Audit Schedule maintained by the local Facilities Managers, which notes any issues / incidents and outcomes. The waste audit tool covers; Waste provision overview; Segregation procedure; Types of waste produced; Personal protective equipment; Bin sizes and condition; Storage.

Waste audits form part of the planned programme of waste management and any issues or outstanding actions is followed up by the Facilities Managers or Senior Facilities management. The Infection prevention and Control Team are included in any communications and any issues raised we work together to ensure that these are resolved as quickly as possible minimising any disruption to clinical service.

Where appropriate a full pre- acceptance waste audit is carried out by the Waste Manager to assess all types of waste and disposal methods. Thereafter audits are completed as part of the cleanliness monitoring by domestic supervisors at all sites.

15. Covid-19

On 31.12.19 The World Health Organisation was informed of an outbreak of cases of pneumonia in Wuhan, China. The organism causing this respiratory illness had not previously been identified; subsequently it was identified as novel coronavirus, SARS-CoV-2. Whilst cases were initially confined to China, sustained transmission was soon reported across the globe with NHSE declaring a level 4 incident on 04.03.20. However, prior to this date the IPCT were already part of the Trust's tactical command group (TCG) and were manging an unprecedented and unpredictable increase in workload. The IPCT adapted quickly to this new set of circumstances and working as one team have worked with Trust colleagues, PHE, the CCG and local authorities to deliver the safe care as quickly as possible whilst working with rapidly changing guidelines. The emergency response continues beyond the period this report covers so further detail will be provided in the 2020/21 annual report and forthcoming quarterly reports.

16. Conclusion

Infection prevention and control remains a priority for CWP. The IPCSC and IPCT continue to maintain and improve on the application, conservation and development of IPC standards. The Trust is committed to working towards excellence in IPC practice to help prevent avoidable infections in our patients including wound and urinary tract infections. When infection does occur, this is recognised early and treated appropriately in line with local antimicrobial guidance. AMR remains a high priority within the Trust and antimicrobial stewardship represents an organisational and system-wide approach to promoting and monitoring the prudent use of antimicrobials.

This report highlights the partnership working and continuous improvements within IPC during 2019/20 and the key priorities for 2020/21 alongside the ongoing response to Covid-19.

17. Work Priorities for 2020/21

- Maintain compliance and assurances with the Health and Social care Act (2015)
- Promote hand hygiene week in May 2021
- Deliver a quality IPC Education event to CWP staff in Q4
- Actively support the staff influenza campaign to achieve 85% uptake in face to face staff

- Undertake a Trustwide mattress audit
- Improve compliance to anti-microbial prescribing using Quality Improvement Methodology
- Develop health economy wide infection prevention and control group across West Cheshire and align IPC with the 10 year NHS Plan.
- Develop a robust systems and processes within the IPC team to manage COVID-19 patient cases and outbreaks

18. Recommendations

The Board is asked to note the Infection Prevention and Control Annual Report for 2019/20 and the work priorities for 2020/21.

19. Appendices

Appendix 1
Glossary

Antibiotic Formulary
A list of approved antibiotics based on evaluations of efficacy, safety, and cost-effectiveness of drugs based on population trends

Antimicrobials
Antimicrobials are substances which are used in the treatment of infection caused by bacteria, fungi or viruses

Aseptic Non Touch Technique
Aseptic Non Touch Technique or ANTT is a tool used to prevent infections in healthcare settings

Assurance Framework
A system for informing their parties that a process of due diligence is in place to assure safety and quality exists within that setting

Audit
Audit is a quality improvement process that aims to improve service user care and outcomes by carrying out a systematic review and implementing change. This is not necessarily complex and in its simplest form shows compliance with a single protocol. Its value is in showing improvement or maintenance of a high standard. Once an audit has been completed and actions taken, repeating the audit will complete the audit cycle

Benchmark
A standard or point of reference against which, things may be compared

Best Practice
A best practice is a method or technique that has consistently shown results superior to those achieved with other means, and that is used as a benchmark

Board
A Board (of Directors) is the executive body responsible for the operational management and conduct of an NHS Foundation Trust. It includes a non-executive chairman, non-executive directors, the chief executive and other executive directors. The Chairman and non-executive directors are in the majority on the Board

Clostridium Difficile Toxin
This is a type of infectious diarrhoea caused by the bacteria Clostridium difficile

CareNotes
The main clinical electronic care record, used within CWP

Carers
Person who provides a substantial amount of care on a regular basis, and is not employed to do so by an agency or organisation. Carers are usually friends or relatives looking after someone at home who is elderly, ill or disabled

Catheter Associated Urinary Tract Infection – CAUTI
Catheter associated urinary tract infections comprise a large proportion of healthcare associated infections and can occur whether a person has either a short-term or a long term catheter

Clinical Commissioning Group – CCG
Clinical Commissioning Groups are groups of GP's that are responsible for designing and commissioning / buying local health and are services in England

Care Quality Commission – CQC
The Care Quality Commission is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations

Colonisation
Where an organism is present on, or within a person's body but without signs or symptom of disease

CPE - Carbapenemase-producing Enterobacteriaceae
Carbapenems are one of the most powerful types of antibiotics. Carbapenemases are enzymes (chemicals), made by some strains of these bacteria, which allow them to destroy carbapenem antibiotics and so the bacteria are said to be resistant to the antibiotics

Cross Infection
Cross infection is the transfer of harmful microorganisms. Bacteria and viruses are among the most common. The spread of infections can occur between people, pieces of equipment, or within the body

CSU
Clinical Support Unit which supports the CCG's

CWP footprint
This is the geographical areas that CWP provide healthcare to its populations

CWaC
Cheshire West & Chester local authority

DATIX
An electronic record for reporting incidents

Decolonisation
A method to temporarily or permanently eradicate the body from an organism that is colonising either skin or tissue

Decontamination
The combination of processes (including cleaning, disinfection and sterilisation) used to make a reusable item safe for further use on service users and for handling by staff

DH
Department of Health

DIPC - Director of Infection Prevention and Control
An individual with overall responsibility for infection control and accountable to the registered provider in NHS provider organisations

EE1
Essential learning which is Mandatory

ESBL
Extended Spectrum Beta Lactamase
HCAI
Health Care Associated Infection

Health and Social Care Act 2008 - The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance.
The guidance and standards used as Part of Regulation 12 and 15 in relation to the CQC standards health providers are assessed against

Healthcare
Healthcare includes all forms of care provided for individuals, whether relating to physical or mental health

Infection
Where the body is invaded, by a harmful organism (pathogen), which causes disease or illness

IPC link practitioners
The Infection Prevention and Control Link Practitioner (IPCLP) will act as a resource and role model in their designated area of work and will liaise with the Trust's Infection Prevention and Control Team (IPCT). The role will help to create and maintain an environment that is safe for service users, visitors and staff

IPCIS
Infection Prevention and Control Integrated Service

IPCN (S)
Infection Prevention and Control Nurse (Specialist)

IPCSC
Infection Prevention and Control Sub Committee

IPCT
Infection Prevention and Control Team

IPS
Infection Prevention Society

LD
Learning disabilities

MDG
Medical Devices Group.

MH
Mental Health

MMG
Medicines Management Group

MRSA
Meticillin Resistant Staphylococcus Aureus

MRSA Bacteraemia
Meticillin Resistant Staphylococcus Aureus infection which enters the patients' bloodstream

Multi Resistant Organisms
Organisms that have a resistance to several groups of antibiotics, typically oral

NSC
National Standards of Cleanliness

Patient, also called Service User

PH
Physical Health

PHE
Public Health England

PLACE
Patient Led Assessment of the Care Environment

Post Exposure Prophylaxis – PEP
Treatment following exposure to prevent further infections or symptoms

Post Infection Review – PIR
A process which allows organisations to understand areas requiring improvement in the patient care pathway, and more importantly, identifies and targets actions to minimise the chance of recurrence for future patients for MRSA Bacteraemia

Root Cause Analysis - RCA
A process which allows organisations to understand areas requiring improvement in the patient care pathway, and more importantly, identifies and targets actions to minimise the chance of recurrence for future patients for Clostridium Difficle Toxin Positive cases

Safety Metrics
A measurement of practice to give assurance and identify gaps

Service User
Anyone who uses, requests, applies for or benefits from health or local authority services

Standard Operating Procedure (SOP)
Standard operating procedures (SOPs) are written instructions intended to document how to perform a routine activity. Many Trusts rely on standard operating procedures to help ensure consistency and quality in their products.

Surveillance
Infection surveillance is the continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of infection prevention and control practice. Such surveillance can serve as an early warning system for impending multi

resistance or increase in emergence of newer organisms, and allow the team to respond appropriately supporting the health care structure for our population

Trajectory/Ambition
A figure dictated by Gov.uk in relation to HCAI performance

UTI's – Urinary Tract Infection
An infection of the Urinary Tract that can be upper or lower and complicated or uncomplicated causing symptoms**.**

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Medicines Management & Optimisation Annual Report 2019-20
Agenda ref. number:	20.21.20
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/07/2020
Presented by:	Chief Pharmacist & Associate Director of Medicines Management

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

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 Medicines Management Annual Report for 2019 – 20 describes the progress with the Trust's journey towards improved medicines optimisation as well as providing assurance with the framework for medicines governance across the Trust.

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

This report provides a summary of the activity and progress that has been made by the Medicines Management Group (MMG) and the Pharmacy Team against the group's annual business cycle and the pharmacy team's quality improvement priorities.

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

The progress, achievements and challenges over 2019 – 20 relating to Medicines Optimisation have been highlighted and assurance is provided of the underpinning mechanisms across the Trust to provide high quality, effective and safe services relating to medicines.

A key focus of the work over the past year has been around a continuous improvement in patient safety through learning from incidents and understanding how we can improve our internal processes to ensure we minimise potential harm from medicines. Innovation of the workforce through scoping out new ways of working and delivering a patient centred service has also been key and is aligned with the recommendations of the 10 year NHS plan and the Carter recommendations for mental health services. Further development of the pharmacy workforce as a key player in multidisciplinary teams across community as well as inpatient services is anticipated to continue to be a key feature during 2020-21 but requires workforce investment in order to realise this.

Much has been achieved over 2019-20 and there is much more to do over the coming years to continue to build on previous years' high standards in pharmaceutical care, including the continuous strive for excellent patient care, innovation and value from medicines.

The report was discussed and approved at Quality Committee on 08/07/20.

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

Board of Directors is asked to discuss and approve the Annual Report.

Who has approved this report for receipt at the above meeting?	Dr A. Sivananthan, Medical Director Quality, Compliance & Assurance
Contributing authors:	Fiona Couper, Jasmeen Islam, Hazel Sharp, Julie Orton, Other members of the Pharmacy Team & MMG membership.

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	MMG Quality Committee Board of Directors	30/07/20 08/07/20

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

Appendix No.	Appendix title
1	Medicines Management & Optimisation Annual Report 2019-20

#cwpQI

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Medical Workforce Annual Report 2019-2020
Agenda ref. number:	20.21.21
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/07/2020
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.	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*

Each year designated bodies had been required to complete an Annual Organisational Audit (AOA) on appraisal and revalidation in order to gain an understanding of the progress made during the last year and assure Responsible Officers and Executive Boards as well as NHS England, that systems for evaluating doctors fitness to practice are in place, functioning, effective and consistent.

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

This year, due to the Covid crisis, the AOA submission was not required. A report had been compiled for the board's information containing the annual figures and information for 2019/2020.

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

36 recommendations to revalidate were made to the GMC between 1/4/2019 and 31/3/2020. All recommendations were completed on time.

CWP have 108 doctors for whom Dr Alam is the RO: 91 Consultants and 17 SAS doctors.

We have 29 medical appraisers. And CWP in now able to provide helpful and constructive feedback to these following the Quality Assurance Panels.

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

For the Board of Directors to discuss and approve the annual report and statement of compliance.

Who has approved this report for receipt at the above meeting?	
Contributing authors:	Rachel McLoughlin Director of Medical Workforce

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	Medical Workforce Annual Report

#cwpQI

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

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[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

  The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The Board of Directors can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: National AOA submissions were cancelled this year as part of the response to Covid 19. Data regarding appraisals completed within the Trust has been compiled through the electronic SARD system and is outlined in the appraisal section of this report. Action from last year: Distribute checklist for doctors to clarify evidence required in appraisal portfolios and QA framework for appraisers to support completion of summaries. Comments: Checklists shared via the Medical Appraiser Peer Group and through feedback to all appraisers. Action for next year: Seek feedback re uptake and usefulness of checklists.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: Appointed Responsible Officer is Dr Faouzi Alam Comments: The RO continues to attend network meetings and updates relevant to this role. Action for next year: Continue to attend updates, lead Responsible Officer Assurance Group (ROAG) meetings within the Trust, attend quarterly GMC Liaison meetings and meetings with the Medical Appraisal team and Director of Medical Workforce (DoMW) to review and shape governance processes.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes/No [delete as applicable] Action from last year: The Responsible Officer is provided with time and resources, including administrative support and key roles to support the RO function. Comments: Support for the RO role to continue. Action for next year: Support for the RO role to continue.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: CWP uses 3 different systems to ensure an accurate and up to date record of medical staff is maintained.

Comments: GMC connect is used to accept new prescribers when a doctor commences with the Trust. This is used to keep a record of when a doctor is due to be revalidated. The SARD system is used to record all appraisal information and the ESR system is used for all medical staff in employment and this keeps update information regarding a doctors' GMC registration and Sec 12/Ac approval dates.

Action for next year: To ensure accurate and up to date information is maintained.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Review and update policy for Handling Concerns about the Conduct, Capability and Health of Medical Staff.

Comments: Reviewed and updated to incorporate a flowchart delineating steps in the identification and management of concerns. Awaiting Trust approval prior to publication.

Action for next year: All policies have a review date to allow for updates and shaping of information as new guidance and information emerges.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: During 2019 the appraisal team met with a peer network of Trusts in the region to benchmark and shape appraisal processes. We agreed a future plan for peer review audits.

Comments: Agreement was reached regarding a peer review process with neighbouring trusts. A plan for a peer review facilitated by Merseycare during 2020 was suspended in response to the Covid 19 pandemic.

Action for next year: Review feasibility of peer review process in 2021.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: All doctors are supported to collect multisource feedback from colleagues and patients to evidence their practice and meet revalidation requirements. For doctors who have a prescribed connection to another organisation, feedback and information is shared between Responsible Officers. Locum and short term placement doctors meet for supervision with Clinical Supervisors/Clinical Directors on a monthly basis. Any performance concerns identified are managed in line with the Handling Concerns about the Conduct, Capability and Health of Medical Staff policy.

During their time with CWP, these doctors are able to access the in-house CIPD activities including weekly teaching, grand round etc..

Comments:

Action for next year: All doctors new to the trust, including those on short term placements, will be invited to attend appraisal training.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: During this appraisal year:

99 Completed appraisals (category 1)

1 Approved Missed appraisal (category 2)

8 missed approved appraisals in response to Covid 19 (category 2)

91 Consultants and 17 Specialty doctors

Comments: The appraisal team continue to source and upload governance information to doctors' electronic portfolios. We are aware this is an extra burden on the departments who provide it and are grateful for their on-going support.

We continue to review the information required for appraisal, consistent with national guidance, particularly the Pearson Review (2017) which recommended medical appraisal should be a process which is supportive, adds value and is not overly burdensome for doctors.

The need for appraisal to reflect the whole scope of practice has been highlighted during training and Appraiser Peer Group meetings, with an emphasis on the provision of evidence to support these activities.

Action for next year: Plan ahead for the needs of doctors who have had approved missed appraisals this year in response to the Covid 19 pandemic. Ensure that doctors are supported to understand requirements for revalidation and are on track to meet these.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Continue to monitor the appraisal process to ensure that the vast majority of appraisals fall into Category 1 in the coming year. Develop checklists to simplify and clarify the evidence required within portfolios.

Comments: In addition to providing training for new appraisers, and those new to the trust appraisal process, we have also provided "refresher" training for

doctors who we identify may benefit from this. Where required, Clinical Directors work with the Appraisal team and Director of Medical Workforce to provide proactive support to clinicians they line manage.

Action for next year: Plan ahead for the needs of doctors who have had approved missed appraisals this year in response to the Covid 19 pandemic. Amend electronic appraisal platform to allow doctors to continue to input information to their portfolio documentation so that they are prepared for when formal appraisal processes are reintroduced.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: A Medical Appraisal policy is in place. It is reviewed regularly to ensure that it remains compliant with national policy and to allow any amendments/updates.

Comments: The policy was updated during the appraisal year to provide greater clarification of the steps to be taken where the appraisal process does not proceed on time. Revised advice on declaration of interests, gifts and hospitality with links to the corporate registers is included.

Action for next year: Continue to review the policy and amend as required in accordance with guidance and updates.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Identify new appraisers to maintain numbers as a cohort of our most experienced appraisers are due to retire during the next 12 months.

Comments: A number of doctors attended appraiser training sessions held during the year and have now started work as new appraisers in the trust.

Action for next year: Continue to monitor numbers to ensure that we are able to maintain a target of 5 appraisals per WTE appraiser over the year. Discuss whether retire and return doctors would wish to use SPA time to maintain appraiser roles.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Pilot Quality Assurance panel. Continue Medical Appraiser Update Sessions (twice a year).

Comments: Completed QA panel process with positive feedback. Feedback shared with all appraisers.

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[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Action for next year: Use of IT to facilitate Medical Appraiser Update group. Explore options for service user involvement with QA panel.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: QA panel process developed and piloted

Comments: Continue QA panel, following successful pilot. Each appraiser will receive individualised feedback over a 3 year cycle and general feedback of key points is sent to all appraisers annually.

Action for next year: Continue QA process. Explore options for service user involvement with this.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Responsible Officer Assurance Group (ROAG) introduced to review evidence over the 5 year revalidation period and make timely recommendations for doctors in the trust.

Comments: ROAG meets quarterly to review evidence for doctors under notice and complete recommendations.

Action for next year: Continue ROAG meetings. Support doctors whose recommendation dates have been extended because of covid 19 to ensure that they are on track for revalidation.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Introduction of revalidation readiness checklist to support doctors and appraisers to monitor progress towards revalidation annually, identify gaps and a plan to meet these. Contact is made with individual doctors ahead of ROAG and any concerns re readiness are discussed. A letter is sent following the meeting confirming the outcome.

Comments: Checklists are completed as part of the appraisal portfolio. Ahead of the ROAG meeting and notice period the appraisal team contacts doctors individually to check that this information is in place.

Action for next year: Continue utilising checklists, ROAG and feedback processes regarding revalidation readiness and recommendations.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Effective clinical governance delivered through:

Implementation of ROAG meetings to allow revalidation readiness to be reviewed and identification of gaps and concerns ahead of revalidation recommendations. Any gaps are captured early and doctors are supported to identify plans to address these.

Piloting of a Quality Assurance appraisal panel to allow benchmarking and provide assurance regarding appraisal outputs.

Utilising electronic systems for appraisal, job planning and annual leave. E-leave was introduced to assist Clinical Directors by providing them an overview of who in their medical workforce is on leave. It also provides the Trust with an auditable record of doctors leave.

Continued DoMW support to Clinical Directors around medical management and the development and implementation of local action plans to address difficulties.

Comments: In addition to the above actions, the CD Peer Group met regularly during the appraisal year, with some specific sessions focused on finance, IT and recruitment.

Action for next year:

Explore options to increase service user involvement in clinical governance processes in the trust e.g through service user representation at appraisal training and QA panel.

Review the quality of electronic job plans, with a focus on SMART service and individual objectives.

Explore the use of team job planning processes for psychiatrists

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Multisource feedback collected by doctors is now routinely shared with both clinical directors and appraisers to allow triangulation of data, identification of good practice and any concerns, and development of actions accordingly. Clinical directors continue to discuss any performance concerns with doctors they line manage, and develop local action plans to address issues where required. Information regarding concerns is incorporated into doctors' appraisal portfolios for reflection and

discussion around learning with appraisers. Any information is discussed with the relevant doctor first, before being incorporated into the appraisal portfolio.

Comments: All multisource feedback is shared with doctors, their clinical directors and appraisers in advance of appraisal. Doctors are expected to provide a reflection on learning around any performance concerns and are also encouraged to reflect upon success and achievements (what went well and why!)

Action for next year: Seek feedback from clinical directors and the medical appraiser group regarding the effectiveness of these processes in capturing information and providing evidence of reflection, learning and outcomes.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Identify update training for Case Investigators within the trust. The Director of Medical Workforce will continue to link with clinical directors to support them with the identification and management of concerns at an early stage. Review Handling Concerns policy.

Comments: A Case Investigator update training session was facilitated by the trust legal team in the summer of 2019. The Director of Medical Workforce (DoMW) maintains regular contact with clinical directors to support them with the identification and management of any concerns regarding capability, conduct, health and fitness to practice of doctors they line manage. The DoMW undertakes the role of Case Manager for any formal investigation processes within the trust and has undertaken specialist training for this role. The DoMW accesses support and advice regarding the management of concerns from NHS Resolution.

The policy Handling Concerns about the Conduct, Capability and Health of Medical Staff was reviewed and updated in 2019, and is awaiting approval for publication.

Action for next year: Continue to offer support to clinical directors and medical managers focused on staff wellbeing and the identification and management of concerns.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be

Action from last year: Continue to provide data on numbers, type and outcome of concerns, and protected characteristics for review at Board.

Comments: Up until 2019 this data was incorporated as free text in the annual report, which is reviewed at the People and Organisational Development Subcommittee (PODSC) prior to submission to Board.

Action for next year: As the new NHSE Board report proforma does not include space to incorporate this detailed analysis, this will be provided as an addendum to the report.(Please see Appendix 1)

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: CWP continue to request information for all new doctors commencing with the Trust, via a 'Responsible Officer transfer of information form'. This form is also completed for doctors who have left the Trust, once requested from their new employing Trust.

Comments: Although this form does not form part of the Trusts pre-employment checks, the form is sent out to the doctors previous RO before the doctors starts in post.

Action for next year: To provide the board with figures on how many incoming and outgoing forms have been completed by the RO.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Safeguards re clinical governance processes and the process for responding to concerns being reviewed as part of a wider trust project exploring concerns and disciplinary procedures.

Comments: During 2019 the Director of Medical Workforce joined other clinical leaders, managers, HR representatives, and equality and diversity and service user participation leads at a number of workshops to map out and review concerns processes within the trust, with a focus on ensuring that processes are fair, free from bias and discrimination.

Action for next year : Identify relevant outcomes/actions from this work and develop an action plan to implement these.

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requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

The Trust is mandated to carry a range of employment checks on all prospective employees before they take up appointment in the NHS, regardless of the term of the contract.

All staff working within CWP are subject to pre-employment checks which are the minimum dataset required by Care Quality Commission (CQC) standards for Mental Health Trusts (these checks also comply with NHS employment checks standards (June 2019)). These include checks on the following:

Verification of identity checks, Right to work checks, Professional registration and qualification checks, Employment history and reference checks, Occupational Health checks and Disclosure and Barring Service (DBS) checks.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of last year's actions**

  A number of actions have been completed, including the successful introduction of ROAG meetings, a Quality Assurance panel for appraisals, sharing of checklists to support appraisal and implementation of electronic annual leave processes.
- **Actions still outstanding**
- **Actions to continue include revisiting peer audit processes with neighbouring trusts in 2021 (with initial plans delayed due to the covid 19 pandemic),**
- **New Actions:**
- **Plan ahead for the needs of doctors who have had approved missed appraisals this year in response to the Covid 19 pandemic. Ensure that doctors are supported to understand requirements for revalidation and are on track to meet these.**
- **Explore options to increase service user involvement in clinical governance processes in the trust e.g through service user representation at appraisal training and QA panel.**
- **Review the quality of electronic job plans, with a focus on SMART service and individual objectives.**
- **Explore the use of team job planning processes for psychiatrists**
- **Further Actions-**

- **Recruiting Consultants continues to be difficult, but over the past 12 months the trust has been successful in recruiting to a number of posts within the Specialist Mental Health care group. At the time of reporting, CAMHS psychiatry is a particularly challenging area. A number of experienced consultants are due to retire over the next 6-12 months, which is likely to create gaps in a number of community teams. CWP will continue to link in with Resourcing and other Trusts in the North West to think about what, if any, additional strategies could be put in place to attract doctors, and to plan for future workforce need. A database has now been developed to map the workforce and assist planning. Care groups are working together to develop more innovative posts e.g all age neurodevelopmental roles, to attract candidates and best serve population needs.**
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Overall conclusion: The report describes work in place to support medical governance within the Trust, in keeping with key principles outlined in the General Medical Council (GMC) handbook on medical governance, and the actions identified to continue to strengthen and shape these processes.

Section 7 – Statement of Compliance:

The Board of Directors has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[5].

There have been no formal investigations undertaken within CWP during the last appraisal year.

The Director of Medical Workforce has supported Clinical Directors with the development and monitoring of, informal action plans for two doctors during the last year.

During the year, CWP have remained committed to ensuring Clinical Directors deal more appropriately with local concerns about a doctor's practice at the earliest possible opportunity, implementing an action plan if appropriate and confirming discussions and agreements in writing to the doctor. This is intended to prevent minor concerns escalating and will also ensure the supporting evidence is there if more formal action needs to be taken in future.

Quarterly meetings with the GMC Employer Liaison Service have continued. They allow helpful, informal discussions with a GMC colleague and the sharing of information in both directions.

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[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

STANDARDISED SBAR COMMUNICATION

NHS Cheshire and Wirral Partnership NHS Foundation Trust

REPORT DETAILS	
Report subject:	Health, Safety and Fire annual report 2019_2020
Agenda ref. number:	20.21.22
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/07/2020
Presented by:	Gary Flockhart, Director of Nursing, Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	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/ No	Patient Safety	Safe	Yes
Finance and use of resources	Yes/ No	Clinical Effectiveness	Effective	Yes
Operational performance	Yes/ No		Affordable	Yes
Strategic change	Yes/ No		Sustainable	Yes
Leadership and improvement capability	Yes/ No	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 Health, Safety and Fire annual report aims to inform Operational Committee, Health and Safety Subcommittee and the local Health and Safety Groups of measures in place to manage Health & Safety and Fire matters in Cheshire and Wirral Partnership NHS Foundation Trust.

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

The HSE (Health and Safety Executive) is the enforcing authority for workers in England, Scotland and Wales. It is recognised that Great Britain is a safe place to work, gains have been made in safety and the focus is shifting onto health and keeping people well.

Assessment – *analysis and considerations of the options and risks*
CWP is fully committed to developing the highest standards of health and safety practice and fire safety. This report details arrangements in place to monitor and maintain those standards.

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

Who has approved this report for receipt at the above meeting?	
Contributing authors:	Senior Health and Safety advisor

Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
2	Operational Committee	22.07.2020

Appendices provided for reference and to give supporting/ contextual information:	
Appendix No.	Appendix title
1	Health, Safety and Fire annual report 2019_2020

#cwpQI

Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Data Protection Annual Board Report 2019/20
Agenda ref. number:	20.21.23
Report to (meeting):	Board of Directors
Action required:	Information and Noting
Date of meeting:	29/07/2020
Presented by:	Dr Faouzi Alam, Medical Director & Caldicott Guardian

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

Which NHSI Single Oversight Framework themes this report reflects:	
Quality	Yes
Finance and use of resources	Yes
Operational performance	Yes
Strategic change	Yes
Leadership and improvement capability	Yes

CWP Quality Framework:		
Patient Safety	Safe	Yes
Clinical Effectiveness	Effective	Yes
	Affordable	Yes
	Sustainable	Yes
Patient Experience	Acceptable	Yes
	Accessible	Yes
http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

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

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

REPORT BRIEFING

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

To brief the Board of Directors on the Trust's progress and compliance with data protection legislation. The General Data Protection Regulation 2016 (GDPR) became directly applicable as law in the UK from 25 May 2018. The UK Data Protection Act 2018 (DPA18), which relates to crime and taxation in the UK which GDPR does not cover, also came into force on the same date.

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

Organisations (data controllers) must be able to demonstrate compliance with the legislation and in particular that they have appropriate technical and organisational measures in place. Annual completion of the NHS Digital Data Security & Protection Toolkit is the mechanism by which the Trust is able to demonstrate compliance. Compliance is overseen by the Trust's Information Governance & Data Protection Sub-Committee (IG & DP SC). Any variance or risk is escalated to the Trust's Operational Committee.

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

Significant progress for data protection compliance has been made by CWP during 2019/20. Completed actions include:

1) National Data Opt-out. The national data opt-out allows a citizen to choose if they do not want their confidential health information to be used for purposes beyond their individual care and treatment i.e. for research and planning. NHS secondary care organisations are mandated to be compliant by 30/09/2020. Where the opt-out may apply e.g. research, the CWP Information Team has implemented a technical solution to enable NHS numbers to be checked with NHS digital to ensure that no information is used for citizens who have registered a national data opt-out preference. A standard operating procedure for applying national data opt-outs has been approved and staff communications for the national data opt-out have been developed.

2) Privacy notices. The public privacy notice was reviewed to incorporate national data opt-out information and re-published in March 2020. The staff privacy notice was also revised and re-published to expand the use of information the Trust holds to detect and prevent crime or fraud. This may now include key fob, premises access systems and Trust owned electronic devices. The information may be shared with other bodies that inspect and manage public funds. A supplementary Covid19 specific privacy notice was published alongside existing Trust privacy notice.

3) Data Protection Impact Assessments (DPIAs). DPIAs, including a risk matrix, have been created and approved by the Caldicott Guardian for all new systems or significant projects involving the use of personally identifiable data. A summary of all DPIA's is published on the Trust website.

4) Staff awareness. Several communications to staff have taken place throughout the year to remind staff of the importance of data protection compliance.

5) Coronavirus (Covid19). During the Covid19 pandemic NHSx have held weekly Covid19 updates for all Data Protection Officers (DPOs). The Trust's DPO attends virtually each week and disseminates key information via appropriate channels. In addition to the production of the Covid19 privacy notice, this has included providing information governance advice in relation to video conferencing solutions.

6) Data security and protection toolkit (DSPT) work plan

Due to the Coronavirus (Covid19) pandemic, the deadline for the final submission for the DSPT has been extended from the end of March to the end of September 2020. There are 5 outstanding ICT items on the work plan. Covid19 work has impacted on progress however action plans are in place to complete by the end of September 2020.

The above actions demonstrate that the Trust continued to made excellent progress with data protection legislation compliance during 2019/20.

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

That the Board notes the GDPR Annual Board Report 2019/20

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Information Governance & Data Protection Sub-Committee	06/07/2020

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

Appendix No.	Appendix title

Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Quality Improvement Report (Special Edition 2020)
Agenda ref. number:	20.21.24
Report to (meeting):	Board of Directors (meeting in public)
Action required:	Information and noting
Date of meeting:	29/07/2020
Presented by:	Dr Anushta Sivananthan (Medical Director/ Executive Lead for Quality)

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

Which NHSI Single Oversight Framework themes this report reflects:		**CWP Quality Framework:**		
Quality	Yes	Patient Safety	Safe	Yes
Finance and use of resources	No	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
N/A	

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

REPORT BRIEFING

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

This report is one of many reviewed by the Trust's Board of Directors that, together, give a detailed view of CWP's overall performance in relation to quality. The report is produced three times a year and this is the third of 2019/20. This edition of the Quality Improvement Report is a special edition to capture quality improvement work undertaken during the emergency response to the COVID-19 pandemic and showcases the innovation and extra lengths staff have gone to for the populations we serve during unprecedented circumstances.

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

The Quality Improvement reports are produced three times a year to update people who access and deliver the Trust’s services, carers, the public, commissioners, internal groups, and external scrutiny groups on progress in improving quality across our services. The Trust is required to formally report on our quality improvement (QI) priorities in the annual Quality Account. The QI report provides a highlight of what CWP is doing to continuously improve the quality of care and treatment that its services provide.

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

The report provides the progress against the three Trustwide QI priorities for 2019/20 and confirms their successful completion and delivery.

- The **patient safety** priority to reduce the severity of the harm sustained by those people accessing CWP services that cause harm to themselves.
- The **clinical effectiveness** priority to improve access to physiological therapies.
- The **patient experience** priority to improve engagement with bereaved families and carers.

The report also confirms the three Trustwide QI priorities for the coming year (2020/21) that have been approved by Quality Committee and how these will be achieved:

- The **patient safety** priority for an improvement in team level patient safety systems and culture, as rated by the people who deliver our services.
- The **clinical effectiveness** priority for an improved and consistent recording and use of outcome measures across inpatient, community, EI, CAMHS and perinatal services (as required by the 2020/21 CQUIN). This priority will also include improvement across all our other services as part of the Trust's 2020/21 outcome measures project.
- The **patient experience** priority for an improvement in asking people who access our services their experience of care and learning from what they tell us to make changes to our services and improve their experience.

Further, this Quality Improvement Report provides a highlight of what CWP is doing to continue to provide care during the current COVID-19 pandemic and the innovative care and services that our staff are delivering in these unprecedented times:

- A 24/7 crisis line for mental health has been established to support the populations we serve
- Colleagues from the Safe Services clinical support team have been redeployed to Bowmere Rehab Unit to strengthen person centeredness and build a 'team around the team' approach
- Personalised support and care planning to patients on Brooklands ward has increased staff confidence to support sustainable improvements and better outcomes for patients
- Clinical prioritisation during the pandemic has ensured continuity of planned appointments
- Perinatal 'staying at home' booklet has helped mothers and families adjust to staying at home
- CWP Recovery College YouTube channel has provided ideas and resources for self-care
- Hand-knitted hearts on Silk ward have kept loved ones connected
- The My Mind CAMHS website hub has provided updates, information and resources for young people
- Adult inpatient facilities have maintained safe staffing though the pandemic
- Mental Health Law and ICT teams have delivered innovative video conference hearings
- A podiatry team innovation has provided continuity of care to people with biomechanical aids
- Overcoming social distancing restrictions has enabled celebration of VE day
- LD CAMHS Wirral COVID-19 resources have provided reassurance to families at home
- Letters to Loved Ones has provided contact between patients and their families

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

The Board of Directors is asked to **approve** this report.

Who has approved this report for receipt at the above meeting?	David Wood – Associate Director of Safe Services
Contributing authors:	Agata Lewis – Patient Safety Improvement Lead Leona Christopher – Patient Safety Improvement Lead

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	22/07/2020

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

Appendix No.	Appendix title
1	Quality Improvement Report (Special Edition 2020)

#cwpQI