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Wirral Community Health and Care NHS Foundation Trust

Safe Staffing Report Quarters 3 - 4: 01 October 2022 – 31 March 2023

Meeting	Board of Directors		
Date	16/08/2023	**Agenda Item**	16
Lead Director	Claus Madsen, Chief People Officer		
Author(s)	Claire Wedge, Deputy Chief Nurse, Helen Lundy, Clinical Safer Staffing Lead, Carla Burns, Deputy Director of HR and OD, Martin Godfrey, Head of HR (Workforce Planning and Resources		

Action required (please select the appropriate box)

To Approve ☐	**To Discuss** ☐	**To Assure** ☒

Purpose

The purpose of this report is to provide assurance to the Board of Directors in relation to compliance with the Care Quality Commission Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 for safe staffing.

Executive Summary

Safe staffing is a key element of the delivery of safe, quality care and support. To ensure safe staffing levels are maintained, the Trust undertakes a bi-annual review of staffing levels across the Trust.

Regular reviews take place with a review currently in progress and six-monthly reviews scheduled. The results will be reported by exception to the People and Culture Committee via the Quarter 2 (2023/24) Safe Staffing Report.

There is a lack of validated safe staffing tools available for the majority of community services. Previous evaluations have relied on triangulation of a number of data sets such as patient safety incidents, complaints and staff feedback. The Trust participated in the NHSE pilot of the Community Nursing Safer Staffing Tool (CNSST) and is part of the first cohort of NHS Trusts to be granted a licence to use the tool. Data was collected during July 2023 and will be repeated in October 2023, in accordance with NHSE recommendations.

Care Hours Per Patient Day is tracked to provide assurance of safe staffing in the Trust's Community Intermediate Care Centre (CICC). This data is reported monthly via IPB and quarterly to People and Culture Committee. In addition to nursing staff, a summary of all available clinical staff has been formally reported from Q4 onwards, to assure clinical safety more broadly.

Data is triangulated against clinical incident data to identify any themes, trends or evidence of harm linked to staffing levels, with quality and safety impacts reported by exception to Quality and Safety Committee.

There have been no incidents of patient harm resulting from staffing levels reported during Quarters 3 and 4, 2022/23.

This report also includes assurance relating to safe staffing in the Community Intermediate Care Centre.

Risks and opportunities:

Nothing to report by exception to the Board of Directors.

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached No.

Individualised care delivery is provided by the Trust, ensuring compliance with equality and diversity standards for staff and people who use Trust services.

Financial/resource implications:

Delivery of high-quality services will support the Trust's financial position, reducing the potential for litigation and regulatory action.

The Trust Vision - To be a population health focused organisation specialising in supporting people to live independent and healthy lives. The Trust Objectives are:

- Populations - We will support our populations to thrive by optimising wellbeing and independence
- People - We will support our people to create a place they are proud and excited to work
- Place - We will deliver sustainable health and care services within our communities enabling the creation of healthy places

Please select the top three Trust Strategic Objectives and underpinning goals that this report relates to, from the drop-down boxes below.

Populations - Safe care and support every time	Populations - People and communities guiding care	Place - Improve the health of our population and actively contribute to tackle health inequalities

The Trust Social Value Intentions

Does this report align with the Trust social value intentions? Yes.

If Yes, please select all of the social value themes that apply:

Community engagement and support ☒

Purchasing and investing locally for social benefit ☐

Representative workforce and access to quality work ☒

Increasing wellbeing and health equity ☒

Reducing environmental impact ☐

Board of Directors is asked to consider the following action

The Board of Directors is asked to be assured by the Quarter 3 and 4 (2022/23) Safe Staffing Report, evidencing delivery of safe care.

Report history (Please include details of the last meeting that received this paper, including the title of the meeting, the date, and a summary of the outcome)

Submitted to	Date	Brief summary of outcome
Q3 (2022/23) Safe Staffing report to PCC.	8 February 2023	Assurance received.
Q4 (2022/23) Safe Staffing report to PCC.	10 May 2023	Assurance received.
Q4 (2022/23) Safe Staffing report with analysis of Aster Ward as per PCC referral.	12 July 2023	Assurance received.

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Safe Staffing Report Q3 - Q4 2022/23

Board of Directors

Date: 16/08/23

Contents

Purpose

The purpose of this report is to:

Provide assurance to Wirral Community Health and Care NHS Foundation Board of Directors in relation to compliance with the Care Quality Commission Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 Safe Staffing

Safe Staffing Governance

The Trust has a robust governance framework in place to support monitoring and oversight of safe staffing, this includes the following:

- Monthly review at SAFE Operations Group (SOG) and People and Culture Oversight Group (PCOG)
- Report by exception to Integrated Performance Board (IPB) based on risk escalation
- Quarterly reporting to People and Culture Committee
- Quality and Safety Committee oversight based on risk escalation
- Bi-annual high-level assurance report to the public Board of Directors

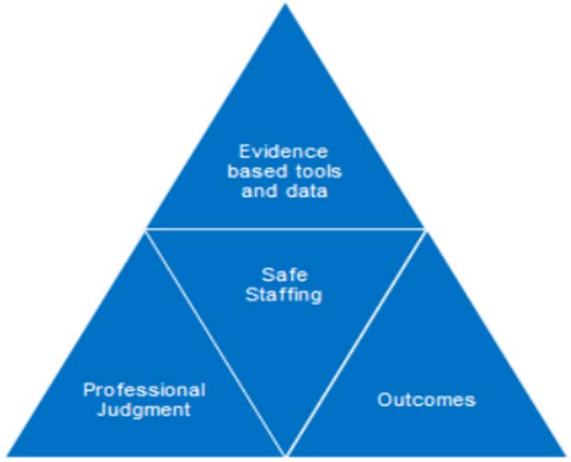
Regulation 18

- Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part
- Persons employed by the service provider in the provision of a regulated activity must:
  - receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform
  - be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and
  - where such persons are health care professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role

Principles of safe staffing

[National Quality Board Safe Staffing guidance]

[NHSE Developing Workforce Safeguards]



Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Implement Care Hours per Patient Day

Develop local quality dashboard for safe sustainable staffing

Measure and Improve
- Patient outcomes, people productivity and financial sustainability -
- Report investigate and act on incidents (including red flags) -
- Patient, carer and staff feedback -

CICC Safe Staffing

- A safe staffing model has been developed to demonstrate the available clinical and professional resource at CICC to ensure safe staffing
- Local **governance safe staffing** processes have been reviewed and have been supported by the introduction of daily board rounds
- **Escalation levels have been** strengthened to ensure transparency to the senior leadership team, supporting mitigation of risk
- Support is also available from **Tele-triage** and the **Nights Community Nursing Team**

Safe Staffing Model

CICC Safe Staffing

- The current nursing baseline staffing model at CICC is 2 Registered Nurses and 4 Health Care Assistants per ward per shift
- The developed safe staffing model supports responsiveness by incorporating professional judgement which maximises the use of available staffing resource. This enables implementation of a holistic multidisciplinary team model including the use of therapy staff to assure safety
- To validate the establishment setting, providing assurance to the Board of Directors in relation to safe staffing levels, the Trust have implemented the nationally approved Safer Nursing Care Tool (SNCT)

Trust-wide Safe Staffing – 6 Monthly Reviews

- The Trust requires operational services to undertake a six monthly safe staffing review of their establishment
- The most recent review is on-going and a summary will be included in the Quarter 2 (2023/24) Safe Staffing report to PCC
- For CICC, the Trust has implemented the national Safer Nursing Care tool to validate the current staffing establishment
- The tool was successfully utilised in January 2023 with further data collection conducted in July and scheduled for August 2023
- Any changes resulting from analysis of the data will be reported to the People and Culture Committee (PCC) by exception in the Quarter 2 (2023/24) safe staffing report

Community Nursing Safer Staffing Tool

- The CNSST was developed by NHSE in collaboration with Community Nursing Services
- The Trust was an active participant in the pilot, testing the national tool in October 2021 and is recognised as a formal contributor to the development of CNSST in the published implementation guide
- WCHC is part of the first cohort of 106 Trusts to be granted a licence to use the tool
- To support implementation across the Community Nursing Service, 170 of our community nursing staff were trained in how to use the tool during February – June 2023
- The first audit using the tool was undertaken across 8 community nursing teams for 1 week in July 2023
- The results of the audit are currently being reviewed
- Based on NHSE recommendations, a further audit will be conducted to validate the data. It is anticipated that this will take place in October 2023 reporting to PCC in the Q3 safe staffing report

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Safe Staffing Data: CICC Quarters 3 and 4 2022/23

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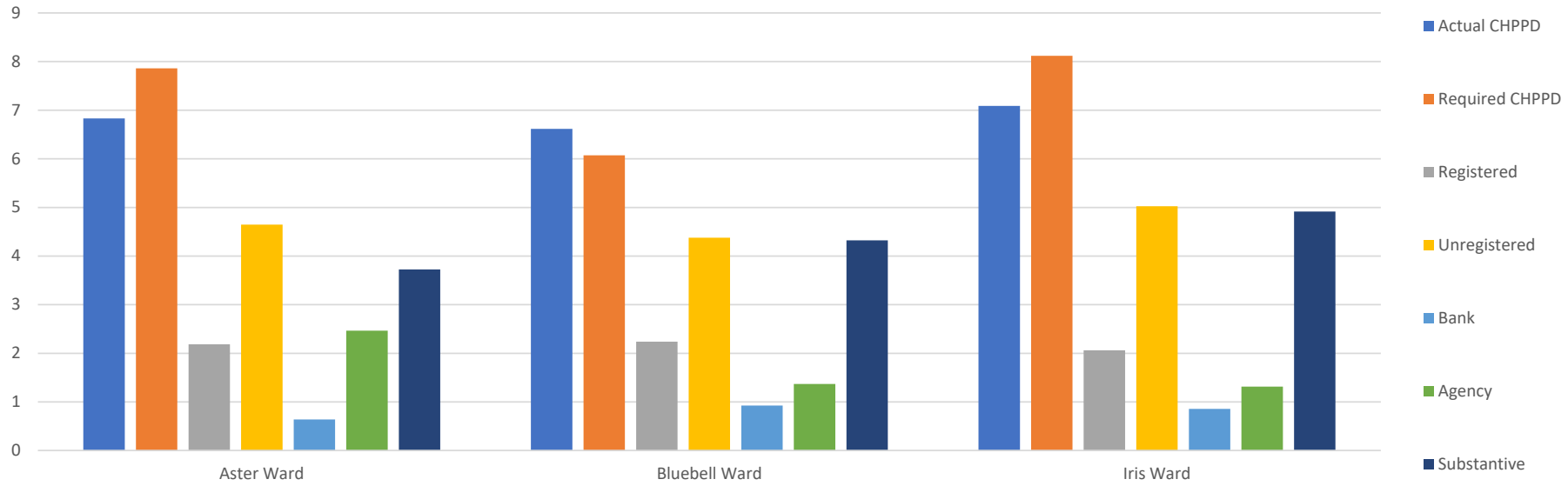
Ward Staffing Summary compared against Care hours Per Patient Day (CHPPD) – Quarter 3 2022/23



Ward Staffing Numbers – Care hours Per Patient Per Day: Quarter 3 2022/23

Row Labels	Sum of Actual CHPPD	Sum of Required CHPPD	Sum of Registered	Sum of Unregistered	Sum of Bank	Sum of Agency	Sum of Substantive
Aster Ward	6.83	7.86	2.18	4.65	0.64	2.47	3.72
Bluebell Ward	6.62	6.07	2.24	4.38	0.92	1.37	4.32
Iris Ward	7.09	8.12	2.06	5.02	0.86	1.31	4.92
Grand Total	20.53	22.05	6.49	14.05	2.42	5.15	12.96

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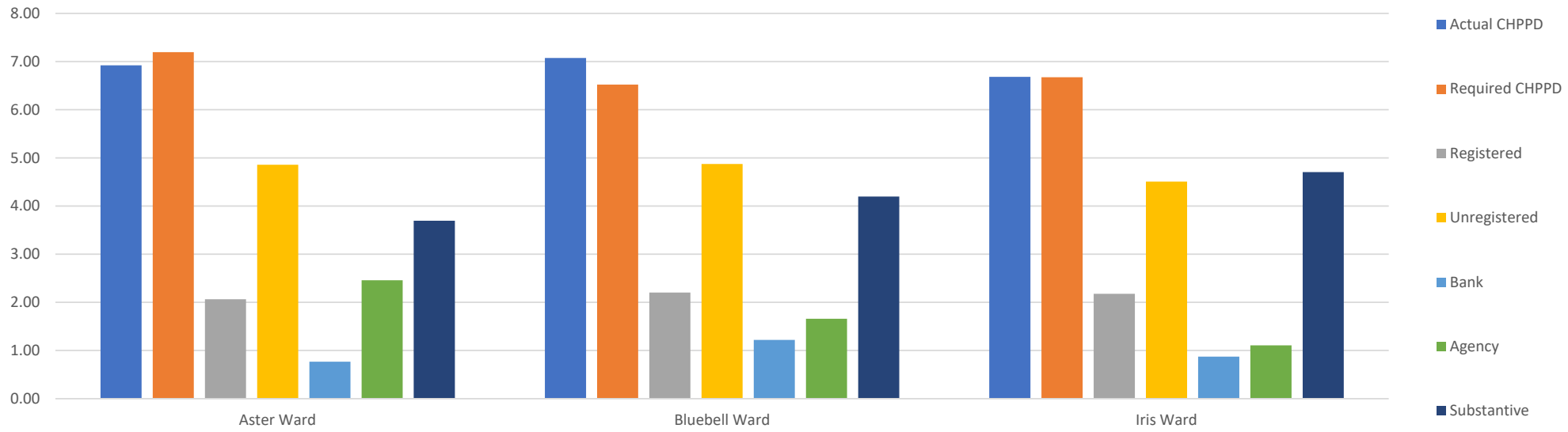
Ward Staffing Summary compared against Care hours Per Patient Day (CHPPD) – Quarter 4 2022/23



Ward Staffing Numbers – Care hours Per Patient Per Day: Quarter 4 2022/23

Row Labels	Sum of Actual CHPPD	Sum of Required CHPPD	Sum of Registered	Sum of Unregistered	Sum of Bank	Sum of Agency	Sum of Substantive
Aster Ward	6.92	7.20	2.06	4.86	0.77	2.46	3.69
Bluebell Ward	7.07	6.52	2.20	4.87	1.22	1.66	4.20
Iris Ward	6.68	6.67	2.18	4.51	0.87	1.11	4.70
Grand Total	20.68	20.39	6.44	14.24	2.86	5.22	12.60

Ward Staffing Numbers – Additional CICC Staff* Average Per Day: Quarter 4 2022/23 (Staff hours additional to CHPPD)

Grade Group	Assigned Duties WTE	Bank WTE	Overtime WTE	Additional WTE	Total
Occupational Therapist	6.69	0.64	0.02	0.05	7.4
Physiotherapy	7.73	0.36	0.41	0	8.5
Therapy Assistants	4.71	0.02	0.02	0	4.75
Totals (Therapy)	19.13	1.02	0.45	0.05	20.7
Nurse Management (Service manager and Ward Managers)	4	0	0	0	0

* Formal reporting from Q4

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Safety Analysis: CICC Quarters 3 - 4 2022/23

Safety Analysis: Quality Metrics

- To assure safety, a robust governance framework has been developed to effectively triangulate staffing quality and safety data

- This supports tracking of agreed quality metrics throughout the Trust governance from frontline teams to the Board of Directors, utilising a consistent, centralised source of data via the Trust Information Gateway (TIG), this includes, but is not limited to:

    - Patient data: including falls, pressure ulcers, infections
    - Patient and staff experience data: including compliments concerns and complaints
    - Staffing data: supervision, appraisals, retention, vacancy and sickness rates
    - Process measures; record-keeping - risk assessments
    - Education: mandatory and role essential training

Safety Analysis: CICC Q3 – Q4 2022/23

- A review of available data for CICC has been conducted for Quarters 3 and 4 2022/23, triangulated with staffing levels and CHPPD to assure standards of safety
- This review has evidenced that the safety systems and mitigations in place at CICC have been effective in minimising impact to patient safety
- Mitigations continue to include utilisation of the available clinical and professional resource at CICC, including therapy staff
- This analysis has progressed throughout the Trust's Safe Staffing Governance framework for assurance

Summary

- The safety systems and mitigations in place at CICC have been effective in minimising impact to patient safety during Quarters 3 and 4, 2022/23

- Triangulation of data will continue to be conducted dynamically in accordance with the Trust's governance framework to assure patient safety, supporting a culture of learning and continuous improvement

- Safe staffing reviews across Trust services are in progress and will be reported by exception to the People and Culture Committee via the Quarter 2 (2023/24) safe staffing report

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Wirral Community Health and Care NHS Foundation Trust

Complaints and Concerns Annual Report 01 April 2022 – 31 March 2023

Meeting	Board of Directors		
Date	16/08/2023	**Agenda Item**	17
Lead Director	Nick Cross, Medical Director		
Author(s)	Ian Salisbury, Senior Complaints Officer Ben Bowsley, Datix and Compliance Manager Claire Wedge Deputy Chief Nurse		

Action required (please select the appropriate box)

To Approve ☒	**To Discuss** ☐	**To Assure** ☒

Purpose

The purpose of the 2022/2023 Annual complaints and concerns report is to provide assurance to the Board of Directors of the Trust complaints and concerns management processes, supporting delivery of safe, effective quality services.

Executive Summary

Wirral Community Health and Care NHS Foundation Trust received 79 formal complaints during the reporting period 01 April 2022 – 31 March 2023 compared with 74 for the previous year.

A total of 78 complaints were investigated and progressed to closure during 2022/23. Of these, 23 (29%) were upheld and 17 (22%) were partially upheld by the Trust. The remaining 38 (49%) were not upheld

Details of learning and action taken from upheld and partially upheld complaints are included within the report. Action plans are developed by the relevant service and monitored at locality SAFE/OPG meetings and via the Trust's weekly clinical risk management group in accordance with the Trust's governance framework.

Equality and diversity monitoring data has been included within the report, ensuring that a review of experience can be analysed from an equality perspective; evaluating if the needs of those with protected characteristics are being met by Trust services.

Priorities for 2023/2024 have been identified and are included within the report.

Risks and opportunities:

Risks are documented within the presentation for the attention of Committee

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached No.

Individualised care delivery is provided by the Trust, ensuring compliance with equality and diversity standards for staff and people who use Trust services.

Financial/resource implications:

Effective complaints management will support organisational learning and the delivery of high-quality care, whilst reducing the potential for litigation and regulatory action.

The Trust Vision – To be a population health focused organisation specialising in supporting people to live independent and healthy lives. The Trust Objectives are:

- Populations – We will support our populations to thrive by optimising wellbeing and independence
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Please select the top three Trust Strategic Objectives and underpinning goals that this report relates to, from the drop-down boxes below.

Populations - Safe care and support every time	Populations - People and communities guiding care	Place - Improve the health of our population and actively contribute to tackle health inequalities

The Trust Social Value Intentions

Does this report align with the Trust social value intentions? Yes.

If Yes, please select all of the social value themes that apply:

Community engagement and support ☒

Purchasing and investing locally for social benefit ☐

Representative workforce and access to quality work ☐

Increasing wellbeing and health equity ☒

Reducing environmental impact ☐

Quality & Safety Committee is asked to consider the following action		
The Board of Directors is asked to be assured by the Trust's 2022/23 complaints and concerns annual report.		
Report history (Please include history of where the paper has been presented prior to reaching this meeting, including the title of the meeting, the date, and a summary of the outcome)		
Submitted to	**Date**	**Brief summary of outcome**
Quality and Safety Committee	12 July 2023	The committee was assured by the information presented in relation to the Complaints and Concerns Annual Report 2022/23 and approved for this to be submitted to the Trust Board.

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Complaints and Concerns Annual Report 2022/23

Contents

Introduction

1. The purpose of this annual report is to provide assurance to Wirral Community Health and Care NHS Foundation Trust Board of formal complaints and concerns activity undertaken across the organisation for the reporting period 01 April 2022 – 31 March 2023, in relation to the Trust's requirements to demonstrate compliance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Principles

2. The NHS Complaint Regulations state that arrangements for dealing with complaints must ensure that:
   - Complaints are dealt with efficiently
   - Complaints are thoroughly investigated
   - Complainants are treated with respect and courtesy
   - Complainants receive as far as is practical:
     (i) Assistance to enable them to understand the complaints procedure
     (ii) Advice on where they may obtain such assistance
   - Complainants receive a timely and appropriate response
   - Complainants are told the outcome of the investigation and actions taken, if appropriate

3. Complaints should be managed in the spirit of the Parliamentary and Health Service Ombudsman's (PHSO) principles – Principles of Good Administration, Principles of Good Complaints Handling and Principles for Remedy. The PHSO recommends NHS organisations follow these principles to ensure effective complaints handling:

   - Getting it Right
   - Being Customer Focused
   - Being Open and Accountable
   - Acting Fairly and Proportionately
   - Putting Things Right
   - Seeking Continuous Improvement

4. The Trust has also adhered to best practice as outlined by the Local Government Ombudsman, when providing Adult Social Care services.

Overview of Trust Services

5. Trust services are local and community-based, provided from around 50 sites across Wirral, including our main clinical bases, St Catherine's Health Centre in Birkenhead and Victoria Central Health Centre in Wallasey.

6. We also provide integrated 0-19 services in Cheshire East, Knowsley and St Helens comprising health visiting, school nursing, Enhanced and Family Nurse Partnership (FNP) and breastfeeding support services from 17 bases.

7. The Trust is commissioned to provide care across three in-patient wards at the Community Intermediate Care Centre: Bluebell, Iris and Aster wards.

8. The wards operate a multi-disciplinary and integrated approach to care, with teams consisting of physiotherapists, occupational therapists, social workers, nurses, health care assistants, administrative staff as well as an extended workforce consisting of students and volunteers.

9. The Trust actively encourages feedback regarding all services to ensure that these experiences shape and inform future service design, support organisation learning and the Trusts' quality improvement infrastructure; this includes complaints and concerns.

10. Experience is a standard agenda item throughout all team meetings and all managers are actively encouraged to share and learn, looking for continuous opportunities to identify quality improvements.

11. As an integrated provider of health and social care during 2022/23, the Trust is committed to the principles as outlined in a user-led vision for raising concerns and complaints (LGO, PHSO and Healthwatch). This ensures that people:

    1. Feel confident to speak up
    2. Feel that making a complaint was simple
    3. Feel listened to and understood
    4. Feel that their complaint made a difference
    5. Would feel confident making a complaint in the future

Organisational Analysis of Complaints and Concerns

12. The Trust currently have two types of investigation, which are discussed and agreed with the person intending to raise a concern or complaint with the Trust. These are as follows:

Concerns Process (Local Resolution)	Complaints (Full Investigation)
Concerns are a way of handling complaints by resolving or clarifying the matter directly with the complainant through discussion in a meeting arranged for the purpose, service responding direct by phone call or in writing. This can be a more proportionate, flexible and responsive way to resolve concerns that do not require a full investigation. The complaints	Complaints are subject to full investigation in accordance with Trust policy and national guidelines. This includes, but is not limited to, a review of written records and procedures, interview with the staff involved and where applicable, witnesses to the event. Services are asked to complete a Rapid Complaint review and asked to present their

process is fully explained and made accessible to all individuals raising a concern with the Trust.	findings to Clinical risk Management Group (CRMG). At the conclusion of the investigation, the complainant receives a response from the Chief Executive or nominated Executive Director. For complex complaints, meetings are also offered with a Senior Manager within the Trust, to provide feedback directly to the complainant.

13. Wirral Community Health and Care NHS Foundation Trust (WCHC) received 79 formal complaints during the reporting period 01 April 2022 – 31 March 2023 compared with 74 received for the previous year.

14. There were 78 complaints closed during 01 April 2022 – 31 March 2023 of these 23 (29%) were upheld and 17 (22%) were partially upheld by the trust. The remaining 38 (49%) were not upheld.

15. Analysis of patient and service user contacts received and recorded on Datix are as follows:

    - 79 formal complaints
    - 242 informal concerns

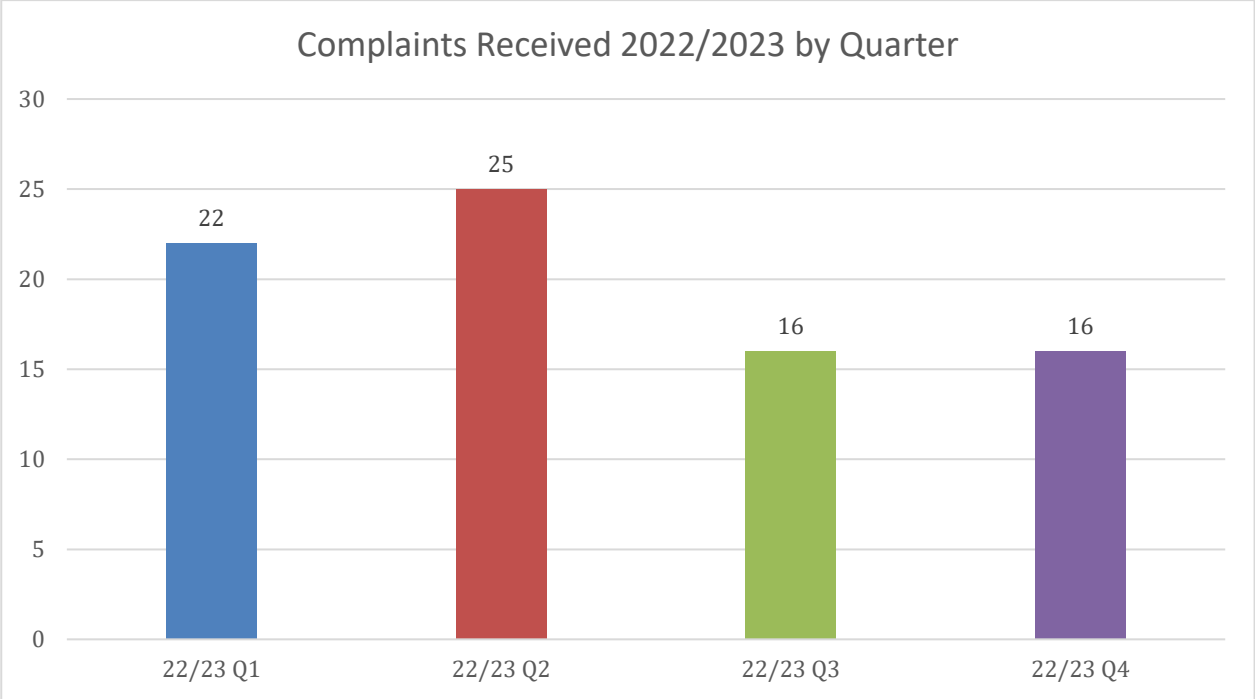
16. The Trust received experience feedback from 27,265 people who accessed services, with an average of 92.2% of those people reporting a very good or good experience.

17. Analysis of the quarterly complaints data from 2018 - 2023 evidences a slight increase in the number of complaints received by the Trust, compared to 2021/2022:

01 April – 31 March	Total number of complaints received
2018/2019	143
2019/2020	96
2020/2021	69
2021/2022	74
2022/2023	79

18. Chart 1 demonstrates the total number of complaints received by quarter during 2022/23:

Chart 1: Comparison of complaints received by quarter



Complaint Responses: Health

19. There were 43 Health Complaints received during the period of 1 April 2022 – 31 March 2023.

20. Out of the 43 complaints received during this reporting period, 3 remained open into 2023/24.

21. Of the 43 Health complaints received 88% were acknowledged within 3 working days. The slight reduction in performance was due to a staffing transition within the complaints team. An improvement plan has been effectivley implemented to improve performance. During Q4, 15 of 16 complaints (94%) were responded to within 3 working days.

22. Of these complaints, 27 (63%) were responded to within the Trust timescales of 40 working days, and 16 (37%) were responded to outside of the 40 working days. An extended timescale may be required to ensure a comprehensive response due to the complexity of the complaint. Complainants are kept fully informed of any extended timescales required. No concerns or complaints regarding response times have be raised with the Trust or external bodies during the annual reporting period.

Complaint Responses: Adult Social Care

23. There were 36 Adult Social Care (ASC) Complaints received during the period of 1 April 2022 – 31 March 2023.

24. Out of the 36 complaints received during this reporting period, 7 remained open into 2023/24.

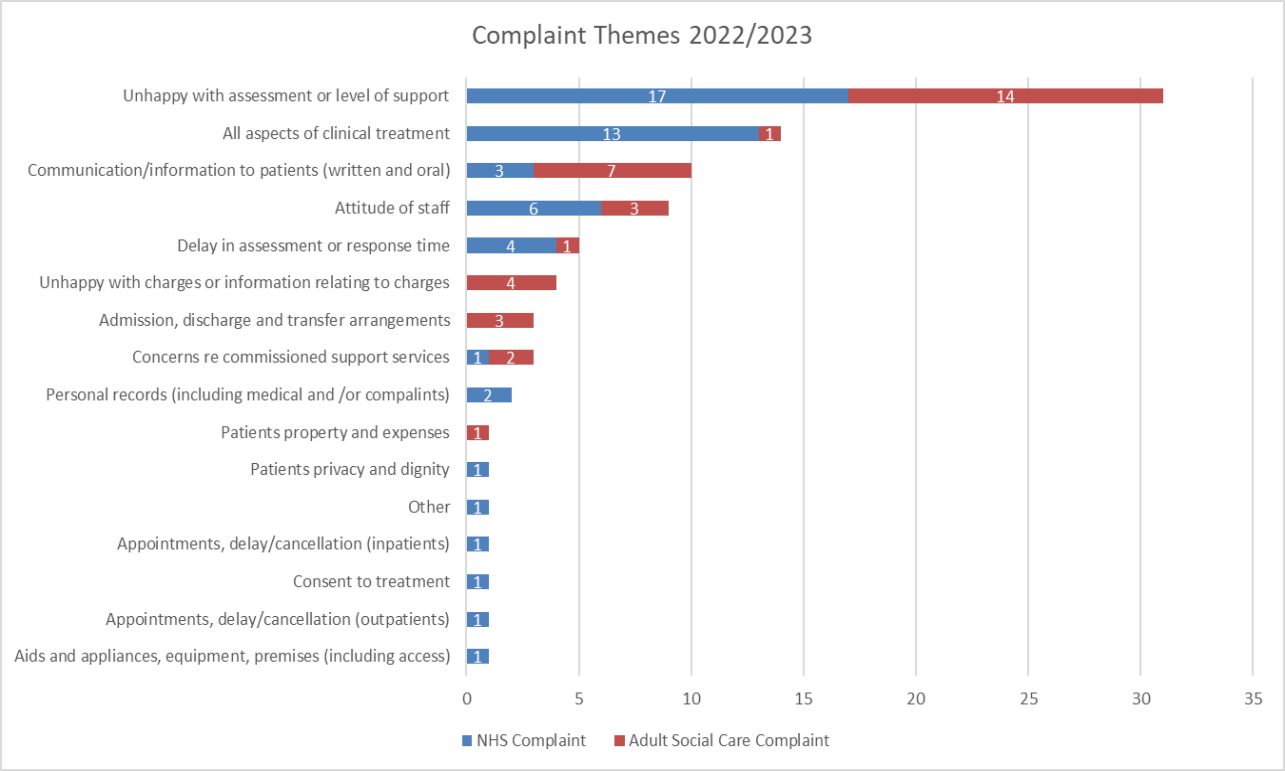
25. Of the 36 ASC complaints 97% were acknowledged within 3 working days.

26. Of these complaints, 19 (53%) were responded to within the agreed timescale of 21 working days. 17 (47%) of the Adult Social Care complaints were not responded to within the agreed timescales. Anticipated delays were negotiated with the Council and Complainant.

Total number of 2022/2023 complaints received by theme

27. The themes for complaints during the reporting period are as follows:

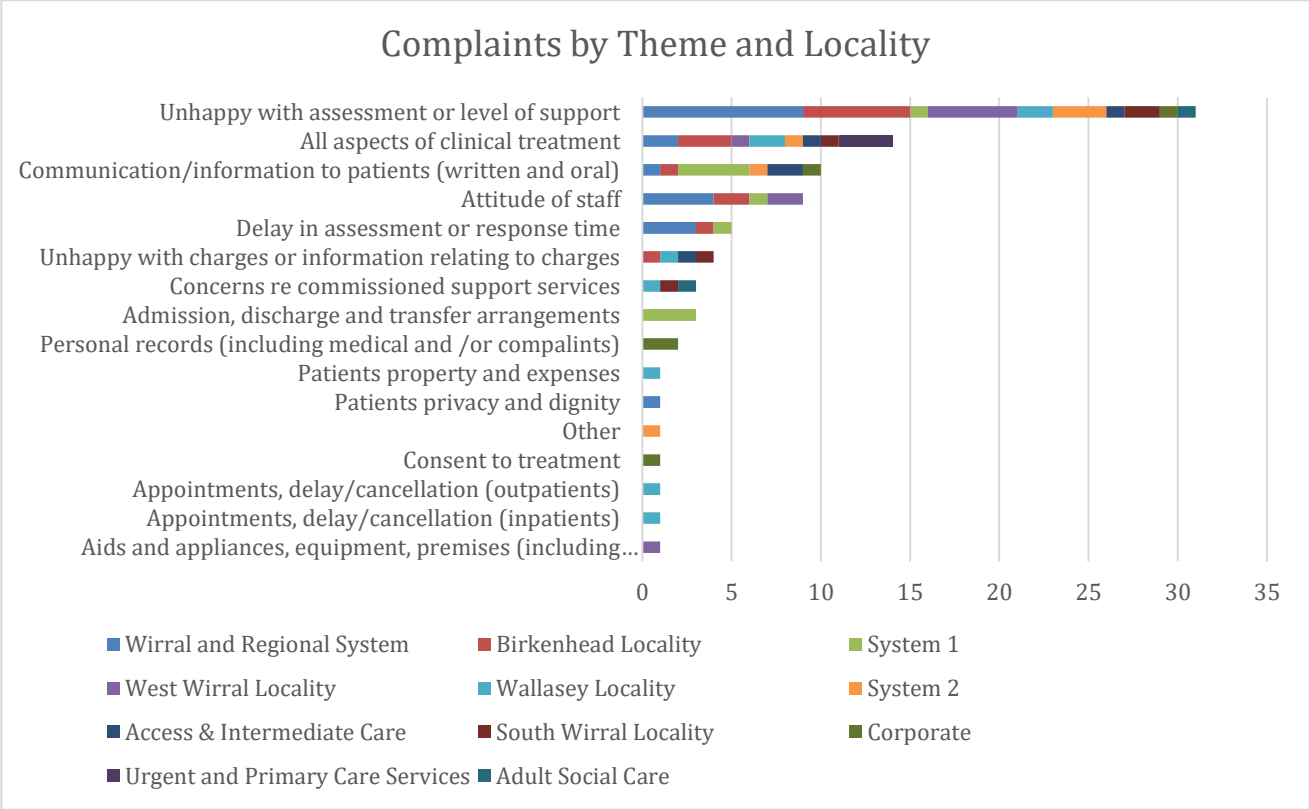
Chart 2 – Complaints received by theme



NB: Complaints can have more than one primary theme recorded subject to complexity. During 2022/23 a total of 88 themes were recorded against the 79 complaints received.

This can be further broken down into Localities as follows.

Chart 3 – Complaints by Locality Theme



28. Analysis and findings from each complaint identified which complaints were upheld, partially upheld and not upheld by the Trust.

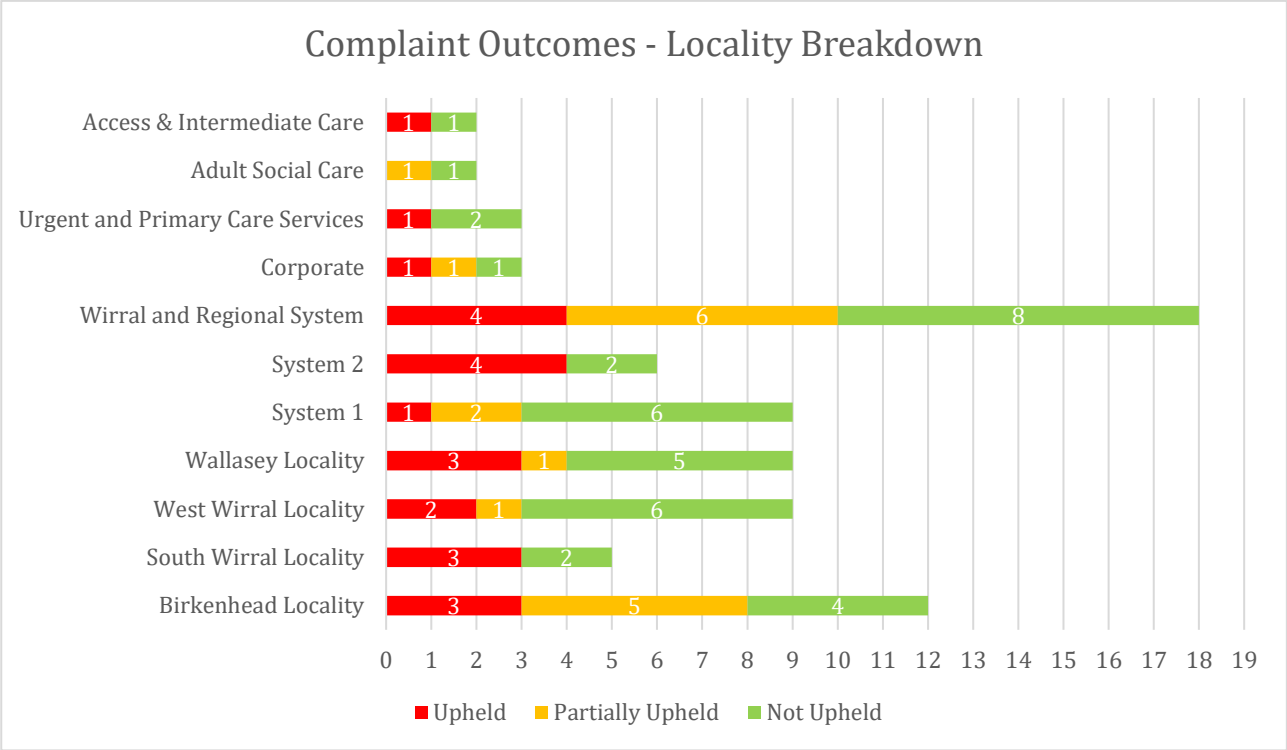
Closed 2022/2023 Complaints		
Upheld	**Not Upheld**	**Partial Upheld**
23	38	17

29. Of the 78 complaints closed during 2022/23, 9 were carried over from the 2021/22 annual period.

30. Of the 79 complaints received during 2022/23, 10 will progress to closure during 2023/24.

31. A further breakdown of upheld/partially upheld and not upheld complaints by service is detailed in chart 4.

Chart 4: Upheld/Partially Upheld and not Upheld complaints by Service



32. For all partially upheld and upheld complaints an action plan is requested to evidence learning for Trust services.

33. Action plans are tracked through the Trust's weekly Clinical Risk Management Group to ensure themes or emerging trends can be identified quickly. This governance mechanism also provides the opporutnity for relevant learning to be disseminated across all Trust services where applicable.

Learning and Improvements made from Upheld and Partially Upheld complaints:

34. This section of the report will focus and analyse the top 4 complaint themes and give greater understanding of learning, improvements made and ongoing management.

Complaint Theme - Unhappy with assessment or level of support

35. There were 33 complaints received categorised as 'unhappy with assessment or level of support', 19 were in relation to health complaints of which 11 were either upheld or partially upheld. 14 complaints were in relation to Adult Social Care of which 4 were upheld.

Learning	Improvements	On-going management
• Communication and learning from experience of complainants and their family/carer • Discuss dementia guidance with all social workers in supervisions in relation to safeguarding • To improve escalation processes to better manage demand and capacity issues within Community Nursing • Palliative care response time audit to be brought forward for Community Nursing • Review information provided to patients and families around end-of-life care	• Systemwide improvement for advocacy referrals for adult social care • Guidance Supporting People with Dementia to be involved in safeguarding enquiries sent to all social workers in the team • Escalation pathways devised for day and night teams to highlight and manage capacity issues earlier in the day. Pathways shared with all teams • Audits have been completed in December 2022 and results show an improved position in relation to response times to visit • EOL leaflets have been updated	• Review of themes and trends at weekly CRMG • Oversight of Trust wide quality improvements and alignment to National Institute for Health and Care Excellence (NICE) guidance

Complaint Theme: All aspect of clinical treatment

36. There were 10 complaints received where 'all aspect of clinical treatment 'was recorded as the primary subject of concern. 6 were in relation to Adult Social Care and 0 were upheld or partially upheld. 4 were in relation to health complaints and 3 were upheld and 1 partially upheld.

Learning	Improvements	On-going management
• Staff to contact family immediately following a fall • Patient documentation needs to be of a better standard and in line with expectations of the trust • Lack of communication with colleagues in relation to safeguarding • Staff to communicate with compassion and sensitivity • Improvement needed from Multi agency Integrated Front Door Team	• Staff training with regards to contacting family members following a fall • Contemporaneous record keeping - clear, concise and up to date • Staff supported during supervision sessions to enhance skills to support compassionate communication with patients • Enhancement of multi-agency learning for the Integrated Front Door team, including timeliness of assessments following referral and quality of communication	• Review of themes and trends at weekly CRMG • Ensure staff training is up to date and reflects identified learning and improvements.

Complaint Theme: Communication and information to patients

37. There were 9 complaints received where 'Communication and information to patients' was recorded as the primary subject of concern. 7 complaints were for related to Adult Social Care of which 0 were upheld or partially upheld. 2 were in relation to health care provision of which 1 was upheld and 1 not upheld.

Learning	Improvements	On-going management
• Staff to fully document financial discussions with patients and upload relevant evidence • Encouragement for services to review local information on Trust websites and social media platforms • Review of comfort calling processes and training for staff within General Practitioner Out of Hours Service (GPOOH)	• Staff to ensure that correct version of Charging Policy is distributed to families and Service Users • Staff training and support for staff within the GPOOH to improve communication • Staff training and support for staff within GPOOH to improve communication 'comfort calling' processes	• Review of themes and trends at weekly CRMG • Monitoring of patient safety investigations where there is an open complaint

Complaint Theme: Attitude of Staff

38. There were 10 complaints received where 'attitude of staff' as the primary subject of concern. 6 were in relation to health services with 4 being upheld or partially upheld. 4 complaints were in relation to Adult Social Care with 4 being upheld.

Learning	Improvements	On-going management
• Staff given training and briefing around specific treatments • Processes reviewed and updated • Staff reminded about behaviours and how patients can perceive communication • Always base decisions on evidence and not opinion	• Training completed to ensure staff are following the correct processes • Escalation pathways developed to support staff if they are unsure how to deal with a situation • Staff debriefs and discussions to take place in supervision sessions • Staff training in relation to good record keeping and uploading evidence and relevant information	• Procedures and training to be regularly reviewed. • Review of themes and trends at weekly CRMG • To use feedback forms to understand patent experience • Via supervision meetings

Parliamentary and Health Service Ombudsman (PHSO) and Local Government Ombudsman (LGO)

39. During the reporting period, Wirral Borough Council has requested information to support five LGO investigations.

40. Three of the investigations have been closed by the LGO following receipt of evidence and assurance provided. Wirral Borough Council are awaiting final decisions on two of the investigations which will be shared with the Trust when available.

41. There have been 3 referrals to the PHSO during the reporting period. All referrals have been closed by the PHSO following submission of evidence by the Trust.

42. All complaints were responded to and managed in accordance with WCHC's Complaints Policy (GP1).

43. Lessons learned from complaints are a valuable tool to assist in the quality of services provided and improve the patient's overall experience. Shared learning is distributed in a variety of ways:

    - Team meetings and agendas
    - "You Said We Did" Posters
    - Safety Sound Bites
    - Medicines Management Bulletins
    - Individual development plans
    - Training and Development
    - Update or development of protocols to promote harm free care
    - Clinical Risk and Management Group (CRMG)
    - Service specific action plans
    - Quality Improvements
    - Leadership visits to teams
    - Development of the new 'Learning Hub' on Staffzone

44. For upheld or partially upheld complaints where learning for the Trust has been identified, action plans are developed by the service and monitored at locality SAFE/OPG meetings and at the Trust-wide CRMG.

Total number of concerns received

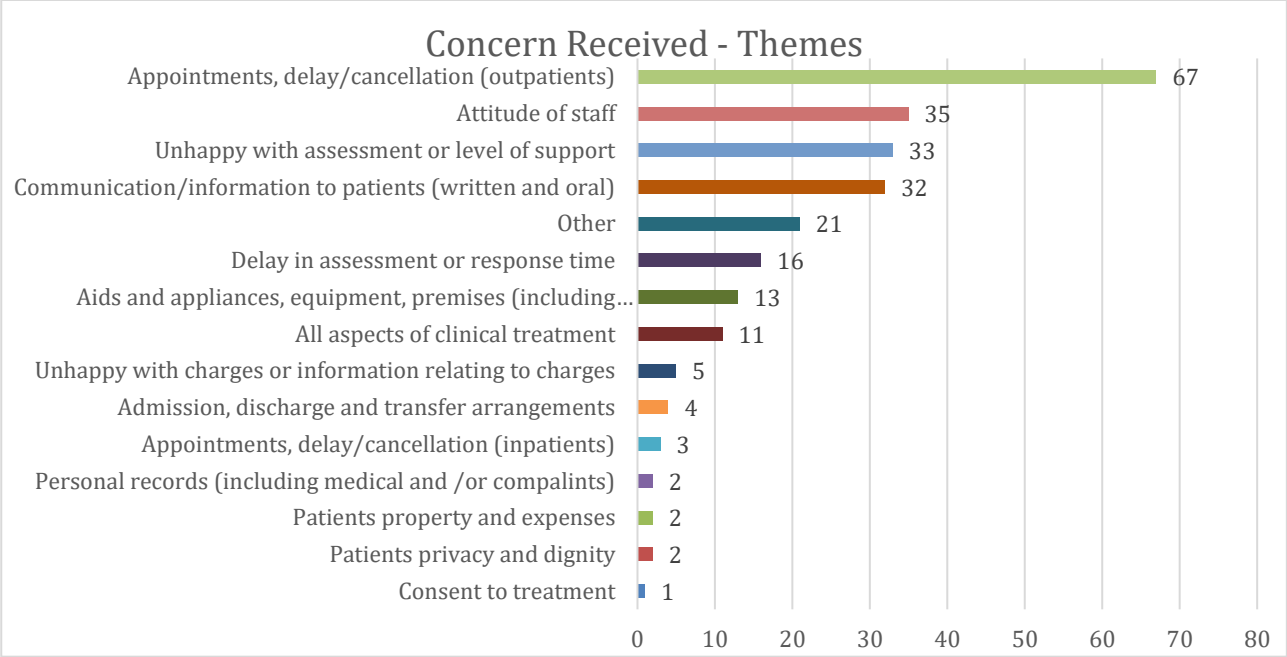
45. A Total of 242 concerns were received by the trust in 2022/2023.

46. All concerns are subject to local management by the relevant service, facilitating a prompt, proportionate flexible response, which is agreeable with the complainant. The formal complaints process is fully explained and made accessible to all individuals raising a concern with the Trust, to ensure escalation if initial local resolution cannot be achieved.

47. This indicates an improved experience across Trust services, which will be subject to further analysis and testing during 2023/2024.

48. Chart 5 provides details of the number of concerns received by subject.

Chart 5: Total number of concerns received by subject



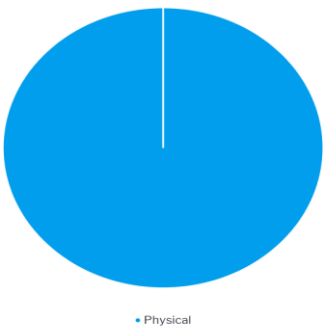
49. All concerns are resolved at local service level and are monitored for themes and trends both at team level and at CRMG.

Equality and Diversity Monitoring

50. All complainants are offered the opportunity to provide equality and diversity information at the point of acknowledgment of their complaint. These are recorded on Datix and were required reasonable adjustments are made to the communication or format of the response. As evidenced below, 1 person who raised a complaint shared that they had a disability.

Chart 6: Number of complaints who reported to have a disability

1 person shared they had a disability



51. This data provides valuable information to ensure that a review of experience can be analysed from an equality perspective, evaluating if the needs of those with protected characteristics are being met by Trust services.

52. All People who access Trust services have the right to be treated fairly and routinely involved in decisions about their treatment and care. They can expect to be treated with dignity and respect and will not be discriminated against on any grounds including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation.

53. Ethic Origin is actively collected for complaints and concerns. The chart below reflects the local demographic; however, it may also show that further work is required to ensure the complaints process is equitable.

Chart 7: Ethnic Origin

215 people share their ethnic origin

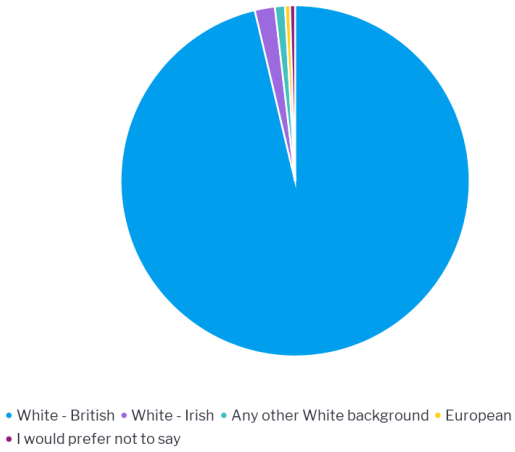
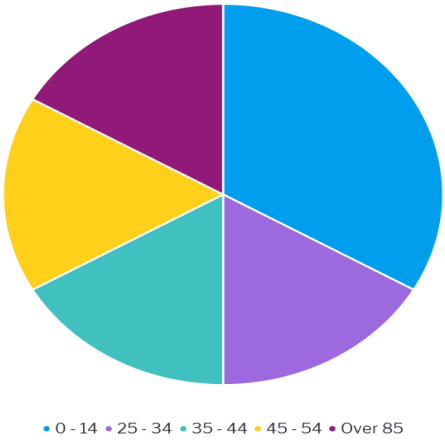


Chart 8: Age demorgraphic



54. The Trust's Equality Delivery System (EDS) measures Trust quality performance with an aim to producing better outcomes for people accessing Trust services. The assessment tool is designed to gather equality evidence that demonstrates compliance and performance with Section 149 of the Equality Act – the Public Sector Equality Duty (PSED).

55. Two of the EDS goals directly relate to potential areas of complaints and concerns:

Better Health Outcomes

- Services are commissioned, procured, designed and delivered to meet the health needs of local communities
- Individual people's health needs are assessed and met in appropriate and effective ways
- Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed

- When people use NHS services their safety is prioritised, and they are free from mistakes, mistreatment and abuse
- Screening, vaccination and other health promotion services reach and benefit all local communities

Improved access and experience

- People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
- People are informed and supported to be as involved as they wish to be in decisions about their care
- People report positive experiences of the NHS
- People's complaints about services are managed respectfully and efficiently

56. The Trust analyses complaints equality data to ensure that there is no evidence that individuals with protected characteristics are unfairly treated or disadvantaged.

Priorities for 2023/24

57. As part of the Trust's Quality Strategy, the Trust are committed to further strengthen and embed existing processes to better understand people's experiences of care; working with patients, service users, families and carers to improve the quality-of-service delivery.

58. An essential element of the strategic objective is to further understand and learn from people's experiences of care but also their experiences of how we manage and respond to complaints and concerns.

59. In line with the NHS Complaint Standards document (2021), the Trust's approach to this will continue to proactively consider:

- A person's confidence in raising concerns or a complaint
- A person's knowledge in how to raise a compliant or concern
- A person's experience of the communication processes and being kept informed
- A person's feelings around the response they received, including the overall outcome and whether their complaint has made a difference
- A person's overall experience with regards to how their complaint was managed

60. Trust learning will consider equality and inclusion to ensure we have considered individual rights and needs as part of the Trust's management of care and complaints. Learning from experiences and engagement will form part of all Trust-wide governance processes.

61. To ensure that all equality and diversity forms sent to patients when complaining have a direct link to your experience email inbox. This will ensure that forms will be completed and managed by the complaints team centrally.

62. The Complaints Team will introduce and develop a quality improvement plan for 2023/2024. This will ensure processes are clear and will also ensure accuracy and good governance across the Complaints Team.

63. A complaint handling training course will be implemented and delivered in 2023/2024 to all relevant staff that investigate and respond to complaints and concerns. This will align and support the quality improvement plan and enhance staff knowledge and skills in relation to complaints.

64. We will continue to align our system and processes with Patient Safety Incident Response Framework (PSIRF) principles, working closely and compassionately with patients and families.

65. During 2023/2024 we will work with complainants to improve uptake of patient families completing equality and diversity information.

66. We will utilise Patient Safety Partners to quality assure a sample of anonymised complaints response letters. This will ensure they are personalised and clearly communicated.

Committee action

67. The Quality and Safety Committee is asked to be assured that the Trust is committed to improving response times and implementing the learning from complaints. This improvement will continue to be monitored to ensure delivery of safe, effective, quality services across the organisation.

Dr Nick Cross
Executive Medical Director

Contributors:
Ian Salisbury Senior Complaints Officer
Ben Bowsley Datix and Compliance Manager

30 June 2023

Compassion Open Trust

Wirral Community Health and Care NHS Foundation Trust

Information Governance Annual Report 2022-2023

Meeting	Board of Directors		
Date	16/08/2023	**Agenda Item**	17
Lead Director	Alison Hughes, Director of Corporate Affairs		
Author(s)	Claire Wedge, Deputy Chief Nurse and Chief Nursing Information Officer, Dave Murphy, Chief Information Officer, Daniel Ebbrell, Information Governance and FOI Officer		

Action required (please select the appropriate box)

To Approve ☒	**To Discuss** ☐	**To Assure** ☐

Purpose

The purpose of this paper is to provide assurance to the Board of Directors on organisational compliance with legislative and regulatory requirements relating to the handling of information and to formally receive and approve the attached Information Governance Annual Report for the financial year 2022-23.

The Finance & Performance Committee received the report on 2 August 2023 and approved it for onward presentation to the Board of Directors.

Executive Summary

The Information Governance Annual Report is presented to the Board of Directors to provide assurance in relation to activity undertaken across the organisation for the reporting period 01 April 2022 - 31 March 2023, in relation to the Trust's organisational compliance with legislative and regulatory requirements relating to the handling of information.

This includes compliance with the Data Protection Act (DPA) 2018, UK General Data Protection Regulation (GDPR) and the Freedom of Information Act (FOIA) 2000.

The Trust is a recognised and registered Data Controller within the Information Commissioner's Data Protection Register. The Trust's Data Protection Registration number is Z2567487. There are no current or historical conditions or cautions against the Trust's data protection registration.

The report also details compliance with the Data Security and Protection Toolkit (DSPT) and provides assurance of on-going improvement in relation to managing risks to information.

Appendix 1 details the outcome of the Trust's DSPT audit conducted by Mersey Internal Audit Agency, resulting in a ***'Substantial Assurance'*** rating, supporting submission of the DSPT with all standards met within national timeframes.

At the meeting of the Finance & Performance Committee on 2 August 2023, the higher number of IG incidents particularly in Cheshire East was noted. This has been reviewed and the Service Director has advised that incident reporting has been actively promoted in the division to provide baseline data to drive continuous quality improvements that will be tracked by the Information Governance & Data Security Group.

Risks and opportunities:

None currently identified

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached No.

Individualised care and Trust governance is delivered to ensure compliance with equality and diversity standards for staff and people who use Trust services.

Financial/resource implications:

None currently identified

The Trust Vision - To be a population health focused organisation specialising in supporting people to live independent and healthy lives. The Trust Objectives are:

- Populations - We will support our populations to thrive by optimising wellbeing and independence
- People - We will support our people to create a place they are proud and excited to work
- Place - We will deliver sustainable health and care services within our communities enabling the creation of healthy places

Please select the top three Trust Strategic Objectives and underpinning goals that this report relates to, from the drop-down boxes below.

Populations - Safe care and support every time	Populations - People and communities guiding care	Place - Make most efficient use of resources to ensure value for money

The Trust Social Value Intentions

Does this report align with the Trust social value intentions? Yes.

If Yes, please select all of the social value themes that apply:

Community engagement and support ☐

Purchasing and investing locally for social benefit ☐

Representative workforce and access to quality work ☒ **Increasing wellbeing and health equity** ☐ **Reducing environmental impact** ☐
Board of Directors is asked to consider the following action
The Board of Directors is asked to receive and formally approve the Information Governance Annual Report for 2022-23.
Report history (Please include history of where the paper has been presented prior to reaching this meeting, including the title of the meeting, the date, and a summary of the outcome)

Submitted to	**Date**	**Brief summary of outcome**
Finance & Performance Committee	02/08/23	The committee approved the report for submission to the Board of Directors and sought further assurance on IG incidents in Cheshire East *(see above).*

NHS

Wirral Community Health and Care

NHS Foundation Trust

Information Governance Annual Report 2022/23

Contents

Background

1. The purpose of this annual report is to provide assurance to Wirral Community Health and Care NHS Foundation Trust (WCHC) Board of Directors on activity undertaken across the organisation for the reporting period 01 April 2022 - 31 March 2023, in relation to the Trust's organisational compliance with legislative and regulatory requirements relating to the handling of information. This includes compliance with the Data Protection Act (DPA) 2018, UK General Data Protection Regulation (GDPR) and the Freedom of Information Act (FOIA) 2000.

2. The Trust is a recognised and registered Data Controller within the Information Commissioner's Data Protection Register. The Trust's Data Protection Registration number is Z2567487. There are no current or historical conditions or cautions against the Trust's data protection registration.

3. This annual report will also detail compliance with NHS Digital's Data Security and Protection Toolkit and provide assurance of on-going improvement in relation to managing risks to information.

Senior Information Risk Owner Key Roles and Responsibilities:

4. It is recommended that the Senior Information Risk Owner (SIRO) is an Executive Director, who is part of the organisation's management hierarchy rather than being in an advisory role and is someone who understands how strategic business goals may be impacted by information risk.

5. The Director of Corporate Affairs is the Trust's Senior Information Risk Owner (SIRO) and has executive responsibility for the management and mitigation of all information risk. The SIRO is a core member of the Information Governance and Data Security Group and reports directly to the Chief Executive Officer.

   The key roles of the SIRO are:

   - reviewing and agreeing action in respect of identified information risks
   - briefing the Board on identified information risk issues
   - ensuring that all information assets have assigned information asset owners
   - annually signing off the information asset register
   - ensuring that the organisations approach to information risk is effective in terms of resource, commitment and execution and that it is communicated to staff
   - taking ownership of the risk assessment processes for information and cyber risk
   - overseeing the development and implementation of an incident risk policy*
     (NHS Digital, 2018)

   *The Trust has in place the Policy for Risk Identification and Management and the Incident Management Policy, both available on Staff Zone.

6. During 2022-23 the SIRO has successfully completed Templar Executives SIRO Training and Templar Executives Cyber Security Board Training.

Caldicott Guardian

7. Recommendation three of The Caldicott Committee's Report on the *Review of patient-identifiable information* (Department of Health, 1997) stated that a senior person, preferably a health professional, should be nominated in each health organisation to act as a guardian, responsible for safeguarding the confidentiality of patient information.

8. The Executive Medical Director is the Caldicott Guardian of the Trust. The Caldicott Guardian has a strategic role with regard to representing and championing information governance and confidentiality at Board and, where appropriate throughout the Trust. The Caldicott Guardian is a core member of the Information Governance and Data Security Group and reports directly to the Chief Executive Officer.

   The key roles of the Caldicott Guardian are:

   - ensuring that personal information collected about patients / service users is used legally, ethically and appropriately, and that confidentiality is maintained
   - applying the eight Caldicott Principles wisely, using common sense and an understanding of the law
   - actively supporting work to enable information sharing where it is appropriate to share and advising on options for lawful and ethical processing
     (UK Caldicott Guardian Office, 2017)

9. During 2022/23 the Caldicott Guardian has actively participated in the UK Caldicott Guardian Council Breakfast Club, received Caldicott Guardian training from Midlands and Lancashire Commissioning Support Unit (CSU) and completed Templar Executives Cyber Security Board Training.

Data Protection Officer

10. The Trust is legally required to employ a Data Protection Officer (DPO), the requirement is set out in Article 37 of the UK GDPR. The DPO should be designated based on professional qualities and expert knowledge of data protection law and practices and the ability to fulfil the tasks referred to in Article 39 of the UK GDPR.

11. The DPO role was held by the Trust's Information Governance Manager from 01 April 2022 – 31 December 2022. From the 01 January 2023 – 31 March 2023 the DPO function has been provided by the Information Governance Service, Midlands and Lancashire CSU.

12. The Data Protection Officer is a core member of the Information Governance and Data Security Group and reports directly to the Deputy Chief Nurse / Chief Nursing Information Officer. The DPO reports indirectly to the Board of Directors through the SIRO and Caldicott Guardian.

    The key roles of the DPO are:

    - monitoring organisational compliance with data protection legislation
    - informing and advising on data protection obligations
    - reviewing Data Protection Impact Assessments (DPIAs)
    - cooperating with the Information Commissioner's Office (ICO)
    - being the first point of contact for the ICO and individuals whose data is processed by the Trust (patients, service users, staff, volunteers etc.)
      (NHS Digital 2018

Assurance Framework

13. The objective of the Information Governance and Data Security Group is to support and drive the information governance agenda, ensure effective management of information risk, providing the Finance and Performance Committee (FPC) with assurance that best practice mechanisms are aligned with national standards, and local contract requirements are in place for information governance and information security within the Trust. The group has overall responsibility for the Trust's Data Security and Protection Toolkit (DSPT).

14. The key duties of the Information Governance and Data Security Group are:

- overseeing and supporting Trust compliance with NHS England's (formerly NHS Digital) Data Security and Protection Toolkit (DSPT) and consequently measuring performance against the National Data Guardian's ten data security standards
- ensuring compliance with legislative and regulatory requirements of information governance
- receiving Cyber Security Assurance through monthly Cyber Security/IT Security Group report
- reviewing information governance and data security guidance relevant to the Trust and escalating them when appropriate to FPC
- monitoring information assets and data flows captured within the Information Asset Register
- monitoring Information Governance / Record Keeping incidents and trends, system access audits outcomes and SAFE IG checklist compliance
- monitoring mitigations, controls and progress of Information Governance and Data Security risks and escalating in line with the Policy for Risk Identification and Management
- reviewing and monitoring Freedom of Information, Environmental Information Regulation and Subject Access Requests
- monitoring, reviewing and approving information governance and data security policies, procedures and guidance in a timely way to support compliance with legislative and regulatory requirements prior to endorsement by FPC
- identifying organisations with which personal data is routinely and regularly shared and developing suitable information sharing arrangements
- reviewing and approving requests for the destruction of records in line with Records Management Code of Practice 2021
- reviewing and approving Data Protection Impact Assessments produced as part of a privacy by design approach to new projects and ways of processing
- overseeing action plans that are developed as a result of information governance and data security incident investigations and escalating them to the appropriate group or committee
- monitoring outcomes of annual record keeping and information quality audits and identifying learning
- monitoring incidents and trends of inappropriate access to confidential information
- monitoring staff compliance with e-Learning for healthcare Data Security Awareness Level 1 and specialist staff compliance with training identified from the annual Training Needs Analysis.

Cyber Security/Information Technology Security Group

15. The objective of the Cyber Security/Information Technology Security Group, is to advise and provide assurance on the Trust's information technology security as it relates to delivering effective healthcare and enabling the Trust to complete its function as an employer.

16. Cyber security is the application of technologies, processes, and controls to protect systems, networks, programs, devices and data from cyber-attacks. It aims to reduce the risk of cyber-attacks and protect against the unauthorised exploitation of systems, networks, and technologies. Information technology security is defined as, the protection of computer systems from the theft or damage to the hardware, software or the information on them, as well as disruption or misdirection of the services they provide.

17. The Cyber Security/Information Technology Security Group makes decisions in relation to Cyber and IT Security, providing a summary report to the IGDS group on a monthly basis for assurance.

Information Governance Policies

18. The Trust's Information Governance assurance framework is underpinned by a robust infrastructure of Trust Policies aligned to national guidance. All Information Governance Policies are currently in-date, as evidenced in the table below. Staff are able to access Trust polices via staffzone.

Table 1: Table of Information Governance Policies and review dates

Policy Name	Review Date
Information Governance Policy IG01	2024
Data Protection and Confidentiality Policy	2024
Records Management Policy	2024
Individual Rights and Accessing Records Policy	2025
Freedom of Information Policy	2025
Data Protection Impact Assessment Policy	2024

Compliance with the Data Security and Protection Toolkit

19. The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool that enables organisations to measure and publish their performance against the National Guardian's ten data security standards. The requirements of the DSPT support key requirements under the UK General Data Protection Regulation (GDPR). All organisations that have access to NHS patient/service user data and systems must use the Toolkit to provide assurance that they are practicing good data security and that personal data is handled correctly.

20. The DSPT requires evidence of compliance with mandatory assertions. Key members of staff with specific roles in Information Governance and Information Security are required to annually update assertion areas with relevant evidence.

21. Following a successful DSPT baseline submission in 2022/23, the Trust commissioned MIAA to conduct a DSPT assurance readiness report to support final submission of the toolkit by the national deadline of 30 June 2023. In accordance with the guidance mandated by NHS England, thirteen DSPT assertions were assessed by MIAA during the review. Following the audit, the Trust were awarded 'substantial assurance' by MIAA. The full report can be seen in **Appendix 1**.

22. The Trust's DSPT was submitted on 29 June 2023 with all standards met.

Information Sharing

23. WCHC recognises that there is a responsibility to work with partners to minimise the burden of data collection and ensure that data is used effectively to support the overall aims of Public Sector and voluntary organisations, ensuring the delivery of safe, high quality clinical care.

24. Under the UK GDPR, the legal basis for most of information shared by the Trust is covered by:
Article 6 (e) *'processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller'*

Article 9 (h) *'processing is necessary for the purposes of preventative or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services on the basis of Union or Member State law or pursuant to contract with a health professional and subject to the conditions and safeguards referred to in paragraph 3'*

25. Consequently, Information Sharing Agreements are only produced for secondary purposes or when sharing with non-NHS organisations. Additionally, legally binding contracts have been put in place with suppliers processing Trust personal data and information flows are recorded within the Trust's Information Asset Register.

Complaints to the Information Commissioner's Office

26. During the 2022/23 period, there was one complaint made to the Information Commissioner's Office about the Trust. The complaint involved a subject access request (SAR) and concerns around Data Sharing which was handled accordingly in line with legislation. The ICO requested a thorough investigation into the complaint and after review, the ICO confirmed that this complaint would not be upheld, and the matter was closed.

Freedom of Information Requests (FOI)

27. During the period from 01 April 2022 to 31 March 2023, the Trust received a total of 291 requests under the Freedom of Information Act (FOIA) 2000; this is an increase of 44 FOIs when compared to the previous reporting year.

28. 253 were managed within the 20-day timescale and 38 responses were not managed within FOI timescales. This equates to 87% of FOI requests being responded to within the required timescale; a 4% increase from 2021/22.

Themes associated with late FOI responses include:

- Complex requests often required a coordinated response from multiple Trust departments resulting in a protracted timescale.
- Extensions to the deadline are occasionally requested in agreement with the requestor

Table 2: Table to show number of FOI requests received by the Trust and % managed within time frame in 2020/21, 2021/22, and 2022/2023

Freedom of Information	2020/21	2021/22	2022/23
Number of FOI requests	212	247	291
% Managed within 20 working days	88%	83%	87%

Subject Access Requests (SARS)

29. The UK General Data Protection Regulation (GDPR) 2018 provides the following rights for individuals:

    1. The right to be informed
    2. The right of access
    3. The right to rectification
    4. The right to erasure
    5. The right to restrict processing
    6. The right to data portability
    7. The right to object
    8. Rights in relation to automated decision making and profiling

30. Article 15 states that individuals have the right to obtain from the controller information that is held on them. Such requests are termed Subject Access Requests (SARs) and have a response time of one calendar month. Under GDPR, SARs are free of charge. Correct and prompt management of SARs increase levels of trust and confidence in the organisation by being open with individuals about the personal information held about them.

31. SARs are monitored monthly by the Information Governance and Data Security Group. During 01 April 2022 to 31 March 2023, the Trust received a total of 482 subject access requests (368 in 2021/22). Of these 482 requests, 62 were identified as relating to another organisation (compared to 50 during 2021/22).

32. Of the remaining 420 Trust relevant requests received, 97% were responded to within the timescale, compared with 97% recorded during 2021/22. See Table 3.

33. Of the requests not responded to within the agreed timescale, 3 were delayed with an internal Trust department.

34. Article 16 describes how data subjects have the right to have inaccurate personal data rectified by the data controller.

35. The Trust received 2 right to rectification requests during 2022/23.

Table 3: Table to show number of Trust relevant Subject Access Requests received and % managed within time frame in 2020/21, 2021/22 and 2022/23.

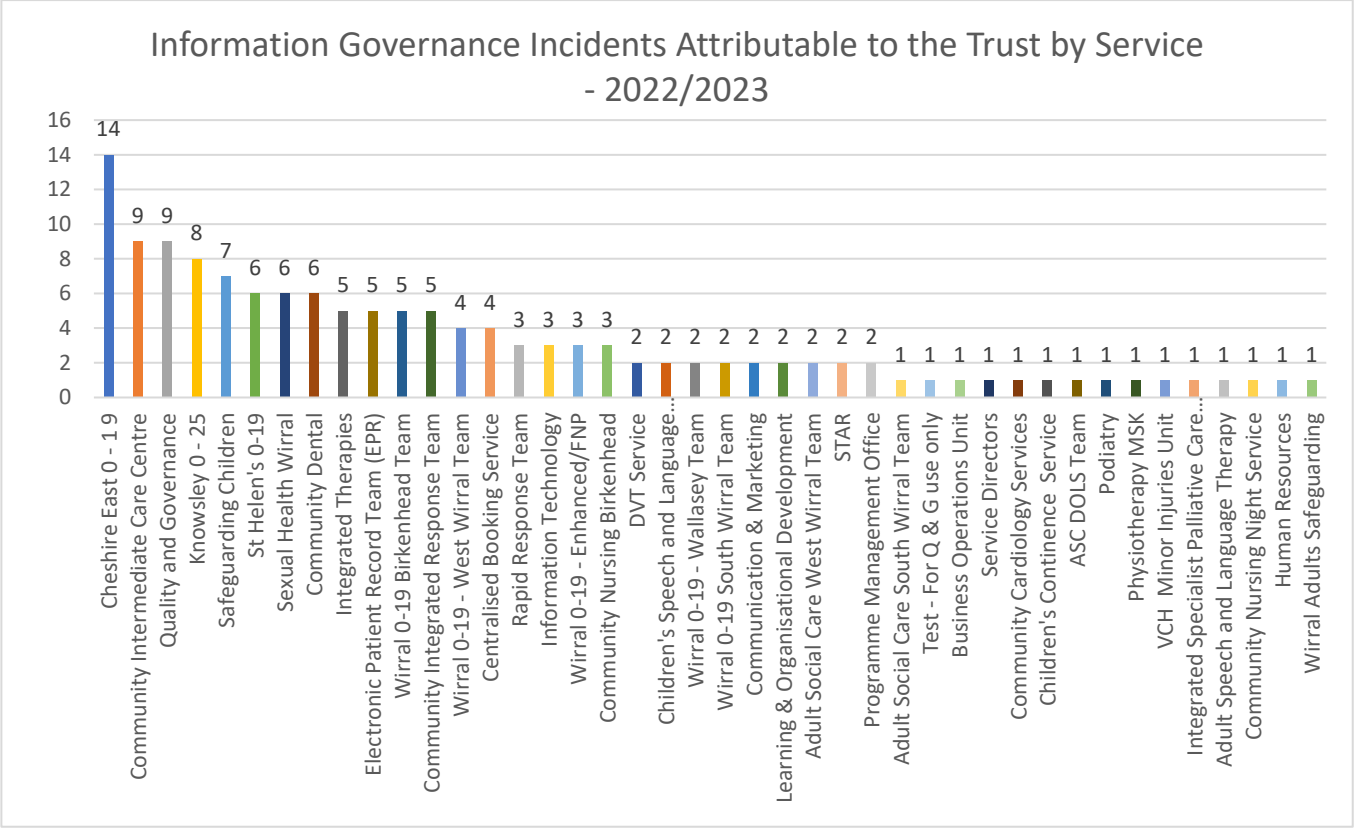
Subject Access Requests	2020/21	2021/22	2022/23
Number of SAR requests	328	368	420
% Managed within one calendar month	94%	97%	97%

Information Governance Incidents

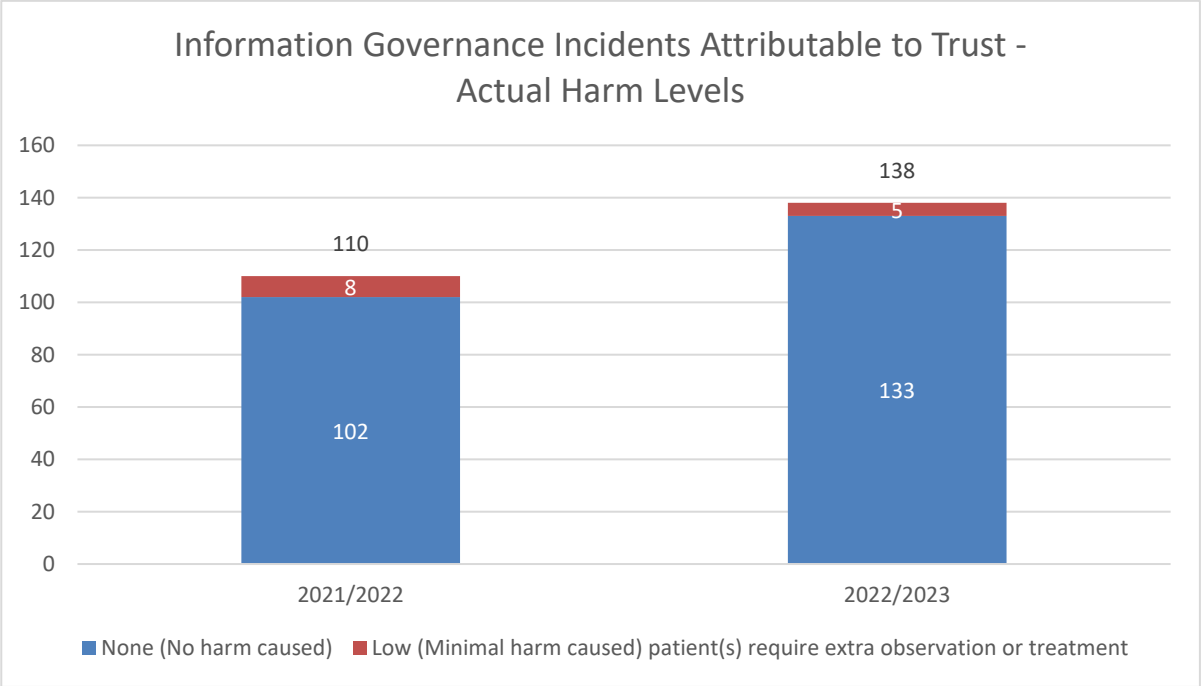
36. During the period 01 April 2022 to 31 March 2023, 208 Information Governance incidents were reported by Wirral Community Health and Care Foundation Trust staff. Of these,138 were deemed attributable to the Trust. This is compared to 110 reported during the 2021/22 period.

    Of the 138 incidents, 133 (96%) were classified as resulting in no harm with the remaining incidents classified as low harm. This is indicative of a strong culture of reporting and learning, supported by the Trust's approach to disseminating learning from incident reporting.

Graph 1: Graph to show Information Governance incidents relating directly to Trust Services between April 2022 and March 2023



Graph 2: Shows the number of different harm levels for IG incidents between April 2022 and March 2023



37. As illustrated in Graph 1 Cheshire East 019 (14), Community Intermediate Care Centre (9) and Quality and Governance (9) reported the most Information Governance incidents between 01 April 2022 and 31 March 2023.

The Trust's Information Governance Team is incorporated in the Quality and Governance Service which shares incidents that are applicable to services Trust-wide to enhance visibility whilst maximising learning opportunities.

Trust wide themes from reported Information Governance incidents include:

- Record Keeping
- Information being emailed to the wrong recipient within the Trust
- Overflowing confidential waste bins
- Paper containing identifiable information found in unlocked cabinets

Learning from incident investigations is disseminated Trust-wide via the twice weekly 'The Update', and example of this is as follows:

38. The Information Governance Team are automatically notified of all Information Governance incidents reported on Datix. The IG Team provide bespoke advice and guidance to incident reviewers. Where service specific trends have been identified, an action plan will be developed to support both mitigation and reduction of incident type.

39. The following actions have been taken to ensure learning from identified Trust wide themes:
    - Communication and guidance for staff through Staff Zone, The Update (staff bulletin), screensavers, the Information Governance area on Staff Zone and through an Information Governance Special Edition:

    - Communications Bulletins have been disseminated following identified areas of improvement.
    - The IG team has continued to offer IG and Record-Keeping training to services across the Trust to ensure compliance with Trust standards.
    - Environmental Information Governance audits have been conducted to identify any breaches and improve staff awareness. Where required, action plans have been put in place to improve IG compliance and to support service specific learning.
    - Information Governance policies have been reviewed and updated where required to outline the Trust's position clearly and consistently on information governance. This ensures the confidentiality, integrity, and appropriate availability of information.
    - Targeted support has been given to services where required when there has been an increase in IG incidents.
    - Processes for permanent removal requests have been updated, following a high number of record-keeping incidents. Weekly monitoring now takes place to ensure that all services are following the processes correctly.
    - The SAFE IG Checklist questions are reviewed every 3 months, based on IG incidents that have been reported in Datix. This ensures that learning from individual incidents is disseminated to all services within the Trust.

Information Governance Incidents Reported to the Information Commissioner's Office

40. WCHC reported 2 incidents to the Information Commissioner's Office between 01 April 2022 to 31 March 2023.

Table 4: Information relating to incidents reported to the ICO by the Trust during 2022/23

Incident ID	Month incident reported to the ICO	Brief description of the incident
W50179	October 2022	Inappropriate access to records with no apparent legitimate access. This incident was raised directly with the service user ensuring transparency and subject to a robust investigation. Learning from the investigation was offered to the service user and implemented in accordance with Trust governance processes.
W49517	August 2022	National cyber-attack targeting NHS supplier Advantage. Advantage acted quickly and isolated the affected servers to minimise impact, however, this resulted in some applications being inaccessible. The impact to the Trust was minimal as only one historical system used in a read only mode for accessing legacy date was affected. The Trust reported the incident in-line with national guidance. The issue was promptly resolved with no impact to patient care.

41. The Information Commissioner's Office (ICO) were satisfied with the internal investigations and measures implemented following both incidents and consequently both cases were closed with no further action.

Information Governance Risks

42. During the period 1 April 2022 - 31 March 2023, 4 Information Governance risks were added to the Trust's risk register each with an initial risk rating of 12. Control measures were effectively implemented to mitigate risk to Trust services.

Table 5: Information Governance risks added to the Trust's risk register in 2022/23

Number	Risk ID	Description	Closed/Active
1.	2856 (Organisation wide)	Access to historical paper records for a service transferred to the Trust. Records are currently being transferred to storage arrangements managed by the Trust.	**Active**
2.	2845	DPIA approved for a product required by 0-19 Wirral to complete Connors Assessments on children. Appropriate steps taken to safeguard data considering international data transfer (UK - USA/Canada).	**Closed**
3.	2800	Delay in FOI responses due to IG resource	**Closed**
4.	2840	Wirral 0-19 use of Connor forms to complete ADHD assessments. The supplier hosts data in the USA.	**Closed**

Annual Data Security Awareness E Learning

43. All employees of the Trust, including Non-Executive Directors bank staff and volunteers, individuals on secondment, trainees, those on a training placement as well as locum or temporary staff employed through an agency are required to complete annual Data Security Awareness Training (1 April to 31 March.) This is mandated against annual training requirements.

44. Assertion 3.2.1 of the DSPT sets a mandatory requirement that all NHS Organisations achieve at least 95% compliance with completion of e-learning for Healthcare **Data Security Awareness E Learning** annually.

45. In 2022/23 Mandatory Data Security Awareness e-Learning was successfully completed by 95% of staff across the Trust.

Summary of Key Achievements in 2022/23

46. During the reporting period 01 April 2022 - 31 March 2023 the following were all achieved in relation to Information Governance:

- Mandatory Data Security Awareness e-Learning was successfully completed by 95% of staff across the Trust
- Board annual training completed
- The Trust was awarded 'Substantial Assurance' for their DSPT following a review by MIAA **(Appendix 1)**
- **DSPT submitted with all standards met**
- All reported Information Governance incidents attributable to the Trust have been reported and presented to the Information Governance and Data Security Group
- All Information Governance policies reflect national standards and remain in-date
- Maintained a strong compliance rate of 97% for Subject Access Requests being responded to within time frame.

  Positive staff response to the Information Governance Special Edition

Priorities for 2023/24

47. The Information Governance priorities for the reporting period 01 April 2023 - 31 March 2024 are:

- Compliance with all mandatory requirements of the 2023/2024 Data Security and Protection Toolkit
- Implementation of the recommendations within the Trust's MIAA DSPT report (**Appendix 1**)
- To strengthen controls by documenting the data security organisational structure and the reporting lines to the SIRO
- To ensure monitoring of the newly announced Data Protection and Digital Information Bill due for Royal Assent in Spring 2024. The Bill is expected to introduce significant changes to the UK GDPR and the Data Protection Act 2018.
- Reduction in the number of ICO reportable Information Governance Incidents
- Implementation of an improvement plan to increase the percentage of Freedom of Information responses managed within national timescales to 90%
- Maintain >95% of staff compliance with Data Security Awareness E Learning

Alison Hughes
Director of Corporate Affairs and Senior Information Risk Owner (SIRO)

Nick Cross
Executive Medical Director and Caldicott Guardian

27 July 2023

Data Security and Protection Toolkit Assessment Summary Report 2022/23 (Final)

Wirral Community NHS Foundation Trust

Report Ref: 133WIRRCFT_2223_902

Date of Issue: 26th June 2023

Contents

Limitations

The matters raised in this report are only those which came to our attention during our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist, or of all the improvements that may be required. Whilst every care has been taken to ensure that the information in this report is as accurate as possible, based on the information provided and documentation reviewed, no complete guarantee or warranty can be given with regards to the advice and information contained herein. Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system.

Reports prepared by MIAA are prepared for your sole use and no responsibility is taken by MIAA or the auditors to any director or officer in their individual capacity. No responsibility to any third party is accepted as the report has not been prepared for, and is not intended for, any other purpose and a person who is not a party to the agreement for the provision of Internal Audit and shall not have any rights under the Contracts (Rights of Third Parties) Act 1999.

Future periods

The assessment of controls relating to the process is that at June 2023. Historic evaluation of effectiveness is not always relevant to future periods due to the risk that:

- The design of controls may become inadequate because of changes in the operating environment, law, regulation or other; or
- The degree of compliance with policies and procedures may deteriorate.

Public Sector Internal Audit Standards

Our work was completed in accordance with Public Sector Internal Audit Standards.

Key Dates

Report Stage	Date
Discussion Document Issued	22nd June 2023
Discussion Meeting	23rd June 2023
Final Draft Report Issued	23rd June 2023
Client Approval Received	26th June 2023
Final Report Issued	26th June 2023

Report Distribution

Name	Title
Mark Greatrex	Chief Finance Officer/ Deputy Chief Executive
Alison Hughes	Director of Corporate Affairs/ SIRO
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Dave Murphy	Chief Information Officer
Anna Simpson	Information Governance Manager / DPO
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Acknowledgement and Further Information

MIAA would like to thank all staff for their co-operation and assistance in completing this review. This report has been prepared as commissioned by the organisation and is for your sole use. If you have any queries regarding this review, please contact the Senior Technology Risk Assurance Manager. To discuss any other issues then please contact the Head of Technology Risk Assurance. MIAA would be grateful if you could complete a short survey using the link below to provide us with valuable feedback to support us in continuing to provide the best service to you. https://www.surveymonkey.com/r/MIAA_Client_Feedback_Survey

1 Introduction, Background and Objective

In 2018 the Information Governance toolkit (IGT) was withdrawn and replaced with the new Data Security and Protection Toolkit (DSPT). It was developed by NHS Digital in response to The National Data Guardian's Review of Data Security, Consent and Opt-Outs published in July 2016 and the subsequent Government response, Your Data: Better Security, Better Choice, Better Care, published in July 2017.

The DSPT is a tool which allows organisations to measure their compliance against legislation and central guidance, and helps identify areas of full, partial or non-compliance.

In July 2021, NHS Digital published a methodology for independent assessment and internal audit providers to implement when performing DSPT audits for 2022/23 which included a set scope for the review.

The published assessment methodology requires assessors/auditors to form a view on the in-scope assertions and key elements of your DSP Toolkit environment including:

- An assessment of the overall risk associated with the organisation's data security and data protection control environment. i.e. the level of risk associated with controls failing and data security and protection objectives not being achieved;
- An assessment as to the veracity of the organisation's self-assessment / DSP Toolkit submission and the assessor's level of confidence that the submission aligns to their assessment of the risk and controls.

The guidance also provides a reporting and scoring standard.

Whilst this guidance has formed the basis of our approach, we have had to apply flexibility and pragmatism to the approach given the impacts and challenges for organisations during the ongoing coronavirus pandemic. As such, review and assessment in some instances has been based on evidence as provided rather than that independently obtained.

2 Scope

In accordance with the guidance mandated by NHS Digital, the selected thirteen DSPT assertions assessed during this review were:

Area	Description
1.3	Accountability and Governance in place for data protection and data security
2.1	Staff are supported in understanding their obligations under the National Data Guardian's Data Security Standards
3.4	Leaders and Board members receive suitable data protection and security training

Area	Description
4.1	The organisation maintains a current record of staff and their roles
4.2	The organisation assures good management and maintenance of identity and access control for its networks and information systems
4.5	You ensure your passwords are suitable for the information you are protecting
5.1	Process reviews are held at least once per year where data security is put at risk and following data security incidents
6.3	Known vulnerabilities are acted on based on advice from NHS Digital, and lessons are learned from previous incidents and near misses
7.2	There is an effective test of the continuity plan and disaster recovery plan for data security incidents
7.3	You have the capability to enact your incident response plan, including effective limitation of impact on your essential service. During an incident, you have access to timely information on which to base your response decisions
8.3	Supported systems are kept up-to-date with the latest security patches
9.3	Systems which handle sensitive information or key operational services shall be protected from exploitation of known vulnerabilities
10.1	The organisation can name its suppliers, the products and services they deliver and the contract durations

The scope of this review included only the mandatory elements of the above selected assertions.

3 Executive Summary

Wirral Community Health and Care NHS Foundation Trust provides high-quality primary, community and social care services to the population of Wirral and Cheshire East.

The Trust have demonstrated a framework was in place in relation to data security and protection with commitment and support by senior management. There was a defined organisational structure with associated committees and supporting policies and procedures were in place.

The Trust has demonstrated its plans for the completion of its toolkit submission in time for the June 2023 submission.

3.1 Areas of good practice

During our review we noted the following areas of good practice:

- There was a range of IG policies and procedures in place which were all within their review period. The Trust had in place a process to monitor compliance with the policies (1.3.1 & 1.3.2).
- It was identified that data security and protection risks were being managed in line with the risk management policy (1.3.5 & 1.3.6).
- There was a data protection by design and by default standard operating procedure in place which had been approved by the Information Governance and Data Security Group (IGDS) (1.3.7).
- Responsibility for data protection and security had been delegated by the Board to the Quality and Safety Committee and ultimately the IGDS (1.3.9).
- There was a mandatory training process for data security awareness for new starters. Testing identified that each new starter within the sample had completed their mandatory training in line with the induction policy (2.1.1).
- Testing undertaken on a sample of leavers identified that each had their access removed in line with the Leavers Procedure. None of the sampled leavers had accessed their accounts subsequent to their termination date (4.2.1 & 4.2.4).
- The Trust had a Logging and Monitoring Standard which governed the review and collection of activity logs. We were provided evidence that user activity logs were retained for at least 12 months (4.2.3).
- There were passwords controls in place at the Trust including password deny lists, password management tools and multi-factor authentication (MFA). The Trust's infrastructure had been tested for weak passwords and there was a robust process to ensure social media accounts operated by the Trust had strong passwords (4.5.1, 4.5.2, 4.5.3 & 4.5.4).
- There was a robust incident management and root cause analysis (RCA) process in place at the Trust. Since July 2022, there had been no incidents that required an RCA to be undertaken. (5.1.1).
- Furthermore, we were informed that there were no data security incidents that had resulted from a known vulnerability (6.3.1).
- Review of the Trust's Cyber Alert KPI report identified that every cyber alert had been responded to within 48 hours (6.3.2).
- The Trust had a backup standard in place which included Recovery Time and Recovery Point Objectives (RTO/RPO). Testing a sample of systems identified that these objectives had been agreed with the IAO for the system. The Trust could demonstrate that backups of critical systems were tested on a monthly basis (7.3.5).

- Testing undertaken on a sample of endpoints and servers identified that each had been patched in line with the Cyber Security Standard. The Trust had the ability to automatically deploy patches to endpoints. (8.3.1 & 8.3.2).
- There was evidence that the Trust was actively using Advanced Threat Protection (ATP) and Microsoft Defender for Endpoint (MDE) as a key part of the cyber security monitoring tooling (8.3.6).
- Evidence was provided that the Trust's server and endpoint estate was above 95% and 98% respectively. It was identified that all of the Trust's servers were on supported operating systems (8.3.7)
- The Trust was registered for and was actively using the NCSC's suite of services including the early warning service and the Webcheck service (8.3.8 & 9.3.7).
- There was a technical solution in place to block connections to malicious websites which was provided by the Smoothwall system (9.3.3).
- Although the Trust did not report any connected medical devices at the time of the review, there were policies in place for the management of medical devices (9.3.8 & 9.3.9).

3.2 Areas of vulnerability and/or where improvement is required

Our detailed findings and recommendations are described in more detail in a spreadsheet that has been provided under separate cover in order that vulnerabilities are not described in detail within this document. The spreadsheet should be treated as confidential as disclosure, without significant redaction, may result in any vulnerabilities becoming more widely known and exploited.

The key areas identified, however, can be summarised thus:

- The Trust should document its process in relation to identifying third party risks and raising these on the corporate risk register (1.3.5).
- Although there was a Data Privacy Impact Assessment (DPIA) procedure in place, it would benefit from being reviewed on a bi-ennial basis in line with the assertion (1.3.8).
- We were not provided evidence the Training Needs Analysis (TNA) had been reviewed and approved (3.4.1 & 3.4.2).
- The Trust should continue its plan to remove/replace systems which do not use windows login credentials for authentication (4.1.1).
- As planned, the Trust should continue to test and implement the Duo system to enhance the MFA controls in place (4.5.3).
- The Trust should develop a cyber security strategy with consideration of the proposed Cheshire and Merseyside Integrated Care System (ICS) Cyber Security Strategy. The Trust should consider documenting any gaps in the cyber security monitoring processes once the strategy is in place (6.3.3).

- It was identified that the Trust could make improvements to its fraud risk assessments process. For example, include documenting which systems have been assessed to be attractive to cyber criminals and the controls in place to mitigate the risk posed (6.3.4).
- As planned, the Trust should complete, document and report the completion of a disaster recovery and business continuity exercise ahead of submission (7.2.1 & 7.2.2).
- The Trust should ensure it retains evidence that the Cyber Incident Response Plan has been reviewed and approved by an appropriate group or committee. As planned, the Trust would benefit from ensuring staff involved in cyber incident management have received appropriate training (7.3.1).
- The emergency contact list should be reviewed on a regular basis. The Trust should retain evidence of the review process (7.3.2).
- Although it appeared that the Trust had an immutable backup solution, the Trust should liaise with the supplier to gain assurance the solution is fully immutable or there is an adequate air gap to the live environment (7.3.6).
- The Trust should review its Cyber Security Standard to include the specific process for the SIRO risk acceptance of critical security updates that cannot be remediated within 14 days or at all. It was noted that 3 of the 10 high risk NHS Cyber Alerts tested had not been remediated within 14 days and there was no evidence of explicit risk acceptance by the SIRO (8.3.3, 8.3.4 & 8.3.5).
- The supplier/contract list should be reviewed on a regular basis. The Trust should retain evidence of the review process (10.1.1).

4 Assessment and Assurance

4.1 Assessment of self-assessment

In our view, the organisation's self-assessment against the Toolkit does not differ / deviates only minimally from the Independent Assessment and, as such, the assurance level in respect of the veracity of the self-assessment is:

Substantial

4.2 Assessment against National Data Guardian Standards

Across the National Data Guardian Standards our assurance ratings, based upon criteria at Appendix B are:

National Data Guardian Standard level	Overall assurance rating at the National Data Guardian level
1. Personal Confidential Data	Substantial
2. Staff Responsibilities	Substantial
3. Training	Substantial
4. Managing Data Access	Substantial
5. Process Reviews	Substantial
6. Responding to Incidents	Substantial
7. Continuity Planning	Substantial
8. Unsupported Systems	Substantial
9. IT Protection	Substantial
10. Accountable Suppliers	Substantial

The rating is based on a mean risk rating score at the National Data Guardian (NDG) standard level. Scores have been calculated using the guidance from the independent assessment Guidance document.

As a result of the above, our overall assurance level across all 10 NDG Standards is rated as:

Substantial

Appendix A: Terms of Reference

Our work aimed to assess and provide assurance based upon the validity of the organisation's intended final submission and consider not only if the submission is reasonable based on the evidence submitted, but also provide assurance based on the extent to which information risk has been managed in this context.

Our scope was based on that recommended as part of the Data Security and Protection (DSP) Toolkit Strengthening Assurance Guide published in 2022 by NHS Digital. As such our assessment involved the following steps:

- Obtain access to your organisation's DSP Toolkit self-assessment.
- Discuss the mandatory assertions that will be assessed with your organisation and define the evidence texts that will be examined during the assessment.
- Request and review the documentation provided in relation to evidence texts that are in scope of this assessment prior to the audit (if applicable).
- Interviewing the relevant stakeholders as directed by the organisation lead, who are responsible for each of the assertion evidence texts/self-assessment responses or people, processes and technology.
- Review the operation of key technical controls on-site using the DSP Toolkit Independent Assessment Framework as well as exercising professional judgement and knowledge of the organisation being assessed.

Selected Assertions

As based on the recommended scoping from NHS digital the selected thirteen assertions are as follows:

Area	Description
1.3	Accountability and Governance in place for data protection and data security
2.1	Staff are supported in understanding their obligations under the National Data Guardian's Data Security Standards
3.4	Leaders and Board members receive suitable data protection and security training
4.1	The organisation maintains a current record of staff and their roles

Area	Description
4.2	The organisation assures good management and maintenance of identity and access control for its networks and information systems
4.5	You ensure your passwords are suitable for the information you are protecting
5.1	Process reviews are held at least once per year where data security is put at risk and following data security incidents
6.3	Known vulnerabilities are acted on based on advice from NHS Digital, and lessons are learned from previous incidents and near misses
7.2	There is an effective test of the continuity plan and disaster recovery plan for data security incidents
7.3	You have the capability to enact your incident response plan, including effective limitation of impact on your essential service. During an incident, you have access to timely information on which to base your response decisions
8.3	Supported systems are kept up-to-date with the latest security patches
9.3	Systems which handle sensitive information or key operational services shall be protected from exploitation of known vulnerabilities
10.1	The organisation can name its suppliers, the products and services they deliver and the contract durations

The scope of this review included only the mandatory elements of the above selected assertions.

Appendix B: Assurance Definitions and Risk Classifications

Overall NDG Standard Assurance Rating Classification	Rating Thresholds when only 1 assertion per NDG Standard is in scope	Rating Thresholds when 2 or more assertions are in scope for each NDG Standard. Mean score (Total points divided by the number of in-scope assertions)
Substantial	1 or less	1 or less
Moderate	Greater than 1, less than 10	Greater than 1, less than 4
Limited	Greater than/equal to 10, less than 40	Greater than/equal to 4, less than 5.9
Unsatisfactory	40 and above	5.9 and above

Overall risk rating across all in-scope standards

Unsatisfactory	1 or more Standards is rated as 'Unsatisfactory'
Limited	No standards are rated as 'Unsatisfactory', but 2 or more are rated as 'Limited'
Moderate	There are no standards rated as 'Unsatisfactory', and 1 or none rated as 'Limited'. However, not all standards are rated as 'Substantial'.
Substantial	All of the standards are rated as 'Substantial'

Level of deviation from the DSP Toolkit submission and assessment findings	Confidence level	Assurance level
High – the organisation's self-assessment against the Toolkit differs significantly from the Independent Assessment For example, the organisation has declared as "Standards Met" or "Standards Exceeded" but the independent assessment has found individual National Data Guardian Standards as 'Unsatisfactory' and the overall rating is 'Unsatisfactory'.	Low	Limited
Medium - the organisation's self-assessment against the Toolkit differs somewhat from the Independent Assessment For example, the Independent Assessor has exercised professional judgement in comparing the self-assessment to their independent assessment and there is a non-trivial deviation or discord between the two.	Medium	Moderate
Low - the organisation's self-assessment against the Toolkit does not differ / deviates only minimally from the Independent Assessment	High	Substantial