NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Meeting of the Trust Board of Directors held in Public
1.30pm on Wednesday 28 November 2018
Boardroom, Redesmere

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/84	Apologies for absence	Receive apologies	Verbal	Chair	1:30pm (2 mins)
18/19/85	Declarations of Interest	Identify and avoid conflicts of interest	Verbal	Chair	1:32pm (2 mins)
18/19/86	Meeting Guidelines	To note	Paper	Chair	1:34pm (1 mins)
18/19/87	Minutes of the previous meeting held on 28 September 2018	Confirm as an accurate record the minutes of the previous meetings	Paper	Chair	1:35pm (3 mins)
18/19/88	Matters arising and action points	Provide an update in respect of ongoing and outstanding items to ensure progress	Paper	Chair	1:38pm (5 mins)
18/19/89	Board Meeting business cycle 2018/19	To note	Paper	Chair	1:43pm (2 mins)
Strategic Change					
18/19/90	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1:45 (10 mins)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/91	Chief Executive's announcements *(including overview of items discussed in closed meeting)*	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	**1:55pm (20 mins)**
18/19/92	Adult & Older People's Specialist Mental Health Redesign: East/South Cheshire/Vale Royal	To note	Presentation	Director of Operations	**2:15pm (40 mins)**
Quality of Care					
18/19/93	Lived experience connector refresher training	To note	Verbal	Associate Director of Patient and Carer Experience	**2:55pm (5 mins)**
18/19/94	CQC Community Mental Health Survey (themes and improvement plan)	To note	Presentation	Associate Director of Patient and Carer Experience	**3:00pm (5 mins)**
18/19/95	Monthly Ward Staffing Up-date September and October 2018	To note the ward staffing reports	Paper	Director of Nursing, Therapies and Patient Partnership	**3:05pm (5 mins)**
18/19/96	Bed Hub Presentation - *Focus on whole system flow to eliminate mental health acute out of area- the national programme*	To note	Presentation	*Dr Ian Davidson & Sarah Quinn*	**3:10pm (40 mins)**
Operational Performance, Finance and Use of Resources					
18/19/97	Healthcare worker flu vaccination best practice management checklist	To approve	Paper	Chief Pharmacist	**3:50pm (5 mins)**

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/98	Operational Plan / Board Performance Dashboard	To note performance	Paper	Director of Finance	**3.55pm (10 mins)**
Well-led (leadership and improvement capability)					
18/19/99	Guardian of Safe Working Quarterly Report	To note	Paper	Guardian of Safe Working	**4:05pm (5 mins)**
18/19/100	Annual Research Report 2017/18	To note	Paper	Medical Director Effectiveness, Medical Education and Medical Workforce	**4:10pm (5 mins)**
Governance and Regulation					
Governance and regulation: Assurance and escalation reports from Board Sub-committees (discussion by exception only)					
18/19/101	Provider Licence Compliance	To note	Paper	Director of Finance	**4:15pm (5 mins)**
18/19/102	Chair's Report of the Operational Committee held on 21 November 2018	To note	Paper	Chair of Operational Committee	**4:20pm (5 mins)**
18/19/103	Chair's Report of the Quality Committee held on 7 November 2018	Review Chair's Report and any matters for note/ escalation	Paper	Chair of Quality Committee	**4:25pm (5 mins)**

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/104	Chair's Report of the Audit Committee held on 13 November 2018 (Including Terms of Reference)	Review Chair's Report and any matters for note/ escalation	Paper	Chair of Audit Committee	**4:30pm (5 mins)**
Closing Business					
18/19/105	Any other business	Consider any urgent items of other business	Verbal	Chair	**4:35pm (5 mins)**
18/19/106	Questions from observers or members of the public. *(relating to specific items on the agenda)*	To encourage openness and transparency	Verbal	Chair	**4:40pm (10 mins)**
18/19/107	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair/ All	**4:50pm (3 mins)**
18/19/108	Key messages for communication	Agree items of particular importance to communicate to staff, governors or other key stakeholders	Verbal	Chair	**4:53pm (5 mins)**
18/19/109	Review of meeting performance	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair/All	**4:58pm (2 mins)**
18/19/110	Date, time and place of next meeting: **Wednesday 30 January 2019 1:30pm – Redesmere**	Confirm arrangements for next meeting	Verbal	Chair	**5:00 (2 mins)**

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting Attendees' Guidance, January 2016

Under the direction and guidance of the Chair, all members are responsible for ensuring that the meeting achieves its duties and runs effectively and smoothly.

Before the meeting

- Prepare for the meeting in good time by reviewing all reports (the amount of time allocated for each agenda item can be used to guide your preparation);
- Submit any reports scheduled for consideration at least 10 days before the meeting to the meeting administrator (using the standard report template);
- Ensure your apologies are sent if you are unable to attend and *arrange for a suitable deputy to attend in your absence.

*some members may send a nominated representative who is sufficiently senior and has the authority to make decisions. Refer to the terms of reference for the meeting to check whether or not this is allowable.

At the meeting

- Arrive on time;
- Switch off mobile phone / blackberry;
- Focus on the meeting at hand and not the next activity or on your emails;
- Actively and constructively participate in the discussions;
- Think about what you want to say before you speak; explain your ideas clearly and concisely and summarise if necessary;
- Make sure your contributions are relevant and help move the meeting forward;
- Respect the contributions of other members of the group and do not speak across others;
- Ensure you understand the decisions, actions, ideas and issues agreed and to whom responsibility for them is allocated;
- Do not use the meeting to highlight issues that are not on the agenda;
- Re-group promptly after any breaks;
- Take account of the Chair's health, safety and fire announcements (fire exits, fire alarm testing, etc).

Attendance

- Members are expected to attend all meetings and at least 50% of all meetings held each year.

After the meeting

- Follow up on actions;
- Inform colleagues appropriately of the issues discussed.

Standards

- All documentation will be prepared using the standard Trust templates. A named person will oversee the administrative arrangements for each meeting;
- Agenda and reports will be issued 7 days before the meeting;
- An action schedule will be prepared and circulated to all members 2 days after the meeting;
- The minutes will be available at the next meeting.

Also under the guidance of the Chair, members are also responsible for the meeting's compliance with relevant legislation and Trust policies, up-to-date versions of which are available on the Trust's website, via the governance team or the Company Secretary.

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DRAFT Minutes of the Public Board of Directors Meeting
Friday 28th September 2018
YMCA, Crewe - commencing at 1.30pm

PRESENT	Mike Maier	Chair
	Sheena Cumiskey	Chief Executive
	Avril Devaney	Director of Nursing, Therapies and Patient Partnership
	Dr Anushta Sivananthan	Medical Director, Quality, Compliance and Assurance
	Andy Styring	Director of Operations
	Tim Welch	Director of Finance
	Andrea Campbell	Non-Executive Director
	Dr James O'Connor	Non-Executive Director
	Lucy Crumplin	Non-Executive Director
	Ann Pennell	Non-Executive Director
IN ATTENDANCE	Gemma Caprio	Head of Corporate Affairs (interim)
	Katherine Wright	Associate Director of Communications and Engagement
	Suzanne Christopher	Corporate Affairs Manager (mins)
	Observing:	
	Keith Miller	Governor
	Ellie Holmes	NHS Professionals
APOLOGIES	Dr Faouzi Alam	Medical Director, Effectiveness, Medical Education and Medical Workforce, Caldicott Guardian
	David Harris	Director of People and Organisational Development
	Rebecca Burke-Sharples	Non-Executive Director
	Edward Jenner	Non-Executive Director

	MINUTES	**ACTION**
18/19/54	**APOLOGIES AND ABSENCE** The Chair welcomed all to the meeting. The meeting was quorate. Apologies were noted as above. The Chair welcomed two visitors to the meeting, Ellie Holmes – NHS Professionals and Keith Millar – Service User and Carer Governor.	
18/19/55	**DECLARATIONS OF INTEREST** There were none declared.	
18/19/56	**MEETING GUIDELINES** The meeting guidelines were noted.	
18/19/57	**MINUTES OF PREVIOUS MEETINGS** The minutes of the meetings held on the **25th July 2018** were reviewed. *Item 18/19/45 – Medical Appraisal Annual Report and Annual Declaration*	

	– reference to patient review is incorrect – instead the review related to appraisals. To clarify the friends and family test will be included in all Doctor's appraisals. The Board of Directors **approved** the minutes of the Open Board held on the **25th July 2018** as an accurate record.	
18/19/58	**MATTERS ARISING AND ACTION POINTS** The action log was reviewed as follows:- *Item 18/19/39 – Strategic Risk Register – Review and Consider the presentation of the BAF.* G Caprio advised that this will be further developed as part of the Register review via the Corporate Governance meetings.	
18/19/59	**BOARD MEETING BUSINESS CYCLE** The Board of Directors **noted** the Business Cycle.	
18/19/60	**CHAIR'S ANNOUNCEMENTS** The Chair provided the following updates: **CQC Well-Led Inspection** The Board were advised the inspection process had concluded the previous week. The Chair acknowledged the huge amount of work that this had involved and reflected how proud he was that the Trust used this as a welcoming opportunity to demonstrate good practice and to consider how we can further improve. The Trust now awaits the report from the CQC which is due later this year. The Chair expressed his thanks to all staff involved in this process. **Trainee Nursing Associates Celebrated** On Monday 10 September, the Trust welcomed Lord Willis of Knaresborough to Sycamore House to celebrate the success of our first ever cohort of local Trainee Nursing Associates. CWP is the lead employer for the Cheshire and Wirral Nursing Associate pilot and has introduced Lived Experience Connectors to support our trainees and to further encourage their Person-Centred approach to care. **Big Book of Best Practice and Annual Members Meeting** On Thursday 4 October, our latest annual Best Practice event will be taking place at Ellesmere Port Civic Hall. This is an opportunity for CWP to share best practice ideas with each other and our partners and to showcase the excellent work staff have carried out over the past year. In the afternoon, we will hold our Annual Members' meeting at which members will hear from our Board about our work, progress and future plans. **Flu Campaign 2018/19** This year's flu campaign will commence very soon. CWP are encouraging all of our staff to take the offer of the flu vaccination to ensure they are protected ahead of the winter months. The campaign will be widely publicised.	

18/19/61	**CHIEF EXECUTIVE ANNOUNCEMENTS** S Cumiskey summarised the items discussed at Closed Board that morning as follows:- Board members: • Discussed the progress across Cheshire and Wirral in integrating care • Considered the informal feedback received from the CQC. • Discussed patient confidentiality issues in regards to serious untoward incidents and complaints. • Considered the Trust's response to the recent Carter Report. • Agreed the maturity matrix for our care group assessment process. • Agreed the Wirral Partnership Memorandum of Understanding. • Considered the risks associated with maintaining safe and effective services in Cheshire East and the mitigations currently in place. • Considered the Trust's financial performance to date. • Received an up-date on the transfer of All Age Disability Services to CWP. • Approved the Medicines Supply Business Case. • Discussed our Improvement Measurement Projects. • Discussed how to take forward our Estates collaboration work. • Approved the establishment of a Task and Finish group to consider the sustainability of services provided by CWP. **All Age Disability Services Transfer** S Edwards advised that the All Age Disability Service transferred to the Trust with effect from 19 August 2018. 124 staff were involved in the transfer, which was completed under a section 75 agreement for a period of five years. S Edwards offered her thanks to all those involved who enabled this process to be successful. A service specification has been agreed to outline how services will be delivered. The first year following the transfer will be a period of stability to allow the service to become established within CWP, before aligning this within one of the Care Groups. The Trust continues to work in partnership with the Local Authority regarding professional support for the Social Workers. Going forward monthly contract meetings will be held to monitor progress. A dashboard is also being developed and will be reported to Quality Committee. A 90 day plan has been developed with clearly established outcomes. At each stage, progress of the mobilisation will be reviewed. The learning from this process will be shared across the Trust and may lead to similar opportunities for CWP in the future. **Suicide Prevention** S Cumiskey advised that a recent report considering suicide prevention had been published which also includes a useful learning guide. As with all national reports, the Trust is considering the detail of the report and will reflect on CWP's practices accordingly. **ACTION** – Report and Learning to be brought back to January 2019 Board.	**Dr A Sivananthan**

	East Cheshire Substance Misuse Services Transfer The Trust's East Cheshire Substance Misuse Services will transfer to a new provider with effect from the 1st November 2018. The Board noted their thanks to the staff and wished them well with their new provider. A number of events will be held to say goodbye and formally thank the staff for all their work.	
18/19/62	**ADULT AND OLDER PEOPLE'S SPECIALIST MENTAL HEALTH REDESIGN: EAST/SOUTH CHESHIRE/VALE ROYAL** S Edwards introduced the item. The SBAR and briefing included in the papers outlined the current position. The findings of the consultation were published on the 10 September 2018. The proposals include less reliance on inpatient beds and look at ensuring good quality community and crisis services to meet the needs of the community. Further to the findings, the CCGs had requested additional information regarding finances, travel arrangements, crisis care, transition processes and estates issues. The CCGs will now lead on this process. An Overview and Scrutiny Committee meeting was also held recently at which it was confirmed that the Committee were satisfied with the consultation process and agreed no further action was required. A decision-making business case will now be prepared by the CCG's and shared with the committees in common, which consists of representatives of the governing bodies of the three CCGs. Assurance will also be provided by the CCGs to NHS England to confirm due process has been followed. Support has been provided to staff members throughout this process and a number of drop in sessions have also been offered. Board members are asked to note the content of the report and the timeline for the next steps. Dr A Sivananthan reiterated that the process is being led by the three CCGs, and CWP are providing advice and support to the process. A number of assurance processes have to be followed and the plans are to provide services to a population of just less than half a million. The plans consider how new models of care can be provided in line with the Five Year Forward View. A Styring confirmed that the focus continues to be around how CWP maintain the delivery of safe and effective services in this area. The Board of Directors **noted** the report and the timeline.	
18/19/63	**MONTHLY WARD STAFFING UP-DATE – JULY & AUGUST 2018** A Devaney introduced the item. The report demonstrates how the Trust is performing in regards to staffing establishments and is presented to Board each time. In both July and August compliance rates were over 90%. Where staffing establishments fall below the appropriate compliance levels, plans are	

	implemented to ensure staffing is safe. A Devaney also provided an overview of the Trainee Nursing Associates. The Trust is planning an in-take of 14 Trainee Nursing Associates in December 2018 and March 2019. The Trainee Nursing Associates are experienced support workers who have taken the opportunity to develop. The standards for this role were published by the NMC on the 27 September 2018. This role is about adding to the skill mix. As a Trust we are developing robust recruitment campaigns, we are pro-actively engaging with local universities. We have organised a recruitment event for Saturday 29 September and have shortlisted 28 candidates. Some of the candidates are due to qualify next year. If successful at interview, and providing they qualify, they will then have a secured position following their studies. Dr J O'Connor queried the staffing reports for Greenways and if this was a reflection of any current concerns. A Devaney confirmed that there have been a number of challenges for the team, but they had pulled together to overcome this and have also been provided with support from outside Greenways. The situation is now improving which will be evident in next month's report to the Board. A Styring advised that the Greenways unit is one of our Learning Disabilities services. A number of patients with very complex needs have been admitted to the unit recently which has resulted in the need for additional staffing. S Edwards advised that the business continuity plans were in place and daily calls are held between the Heads of Operations to consider the potential gaps in staffing. Weekly staffing meetings are also held to ensure gaps are closed or alternative arrangements are made. Staff are re-allocated to different work areas as appropriate and work patterns have also been amended to ensure appropriate safe staffing levels across the patch. Issues regarding flow are also being considered, such as considering how to unblock any potential delays with discharge. A Styring reminded the Board that business continuity plans are in place given the pressures in East Cheshire currently. Medical staffing is also being considered. There is a continual review process in place and issues are escalated accordingly. The Board of Directors **noted** the report.	
18/19/64	**SAFEGUARDING ADULTS AND CHILDREN'S ANNUAL REPORT** A Devaney introduced the paper which set out how the Trust has met its obligations and describes the Trust's safeguarding activity during the year. In terms of risk, Board are aware that a safeguarding risk was added to the Strategic Risk Register in November last year. This was in response to an increase in sickness levels amongst the team as well as the added volume of work as a result of the multi-agency reviews. The Trust was at risk of not meeting its contractual requirements. The report also highlights the priorities for the coming year. The	

	governance structures are currently being reviewed in view of our move to a Care Group structure; safeguarding training is also being reviewed following a national publication three weeks ago; a safeguarding service review is also underway in accordance with the actions identified from the strategic risk register; supervision is also being considered to ensure staff are supported appropriately. Dr J O'Connor commented that the report was very useful and acknowledged the huge amount of work that the team undertake. Dr J O'Connor raised a concern in regards to the reduction on social care and if this was being explored further. A Devaney advised that this would be included in the update to Board next month or escalated earlier if concerns arose. The Board of Directors **noted** the report and **approved** the objectives.	
18/19/65	**MEDICINES MANAGEMENT & OPTIMISATION ANNUAL REPORT 2017-18** Dr A Sivananthan introduced the item explaining that the report outlines the progress with the Trust's journey towards improved medicines optimisation as well as providing assurance with the framework for medicines governance across the Trust. During the past year there were two key focus areas for Quality Improvement in prescribing:- • Valproate and Risk to Unborn Babies • High Dose Antipsychotic Therapy – Reduction of Risks to Patients Assurance was provided to the Board in regards to how new medicines are introduced to the Trust. They are first assessed for effectiveness and cost effectiveness. This is completed in conjunction with the CCGs. The Trust also has a medicines safety officer in place who reviews all medicine safety incidents. This post has helped to reduce incidents. The Trust also has a medicines formula, so we are clear about prescribing. In terms of the administration of controlled drugs, a twice yearly report is provided to the Medicines Management Group. In year, a MIAA internal audit of the process was undertaken. One area for improvement was identified which has now been addressed and there are no further concerns. Significant assurance was provided. The Board of Directors **noted** the report.	
18/19/66	**FREEDOM TO SPEAK-UP SELF-ASSESSMENT** A Devaney introduced the item. The Board was reminded that in May 2018 the National Guardian Office published a self-review tool for Trusts to determine their position in line with identified key indicators. Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust. Board members contributed to a Board session to assess progress. Comments have also been received from Board members following that	

	session. The report outlined the findings of that feedback. On the whole a very positive picture was reported and the freedom to speak-up role appears well established within the Trust. As a Trust we are aware that this extends beyond the guardian role. Within the self-assessment, there is one area that has not been met as this was not referenced within our annual report and accounts as the guidance requiring this was issued after the annual report was produced. Consideration is currently being given to how we share learning from concerns raised via the Speak-up Guardian, given that these can often be sensitive issues. The teams are also looking at how the profiles of the ambassadors can be raised to encourage issues to be addressed locally with their support. Actions from the self-assessment have been included in the improvement plan and will be monitored via Quality Committee. A Pennell commented that perhaps there is also an opportunity for NEDs to triangulate this as part of the quality visit process. A discussion took place in respect of how the ambassadors are capturing the themes in order that learning can be shared. It was confirmed that a network meeting has been arranged with the ambassadors to discuss exactly how this can be taken forward. Monitoring is important; however, this must not become the driver. Ambassadors need to own this process. The Board of Directors agreed the self-assessment.	
18/19/67	**OPERATINAL PLAN / BOARD PERFORMANCE DASHBOARD** T Welch introduced the paper. The dashboard demonstrates how the Trust is performing against key performance areas. The areas currently off track were highlighted to Board members. During this meeting, Board members had been made aware of the staffing issues that currently exist and how these are being mitigated against. D Harris and his team are currently looking at the appraisals data to clarify the current position. Significant progress has been made in this area. In relation to Neuro-developmental services, A Styring discussed this at Operational Committee. There are currently issues in respect of delivery and commissioning. Gatekeeping targets are currently presenting a difficulty and are being worked on by the Teams. The data is also being worked on and will be rectified for next month. The report will evolve over time and gradually become more in line with the reports being developed for Quality Committee and Operational Committee. Also between now and the 1st April 2018, the Trust will transfer to a new system.	

	S Cumiskey reported on behalf of D Harris that the following areas are being reviewed:- • Vacancies – a number of practical solutions are being considered to address the current gaps. The Trust is also looking at the triggers we set for ourselves. Currently the threshold is quite low, so this is perhaps escalated to Board members too early. • Medical vacancies – there is currently a pinch point. However, a range of mitigations are in place to consider short, medium and long term solutions. • Appraisal – this will continue to be monitored. There is evidence to show a high correlation between appraisal of staff and good standards of care. As Care Groups have been developed, the appraisal process has had to be re-aligned. This process has paused whilst care groups are established. Work has also had to take place within our ESR system to re-align hierarchies against the new care groups. All the above has impacted on the current dashboard report. The Board of Directors **noted** the report.	
18/19/68	**QUALITY IMPROVEMENT REPORT** Dr A Sivananthan presented the report. This is one of a number of reports received by Board to demonstrate quality. This also accompanies the Trust's Big Book of Best Practice and the Quality Improvement Portal. Dr A Sivananthan highlighted some areas that had been discussed in detail at the recent Quality Committee Meeting:- • Quality Account Priorities – these are progressing and are on track. • Non-medical Prescriber Initiative – in the services provided by the Trust our approach is one of multi-disciplinary. • Red to Green Pilot – is an initiative to ensure people who need to be at home get home in a timely fashion. The initiative has been very successful to date. A multi-disciplinary review is held each morning to consider patient needs and their treatment journey. This was also presented to the NHS Expo. Dr Ian Davidson and his team are currently offering advice to NHSI on how to roll this out. • Centralisation of electro convulsive services - Board members are aware that the Trust centralised this service. An impact assessment has been undertaken as well as a patient experience survey. This has shown that taking this action has helped to improve services for those receiving ECT. M Maier advised that he had received comments from E Jenner to say he had found this a very motivational read. Others echoed this. Dr J O'Connor commented that this is always an excellent read, with the number of projects increasing year on year. This will also be experienced in more detail at the Big Book of Best Practice Event and Annual Members' Meeting. The Board of Directors **endorsed** the report.	

18/19/69	**BOARD DEVELOPMENT PLAN** M Maier introduced the item and explained that a number of sessions had been held with the Non-Executive Directors to consider what is included in the plan. The document presented to Board members set out the proposed development areas to be considered over the next six months. A development day is already planned with NTW and a Board to Board is scheduled in January 2019. A Board Away Day will take place in February 2019 and an external seminar will be facilitated in April 2019. Dr J O'Connor suggested the feedback from the CQC inspection also inform the programme going forward. S Edwards enquired if consideration could also be given to the Social Work Landscape to assist the Boards understanding given the recent transfer of the All Age Disability Service. **ACTION** – Head of Corporate Affairs to ensure CQC feedback and the Social Work Landscape are included in the Board Development Plan. The Board of Directors **approved** the plan.	**Gemma Caprio**
18/19/70	**BOARD ASSURANCE FRAMEWORK** Dr A Sivananthan introduced the item and explained that the document provides a summary of the risks against delivery of our strategic objectives. This month the Trust reported a total of 11 risks included on the strategic risk register – two red and nine amber. One risk is listed as in-scope. Three new risks were reported to Board Members as follows:- Risk 10 – *Due to pressures on acute care bed capacity, there is a risk that people who require admission may have to wait longer than 4 hours for a bed to be allocated.* Pressures are monitored on a daily basis by the Bed Management Hub to ensure the best use of available capacity. Sleeping out is only utilised during a peak in demand, with safeguards in place to ensure patient safety. An incident report is completed each time this event occurs. It was noted that 4 hours is a self-imposed target with the national target being 12 hours. CWP felt this was too long. The red and green project has also been implemented to mitigate against this and is monitored by the bed hub. Risk 7 – *Potential clinical, operational and financial risks associated with services being delivered to or by CWP for which there is no assurance of adequate contractual documentation being in place.* Risk treatment has commenced between Effective Services, Estates, Finance, IT and Procurement to devise a single contract repository. Processes are currently being established to ensure the effective review and monitoring of this mitigation work. Risk 9 – *Risk of harm due to deficits in familiarity with and staff capability in applying safety critical policies and frameworks.* The current policy management framework is under review to align policies to pathways. The work of the Clinical Practice & Standards Sub Committee is overseeing a plan of work to ensure clinical practice policies and	

	frameworks are impact assessed to ensure responsive education and training needs analyses to support staff with the guidance, skills and confidence in delivering their clinical practice. Further, assurance and quality improvement processes associated with policies are being developed, aligned to the Trust's safety management system. The in-scope risk concerns - *Supervision compliance rates that are below the Trust target of 85% and show varying levels of compliance across clinical and non-clinical staff groups*. A rapid improvement exercise is planned to ensure accurate capture of supervision and to build capacity to enable supervision compliance. Risk scores have been amended in relation to the risk of a cyber-attack, the transition to care groups and safeguarding contractual obligations. Work is currently taking place with MIAA to deliver training to our care groups to assist in strengthening their processes. Quality Committee and Audit Committee consider the risk register in detail as part of our governance arrangements. The Board of Directors **approved** the report.	
18/19/71	**LEARNING FROM EXPERIENCE REPORT, INC LEARNING FROM DEATHS (EXECUTIVE SUMMARY)** A Devaney introduced the item and invited feedback from Board members regarding the level of detail of the report. Additional detail is provided for Quality Committee. Board members suggested that including some additional context may be helpful. A further suggestion was to consider the structure of the report to better highlight the key areas to be escalated to Board members. The following key issues were highlighted to Board members: • Page three of the report demonstrates how the team are now analysing data in respect of care groups. • Consideration is also being given to developing a training programme to strengthen overall reporting. • In regards to learning from deaths, the report demonstrates how this has further improved both in respect of the number of reviews and the work with the families. • Work is being undertaken to ensure that all deaths are appropriately recorded. Links are now in place with the national system in order that we can undertake appropriate comparisons. • Three priority areas have been identified in respect of incidents associated with the management of behaviour that challenges for further work to be undertaken. These include; improving reporting and data quality of restraint episodes; capturing the experience of people who have been restrained; and developing more effective clinical education and training. Recommendations from this trimester have been discussed and agreed in Quality Committee. An update on progress was included in appendix 1 to the report.	

	The Board of Directors **noted** the report and **approved** the recommendations.	
18/19/72	**EQUALITY AND DIVERSITY ANNUAL REPORT** A Devaney introduced the report. The detail of the report reflects the amount of work in this area. One of the challenges for the Trust is the establishment of staff networks for those staff with protected characteristics. Our geography contributes to the challenge of establishing such networks. To assist the Trust in considering the best way forward, external advice has been sought as well as learning from other Trust's experiences. The EDS2 assessment has been completed with involvement from Healthwatch and Staff Side Colleagues. 'Access for all' needs to be the Trust's focus going forward. The team are considering systems and processes that may act as obstacles for particular individuals. Workforce Disability Equality Standard (WRES) data is included in the report. The Trust has concerns about the number of people with BME backgrounds entering into disciplinary processes, as well as the apparent level of bullying towards people from patients / public. Work will be undertaken to further understand this. Care Groups have all accepted the challenge to analyse this within their own teams and consider how these issues can be addressed. NEDs commented that it was disappointing to see the statistics in regards to harassment and that this was unacceptable. Executive colleagues concurred. Care Groups have been asked to report back the actions they intend to take to help address this and consider how staff can support each other in such circumstances. It was agreed that a message should be sent out Trust wide from Board members with the help of the Communications Team. **ACTION** – Communications team to devise suggested wording to be communicated on behalf of the Board members. It was also suggested that training specifically in regards to Equality and Diversity should be included in the Board Development Programme. **ACTION** – Equality and Diversity training to be added to the Board Development Programme. The Board of Directors **noted** the report.	**Katherine Wright** **Gemma Caprio**
18/19/73	**REGISTER OF SEALS** T Welch introduced the paper which summarised the circumstances that the Trust use the seal and covers the period April 2018 to September 2018. Four seals are detailed in the report and have also been reviewed by Audit Committee members.	

	The Board of Directors **noted** the report.	
18/19/74	**CHAIR'S REPORT – OPERATIONAL COMMITTEE** S Cumiskey introduced the Chair's report advising that the report highlights key activity from the Operational Committee to Board members. This month's report highlighted the following :- Operational Committee Dashboards – information is being migrated from localities to Care Groups. Work continues with the Heads of Operations to ensure data is transferred accordingly. East and Central Re-Design – the Operational Committee maintain an overview of progress in this area and receive assurance that safe and effective services continue in this area. All Age Disability Services – the plans and transfer have been monitored by Operational Committee. An up-date for Board was provided to Board members at this meeting. The Medicines Supply Business Case was approved by the last Operational Committee before being presented to Board. Care Groups Maturity Matrix was considered and endorsed by the Operational Committee before submission to Board members. The Board of Directors **noted** the Chair's report.	
18/19/75	**CHAIR'S REPORT – QUALITY COMMITTEE** Dr J O'Connor introduced the Chair's report highlighting the following areas:- The Integrated Governance Framework was previously presented to Board members. Further discussion was held at Quality Committee in particular how we continue to ensure assurance is provided to Board. The Strategic Risk Register was discussed during this meeting and the changes were presented to and considered by Quality Committee before being submitted to Board Members. Ancora House Rapid Improvement Task and Finish Group was discussed. This work was identified during an inspection and related to aspects of the Mental Health Act. CQC were in attendance at the last Quality Committee and appeared impressed with what the Trust had achieved. CQC were also pleased to hear how CWP was acting on their recommendations. Sexual Safety. A report was recently issued by the CQC in respect of sexual safety and included eight recommendations. A number of Trust's have chosen to wait for National Guidance in this area. CWP chose to act on the recommendations provided within the CQC report and have progressed this work ahead of National Guidance.	

	The Board of Directors **noted** the Chair's report.	
18/19/76	**CHAIR'S REPORT – AUDIT COMMITTEE** In the absence of E Jenner, Dr J O'Connor presented the Audit Committee Chair's report. The Audit Committee discussed the current arrangements for the Integrated Care Partnership governance. The Committee discussed their role to support the Board. Clarity about responsibilities is required to enable clinicians to work together and share learning. The Audit Committee agreed to monitor the status at future meetings. The Audit Committee reviewed the results of the MIAA Conflicts of Interest Audit which recommended a threshold for the acceptance of gifts. Due to the vulnerability of patients, frequency of admissions and the likelihood of cumulative gifts, the threshold was increased from £20 to £30. This will be reviewed again in 12 months. Further to the above meeting a closed meeting was held that considered the tender process for the external and internal Trust auditors. Board members are aware that within standing orders contracts can be in place for a maximum of five years. The Trust contract with its external auditors expires next year. This was reported to the last Council of Governors Meeting, at which a steering Group was approved to consider the way forward. The group will consist of the Lead Governor, a Governor representative, the Chair of the Audit Committee and the Deputy Director of Finance. The Audit Committee concluded that it would not be appropriate to tender both services at the same time, therefore, the current contract for internal audit will be extended for one year. The Board of Directors **noted** the Chair's report.	
18/19/77	**ANY OTHER BUSINESS OTHER BUSINESS** S Cumiskey noted the Boards thanks to the Governors for their support to the East and Central Redesign and requested that K Millar pass this on to the Council. Thanks were also offered to the Governors for their support during the CQC well-led inspection process, in particular their involvement in the focus group in the previous week.	
18/19/78	**QUESTIONS FROM OBSERVERS OR MEMBERS OF THE PUBLIC** K Millar offered the following comments: 1. In September the Health Service Journal had reported that East Cheshire CCG had reduced their mental health expenditure by 2.1%. As a Governor this was a concern. 2. It was encouraging to hear the discussion amongst Board members in respect of the Strategic Risk Register and to be assured that when risks are archived they are re-escalated as appropriate. This shows that the document is live and dynamic. 3. K Millar advised that he is the Chair of the West Cheshire Mental Health Forum who also link with Cheshire Police on hate crime issues for which there is a presentation. K Millar wondered if this might be an opportunity for training with staff in relation to the BME	

	issues discussed by Board. K Millar was thanked for his comments and suggestions.	
18/19/79	**REVIEW OF RISK IMPACTS OF ITEMS DISCUSSED** No new risks identified.	
18/19/80	**KEY MESSAGES FOR COMMUNICATION** The Chair summarised the key items discussed and considered by the Board members during the meeting.	
18/19/81	**REVIEW OF MEETING PERFORMANCE** It was noted that the meeting had been effective.	
18/19/82	**Date, time and place of next meeting:** • 28th November 2018 – Board room, Redesmere. 1pm	

Signed

Mike Maier, Chair

Date:

Cheshire and Wirral Partnership
NHS Foundation Trust

Action points from Board of Directors Meetings
September 2018

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
25/07/18	18/19/39	**STRATEGIC RISK REGISTER** Review and consider the presentation of the BAF.	Sept 2018	Head of Corporate Affairs	In progress	Propose Close
28/09/18	18/19/61	**CHIEF EXECUTIVE ANNOUNCEMENTS** Suicide Prevention – recent report and learning to be brought back to January 2019 Board meeting.	January 2019	Dr A Sivananthan		Open
28/09/18	18/19/69 18/19/72	**BOARD DEVELOPMENT PLAN** Head of Corporate Affairs to ensure CQC feedback and the Social Work Landscape are included in the Board Development Plan. Equality and Diversity training to be added to the Board Development Programme.	Nov 2018	Head of Corporate Affairs		Open
28/09/18	18/19/72	**EQUALITY AND DIVERSITY ANNUAL REPORT** It was agreed that a message should be sent out Trust wide from Board members with the help of the Communications Team. Communications team to devise suggested wording to be communicated on behalf of the Board members.	Nov 2018	Katherine Wright		Open

Cheshire and Wirral Partnership NHS Foundation Trust
Board of Directors meeting Business Cycle 2018/19 - meeting in public

No:	Agenda Item	Executive/ Non Exec Lead	Responsible Committee/ Subcommittee	25/04/2018 Seminar	30/05/2018	27/06/2018 Seminar	25/07/2018	26/09/2018	31/10/2018 Seminar	28/11/2018	20/12/2018 Seminar	30/01/2019	27/02/2019 Seminar	27/03/2019
Strategic Change														
1	**Chair and CEO report and announcements**	Chair and CEO	N/A		✓		✓	✓		✓		✓		✓
2	**ICP Board/s (minutes)**	CEO	Operational Committee		✓		✓	✓		✓		✓		✓
Quality of Care														
3	**Receive Chair's Report of the Quality Committee**	Non Executive Director	Quality Committee		✓		✓	✓		✓		✓		✓
4	**Freedom to speak up six monthly report**	Director of Nursing, Therapies and Patient	Quality Committee		✓							✓		
5	**Infection Prevention Control Report**	Director of Infection Prevention and Control	Quality Committee		✓							✓		
6	**Director of Infection Prevention and Control Annual Report inc PLACE**	Director of Infection Prevention and Control	Infection Prevention and Control sub committee (Quality Committee, Operational Board re PLACE)				✓ May in 2019							
7	**Safeguarding Adults and Children Annual Report**	Director of Nursing, Therapies and Patient	Quality Committee					✓						
8	**Accountable Officer Annual Report inc. Medicines Management**	Medical Director Compliance, Quality and Assurance	Quality Committee					✓ May in 2019						
9	**Monthly Ward Staffing update (monthly and six monthly reporting)**	Director of Nursing, Therapies and Patient Partnership	Operational Committee		✓		✓	✓		✓		✓		✓
10	**Research Annual Report**	Medical Director Effectiveness, Medical Education and Medical Workforce	Quality Committee							✓				
11	**Annual Workforce Report**	Director of People and OD												✓

12	**Medical Appraisal Annual Report and annual declaration of medical revalidation**	Medical Director Effectiveness, Medical Education and Medical Workforce	Operational Committee				✓							
Finance and Use of Resouces/ Operational Performance														
13	**Operational Plan/ Board performance dashboard (incorporating Operational and Quality dashboard)**	Director of Finance	Operational Committee/ Quality Committee		✓		✓	✓		✓		✓		✓
14	**Chair's Report of the Operational Committee**	Chief Executive	Operational Committee		✓		✓	✓		✓		✓		✓
15	**Annual Report, Accounts and Quality Account**	Director of Finance	Audit Committee (Quality Committee for QA)		✓									
16	**Health and Safety Annual Report and Fire and link certification**	Director of Nursing, Therapies and Patient Partnership	Operational Committee				✓							
Well-led (leadership and improvement capability)														
17	**Board Assurance Framework**	Medical Director Compliance, Quality and	Quality Committee		✓			✓				✓		✓
18	**Learning from Experience Report, inc Learning from Deaths**	Director of Nursing, Therapies and	Quality Committee		✓			✓				✓		
19	**Quality Improvement Report**	Medical Director Compliance, Quality and	Quality Committee				✓			✓				✓
20	**Integrated Governance Framework**	Medical Director Compliance, Quality and	Quality Committee									✓		
21	**CQC Community Patient Survey Report (themes and improvement plan)**	Director of Nursing, Therapies and	Quality Committee							✓				
22	**NHS Staff survey (themes and improvement plan)**	Director of People and OD	Operational Committee											✓
23	**Equality Act Compliance inc. WRES**	Director of Nursing, Therapies and	Operational Committee					✓						
24	**Guardian of Safe Working quarterly report**	Medical Director Effectiveness, Medical Education	Operational Committee		✓		✓			✓		✓		
Governance														
25	**Provider Licence Compliance**	Director of Finance	Audit Committee		✓					✓				
26	**CQC Statement of Purpose**	Medical Director Compliance, Quality and Assurance	Quality Committee									✓		

27	**Information Governance Toolkit**	Medical Director Effectiveness, Medical Education and Medical Workforce	Operational Committee											✓
28	**Register of Sealings**	Director of Finance	Audit Committee					✓						
29	**CEO/ Chair Division of Responsibilities**	Chair	N/A		✓									
30	**Corporate Governance Manual**	Director of Finance	Operational Committee									✓		
31	**Chair's Report of the Audit Committee**	Non Executive Director	Audit Committee		✓		✓	✓		✓		✓		✓
32	**BOD Business Cycle**	Chair	N/A											✓
33	**Terms of reference of Quality Committee and Operational Committee**	Non Executive Director/ CEO	Quality Committee/ Operational Committee		✓									
34	**Review risk impacts of items**	Chair/ All	N/A		✓		✓	✓		✓		✓		✓
35	**AOB (including matters that are NOT commecial-in-confidence)**	Chair/ All	N/A		✓		✓	✓		✓		✓		✓

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Ward Daily Staffing Levels September and October Data 2018
Agenda ref. no:	18.19.95
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	28/11/2018
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	No
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
35T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
35T	

REPORT BRIEFING

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

This report details the ward daily staffing levels during the months of September and October 2018 following the submission of the planned and actual hours of both registered nurses (RN) and clinical support workers (CSWs) to UNIFY (appendix 1 and 2). The themes arising within these monthly submissions continue to mirror those that have arisen previously. These themes identify how patient safety is being maintained on a shift by shift basis.

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

The monthly reporting of daily staffing levels is a requirement of NHS England and the National Quality Board in order to appraise the Board and the public of staffing levels within in-patient units.
The recommendations made within the latest six monthly report are being followed through and will be monitored via the Inpatient Service Improvement Forum and the People Planning group which oversees the strategic approach to safe staffing. The Trust is engaged in the national Optimum Staffing Project a programme of work commissioned by Health Education England to develop a generic tool (multi-disciplinary) for Safe Staffing that can be used in any service setting for inpatient mental health services.

Assessment – *analysis and considerations of options and risks*

During September 2018 the trust achieved staffing levels of 95.8% for registered nurses and 93.8% for clinical support workers on day shifts and 94.8% and 97.7% respectively on nights. During October 2018 the trust achieved staffing levels of 97.3% for registered nurses and 95.3% for clinical support workers on day shifts and 97.6% and 99.2% respectively on nights.

In the months of September and October 2018 the wards continued to experience pressures in terms of staffing in particular on the wards in Central and East locality due to staff sickness, maternity leave, patients on increased levels of observations and vacancies.

Where 100% fill rate was not achieved patient safety on in-patient wards was maintained by nurses working additional unplanned hours, staff cross covering across wards, the multi-disciplinary team and ward manager supporting nursing staff in the delivery of planned care and patient care being prioritised over non-direct care activities. Appendix 1 and 2 details how wards, who did not achieve overall staffing of 95%, maintained patient safety.

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

The Board of Directors are recommended to note the report.

Who/ which group has approved this report for receipt at the above meeting?	Gary Flockhart, Associate Director of Nursing [MH and LD] and Avril Devaney, Director of Nursing, Therapies and Patient Partnership
Contributing authors:	Charlotte Hughes

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Gary Flockhart, Associate Director of Nursing [MH and LD] Avril Devaney, Avril Devaney, Director of Nursing, Therapies and Patient Partnership	19/11/2018 19/11/2018

Appendices provided for reference and to give supporting/ contextual information:
Provide only necessary detail, do not embed appendices, provide as separate reports

Appendix no.	Appendix title
1	Ward Daily Staffing September 2018
2	Ward Daily Staffing October 2018

	Ward	Day				Night				Fill Rate				Safe Staffing was maintained by:
		Registered		Care Staff		Registered		Care Staff		Day		Night		
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	
East	Adelphi	1087.5	979.5	1231	1157	759	667	1092.5	1035	90.1%	94.0%	87.9%	94.7%	Cross cover arrangements.
	Alderley Unit	876.5	827.3	1311	1275	690	591	690	777.5	94.4%	97.3%	85.7%	112.7%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Bollin	1300.5	1146.5	1322	1184.5	708	677.5	1345.5	1301	88.2%	89.6%	95.7%	96.7%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Croft	1041	983	1705.25	1509.25	667	620.5	1385	1323.65	94.4%	88.5%	93.0%	95.6%	Nursing staff working additional unplanned hours. Cross cover arrangements. Multi Disciplinary Team actively worked within the staffing establishment.
	Greenways A&T	1177.5	1038.5	2070	1706.5	690	506	1380	1483.5	88.2%	82.4%	73.3%	107.5%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	LimeWalk Rehab	1077.5	928.5	1035	659.5	690	474.5	690	506.5	86.2%	63.7%	68.8%	73.4%	Nursing staff working additional unplanned hours. Cross cover arrangements. Multi Disciplinary Team actively worked within the staffing establishment.
	Saddlebridge	864	822.5	1521	1507	632.5	609.5	782	782	95.2%	99.1%	96.4%	100.0%	
Wirral	Brackendale	996	991.25	977.5	966	701.5	690	747.5	713	99.5%	98.8%	98.4%	95.4%	
	Brooklands	817	790	1253.5	1253.5	690	667	736	759	96.7%	100.0%	96.7%	103.1%	
	Lakefield	942.5	942.5	920	919.5	644	644	782	770.5	100.0%	99.9%	100.0%	98.5%	
	Meadowbank	917.5	883	1419	1081	644	598	989	989	96.2%	76.2%	92.9%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Oaktrees	1186.5	1189	1062	1050.5	586.5	448.5	448.5	379.5	100.2%	98.9%	76.5%	84.6%	Nursing staff working additional unplanned hours.
	Willow PICU	922	921.5	934	934	667	667	690	690	99.9%	100.0%	100.0%	100.0%	
West	Beech	1283	1233	893	878.5	674.5	674.5	778	766.5	96.1%	98.4%	100.0%	98.5%	
	Cherry	1252.5	1252.5	1207.5	1196	494.5	655.5	1000.5	1000.5	100.0%	99.0%	132.6%	100.0%	
	Eastway A&T	936.5	890.5	1782.5	1771	667	667	1299.5	1299.5	95.1%	99.4%	100.0%	100.0%	
	Juniper	1206.65	1177.15	922	899.5	651	651	727.65	737.5	97.6%	97.6%	100.0%	101.4%	
	Coral	1148	1148	1196	1196	713	713	805	805	100.0%	100.0%	100.0%	100.0%	
	Indigo	912.5	901	914.5	860.5	517.5	506	793.5	728	98.7%	94.1%	97.8%	91.7%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Rosewood	1001.5	1001.5	1541	1541	632.5	632.5	667	667	100.0%	100.0%	100.0%	100.0%	
	Trustwide	20946.65	20046.7	25217.75	23545.75	13119.5	12360	17829.15	17514.15	95.8%	93.8%	94.8%	97.7%	

	Ward	Day				Night				Fill Rate				Safe Staffing was maintained by:
		Registered		Care Staff		Registered		Care Staff		Day		Night		
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	
East	Adelphi	1325.00	1227.50	1278.00	1128.00	690.00	690.00	1207.50	1167.50	92.6%	88.3%	100.0%	96.7%	Nursing staff working additional unplanned hours. Cross cover arrangements. Multi Disciplinary Team actively worked within the staffing establishment.
	Alderley Unit	1035.50	995.00	1525.50	1470.00	713.00	667.00	793.50	830.00	96.1%	96.4%	93.5%	104.6%	Nursing staff working additional unplanned hours. Cross cover arrangements. Multi Disciplinary Team actively worked within the staffing establishment.
	Bollin	1620.50	1450.50	1374.00	1137.00	713.00	713.00	1368.50	1334.00	89.5%	82.8%	100.0%	97.5%	Nursing staff working additional unplanned hours. Cross cover arrangements. Multi Disciplinary Team actively worked within the staffing establishment
	Croft	1198.50	1174.99	1661.00	1323.50	656.50	641.00	1595.50	1495.75	98.0%	79.7%	97.6%	93.7%	Nursing staff working additional unplanned hours. Cross cover arrangements. Multi Disciplinary Team actively worked within the staffing establishment.
	Greenways A&T	1227.00	1217.15	2139.00	1891.50	713.00	655.50	1426.00	1460.50	99.2%	88.4%	91.9%	102.4%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.Multi Disciplinary Team actively worked within the staffing establishment .
	LimeWalk Rehab	1097.50	1078.00	1104.00	938.75	713.00	681.50	713.00	707.75	98.2%	85.0%	95.6%	99.3%	Nursing staff working additional unplanned hours. Cross cover arrangements. Multi Disciplinary Team actively worked within the staffing establishment.
	Saddlebridge	827.50	818.50	1460.50	1439.00	644.00	607.50	770.00	758.50	98.9%	98.5%	94.3%	98.5%	Nursing staff working additional unplanned hours. Cross cover arrangements. Multi Disciplinary Team actively worked within the staffing establishment.
Wirral	Brackendale	1209.00	1164.50	1012.00	1000.50	713.00	701.50	713.00	713.00	96.3%	98.9%	98.4%	100.0%	
	Brooklands	945.50	945.50	1250.00	1250.00	690.00	644.00	1012.00	1012.00	100.0%	100.0%	93.3%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements
	Lakefield	1188.50	1188.50	1028.00	1028.00	724.50	724.50	891.50	891.50	100.0%	100.0%	100.0%	100.0%	
	Meadowbank	977.50	912.50	1650.00	1627.00	701.50	701.50	1035.00	1035.00	93.4%	98.6%	100.0%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements
	Oaktrees	1280.30	1222.30	747.50	742.50	586.50	586.50	512.50	512.50	95.5%	99.3%	100.0%	100.0%	
	Willow PICU	834.50	834.50	1207.50	1207.50	678.50	621.00	747.50	747.50	100.0%	100.0%	91.5%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements
West	Beech	1338.50	1315.50	1053.00	972.50	654.00	654.00	819.50	808.00	98.3%	92.4%	100.0%	98.6%	Nursing staff working additional unplanned hours. Cross cover arrangements
	Cherry	1176.00	1176.00	1034.50	1034.50	644.00	644.00	1081.00	1081.00	100.0%	100.0%	100.0%	100.0%	
	Eastway A&T	1223.20	1223.20	1541.00	1538.00	575.00	575.00	1506.50	1497.50	100.0%	99.8%	100.0%	99.4%	
	Juniper	1223.00	1205.00	942.00	939.00	696.00	696.00	685.50	659.00	98.5%	99.7%	100.0%	96.1%	
	Coral	1121.00	1121.00	1276.50	1276.50	736.00	736.00	1058.00	1058.00	100.0%	100.0%	100.0%	100.0%	
	Indigo	1098.15	1029.15	1000.50	989.00	591.00	568.00	718.50	701.50	93.7%	98.9%	96.1%	97.6%	Nursing staff working additional unplanned hours. Cross cover arrangements
	Rosewood	985.30	958.30	1449.00	1449.00	598.00	598.00	678.50	678.50	97.3%	100.0%	100.0%	100.0%	
	Trustwide	1146.60	1112.88	1286.68	1219.09	671.53	655.28	966.65	957.45	**97.3%**	**95.3%**	**97.6%**	**99.2%**	

Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Healthcare Worker Flu Vaccinations Best Practice Management Checklist
Agenda ref. no:	18.19.97
Report to (meeting):	Trust Board
Action required:	Discussion and Approval
Date of meeting:	28/11/2018
Presented by:	Fiona Couper, Chair flu planning group

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
36T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
36T	

REPORT BRIEFING

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

This paper details the activity undertaken throughout the Trust, coordinated via the Workforce Wellbeing Service, in support of the 2018/19 Flu Vaccinations Campaign within Cheshire & Wirral Partnership NHS Foundation Trust (CWP). We have been instructed by NHS Employers in a letter dated 7 September 2018 to the Chief Executive that we must publish a self-assessment for the Board that details the performance of the Trust against the recommended best practice management checklist and this is attached.

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

This year NHS Employers have proposed that 100% of healthcare workers with direct patient contact are vaccinated and CWP always strives to achieve this target.

The attached Healthcare Worker Flu Vaccination best practice management checklist provides evidence of how CWP intend to achieve this result (appendix 1).

Assessment – *analysis and considerations of options and risks*

Consideration of factors that will impact upon the attainment of 100% Uptake:

- Some staff have a genuine fear of the safety of the vaccine
- Some staff have significant fear of needles

Attainment of Flu Vaccination Target is dependent on the following Strategic Approach:

- Committed leadership and promotion at all levels throughout CWP
- Effective and dynamic communications plan,
- Ensure that all staff are aware of the benefits of being vaccinated.
- Vaccinator presence at all large meetings and training events
- Ensure staff have the opportunity to be vaccinated at their convenience.

What motivates staff:

- Peer support
- The belief Flu vaccinations will protect their families and their patients
- Easy access to vaccination clinics

Timescales:

- Vaccinations have been available from 1st October 2018. The campaign is planned to continue until the 28th February 2019. However, it is hoped staff will access vaccinations as early in the Campaign as possible to increase the herd immunity within CWP.

Resources:

- The Campaign is coordinated via Workforce Wellbeing Service with support from trained peer vaccinators and augmented by Flu Bank nurses to increase the flexibility of the Campaign.

With all of the above taken into consideration the attached Checklist (appendix 1) reflects CWP's position.

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

The attached appendix demonstrates evidence of best practice in the effective delivery of the Flu Campaign for CWP's Workforce. Despite the desire to achieve 100% uptake amongst front line staff by NHS Employers, there will likely be a cohort of staff who choose to make an informed decision to decline the offer of the vaccine. The reasons for refusal where possible will be captured and submitted to Public Health England.

The Board is asked to agree the content of the attached Best Practice Checklist.

Who/ which group has approved this report for receipt at the above meeting?	36T
Contributing authors:	Fiona Couper, Karen Philips

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
2	36T	22/11/18

Appendices provided for reference and to give supporting/ contextual information:
Provide only necessary detail, do not embed appendices, provide as separate reports

Appendix no.	Appendix title
1	Healthcare Worker Flu Vaccination Best Practice Management Checklist
2	Terms of Reference Flu Planning Group 2018/2019

A	Committed leadership	Evidence	Trust self-assessment
A1	**Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decided on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so:**	The Operations Committee received a report from the Flu Planning Group on 20 June 2018. All recommendations were agreed. The ambition is always to achieve 100% of all staff vaccinated. Staff declining the offer of a Flu vaccine will be asked to complete anonymised proforma to capture reasons for refusal. This proforma was circulated to all staff via email from the Deputy Chair of the Flu Planning Group. Vaccinators will also have a supply of this proforma to ensure those staff who do not have access to emails can also be captured. Returns via Workforce Wellbeing Service will be collated and reported to Public Health England. It has also been agreed that those staff who do not wish to have a flu vaccination will not be moved from their current work place, due to the risks this would involve in safe staffing levels, but the Trust would continue to promote the benefits of vaccination and herd immunity. Should there be significant outbreaks of Flu, this decision will be reviewed by the Board.	
A2	**Trust has ordered and provided the Quadrivalent (QIV) flu vaccine for healthcare workers:**	A supply of Quadrivalent Vaccine (QIV) and also Adjuvanted Trivalent Vaccines (aTIV) for 65 year olds and above, as per PHE Guidance, has been ordered. Vaccines have been delivered to the Trust.	
A3	**Board receive an evaluation of the flu programme 2017-18, including data, successes, challenges and lessons learnt:**	A Report was submitted with lessons learned and recommendations for the 2018/19 Campaign, to the Operations Committee on 20 June 2018.	

A4	**Agree on a Board champion for Flu Campaign:**	David Harris, Director of People and Organisational Development, is the Board Champion for the Flu Campaign. The Flu Planning Group Chair is CWP's Chief Pharmacist; the Deputy Chair is the Associate Director Of Patient & Carer Experience (Interim). The Operational Lead is the Head of Workforce Wellbeing.	
A5	**Agree how data on uptake and opt out will be collected and reported:**	This year CWP will use ESR to record vaccine uptake and the People Information Department will pull Reports regarding uptake on a weekly basis for circulation to Heads of Operations to cascade to their teams.	
A6	**All Board members received flu vaccination and publicise this:**	Vaccinators have attended the Board Meeting on 31st October to vaccinate Board members and this has been publicised via the Intranet and CWPTV, with consent of members.	
A7	**Flu team formed with representatives from all directorates, staff groups and trade union representatives:**	Please see attached Terms of Reference. Membership is comprehensive and representative of CWP's staff and services, including Staff-side.	
A8	**Flu team to meet regularly from August 2018:**	The Flu Planning Group has continued to meet monthly since the end of the last Campaign to ensure momentum and commitment and now has a Clinical Lead in the Chair (Fiona Couper, Chief Pharmacist).	
B	**Communications Plan**		
B1	**Rational for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions:**	A letter and an email was sent out by the Deputy Chair of the Flu Planning Group to all staff. A robust communications plan is also in place.	
B2	**Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on**	Clinics are advertised via CWP Essential, the "News in the Loos" Approach will once again be utilised for advertising	

	paper:	Clinics and “Dial a Jab” details. CWP Facebook is promoting Vaccine uptake, regular tweets will be used via Communications and the Vaccinators during Clinics. There is a daily Bulletin from Comms advertising clinics times and venues and a two week clinic schedule advertised via a screensaver.	
B3	**Board and senior managers having their vaccinations to be publicised:**	Vaccinators and Communications Team attended the Board Seminar on 31st October 2018, to vaccinate Members and promote throughout the Trust.	
B4	**Flu Vaccinations programme and access to vaccination on induction programmes:**	Vaccinators are scheduled to attend all upcoming Induction and large training events. Staff are also able to access “dial-a-jab” Vaccinators” if unable to attend scheduled clinics. The Workforce Wellbeing Service is also responding to individual and team requests for vaccinators to attend their bases or book appointments.	
B5	**Programme to be publicised on screensavers, posters and social media:**	As per B2	
B6	**Weekly feedback on percentage uptake for directorates, teams and professional groups:**	As per A5	
C	**Flexible Accessibility**		
C1	**Peer vaccinators ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered:**	The number of Peer Vaccinators we have trained is approximately 62 from within all areas of CWP. The expectation is that if Vaccinators attended the training they will complete at least 3 Clinics throughout Campaign. A comprehensive Clinic Programme has been run throughout the Campaign.	

C2	**Schedule for easy access drop in clinics agreed:**	A comprehensive Flu Clinic Schedule has been promoted throughout the Campaign. Clinics offered on a "no appointment needed" drop in format, but also appointments can be booked if individual's prefer.	
C3	**Schedule for 24 hour mobile vaccinations to be agreed:**	We have daily Flu Clinics available, along with the "dial-a-jab" system for out of hours access to vaccinators. Teams can also request vaccinators to visit their team bases, meetings etc and individuals can drop into Workforce Wellbeing Bases or request appointments at more convenient times.	
D	**Incentives**		
D1	**Board to agree on incentives and how to publicise this:**	The 2017/18 Flu Campaign was the first Campaign with CWP where we had not used incentives of any description and we had our highest uptake so far of 72%. This approach was agreed within the Flu Planning Group after feedback suggested the majority of CWP workforce thought incentives did not work and would not encourage them to have a Flu vaccination.	
D2	**Success to be celebrated Weekly:**	The Communications Plan incorporates how we will celebrate success on an ongoing basis.	

2018/19 Flu Planning Group

Terms of Reference

1. Constitution

The Emergency Planning sub-committee and People & OD sub-committee hereby resolves to establish a sub-group of the sub-committees to be known as the Seasonal Flu Planning Group. The Group has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Duties

The Group is responsible for the planning and evaluation of the annual staff seasonal flu vaccination programme, and providing leadership within individual services to champion the flu vaccination uptake.

3. Membership

Membership will consist of the following*:

- Chief Pharmacist (Chair)*
- Associate Director of Patient & Carer Experience (Deputy Chair)*
- Head of Workforce Wellbeing
- Workforce Wellbeing Practitioner
- Workforce Wellbeing Representatives*
- Emergency Planning Lead
- Modern Matrons
- Medical Representation*
- Locality Operational Leads per Care Group*
- Infection Prevention & Control Representatives
- Pharmacy Representative*
- Public Health Representative
- Staff-side Representative
- Estates & Facilities Representative
- Communications Representative
- IT Representation
- Finance Representative
- People Information Service Representative

* or their nominated representative

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

The meeting will be chaired by the Chief Pharmacist with the Associate Director of Patient & Carer Experience acting as Deputy Chair.

a. Quorum

A quorum shall be Chair or Deputy Chair, Workforce Wellbeing Representative, one representative from each Care Group and Pharmacy Representative.

b. Voting

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

c. Attendance by members

Members will be required to attend a minimum of 100% of all meetings or their deputy.

d. Attendance by officers

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

4. Accountability and reporting arrangements

The Flu Planning Group will be accountable to the Quality Committee, Emergency Planning Sub-committee and the Workforce Wellbeing Group, in to People & OD Sub Committee.

The minutes of the Flu Planning Group will be formally recorded and submitted to all of the above. The Chair shall draw attention to these Groups and Infection, Prevention and Control Sub-committee, any issues that require disclosure to it, or require executive action.

Trust Standing Orders and Standing Financial Instructions apply to the operation of the Flu Planning Group.

5. Frequency

Meetings shall be held monthly for the duration of the campaign, including preparation and conclusion.

6. Authority

The Flu Planning Group is authorised to:

- Develop an implementation plan for the delivery of the seasonal flu vaccination programme;
- Develop a robust communications plan;
- Agree delivery model;
- Determine required resources needed;
- Evaluate the effectiveness of the programme;
- Recommend future delivery models;
- Monitor compliance with Flu delivery NHS England CQUIN

7. Monitoring effectiveness

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

8. Administration

The Committee shall be supported administratively by the Workforce Wellbeing Admin team whose duties in this respect will include:

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

9. Review

These terms of reference will be reviewed at least annually by the Committee.

Date reviewed by Flu Planning Group	
Date approved by Emergency Planning Sub-committee	
Review date: October 2019	

10. Version control

Version control	**Date**	**Comments**
5	October 18	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Operational Plan 2018/19- delivery indicators dashboard [October data]
Agenda ref. no:	18.19.98
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	28/11/2018
Presented by:	Tim Welch, Director of Finance/Deputy Chief Executive

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	Yes
36T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
36T	

REPORT BRIEFING

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

The Operational Plan 2018/19 sets out the Trust's approach to activity, quality, workforce planning and financial planning.

The dashboard attached in **appendix 1** reflects the key performance indicators (KPIs) defined to enable the Board to monitor the delivery of the Operational Plan and the Trust's strategic objectives and any risks to achievement and has been updated to reflect the priorities for 2018/19. This report relates to October 2018 Performance.

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

The operational plan delivery indicators dashboard in appendix 1 reflects the review of the metrics that has been undertaken with lead officers to ensure that the focus of monitoring the delivery of the Operational Plan and the Trust's strategic objectives is in line with the revision of the Operational Plan 2017/19 and highlights areas for improvement.

All priority projects have been aligned to Care Groups and there are three new projects identified this year (two are enabling projects).

Following the Board seminar earlier this year work is being undertaken to align reporting formats/ styles/ definitions across the Trusts committee structures, phase one of this work is focusing on the Quality Committee and Trust Board dashboard reporting, and the redevelopment of the dashboard will be delivered for the new year, following the December Board Seminar

Assessment – *analysis and considerations of options and risks*

The performance framework attached at **appendix 1** sets the range of Board key performance indicators (KPI) based on the key delivery areas of the Operational Plan. Where KPI performance trajectories have been set for the year these can be found in **appendix 2**.

The dashboard reflects month 7 (October) performance and there are 12 indicators off track.
SO1: 1.3 Clinical Effectiveness
SO1.1.6 & 1.8 Patient Safety Indicators
SO3: 2.1 Competence
SO3: 2.2 Competence: % of staff receiving annual appraisal
SO3: 2.3 % staff absence due to sickness
SO3: 3.1 NHSI Targets
SO3: 3.3/6/7b /9/13 Priority Projects

Following review of the operational performance dashboard, at Operational Committee, it was agreed that the following indicators would be escalated to Trust Board for oversight and discussion:

- CHEDs 4 week wait for routine referrals NHSI target has been challenging. Plan now in place and expected to back on track in November
- Appraisal across the trust has achieved 91%
- Improved gatekeeping processes have improved performance

Challenges:

- Sickness absence
- Acute Care bed pressures
- Efficiency savings (please refer to finance report)

Where any threshold variance is exceeded, the commentary in **appendix 1** will describe how remedial action is being taken to improve.

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

The Board are recommended to **note** the October 2018 Board Operational Plan dashboard.

Who/ which group has approved this report for receipt at the above meeting?	Tim Welch, Director of Finance
Contributing authors:	Mandy Skelding-Jones, Associate Director Performance & Redesign

Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1 2	Tim Welch Tim Welch 36T	21/11/2018 21/11/2018

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1 2	October 2018 Board Operational Plan Dashboard. Operational Plan 2017/18 – Delivery Indicators/ Board KPIs

Appendix 1: Trust Dashboard

	Indicator	Outturn 2017/18	Target or Thresholds for escalation	Target	Q1	Q2	Oct-18	Nov-18	Dec-18	Q3	Q4	Year End	General Comment
Strategic Objective 1 – Quality													
SO1: 1.8	Patient Safety: Reduction in the severity of harm (by 20%) sustained by those people accessing CWP services that cause harm to themselves	121 (10 per month)	97 (8 per month)	8 per month	31	25	9						Long term trajectory is continuous improvement against 2017/18 outturn however progress needs to be made in the remainder of quarter 3 and quarter 4. A driver diagram has been developed and QI work is being implemented.
SO1: 1.2	Patient experience: Demonstrable increase in the uptake of the Friends and Family Test (FFT) each quarter	Average 201 (per month)	330 per month	330	841	711	333						
SO1: 1.3	Clinical Effectiveness: Demonstrable improvement in the Trustwide average bed occupancy rate, excluding leave, for working age adult wards	93.30%	Improvement to 85% by KH03's month 12 (December 2017)		93.58%	91.16%	92.97%						There is a downward trend, in the bed occupancy levels across all bed types. The trust has experienced improvement in the bed occupancy rates this year. However this improvement continues to be at a level that is higher than the Royal Psychiatrist nationally reccomended bed occupanct rate of 85%.
SO1: 1.4	Patient Safety: Total % inpatient deaths subject to a case record review	100%	100%	100%	100%	**N/A**	N/A						N/A
SO1: 1.5	Patient Safety: Total number of inpatient deaths subject to a case record review identifying that there may have been a problem in the care provided	3	2 in 2018/19 (1 in any month)	2	1	**N/A**	N/A						N/A
SO1: 1.6	Patient Safety: Total % deaths reported by and to the Trust (including inpatient deaths) subject to a case record review	18%	15%	15%	* 34%	*54%	52.00%						* Includes only CAREnotes and PCMIS data in the denominator - Amber rating reflects this position. The mortality monitoring group will meet in January 2019 to discuss inclusion of EMIS data in the denominator due to the difference to the deaths in scope for this population.
SO1: 1.7	Patient Safety: Total number of deaths (including inpatient deaths) subject to a case record review identifying that there may have been a problem in the care provided	4	3 in 2018/19 (1 in any month)	3	**0**	**0**	0						N/A

Strategic Objective 2: People and OD/ Approach to workforce													
SO3: 2.1	Capacity: % of staff vacancies (Contracted)	5.00%	equal to or below baseline 5.31%		5.98%	5.57%	5.72%						The previously reported recruitment has now been addressed and time to hire is reducing again, This despite an increase in demand over the Summer and the additional work involved in the TUPE transfers for All Age Disability. There is a question about whether the escalation threshold for vacancies has been set too low, which can be addressed as part of the Board Seminar in December.
SO3: 2.2	Competence: % of staff receiving annual appraisal (via new proposed framework)	97.6%	100.0%		89.14%	82.91%	91.08%						9% improvement from last month's figure following issues of letters of concerns issued to heads of services. Work is ongoing to address compliance gaps by contacting individuals and team leaders directly, together with POD BP's escalating concerns with Care group service leads. In addition to addressing compliance gaps, services with 100% compliance are also being recognised for good practice.
SO3: 2.3	% staff absence due to sickness	5.89%	Above annual plan (appendix 3) projection for 3 months		5.24%	6.04%	6.49%						This is the second month that this indicator has been higher than target threshold.
SO3: 2.4	Staff, in month, Turnover rate (as a percentage)	0.91%	3 consecutive months where the turnover rate is 25% above the planned rate		0.78%	0.67%	0.64%						

Operational Performance / Priority areas													
SO3: 3.1	100% of the 13 NHSI operational performance targets achieved (including waiting times)	100%	100%	100%	100.00%	93.0%	93.0%						The trust has not achieved 100% compliance for three consecutive months due to: o CHEDS Routine (4 week) waiting time (88.89% both months): a full briefing has been provided to Operational Committee and work is in progress to rectify this.
SO3: 3.2	100% Contractual targets met	324 (98.1%)	100%	100%	95.5%	95.6%							This indicator reports a month behind 12 indicators have not met the contractual targets for three consectutive months, 3 were due to operational performance.
	CQUIN performance quarterly review		100%										Q2 CQUIN submissions are made to commissioners by 31st October. Quality Committee receive breifings on progress. West Physical Health CQUINs have met the required standards and the trust awaits confirmation from CCGs on all MH CQUIN submissions
Trust Priority Projects													
Care Group: Neighbourhood Care													
SO3: 3.3	Single Model for Integrated Care	N/A	Delivery of Key Milestones										Revised timescales for project plan to be agreed in line with system planning expectations
Care Group: Specialist mental Health													
SO3: 3.7a	Redesign Adult OP MH services - Responsive Care in Communities	N/A	Delivery of Key Milestones										
SO3: 3.7b	Redesign Adult & Older peoples MH services - Bed based	N/A	Delivery of Key Milestones										Project next steps awaiting the outcome of consultation
SO3: 3.10	Wirral All Age Disability	N/A	Delivery of Key Milestones										
Care Group: Children Young People & Families													
SO3: 3.5	Children and Young Families Prevention/ Early interventions:	N/A	Delivery of Key Milestones										
SO3: 3.4	0-19 Starting Well Service Implementation	N/A	Delivery of Key Milestones										
Care Group: Learning Disabilities & Nuero Developmental (LD&ND)													
SO3: 3.6	Transforming Care - LD	N/A	Delivery of Key Milestones										Awaiting commissioner commitments to nationally agreed service model and funding
SO3: 3.9	ADHD	N/A	Delivery of Key Milestones										Service reviewed and project plans developed. Expect to start delivering against project milestones from November
Enablers													
SO3: 3.11	People& OD Strategy	N/A	Delivery of Key Milestones										
SO3: 3.12	Health Informatics	N/A	Delivery of Key Milestones										
SO3: 3.13	Quality Improvement Strategy	N/A	Delivery of Key Milestones										Revised delivery plan being developed and agreed
SO3: 3.14	Communications & engagement	N/A	Delivery of Key Milestones										
Strategic Objective 6: Financial Planning													
SO6: 1	Use of resources	1	Use of Resources [UoR]		**1**	**1**	1						Further detail is available in Finance Report

Appendix 2: Trust Dashboard Reporting Framework

Op Plan ref	Indicator	Target or Thresholds for escalation	Base line	Reporting and Frequency	Reporting Months	Reporting Committee	Reporting Format	Director	Project Lead	Risk Register/ CAF ref
Strategic Objective 1 – Quality										
SO1: 1.1	Patient safety: The target for improvement is a 10% increase in the number of D&E incidents reported, based on numbers reported at the start of Trimester 1 of this year. The indicator is shown as a rate per 1,000 episodes of care.	10% improvement in reporting of low and no harm incidents **Escalation Thresholds** Red: Below 2016/17 outturn Amber: better than 2016/17 outturn (58.6) Green: above 2016/17 target (64.5)	Red: Below 2016/17 outturn Amber: better than 2016/17 outturn Green: above 2016/17 target(64.6)	Learning from Experience report Every 4 months	May August January April	Quality Committee	Trend line	Anushta Sivananthan/ Avril Devaney/ Jim O'Connor	David Wood	Risk 6 – learning from incidents (red 16)
SO1: 1.8	reduction in the severity of harm sustained by those people accessing CWP services that cause harm to themselves	97 (per year) **Escalation Thresholds** Red: higher than outrurn Amber: = to outturn position but higher than target Green: = to or below target	121 (10 per month)	Learning from Experience report Every 4 months	May August January April	Quality Committee	Achievement trend line	Avril Devaney/ Anushta Sivananthan	David Wood	
SO1: 1.2	Patient experience: Demonstrable increase in the uptake of the Friends and Family Test (FFT) each quarter	10% improvement in Trustwide uptake of FFT based on 15/16 outurn	Average 201 per month (16/17)	Quality Improvement Report Every 4 months	May August January April	Patient and Carer Experience Sub Committee	? Trajectory for improvement	Avril Devaney/ Jim O'Connor	Cathy Walsh	Risk 5 – feedback from learning (red 16)
SO1: 1.3	Clinical Effectiveness: Demonstrable improvement in the Trustwide average bed occupancy rate, including leave, for working age adult wards	Improvement to 85% by KH03's month 12 (December 2017)	93.30%	Continuous Improvement Report Monthly	May-March	Quality Committee	Tabular	Faouzi Alam/Anushta Sivananthan/ Jim O'Connor/	Sarah Quinn	
SO1: 1.4	Patient Safety: Total % inpatient deaths subject to a case record review	100%	100%	Learning from Experience report Every 4 months	May August January April	Quality Committee	Tabular	Avril Devaney/ Jim O'Connor	Lisa Parker	
SO1: 1.5	Patient Safety: Total number of inpatient deaths subject to a case record review identifying that there may have been a problem in the care provided	2 (improvement by year end)	3	Learning from Experience report Every 4 months	May August January April	Quality Committee	Tabular	Avril Devaney/ Jim O'Connor	Lisa Parker	

SO1: 1.6	Patient Safety: Total % deaths reported by and to the Trust (including inpatient deaths) subject to a case record review	KPI escalation via Learning from Experience report	18%	Learning from Experience report Every 4 months	May August January April	Quality Committee	Tabular	Avril Devaney/ Jim O'Connor	Lisa Parker	
SO1: 1.7	Patient Safety: Total number of deaths (including inpatient deaths) subject to a case record review identifying that there may have been a problem in the care provided	3 (improvement by year end)	4	Learning from Experience report Every 4 months	May August January April	Quality Committee	Tabular	Avril Devaney/ Jim O'Connor	Lisa Parker	
SO3: 2.1	Capacity: % of staff vacancies	5.00%	5.00%	Any 3 consecutive months where we are above the baseline for staff vacancy rate by 10%	By exception	People and OD subcommittee	Chairs escalation	Dave Harris	Viv Williamson	Risk 11 – staffing (rated red 20)
SO3: 2.2	Competence: % of staff receiving annual appraisal (via new proposed framework)	100% of available eligible cohort	97.6%	Any quarter in which each of the three months the appraisal rate is below the baseline position	Quarterly	People and OD subcommittee	Performance against plan chart or variance from plan	Dave Harris	Hayley Rigby	Risk 11 – staffing (rated red 20)
SO3: 2.3	% staff absence due to sickness	5.30%	5.89%	Any 3 consecutive months where we are above the monthly baseline set out in the annual plan.	By exception	People and OD sub committee	Variance from target trend line	Dave Harris	Chris Sheldon	Risk 11 – staffing (rated red 20)
SO3: 2.4	Staff , in month, Turnover rate		0.91%	3 consecutive months where the turnover rate is 25% above the planned rate	By exception	People and OD sub committee	variance from plan	Dave Harris	Gill Kelly	

Operational Performance / Priority areas										
SO3: 3.1	100% of the 13 NHSI operational performance targets achieved (including waiting times)	100%	100%	Any occasion where the compliance with any monitor target is missed for 3 consecutive months	By exception	Operational Board	Achievement trend line	Andy Styring/ Tim Welch	Service Directors	Risk in scope re. IAPT delivery
SO3:3.2	100% Contractual targets met	100%	Avg 98.1%	Any occasion where the same target for any contractual KPI is missed	By exception	Operational Board	Achievement trend line	Andy Styring/ Tim Welch	Service Directors	Risk in scope re. IAPT delivery
	CQUIN Achievement of milestones	(100% of CQUIN Milestones achieved)		Report quarterly on CCG confirmed achievement against milestones	By exception	Operational Board	written report	Andy Styring/ Tim Welch	Service Directors	Risk 14 Financial performance/ CIP delivery (rated red 16)
Op Plan ref	**Indicator**	**Target or Thresholds for escalation**	**Base line**	**Reporting and Frequency**	**Reporting Months**	**01/04/2017**	**01/05/2017**	**Executive Sponsor**	**Project Lead**	**Risk Register/ CAF ref**
SO3: 3.3	Priority project 1: Children and Young Families Prevention/ Early interventions:	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	April - March	Operational Board	Delivery of Key Milestones	Avril Devaney and Dave Harris	Val Sturgess	Risk 13 – tendering of services (rated amber 12)
Care Group: Neighbourhoods										
SO3: 3.3	Single Model for Integrated Care (Improved Place Based Care)	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Dave Harris	Karen Moore	
Care Group: Specialist Mental Health Services										
SO3: 3.7a	Redesign Adult & Older peoples MH services- responsive care in the community	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Nush Sivananthan & Faouzi Alam and Dave Harris	Sally Sanderson	
SO3: 3.7b	Redesign Adult & Older peoples MH services- Bed Based	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Nush Sivananthan & Faouzi Alam and Dave Harris	Suzanne Edwards	
SO3: 3.8	EI Review & delivery			Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Faouzi Alam	Trish McCormack	
SO3: 3.10	Wirral All Age Disabilities	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Andy Styring	Trish McCormack	

Care Group Children & Young People										
SO3: 3.5	Children and Young Families Prevention/ Early interventions:	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Avril Devaney	Fiona Pender	
SO3: 3.4	0-19 Starting Well Service Implementation	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Avril Devaney	Val Sturgess	
Care Group: Learning Disabilities & Nuero Developmental										
SO3: 3.6	Transforming Care - LD Care Model	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone	Monthly	Operational Board	Delivery of Key	Andy Styring	Mahesh Odiyoor	
SO3: 3.9	ADHD	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Andy Styring	Mahesh Odiyoor	
ENABLERS										
SO3: 3.11	People & OD Strategy	N/A	Delivery of Key Milestones		Monthly	Operational Board	Delivery of Key Milestones	Dave Harris/ Faouzi Alam	Jane Woods	
SO3: 3.12	Health Informatics	N/A	Delivery of Key Milestones		Monthly	Operational Board	Delivery of Key Milestones	Tim Welch	Jane Thomas/ Mandy Skelding-Jones	
SO3: 3.13	Quality Improvement Strategy				Monthly	Operational Board	Delivery of Key Milestones	Anushta Sivananthan	Hayley Cavanagh	
SO3: 3.14	Communication & Engagement	N/A	Delivery of Key Milestones		Monthly	Operational Board	Delivery of Key Milestones	Avril Devaney	Kathrine Wright	
Strategic Objective 6: Financial Planning										
SO6: 1	Use of resources	Use of Resources [UoR] score of 3 or 4	Plan	Monthly	April - March	Trust Board		Tim Welch/ Edward Jenner	Andy Harland	

Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Quarterly Report of the Guardian of Safe Working Hours
Agenda ref. no:	18.19.99
Report to (meeting):	Trust Board of Directors
Action required:	Information and noting
Date of meeting:	28/11/2018
Presented by:	Dr Sumita Prabharakan

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	Yes
36T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
36T	

REPORT BRIEFING

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

This report sets out data regarding rotas, locum/agency usage and safe working for the period of June 2018 - October 2018 for doctors in training across the Trust. It considers current areas of risk and suggested areas of future risk which should be addressed.

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

The implementation of the 2016 contract for Doctors in Training involved the creation of the position of Guardian of Safe Working Hours in order to monitor and provide reassurance of safe working practice related to hours worked. The post is an independent safeguard within the terms and conditions of the contract and comes with a responsibility to provide quarterly and annual reports to the Trust Board.

Assessment – *analysis and considerations of options and risks*
Detailed information can be found in the attached report as directed by NHS Employers. During the reporting period we had 21 doctors working under the terms and conditions of the 2016 contract. There were considerable vacancies related to HENW posts not being filled, maternity leave, LTFT and higher trainees completing training. We have received two exception reports which have been resolved through time in lieu.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors are asked to note this report

Who/ which group has approved this report for receipt at the above meeting?		Dr Faouzi Alam
Contributing authors:		Dr Sumita Prabharakan
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
Full	Junior Doctor Forum	To be brought to meeting

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1	Guardian of Safe working Hours Report to the Trust Board for the period June – October 2018

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

June 2018 – October 2018

Report Author: **Dr Sumita Prabhakaran**

Guardian of Safe Working Hours

Executive summary

The following report is the first of the quarterly reports to the Trust board and details the months from June 2018 to October 2018.

There have been 2 exception reports submitted by doctors in training working for CWP during the report period. Both exceptions have been resolved by agreeing time off in lieu with the doctors concerned. There have been no exception reports relating to safe working or access to educational and training opportunities.

Areas of concern include the management of exceptions arising from the non-resident 2nd on call rota and the availability of information regarding doctors completing extra work for other trusts or agencies.

Introduction

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

High level data

Number of doctors in training (total):	52
Number of vacancies:	9
Amount of time available in job plan for guardian to do the role:	0.5 PAs per week
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

a) Exception reports (with regard to working hours)

We have had two exceptions regarding working hours reported at the time of preparation of the report. This was both reported in August by one trainee who is a Foundation Year 1 doctor. They have both been resolved with time off in lieu, after discussion with the Clinical Supervisor. One was due to being on call and covering the ward without senior cover, where the doctor had to stay late to handover and complete documentation. The second exception was due to a delay in handover

and no night core trainee was available. Both exceptions were due to staying for less than an hour over their scheduled work time.

b) Work schedule reviews

There have been no work schedule reviews requested or completed in this reporting period.

c) Locum bookings

Vacancies currently at a total of 9 across all doctors in training grades.

HIGHER TRAINEE INFORMATION

CWP introduced a Trust wide Higher Trainee on call rota in August. This has changed the rota, the availability for assessments as well as cover. Listed below are the shifts that have been covered with a locum or remained vacant. Please note that we are carrying 2 WTE vacancies on the rota. A monitoring exercise was complete within 6 weeks of the introduction of the new rota and feedback received off the supernumerary bleep holder.

26 vacant night shifts.
13 vacant evening shifts
2 vacant Saturday long day shifts
2 vacant Sunday long day shifts

TW HIGHER TRAINEE BLEEP HOLDER 09:00hrs - 13:00hrs	**TW HIGHER TRAINEE BLEEP HOLDER 13:00hrs - 17:00hrs**	**TW HIGHER TRAINEE BLEEP HOLDER 17:00hrs - 21:30hrs**	**TW HIGHER TRAINEE BLEEP HOLDER 21:00hrs - 09:30hrs**

BREAKDOWN OF HOW COVERED.

11 Night duties covered with internal locums
9 Evening on calls covered with internal locums.
1 Saturday on call covered with internal locums
1 Sunday on call covered with internal locums
1 Saturday on call covered with Agency locum sourced by Temp Staffing.
1 Sunday on call covered with Agency locum sourced by Temp Staffing.
15 Nights remained uncovered.
4 Evening shifts remained uncovered.

c) **Fines**

To date there have been no fines levied against the trust.

Issues arising

- We have received 2 exception reports which have been resolved.
- It is part of the role of the Guardian of Safe Working to chair a Junior Doctor Forum. This has happened on two occasions after Postgraduate Teaching in the hope of maximizing

engagement, since my appointment. There has been good engagement and the issues raised regarding the process of reporting has been raised and addressed.

Summary

In summary, to date we have 21 doctors working under the terms and conditions of the 2016 contract. There are considerable vacancies related to HENW placements not being filled. We have received two exception reports, which have been resolved. There have been no concerns raised regarding safe practice or access to education and training experiences.

The Trust could consider an electronic monitoring in real time to guarantee that the Junior Doctors work safely and there are no breaches with the European Working Time Directives.

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NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Annual Research Report 2017/18
Agenda ref. no:	18/19/100
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	28th November 2018
Presented by:	Dr Faouzi Alam, Medical Director

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

REPORT BRIEFING

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

CWP has invested in research and seeks opportunities to participate in as many studies as possible to help drive improvement in care for the population we serve.

This report provides an overview of research activity undertaken within the trust during 2017-2018 and provides an update on progress against each of the priorities outlined in the CWP Research Strategy for 2015 – 2018.

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

The Board of Directors approved the following research priorities for 2015-2018 as part of the CWP Research Strategy:

- Priority 1 Raise profile of CWP research internally and externally
- Priority 2 Strengthen links with internal partners
- Priority 3 Secure external funding from academia and/or industry

The trust undertakes a wide variety of research and produces monthly updates of both portfolio and non-portfolio studies to monitor performance on time and targets.

In May 2017, the Research Team relocated from Wirral to the Countess of Chester Health Park where a dedicated clinic room has been established. This has strengthened the trust's ability to participate in new trials as a result of being able to undertake physical examinations.

Assessment – *analysis and considerations of options and risks*

During 2017/18, opportunities have been sought to progress each of the Research Strategy priorities resulting in the following key achievements:

- successfully recruited 1,878 participants to portfolio studies (highest recruiting trust within the Local Delivery System & fourth highest recruiter in the NW Coast Clinical Research Network)
- hosted 'Grand Round' dedicated to research, leading to an increase in the number of clinicians involved in delivering research across the trust
- highlighted the importance and findings of key pieces of research at the CWP annual research conference
- developed, and maintained, positive working relationships with external organisations leading to placement of further trials
- developed an innovative programme of research in the area of clinical decision-making
- strengthened junior doctor training by working in conjunction with the Clinical Research Unit at Royal Liverpool & Broadgreen to offer the experience required to become a Principal Investigator

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

Trust Board is asked to note the contents of the Annual Research Report for 2017/18.

Who/ which group has approved this report for receipt at the above meeting?	Dr Faouzi Alam
Contributing authors:	Pat Mottram / Claire James / Taj Nathan

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1		

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

Appendix no.	Appendix title
1	Poster - The use of acute psychiatric beds: study of in-vivo clinical decision making
2	Publication in the European Psychiatry Journal
3	Poster – The risk to the clinician of risk management
4	Poster – Exploratory study of approaches to the assessment & formulation of psychotic-spectrum symptoms in routine clinical practice
5	Portfolio studies
6	Non-portfolio studies
7	List of CWP publications 2014 – 2018
	Link to appendix 1-7

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NHS Foundation Trust

Annual Research Report

2017 – 2018

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

ABOUT CWP RESEARCH

The NHS for many years has been providing information on the benefits to all patients of research active Trusts. The UK Policy for Health and Social Care Research states that *"evidence suggests the quality of current care may be higher in organisations that take part in research, adopt a learning culture and implement research findings"*. Cheshire Wirral Partnership NHS Foundation Trust (CWP) has, therefore, always aimed to prioritise and grow research as part of its core business. CWP has invested in research and seeks opportunities to participate in as many studies as possible to help drive improvement in care for the population we serve. The trust undertakes a wide variety of research, including some commercially sensitive pharmaceutical trials.

Following the re-location of the Research Team from Springview, Wirral to the Countess of Chester Health Park in May 2017, a dedicated clinic room has been established for research. This facilitates acceptance of clinical trials which require physical examinations to be undertaken. The research team is now also able to process and despatch blood samples safely and store samples prior to shipping, or sending to pathology as a result of new equipment. This has strengthened the trust's ability to participate in new trials.

RESEARCH STRATEGY – DELIVERY PLAN 2017/18

Research and its evidence translated into practice are vital in transforming services and improving patient outcomes across the NHS. Recognising this, the Board of Directors approved CWP's Research Strategy for 2015-2018. The strategy identifies the following three priorities:

- Priority 1 Raise profile of CWP research internally and externally
- Priority 2 Strengthen links with external partners
- Priority 3 Secure external funding from academia and/or industry

This section provides an update on progress against each of these priorities.

Priority 1 Raise Profile of CWP research internally and externally

Research staff have continued to raise the profile of research within CWP. The SSHEW trial (referenced on page 7 of this report) has helped considerably as a large number of staff have participated in a randomised controlled trial, giving them practical experience of being in a trial and offering research staff an opportunity to discuss research more generally. The team regularly attend the trust induction sessions to meet new people joining the trust, let them know that we are research active and to offer support to staff wishing to become involved in research.

Research has taken place across all of CWP services including Mental Health, GP surgeries and Community Services. The research team have visited locations including Trafford, Warrington and Sefton, as well as more local services across Cheshire and Wirral to ensure that research is part of CWP culture.

Since the start of this strategy, the number of participants involved in portfolio studies has increased from 500 to 1878 representing a substantial increase during the first two years of the strategy period. In addition, CWP has maintained the number of non-Portfolio studies and we are now working on developing more in-house studies with the aim to bid for grants in the future. CWP continues to provide high quality support for these projects, most of which are of an educational nature, but more recently we have become involved in working with the Collaborations for Leadership in Applied Health Research and Care (CLAHRC) on clinical research where funding is being provided to support trusts to conduct projects aimed at reducing admissions to hospital. This has directly lead to a poster presentation at an international conference, and internal and external meetings where the findings have been discussed. It has both created interest in the findings and interest in others getting involved.

CWP continues to develop and increase the number of clinicians involved in delivering research across the Trust by encouraging them to complete Good Clinical Practice (GCP) training and also to attend training on becoming a Principal Investigator (PI). CWP has also been supporting trainee doctors to become actively involved in research and arranged for them to gain experience both within CWP and at a Phase 1 Clinical Trials Unit. In the last year, there has also been a Grand Round devoted to research within CWP to encourage clinicians to become involved.

CWP hosted it's annual conference in September 2018 to highlight the importance and findings of research within the trust. In addition, research staff have attended a number of external events to publicise the research we are doing.

The trust runs a "Consent to Contact" system whereby patients can opt to express an interest in being involved in research. The research team will contact patients if they are eligible for any studies that the trust is involved in so that they can consider if they wish to take part. This process is currently being reviewed in light of the new regulations on General Data Protection Regulation (GDPR).

Priority 2 Strengthen links with external partners

CWP continues to build good working relationships with external organisations. The best indicator of the working relationship we have with other organisations is the number of studies that we work on which result in further studies being placed as a result of successful delivery of outcomes. We have a particularly close working relationship with the Health and Safety Executive, demonstrated by our current recruitment to a third trial and work on the development of a fourth. The team is also conducting a third trial with the same group at Manchester University and is working on a number of studies around clozapine looking at the genetic profile of people who develop serious side effects, all with the same team at Liverpool University. We have an extremely positive relationship with the Phase 1 Clinical Research Unit at the Royal Liverpool and Broadgreen University Hospital Trust (RLBUHT) where we have completed one Phase 1 (small trial of drug "first in human") study in Alzheimer's Disease and have been approved to start a further two Phase 1 studies in the near future.

CWP also works closely with a number of other universities including York, Cardiff, and Chester. The research team always endeavour to provide a good service and a maintain positive relationships with all organisations.

During 2017/18, CWP has started to build its reputation with the pharmaceutical industry. Good working relationships exist with a number of pharmaceutical companies and we are now starting to see the benefits in terms of trials being placed with the Trust. The close working with the Phase 1 Clinical Research Unit at RLBUHT has facilitated the development of our Principal Investigators (PI) and we have also started to develop the trainee doctors currently placed within the trust. This has been of great benefit to running the trials in CWP, as well as enabling these doctors to gain the experience that they need to become principle investigators in their own right.

Progress slowed during 2017/18 in respect of the South Mersey Research Collaboration between CWP, Countess of Chester Hospital, Wirral Community Hospital and Wirral Community Trust following senior staffing changes within the Countess of Chester. However, discussions are continuing with a view to developing a research collaboration which offers the following potential benefits:

- Stopping duplication of work with regard to CRN applications
- Stability of structure over time
- Sharing out experience, expertise and competencies
- Opportunities for wider applications due to the greater level of expertise across the collaboration
- Capacity to scale up due to collaboration and access to larger populations
- Attractiveness to commercial and academic partners given the single point of access to the collaboration
- Greater pool of expertise to support protocol development and grant writing
- Fertilisation of collaborative research ideas across the organisations
- Sharing processes for approval of sponsorship
- In the longer term, the possibility of shared office / clinical space

Additionally, the trust research team is now working more closely with Lancashire Care NHS Foundation Trust and having regular meetings to explore how we can collaborate further in developing research.

Priority 3 Secure external funding from academia and/or industry

Funding was secured from both academia and industry during the year in respect of Alzheimer's studies. Three of the studies are based at RLBUHT, however, one will be running within CWP and this will potentially attract a substantial level of funding if recruitment is successful. In addition, a small allocation of funding was received from the CLAHRC.

The trust has doubled the level of industry funding received, and, although the sums are still modest, we hope to increase year on year. A small amount of additional funding was received for work conducted with the RLBUHT on the AC Immune Trial, a Phase 1 study. Funding was to cover the costs of staff working on the study and was used to employ the additional staff required. This was via a tri-partite agreement with the RLUBHT and attracted income of £14,899. A further amount has been invoiced for the phase 3 trial which includes payments that we will be passing on for pharmacy, MRI and PET scans of £20,713.

DEVELOPING CWP RESEARCH

Over the past 2 years, CWP has developed an innovative programme of research in the area of clinical decision-making. Our research team recognised that although there is an extensive empirically-based literature evaluating the effectiveness of mental health interventions, this literature tends to focus on discrete 'treatments' for specific conditions such as psychological therapies and courses of medication. However, the reality of mental health provision is that these well-defined and researched macro-interventions sit within a wider spectrum of activities, such as assessments, follow-up contacts, referrals, transfers of care and admissions to mental health facilities. These activities rely on clinicians' knowledge, skills and expertise and can influence outcomes in a number of ways. There is very limited research into both the patient-based and wider contextual factors influencing mental health practitioners' decision-making. Such research is essential to understand the reality of service provision and to inform approaches to decision-making and service design that makes the best use of available resources to achieve the best outcomes for service users.

This programme of work has included an ongoing collaboration between CWP and the NIHR Collaboration for Leadership in Applied Health Research and Care (North West Coast). Having successfully applied for a CLAHRC internship in 2017, work commenced on a qualitative study of decision-making in acute mental health scenarios with a particular focus on clinical decisions to admit service users to in-patient facilities. Of the less well-defined interventions, acute admission to hospital is one of the most significant in terms of patient experience, micro-therapeutic opportunities, and resource utilisation. A more detailed exploration of the way these decisions is necessary to uncover the reasons for variability and to provide a baseline understanding of the how inpatient services are currently being utilised in practice. The initial findings of this work, was presented at the CLAHRC dissemination event in Preston (see Appendix 1).

Subsequently the study was presented at the 26th European Congress of Psychiatry in Nice in March 2018 (Appendix 2) and published in the European Psychiatry Journal.

CWP's research group on clinical-decision making has moved to focus on a particular area for more detailed study. Although standardised approaches to documenting risk assessment are regularly used in mental health services, the everyday process of risk assessment and related decision-making is less well understood. This work has included an examination of the impact on clinicians of the fear of anticipated consequences of their decisions as presented to the Royal College of Psychiatrist Annual Liaison Psychiatry conference in Liverpool in May 2018 (Appendix 3).

Further to the successful application for a second CLAHRC internship, the research team have commenced a series of audio-recorded focus groups with clinicians involved in acute service provision to gain a more in-depth understanding of risk assessment and management in practice. The findings from this study will inform an evidence-based approach to risk assessment and formulation for day-to-day decision-making.

Working with trainee doctors has also led to some interesting research. The poster in Appendix 4 was presented at the Royal College and it won the presentation prize at the meeting.

Further developments are planned for the future of this research including collaborative work with the Countess of Chester Hospital.

EXAMPLES OF COMPLETED RESEARCH STUDIES

The London Downs Syndrome Consortium (LonDownS)

What did the study aim to find out?

The study was looking at the differences in cognitive function in Down's syndrome where a wide variation is found between people in terms of attention, task planning, memory and language. Alzheimer's disease occurs more often in individuals with Down syndrome compared to typically developing individuals. Differences in terms of genetics or cellular development may help to explain cognitive variations in individuals with Down syndrome, and explain why some individuals with Down syndrome develop Alzheimer's disease whilst others do not.

How was the study designed?

The LonDownS study was designed by a consortium at University College London. Participants in this study were given a variety of tasks to investigate their cognitive functions. Participants were asked to give a blood or saliva sample for genetic (DNA) analysis and a hair sample from their head to investigate how their cells develop.

The study also involved an investigation of brain activity of some of the participating individuals, to investigate whether differences in brain activity can help to explain the large cognitive variability in individuals with Down syndrome. To do this, participants were asked for consent to place a special cap on their head for their brain activity to be investigated. This cap contains electrodes, and required participants to sit as still as possible whilst brain activity was recorded.

The research team collected data from a large number of individuals with Down syndrome to investigate some of the genetic and biological reasons that help to explain this large cognitive variability. The data collected may also help us to understand the variability in terms of the clinical signs of Alzheimer's disease in people with Down syndrome with a view to improving the care and treatment of individuals with Down syndrome, and the potential to contribute to the development of new treatments for Alzheimer's disease.

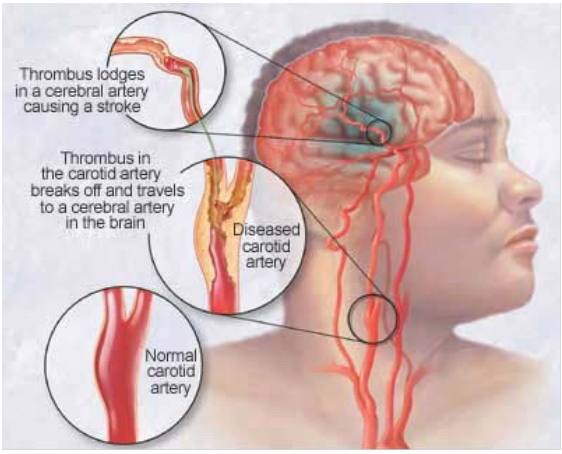
What was the outcome?

The CWP research team recruited 25 participants for this study, which was five times the target set. All patients gave a blood sample and answered a series of questionnaires. All of the samples and questionnaires were returned to the study team.

The study team have now published 19 papers using the data from this study. These have been genetics papers looking at a wide variety of topics including neopterin models and cellular immunity, how Down's syndrome with Alzheimer's differ in terms of cognitive deficits from older people, biomarkers in Alzheimer's disease and Down's syndrome, predictors of age of onset of Alzheimer's disease and survival. The study team has also developed an informant questionnaire of cognitive abilities in Down's syndrome and further publications are anticipated.

Accelarating Delivery of Psychological Therapy after Stroke (ADOPTS)

What did the study aim to find out?



This study was set up by the University of Central Lancashire (UCLAN) by Professor Caroline Watkins and is one of a range of studies looking at health inequalities. The study focussed on emotional support provided to patients, and their families, post stroke and looked at whether this helped them adjust to post stroke life. This was conducted by contacting staff working in these services and asking them about any training that had helped and seeking their views on what they thought would make services more accessible to people who have had a stroke.

How was the study designed?

The study was a qualitative study using focus groups across a wide range of NHS Trusts asking staff to take part and discuss their services and ask for their ideas on how to improve access. The focus groups were recorded and then analysed.

What was the outcome?

The ADOPTS team gathered and analysed all of the data, including evidence of variation in provision across the area. The end result was the production of a manual to help trusts to develop a more inclusive and effective service for stroke-sufferers.

EXAMPLES OF ONGOING RESEARCH STUDIES

Stopping Slips among Healthcare Workers (SSHeW):

Does slip resistant footwear reduce slips among healthcare workers? A randomised controlled trial

What does the stuidy aim to find out?

Slips, trips and falls are a major cause of accidents in the workplace. It is estimated that over 100,000 people are injured due to a slip, trip or fall at work each year, with 6,000 in health occupations (HSE, 2015). These represent about 40% of all injuries and 57% of major injuries reported to the Health and Safety Executive (HSE, HSE 2014). The injuries resulting from these incidents can have long-lasting effects. Furthermore, it has been estimated that one million days were taken off work in 2012/13 due to such injuries (Labour Force Survey, 2015). People working in health and social care report the highest number of non-fatal employee slips, trips and falls. This is partly due to the nature of the flooring on health service premises which is often very smooth and may be slippery when wet due to frequent cleaning for infection control purposes or due to contaminants. The University of York in conjunction with the Health and Safety Executive (HSE) have devised this study.

There is some evidence that this accident burden can be reduced through the use of appropriate footwear. There is promising evidence that slip resistant footwear can significantly reduce the burden of accidents at work. However, it is important to confirm these findings in a large pragmatic trial within a UK setting. The aim of this study is to find out if slip resistant shoes can stop NHS staff from slipping, falling or hurting themselves. If the intervention is effective it will reduce the number of work related injuries and, as a consequence of this reduction, fewer lost working days and litigation to the NHS and other industries will occur which will lead to a reduction in costs.

How was the study designed?

Half of the participants received their shoes at the start of the trial, and the other half received their shoes at the end of the trial. The pilot lasted for 14 weeks. Half of the staff who participated in the study wore special anti-slip shoes (intervention group) from 'Shoes for Crews' and 50% wore their own shoes (control group). Every week participants reported (via text) whether or not they had a slip, and if so, how many. At the end of the 14 weeks participants were sent a questionnaire to collect data on compliance with the footwear and reasons for wearing/not wearing the shoes (directed at intervention participants only), whether participants had time off work (annual leave or sick), and to ask how many slips and how many falls they had at work in total over the period.

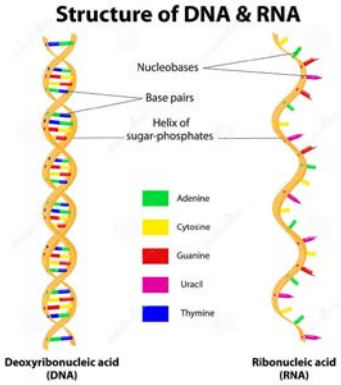
The study team has also recently conducted tests on the slip resistance of shoes that CWP staff are wearing on the wards. The HSE have devised a device which can categorise footwear into 0-5 depending on the results. The footwear provided by the trial is a 5. Some of the footwear being worn on the ward has been a 0. This means that it slips very easily on a wet surface. It does not seem to depend on the cost or brand of shoe, as some of the worst have been expensive brands and some of the better ones costing £10 at the supermarket. Further testing is needed and will form part of the final report.

Findings so far?

So far, the study team has concluded that people are having a lot more slips than they anticipated. Additional recruitment to the trial is now underway to ensure that people who work part time have an opportunity to be involved and this is expected to significantly increase the number of participants. To date, we have recruited 607 members of staff, who have all been randomised, and a further 100 plus have signed up to the trial and are receiving their initial texts. Some staff have withdrawn from the trial as they found the shoes uncomfortable to wear, but the numbers are yet to be confirmed. The trial has proved time-consuming as a result of needing to swap a lot of shoes for different sizes or models due to some participants not finding the shoes they originally picked comfortable, or an appropriate fit. Staff members have been very helpful and generally very positive about this study. The results of the SSHeW study are expected to be published in late 2018 and this will include recommendations about the use of non-slip footwear.

Commercial Alzheimer's treatment trials - AC Immune, Mission and IONIS

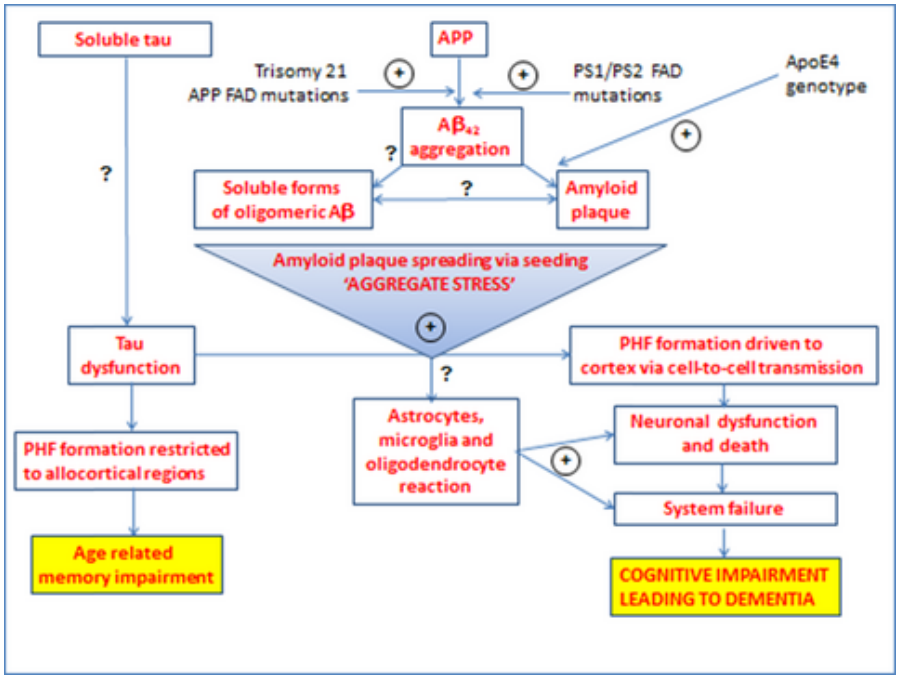
What do these studies aim to find out?



CWP has been working on several studies which aim to find a drug to either hold, or slow, the progression of dementia. The first of these studies has been completed. CWP worked with the Royal Liverpool and Broadgreen University Hospital Trust (RLBUHT) to investigate an injected vaccine against dysfunctional tau (tau which has become altered and causes neurofibrillary tangles). The second study based completely in CWP is a phase 3 study investigating the use of a small-molecule BASE1 inhibitor in tablet form hoping to reduce amyloid β (plaques which form in the brain). The final study is a phase 1 study working with RLBUHT in using an intrathecal injection (into the spine) as the drug does not cross the blood brain barrier. It aims to replace the defective DNA or RNA with a synthetic strand of nucleic which will turn off the problem gene.

How were the studies designed?

All of the studies are based on the amyloid cascade model detailed in the diagram below and hope to disrupt the process leading to the deposition of amyloid and the dysfunction of Tau.



Each of the studies requires the identification of patients who have either mild cognitive impairment, or mild Alzheimer's disease. Following initial screening, either lumbar punctures or PET scans are used to confirm that the person has Alzheimer's disease. There is a prolonged period of screening to ensure that all the patients are physically stable with no contraindicated illnesses or drugs. They have MRIs, PET scans and/or lumbar punctures. A considerable amount of training has to be undertaken by the team to ensure that all the results are comparable across the world. Data are closely monitored by a team of people to ensure it is accurate.

What are the findings so far?

CWP has completed the AC Immune Phase 1 vaccine study and over recruited against targets. The Mission Phase 3 study is only in the early stages of recruitment but one patient has already been randomised. The IONIS Phase 1 study is ready to start and one patient has been identified as potentially suitable. The Phase 1 studies will take several years to conclude before new drugs would be ready for market. The Phase 3 study, however, has the option for patients to continue on the active drug once the study has finished, until such time that it is determined that the drug does not work, or it is licensed for sale in the UK.

RESEARCH PERFORMANCE

A brief description of all of the recent, and current research, and the number recruited to each study is provided in Appendix 5.

Performance in research is monitored by the Comprehensive Research Network, North West Coast. It monitors the number of trials and recruitment in real-time via the EDGE database and the National Open Data Platform Database. Reports are submitted quarterly to the Clinical Trials Performance (CTP) where performance in initiating and delivering research is monitored. Monthly updates of both Portfolio and Non-portfolio studies are undertaken to monitor performance on time and target.

Time and target

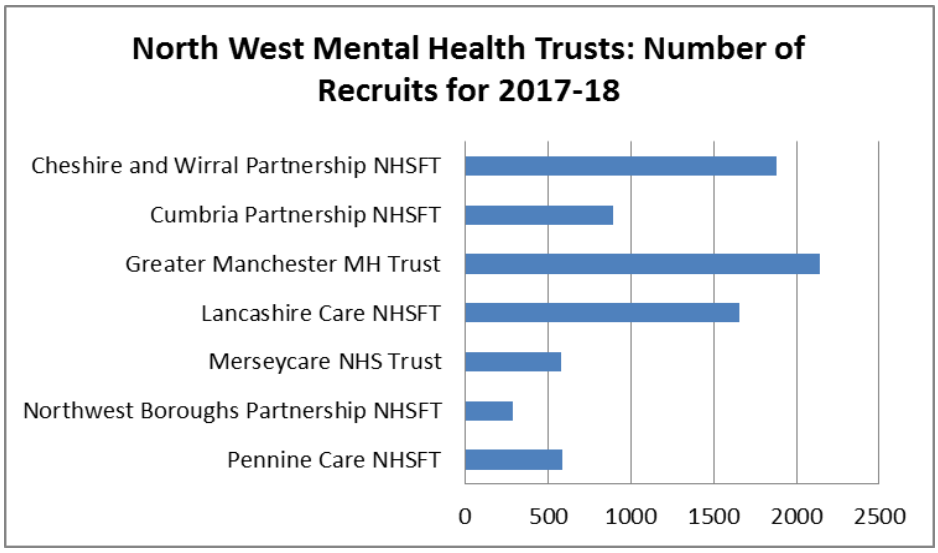
CWP Research has achieved time and target for the majority of the studies undertaken in 2017 – 2018. There have been a few exceptions, but delays and problems related to the sponsor have been responsible for all of these. Notably the DFEND study (see P.5, Appendix 5) which was waiting for the Green Light (go ahead) from the monitor and this delayed the start of the study.

Non-portfolio studies

These studies are supported by a dedicated member of the research team and many are educational. Additionally, there is a growing series of clinical studies addressing service related questions. Most notably, as part of CWP's involvement in the Collaboration for Leadership in Applied Health Research and Care (North West Coast), studies have been undertaken, and further studies are commencing, in the areas of clinical decision-making in acute clinical scenarios and of risk assessment. Additionally, psychiatric trainees are being supported to take on researcher roles in a series of studies relating to the assessment and understanding of psychopathology. It is hoped that these will lead to increasing capacity to undertake further research and to apply for grants from within the Trust. Appendix 6 provides an overview of non-portfolio studies.

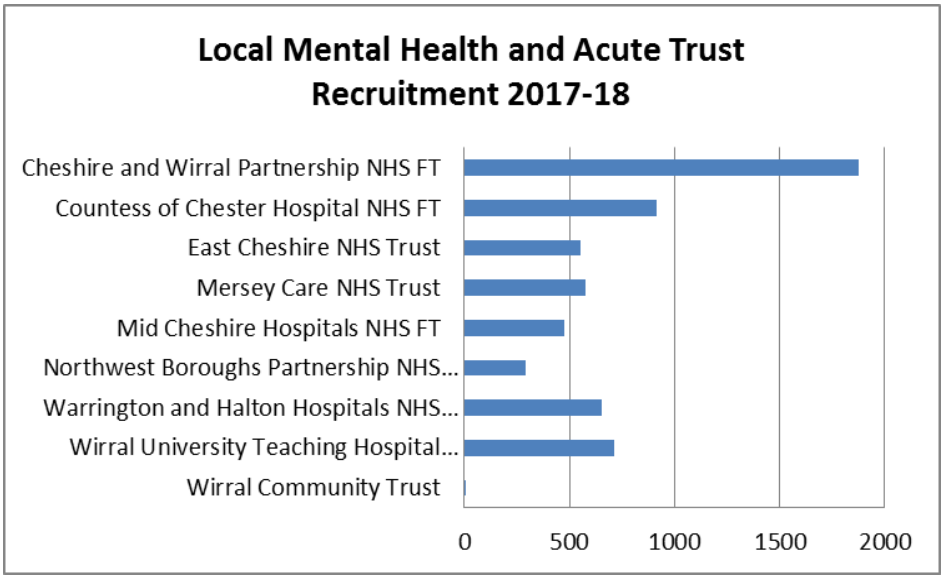
Recruitment to National Portfolio Studies

CWP has been very successful over the year April 2017 to March 2018 and has recruited 1,878 participants into studies. This is the highest number that the trust has ever recruited and we outperformed most of the other local acute and mental health trusts in the North West. The graph below shows a comparison with other North West Mental Health Trusts (Greater Manchester MH Trust was formerly Greater Manchester West and Manchester Mental Health Trust and have now merged). Overall CWP was the fourth largest recruiter in the North West Coast area after Royal Liverpool and Broadgreen, Alder Hey, Lancashire Teaching Hospitals and Liverpool Women's.



Data from ODP 1st May 2018

Performance has also been excellent in the context of the Cheshire and Wirral Local Delivery System, as demonstrated by the graph below for acute and mental health trusts.



Data from ODP 1st May 2018

The high recruitment levels were mainly as a result of two studies; the Wirral Child Development Study, a cohort study, and the SSHEW study, a non-slip shoe trial in staff. Additional staff have been employed on a temporary basis to cover the additional work generated by these studies.

RESEARCH FUNDING

CRN Funding

The Trust receives funding every year to support recruitment costs to portfolio studies. The NHS Support Funding covers the cost of staff employed to recruit to portfolio studies and related travel expenses. There is also a small amount to cover some staff time for research governance/ Health Research Authority related work. This funding is based on staff grade and incremental point for each individual member of staff employed.

CRN Funding 2017- 2018	
NHS Support Funding	£216,716
Contingency Funding	£22,228
Research Capability Funding	£20,000
Total	**£258,944**

The trust received a minimal uplift in funding in 2017/18 to cover the cost of staff salary increments. CWP also bid, and was successful, in receiving Contingency Funds of £21,270 to cover the extra costs associated with the SSHEW study where a large number of subjects were to be recruited to an individual study that could not be managed within the allocated staffing.

PUBLICATIONS

CWP has published or contributed to 109 papers between 2014 and 2018 and these have been published in a variety of journals, some of which have a high impact. These papers are used to provide better treatment to patients internationally. A list of all the publications is available in Appendix 7, or from the CWP Library.

CONCLUSIONS

CWP has maintained its high standards of recruitment to NIHR portfolio studies in 2017/18, with a total of 1,878 participants recruited – higher than ever before.

Increased numbers of clinical staff are now engaged in research and work will continue to encourage staff to take part in and use research in their practice in coming years. CWP has started to develop research in-house which we will answer questions that the Trust identifies. It is hoped that in the future these will develop into bids for research funding.

Work will now progress on the development of a new Research Strategy for 2019 – 2021.

Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	CWP Provider Licence – Quarterly self-assessment
Agenda ref. no:	18/19/101
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	28/11/2018
Presented by:	Tim Welch, Director of Finance

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	No
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	Yes
36T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
36T	

REPORT BRIEFING

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

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

Key components within the licence criteria are reviewed on a quarterly basis. The Board receives assurance on licence compliance on a six monthly basis, with the Audit Committee reviewing this information prior to the Board of Directors. The last review of the licence for assurance purposes was undertaken at the end of Q4 2017/18.

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

This report details the NHS provider licence criteria self-assessment for end of Q2 2018/19. The licence contains obligations for the Trust and this assessment aims to help the Audit Committee and Board members in confirming the accuracy of requirements that CWP is required to comply with as a license holder.

Assessment – *analysis and considerations of options and risks*

Appendix 1 contains the high level excerpts from the full licence document and enables Board members to consider the key licence conditions and any risks to compliance. Following review, all conditions are considered as Green (compliant), with the following improvement:

- Condition/ licence provision G4(2): *Is the Trust aware of any reason why a newly appointed Director or a Director in post is unfit to be a Director?*
  Processes have been strengthened in accordance with the licence and CQC Fit and Proper Persons Regulations, with further assurance built into processes following CQC well-led pilot report. The condition was reassessed at CQC trustwide well-led inspection in September 2018 and no areas for improvement were identified.

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

The Board of Directors is invited to **note** the Q2 2018/19 Licence position.

Who/ which group has approved this report for receipt at the above meeting?		Audit Committee
Contributing authors:		
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
N/A	N/A	N/A

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1	Key Provider licence conditions as at end Q2 2018/19

Appendix 1: Self-assessment evidence against NHS provider licence key criteria as at end Q2 2018/19

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

Licence reference	Licence provision	Self assessment	End quarter 2 2018/19 position	Comments/ Further actions for completion
1. General provisions				
G2	Has NHSI given any direction regarding setting or limiting conditions within the Provider Licence?	**GREEN**	Compliant	No issues identified.
G4(1)	Is the Trust aware of any reason why a newly appointed Governor or an appointed Governor is unfit to be a Governor?	**GREEN**	Compliant	No issues identified.
G4(2)	Is the Trust aware of any reason why a newly appointed Director or a Director in post is unfit to be a Director?	**GREEN**	Compliant	No issues identified – processes in place in accordance with the licence and CQC Fit and Proper Persons regulations. Further assurance built into processes following CQC well-led pilot report. Reassessed at CQC trustwide well-led inspection September 2018. No areas of improvement identified.
G5	Has NHSI issued new guidance relating to the provider licence in the quarter?	**GREEN**	Compliant	Last update March 2018. No issues identified.
G6	Executive to consider any new licencing risks identified in the quarter – update of Board Assurance Framework for Board approval?	**GREEN**	Compliant	No new licencing risks.

Licence reference	Licence provision	Self assessment	End quarter 2 2018/19 position	Comments/ Further actions for completion
G6(3)	Publication of Annual Governance Statement (AGS)?	**GREEN**	Compliant	Completed for 2017/18. Published as part of Annual Report and Accounts.
G7	Consider CQC registration status in quarter – note cancellations and registrations (G7(2))?	**GREEN**	Compliant	Changes to CQC registration have been made to reflect change and acquisition of services including: • Acquisition of All Age Disability Service in August 2018. • The registration of Millennium Centre as a location for the Family Support Service.
G8	Consider if all information on range of services and information on who can access them is published	**GREEN**	Compliant	Details of all services including eligibility (age range/ conditions) and referral routes are within each service listed on the CWP website.
G9	Consider whether Commissioner Requested Services have been amended?	**GREEN**	Compliant	Commissioner Requested Services with NHS England, Specialised Services for the following services: CAMHS Tier 4, Adult Eating Disorders, Secure and Mental Health Services (adult) and Learning Disabilities.
G9(12)	Have the contractual requirements to activities or any mandatory services been amended?	**GREEN**	Compliant	No change since Q4 2017/18 review.
2. Pricing				
P1(4)	Have any services been sub contracted?	**GREEN**	Compliant	Starting Well Service contract has sub contracting arrangements in place – governance monitoring arrangements are in place.
3. Choice and competition				
C1(3)	Are clear systems in place for notifying individual patients about choice?	**GREEN**	Compliant	No change since Q4 2017/18 review.
4. Integrated care				
IC1	Are there any service changes that require staff/ public consultation (need to	**GREEN**	Compliant	Rated compliant at this time. Public consultation on Central and East Cheshire services completed and published in September 2018.

Licence reference	Licence provision	Self assessment	End quarter 2 2018/19 position	Comments/ Further actions for completion
	be cognisant of Public Interest)?			
5. Continuity of services				
CoS1	Have any contract variations been completed to service specifications [if Yes action required CoS1(4)]?	**GREEN**	Compliant	No contract variations completed during the period.
CoS2	Have any assets been disposed of that would impact on the ability to provide 'Commissioner Requested Services'?	**GREEN**	Compliant	No change since Q4 2017/18 review.
6. NHS Foundation Trust conditions				
FT1	Has the Constitution been amended? Amended constitution should be submitted to NHSI with 28 days of amendment.	**GREEN**	Compliant	No change since Q4 2017/18 review.
FT4(8)	Submit to NHSI Corporate Governance Statement following Board approval in Q1 by 30 June.	**GREEN**	Compliant	Statements are approved at the May meeting of the Board of Directors. Current statements (24 May 2018) published in accordance with Licence requirements.

CHAIR'S REPORT
OPERATIONAL COMMITTEE – 21st November 2018

The following is a summary of issues discussed and any matters for escalation from the November 2018 meeting of the Operational Committee:

Operational Committee Dashboard
Work continues to further refine the data within the dashboards. Teams have made significant improvements in respect of appraisal compliance. Work continues to address attendance, current vacancies and CIP in a number of the care groups.

Programme Support Office (PSO) Exception Report
The Trust currently has 13 priority projects. 12 status reports were received prior to the Operational Committee meeting. 1 project was reported as red, 4 projects were reported as amber and 8 projects were reported as green. The project currently reported as red relates to the ADHD Model. An update was provided to the Committee that confirmed the significant work that has taken place in this area, and that the project is progressing well. It was agreed, that if the project continued to progress in this way it could move to an amber rag rating.

PSO: Enhancing our Teams Projects
Feedback was provided to the Committee in regards to the new ways of working recently piloted within the Broxton Community team. The benefits of this method have been very evident and have delivered good levels of team and patient satisfaction. The Operational Committee approved the roll out of this model to other Community teams.

Payroll Provider
The current Trust SLA is due to come to an end. The Trust would like to extend the current contract for a period of 12 months to allow time to fully implement the e-expenses project. Within the next 12 months, it is also anticipated that a Cheshire and Merseyside approach to payroll would be developed. The Operational Committee approved the proposals.

Exceptions from Risk Registers
Each Care Group presented their current risk register, highlighting their current red risks to the Operational Committee. The Operational Committee noted the reports and agreed to escalate matters as appropriate.

CAMHS Benchmarking Presentation
Dr Warren Levine provided a presentation to the Committee that highlighted CWP performance within our CAMHS services against national data. The presentation highlighted that CWP receive and accept a high volume of referrals compared to other Trusts. Despite this, CWP waiting times are below average, contacts per year are above the national mean, and caseloads per FTE are comparable to the national average.

Review of Internal Audit Reports (MIAA)
The Quality Spot Checks internal Audit report was presented to the Operational Committee for noting. The report was discussed at the previous meeting, however, it was highlighted that discussions continued with MIAA in respect of the report findings. The report had already been agreed by the Executive Team before being referred to Audit Committee for

their approval. The report included three recommendations which have now all been addressed.

Workforce Race Equality Standard Information Report

The Committee were provided with a summary of the data that highlighted a number of areas that the Trust will now focus its attention. The report clearly outlined the actions to be taken forward. This work will be reported through the People and Organisational Development Sub-Committee and reported to Operational Committee via the POD Chair's reports.

Central and East Redesign

A presentation was provided to the Committee to outline the process to date and the proposed plans going forward. The Committee were advised that the process is now approaching its final stages. The decision making paper is due to be presented to the Committees in Common (which includes the three CCG's) on the 22nd November 2018. Further to this meeting, the Trust should then be clear if progression to the implementation stage is possible. The Committee acknowledged the amount of work that has gone into this process to date, and all involved were thanked for their efforts. It is hoped that should the proposals be approved, the plans will make a considerable difference to the population and to the staff working in that area.

Sheena Cumiskey
Chair of Operational Committee / Chief Executive

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

CHAIR'S REPORT –
QUALITY
COMMITTEE
7 NOVEMBER 2018

The following issues and exceptions were raised at the Quality Committee, which require escalation to the Board of Directors:

1. Family Nurse Partnership

Two presentations were received from the Family Nurse Supervisor; the first to update on impacts post acquisition of the Starting Well (0-19) Service; the second to update on how the Family Nurse Partnership had benefitted from its patient safety improvement review – PSiR.

(1) The Starting Well Service has received positive informal feedback following the CQC core service inspection regarding the integration of the service into CWP. The service is an example of the strategic shift that is the aspiration for CWP, e.g. improving health and well-being at an early age and at a family and community level, using the principles of trauma informed practice to address any adverse experiences experienced by people.

(2) The Family Nurse Partnership, which is a preventative programme delivered to families for two and a half years from pregnancy through to early childhood, has used its PSiR as a safe, reflective space and it has enabled the team to celebrate what works well and think about areas for improvement in relation to safety – including implementing reflective team discussions and the Patient Safety Leader role helping the team to learn from all safety information, lower harm incidents and best practice.

The Board is asked to note that monitoring has demonstrated that there have been no adverse clinical and quality impacts post acquisition of the Starting Well Service.

2. Strategic risk register

The Quality Committee received assurance on progress against the mitigating actions identified against the Trust's strategic risks and the controls and assurances in place that act as mitigations against each current strategic risk. Three of the previous four risks in scope have been modelled, the outstanding risk associated with supervision compliance rates showing varying levels of compliance across clinical and non-clinical staff groups will be modelled with the benefit of considering feedback from the CQC (as part of the Trustwide annual inspection) on this issue. A rapid improvement exercise is planned to ensure accurate capture of supervision and to build capacity to enable supervision compliance. Other notable updates include:

(1) The risk that people who require admission may have to wait longer than 4 hours for a bed to be allocated, due to pressures on acute bed capacity, has been escalated to a red risk score of 16 (from 12) due to real time monitoring highlighting increasing waits and risk of potential premature discharge. Corporate support has been identified to work with, in the first instance, Wirral, to seek to understand reasons for increasing difficulty in community services being less able to cope without needing acute bed days. Learning will be shared across the whole of CWP to reduce the risk of similar impacts elsewhere.

(2) The potential for ineffective control and management of risks and inattention on business as usual associated with the transition to the Trust's clinician-led operational (Care Group) structure as part of CWP Forward View strategy has a reduced risk score from 12 to 8 (amber) as a result of the ongoing implementation of the risk treatment plan, also validated by positive informal feedback from the CQC Trustwide inspection.

(3) The risk of not achieving safeguarding contractual obligations and subsequent reputational impact, due to increased inspectoratory burden and acute increase in the volume of multiagency case reviews, was discussed in detail by the Quality Committee and it was agreed to increase the risk score due to the further delay to the intended service review and due to risk matters escalated in the Chair's Report from the Safeguarding Sub Committee.

The Quality Committee approved the amendments made to the strategic risk register for update of the corporate assurance framework to the Board.

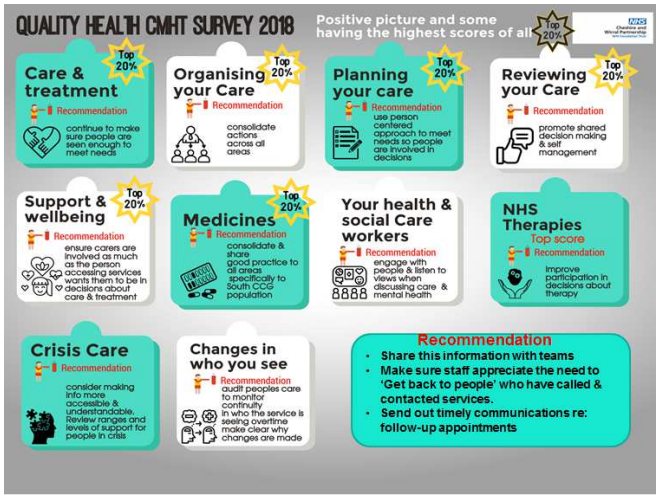
3. Quality Improvement Hub

A presentation was received on progress with the development of a QI Hub (intranet portal); the presentation was delivered by Safe Services and included the work contributed to by other teams (clinical and non-clinical) in making this an effective resource. The hub is a centralised resource for all staff to access QI resources and support and to learn from others' QI projects. A supplementary element of this is CWP's Twitter feed entitled #cwpQI. The hub is progressing at pace and scale – already it has all clinical support team QI charters, various accessible resources, and video clips from clinicians who have shared their QI successes. The Twitter feed already has 150 followers.

The Board is asked to note this pivotal QI infrastructural development that will enable QI capability to be built across the organisation.

National CMHT Survey 2018

The sample for this survey was generated at random on the agreed national protocol from all people on CPA and non-CPA seen between 1 September and 30 November 2017. CWP is in the top 20% of trusts surveyed for many of the questions, scoring the highest of all trusts for three questions; the remaining scores are in the intermediate range (there are no scores are in the lowest 20%). 27% of people ranked their experience of CWP services as 9 or 10 out of 10, compared with 18% nationally; however year-on-year, the number of lower rate responses scoring 0 – 5 has been increasing, which will inform QI work. Knowing who to contact in a crisis is also an area that will be subject to QI work.



The results, including thematic areas for improvement, will be shared with the teams involved and will also be shared with the Trustwide workstream looking at responsive mental health care in the community (the Trust's signature QI initiative) to inform potential pathways of care and how service structures might operate. The Quality Committee will be receiving an update as part of assurance around the QI strategy implementation in January 2019.

Dr Jim O'Connor
Non Executive Director/ Chair of Quality Committee

Cheshire and Wirral Partnership
NHS Foundation Trust

CHAIR'S REPORT –
AUDIT COMMITTEE 13 NOVEMBER 2018

The following issues and exceptions were raised at the Audit Committee, which require escalation to the Board of Directors:

- Quality Assurance Dashboard
  The Audit Committee received a presentation from the Quality Surveillance Team about the Quality Assurance Dashboard. The Committee was impressed with the Dashboard and the further potential it could offer the organization and, in particular, Board reporting.

- Quality Spot Check Report
  The Audit Committee received the Quality Spot Checks – ward cleanliness report which provided moderate assurance and three 'medium' level recommendations. The report noted areas of good practice and high standards of cleanliness being demonstrated and maintained. However, the Committee remains concerned that there are still areas for improvement and an update will be reviewed at the next meeting in January 2019.

- Cyber Essentials Certification: Gap Analysis Review Report 2018/19 and IT Service Continuity Review 2018/19
  The Committee received two reports, both of which provided moderate assurance. The Trust demonstrated good practice and sound internal controls in a range of areas. An options report is being prepared which will inform the IT plan for next year.

- Oversight and Assurance of coherent workforce planning
  The Audit Committee considers that there is a lack of clarity with respect to the coherence of the Trust's workforce planning. The current work of the revised governance framework and mapping out business cycles will provide clarity on roles and responsibilities. A planned audit has now been delayed twice and the Committee has requested an update on this as soon as possible.

- Risk Register
  The committee noted the range of high-level risks and the ambition to strive for better articulation of the risk components within the register.

- Safeguarding Assurance
  The committee noted the recent report presented to the quality committee and a number of high level risks which were identified. The committee were satisfied that the actions in the next period seek to mitigate the risk of not achieving safeguarding contractual obligations. However, the committee agreed that an audit of processes, reporting mechanisms and accountabilities should take place as an additional piece of work within this audit calendar

Edward Jenner
Non Executive Director/ Chair of Audit Committee

Cheshire and Wirral Partnership
NHS Foundation Trust

Audit Committee

Terms of Reference

1. Constitution

The Board of Directors hereby resolves to establish a Committee to be known as the Audit Committee. The Committee is a non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Duties

The Committee is responsible for:

a. Governance, risk management and internal control

The Committee shall have primary responsibility and review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievements of the Trust's objectives. It will provide an independent and objective view on internal control and probity. In addition, the Committee will monitor any formal announcements relating to its financial performance, reviewing significant financial reports and the judgements contained in them.

In particular the Committee will review the adequacy of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance to external bodies), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, licence requirements and related reporting and self-certification.
- Finance-related policies and procedures including Standing Orders, Standing Financial Instructions, Scheme of Delegation.
- The policies and procedures for all work related to fraud and corruption as required by the NHS Counter Fraud Authority.
- The arrangements by which Trust staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. In so doing the Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

In carrying out this work the Committee will utilise the work of internal audit, external audit and other assurance functions but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

b. Internal audit

The Committee will ensure that there is an effective internal audit function established by management that meets public sector internal audit standards and NHS internal audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.
- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework.
- Consideration of the major findings of internal audit work (and management's response) and ensuring coordination between internal and external auditors to optimise audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the Trust.
- Annual review of the effectiveness of internal audit.
- Annual self-assessment of the Committee, facilitated by Internal Audit.

c. External audit

The Committee shall review the independence, objectivity and work of the external auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the external auditor, including liaising with and making recommendations to the Council of Governors regarding the former.
- The duration of each term will be three years with an option for an additional two years. Once the term has expired, the appointment must be subject to open tender.
- Discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the annual plan and ensure coordination with internal auditors and with other external auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any audit work performed outside the annual audit plan, together with the appropriateness of management responses.

- Approval of the engagement of the external auditor in respect of non-audit work where the cost is over £5,000, taking into account relevant ethical guidance regarding the provision of such services. The Director of Finance will inform the Committee of any non-audit engagements below this figure and in all cases the Committee will report them to the Council of Governors.
- Annual review of the effectiveness of external audit.

d. Other assurance functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust. It will review, appraise and report in accordance with Public Sector Internal Audit Standards (PSIAS) and best practice. These will include, but will not be limited to, reviews and reports by Department of Health and Social Care's arm's length bodies or regulators/inspectors e.g. Care Quality Commission, NHS Resolution, etc, professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc), the Local Counter-Fraud Specialist (LCFS).

In addition the Committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality Committee and Operational Committee. With regard to the former and issues around clinical risk management the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

The Committee will also review all suspensions of Standing Orders and variation or amendment to Standing Orders.

At each meeting, the Committee may wish to review any "red" rated risk from the Risk Register and may request it receives a presentation in person from the senior clinical / other professional responsible for addressing this particular risk.

The Audit Committee will report to the Board and to the Council of Governors any matters in respect of which it considers action or improvement is needed.

e. Counter- fraud

The Audit Committee shall satisfy itself that the Trust has adequate arrangements in place for countering fraud and will approve the appointment of the Local Counter-Fraud Specialist. The Committee will review the outcomes of counter-fraud work.

f. Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements.

g. Statutory reporting (Financial & Quality Accounts)

The Audit Committee shall review the Trust's annual report and associated accounting statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Major judgemental areas
- Significant adjustments resulting from the audit
- Letter of representation
- Qualitative aspects of statutory reporting

The Committee shall monitor the integrity of the accounting statements of the Trust and any formal announcements relating to the Trust's reported performance. The Committee should also ensure that the systems for both financial and qualitative reporting to the Board are subject to review as to completeness and accuracy of the information provided to the Board.

3. Membership

Membership will be appointed by the Board of Directors from amongst its Non-Executive members and will consist of not less than three members, at least one of whom should have recent and relevant financial experience. The Chair of the Quality Committee shall be a member of the Audit Committee.

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

The Board will appoint one of the members to be Chair and another Vice Chair from the outset. The Vice Chair will automatically assume the authority of the Chair should the latter be absent. The Chair of the Trust shall not be a member of the Committee.

a. Quorum

A quorum shall be two members.

b. Voting

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

c. Attendance by members

Members will be required to attend a minimum of 50% of all meetings. The Committee shall be able to co-opt further members to the Committee for special purposes.

d. Attendance by officers or others

Either the Director of Finance or the Deputy Director of Finance and appropriate internal and external audit representatives shall normally attend meetings. At least once a year the Committee will meet privately with the external and internal auditors.

The Chief Executive and other executive directors will be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

The Chief Executive will also be required to attend when the Audit Committee discussed the process for assurance that supports the Annual Governance Statement.

The Trust's Head of Corporate Affairs will be Secretary to the Committee and will attend to take minutes of the meeting and provide appropriate support to the Chair and the Committee members.

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

Governors may be invited to observe meetings of the Audit Committee.

4. Accountability and reporting arrangements

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

The minutes of the Audit Committee will be formally recorded and submitted to the Board of Directors. The Chair of the Audit Committee shall draw to the attention of the Board of Directors any issues that require disclosure to it, or require executive action.

The Audit Committee will refer to the other two Board governance Committees (the Quality Committee and the Operational Committee) matters considered by the Committee deemed relevant for their attention. The Committee will consider matters referred to it by those two governance Committees.

The Audit Committee will receive reports from the Quality Committee regarding assurances relating to the effective operation of controls and in the event of a significant risk arising, the risk will be reported as per the Trust's integrated governance framework and risk management processes.

The Committee will report to the Board annually on its work and performance in the preceding year and, as part of this report, will provide commentary in support of the Annual Governance Statement, specifically dealing with the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the Trust, the integration of governance arrangements and the appropriateness of the evidence compiled

to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the quality accounts.

Trust Standing Orders and Standing Financial Instructions apply to the operation of the Audit Committee.

5. Frequency

Meetings will normally be held bi-monthly.

The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

6. Authority

The Audit Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. The Committee is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, subject always to compliance with Trust delegated authorities.

7. Monitoring effectiveness

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

8. Administration

The Committee shall be supported administratively by Corporate Affairs whose duties in this respect will include:

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

9. Review

These terms of reference will be reviewed at least annually by the Committee.

Date reviewed by Committee	September 2018

Date approved by Board of Directors	September 2018
Review date	September 2019

10. Version control

Version control	Date	Comments
1	7 July 2010	Amends made by Audit Committee members and by Company Secretary following review of (as yet unpublished) Department of Health Audit Committee Handbook 2010
2	26 July 2010	Amends made by Audit Committee members and Deputy Director of Finance
3	27 July 2010	Further amends made by Audit Committee members
4	4 May 2011	Further amends made by Audit Committee members
5	6 March 2012	Further amends made by Audit Committee members
6	5 March 2013	Reviewed by Audit Committee
7	1st May 2014	Reviewed by Audit Committee, amendments agreed
8	5th May 2015	Reviewed by Audit Committee, amendments agreed (references to anti-fraud and annual governance statement)
9	1st March 2016	Amendment to section 2a.
10	5th July 2016	Addition of co-option of members to membership section.
11	2nd May 2017	Amendments made as follows: • Requirement for Chair of Quality Committee to be a formal member of the Audit Committee • Addition of Audit Committee Chair to have 'recent and relevant financial experience.' • Removal of reference to Operational Board in section 2a • Addition of reference to Licence requirements in section 2a. • Addition of Governor attendance in section 3d. • Addition of reference to Quality Committee reporting in section 4.
12	4 September 2018	Amendments made in accordance with HFMA NHS Audit Committee Handbook as follows: • NHS Litigation Authority amended to NHS Resolution. • Operational Board amended to Operational Committee. • Government Internal Audit Standards amended to Public Sector Internal Audit Standards (PSIAS).