Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting of the Trust Board of Directors held in Public[1]

Wednesday 30 May 2018 at 1.30 pm

Boardroom, Redesmere, Countess of Chester Health Park

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/01	Apologies for absence	Receive apologies:	Verbal	Chair	1.30 (1 mins)
18/19/02	Declarations of Interest	Identify and avoid conflicts of interest	Verbal	Chair	1.31 (2 mins)
18/19/03	Meeting Guidelines	To note	Written	Chair	1.33 (1 mins)
18/19/04	Minutes of the previous meeting • 28th March 2018	Confirm as an accurate record the minutes of the previous meetings	Written minutes	Chair	1.34 (5 mins)
18/19/05	Matters arising and action points	Provide an update in respect of ongoing and outstanding items to ensure progress	Written action schedule and verbal update	Chair	1.39 (5 mins)
18/19/06	Board Meeting business cycle 2018/19 (Draft)	Confirm that agenda items provide assurance that the Board is undertaking its duties	Written Report	Chair	1.44 (5 mins)

1 In accordance with the Health & Social Care Act 2012, all Trust Board meetings must be held in public. All decisions which require the board's collective approval can only be made at a Trust Board (or a meeting held in closed session to discuss patient sensitive or confidential matters).

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/07	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	**1.49 (10 mins)**
18/19/08	Chief Executive's announcements *(including overview of items discussed in closed meeting)*	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	**1.59 (20 mins)**
Quality of Care					
18/19/09	Learning from Experience Report – Executive Summary	To note report	Written Report	Director of Nursing, Therapies and Patient Partnership.	**2.19 (5 mins)**
18/19/10	Quality Improvement Report	To note report	Written Report	Medical Director, Compliance, Quality and Regulation.	**2.24 (5 mins)**
18/19/11	Quarterly Infection Prevention Control Reports	To note report	Written Report	Director of Infection Prevention and Control.	**2.29 (5 mins)**
18/19/12	Monthly Ward Staffing Up-date	To note the ward staffing reports	Written Report	Director of Nursing, Therapies and Patient Partnership.	**2.34 (5 mins)**
18/19/13	Speak Up Guardian – F2SU Report – 2017-2018	To review and note report	Written Report	Freedom to Speak Up Guardian	**2.39 (5 mins)**
(**10 minute break 2.44 – 2.54 approx.**)					
18/19Strategic Change					
18/19/14	Central and East redesign – Consultation Up-date	To note progress	Verbal	Katherine Wright	**2.54 (5 mins)**
18/19/15	Strategic Risk Register and Corporate Assurance Framework	To review new/ existing risks and assurances	Written	Medical Director, Compliance, Quality and Regulation.	**2.59 (5 mins)**

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
Operational Performance, Finance and Use of Resources					
18/19/16	Board Performance Dashboard	To note performance	Written	Director of Finance	**3.04 (10 mins)**
18/19/17	Apprenticeship Summary Report	To note report	Written	Director of People and OD	**3.14 (10 mins)**
Governance and Regulation					
Governance and regulation: Assurance and escalation reports from Board Sub-committees (discussion by exception only)					
18/19/18	Audit Committee Chair's report: • 1st May 2018 • Audit Committee Review of Effectiveness	Review Chair's Report and any matters for note/ escalation Review outcome of effectiveness review.	Written	Vice Chair of Audit Committee	**3.24 (5 mins)**
18/19/19	Quality Committee Chair's report: • 9th May 2018 • Terms of Reference	Review Chair's Report and any matters for note/ escalation Approve revised terms of reference	Written	Chair of Quality Committee	**3.29 (2 mins)**
Closing Business					
18/19/20	Any other business other business *(Any items should have been previously notified to the Chair)*	Consider any urgent items of other business	Verbal	Chair	**3.31 (5 mins)**
18/19/21	Questions from observers or members of the public. *(relating to specific items on the agenda)*	To encourage openness and transparency	Verbal	Chair	**3.36 (10 mins)**
18/19/22	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair/ All	**3.46 (2 mins)**

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/23	Key messages for communication	Agree items of particular importance to communicate to staff, governors or other key stakeholders	Verbal	Chair	**3.48 (5 mins)**
18/19/24	Review of meeting performance	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair/All	**3.53 (5 mins)**
18/19/25	Date, time and place of next meeting(s): • **25th July 2018 – 1:30pm – Redesmere – Board Room**	Confirm arrangements for next meeting	Verbal	Chair	**3.58 (Close)**

Cheshire and Wirral Partnership NHS
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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.

Cheshire and Wirral Partnership NHS
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UNCONFIRMED Minutes of the Board of Directors Meeting held in Public
Wednesday 28 March 2018 at 1.30 pm
Boardroom, Redesmere, Countess of Chester Health Park

PRESENT	Mike Maier, Chair (MM) Dr Faouzi Alam, Medical Director (Effectiveness, Medical Education and Medical Workforce) (FA) Andrea Campbell, Non-Executive Director (AC) Dr James O'Connor, Non-Executive Director (JO'C) Lucy Crumplin, Non-Executive Director (LC) Sheena Cumiskey, Chief Executive (SC) Avril Devaney, Director of Nursing, Therapies and Patient Partnership (AD) David Harris, Director of People and Organisational Development (DH) Andy Styring, Director of Operations (ASt) Tim Welch, Director of Finance (TW)

IN ATTENDANCE	Elizabeth Bott, Public Governor – Cheshire West and Chester (EB) Nigel Richardson, Out of Area Governor Brain Crouch, Lead Governor/ Service User Carer Governor (BC) Jacqueline McGhee, Service User Carer Governor (JM) Julie Dawes, Head of Corporate Affairs (JD) David Wood, Associate Director of Safe Services Katherine Wright, Associate Director Communications and Engagement (KW)

OBSERVER	Rachael Davies, CQC Inspector, Hospital Directorate – Mental Health North West (RD)

APOLOGIES	Edward Jenner, Non-Executive Director (EJ) Dr Anushta Sivananthan, Medical Director (Quality, Compliance and Assurance) (ASi)

	MINUTES	**ACTION**	
17/18/111	**WELCOME AND APOLOGIES FOR ABSENCE** The Chair welcomed everyone to the meeting and extended a particularly warm welcome to Rachael Davies who was in attendance as an observer of the meeting as part of the Care Quality Commission's new framework around the assessment of the well-led domain. It was reported that apologies had been received from Edward Jenner, Non-Executive Director and Dr Anushta Sivananthan. The Chair confirmed that the meeting was quorate and declared the meeting being held in public as open.		
17/18/112	**DECLARATIONS OF INTEREST** It was CONFIRMED that there were no declarations of interests in relation to matters on the agenda or any notification of changes to the Trust's Register of Interests for Directors.		
17/18/113	**MINUTES OF PREVIOUS MEETING – 31 JANUARY 2018** The Chair reported that approval of the Minutes of the meeting held on 31 January 2018 would be deferred until the April meeting. It was noted that in the meantime, the Minutes would be circulated to Board members for consideration and approval in principle outside the meeting.		

17/18/114	**MATTERS ARISING AND ACTION POINTS** It was noted that in light of the unavailability of the Minutes of the previous meeting, as per the minute 17/18/113, review of the action tracker would be deferred until the April meeting. In the meantime, required actions were being progressed by Executive Directors.		
17/18/115	**BOARD MEETING 2017/18 BUSINESS CYCLE** The current Board business cycle for 2017/18 was received and NOTED.		
17/18/116	**CHAIR'S ANNOUNCEMENTS** The Chair drew attention to the following noteworthy matters: a) Update on Board development programme for 2018/19 The Chair explained that the Board development programme will include a blend of knowledge based skills and softer skills such as Board dynamics, constructive challenge and holding to account, leadership styles and behaviours. The Chair reported that he had a useful discussion with the NEDs to shape the programme; equally the executive directors have a meeting scheduled for 6 April to discuss this. Options are being explored for securing external professional support to facilitate this process, whilst Hill Dickinson's healthcare team is facilitating a development session at the next Board Seminar meeting on 25 April. b) Board Business Cycle 2018/19 The Chair reported that owing to the wider governance review currently taking place to reflect the establishment of Care Groups from 1 April; this scheduled item has been deferred to ensure that the meetings framework across the organisation is properly aligned to enable effective reporting, accountability, escalation and assurance. c) Council of Governors and Membership The Chair reported that, sadly, Gladys Archer, a service user/ carer Governor, has decided to step down from the Council of Governors for personal reasons and asked the Board to formally thank Gladys for her contribution. Governor elections are scheduled to take place in late spring/ early summer. The Chair provided a reminder that the next Joint Board of Directors and Council of Governors meeting is on Monday 23 April, where there will be an opportunity for Board members to formally engage with Governors about implementing the Trust's Forward View Strategy. The Chair reported that as part of his engagement with Governors, he had recently attended a Staff Governors meeting on 12 March. The Chair reported also that the Trust has been invited by to take part in the NHS Providers Governor Advisory Committee (GAC) forthcoming elections. The closing date for the Trust to submit its vote is by noon on Monday, 30 April 2018. This will be included as an agenda item at the next Council of Governors meeting in April and the corporate affairs team are currently liaising with Governors to facilitate		

	this process. d) Overview of Chair and NED activity/ visibility The Chair reported that NED visits to teams, aligned to the Board safety management system and programme of patient safety improvement reviews, were working extremely well and were receiving excellent feedback from those NEDs who had attended these visits. He thanked the Associate Director of Safe Services, David Wood and his team for developing this framework. The Board of Directors received and NOTED the Chair's verbal report.		
17/18/117	**CHIEF EXECUTIVE'S ANNOUNCEMENTS** *(including overview of items discussed in closed meeting)* a) The Chief Executive summarised the discussions held earlier in the closed Board meeting. These included: • Update on transformation progress across the CWP footprint • Update on Serious Untoward incidents • Discussion on Quality Improvement approach to desktop thematic review on inpatient deaths looking at the experience of care. • Update on Thorn Heys short stay respite service and approval of re-opening of Thorn Heys Unit on 5 April 2018 working towards transitioning the service to accommodation with care. • Approval of CWP Forward View Strategic Plan and how this will be developed through the Care group charters. • Considered the approval process for developing the Care Groups and the assurance process for Care groups. This included discussion how to do this in an innovative co-produced way balanced with clear accountability • Approval of the key project priorities across the Care Groups • Approval of the external strategic partner to support the Quality Improvement Strategy • Noted that the Trust is on track to achieve its control total for 17/18. • Noted the Operational Plan for 2018/19 as submitted to NHS Improvement In addition, the Chief Executive drew attention to the following noteworthy matters: b) National updates The Chief Executive fed back that details on the national NHS Pay Award had now been released. These indicated that the proposed pay award will be fully funded and, subject to formal approval processes, would be in force from July 2018. Subject to this agreement, the next step for the Trust would be to undertake an impact assessment, which would be reported to the Operational Board at the appropriate time. c) Procurement Team award The Chief Executive congratulated the CWP Procurement Team for winning Best Procurement Support/ Service, in partnership with "de Poel health+care", at the HSJ Partnership Awards on 8 March. d) Royal reception Linda Johnstone, lead nurse and clinical director for CWP's Substance Misuse Service, recently attended a royal reception at Buckingham		

	Palace, hosted by the Prince of Wales. This celebratory event was to thank those engaged in frontline nursing across the United Kingdom. She was one of 350 guests representing nurses from throughout the profession. The Board of Directors received and NOTED the Chief Executive's verbal report.		
17/18/118	**SAFER STAFFING** The Director of Nursing, Therapies & Patient Partnership, Avril Devaney, presented the Safer Staffing report which included daily staffing levels during January and February 2018. The themes arising from these reports identify how patient safety is being managed and maintained on a shift by shift basis, they also continue to mirror those that had previously arisen. The recommendations made within the last 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. Avril Devaney reported that despite maintaining safety, as demonstrated in the report, staff were currently operating under pressure as a consequence of sickness levels. Where this was proving to be a challenge, ward managers were, at times, working as part of the team rather than being supernumerary. In response, the following comments were received: a) The Director of Operations commented that a positive indicator was that the Trust was still not placing people out of area. He also described the positive work being undertaken by the centralised bed management hub and quality improvement work in relation to 'Red to Green bed days'. b) Dr O'Connor, NED, commented that the report could be enhanced for the future by commenting on how staff were feeling. The Director of People and Organisational Development responded that fluctuations in capacity and demand make it difficult to measure well-being on an ongoing basis. The Director of Nursing, Therapies & Patient Partnership stated that this report contained stipulated content and would be further developed to provide further information to the Board. This will be discussed collectively by the Executive Team. Following discussion, it was RESOLVED that: 1. The Executive Team would scope a suite of triangulated assurance alongside the next six monthly report, which would include further key performance indicators with respect to staffing. 2. The Board of Directors NOTED the report.	**AD/ DH**	**30/5**
17/18/119	**NHS STAFF SURVEY RESULTS 2017** The Director of People & Organisational Development, David Harris, presented the NHS Staff Survey results for 2017, explaining that the embargo was lifted on 6 March 2018, in which CWP's key findings were published nationally. The NHS Staff Survey is an exercise that all NHS		

	trusts in England are required to undertake and offers a valuable insight into staff experiences within the Trust. David Harris further added that the CWP survey response rate was 53%, a 6% percent increase from 2016, and 2% higher when compared to other trusts within the sector. David Harris delivered the highlights of the survey results and analysis. Overall he reported that there was a generally positive improvement within the report, but there were also areas deemed as requiring improvement. David reported that following a review into the results, a plan would be developed to cascade them and develop a Trustwide action plan. Any particular issues that warranted it would be added to the current strategic risk number 11. The Chief Executive reminded the Board of Directors that the results and analysis of the NHS Staff Survey 2017 would be discussed in collaboration with operational colleagues via the next scheduled Clinical Engagement and Leadership Forum and Operational Board meeting. The Board of Directors received and NOTED the report.		
17/18/120	**GUARDIAN OF SAFE WORKING HOURS QUARTERLY REPORTS** The Medical Director (Effectiveness, Medical Education and Medical Workforce), Dr Alam, presented the following quarterly reports provided to the Board of Directors by the Guardian of Safe Working: i. 17/18/120.1 June – August 2017 report ii. 17/18/120.2 September – November 2017 report Dr Alam familiarised the Board of Directors that Guardians of Safe Working (GoSW) were introduced as part of the 2016 contract for doctors in training. He explained that reports from the guardian are mandated nationally and are required to provide assurance that patients and medics are protected by making sure that medics are not working unsafe hours and escalating where they are not able to access the required education. No issues regarding safe working hours have been raised within either report and there have not been any fines imposed against the Trust before or during the reporting period. In response, the following comments were received: a) Rebecca Burke-Sharples, NED, queried what was being done about the lack of a formal process by which internal locum work undertaken by doctors is monitored to ensure safe working hours are adhered to. Dr Alam assured the Board that the establishment of the medical bank now ensures that all of the undertaken internal locum work is streamlined and has addressed this gap. The agenda of next Medical Staffing Group will be updated to discuss the monitoring of adherence to safe working hours and the working time directive. b) Lucy Crumplin, NED, stated that she found the report difficult as a means of assurance. Dr Alam explained that this was a limitation of the report's content being mandated in the way it was. The Chief Executive raised caution that this was an independent report of the findings of the guardian, acting under the requirements of the mandated guidance that sets out the contents of the report. However, she suggested that the next report could be strengthened by being		

	more assurance focussed, as per the verbal assurances provided at today's meeting, with the mandated element of the report featuring as an appendix. The Board of Directors welcomed this as a positive and helpful way forward to bolster the future assurance it will receive. Dr Alam agreed to discuss this with Dr Porter, the Trust's GoSW, so that this could be effected for the next scheduled report. Following discussion, it was RESOLVED that the Board of Directors received and NOTED the report.	**FA**	**25/7**
17/18/121	**GENDER PAY GAP REPORT** The Director of People and Organisational Development, David Harris, introduced this report, explaining that any employer with more than 250 staff are required to publish annually their gender pay gap information. David explained that the report was not about equal pay, it was about hourly pay and reporting any differences. David Harris went on to present the more detailed analysis. CWP employed 3,490 staff as at 31 March 2017 – 78.65% female and 21.35% male. The snapshot of hourly rates as at 31/03/2017 shows that on average men were paid 11.98% more than women with the median difference being 4.79%. The national figures for public sector in 2017 are 17.7% and 19.4% respectively, indicating a lesser gender pay difference within CWP. The gender pay gap for hourly rates reduces significantly if medical staff are excluded – men are paid 0.29% on average higher, while there is no difference in the median pay. There are a number of reasons why a gender pay difference exists, such as women being more likely to have unpaid carer responsibilities and occupational segregation, but further investigation is needed into the detail and the reasons for the differences in CWP. David suggested that the Equality and Diversity Group undertake the work to investigate the reasons for differences and develop an action plan to close the gap. The effectiveness of this action plan will be tracked by analysing improvements in the next annual report. David stressed that the issue to look at is what the barriers are to progressing up pay scales, rather than the gender pay gap. Dr O'Connor, NED, commented that looking at Clinical Excellence Awards as part of this work will make a difference to the gaps being reported. It was resolved that the Board of Directors: 1. APPROVED the figures for upload to the Government website. 2. APPROVED the narrative for the CWP website. 3. APPROVED the recommendation to task the Equality and Diversity Group to undertake the work to investigate the reasons for the differences in CWP and develop an action plan to improve.		
17/18/122	**PUBLIC CONSULTATION FOR THE REDESIGN OF ADULT AND OLDER PEOPLE'S SPECIALIST MENTAL HEALTH SERVICES** The Director of Operations, Andy Styring, presented an update on the public consultation for the redesign of adult and older people's specialist mental health services in South and East Cheshire and Vale Royal. The public consultation commenced on 6 March and will run through until 29		

	May. The first public event took place on 21 March. In addition to public meetings, there will also be the continuation of meetings with key local community groups and scrutineers, including Healthwatch and the three mental health forums. Andy reported that the Medical Director, (Quality, Compliance and Assurance), is acting as CWP's clinical leader for this consultation alongside the clinical chairs of the three CCGs. He fed back on emerging themes received by the CWP team who had attended and facilitated the first public event, which had been an opportunity for reflection and learning on the ideal format to ensure that people have a wide range of opportunities to learn about the proposals and share their views. The main, early theme centred on maintaining the existing physical building, Millbrook Unit, whereas the narrative needs to help people with better understanding about the proposals. This includes being open about the current building not being fit for purpose and consuming resources in an area of specialist mental health provision that is already under-resourced. The Chief Executive expressed that the public events are important to respond to such feedback and welcomed them as an opportunity to have an open, balanced conversation. The Board of Directors NOTED the launch of the public consultation and the planned communications/ engagement approach.		
17/18/123	**OPERATIONAL PLAN AND PERFORMANCE DASHBOARD – FEBRUARY 2018** The Director of Finance, Tim Welch, presented the February 2018 (month 11) performance against the key performance indicators defined to enable the Board to monitor the delivery of the Operational Plan, the Trust's strategic objectives and any risks to achievement. The dashboard reflects that in month 11, there were six indicators meeting the threshold for escalation. Tim Welch directed the Board to Appendix 1, which provides commentary describing how remedial action is being taken. Tim also invited the Board to review those key performance indicators meeting or exceeding target performance, including the use of resources rating of 1 (1 being the best rating). The Board of Directors NOTED the report.		
17/18/124	**DATA SECURITY AND PROTECTION REQUIREMENTS – GDPR READINESS** The Medical Director (Effectiveness, Medical Education and Medical Workforce), Dr Alam, presented CWP's preparations for the implementation of the General Data Protection Regulation (GDPR) into British law. Dr Alam started by explaining the preparations for GDPR have been managed by a GDPR Task and Finish Group. The first GDPR action plan was first introduced to the Board of Directors on 28/09/2016 and an updated paper was presented to the Board of Directors on 26/07/2017. During mid-February 2018, further national guidance was released by the Information Governance Alliance, which clarified a number of key points, all of which are being incorporated into the Trust's plans for preparedness, with clearer ownership and delivery timeframes being added as a result. Dr Alam further added that whilst the priority of the Trust has been on		

	ensuring that health records are GDPR compliant, further work had also been going on regarding across other support service areas like human resources, contracts and procurement. More work is required within these areas, but more work is being demonstrated within the overall work plan. A further updated action plan will be provided to the Board of Directors in July 2018. Dr Alam closed by assuring the Board of Directors that the collective actions taken represent the Trust's readiness for GDPR adoption on 25 May 2018. The Board of Directors received and NOTED the update.	**FA**	**25/7**
17/18/125	**INFORMATION GOVERNANCE ANNUAL REPORT** (*Including Information Governance Toolkit 2017/18 submission)* The Medical Director (Effectiveness, Medical Education and Medical Workforce), Dr Alam, presented the Information Governance Annual Report. He explained that compliance with information governance standards are annually assessed through the completion of an Information Governance Toolkit (IGT) hosted by NHS Digital. Dr Alam stated that the planned final March 2018 IGT will be 94%. The Willaston Surgery submission had increased by 3% to 94% compliance, further its compliance score has increased by over 25% from 66% to 94% since services from the practice have been delivered by CWP from December 2017. Mersey Internal Audit Agency have also untaken an annual assessment of the Trust's IGT scores with supporting evidence and have awarded a 'significant assurance' rating for the sixth consecutive year. This further supports the case that the current information governance arrangements within the Trust are appropriate and fit for purpose. The 2018/19 work plan's focus will be centred on providing assurance against the IGT replacement from 1 April 2018, i.e. the Data Protection and Security Toolkit. It was resolved that the Board of Directors: 1. APRROVED the Information Governance Annual Report for 2017/18 and the statement therein that the Trust's current information governance arrangements are considered 'fit for purpose'. 2. APPROVED the proposed submission of the 2017/18 information governance toolkit by 31 March 2018. 3. NOTED the introduction of the new information governance toolkit arrangements from 1 April 2018.		
17/18/126	**BOARD ASSURANCE FRAMEWORK AND STRATEGIC RISK REGISTER** The Associate Director of Safe Services, David Wood, presented the current status of the Board Assurance Framework. David explained that, as at March 2018, the strategic risk register contains four red and three amber rated strategic risks, with four strategic risks currently in-scope. He referred the Board of Directors to the heat map feature of the Board Assurance Framework, which gives an indication of the level of risk the		

Trust is engaging with in working towards meeting its strategic objectives. The number and level of risk represented by this indicates that the Trust has capacity to handle the risks to achieving its objectives. To enhance this further, David reported that the Medical Director (Quality, Compliance and Assurance) and he had recently met with all Chairs of subsidiary committees of the Board of Directors to discuss how their business cycles could be better aligned to providing assurance of the adequate treatment of strategic risks relevant to their duties.

New risks/ risks in-scope

- *Risk of potential loss of Trust income and delivery of improved quality outcomes arising from failure to reach agreed targets within the CQUIN programme*. The quarter 3 submission for the Trust shows a current risk of £96k associated with failure to deliver CQUIN requirements as such the risk score has been increased from 6 to 9. However, the Trust currently has an opportunity to provide additional evidence to mitigate this risk. As the Trust moves to the new Care Group operational structure and staff are embedded into their new roles, it is intended that single named leads will be identified for each CQUIN to ensure greater responsibility and accountability at an operational level.
- *Risks associated with the transition to the Trust's clinician-led operational (Care Group) structure as part of CWP Forward View strategy*. The Forward View transition task and finish group is established and a local risk register has been modelled that clearly states all possible risks and current control measures. The register is regularly monitored and reviewed by this group.
- *Risk of significantly reduced capacity within the Performance & Redesign team, resulting in a reduced ability to support/ develop current work and new commissions*. The team remains in business continuity mode, which has been communicated via CWP Essential as a reminder to all staff. Regular meetings are being held with the emergency planning lead and updates are being provided to the Executive Team by exception. Operational recruitment processes continue.
- *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*. This has recently been explored by the Head of Safeguarding and the Trustwide Safeguarding Sub Committee and a full risk treatment plan will be developed.

Amended risk scores

Risk of failure to achieve Trust control total due to in-achievement of cost improvement programme. It is envisaged that the Trust will achieve its control total for this year. This risk has been re-scored to its target score and the Quality Committee has therefore recommended the risk for archive, with re-escalation in 2018/19 as necessary.

Exceptions – overdue risk treatment action points

Risk that the CWP workforce may not have sufficient capability (capacity, confidence, competence) to deliver place-based, person-centred care. There is one overdue action, which was scheduled for discussion at the People and Organisational Development Sub Committee meeting on 19 March 2018. The Director of People and Organisational Development, David Harris, confirmed that this had been discussed and the overdue

	action remedied. Finally, David Wood shared with the Board of Directors that the annual review of the Board Assurance Framework by the Trust's internal audit function has returned a positive assurance opinion for 2017/18, such that the framework is structured to meet NHS requirements, is visibly used by the Board, and clearly reflects the risks discussed by the Board. The Board of Directors APPROVED the amendments made to the Board Assurance Framework as recommended by the Quality Committee, including archive of the strategic risk of failure to achieve Trust control total due to in-achievement of cost improvement programme.		
17/18/127	**CORPORATE GOVERNANCE BRIEFING UPDATE** Julie Dawes gave a verbal update on pertinent corporate governance matters, including collective work being undertaken by the People Services and Corporate Affairs teams to review the current positive assurance in relation to compliance with the fit and proper persons regulations, in order to ensure ongoing compliance. The Board of Directors NOTED the verbal update.		
17/18/128	**AUDIT COMMITTEE CHAIR'S REPORT** ▪ **Chair's report of meeting held 6 March 2018** Rebecca Burke-Sharples, NED, on behalf of Edward Jenner, NED, provided an overview of discussions at the March 2018 Audit Committee meeting. Rebecca highlighted that following the Audit Committee's enquiry regarding assurance systems following the outcome of the internal audit on quality spot-checks of inpatient services, the Chief Executive had met with the Non-Executive Directors as part of her routine meeting with them and the NEDs were very satisfied with the significant assurance provided. This assurance will formally be noted at the next meeting of the Audit Committee. The Board of Directors receive and NOTED the Chair's report from the Audit Committee meeting.		
17/18/129	**QUALITY COMMITTEE CHAIRS REPORT** ▪ **Chair's report of meeting held 7 March 2018** The Quality Committee Chair's report was presented by Dr O'Connor, NED, who gave an overview of the discussion at the March Quality Committee meeting. Dr O'Connor highlighted that the Quality Committee had received a presentation on the current operation of the primary care streaming model of care that operates between CWP and the Countess of Chester Hospital NHS Foundation Trust as part of an Urgent Treatment Centre (UTC) format, as mandated by NHS England. As this can include referral to the local GP out of hours service provider and therefore includes North Wales, the Quality Committee has requested a review to ensure clinical risks and commissioning arrangements for people not registered with West Cheshire GPs is being managed appropriately. The Director of		

	Operations, Andy Styring, updated that the senior clinical and operational leadership team are developing a mitigation plan, to be reported to the next meeting of the Quality Committee, with a target date for resolution of July 2018. The Board of Directors received and NOTED the Chair's report from the Quality Committee meeting.		
17/18/130	**ANY OTHER BUSINESS** It was CONFIRMED that there were no further matters of business to report.		
17/18/131	**QUESTIONS FROM THE OBSERVERS OR MEMBERS OF THE PUBLIC** The Chair invited questions from those observing the meeting. Elizabeth Bott (Governor) asked who employs locum doctors. The Director of People and Organisational Development, David Harris, confirmed that medical bank staff are employed by CWP. Nigel Richardson (Governor) asked for an understanding of CQUIN. The Associate Director of Safe Services, David Wood, confirmed that this was the Commissioning for Quality and Innovation framework, which means some of the Trust's income is conditional on achieving quality goals agreed between the Trust and commissioners. Nigel also asked about the NHS Patient Survey, having heard discussion of the NHS Staff Survey at today's meeting. The Associate Director of Communications and Engagement, Katherine Wright, agreed to provide him with a copy of the most recent community mental health survey for CWP.	**KW**	**ASAP**
17/18/132	**REVIEW OF RISK IMPACTS OF ITEMS DISCUSSED** Rebecca Burke-Sharples, NED, requested that, as per discussion in agenda item 17/18/118, staff well-being be considered for its risk impact as part of the report that had been agreed to come to a future meeting of the Board of Directors. Excepting this, it was agreed that all matters had been adequately covered and risks were already contained within the strategic risk register.		
17/18/133	**KEY MESSAGES FOR COMMUNICATION** • NHS Staff Survey results 2017. • Gender pay progression. • Public consultation for the redesign of adult and older people's specialist mental health services in South and East Cheshire and Vale Royal. • Operational Plan 2018/19. •		
17/18/134	**REVIEW OF MEETING PERFORMANCE** The Chair invited the Board to reflect on the performance of the meeting. Members agreed that overall the meeting had been effective, in terms of content, structure, length of the agenda, and allowing sufficient discussion		

	time.		
17/18/135	**DATE, TIME AND PLACE OF NEXT MEETING** Wednesday 30 May 2018, 1.30 pm, Boardroom, Redesmere		
	There being no further business, the Chair thanked everyone for their participation and declared the meeting closed at 4.20 pm.		

Signed as a true and accurate record of the meeting.

……
Mike Maier, Chair

Date: 30 May 2018

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Action points from Board of Directors Meetings
March 2018

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
29/11/17	17/18/78c	**WRES update** Add further WRES update to Board business cycle to continue line of sight on the issues raised.	Jan 2018	LB/ JD	2018/19 business cycle to include WRES update Noted at the January 2018 meeting that this action remained outstanding. Head of Corporate Affairs (JD) to ensure WRES update is scheduled in the Board Business Cycle for 2018/19.	Open
31/01/18	17/18/92	**BOARD BUSINESS CYCLE** TW and JD to determine CCICP's future reporting to the Board.	March 2018	TW /JD		Open
31/01/18	17/18/95	**OPERATIONAL PLAN AND PERFORMANCE DASHBOARD: DECEMBER 2017** Outdated reference to previous NED (FC) under patient experience section to be removed. A more detailed explanation of this report to be provided at the Board Seminary – May 2018 in order to facilitate Board's understanding and oversight.	May 2018	TW TW/JD		Closed Open

31/01/2018	17/18/99	**SAFER STAFFING: 6 MONTHLY REVIEW – ENDING OCTOBER 2017** Potential impact on multi-disciplinary teams and clinical psychologists on patient outcomes to be followed up with Marjorie Gould (Nurse Consultant) by Gary Flockhart.	May 2018	GF		Open
31/01/2018	17/18/99	**SAFER STAFFING: 6 MONTHLY REVIEW – ENDING OCTOBER 2017** A more detailed and regular up-date on both East Inpatient and East CMHT pressures to be provided to Board.	July 2018	GF		Open
28/03/2018	17/18/118	**SAFER STAFFING** The executive team would scope a suite of triangulated assurance alongside the next 6 monthly report, which would include further key performance indicators in respect of staffing.	May 2018	AD / DH		Open
28/03/2018	17/18/120	**GUARDINA OF SAFE WORKING HOURS QUARTERLY REPORTS** Report to be more assurance focused, with the mandated element of the report featuring as an appendix. Dr Alam to discuss with Dr Porter for the next scheduled report.	July 2018	FA		Open

28/03/2018	17/18/131	**QUESTIONS FORM OBSERVERS / MEMBERS OF THE PUBLIC** KW to provide a copy of the most recent MH Survey for CWP to Govenror Nigel Richardson.	ASAP	KW		Open
28/03/2018	17/18/124	**DATA SECURITY AND PROTECTION REQUIRMENTS – GDPR READINESS** Further up-dated action plan to be provided to Board of Directors in July 2018.	July 2018	FA		Open

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

No:	Agenda Item	Executive 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	N/A		✓		✓	✓		✓		✓		✓
2	**Strategic Risk Register and Corporate Assurance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee		✓			✓				✓		✓
Quality of Care														
3	**Learning from Experience Report executive summary**	Director of Nursing, Therapies and Patient Partnership	Quality Committee		✓			✓				✓		
4	**Quality Improvement Report**	Medical Director Compliance Quality and Regulation	Quality Committee		✓			✓				✓		
5	**CQC Community Patient Survey Report 2017/18 and Action Plan**	Director of Nursing, Therapies and Patient Partnership	Operational Board					✓						
6	**Zero Harm strategy**	Medical Director Compliance Quality and Regulation	Quality Committee									✓		
7	**Staff survey 2018/19**	Director of HR and OD	People and OD subcommittee (Operational Board)											✓
8	**Freedom to speak up six monthly report**	Director of Nursing, Therapies and Patient	Operational Board					✓						✓
9	**Receive Quarterly Infection Prevention Control Reports**	Director of Infection Prevention and Control	Infection, Prevention and Control subcommittee		✓			✓		✓		✓		
10	**Director of Infection Prevention and Control Annual Report 2017/18 inc PLACE**	Director of Infection Prevention and Control	Infection, Prevention and Control subcommittee (Quality				✓							
11	**Safeguarding Children Annual Report 2017/18**	Director of Nursing, Therapies and Patient	Safeguarding subcommittee				✓							

12	**Quartely Safeguarding Report**	Director of Nursing, Therapies and Patient Partnership	Safeguarding subcommittee				✓	✓		✓		✓		
13	**Safeguarding Adults Annual Report 2016/17**	Director of Nursing, Therapies and Patient	Safeguarding subcommittee				✓							
14	**Accountable Officer Annual Report inc. Medicines Management 2017/18**	Medical Director Compliance Quality and Regulation	Medicines Management Group (Quality Committee)				✓							
15	**Monthly Ward Staffing update**	Director of Nursing, Therapies and Patient Partnership	Quality Committee		✓		✓	✓		✓		✓		✓
16	**Receive Research Annual Report 2017/18**	Medical Director Effectiveness Medical Education and Medical Workforce	Operational Board					✓						
17	**Receive Medical Appraisal Annual Report 2017/18 and annual declaration of medical revalidation**	Medical Director of Effectiveness and Medical Workforce	People and OD subcommittee (Operational Board)				✓							
18	**Care Quality Commission Registration Report**	Director of Finance	Operational Board									✓		
Finance and Use of Resouces														
19	**Receive Annual Report, Accounts and Quality Account**	Director of Finance	Audit Committee (Quality Committee for QA)		✓									
Operational Performance														
20	**Provider Licence Compliance**	Director of Finance	Audit Committee		✓					✓				
21	**Information Governance 2018/19Toolkit**	Medical Director	Records and Clinical Systems Group (Quality Committee)											✓
22	**Health and Safety Annual Report and Fire 2017/18and link certification**	Director of Nursing, Therapies and Patient Partnership	Health, Safety and Well-being subcommittee (Operational Board)				✓							
23	**Security Annual Report 2017/18**	Director of Operations	Health, Safety and Well-being subcommittee					✓						

24	**Central Cheshire Integrated Care Partnership (CCICP) reporting**	Director of Operations	Operational Board		✓		✓	✓		✓		✓		✓
25	**Equality Act Compliance**	Director of Nursing, Therapies and Patient Partnership	Operational Board					✓						
26	**Board Performance Dashboard**	Director of Finance	Operational Board		✓		✓	✓		✓		✓		✓
Governance														
27	**Receive Register of Sealings Report**	Director of Finance	Audit Committee					✓						
28	**CEO /Chair Division of Responsibilities**	Chair	N/A		✓									
29	**Integrated Governance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee					✓						
30	**Receive minutes and Chair's Report of the Quality Committee**	Non Executive Director	N/A		✓		✓	✓		✓		✓		✓
31	**Receive minutes and Chair's Report of the Audit Committee**	Non Executive Director	N/A		✓		✓	✓		✓		✓		✓
32	**Audit Committee annual effectivenes review**	Non Executive Director			✓									
33	**BOD Business Cycle 2018/19**	Chair	N/A		✓		✓	✓		✓		✓		✓
34	**Approve BOD Business Cycle 2019/20**	Chair	N/A											✓
35	**Review Risk impacts of items**	Chair/All	N/A		✓		✓	✓		✓		✓		✓

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Report subject:	Learning from Experience report – trimester 3 2017/18 (incorporating an update on the national Learning from Deaths framework)
Agenda ref. no:	18.19.09
Report to (meeting):	Board of Directors meeting in public
Action required:	Discussion and approval
Date of meeting:	30/05/2018
Presented by:	Avril Devaney, Director of Nursing, Therapies & Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	No
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
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
N/A	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

1. Situation

This Learning from Experience report aggregates qualitative and quantitative analysis from key sources of feedback from people who access and deliver the Trust's services, and other relevant sources of learning, covering the period from December 2017 to March 2018, trimester 3 of 2017/18. The report compares current performance across a four trimester time series to mitigate seasonal variations, whilst also facilitating the identification of potential triggers to detect and prevent incidents by comparing current performance with the previous trimester.

The in-depth Learning from Experience report received by the Quality Committee uses Statistical process Control (SPC) charts to help with more effective and visual depiction of learning from experience and identification of recommendations, as well as to alert, as part of an early warning framework, any emerging trends. The use of SPC will be reflected more in future reports to the Board of Directors.

2. Background – Key performance indicators

2.1 Performance indicators

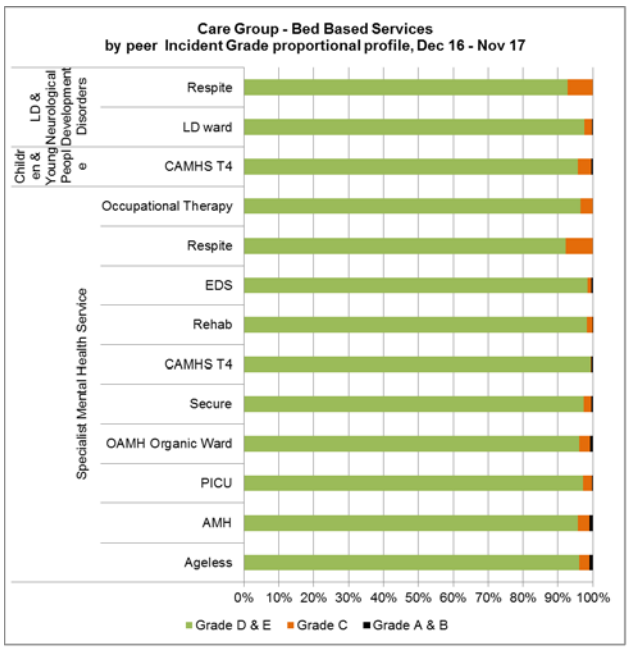
Performance indicator			2016/17	2017/18			RAG rating
			T3	T1	T2	T3	
Number of safety incidents reported			**3178**	**3186**	**3347**	**3004**	
Number of safety incidents by speciality	*Inpatient*		*2002*	*2154*	*2318*	*1954*	
	Community physical health		*742*	*602*	*575*	*557*	
	Community mental health		*364*	*370*	*365*	*384*	
	Other		*70*	*60*	*89*	*83*	
Reports to external agencies	**StEIS**		45	33	**59**	**53**	
	National Reporting & Learning System		1686	1576	**1985**	**1755**	
	NHS Resolution	Non clinical	2	0	**4**	**4**	
		Clinical	1	1	**2**	**1**	
	NHS Protect						
	Staff assaults		258	288	**310**	**297**	
	Missing patient		36	44	**70**	**106**	
	Suspected theft		5	3	**9**	**4**	
	Damage to property		19	18	**15**	**30**	
	Lost or missing items		92	65	**39**	**33**	
Number of complaints			100	84	**97**	**125**	
Number of compliments			1040	822	**1203**	**957**	

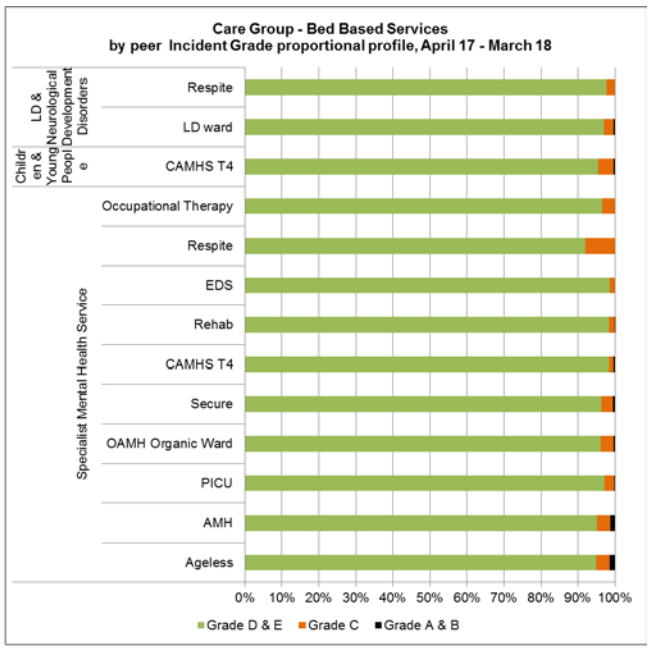
All incident and compliment numbers above and as detailed in the main body of this report represent a snapshot at the time of publication of the report and are subject to change over time, for example: re-categorisation of incidents following receipt of further information since the previous report,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

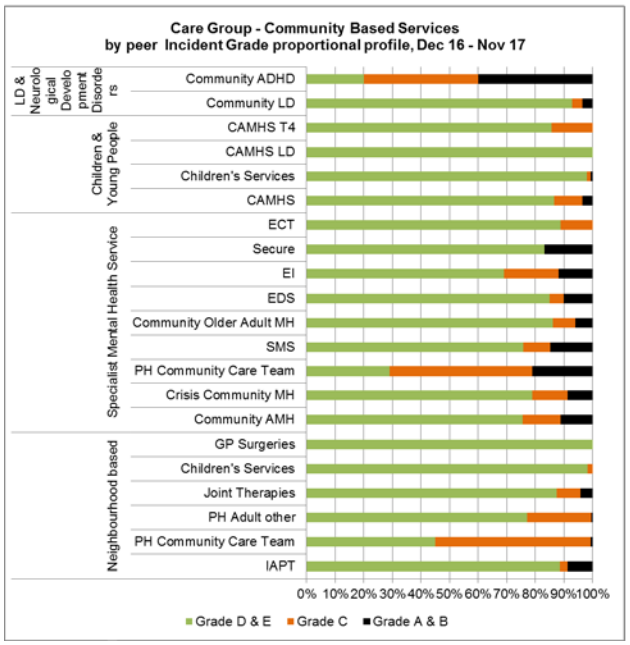
2.2 Proportional reporting performance indicators – Incident reporting

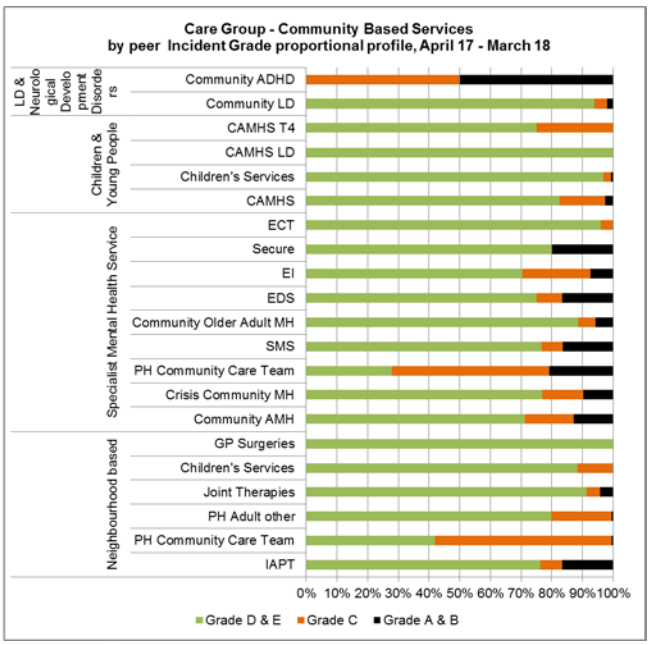
The charts below show a proportional split of incident grade per service type and service peer group[1]. By presenting the incident reporting profiles in this way, the charts reveal fundamental differences between the service types that can be used to identify where focus is needed to reinforce the Zero Harm message that reporting no or lower harm incidents promotes learning to be able to potential mitigate future actual or significant harm incidents. The charts can further inform potential opportunities for both Service Improvement and Quality Improvement activity.

[1] Service Peer Groups are a tier mechanism to group together teams that provide similar services. The development has been shared with the Learning from Experience Group meetings that they support and have been published in each of the most recent ward and community LDPs and they are aligned to the organisational redesign to Care Group structures.









3. Analysis

3.1.1 Incident reporting

Analysis of the last four trimesters of incident reports shows a decrease in the number of incidents reported, however this does not represent a significant decrease and trimester 3 has previously been the lowest reporting period of the year. All service areas have contributed to the decrease, excepting community physical health services. Reporting incidents shows that patient safety is a high priority and that we have the capability to learn from experience.

Six fewer serious incidents were reported to StEIS this trimester. The top five ranked incident categories are self-harm (1); violence (2); estates and facilities (3); pressure ulcers (4); falls (5). Each rank has remained the same position as trimester 2 2017/18.

Organisation Patient Safety Incident Reports for the providers of the NHS in England were published by *NHS Improvement* in March 2018. CWP have reported 2365 patient safety incidents to the *National Reporting & Learning System* that occurred between April 2017 and September 2017. The report showed that CWP continues to rank 24th for reporting of incidents when benchmarked against 54 other mental health trusts across the NHS in England. CWP are in the

upper middle range of reporters, demonstrating a good reporting culture in providing safe services and improving care and quality. The report indicated that CWP reports 20% more self-harm related incidents compared to other mental health trusts; encouraging reporting of lower harm incidents and thereby reducing severe or moderate harm incidents is a priority area for Quality Improvement that has been identified in the Quality Account for this year. Since the period of the NRLS report however, the number of self-harm incidents this trimester has reduced by 30%, further the Board dashboard for the month of April 2018 demonstrates a reduction in severe and moderate self-harm incidnts. This represents a good starting point for the said planned quality improvement work in this area.

The incidents team have taken suggestions from staff who report and approve incidents to improve the efficiency and effectiveness of incident reporting. Datix have made the suggested changes and these will be tested in April 2018.

3.1.2 Mortality monitoring

As per the expectations of national guidance regarding improving learning from deaths and mortality reporting, CWP is continuing to increase the learning from those deaths reported to the Trust that do not meet the criteria as a serious incident. To identify all deaths, CWP has devised a mortality comparison report from the national list of deceased persons held by NHS Digital. The report compares the list to the information held on the CWP clinical care record to identify people who have died while accessing our care including people discharged from our care within six months of their death. The report is updated in retrospect of a person's death, thus increasing the scope and number of deaths to review further.

The Mortality task and finish group undertook the final test series of PDSA (Plan, Do, Study, Act) tests in March 2018, further recommendations were made in relation to refining the case record review template in preparation to be made available onto electronic care notes and EMIS from April 2018. Further work is being undertaken to make the template available on PCMIS.

During this trimester, n.15 case record reviews have been discussed at the weekly meeting of harm, none of which has led to further investigation. A clinical audit tool was developed and tested by sub members of the task and finish group. A total n.17 case record reviews, reported as no problems in care, were clinically audited, of which one required further investigation. Learning outcomes from case record reviews identified:

- Need to review adequacy of systems to reliably contact the District Nursing Service out of hours.
- Improvements required to communication with families in relation to medication regimens in place for people receiving palliative care.

There is a 5% quality control process in place for reviewing case record reviews judged as their having been no problems in care, this will be monitored by the Mortality task and finish group who are next due to meet later in quarter 1 of 2017/18.

The data relating to learning from deaths is available on the Board dashboard as a quality objective, it is published every two months with the agenda for the meeting of the Board in public. The Secretary of State for Health & Social Care has confirmed the Trust's compliance with this requirement. By the end of May 2018, an accessible learning from deaths web page will be available to publish the nationally required mortality monitoring data and provide information to describe the support that bereaved families can access. It is important to note that mortality reporting is not about benchmarking different trusts; rather it is about encouraging a dialogue about safety being the most important part of quality and not just about avoiding harm but appropriate delivery of high quality care. The Board will initially be required to come to a collective decision about how it defines and reports 'preventable deaths', then for the future, 'avoidable harm'. The current requirement is to report on those deaths reported by and to the Trust that do not meet StEIS criteria but may have been contributed to by problems in care (as identified by a case record review).

Mortality monitoring	2017/18	
	T2	T3
Inpatient deaths (including deaths 30 days after discharge)/ subject to a case record review	**3/ 100%**	**0/ 100%**
Deaths reported by and to the Trust (including inpatient deaths)/ subject to a case review record	**420/ 18%***	**558/ 18%**
Deaths reported as a serious incident/ subject to a serious incident investigation	**25/ 100%****	**25/ 100%****

*The % reflects the case record reviews undertaken by teams subject to a pilot of the new mortality review process. From Q1 2018/19, the aim is to implement the new mortality review process Trustwide, when the target will be 100%.

**For deaths meeting NHS England criteria as a serious incident, investigatory performance is 100%.

3.2 Reduction in incidents associated with access to potentially harmful ignition sources
Estates and facilities incidents noted a further reduction in the number of people found with access to an ignition source (from 361 to 210). Statistical analysis identified that the number of incidents reported this trimester is within the expected control limits but represents a notable decrease. The Nicotine Replacement Therapy Lead continues to promote the reporting of incidents and provision of support to people accessing and delivering the Trust's services to further help deliver safe services.

3.3 Falls incidents
There has been a Trustwide increase in the reported number of falls this trimester from 223 to 303, of which 96% of incidents resulted in either low or no harm, which is the same proportion as reported in trimester 2 2016/17. Quality Improvement work is continuing (in both inpatient and community settings) in line with the Trust's Zero Harm approach.

3.4 Incidents associated with managing behaviour that challenges
Following the restraint reduction 90-day quality improvement project in 2017, three priority areas for further work have been identified. These are: to improve reporting and data quality of restraint episodes; capturing the experience of people who have been restrained; and developing more effective clinical education and training. A Quality Improvement project is in progress, with multi-disciplinary involvement, and is being led by the Clinical Champion for Quality Improvement and the Associate Director of Safe Services.

3.5 Feedback from people who access the Trust's services
During this trimester, the Trust received 125 complaints under the NHS complaints procedure. Of these, they were received per locality as follows: CWP Central & East *n. 64* complaints, CWP West *n. 33* complaints, CWP Wirral *n. 28* complaints and Corporate Support Services *n. 0*. The communication and information category associated as a theme has become the highest ranked theme the past two trimesters, although this trimester there has been an improvement in communication with carers and families. This trimester, there has been a decrease in the number of compliments recorded, from 1203 to 957. The complaints team have been working with services to gather feedback in order to make improvements to the way we capture compliments.

4. Recommendation

Recommendations from trimester 3 analysis
The recommendations below have been identified from the detailed analysis of learning from experience that is received by the Quality Committee. Updates and assurances received against these recommendations will be presented in the next report to the Board of Directors.

4.1 The Safe Services Department should develop, by May 2018, an accessible learning from deaths web page to (a) publish the nationally required mortality monitoring data, and (b) provide information to describe the support that bereaved families can access.

4.2 Head of Clinical Governance to allocate investigation managers to the 16 outstanding investigations to ensure that CWP contributes to the national LeDeR programme.
4.3 Further analysis to be undertaken by the Safe Services Department and the Care Groups to streamline complaints categories to ensure they capture the best description of the actual theme to enable the identification of better learning from experience.
4.4 The Complaints Team should review the complaints received by the Trust over the 2017/18 year to assess whether the themes that highlighted in the *PHSO* report are similar to those in the report and where they are, the national learning should be shared. A report should be presented to each of the local governance/ learning from experience meetings in July 2018 to help to identify quality improvement plans.

In addition, to strengthen 'ward to Board' assurance, the Quality Committee has agreed to a new approach of seeking assurance of learning from experience, thus:

Clinical support service teams have been asked to:
- Review the findings and key analysis within the report and identify any changes for improvement required to their enabling work programmes.

Clinical services have been asked to:
- Review the findings and key analysis within the report at local Learning from Experience groups and identify:
    - Any areas of practice that warrant quality improvement work.
    - Any areas of practice that require enabling support from clinical support services.

An update in respect of the above will be sought for the next report to the Quality Committee.

Recommendation to the Board of Directors
The Board of Directors is asked to **approve** the report and **endorse** the recommendations contained within.

Who/ which group has approved this report for receipt at the above meeting?	David Wood Associate Director of Safe Services
Contributing authors:	Audrey Jones, Head of Clinical Governance Lisa Parker, Incidents Manager David Wood, Associate Director of Safe Services

Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Board of Directors	23/05/2018

Appendices provided for reference and to give supporting/ contextual information:	
Appendix number	Appendix title
1	Updates and assurances received against trimester 2 2017/18 recommendations

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

Consider self-harm as the Trust's identified "patient safety" quality improvement priority for 2018/19 as described in the Trust's Quality Account 2017/18.
The Trust's "patient safety" quality improvement priority 2018/19 has been agreed as a reduction in the severity of the harm sustained by those people accessing CWP services that cause harm to themselves.
The Mortality task and finish group to refine the GR47 - Learning from Deaths Policy to respond to the findings of PDSA (Plan, Do, Study, Act) cycles prior to full implementation of the policy, particularly in relation to case record reviews, across the Trust.
Policy reviewed in trimester 1 2017/18 (approval at 09/05/2018 meeting of the Quality Committee).
CWP Consultant Nurse lead for LeDeR to be asked to present at the next Quality Committee meeting to update on how CWP is supporting this programme and to update on the governance framework from an NHS England perspective and the role of adult safeguarding boards.
The Consultant Nurse, Learning Disability Services, presented on the learning disability services mortality audit and presented feedback from a learning event at the May 2018 Quality Committee.
The Medication Safety Officer (MSO) should work closely with the Safe Services Department to review those medicines incidents classified as 'other'. Analysis of any trends will be undertaken by the MSO as more data becomes available and as learning is discussed at the Medicines Management Group to identify improvements
The MSO has worked closely with the Safe Services Department to review those medicines incidents classified as 'other' and this category will be removed for the reporting period 2018/19. Analysis of trends will be more meaningful in 2018/19 as there will be comparative data available from 2017/18.
The business cycle of the Health and Well-being Group should include routine review of staff accident incidents resulting in harm to identify safer systems and mitigate harm.
The Health and Well-being Group reviews staff accident incidents resulting in harm to identify safer systems to mitigate harm.
Further analysis to be undertaken by the Safe Services Department to understand system weaknesses where control measures were in place but still resulted in an incident.
This work will be revisited once the developing guidance, nationally, on defining avoidability is published to ensure alignment, starting with judgements around those as per the current mortality work.
The business cycle of each sub committee should include at least one publication a year to assist with practice development through sharing a subject/ case scenario. These will be edited by the Director of Nursing and Medical Director (Quality).
This will be ensured as part of the corporate meetings review and the review of sub committee business cycles scheduled to be undertaken by the Medical Director (Quality) and the Associate Director of Safe Services.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Quality Improvement Report: Edition 3, 2017/18
Agenda ref. no:	18.19.10
Report to (meeting):	Board of Directors – meeting in public
Action required:	Information and noting
Date of meeting:	30/05/2018
Presented by:	Dr Anushta Sivananthan, Medical Director – Executive Lead for Quality

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

The purpose of this paper is to update the Board on Edition 3 (December 2017 – March 2018) of the Quality Improvement report. This is produced three times a year with the aim of updating people who access and deliver the Trust's services, and other stakeholders, on progress in improving quality across CWP's services. The report describes projects that are improving the quality of care.

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

The aim of the Quality Improvement report is to provide a detailed focus on individual projects, describing the aims, methodology, results and next steps in the spirit of continuous improvement. This edition of the Quality Improvement report was approved by the Quality Committee on 09/05/2018.

Assessment – *analysis and considerations of options and risks*

Alongside the Best Practice portal and the annual Big Book of Best Practice, the Quality Improvement report is a vehicle for staff to share examples of quality improvement projects, share learning and celebrate successes. The report describes projects in an accessible way with an aim of encouraging more staff to get involved in quality improvement in their areas. It will be shared via CWP Essential and via email to ward and team managers, and management teams, copies are also provided to the Trust's Governors.

The Healthcare Quality Improvement team will continue to work with clinical teams to ensure that examples of best practice are publicised and that a culture of sharing best practice and learning becomes embedded.

Highlights in this edition are:

- The team on Croft ward have piloted a project to improve patient safety around the administration of medication, further allowing nurses to increase their therapeutic time with patients.
- Education CWP are implementing a rolling annual education programme, "Care Planning in Action", to ensure the person-centred initiative of formulating immediate safety plans is embedded into practice.
- The Quality Surveillance team and West's Business Administration team have collaborated to streamline the monitoring and reporting process around the national 18 week target for any clinical intervention.
- The Quality Surveillance team and the Bed Management team have developed a process to monitor and improve ward-to-ward transfers within the Trust.
- Cheshire East Council and CWP are working in partnership to provide advice on housing options and assistance to people with enduring mental health conditions.
- A pilot of a person-centred discussion group is being implemented in West's Community Mental Health services to support staff.
- The Recovery College has collaborated with local libraries to support students around the process of loaning books.

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

The Board is asked to **endorse** the Quality Improvement report.

Who/ which group has approved this report for receipt at the above meeting?	David Wood, Associate Director of Safe Services
Contributing authors:	Hayley Cavanagh, Head of Quality Assurance & Improvement

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	23/05/2018

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

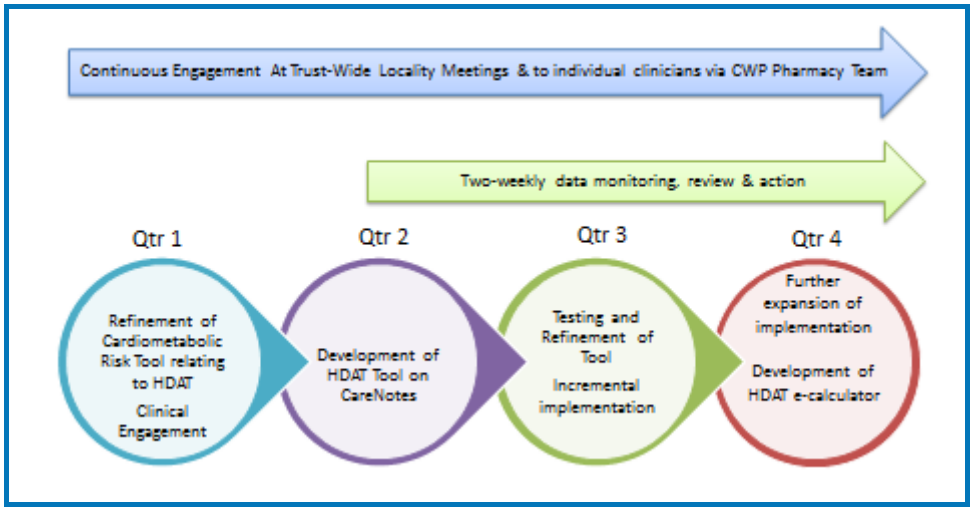
Appendix no.	Appendix title
1	Quality Improvement Report, Edition 3: December 2017 – March 2018

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Quality Improvement Report

Edition 3
December 2017 – March 2018

Vision:
Working in partnership
to improve health and well-being by providing high quality care



Pharmacy team achieve success through a year long quality improvement programme (see page 4)

Care • Well-being • Partnership

Welcome to CWP's third *Quality Improvement* Report of 2017/18

These reports are produced three times a year, this being the final edition of 2017/18, to update people who access and deliver the Trust's services, carers, the public, commissioners, internal groups, and external scrutiny groups on progress in improving quality across our services. We are required to formally report on our quality improvement priorities in the annual *Quality Account*.

At CWP, we are starting to look at quality in more detail to better demonstrate where we are making real improvements, with the aspiration to achieve equity of care through Quality Improvement (QI). We are using international ways of defining quality to help us with this aim.

CWP's *Quality Account* and *Quality Improvement Report*s are available via:

http://www.cwp.nhs.uk/resources/reports/?ResourceCategory=2335&Search=&HasSearched=True

Reporting on the quality of our services in this way enhances involvement of people by strengthening our approach to listening and involving the public, partner agencies and, most importantly, acting on the feedback we receive.

QUALITY					
Patient safety	Clinical effectiveness			Patient experience	
Safe	Effective	Affordable	Sustainable	Acceptable	Accessible
Achieving Equity and Person-centred Care through CO-PRODUCTION, CO-DELIVERY, QUALITY IMPROVEMENT & WELL-LED SERVICES					
Delivering care in a way which increases safety by using effective approaches that mitigate unwarranted risks	Delivering care that follows an evidence base and results in improved health outcomes, based on people's needs	Delivering care in a way which maximises use of resources and minimises waste	Delivering care that can be supported within the limits of financial, social and environmental resources	Delivering care which takes into account the preferences and aspirations of people	Delivering care that is timely, geographically reasonable, and provided in a place where skills and resources are appropriate to meet people's needs

This report is just one of many reviewed by the Trust's Board of Directors that, together, give a detailed view of CWP's overall performance.

This *Quality Improvement Report* provides a highlight of what CWP is doing to continuously improve the quality of care and treatment that its services provide. It also provides examples of Quality Improvement (QI) projects. This edition includes some of our QI projects which demonstrate the dimensions of quality which we have added to our Quality framework, such as *affordable, sustainable, acceptable* and *accessible* care.

Implementation of our new Quality Improvement strategy commences in April 2018. Phase 1 of the strategy stretches across 3 years and describes how our people and teams who deliver and support the delivery of our services will work together to create a culture where QI can flourish. The projects described in this edition show how our teams are using the *Model for Improvement*, to make changes and test whether the desired improvement is seen. We are using PDSA (Plan-Do-Study-Act) cycles, wherever possible, which will help us identify what does and does not work before we commit to take steps to make changes and redesign services.

EXECUTIVE SUMMARY
QUALITY IMPROVEMENT HEADLINES THIS EDITION

The team on Croft ward have piloted a project to improve patient safety around the administration of medication, further allowing nurses to increase their therapeutic time with patients
➲ see page 7

Education CWP are implementing a rolling annual education programme, “Care Planning in Action”, to ensure the person-centred initiative of formulating immediate safety plans is embedded into practice
➲ see page 8

The Quality Surveillance team and West’s Business Administration team have collaborated to streamline the monitoring and reporting process around the national 18 week target for any clinical intervention
➲ see page 9

The Quality Surveillance team and the Bed Management team have developed a process to monitor and improve ward-to-ward transfers within the Trust
➲ see page 10

Cheshire East Council and CWP are working in partnership to provide advice on housing options and assistance to people with enduring mental health conditions
➲ see page 11

A pilot of a person-centred discussion group is being implemented in West’s Community Mental Health services to support staff
➲ see page 12

The Recovery College has collaborated with local libraries to support students around the process of loaning books
➲ see page 12

QUALITY IMPROVEMENT PRIORITIES

We have set three **Trustwide QI priorities** for 2017/18, which reflect our current vision of "**working in partnership to improve health and well-being by providing high quality care**". They are linked to the Trust's strategic objectives, and reflect an emphasis on **patient safety**, **clinical effectiveness** and **patient experience**.

We have made a commitment in our *Quality Account* to monitor and report on these goal driven measures in our *Quality Improvement Report*s. This year, the common focus across all the priorities has been **reducing unnecessary avoidable harm** to help reduce avoidable variations in the quality of care and to improve outcomes. The end of year position on these three quality improvement measures are below.

Goal driven measure for **patient safety**

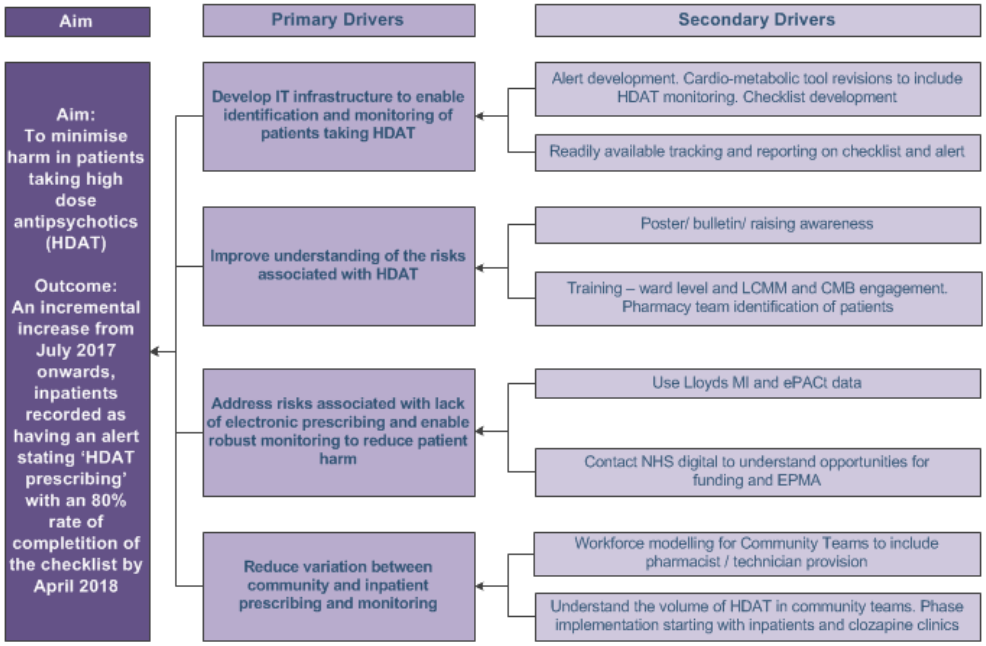
Increase in the identification of patients taking monotherapy or combination antipsychotic treatment, in which daily doses exceed the recommended maximum limits (according to the British National Formulary) to improve monitoring of the associated risks

At the start of 2017/18, we set a goal to minimise harm in patients taking high dose antipsychotic treatment (HDAT). There are greater risks, including serious physical side effects, when antipsychotic drugs are taken in high dose or in combination.

We wanted to:
Increase the identification of patients taking monotherapy or combination antipsychotic treatment, in which daily doses exceed the recommended maximum limits (according to the British National Formulary) to improve monitoring of the associated risks.

This is because there are greater risks, including serious physical side-effects, associated with antipsychotics taken in high doses or in combination.

We developed this driver diagram to help us describe our aim:



At the start of 2017/18 we set ourselves a target to achieve an incremental increase (from quarter 2 onwards) in the number of people who had a documented HDAT alert and completed checklist. We also set ourselves a target of achieving an 80% rate of completion of HDAT checklist by quarter 4.

The results we achieved:

38 HDAT alerts added to people's records, compared to a baseline of zero over October 2017 to March 2018

82% completion of the HDAT checklist by the end of March 2018, compared to a target of 80%

How we achieved these improvements:

- ✓ We developed training to improve the skills of clinicians in identifying risks associated with taking high doses of antipsychotic medications.
- ✓ A checklist and an alert on our computer systems was introduced to help clinicians to monitor these risks.
- ✓ We participated in the *Royal College of Psychiatrists*' audit of this issue. Our results showed that we have halved the number of people we prescribe high dose antipsychotics to since 2012, and significantly reduced the proportion of people in forensic and rehabilitation/ complex needs services prescribed high dose antipsychotics. We also equalled the national average for people receiving physical health checks (in line with good practice), whilst in our care.

For more information, please contact Jasmeen Islam, Deputy Chief Pharmacist on 01244 397380

Goal driven measure for **clinical effectiveness**

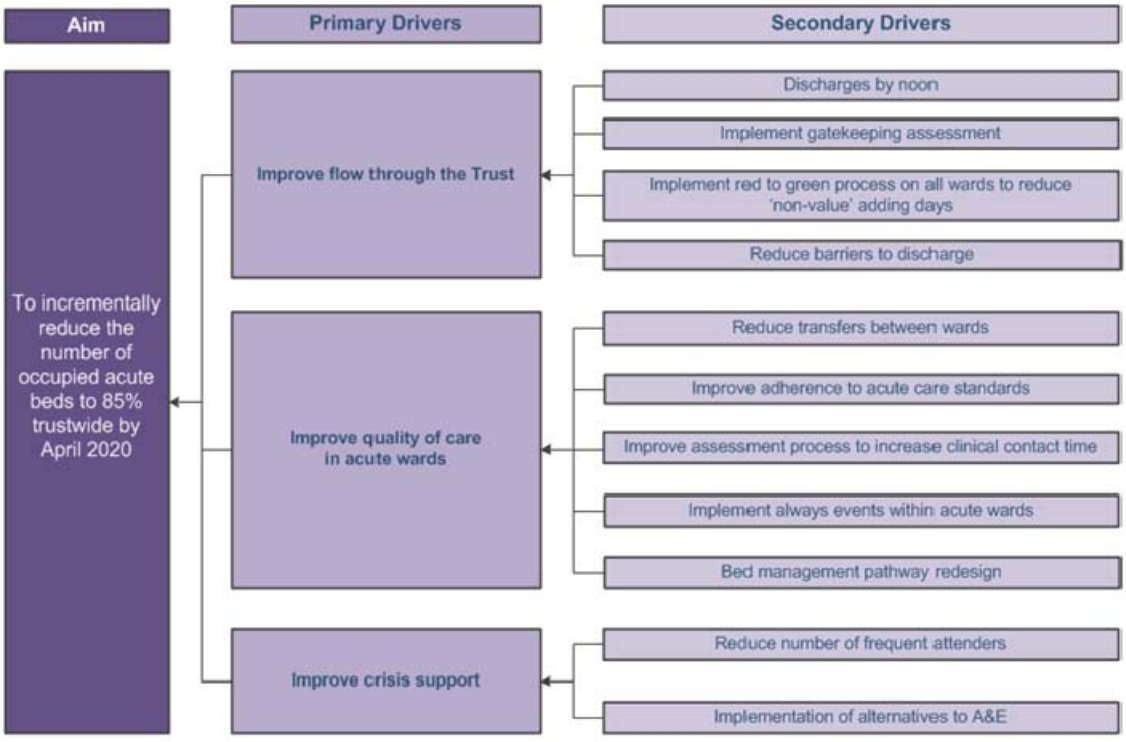
Improvement in the Trustwide average bed occupancy rate for adults and older people

Very high bed occupancy rates can affect the quality and safety of the care people receive.

We wanted to:

Reduce the average Trustwide bed occupancy rate to 85% by the end of December 2017 on our adults and older people's inpatients wards. This target is taken from the *Royal College of Psychiatrists'* research into the optimal level of bed occupancy. Bed occupancy rates are a main driver of inpatient care standards, and a rate of no more than 85% is seen as the ideal level to ensure people receive high quality care.

We developed this driver diagram to help us describe our aim:



The results we achieved:

We identified a centralised 'bed hub', a system that ensures that everyone needing an inpatient bed is in the best bed for their needs that day. Although we have yet to meet our 85% target, a number of improvement projects are continuing to work towards this challenging goal. For quarter 3 to the end of December, we achieved an 89.6% bed occupancy rate.

How we achieved these improvements:

- ✓ Our 'Red and Green days' quality improvement project – which identifies and reduces internal and external delays in patient care in order to improve flow. We can see from the data and staff feedback that the project has had a positive impact, both in terms of progressing the patient journey to them receiving active care and interventions, and also in reducing length of stay. We plan to further roll-out this project to other wards.

- ✓ Improving use of the 'Gatekeeping Assessment form' – this project aims to ensure that whenever a person is admitted, there is a clear plan of care for them to ensure their needs are met and they are cared for in the right way and in the right place. This has resulted in some people experiencing a shorter length of stay on the ward.

- ✓ Detailed investigation and analysis of our bed occupancy data to look at the quality of people's experience whilst on our wards. Quality measures include: number of transfers between wards and reasons for these; comparisons between admission and discharge data for different wards; comparisons in bed occupancy rates within wards in our different geographical locations.

- ✓ Acute Care 'Away Days' – held in July 2017 and February 2018 to provide an opportunity for staff working in our acute wards to share ideas, best practice and learning, to minimise variation in how care is delivered across inpatient units.

For further information, please contact Sarah Quinn, Head of Operations, on 0151 488 7444

Goal driven measure for patient experience

Improvement in embedding a person-centred culture across the organisation

In March 2017, the Trust implemented a person-centred framework. CWP defines person-centredness as "connecting with people as unique individuals with their own strengths, abilities, needs and goals".

We wanted to:

Demonstrate how the person-centred framework is helping to improve the organisation's person-centred culture.

At the start of 2017/18, we set ourselves a goal to demonstrate that 90%, or more, of our staff are able to respond positively in the NHS Staff Survey that they are able to deliver a person-centred approach in their practice/ delivery of care.

The result we achieved:

Result = 93.5%

How we achieved this result:

- ✓ Support available on a dedicated page on the Trust's intranet.

- ✓ Face-to-face training sessions facilitated by the Consultant Nurse for learning disabilities and the Participation & Engagement Lead. Over 200 staff have attended so far, feedback has been positive.

- ✓ The work of the Person-centred Framework Group, which oversees 5 subgroups: care planning; patient stories; 'be the best you can be'; shared decision-making; and person-centred thinking training.

Patient Safety Improvements

Delivering *Safe* care

The following projects illustrate how CWP teams are delivering care which increases safety by using effective approaches that mitigate unwarranted risks.

Improving patient safety in the administration of medication on Croft ward

Background:

In recent years, the acuity and complexity of people admitted to hospital has increased and the proportion of people with complex medication needs has also risen. Combined with growing prescribing and increased products in the market, clinical pharmacy services have evolved to adapt to the demands of accelerated patient flow, whilst continuing to provide safe and efficient medicines management services. Improving skill mix, through developing the roles of medicines management technicians and independent pharmacist prescribers, has helped with this aim. The Lord Carter Report on Operational Productivity and Performance in English Hospitals highlights the increasing spend on medicines in hospitals and recommends that *"more clinical pharmacy staff are deployed – working more closely with patients, doctors and nursing staff and independently – to deliver optimal use of medicines, make informed medicines choices, secure better value, and drive better patient outcomes".*

What did we want to achieve?

We wanted to improve medicines management on the ward and maximise nursing time to allow greater therapeutic contact with people. This was done through the introduction of lean strategies through reviewing tasks and skill mixes and integrating a pharmacy technician role, qualified to administer medication, within the ward team.

What we did:

A pilot was identified to train a pharmacy technician to safely administer medicines on Croft ward. It is a multi-disciplinary team pilot quality improvement project, with the technician initially observing and then moving onto being assessed by a nurse mentor to administer medicines against set competencies. The full service will be commencing, following a successful pilot, in August 2018.

Next steps:

On completion of the pilot, the service will be audited, and the following will be reviewed:

- Safe and timely administration of medication
- Reduction in missed doses including critical medication
- Patient/ carer education including appropriate use of their medication
- Prudent use of staff, utilising the technician's knowledge of medicines
- Nurse capacity to prioritise caring for people with the greatest needs and to focus on other roles
- Reduction in pressure ulcers and falls

For more information, contact Kate Chapman, Matron, on 01625 663021

Care and Safety Planning in Action

Background:

Through co-production with carers who had lived experience of suicide within their family, Education CWP undertook to support staff to improve the quality of care planning, the overarching aim of which was to ensure that clinicians *"co-create an immediate safety plan helping the person to stay safe and establish a network of support, and include the names of family and friends as well as support from other professionals".*

To support this aim, the Clinical Education team conducted a short audit around care planning with Community Mental Health Teams and Home Treatment Teams, which demonstrated that barriers existed in relation to the functionality of CAREnotes, the electronic clinical notes system, that were preventing staff from fully using the evidence based safety plan.

What did we want to achieve?

- Development of a quality improvement approach to care planning
- Improvement in the quality of contingency and safety plans for people being cared for by the community mental health teams in Ellesmere Port and Neston
- Staff to be confident in writing person-centred care plans
- Development of a standardised process for care planning
- Ensure patient and family-centred care

What we did:

Education CWP have developed a training package that supports staff with competencies related to risk assessment, formulation and management, and in determining what good looks like in terms of an effective safety plan. The training has a strong patient experience focus, and draws on Myers Briggs techniques, to help staff understand how their preferences and personality types might influence the way they work with people, and how people engage with the care planning process.

Results:

The pilot has been well received Education CWP now plan to implement a rolling annual education programme, 'Care planning in action', with all clinical teams to ensure that the concept of the immediate safety plan is realised, which will complement and reinforce the contingency section of every care plan. The training programme will continue to be evaluated and feedback from participants will be used to continuously improve this patient safety critical training course.

For more information, please contact Ruth Gaballa 01244 650303

Delivering a*ffordable* care

The following projects illustrate how CWP teams are delivering care which maximises use of resources and minimises waste.

Ensuring access to timely care

Background:

If people are waiting a long time for treatment, this has a detrimental effect on their overall experience of care and also can have a negative effect on the outcome achieved for the person. We have therefore set a limit on the time we think is reasonable to wait for any required treatment. In line with national quality measures, this has been set at 18 weeks for all interventions.

What did we want to achieve?

All of our clinical teams have systems for ensuring nobody waits beyond this 18 week limit for care, and administrators within teams are tasked with searching clinical systems to spot people who are in danger of breaching this limit and to investigate the reason why when a breach does occur. One of our older age mental health teams in West Cheshire identified an opportunity to improve this process when they realised that this was taking up a large amount of administration time, they enlisted the help of our quality surveillance analysis team to help streamline the process.

What we did:

One of our Quality Surveillance Analysts met with our Administration Business Information Officer for Adults and Older People Mental Health Services for West and quickly helped her to identify some efficiencies:

- The original process used a report extracted from CAREnotes up to 2 weeks beforehand, which was identified as being inefficient.
- Working together, a contemporaneous approach was established using Report Manager to access data in real time.
- In this way, it removed unnecessary checks on people who had subsequently been seen and allowed sight of people approaching the 18 week deadline, thus allowing an alert and avoid approach to be taken.
- A recommendation was made that the team establish a record of genuine breaches that have been previously checked in order to be able to identify and avoid re-checking the same people each time.
- Furthermore, it was also recommended the team establish a record where an input error was discovered that when corrected meant the person did not breach. The intention behind this is to identify specific refresher training or hints and tips to share in team meetings that will in turn reduce the number of records needing to be scrutinised.

There was recognition that these efficiencies would also improve the external reporting to *NHS England* by reducing the number of breaches, both genuine and those created by input error.

Results:

The immediate result was working with contemporaneous data, rather than 2 week old data, which also provided a view of people approaching the 18 week deadline and allowing targeted action. This delivered both time efficiency and better impact from the process. Sharing learning from input errors is iterative and results will be seen over time in terms of less time spent correcting entries and improved front end input to CAREnotes.

Next steps:

The intention is to trial this approach with the Adults and Older People Mental Health Business Administration team and measure both the administration time saved and the data quality improvements realised. This will then be shared as best practice to other administration teams with responsibility for monitoring 18 week waits.

For more information, please contact Beverley Tudor, Quality Surveillance Analyst, on 01244 393327

Delivering *Sustainable* care

Quality services and systems include sustainability as a fundamental principle. The following projects illustrate how CWP teams are delivering care that can be supported within the limits of financial, social and environmental resources.

Transfers ward-to-ward and "sleeping out"

What did we want to achieve?

The centralised bed hub, set up to deliver the QI priority of improving the Trustwide average bed occupancy rate for adult and older adults, identified anecdotal evidence of increasing issues and bed pressures that were possibly related to ward transfers and people "sleeping out". The definition of sleeping out is where a person receives their daytime treatment on the right ward, but then sleeps on another ward. The definition of "transfer" is a physical move for all aspects of care to another ward.

There was no available data from CAREnotes to support the anecdotal intelligence, meaning that analysis was not possible. A system was set up to capture and monitor data about people moving between wards to test this perception and monitor any unintended consequences.

What we did:

One of our General Managers enlisted the support of our Quality Surveillance team to design a recording system for the Divisional Bed Manager in the form of an Excel spreadsheet with two workbooks; one each for sleeping out and one for transfers. The recording system was designed to be user friendly, sustainable and minimise daily input.

Results:

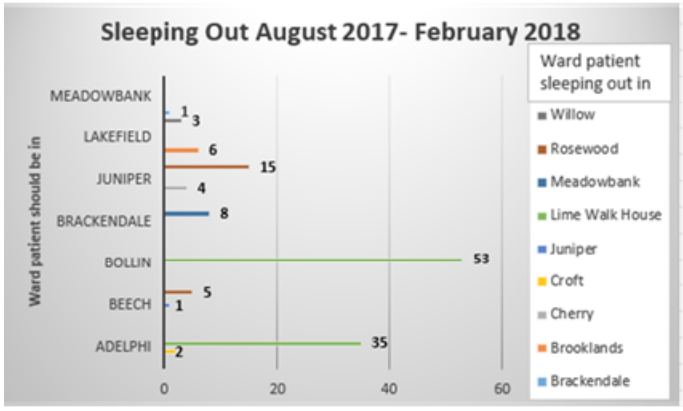
The data captured by this new system is now used to help the bed hub quickly identify any areas of pressure, and respond to minimise any negative impact on patient care. Furthermore, the data is also included in ward data packs to enable them to see patterns and themes over time and make improvements. The availability of the data has enabled the Quality Surveillance team to introduce two new areas of patient experience and activity data in the ward data packs:

Ward Transfers August 2017 - February 2018

Ward Type transferred from \ Ward Type transferred to	Ageless	AMH	LD	OAMH	PICU	Rehab	Secure	Not Recorded
Ageless	36	69		15	15	3		
AMH	44	28		5	46	4		
OAMH	3	2		12				
PICU	14	51	1	1	19	2	2	
Rehab		1				1		
Not Recorded								1

The shading show match logical ward type transfers.
The transfers shaded in amber do not appear to be logical transfers

Reason for Ward Transfers, as recorded by bed hub team	
Clinical	212
PICU	61
U65 to make way for over 65	33
patient or family request	26
ECT treatment	25
Safeguarding	9
Over 65 to make way for under 65	3
Mixed Sex Accomodation	2
not recorded	2
PALs	2
Grand Total	375



Feedback from the Divisional Bed Manager is that the use of drop down lists saves her a great deal of time and that the spreadsheet has enabled easier collation and that the data is more efficient to analyse.

Next steps:

The bed hub project continues to use the output from this data to monitor the use of sleeping out and the numbers and reasons for ward transfer, sharing relevant findings with colleagues. The ward data pack content will be developed towards times series rather than cumulative reporting.

For more information, please contact Sarah Quinn, Head of Operations, on 0151 488 7444

Patient Experience Improvements and Patient Feedback

Delivering *Acceptable* and *Accessible* care

The following projects illustrate how CWP teams are delivering care which takes into account the preferences and aspirations of people. They also show how CWP teams are delivering care that is timely, geographically reasonable, and provided in a place where skills and resources are appropriate to meet people's needs.

Housing & Health Link Worker Scheme

Our Person-centred Framework is a set of overarching principles that ensure that person-centred thinking runs through everything we do. This project exemplifies how one of our teams has applied these principles to provide care and support to particularly vulnerable people who have used their services.

Background:

Cheshire East Council's Housing Options Team has created the Housing & Health Link Worker (HHLW) scheme in partnership with the CWP, with the primary purpose of providing advice on Housing Options and assistance to people with enduring mental health conditions currently resident on the wards within the Millbrook Unit in Macclesfield. The HHLW also supports people working with CWP teams in the community, where they are vulnerable to homelessness or housing difficulties.

What did we want to achieve?

We wanted to put the person at the centre of the support available to ensure they are assisted appropriately at a time when they would be particularly vulnerable and further to build support around them to match their housing aspirations, where possible.

What we did:

The primary purpose of the Housing & Health Link Workers is to work with people, other professionals and agencies to prevent homelessness where possible, and if not to support people through the current statutory homelessness process. The Housing and Health Link Workers consider the options available to the person in terms of assisting them to remain in their current accommodation or to find alternative accommodation in either the social, private or lower level supported accommodation sectors. For people currently on the Millbrook Unit in Macclesfield who are ready for discharge but would be street homeless, we have access to four emergency accommodation bed spaces. Two are located in Congleton and two in Sandbach. Whilst in the emergency accommodation, the link worker puts the person at the centre of a support plan which, other than looking into their housing options, would also include tenancy support, community integration projects, income maximisation and ensuring healthcare support as required.

Results:

The link workers have had 40 referrals from October until the end of March, and they have had had full occupancy in the emergency beds in Congleton/ Sandbach. CWP and *Cheshire East Council* have been shortlisted for the "Northern Housing Awards". The awards ceremony is at the Midland Hotel in Manchester on Wednesday 16 May 2018.

For more information, please contact John Hyde or Victoria Cole, Housing and Health Link Workers on either 07976 767901 or 07773 227934, respectively

Person-centred Discussion Group

Innovative therapeutic support for staff

Tony McSherry, psychotherapist for West Cheshire CMHTs, has been piloting a person-centred discussion group for staff in Ellesmere Port CMHT, following completion of his PhD, to support staff in the workplace with complex and challenging cases using the "Balint model" as a basis. The Balint model encourages health professionals to meet in small groups to discuss cases in a supportive environment.

The aim is to provide a therapeutic and confidential forum for any clinician to talk about troubling cases, or how individual cases may impact on them in other ways outside of a clinical supervision model. Confidentiality is seen as very important, as sometimes staff may not feel safe enough to speak about their own difficulties with some people on their caseload for fear of being seen as 'not coping'. Being closed off from the therapeutic support of others in this way can lead to poor performance, sickness, burnout, or worse. The view is that when clinicians have their experiences taken seriously, then this can have a positive effect on working with others. The idea is to facilitate how a clinician may become more aware of their own good practice, and have this acknowledged, while also being open to other ways of relating or being with the people they are working with, which may be helpful.

For more information, please contact Tony McSherry, Psychotherapist, on 0151 357 7504

Recovery colleges collaborate with local libraries

Background:

Recovery College students often use local libraries as part of their learning programme, however, they can experience challenges around fines due to returning books late as a result of poor memory, for example, which is symptomatic of their condition. For some of students this has contributed to them no longer accessing the services that libraries provide.

What did we want to achieve?

We wanted to ensure that students weren't disadvantaged as a result of certain challenges they experience living with a mental health condition.

What we did:

Sandra Lewis, Recovery College Lead Co-ordinator, has been working with the local library in Blacon, having highlighted some of the problems that Recovery College students find when using the libraries, to look at possible solutions.

Results:

Recovery College students can now present a letter from the Recovery College to libraries across the CWP footprint to show that they are accessing learning through the College. As a result, the libraries have agreed to apply extended loan periods and fines will not be applied.

For more information, please contact Sandra Lewis, Recovery College Lead Co-ordinator, on 01244 385 070

Between December and March 2017/18, CWP formally received 957 compliments from people accessing the Trust's services, and others, about their experience. Below is a selection of the comments and compliments received:

CWP East

OT Millbrook Unit – "Always caring, compassionate with patients, always very peaceful. The staff are wonderful."
Wellbeing Hub, South/ Vale Royal – "I am very grateful for everything you have done that thank you does not seem enough. This service really helped me find my sparkle again and helped me believe in myself."
Adelphi ward – "Without exception, staff were always willing to help and requests were always considered and acted upon. Encouragement was always given."
0-16 Crewe CAMHS – "The service has been outstanding and I don't know what our family would have done without CAMHS. We have always been treated with dignity and respect in a very welcoming and calm environment."
Drug and Alcohol Service – "Just wanted you to know how much our chat meant the other day, you were extremely helpful."

CWP West

Beech ward – "I am very impressed with all the staff on Beech ward, for the speed at which my loved one has recovered. I do believe that the input from the marvellous Consultant has been a great asset to his recovery."
Primary Care Mental Health Team – "I feel as though I was listened to, I did not feel under pressure or rushed, which made me feel valued."
Coral ward – "We wanted to say a very big thank you for all the help and support you have given our daughter over the past few months, we have greatly appreciated all that you have done for her during this difficult time. We are also grateful for the support, advice and guidance."
Cherry ward – "Family thanked staff for their outstanding care on the ward. They stated that communication and family involvement has been brilliant. And very pleased and impressed that care plans for their relative in the community have been taken on board and implemented."
Crisis and Reablement Team – "The carers that attended my mum were lovely, treating her with respect and kindness."

CWP Wirral

Lakefield ward – "Lakefield have amazing staff who help you through a very difficult period in your life."
Wirral CAMHS Choice Team – "The therapist was fantastic with us, he listened, gave us lots of helpful information and made us feel like we could open up. Thank you."
Wirral CAMHS 14-18 Team – "I want to say thank you for everything you have done for me over the last few years! I have really appreciated all of your help and guidance."
Wirral CLDT – "Thank you doesn't seem enough for all the help, care and support you have given my son. You cared deeply about getting my son the right support and environment to keep him safe and to enable him to have a fulfilled life."
Oaktrees – "Thanking staff for helping patient through the hard time of her life, support has really helped and kept her motivated. Feels grateful that she had the chance to have a much better experience"

Share your stories

We welcome your best practice stories and Quality Improvement successes; please share your work via the Safe Services Department using the Best Practice and Outcomes page on the intranet or contact the Healthcare Quality Improvement Team on 01244 397410

Look out for more about Quality Improvement in Edition 1 2018/19 of the Quality Improvement Report

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Director of Infection Prevention & Control Quarter 4 Report 2017/18
Agenda ref. no:	18.19.11
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	30/05/2018
Presented by:	Victoria Peach

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
Click here to enter text.	
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
Click here to enter text.	

REPORT BRIEFING

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

Please find Quarter 4 report for Infection Prevention and Control (IPC). This is a mandatory requirement and requires discussion and approval.

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

The Director of IPC and Nurse Consultant for IPC, deliver a quarterly report to appraise the IPCSC and Board of Directors regarding IPC activity and any associated risks.

Assessment – *analysis and considerations of options and risks*

The report will detail the work undertaken prior to, and during Quarter 4, and will discuss future actions to minimise the infection risks associated with healthcare. This includes invasive / medical devices and skin integrity issues, to help prevent avoidable harm to service users.

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

The IPCSC has agreed and approved the Quarter 4 report 2017/18 to forward to the Board of Directors for discussion and approval at the May 2018 meeting.

Who/ which group has approved this report for receipt at the above meeting?		IPCSC
Contributing authors:		Julie Spendlove
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
2	Chief Executive	May 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	Q4 – 2017-18 DIPC report

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Director of Infection Prevention and Control (DIPC) Quarterly Board Report, quarter four (Q4 - January to March 2018).

Contents

1. Purpose of the report

The purpose of this report is to provide Cheshire and Wirral Partnership NHS Foundation Trust (CWP) Board of Directors with an update in respect of assurance, activity and performance for infection prevention and control (IPC), which CWP is responsible for, during quarter 4 (Q4 January – March 2018).

2. Infection Prevention and Control Activity

During Q4 there was one case of *Methicillin Resistant Staphylococcus Aureus* (MRSA) Blood Stream Infection (Bacteraemia) reported to the infection prevention and control team (IPCT), within CWP. This was a community acquired infection: A 'community acquired specimen' is a blood culture that is taken from a patient's blood sample within 48 hours of admission to hospital and is a national definition.

A post infection review (PIR) was completed collaboratively between the CWP IPCT, Countess of Chester (COCH) IPCT, microbiology and the GP practice, as per national guidance. The PIR involved a review of the patient healthcare records including the GP records and concluded that the infection was unavoidable.

There were no cases of *Clostridium Difficile* infection in CWP during Q4.

2.1 Outbreaks

Nationally this flu season has seen a wide circulation of Influenza B; a small number of patients cared for within CWP suffered from the virus during Q4. Patients suffering from influenza presented with low grade respiratory illnesses and in some cases associated chest infections. Both Influenza A and Influenza B were isolated, from swabs taken from our patients, within all 3 localities. On 2 occasions the IPCT have closed wards to admissions to restrict the spread of the virus. Good practice is for a closed ward due to Influenza, to remain closed to admissions for 5 days after the last patient started with symptoms; this was achieved. Patients on both affected wards were treated with Tamiflu if they were symptomatic of influenza and offered prophylactic doses if they were in risk groups for influenza in accordance with national guidance.

During March 2018 a decision was made, in conjunction with the senior management team, to close Millbrook Unit in Macclesfield to admissions, due to a severe outbreak of diarrhoea and vomiting that started on Adelphi ward and affected Bollin ward. The aim of the closure was to prevent spread onto Croft ward. A total of 18 patients and 14 staff were affected. The outbreak was confirmed to be Norovirus.

Excellent collaborative working and communication between all the staff on Millbrook, the modern matron, ward managers, IPCT and facilities, alongside senior managers and the emergency planning team, enabled the wards to re-open to admissions promptly after 5 days closure, with no further spread to Croft ward.

To learn from experience, post-outbreak meetings took place within 5 working days of the end of an outbreak. These meetings were multi-disciplinary and included clinical service managers, modern matrons, ward managers, temporary staffing, occupational health, practice education facilitator and facilities manager where appropriate. Additionally teams receive feedback highlighting areas of good practice and any requirements for improvement.

2.2 Audits

Audits have been undertaken on 10 inpatient wards and clinics. Eight of these have met the achievement requirements, with scores of over 93%. One area that was non-compliant was Chester Eating Disorder Service (CEDS); this is not a CWP building, as such not all the identified improvements are within CWP area of responsibility. The IPC team are supporting the staff at CEDS to improve compliance within our remit and the report, including recommendations for action has been forwarded to the landlord.

The other premise that was non-compliant was Neston clinic that had a score of 90%. Improvements identified are to have hand hygiene posters, facilities for visitors to wash their hands when they enter the building and ensure areas are free from dust and stained chairs are replaced. Improvement requirements will be reviewed within three months by the IPCT.

2.3 Training

A total of 1080 staff have attended IPC training, including induction, during the period of Q4 and within this period 78% of staff Trust wide were compliant with IPC training. This is below the expected compliance rate for mandatory training; care groups and services will be providing assurance to future Infection Prevention and Control sub-committee regarding local strategies for improvement.

The IPCT have developed an IPC e-learning package for staff to access across the organisation. This will provide an alternative method of learning and it is proposed that staff will be able to access the e-learning bi-annually and will have face to face learning alternative years. This training will be due for roll out during Q2 2018/19.

The IPC training continues to receive very positive evaluations during Q4 with 97% of the attendees rating the training as good or excellent.

3. Antimicrobial Resistance

Within Q4, there have been no multi drug resistant organisms (MDRO) brought to the attention of the IPC team.

The team continue to work very closely with pharmacy teams across the Trust and collect data around antimicrobial prescribing and compliance to formulary. The data shows that 61% of all antimicrobial prescribing was in line with West Cheshire Clinical Commissioning Group prescribing guidelines; a further 12% was prescribed based on sensitivities or advice from the microbiologist; and 17% had been commenced by another provider. Therefore, actual non – adherence to formulary was 10% which is a slight improvement of 1% from Q3.

The IPCT will work collaboratively with the pharmacy teams to look at ways of challenging prescribers further to improve compliance to above 95%. This will be reported in Q1 2018-19.

4 Influenza

The IPCT continued to be actively involved in supporting Workforce Wellbeing to deliver this year's staff flu campaign during Q4. The final uptake of the influenza vaccine by frontline staff was 72% which is a significant improvement of 14% on the previous year from 58%. The IPCT will continue to work collaboratively with Workforce Wellbeing and the Communications team in promoting the message that the flu vaccine is the best protection we have against flu. Preparations and planning for the 2018-19 flu campaign has commenced.

5. Quality Premium - Gram Negative Blood Stream Infections (GNBSI)

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

An improvement plan was developed and submitted by the CCG to NHS England in September 2017 in conjunction with the IPCT focussing on improving practice in keys areas that could result in this type of infection, including; catheter care, appropriate management and treatment of patients presenting with a urinary tract infection; appropriate antimicrobial prescribing; PICC line management and chronic wound care management. Implementation of this action plan continued into Q4 and has resulted in a full review and update of Catheter Care Pathway in the community. This piece of work has now concluded.

There is an additional working party currently looking at the appropriate management and treatment of patients presenting with a urinary tract infection and includes the appropriateness of antimicrobial prescribing. This particular piece of work is being led by microbiology, pharmacy and GPs but its outcome will benefit our patient population across Cheshire West.

6. Safety Devices

Most sharps injuries can be prevented and there are legal requirements for employers to take steps to prevent healthcare staff being exposed to infectious agents from sharp injuries. As of May 2013, new regulations were implemented by the Health and Safety Executive (HSE), to ensure that risks from sharp injuries to healthcare staff are adequately assessed and that appropriate control measures are in place. The regulations build on existing law and provide specific detail on requirements that must be taken by healthcare employers.

Trusts are therefore required to substitute traditional, unprotected medical sharps with a 'safer sharp' where it is reasonably practicable to do so. CWP are not currently fully complaint with the regulations.

A joint programme (involving IPCT, Health and Safety and Procurement) to achieve full compliance is in place: the expectation is that full compliance will be achieved by the end of Q2 2018/19. This will exclude podiatry, as current safer sharps available are not practicable. A rolling programme to review suitable safety products as they come to market will be in place for podiatry. The Infection Prevention and Control Sub – Committee will receive quarterly progress reports.

7. Sepsis Care Improvement Programme (SCIP) – Pilot

In the United Kingdom, there are more than 250,000 episodes of sepsis annually, with at least 44,000 people dying as a result. Sepsis costs the NHS between £1.25 and £2 billion annually. Urgent basic care can make a real difference between survival and death. Evidence shows that early intervention saves lives and can also reduce the length of hospital stay for patients.

A pilot programme, to raise awareness of early signs of sepsis, has been completed using an in-patient elderly ward and GP Out of Hours Service. The three month pilot concluded in January 2018. A period of evaluation has been completed and final changes are being made to the pathways and education package based on feedback, before a phased trust wide roll out of the programme during Q1 2018-19.

Work has also commenced with our community based colleagues with the launch of 'Sepsis in the Community' in February 2018. Community staff, within physical health West, will be invited to access the e-learning package and have commenced use of a Community Sepsis Screening & Action Tool to assist in their decision making processes.

A Sepsis update newsletter has been circulated and Sepsis information continues to be included in mandatory EE1 IPC Training. Sepsis resources have been purchased, and resource packs put together for the roll out. Following this roll out the work will be made available to all other community teams including Learning Disability and Mental Health; this will be scheduled within the 2018 / 2019.

Sepsis Success Stories

There is already evidence of the positive impact of the SCIP, with three cases being referred by the inpatient setting to acute care during the pilot scheme, and multiple situations where the GP Out of Hours Service triaged patients and the outcome was appropriately transfer to acute care via ambulance.

Since the launch of SCIP in the community, there has also been a very positive interaction during a home visit. The patient's wife was noticeably unwell and following use of the sepsis triage tool, symptoms were acknowledged and an ambulance called. Sepsis was confirmed and treated by the acute trust.

8. Tissue Viability

A member of the IPCT also provides a Tissue Viability service for the inpatient wards across the organisation. During the last 12 months this service has developed and provided the following:

- Standardisation of a CWP wound dressing formulary for all inpatient areas resulting in improvement in care standards by achieving consistency and enhanced knowledge.
- Development of a protocol for hiring pressure relieving equipment, in collaboration with a ward manager in the Wirral locality, saving the organisation £23,000.
- High visibility across all localities to highlight the importance of recognising wound infection and the subsequent costs associated with incorrect prescribing of antibiotics in the fight against antimicrobial resistance (AMR).

- Enabling best practice to be communicated to all staff via positive role modelling, in practice learning and through local teaching sessions.

The presence of a Tissue Viability Nurse has reduced the need for external Service Level Agreements with other providers.

9. Recommendations

The Board of Directors is asked to:

- Receive assurance that the Infection Prevention and Control activity and performance is being managed effectively in line with national guidance.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Ward Daily Staffing Levels March and April Data 2018
Agenda ref. no:	18.19.12
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	30/05/2018
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 March and April 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 March 2018 the trust achieved staffing levels of 95.5% for registered nurses and 97% for clinical support workers on day shifts and 97.1% and 97.9% respectively on nights. During April 2018 the trust achieved staffing levels of 96% for registered nurses and 98.7% for clinical support workers on day shifts and 95.8% and 97.9% respectively on nights.

In the months of March and April 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	11/05/2018 11/05/2018

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 March 2018
2	Ward Daily Staffing April 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	1361.5	1246.5	1487	1268.5	784	726.5	1270.5	1190	91.6%	85.3%	92.7%	93.7%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Alderley Unit	1032	975.5	1451	1373	713	621	713	805	94.5%	94.6%	87.1%	112.9%	Non mandatory staffing activity was cancelled. Ward Manager actively worked within the daily staffing numbers when required.
	Bollin	1308.5	1202	1517.5	1358	733.5	726	1315	1211.5	91.9%	89.5%	99.0%	92.1%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Croft	1227	1028.5	1531	1610	713	691.5	1380	1340.5	83.8%	105.2%	97.0%	97.1%	Nursing staff working additional unplanned hours.
	Greenways A&T	1217	998.5	2139	1828.5	713	632.5	1426	1449	82.0%	85.5%	88.7%	101.6%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	LimeWalk Rehab	1093.5	1035.5	1023.5	1008.5	713	671	713	731	94.7%	98.5%	94.1%	102.5%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Saddlebridge	1098.5	987.5	1296	1281.5	724.5	678.5	713	708	89.9%	98.9%	93.7%	99.3%	Non mandatory staffing activity was cancelled. Ward Manager actively worked within the daily staffing numbers when required.
Wirral	Brackendale	1080.5	1058.5	1063	1028	713	713	713	713	98.0%	96.7%	100.0%	100.0%	
	Brooklands	949.15	945.15	1233.5	1176	675.5	675.5	912	912	99.6%	95.3%	100.0%	100.0%	
	Lakefield	1204.5	1193	1012	1000.5	747.5	713	897	874	99.0%	98.9%	95.4%	97.4%	
	Meadowbank	917.5	906	1644.5	1621.5	586.5	574.5	1391.5	1368.5	98.7%	98.6%	98.0%	98.3%	
	Oaktrees	1179	1124	1198	1187.5	713	713	346.5	276	95.3%	99.1%	100.0%	79.7%	Nursing staff working additional unplanned hours. Ward Manager actively worked within the daily staffing numbers when required.
	Willow PICU	1018	1006.5	845.5	822.5	724.5	712.5	655.5	632.5	98.9%	97.3%	98.3%	96.5%	
West	Beech	1401.65	1352.65	1003.5	955.5	713	713	743	731.5	96.5%	95.2%	100.0%	98.5%	
	Cherry	1148.5	1148.5	1280	1314.5	575.5	575.5	1104	1104	100.0%	102.7%	100.0%	100.0%	
	Eastway A&T	892.5	892.5	1127	1127	590.5	590.5	870.5	870.5	100.0%	100.0%	100.0%	100.0%	
	Juniper	1164.5	1134	1122.5	1112	713	713	862.5	832	97.4%	99.1%	100.0%	96.5%	
	Coral	1276.5	1276.5	1150	1150	586.5	586.5	954.5	954.5	100.0%	100.0%	100.0%	100.0%	
	Indigo	1134.5	1116	908.5	903.5	658	646.5	830.5	766	98.4%	99.4%	98.3%	92.2%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Rosewood	960.5	960.5	1322.5	1322.5	506	506	897	897	100.0%	100.0%	100.0%	100.0%	
	Trustwide	22665.3	21587.8	25355.5	24449	13596.5	13179.5	18708	18366.5	95.5%	97.0%	97.1%	97.9%	

	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	1465.5	1256	1296	1207	694.5	660	1261.5	1204	85.7%	93.1%	95.0%	95.4%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Alderley Unit	1070	965.5	1543.5	1494.5	713	690	770.5	782	90.2%	96.8%	96.8%	101.5%	Nursing staff working additional unplanned hours.
	Bollin	1393.5	1316.5	1391.5	1293	732	674.5	1334	1307	94.5%	92.9%	92.1%	98.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Croft	1177.5	1160.5	1448	1514.5	690	667	1322.5	1329.5	98.6%	104.6%	96.7%	100.5%	
	Greenways A&T	1170	974.5	1817	1805.5	690	563.5	1380	1403	83.3%	99.4%	81.7%	101.7%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	LimeWalk Rehab	1062.5	1057.5	1000.5	1039.5	690	621	690	695	99.5%	103.9%	90.0%	100.7%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Saddlebridge	1077.5	999	1357	1345.5	644	644	793.5	793.5	92.7%	99.2%	100.0%	100.0%	Non mandatory staffing activity was cancelled. Ward Manager actively worked within the daily staffing numbers when required.
Wirral	Brackendale	1065.5	1066.5	971	910.5	678.5	678.5	701.5	690	100.1%	93.8%	100.0%	98.4%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Brooklands	949	888.5	1118.5	1118.5	688	607	719.5	707.5	93.6%	100.0%	88.2%	98.3%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Lakefield	1098.5	1098.5	1023.5	1023.5	736	657.5	793.5	782	100.0%	100.0%	89.3%	98.6%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Meadowbank	1175.5	1095.5	1524	1520	621	540.5	1434	1184.5	93.2%	99.7%	87.0%	82.6%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Oaktrees	1361	1377	1215.5	1207	690	655.5	345	310.5	101.2%	99.3%	95.0%	90.0%	Nursing staff working additional unplanned hours. Cross cover arrangements. Ward Manager actively worked within the daily staffing numbers when required.
	Willow PICU	806.5	783.5	908.5	920	759	759	724.5	724.5	97.1%	101.3%	100.0%	100.0%	
West	Beech	1483	1469.5	854	844	747.5	747.5	649	632.5	99.1%	98.8%	100.0%	97.5%	
	Cherry	1016.25	1016.25	1445	1433.5	717.5	717.5	1162	1162	100.0%	99.2%	100.0%	100.0%	
	Eastway A&T	812.8	801.3	1512.5	1512.5	661.5	661.5	890.5	890.5	98.6%	100.0%	100.0%	100.0%	
	Juniper	1368.2	1322.2	1007	987.5	701.5	701.5	689.8	683.8	96.6%	98.1%	100.0%	99.1%	
	Coral	1389	1375	951.5	951.5	563.4	563.5	1012	1012	99.0%	100.0%	100.0%	100.0%	
	Indigo	1233.95	1191.45	739.5	696.5	542	542	874.5	828.5	96.6%	94.2%	100.0%	94.7%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Rosewood	861.25	872.75	1421.5	1421.5	593.5	616.5	616.5	616.5	101.3%	100.0%	103.9%	100.0%	
	Trustwide	23036.95	22087.45	24545.5	24246	13552.9	12968	18164.3	17738.8	96.0%	98.7%	95.8%	97.9%	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Freedom to Speak up Annual Report
Agenda ref. no:	18.19.13
Report to (meeting):	Board
Action required:	Discussion and Approval
Date of meeting:	16/05/2018
Presented by:	CWP Freedom to Speak up Guardian

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	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	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	Choose an item.
Click here to enter text.	
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
Click here to enter text.	

REPORT BRIEFING

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

This report is to provide the Freedom to speak up annual report to the Board and to feedback themes from the concerns raised with the Freedom to Speak up Guardian (F2SU Guardian) during 2017/18. The report will also provide the Board with an update of the actions taken and set out CWP plans for 2018/19 and beyond.

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

The Freedom to Speak Up (F2SU) Review was an independent review, led by Sir Robert Francis QC, into creating an open and honest reporting culture in the NHS following concerns raised by NHS staff and the treatment of some who had spoken up. The review produced a comprehensive report providing details good practice which is taking place and to address the gap and variation, the report covers how organisations can create the right culture, how concerns should be handled and what is needed to ensure the system works. In 2015 The Office of the National Guardian published a guide for NHS Trusts on establishing the Freedom to Speak Up (FTSU) Guardian role The guidelines also set out the expectations of the role including providing a six monthly report to Boards. This report forms part of that compliance and is the third annual report provided to Board.

Assessment – *analysis and considerations of options and risks*

The report outlines the actions of the FTSU Guardian and the progress made in relation to Improving processes; building confidence and capability and measuring progress durning 2017 – 2018 and the plans for continuing this work into 2018 – 2019.

The report provides the board with information on the number, location, and type of concerns raised with the FTSU guardian and some analysis of when, which service and who is reporting concerns. The Board should bear in mind the low numbers involved and therefore the limited assurance insofar as identification of potential themes or trends. The report provides the board with an overview of the actions taken in response to concerns raised.

The report highlights the encouraging results from the 2017 Staff Survery in regards to questions asked relating to raising concerns.

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

The Board is requested to discuss and note the content of the report and agree the plans identified for 2018 – 2019.

Who/ which group has approved this report for receipt at the above meeting?		Director of Nursing, Therapies and Patient Participation
Contributing authors:		Click here to enter text.
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
Click here to enter text.	Click here to enter text.	Click here to enter text.

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	Speak up Guardian – Annual Report 17-18

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document Reference (2017/18)

Report to Board:	Operational Board and Trust Board
Date of Meeting:	
Title of Report:	Annual update of Freedom to Speak Up actions 2017 - 2018
Action sought:	
Author:	Gary Flockhart / Victoria Peach
Presented by:	Gary Flockhart

Strategic Objective(s) that this report covers *(delete as appropriate):*
SO1 - Deliver high quality, integrated and innovative services that improve outcomes
SO2 - Ensure meaningful involvement of service users, carers, staff and the wider community
SO3 - Be a model employer and have a caring, competent and motivated workforce
SO5 - Improve quality of information to improve service delivery, evaluation and planning
SO6 - Sustain financial viability and deliver value for money
SO7 - Be recognised as a progressive organisation that is about care, well-being and partnership

Distribution

Version	Name(s)/Group(s)	Date Issued

Executive director sign-off

Executive director (name and title)	Date signed-off
Avril Devaney	

Annual report April 2017 – March 2018

Contents

1.0 Background and Context

1.1 In 2016 Cheshire and Wirral Partnership NHS Foundation Trust (the Trust) in response to The Office of National Guardian guidance established a Freedom to Speak Up (FTSU) Guardian. The overall purpose underpinned by the guidance is to make the NHS a 'better place to work and a safer place for patients'.

1.2 The purpose of the FTSU Guardian is to support organisations to create an open and honest reporting culture. The FTSU Guardian is integral to ensuring all staff within the Trust are able to raise any issues or concerns, or challenge any wrongdoing, safe in the knowledge that they will be addressed confidentially, promptly, and in line with best practice.

1.3 Freedom to Speak Up Guardians are supported through a national agenda to ensure that the new role is meeting its intended purpose; fulfilling the expected standards and providing data.

1.4 This, the third annual Freedom to Speak Up report forms part of the national compliance requirements and provides assurance to the Trust Board.

2.0 Actions 2017 – 2018

2.1 Our 2017 – 2018 person centred commitment to Freedom to Speak Up is that "we will have the courage to speak up and voice our views. We will always try to improve things to make a lasting difference". The following has been completed to achieve this:

2.2 Speak up Guardian.

- The Trust's FTSU Guardian has attended national training and networking events facilitated by NHS Employers to enable benchmarking and sharing of best practice.
- Attended the National Guardian's Office (NGO) meeting with the National Guardian Dr Henrietta Hughes to ensure the Trust is able to progress in accordance with national expectations.
- The NGO has worked with the Trust to evaluate the Freedom to Speak Up App that has been developed.

2.3 Board Champion.

- Rebecca Burke-Sharples has continued to be the nominated Non - Executive Director Freedom to Speak Up Champion by the Trust Board of Directors.

2.4 Improving Processes.

2.4.1 Access to Information.

- Freedom to Speak Up information is easily accessible for staff on the Trust Intranet mini site. The Trust mini site continues to be updated with pertinent information, inclusive of the FTSU reports, links to the National Guardians Office containing details of the FTSU Guardian role and links to other resources.

- The Trust has a confidential dedicated FTSU email address and a direct line to the FTSU Guardian in place, this is published on the intranet details and posters advising of contact details are displayed in staff areas.

- One of the challenges for the Trust is reaching all grades of staff with information

regarding the access to FTSU Guardian to enable them to raise any issues or concerns, or challenge any wrongdoing, through this route. Many staff have limited access to email and some do not have mobile devices supplied by the organisation but do have their own mobile phones. The development of a FTSU App is one approach to enhance accessibility to the FTSU Guardian, which has gained Executive Director support. The intention is that the FTSU App will be accessible to all staff; through a work or personal device.

The main purpose of the App is to educate, encourage and facilitate the raising of concerns by staff members in a simple, convenient and innovative way. Additional benefits of the app are that staff can report concerns from anywhere, at any time, and concerns raised are secure and will only be seen by the Guardian. The App provides an additional line of communication, allows the Trust to communicate with staff via push notifications, news articles and informs staff members of the protection they will receive should they report a concern.

The App has a comprehensive back office 'portal'. This area, only accessible to the App administrator, will hold the encrypted reports, manage the content and set up of the App, and provide graphs with key statistics: for example; number of downloads, activity and identification of most popular areas visited. This information will enable areas of lower usage to be targeted with awareness campaigns to provide assurance that all staff have received details of how to raise a concern to the FTSU Guardian should they wish to do so.

2.4.2 Policy

- The Trust's 'How to Raise and Escalate Concerns' policy is in place and is in line with the NHS England and NHS Improvement standard integrated policy (April 2016), which is required to be adopted by all NHS organisations as a minimum standard.

2.4.3 Building Confidence and Capability

- The Trust has recruited Speak Up Ambassadors. These are self-nominated staff who provide immediate support and signposting for colleagues in raising concerns, determining the best course of action and advising the staff member of their options. The first cohort of 15 ambassadors has been recruited, provided with training and regular peer support established. A two monthly rolling recruitment process will continue throughout 2018/19.
- Staff are able to raise concerns to the FTSU Guardian on an anonymous basis, such concerns are considered and investigation. However, personal evidence and clarification from individuals can be essential to enable a comprehensive investigation. In order to continue to improve the culture regarding raising concerns staff are encouraged to be open with the confidence that the FTSU Guardian will provide confidential support and only use the anonymous route when absolutely necessary.

2.4.4 Measuring Progress

- Learning from concerns is shared within the team, service and locality as appropriate, and across the organisation via the Learning from Experience report which is reviewed at Quality Committee on a quarterly basis. Learning is also highlighted in the Trust's Annual Quality Report.
- Success should not be measured in the number of concerns and issues being raised. However, the trends of reporting can be useful when triagulated with wider data and can support the identification of early warning that can enable prompt and appropriate intervention and support.

- Systems are in place to record and monitor concerns raised to the FTSU Guardian, in accordance with Step 3 and above within the How to Raise and Escalate Concerns policy. This information is reviewed and refined to ensure the Trust responds in a timely and proportionate way and to identify any themes and trends.
- The majority of concerns will be addressed as lower level concerns, in accordance with Step 1 and Step 2 outlined within the How to Raise and Escalte Concerns policy. There is no requirment to collate this information, as such no central record of these concerns is maintained.

3.0 Concerns Raised from 2015 to 2017 / 2018.

3.1 The FTSU Guardian role continues to be utilised across the Trust; the number of concerns raised in 2017 / 2018 has exceeded previous years. This demonstrates that awareness and confidence of staff to utilise the FTSU Guardian continues to grow.

Locality	**2014- 2015**				**2015 – 2016**				**2016 – 2017**				**2017 – 2018**			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Central and East	1			1	4			2	2		3		1	8*	5	1
Wirral		1			1	2		1		1	1			1		2
West	1			3	4	1	2	1	1		2	1	2	2		1
Trust wide						1		1		1						
Sub Total	2	1	0	4	9	4	2	5	3	2	6	1	3	11	5	4
Year Total	7				20				12				23			

Table 1 - Total numbers of concerns raised by locality over last four years.
*See 3.3 below.

3.2 The results from the 2017 National Staff Survey are encouraging with staff responses to all four questions related to FTSU being the same or higher than the national average. The FTSU Guardian will continue to work with Organisational Development to sustain the improvements made and understand the opportunities for further development in those areas that have seen a slight reduction locally compared to 2016 response.

Question	National Response 2017	CWP 2017 response	CWP 2016 response	CWP 2015 response
If you were concerned about unsafe clinical practice, would you know how to report it?	97%	98%	97%	97%
I would feel secure raising concerns about unsafe clinical practice.	73%	77%	76%	69%
I am confident that my organisation would address my concern.	60%	64%	66%	59%
My organisation treats staff who are involved in an error, near miss or incident fairly.	53%	53%	55%	50%

Table 2 - Staff survey results 2015 - 2017

3.3 Analysis of 2017/18

- All the concerns raised have been investigated and responded to in a proportionate way by a variety of methods, examples include; issues identified with specific individuals may be addressed at supervision. Scheduled and commissioned reviews have been undertaken to explore some issues raised, any actions identified are taken forward by teams/services.

- Some concerns will have identified more than one issue however the concern is only recorded once. Caution should be noted when considering the analysis due to the small numbers involved.

- There were three concerns raised anonymously in 2017 / 2018: Two were in relation to patient safety concerns, these were raised directly with the Care Quality Commission (CQC) and followed up by the FTSU Guardian. One was related to management issues. The FTSU Guardian role is being promoted to encourage staff to report via this route however, staff will be able to raise concerns directly with the CQC should they feel this is the most appropriate method.

- There has been an increase in the total number of concerns reported to the FTSU Guardian this financial year. The method of collating data has impacted upon the total number; for instance one concern raised within a team meeting by eight staff members has been recorded eight times, previously this would have been captured as one concern. This would result in a total of 16 concerns raised comparable to previous years.

- The FTSU Guardian is accessible to all staff regardless of their role in the Trust. Concerns have been received from a variety of staff such as nurses, domestics, and clerical staff.

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

Patient Safety / Quality	Staff Safety	Behavioural / Relationship	Bullying / Harassment	System / Process	Infrastructure / Environmental	Cultural	Leadership	Management issue	Fraud
5	2	1	1	1	0	12	1	11	0

Table 3 – Number of concerns raised 2017 / 2018 within NGO defined categories

- Review of the quarter 4 2017 / 2018 data submitted to the NGO provides evidence that the Trust is not an outlier when compared similar sized combined mental health and community trusts.

Total Number of Comparable Trusts	15
Total Number of Concerns Raised	112
Range	0 - 25
Average (mean)	7
Median	4
CWP	4

Table 4 – Comparable Trust Calculations for quarter 4 2017 / 2018

4.0 Plans for the Forthcoming Year 2018 - 19

4.1 Improving process and progress.

- The FTSU Guardian role will be shared by the two Associate Directors of Nursing. This will enable greater independence of the role to be promoted across physical and mental health services and enable increased access.
- The FTSU Guardian role will be further promoted internally and outside the organisation.
- Regular clinical presence by the FTSU Guardians within mental health and community physical health settings both informally and directly in response to concerns raised.
- The Trust Intranet mini site will continue to be developed and updated to act as an internal resource and to signpost staff internally and externally for help, support and advice.
- Ability to download the FTSU App on Trust mobile devices will be enabled.
- The use of the App, on Trust or personal devices, will be promoted across the organisation.

4.2 Building Confidence and Capability

- Additional speak up ambassadors will be recruited and their roles will be supported across all localities and services, including those delivering clinical support services.
- A bespoke eLearning approach will be developed.

4.3 Measuring Progress

- Feedback mechanisms will be developed highlighting changes in policy, process or practice as an outcome of staff raising concerns.
- The FTSU Guardian will support the work of organisational development to understand the matters which contribute to related areas highlighted in the staff survey.
- An evaluation process of the FTSU app will be developed in collaboration with the NGO.

5. Recommendations

The Board of Directors is asked to note the contents and progress to date and agree the plans for 2018 – 2019.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Corporate assurance framework and strategic risk register – update report
Agenda ref. no:	18.19.15
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	30/05/2018
Presented by:	Dr Anushta Sivananthan, Medical Director (Executive Lead for Quality)

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which 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
All strategic risks	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	Yes
As per report	

REPORT BRIEFING

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

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

As at May 2018, the Trust has three red and five amber rated strategic risks. Four strategic risks are currently in scope.

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

The Board of Directors monitors and reviews the corporate assurance framework and receives assurances on strategic risk via the Quality Committee. This is a key component of the Trust's integrated governance strategy which provides assurance regarding the quality and safety of the services that the Trust provides. The Quality Committee undertakes individual in-depth reviews of risks, with the Audit Committee undertaking periodic reviews of risk treatment processes for individual risks on an escalation/ enquiry basis.

Assessment – *analysis and considerations of options and risks*

New risks/ risks in-scope

- *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.*
  This risk was previously in-scope but has now been modelled as a new risk with an accompanying full risk treatment plan.
- *Risks associated with the transition to the Trust's clinician-led operational (Care Group) structure as part of CWP Forward View strategy.*
  This risk remains in-scope. The Forward View transition task and finish group is established and has a risk register detailing potential risks at all levels and the current control measures. The register is regularly monitored and reviewed. A modelled, new risk is scheduled for approval at the next Quality Committee.
- *Risk that the medicine supply contract with Lloydspharmacy will not be extended from 18 May 2018, for a further twelve months, due to an increase in the price schedule.*
  The immediate risk, as described, was mitigated following discussion at the Executive Directors meeting on 17 April 2018 and Operational Board on 16 May 2018. A risk description that is reflective of the medium to longer term issues is currently being developed based on a number of potential options to ensure that a medicine supply to the Trust is sustained.
- *Risk of inability to fulfil corporate governance responsibilities due to capability within the corporate affairs team.*
  This risk was agreed with the Chief Executive and Chair on 25 April 2018, the immediate mitigating action is implementation of a business continuity plan to enable the emergency planning lead to support the effective delivery of corporate governance by ensuring the collective resources of the Trust can be deployed.
- *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.*
  Demand has been building during April and May, resulting in some isolated breaches of the Trust's internal standards. Short term plans are being worked up and the risk treatment plan will consider longer term plans.

Amended risk scores or re-modelled risks

- *Risk of significantly reduced capacity within the Performance & Redesign team, resulting in a reduced ability to support/ develop current work and new commissions.* Recruitment has now been undertaken to the vacancies within the Performance & Information Team. The team are still to enter the recovery phase following a period of business continuity. A future workshop is planned following the business continuity phase with key stakeholders to support the understanding of the complexity of data requests and consider future workload management. The current risk score has been revised and reduced to 9.

Archived risks

- *Risk of potential loss of Trust income and delivery of improved quality outcomes arising from failure to reach agreed targets within the CQUIN programme.*
  Further to discussion at Operational Board on 18 April 2018 and recommendation to Quality Committee on 9 May, it is recommended that this risk is archived. A Trustwide approach will now be taken, with a single operational lead for each scheme, to ensure a consistent approach to their implementation and reporting, as well as escalation of issues relating to partnership working and variation in measurement by commissioners.

Exceptions – overdue risk treatment actions

- *Risk of cyber-attack resulting in loss of access to key systems and/ or data files with possible impacts on healthcare delivery, financial penalties and reputational damage.*
  Regarding the appointment of a specialist cyber security role, initial timeframes have been extended due to the preferred service partner for ICT services withdrawing in December 2017. A further review of the ICT service structure is in progress, this will include ensuring access to cyber specialist expertise. There is no change to the risk score currently, based on current mitigations.

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

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

Who/ which group has approved this report for receipt at the above meeting?	Board of Directors – business cycle requirement
Contributing authors:	S Christopher, D Wood

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	23/05/2018

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

Appendix no.	Appendix title
1	Strategic Risk Register

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Operational Plan 2017/19 – delivery indicators dashboard [April 2018 data]
Agenda ref. no:	18.19.16
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	30/05/2018
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
All relevant strategic risks	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

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

The Operational Plan 2017/19 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 April 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 KPIs 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).

Baseline/ targets and escalation criteria have been updated where relevant.

SO1: 1.1 has been replaced with a new patient safety KPI (SO 1: 1.8), as approved by Quality Committee as part of the Quality Account quality improvement priority setting. This is a reduction in the severity of harm sustained by those people accessing CWP services that cause harm to themselves. It reflects the Care Quality Commission's priority to reduce the wide variation between services in the frequency of self-harm ('State of Care' report). CWP's priority is in line with the international recognised approach to learning from experience, i.e. to encourage reporting of lower level harm reporting (in this case self-harm) to facilitate learning from those incidents and thereby reduce unwarranted incidents of severe or moderate harm (again in this case self-harm). SO1: 1.1 itself continues to be tracked through the Quality Account process.

The clinical effectiveness and patient experience Quality Account priorities reflect priorities from previous years (regulations require the Trust to be able to track previous years priorities) as the 2018/19 priorities do not lend themselves to monthly monitoring, oversight of progress with these will be tracked through the Quality Improvement report to Board.

Assessment – *analysis and considerations of options and risks*

The performance framework attached at **Appendix 1** sets the range of Board KPIs 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 1 (April) performance and those indicators rated as Amber or Red are at a performance threshold that is less than target performance.

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

- CQUIN performance
- Bed pressures
- Capacity % staff vacancies

Where any threshold variance is exceeded, the commentary in **Appendix 1** describes 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 April 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	Tim Welch	21/05/2018

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

Appendix no.	Appendix title
1	April 2018 Board Operational Plan Dashboard
2	Operational Plan 2017/19 – Delivery Indicators/ Board KPIs

Appendix 1: Trust Dashboard

	Indicator	Outturn 2017/18	Target or Thresholds for escalation	Apr-18	May-18	Jun-18	Q1	Q2	Q3	Q4	Year End	General Comment
Strategic Objective 1 – Quality												
SO1: 1.8	Patient Safety: Reduction in unwarranted incidents of severe or moderate harm sustained by those people accessing CWP services that cause harm to themselves	121 (10 per month)	97 (10 per month)	8								
SO1: 1.2	Patient experience: Demonstrable increase in the uptake of the Friends and Family Test (FFT) each quarter	Average 210 (per month)	330 per month	305								
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)	95.95%								
SO1: 1.4	Patient Safety: Total % inpatient deaths subject to a case record review	100%	100%	100.00%								
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)	* 1								Inpatient death following non-fixed ligature incident. A level 3 investigation is underway. As a serious incident investigation, April outturn will be reviewed retrospectively once this has been completed.
SO1: 1.6	Patient Safety: Total % deaths reported by and to the Trust (including inpatient deaths) subject to a case record review	18%	Quarterly continuous improvement targets to be agreed for Q1, Q2, Q3 and Q4	* 36%								* Includes only CAREnotes and PCMIS data in the denominator - Amber rating reflects this position. Data in June will be refreshed to include EMIS for the whole of Q1, the Q1 outturn will be reviewed/ adjusted then.
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)	0								
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%	5.96%								
SO3: 2.2	Competence: % of staff receiving annual appraisal (via new proposed framework)	97.6%	100.0%	94.01%								Managers have been asked to ensure that they are recording completion of appraisals.
SO3: 2.3	% staff absence due to sickness	5.89%	Above annual plan (appendix 3) projection for 3 months	5.15%								

Operational Performance / Priority areas												
SO3: 3.1	100% of the 13 NHSI operational performance targets achieved (including waiting times)	100%	100%	78.0%								Both CYPD Eating Disorder waiting Times were not met: o CYP Eating Disorders - % urgent in 1 week – 0% (0/1) patient seen in 13 days o CYP Eating Disorders - % routine in 4 weeks – 83% (10/12) patients average wait 16.5 days max wait 63 days
SO3: 3.2	100% Contractual targets met	324 (98.1%)	100%									This reports a month behind April position will be available in June report
	CQUIN performance quarterly review		100%									This indicator reports position following CCG feedback on CQUIN quarterly submissions
Trust Priority Projects												
Care Group: Neighbourhood Care												
SO3: 3.3	Single Model for Integrated Care	N/A	Delivery of Key Milestones									
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									
SO3: 3.8	Early Intervention Trust Wide Review	N/A	Delivery of Key Milestones									
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 & Neuro Developmental (LD&ND)												
SO3: 3.6	Transforming Care - LD	N/A	Delivery of Key Milestones									
SO3: 3.9	ADHD	N/A	Delivery of Key Milestones									The Project has transferred to the LD & ND Care Group and a service review the project plan will be reviewed and implemented, mitigations have been put in place and further detail is available in the full PSO report.
Enablers												
SO3: 3.11	People& OD Strategy	N/A	Delivery of Key Milestones									
SO3: 3.12	Health Informatics	N/A	Delivery of Key Milestones									Key measures to be approved by Board in May
SO3: 3.13	Quality Improvement Strategy	N/A	Delivery of Key Milestones									
SO3: 3.14	Communications & engagement	N/A	Delivery of Key Milestones									Milestones being developed
Strategic Objective 6: Financial Planning												
SO6: 1	Use of resources	1	Use of Resources [UoR]	2								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: 1.8	reduction in the severity of harm sustained by those people accessing CWP services that cause harm to themselves	97 (per year)	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	Average 201 per month	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, excluding 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 quarter in which each of the three months the staff vacancy rate is above the base line position	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 quarter in which each of the three months the sick absence rate was % above the profile set out in the	By exception	People and OD sub committee	Variance from target trend line	Dave Harris	Chris Sheldon	Risk 11 – staffing (rated red 20)
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
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	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	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 & Neuro Developmental										
SO3: 3.6	Priority project 2: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	

Appendix 3: Trust Dashboard 2017 Reporting month August

Annual Plan Trust Board Key Performance Indicators Trajectory 17/18

Please enter your key performance indicators that are reported internally. Enter in a short description of the KPI and the threshold which that KPI is measured against.	Target	Plan M1 Month Ending 30-Apr-16	Plan M2 Month Ending 31-May-16	Plan M3 Month Ending 30-Jun-16	Plan M4 Month Ending 31-Jul-16	Plan M4 Month Ending 31-Jul-16	Plan M6 Month Ending 30-Sep-16	Plan M7 Month Ending 31-Oct-16	Plan M8 Month Ending 30-Nov-16	Plan M9 Month Ending 31-Dec-16	Plan M10 Month Ending 31-Jan-17	Plan M11 Month Ending 28-Feb-17	Plan M12 Month Ending 31-Mar-17	Plan Year Ending 31-Mar-17
Patient experience: Demonstrable increase in the uptake of the Friends and Family Test (FFT) each quarter	85.00	88.00	88.00	88.00	88.00	851.00	88.00	88.00	88.00	88.00	88.00	88.00	88.00	88.00
Supervisions	85.00	54.00	57.00	60.00	63.00	67.00	70.00	73.00	77.00	80.00	82.00	84.00	85.00	85.00
Sickness	4.50	5.8%	5.7%	5.6%	5.6%	5.6%	5.5%	5.5%	5.4%	5.4%	5.4%	5.3%	5.3%	5.3%
Safeguarding training	80.00	83.00	83.00	83.00	83.00	83.00	83.00	83.00	83.00	83.00	83.00	83.00	83.00	83.00
Bed Occupancy [including leave]	85.00	89.00	89.00	89.00	89.00	89.00	89.00	89.00	89.00	89.00	89.00	89.00	89.00	89.00
Friends and Family Test	0.00	0.05	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00

Operational Plan

	Indicator	Target	Plan M1 Month Ending 30-Apr-17	Plan M2 Month Ending 31-May-17	Plan M3 Month Ending 30-Jun-17	Plan M4 Month Ending 31-Jul-17	Plan M5 Month Ending 31-Aug-17	Plan M6 Month Ending 30-Sep-17	Plan M7 Month Ending 31-Oct-17	Plan M8 Month Ending 30-Nov-17	Plan M9 Month Ending 31-Dec-17	Plan M10 Month Ending 31-Jan-18	Plan M11 Month Ending 28-Feb-18	Plan M12 Month Ending 31-Mar-18	Plan Year Ending 31-Mar-18
SO1: 1.1	Patient safety: Demonstrable improvement in the alignment of the Trust-wide incident reporting profile in line with the Heinrich ratio each trimester	75.6 per 1,000 episodes	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6
SO1: 1.2	Patient experience: Demonstrable increase in the uptake of the Friends and Family Test (FFT) each quarter	237	237	237	237	237	237	237	237	237	237	237	237	237	237
SO1: 1.3	Clinical Effectiveness: Demonstrable improvement in service level health related outcome ratings each quarter	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
SO3: 2.1	Capacity: % of staff vacancies (Contracted)	equal to or below baseline	4.15%	4.15%	4.15%	4.15%	4.15%	4.15%	4.15%	4.15%	4.15%	4.15%	4.15%	4.15%	4.15%
SO3: 2.2	Competence: % of staff receiving annual appraisal (via new proposed framework)	100%	70%	80%	90%	80%	80%	90%	80%	90%	100%	100%	100%	100%	100%
SO3: 2.3	% staff absence due to sickness	5.30%	5.8%	5.7%	5.6%	5.6%	5.6%	5.5%	5.5%	5.4%	5.4%	5.4%	5.3%	5.3%	5.3%
SO3: 3.1	100% of the 13 Monitor operational performance targets achieved (including waiting times)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SO3: 3.2	100% Contractual targets met	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Capital expenditure position	100%					100%			100%			100%		100%
SO3: 3.3	Strategy priority 1: CAMHS T4	Delivery of Key Milestones					✓								
SO3: 3.4	Strategy priority 2: West Cheshire 0-19 services	Delivery of Key Milestones							✓					✓	
SO3: 3.5	Strategy priority 3: Local implementation of the transforming Learning Disability services strategy	Delivery of Key Milestones								✓					
SO3: 3.6	Strategy priority 4: Further development of integrated community health services	Delivery of Key Milestones				✓			✓					✓	
SO3: 3.7	Strategic priority 5: Developing potential options for enhancing inpatient provision	Delivery of Key Milestones			✓					✓	✓				
SO3: 3.8	Strategic priority 6: Transformation, of trust wide IAPT services	Delivery of Key Milestones						✓	✓						
SO6.1	Use of Resources rating	Use of Resources [UoR] score of 3 or 4	3	2	2	2	2	2	2	2	2	2	2	2	2

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Apprenticehsip Levy update
Agenda ref. no:	18.19.17
Report to (meeting):	Board
Action required:	Information and noting
Date of meeting:	30/05/2018
Presented by:	Louise Kitchener, Head of Education Sandra Johnson, Professional and Personal Development Lead

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	Choose an item.
Effective services	Choose an item.
Caring services	Choose an item.
Well-led services	Choose an item.
Services that are responsive to people's needs	Choose an item.
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Choose an item.
Capability and culture	Choose an item.
Process and structures	Choose an item.
Measurement	Choose an item.
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
Click here to enter text.	
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	Choose an item.
Click here to enter text.	

REPORT BRIEFING

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

This update report provides information regarding progress in relation to maximising the apprenticeship levy for the Trust during 2017-2018.

Our apprenticeship levy successes during 2017-2018 include committing the levy fund to develop members of staff in a variety of apprenticeship programmes, leading on changing the culture of understanding within CWP regarding apprenticeships in the 'new world', building strong collaborative relationships with other Trusts across the region, understanding national strategies and active participation in regional strategies and groups.

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

The levy was introduced in April 2017 with funds for apprenticeship programmes including either existing staff or new recruits as long as the training meets the approved standard and the employee meets the apprentice eligibility criteria. We supported apprentice programmes to maximise the levy and proposed targeting 3 main apprenticeships: Business and Admin(level 2 and 3), HealthCare Support Worker (level 3) and management qualifications (Level 2, 3 and 6) with Nursing Associates and other clinical roles to follow in phase 2 as future Workforce plans indicate.

Assessment – *analysis and considerations of options and risks*

CWP's levy payment 2017-18 was £450,225. To date we have 40+ staff on apprenticeship programmes (lasting between 1- 4 years) and have committed £488,180. (The year prior to the commencement of the levy we had 10 members of staff undertaking apprenticeship qualifications). We are currently planning our second CWP apprenticeship development day which will be hosted by University of Chester Business School, this is open to anyone within CWP who is currently undertaking an apprenticeship programme. Our Task and Finish group success is as a result of working in partnership with operational services, this group is being reviewed to ensure membership reflects the emerging Care Groups. We hope this will support us with further developing apprenticeships and information regarding apprenticeship programme planning going forward. Expanding apprenticeship programmes has been limited by the range of national programmes available, however this is now extending to a wider range including Trainee Nurse Associates, Advanced Practice and Physician Associate programmes.

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

Continued support for ensuring we maximise the apprenticeship levy for 2018-2019 via the Care Group structure.
People and OD Business Partners to work with the Care Groups to determine workforce priorities for this financial year.

Who/ which group has approved this report for receipt at the above meeting?		Click here to enter text.
Contributing authors:		Anna Beaver
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
Click here to enter text.	Click here to enter text.	Click here to enter text.

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	Summary Report

Apprenticeship Summary Report

May 2018

Summary

Our apprenticeship levy successes during 2017-2018 include committing all of this fund to develop members of staff in a variety of apprenticeship programmes, leading on changing the culture of understanding within CWP regarding apprenticeships in the 'new world', building strong collaborative relationships with other Trusts across the region, active participation in regional strategies and groups and understanding national strategies.

We proposed to commence by targeting 3 main apprenticeships: Business and Admin(level 2 and 3), HealthCare Support Worker (level 3) and management qualifications (Level 2, 3 and 6) with Nursing Associates and other clinical roles to follow in phase 2 as future Workforce plans indicate.

Apprenticeship Programme Applications/Enquiries
Table below indicates current activity for new apprentices and current staff apprenticeship programmes that are in progress or planned.

	West	Central/East	Wirral	Corporate
New Apprentices				
Electrical	1			
Bus/Admin				1
Current Staff				
4 Trainee Nurse Associate	3	1		
Health &Social Care	1	1		
Bus/admin Levels 3 or 4	9	2	2	
Plumbing	1			
Team Leading/Supervisor Level 2 or 3	7	1		
Intermediate Professional Cookery			1	
Operations/Departmental Manager Level 5 (ILM)		2		
Management Degree		1	1	5
MBA	1	3	1	
Data Analyst L4				1
In Planning				
Chartered Management Degree	1	2		
MBA	1	1		1
4 Trainee Nurse Associate (Sept 18)				
Team Leader L3		1		
Business and Admin L3	1			
Health and Social Care L3	1			
Painter/Decorator L3				1
4 per year Starting Well Service				

We have increased our providers which now include, Universities of Chester, Manchester Met and Liverpool John Moores, Wirral Met, Macclesfield and in the near future South Cheshire colleges.

We are currently working with other Trusts across the region for example,

- Trainee Nurse Associates most recent cohort is via the apprenticeship levy with University of Chester
- Possibilities for development and joint commissioning of Advanced Practice Apprenticeship
- We recently joined CWP members of staff who were commencing with University of Chester for the launch of the first ever MBA Apprenticeship programme

CWP's levy payment 2017-18 was £450,225. To date we have 40+ staff on apprenticeship programmes (lasting between 1- 4 years) and have committed the levy funds for 2017-18.

We are currently planning our second CWP apprenticeship development day which will be hosted by EducationCWP and University of Chester Business School and will be held at the Universities' Campus in Handbridge, Chester. The first day was co-delivered by EducationCWP and Wirral Met College and included apprenticeship information (20% off the job training, funding) and bespoke managing your time, planning and implementing change and communicating your learning sessions.

Our Task and Finish group is being review to ensure we reflect Care Groups and membership will be confirmed in the near future. We hope this will further support us with further developing apprenticeships and information regarding apprenticeships programme planning going forward. The slow national implementation of a wide range of both clinical and non-clinical apprenticeship programmes has impacted on CWP's flex in relation to the roles developed. We anticipate that this will improve as more programmes become available.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

AUDIT COMMITTEE – 1 May 2018

CHAIR'S REPORT

The following is a summary of issues discussed and any matters for escalation from the 1 May 2018 meeting of the Audit Committee:

Internal Audit progress update

Final Internal Audit Plan 2018/19
The draft internal audit plan was brought back to this Committee following review by the Operational Board. There were no revisions made, but confirmed that Quality Spot checks would now be considered in quarter 2 across all wards. It was noted that Flexible working/Retirement & Return Policies may be deferred to a later quarter. A review of the Fit and Proper Persons is now starting.

Director of Audit Opinion and Annual Report 2017/18
It was confirmed that overall the standard of assurance is good with good standards of control. There are some areas which may require follow up within the AGS. The Assurance level awarded overall is Substantial.

Three recently completed audits were reviewed by the Audit Committee. These were:

- Payroll / Human Resources (ESR) – Significant Assurance
- Health Rostering Review – Limited Assurance
- Information Governance Review – Significant Assurance

Assurance Framework Review 2017/18 and Well Led Follow-Up Final Assignment Report 2017/18
It was confirmed that The Assurance Framework Review Report in summary confirms that it is fit for purpose and awards greens across the board. A good result was noted overall.

External Audit update
The refresh of the Annual Plan 2017/18 was brought back to the Committee from the January 2018 meeting and an update on the amended content was discussed.

- Local Government Pensions is not material and presents no significant risk. Therefore, this has been removed from section 10
- An update has been made to some of the information in respect of valuation of buildings

Draft Annual Governance Statement (AGS) 2017/18
The Committee agreed that the content of the AGS reflects the reports and assurances provided to the Committee throughout the year.

NHS Provider Licence – Assessment of Compliance
The Committee was advised of areas in respect of the evidence provided by the Trust. The Committee noted the report and approved amendments.

Internal and External Inspections and Regulatory Visits
The Committee was updated on the above and confirmation that the Patient Safety Improvement Report would be brought back to the Audit Committee meeting on a six monthly basis.

Strategic Risk Register and Board Assurance Framework
The Committee reviewed the changes to the risk register and assurance framework.

NHS Code of Governance – Compliance Assurance
The Committee to review the report and forward any comments to David Wood or Suzanne Christopher.

Governance Matters
The Audit Committee noted minutes and / or chair's reports from the Quality Committee and the Operational Board.

Edward Jenner
Chair of Audit Committee

8 May 2018

Mersey Internal Audit Agency

Audit Committee Effectiveness Session

May 2018

Cheshire and Wirral Partnership NHS Foundation Trust

Contents

1. Introduction and background

The effective operation of the Audit Committee is a significant component of the Trust's assurance arrangements. The Trust has previously used the Audit Committee Handbook checklist or alternative survey to self-assess the effectiveness of the Committee. Recognising the opportunity for an annual assessment using a new approach, it was timely to take stock of current Committee operation, its challenges in the future, and how those challenges might be addressed.

2. Overall Approach

The session was led by Anne-Marie Harrop, Assistant Director from MIAA and was structured as follows:

i. **Current performance and impact**: gain agreement through discussion on what the Committee currently does well, where it makes an impact and where it could do things differently.

ii. **Principles**: gain consensus on the principles for delivery of the Committee duties (as per the Terms of Reference) and consider wider aspects of interaction within the organisation.

iii. **Build a development plan:** setting out the challenges as a prompt for how we get from our current position to where we want to be.

3. The Facilitated Session Discussions and Outcomes

In order to understand views on current activity a process was used to evaluate the performance of the committee in respect of its key duties. This involved consideration of impact along with how well each duty was being performed. The participants were asked to consider each element and their conclusions as set out in Figure 1 below:

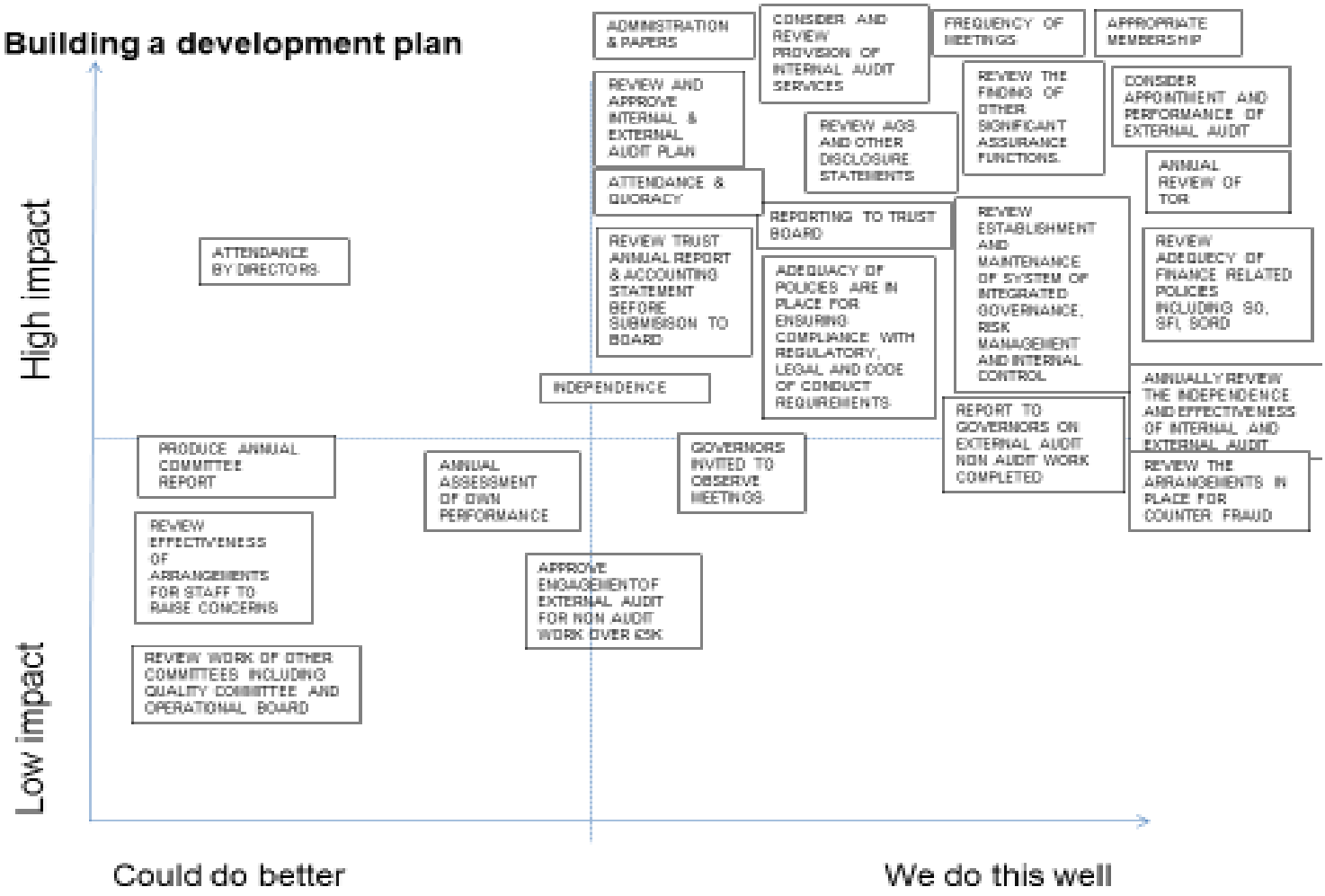


Figure 1: Self-Assessment against TOR

Essentially, the figure above can be helpful in making sure the Committee continues to focus upon the duties it is doing well that have a high impact; stops doing things that add little value; and considers how to improve performance for duties that are not being done that well but could make a high impact if done better.

Looking to the top right hand corner of Figure1 reveals that the committee delivers high impact core duties and responsibilities particularly in respect of attendance and quoracy, review of the key financial statements and accounts, and recommendations to Board, arrangements in place for internal and external audit and counter fraud and review of the assurance framework, risk management and internal control assurances.

Looking to the top left hand corner the committee agreed that there is room for improvement in the attendance of Directors at the committee and there has been a recent agreement that Lead Directors will attend whenever the Trust receives a Limited Assurance review. Other areas for development included interactions and assurances from other committees and the duty for the committee in seeking assurance over "Raising Concerns" systems and processes.

Summarised below are some of the discussions from the facilitated session:

- **Membership, Authority and Attendance**. Discussions confirmed that there is now strong membership, and members also welcomed the breadth of different skills within membership. Attendance is good and the Committee is confident with the level of authority and autonomy provided.

- **Understanding of the role of the Audit Committee.** Members agreed that the role of the Audit Committee was well understood within the Trust. The feedback to Trust Board through the Audit Chair has helped in understanding the business of the committee.

- **Frequency of Meetings.** Members confirmed that the frequency of meetings met the requirements of the Terms of Reference (TOR), and that this was adequate.

- **Quoracy.** All agreed that this improved with the requirement of 2 voting members to complete quoracy.

- **Independence.** Independence is achieved through the lay membership and all members agreed that there were no issues with independence.

- **Administration and Papers.** Discussions confirmed that papers are received in a timely manner and committee meetings are scheduled throughout the year allowing Non-Executive Director members to plan attendance.

- **Reporting to Trust Board.** Reporting to Trust Board is via the Chairs report and a brief commentary from the Audit Committee Chair. Members agreed that the Audit Committee is recognised by the Trust Board, Senior Managers and Governors.

- **Review of Annual Governance Statement and Risk and Disclosure Statements.** Members agreed this was done well.
- **Review adequacy of Policies and Procedures for ensuring compliance with regulatory, legal and code of conduct compliance.** All agreed that key policies were available to all members and confirmed that they were aware of the policies in place. Assurances in respect of compliance are received via the work of the auditors and other internal assurance reports.

- **Review of Internal and External Audit.** Members confirmed that all members recognised the duties of the internal and external auditors and the effectiveness of the internal and external audit processes was annually reviewed. Both internal and external audit confirmed that there was a low risk of 'cosy relationships' due to the regular changes in auditors completing reviews at the Trust and that independence was a key professional and ethical duty for both auditors. All members agreed that reports were well written and easy to understand and there are opportunities at each Audit Committee meeting to review and challenge audit findings.

- **Counter Fraud Arrangements.** Members agreed that there was adequate counter fraud arrangements, there is the opportunity to challenge and ask questions and all members are aware of the counter fraud inductions, briefings and investigation work ongoing at the Trust.

4. Conclusion and Way Forward

The Audit Committee recognises the important role it undertakes as part of the overall governance framework at the Trust. The request to undertake a self-assessment review reflects the Committee's attentiveness to its responsibilities and its understanding that the broadening remit of the Committee within a changing governance structure requires ongoing development.

The self-assessment concludes that the Audit Committee is effectively delivering its core duties. There were some areas for enhancement which have been summarised in the development plan at Appendix 1 below. The Committee also plan to review their terms of reference in line with the new Audit Committee Handbook 2018.

Appendix 1 - Development Plan

Actions	(Date)
A1. Attendance by Directors: Where a limited assurance opinion is received the lead Director should attend the Audit Committee to provide the Trust's response in terms of taking forward the findings and recommendations agreed.	In Place May 2018
A2. Review work of other committees: Whilst not wanting to duplicate there needs to be mechanisms for receiving assurance from the other Committees. There are established arrangements with the Quality Committee but assurances in respect of OD/Workforce and Operational Board remain a gap.	By Nov 2018
A3. Review effectiveness of arrangements for staff to raise concerns: This is a duty for the Audit Committee in line with the Audit Committee Handbook but is currently routed through the Board and Quality Committee.	By Nov 2018
A4. Audit Committee Annual Report: In line with good practice, the Audit Committee needs to produce an annual report, incorporating its self-assessment and report to the Trust Board.	For Year end 2018/19
A5. Audit Committee Meeting Protocol: In line with good practice, the Audit Committee members alone will have a closed session with the Trust's audit partners prior to the commencement of each open Audit Committee meeting.	From 03/07/2018

Facilitated Session Participants

Name	Title
Edward Jenner	Non-Executive Director (Audit Chair)
Rebecca Burke-Sharples	Non-Executive Director
Andrea Campbell	Non-Executive Director

Key Contact

Name	Title
Anne-marie Harrop	Assistant Director, MIAA

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

CHAIR'S REPORT –
QUALITY COMMITTEE
9 MAY 2018

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

- **Annual review of effectiveness – including proposal to develop a quality assurance dashboard**
  The Quality Committee has undertaken an in-depth review of its effectiveness throughout 2017/18. This has resulted in an update to the terms of reference for 2017/18, which includes receipt of assurance on organisational quality of care, via a quality assurance dashboard, to provide a framework of assurance and understanding in relation to measures reported to the Quality Committee, to allow members to direct their focus on those measures where there is early warning of the need for improvement indicated. A real worked example of the prone position restraint measure as it would feature in the quality assurance dashboard will be presented at the next meeting of the Quality Committee. This assurance approach has been referred to and discussed by the Operational Board also at its meeting on 16 May 2018; together, a streamlined approach will strengthen the alignment of the Trust's integrated governance framework to the NHS Improvement operating model and Single Oversight Framework.
  The Board is asked endorse the approval of the Quality Committee's terms of reference for 2018/19.

- **Substance misuse service deaths analysis**
  The Quality Committee received a report that reviewed 14 drug and alcohol related deaths of people who had accessed Cheshire East substance misuse services in the 2016/17 financial year. The review highlighted an overall positive picture of the service when using national comparators and including the positive findings from the CQC inspection of the service. The report highlighted whole systems risk, including variation in the number of drug and alcohol related deaths across the different CCGs.
  The Quality Committee has requested that this Chair's Report highlight the issue of whole system risks to encourage debate amongst commissioners of substance misuse services.

- **Thorn Heys – assurance of safe and effective service delivery**
  An initial verbal update was provided to the Quality Committee from the service. A data set has been developed to track assurance of safe and effective service delivery at Thorn Heys now that the service has reopened. The performance against the measures in the data set will be monitored weekly by the Executive team and will also be monitored by Operational Board.
  The Operational Board will escalate any issues of a qualitative nature, by exception, to the Quality Committee, including providing a recommendation of when weekly monitoring can be de-escalated.

- **Quality Improvement report – Edition 3 2017/18**
  The Board of Directors is receiving Edition 3 of the Quality Improvement report at today's meeting. This report is a significant contributor to the overall annual Quality Account, which is a component of CWP's annual report at today's meeting. Overall CWP is performing well in relation to the mandated areas of quality that it is required to report on, including significant improvements made against its own quality improvement priorities.
  The Board is asked to endorse the Quality Account (as part of the annual report) at today's meeting.

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

QUALITY COMMITTEE

Terms of Reference

1. Constitution

The Board of Directors hereby resolves to establish a committee to be known as the Quality Committee.

2. Duties

The Quality Committee is responsible for receiving assurance on organisational quality governance and quality improvement and ensuring that that the strategic priorities for quality improvement are identified, implemented and monitored. The Quality Committee has delegated responsibility from the Board of Directors for monitoring strategic risks within the organisation. The Quality Committee's duties can be categorised as:

a) Receiving assurance, via assurance reports and via a quality assurance dashboard, on organisational quality of care, aligned to the national "Single Oversight Framework", across the domains of safe, effective, caring and responsive services.
b) Identifying the strategic priorities in relation to quality improvement as per the Trust's Quality Improvement strategy, including those required on an annual basis as part of the regulatory Quality Account, and oversight of the implementation of these strategic priorities.
c) Receiving assurance on the clinical and quality impact of the delivery of:
   i. the key priority projects identified as part of the CWP Forward View/ Trust strategy (routine reporting of activity);
   ii. all current services (exception reporting of real/ near-real time issues); and
   iii. financial decisions within the Trust (exception reporting from the Efficiency Strategy Group).
d) Review of the Trust's Quality Account and recommending its approval to the Board of Directors.
e) Oversight of the quality schedules (including CQUINs) of the Trust's contracts with commissioners, including ensuring that any escalated issues are addressed or referred to the Board of Directors as appropriate.
f) Ensuring that the patient safety agenda is implemented throughout the Trust. This includes:
   - Updates from patient safety initiatives, including thematic reports as an output of implementing the Trust's safety management system.
   - Oversight of serious incident management processes, including response to Regulation 28 reports.
   - Oversight of complaints and claims processes.
   - Monitoring of the Trust's risk register processes.
   - Receipt of assurance in relation to whether the Trust is learning from past harm and integrating best practice, through receipt of the Learning from Experience report and Quality Improvement report.
g) Ensuring that the clinical effectiveness agenda is implemented throughout the Trust. This includes:
   - Updates from clinical effectiveness initiatives.
   - Through service-level outcome reporting, receipt of assurance in relation to whether the Trust adheres to best practice and evidence based best practice (NICE guidance including quality standards, Royal College standards etc.).
   - Through service-level outcome reporting, monitoring the processes around outcome/ impact/ variance measurement against care pathways.
h) Ensuring that the patient and carer experience agenda is implemented throughout the Trust. This includes:

- Updates from the Patient & Carer Experience Sub Committee.
- Oversight of PALS processes.
- Receipt of assurance in relation to whether the Trust is learning from patient and carer experience initiatives, through receipt of the Learning from Experience report and Quality Improvement report.
- Receipt of the annual CQC community mental health survey analysis.

i) Receiving, monitoring and seeking assurance of (including through improvement plans) service-level quality performance as presented in exceptions from the quality assurance dashboard.
j) Monitoring and reporting on the Trust's delivery of integrated governance, exercising oversight of the systems and escalating any matters of concern as appropriate.
k) Seeking assurances that the Trust complies with external regulations and standards of quality and governance, including Care Quality Commission registration requirements.
l) Receiving reports from the Board of Directors and Operational Board for information, context, assurance and/ or action as appropriate.
m) Approving the terms of reference and membership of its reporting sub committees and overseeing the work of those sub committees, receiving reports from them for consideration and action as necessary and routinely receiving the Chair's reports of their meetings.
n) Receiving and reviewing the corporate strategic risks (including those referred from other committees which are concerned with quality matters) allocated to the Quality Committee, monitoring progress made in mitigating those risks, identifying any areas where additional assurance is required and escalating to the Board of Directors as agreed by Quality Committee members.

3. Membership

Membership will be appointed by the Board of Directors and will consist of the following:

i. Non Executive Director (Chair)
ii. Two additional Non Executive Directors (one of whom shall be Vice Chair)
iii. Chief Executive (Accountable Officer)
iv. Medical Director (Quality)
v. Medical Director (Effectiveness and Medical Staffing)
vi. Director of Finance
vii. Director of Nursing, Therapies & Patient Partnership
viii. *Director of Operations
ix. *Director of People & Organisational Development
x. [+]Associate Director of Nursing & Therapies (Mental Health)
xi. [+]Associate Director of Nursing & Therapies (Physical Health)/ Director of Infection Prevention and Control (DIPC)
xii. **Strategic Clinical Directors
xiii. **Associate Directors of Operations
xiv. Associate Director of Safe Services
xv. Associate Director of Effective Services
xvi. Associate Director of Patient & Carer Experience
xvii. [+]Head of Clinical Governance
xviii. [+]Head of Quality Assurance & Improvement
xix. [+]Clinical Champion for Quality Improvement

*or their nominated representative who will be sufficiently senior and have the authority to make decisions
** or their nominated representative who will be sufficiently senior and have the authority to make decisions – quoracy requires at least one representative of each Care Group from the membership listed at xii or xiii (sufficient seniority for xii includes Speciality or Place Based Clinical Directors; sufficient seniority for xiii includes Head of Operations)

[+]responsive attendance based on agenda

(otherwise, core members)

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

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

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

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

a. Quorum
A quorum shall be 50% of core membership including the Chair or Vice Chair, two Executive Directors, two Non Executive Directors (which can include the Chair) and a representative from each CWP Care Group.

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

c. Attendance by members
Core members identified above will be required to attend a minimum of 50% of all meetings in-year, this is in addition to the requirement to ensure that a nominated deputy attends.

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

4. Accountability and reporting arrangements

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

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

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

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

5. Frequency

Meetings shall be held every two months, with at least 5 meetings per year, and additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.

6. Authority

The Quality Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Quality Committee.

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

7. Monitoring effectiveness

The 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 a member of the corporate affairs/ board support team, whose duties in this respect will include:

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

9. Review

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

Date reviewed by Committee	9 May 2018
Date approved by Board of Directors	30 May 2018 (pending as at 23 May 2018)
Review date	As per 2019/20 business cycle