Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting of the Foundation Trust Board of Directors

Wednesday 29th January 2014 at 1.00pm

Boardroom, Redesmere, Countess of Chester Health Park

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
13/14/86	Apologies for absence	Receive apologies	Verbal	Chair	1 min (1300)
13/14/87	Declarations of interest	Identify and avoid conflicts of interest	Verbal	Chair	1 min (1301)
13/14/88	Minutes of the previous meeting held 27th November 2013	Confirm as an accurate record the minutes of the previous meetings	Written minutes	Chair	3 mins (1302)
13/14/89	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	5 mins (1305)
13/14/90	Board Meeting Business Cycle 2013/14	Confirm that agenda items provide assurance that the Board is undertaking its duties	Written Report	Chair	2 mins (1310)
13/14/91	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	5 mins (1312)
13/14/92	Chief Executive's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	5 mins (1317)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
Assurance: Quality/ Effectiveness/ Experience/ Safety					
13/14/93	Q3 Quality Report	Receive an update on progress with implementation of Quality priorities	Written Report	Medical Director	10mins (1322)
13/14/94	Learning from Experience Report	To receive the second trimester report	Written Report	Director of Nursing, Therapies and Patient Partnership	15mins (1332)
13/14/95	Community Services Improvement Programme- 6 month evaluation	To feedback from local evaluation	Written Report	Director of Operations	10 mins (1347)
13/14/96	Board Assurance Framework and Risk Register	To note and approve current Board Assurance Framework and Risk Register	Written Report	Medical Director	10mins (1357)
13/14/97	Continuous improvement plans for the delivery of patient safety and effective care	To review proposed next steps	Written Report	Medical Director	10mins (1407)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
Strategy and Planning					
13/14/98	NHS England Planning Guidance, changes to the Monitor strategic planning process and development of Monitor two year Operational Plan	To update on the revised strategic planning process	Written Report	Deputy Director of Finance	15 mins (1417
13/14/199	CWP Clinical Strategies	To approve the locality clinical strategies and actions plans	Written Report	Director of Operations/ Service Directors	20 mins (1432)
Performance					
13/14/100	Corporate Performance Report - December 2013	Review Trust performance	Written Report	Deputy Director of Finance	10 mins (1452)
13/14/101	Monitor Q3 submission and Assessment of Quality Governance	To approve the Q3 submission to Monitor	Written Report	Deputy Director of Finance	10 mins (1502)
Assurance: Governance					
13/14/102	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	5 mins (1512)
13/14/103	Any other business	Consider any urgent items of other business	Verbal or written	Chair/ All	5 mins (1517)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
13/14/104	Review of meeting	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair/All	5 mins (1522)
13/14/105	Date, time and place of next meeting: Wednesday 26th March, 1.00pm at Romero Centre, Macclesfield	Confirm arrangements for next meeting	Verbal	Chair	2 mins (1527)

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Minutes of the Board of Directors Meeting
Wednesday 27th November
Redesmere, Countess of Chester Health Park, Chester,
commencing at 1.00pm

PRESENT	David Eva, Chair Sheena Cumiskey, Chief Executive Dr Faouzi Alam, Medical Director Effectiveness & Medical Workforce Avril Devaney, Director of Nursing, Therapies & Patient Partnership Fiona Clark, Non-Executive Director Lucy Crumplin, Non-Executive Director Ron Howarth, Non-Executive Director Mike Maier, Deputy Chair and Non-Executive Director Stephen McAndrew, Non-Executive Director and Senior Independent Director Dr Anushta Sivananthan, Medical Director Compliance, Quality & Assurance Andy Styring, Director of Operations Tim Welch, Director of Finance & Deputy Chief Executive
IN ATTENDANCE	Louise Hulme, Head of Corporate Affairs (inc. CoSec) Maria Nelligan, Associate Director of Nursing (for item 13/14/73) Helen Pilley, Infection, Prevention and Control Nurse (for item 13/14/73) Bill Woods, Clinical Service Manager (for item 13/14/78) Rosalind Davison, Service User/Carer Governor Phil Hough- Involvement Representative Simon Hough - Involvement Representative
APOLOGIES	None

	MINUTES	**ACTION**
13/14/64	**WELCOMES AND APOLOGIES FOR ABSENCE** The Chair welcomed everyone to the meeting. The meeting was quorate.	
13/14/65	**DECLARATIONS OF INTEREST** There were no interests declared.	
13/14/66	**BOARD MINUTES- MEETING OF 24TH JULY 2013** The minutes of the meeting held on 25th September were **approved** as a correct record.	
13/14/67	**MATTERS ARISING AND ACTION POINTS** Item 13/14/44 - it was reported that there is no increased risk in implementing the policy. Item closed	

	Item 13/14/48 - This item is on the agenda. Item closed Item 13/14/49 - It was confirmed that the PLACE assessment results are published on the NHS information website. Item closed. Item 13/14/51 - It was confirmed that staff feedback is being reported into locality groups and staff-side meetings. There are also locality focus groups and other opportunities locally to feed into the overall evaluation. This is also covered by the CPNC. Item closed. Item 13/14/51 - It was confirmed that S136 cases are being directed to A and E units. Item closed. Item 13/14/52 - This is being progressed. Item 13/14/53 - An equality and diversity update has been developed. This will be circulated to Board members. Item closed Item 13/14/56 - Confirmation was received that this had been externally validated by the CSU. Item closed	
13/14/68	**BOARD MEETING BUSINESS CYCLE 2013-14** The business cycle was noted.	
13/14/69	**CHAIR'S ANNOUNCEMENTS** The Chair informed the meeting that; **National Dementia Care Award** Two occupational therapists from Springview Hospital, Wirral won with the first ever Ken Holt Memorial Award at the national Dementia Care Awards held in Nottingham. Both Rachael O'Sullivan and Susie Walsh from Meadowbank Ward, were recognised for integrating 'life story' reminiscence work into day to day clinical practice. **NHS North West Leadership Recognition Awards** CWP celebrated a double award win at the NHS North West Leadership Recognition Awards, held in Manchester. Jane Newcombe, clinical service manager for CWP Wirral's drug and alcohol service picked up the NHS Partnership/System Leader of the Year Award and Anushta Sivananthan, CWP consultant psychiatrist and medical director was recognised in the NHS Quality Champion/Innovator of the Year category. **Annual Members' Meeting 2013** The CWP Annual Members' Meeting took place at the Floral Pavilion in New Brighton on Monday 18th November. Over 100 Trust members joined CWP's Board of Directors and Council of Governors for a morning of reflection and celebration of the last year. Following the formal Annual Members' Meeting there was an audience Q&A session with key staff, followed by an awards ceremony to reward staff and volunteers for their efforts over the year.	

	International Leadership Exchange CWP has been selected by the Department of Health to host England's Recovery Theme as part of the annual International Leadership Exchange organised by the International Initiative for Mental Health Leadership (IIMHL). The visit will take place in June 2014. More information can be found on www.cwp.nhs.uk. **National Clinical Director for Mental Health commends CWP** NHS England's leading director for mental health, Dr Geraldine Strathdee, commended CWP for its 'can do' ethos at the recent internal Best Practice event. Dr Strathdee, said: "CWP has an obvious passion for quality, recovery focussed patient care. In light of recent reports such as the Keogh Review, where the focus is on driving excellence in care; having a culture that nurtures innovation is very special. The CWP ethos is that of a supportive family, with a positive can do attitude."	
13/14/70	**CHIEF EXECUTIVE'S ANNOUNCEMENTS** Sheena Cumiskey informed the Board that recently the government had announced their intention to mandate the publication of daily ward staffing levels. With reference to mental health wards, this is work in progress. Within CWP, work is on-going to understand ward staffing levels requirements to ensure all needs are met. Sheena Cumiskey updated on the on-going work to look at urgent care/ emergency care work. This is happening differently across the Trust footprint. Work is on-going in the West locality to look at community pathways to support lesser dependence on A and E departments. In the other locality areas, plans for urgent care include mental health and ensuring that there are sufficient crisis response services.	
13/14/71	**SECURITY ANNUAL REPORT 2012-13** Andy Styring highlighted the key points to the report. These included: • incidents of violence towards staff has reduced • a 50 % reduction in the number of category B incidents • a 43% reduction in injuries from incidents of restraint • an increase in the number of MVA trained staff and an overall improved attendance at training • an increase in police recorded incidents mainly due to absconsions Avril Devaney reported that the Trust has bid for research funding around 'No Force First' and have adopted these principles in practice. It was also reported that when it is deemed that a service user may require a physical intervention sometime during their care, they are given the opportunity to discuss this first. This can also be via pictorial means dependent on the service user's needs. Dr Faouzi Alam queried the learning from other Trusts that have adopted a no restraint policy. Avril Devaney confirmed that CWP are keeping close to Merseycare on this issue to see the impact of their policy.	

	The Board the **resolved** to receive and **approve** the report.	
(13/14/80)	**JOINT STRATEGIC AND OPERATIONAL PLANNING IN THE NHS** The Chair requested that this item be taken earlier than scheduled due to the Director of Finance needing to leave the meeting early. Tim Welch reported that a letter had been received from various bodies including Monitor, NHS England and the Local Government Association setting out their expectations for a joint planning framework. The key objectives for this are to improve integration and sustainability. There is to be a unit approach to planning which will be further detailed shortly. The major implication of the new approach to planning is the revision to the timescales for production of strategic plans which has been brought forward. The Board will receive draft projections in January 2014 to enable the full plan sign off by the end of March 2014. The Board the **resolved** to **note** the report	
(13/14/81)	**CORPORATE PERFORMANCE REPORT - OCTOBER 2013** The Chair requested that this item be taken earlier than scheduled due to the Director of Finance needing to leave the meeting early. Tim Welch introduced the Corporate Performance Report and requested Board members raise any queries or items of interest on the report. The Board the **resolved** to **approve** the report.	
13/14/72	**UPDATE ON THE IMPLEMENTATION OF THE FRANCIS INQUIRIES 5 THEMES** Dr Anushta Sivananthan updated on the progress of the 5 themed areas following the work undertaken in the Trust to map the 290 recommendations from the Francis inquiries. This work also encompasses learning from the recent Keogh and Berwick reviews. Dr Anushta Sivananthan also reported on a recent audit undertaken by PriceWaterhouse Coopers on the quality dashboard to provide additional assurance. The full report on this audit will be received shortly. The Board the **resolved** to **note** the report.	
13/14/73	**INFECTION PREVENTION AND CONTROL QUARTER 2 REPORT** The Chair introduced Maria Nelligan and Helen Pilley to the meeting. Helen Pilley drew the Board's attention to the key areas of the report which included: • on-going work with community mental health teams providing hygiene training	

	• the 2013 flu campaign and raising the profile of the campaign Fiona Clark queried the increasing rates of e-coli identified in the report. Helen Pilley advised that this is a national issue being reviewed by NHS England and that patients tend to be colonised by e-coli as oppose to being infected. Maria Nelligan advised that these cases are identified from lab surveillance and could be related to GP practices and nursing homes as examples. David Eva queried the take up of the flu vaccination across the Trust. Maria Nelligan advised that the numbers have been lower than expected. The target is 70% compliance. Maria Nelligan commended the IPC team for their flexibility in meeting the needs of the vaccination programme. There are also a reduced number of vaccinators this year and the length of the campaign also needs to be extended. The Board the **resolved** to receive and **note** the report.	
13/14/74	**CQC INSPECTION REPORT: EASTWAY** Andy Styring reported that following the implementation of the Eastway action plan, the unit was re-inspected on the 27th September 2013 by the CQC. Following this re-inspection, the unit was deemed to be fully compliant in respect of all standards. Subsequently, the Trust has achieved a green risk rating from Monitor. The report has been published on the CQC website. The Board the **resolved** to **note** the report.	
13/14/75	**UPDATE ON LEARNING DISABILITY SERVICE REDESIGN** Andy Styring presented the update to the Board. As a result of the work undertaken by the task and finish group to look at pathways, there has been a reduced reliance on in-patient beds demonstrating the effectiveness of community provision. Overall length of stay for those requiring in-patient provision has also reduced. Andy Styring reminded the Board that the Trust receives a block contract for learning disability services. Work is needed with the CCGs to ensure comprehensive services are commissioned in this area going forward. Andy Styring advised that the learning disability service now has a full complement of medical staff. Overall regarding staffing, 203 staff were affected by the re-design and the recruitment process is due to conclude in December 2013. The result has been a change in the overall staff mix across the service. Andy Styring informed that the development of the clinical strategies has accelerated the timeframe for learning disability services being integrated into localities. This will now happen from January 2014.	

	Andy Styring also advised that presentations had been given to the three health and well-being scrutiny committees recently to update them on the re-design. It was agreed that a further presentations will be given in six months to provide an additional update. Ron Howarth queried why the capital expenditure scheme to upgrade Eastway had been delayed. Andy Styring advised that this is due to a wider strategic look at in-patient services across the pathways linked to the learning from the Winterbourne View inquiry. New pathway developments mean that there will be a decrease in admissions so there is need to consider the future use of Eastway in this context. Andy Styring also advised that the Trust needs to better articulate the care requirements of those with very complex needs rather than just looking at bed numbers. Tim Welch commented that this information needs to be shared with commissioners. Fiona Clark advised that there is need to keep close to developments with private sector providers in this area. The Board the **resolved** to **approve** the report.	
13/14/76	**REVIEW OF INPATIENT LEARNING DISABILITY SERVICES AT CWP BY CHESHIRE AND WIRRAL AREA TEAM AND ACTIO PLAN** Sheena Cumiskey advised the Board that the report by the Local Area Team had recently been concluded. All actions for the Trust have been completed. The Trust has been invited to attend a follow up meeting with the Local Area Team next week to discuss and evidence progress. Much of this has been demonstrated by the previous two items discussed by the Board. The Board the **resolved** to **note** the report and action the report requirements.	
13/14/77	**QUARTER 2 QUALITY REPORT** Dr Anushta Sivananthan introduced the report and outlined the key headlines. These included: • the achievement of the all the Q2 quality priority milestones • the outcomes from the Wirral healthy lifestyle group • the opening of further recovery colleges in localities • the My Life, My Say event which was well attended by service users and carers • 515 compliments received during the quarter • All CQUIN schemes are on track David Eva queried the longevity of Dragons Den CQUIN schemes. Dr Anushta Sivananthan reported that these projects do come to an end but efforts are made to try and build them into core services as part of the clinical strategy development. Sheena Cumiskey commented on the importance of evaluating the Dragons Den schemes and promoting the idea of innovation and using	

	schemes to test hypotheses and then embed into practice. The Board the **resolved** to **approve** the report. Tim Welch left the meeting.	
13/14/78	**NICOTINE MANAGEMENT POLICY IMPLEMENTATION UPDATE** The Chair welcomed Bill Woods, Simon Hough and Phil Hough to the meeting. Avril Devaney introduced the item and commented on the recent publication of NICE guidance around no smoking on NHS sites. Avril Devaney reported that a number of local conferences had been held in the autumn to progress the policy implementation. Avril Devaney advised that a Trust wide steering group involving clinical and corporate representatives has been developed to support with improving policy awareness. The steering group are also looking at the practical issues in localities and staff guidance on what to do if patients or carers bring cigarettes onto wards. Avril Devaney reported that work is ongoing to develop distraction activities on wards. This has also included improvements to external spaces and exercise equipment. Pharmacy support is also being provided to look at the range of NRT products and access to these. Simon Hough commented that initially he was against the policy implementation; however, he has now given up smoking aided by his voluntary work on wards. Simon Hough commented that positive peer support can encourage smoking cessation amongst patients and commented on his support for the policy. Phil Hough commented that the policy has encouraged a focus on patient's dependency on nicotine. It also has supported staff to take a different approach to supporting patients to give up smoking. Avril Devaney advised that the implementation of the policy is on track to take effect from February 2014. The team are aware that this may not be an easy process but work is ongoing to try and pre-empt any issues and to try to find solutions. Mike Maier commended the work and queried whether people wishing to give up smoking could have access to e-cigarettes. Avril Devaney reported that people would not be offered e-cigarettes as these are not licenced and research shows that they are not always safe. The policy may need to be re-visited in future should these products become licenced. Dr Anushta Sivananthan advised on the need for service users who are prescribed clozapine to be flagged as there is a patient safety issue regarding absorption of the drug dependent on nicotine levels in the blood. Ron Howarth queried how the policy would be monitored. Avril Devaney	

	advised that the Trust will be working closely with the Countess of Chester Hospital to ensure that policies are aligned. The Director of Public Health is also supportive of the policy. The Chair invited Rosalind Davison, service user/ carer governor to ask a question. Rosalind Davison queried the Trust's position should the service user or carer wish to smoke and makes an informed decision to do so as set out in the NICE guidance. Avril Devaney advised that this NICE guidance is now superseded by the one issued recently and that the guidance now advises that mental health trusts should be smoke free. Rosalind Davison commented that this will mean service users and carers have to leave the hospital site to smoke which may be unsafe. Avril Devaney commented that this has not happened at this stage of the policy implementation. Fiona Clark queried the support for service users on discharge. Avril Devaney advised that the policy focuses on in-patients at the moment however this will be extended to community services in future. NRT will be provided prior to discharge and support will continue from community services to maintain the cessation. Lucy Crumplin commented on the support to enable staff to stop smoking and the possibility of using incentives for this. Avril Devaney commented on the Trust's commitment to support staff to stop smoking. The Board the **resolved** to **note** and **approve** the report. Dr Faouzi Alam left the meeting.	
13/14/79	**2013 NHS COMMUNITY MENTAL HEALTH SERVICE USER CARER SURVEY** Avril Devaney informed the Board of the recent NHS community mental health service user/ carer survey. The survey had been undertaken during the implementation of the community services implementation programme (CSIP) so a slight decrease in perception of services and been anticipated. The results are being fed into the CSIP evaluation and action plan. Sheena Cumiskey informed the Board of the need to supplement this information with more 'real time' information to improve understanding of these issues. The Board the **resolved** to **note** the report.	
13/14/82	**REVIEW OF RISK IMPACTS OF ITEMS DISCUSSED** There were no further risk areas identified.	
13/14/83	**ANY OTHER BUSINESS** There were no items of other business raised.	

13/14/84	**REVIEW OF MEETING** Board members were asked to complete the short on-line survey regarding meeting effectiveness.	
13/14/85	**DATE, TIME AND PLACE OF NEXT MEETING** Wednesday 29th January 2014, 1.00pm, Board Room, Redesmere, Countess of Chester Health Park.	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Action points from Board of Directors Meetings
29th January 2014

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
~~29.5.13~~	~~13/14/02~~	~~**Declarations of Interest** Grahame Owen informed the Board that his term as a lay member of the Nursing and Midwifery Council has expired, therefore this should be removed from the Non-Executive Director register of interests. LH to action this accordingly.~~	~~June~~	~~LH~~	~~Declaration removed from Register of Directors Interests~~	~~Completed/ Closed~~
24.7.13		**No actions arising**				
~~25.9.13~~	~~13/14/44~~	~~**Health and Safety (including Fire) Annual Report 12/13** With reference to the fire risks set out on page 11 of the report and the references to smoking in en-suite bathrooms, are there additional risks regarding the nicotine policy that should be considered here. Andy Styring to clarify this with Avril Devaney~~	~~October 2013~~	~~AS/AD~~	~~No further risks reported~~	~~Completed/ Closed~~

25.9.13	13/14/44	**Health and Safety (including Fire) Annual Report 12/13** With reference to the future priorities set out on p. 13 indicating an increase in assessments. This is a significant uplift in work, are there sufficient resources in the department to undertake this. Andy Styring to confirm this with John Loughlin.	October 2013	AS/JL	No further risks reported	Completed/ Closed
25.9.13	13/14/45	**Keogh Report: Review into the Quality of Care and Treatment provided by 14 hospital Trusts in England** Quality Committee to specifically consider Keogh ambition around data quality and Board's using data to aid improvement and what more we should be doing on this issue	November 2013	AS/FC	As below	Completed/ Closed
25.9.13	13/14/45	**Keogh Report: Review into the Quality of Care and Treatment provided by 14 hospital Trusts in England** Update report on progress/ learning from Keogh report to come to January 2014 Board.	January 2014	AS	November Board received further update on learning from Francis/ Berwick and Keogh. Further progress report scheduled for March 2014.	Completed/ Closed

25.9.13	13/14/48	**Review of Inpatient Learning Disability at CWP by Cheshire, Warrington and Wirral Area Team and action plan** Final report to be rescheduled once embargo is lifted.	October/ November 2013	SC/LH	Report received by November Board	Completed/ Closed
25.9.13	13/14/49	**CWP results: Patient Led Assessments of the Care Environment (PLACE)** Andy Styring to confirm whether the individual results of the PLACE surveys are published nationally.	ASAP	AS	Confirmation received	Completed/ Closed
25.9.13	13/14/51	**Community Mental Health Team redesign Review of quality impact following implementation (May - July 2013)** Lucy Crumplin queried how the redesign impact on staff was being reported. Sheena Cumiskey/ Andy Styring to confirm the methods in place to look at monitoring staff impact	October 2013	AS/SC		Completed/ Closed

25.9.13	13/14/51	**Community Mental Health Team redesign Review of quality impact following implementation (May - July 2013)** Andy Styring to clarify where patients on s.136 are being redirected to if they are not being directed to A and E units.	October 2013	AS	Confirmation received	Completed/ Closed
25.9.13	13/14/52	**Learning from Experience Report - Executive Summary and Recommendations** Quality Committee to look at bench-marking around Cat E incidents and the learning from the near misses and what may have happened and to ensure that overall high rates of reporting are not masking the Trust having a concerning number of incidents.	November 2013	FC/AS		
25.9.13	13/14/53	**Update on Equality and Diversity Plan /Objectives** The update report is not clear on whether the Trust is meeting its legal obligations around The Equality Act 2010. LH to ascertain from Trust E&D lead that this is the case	October 2013	LH	Statement provided to Board from E&D lead	Completed/ Closed

25.9.13	13/14/54	**Research Annual Report 2012/13** It was noted that a number of embedded documents in the report where not in the PDF document. LH to advise report authors that only essential documents are embedded in Board reports	On- going	LH		Completed/ Closed
25.9.13	13/14/56	**CWP Major Incident Plan** Andy Styring to look into external validation of the Major Incident Plan for additional assurance	October 2013	AS	External validation confirmed	Completed/ Closed
25.9.13	13/14/61	**Governor query** Avril Devaney to provide information on governor involvement in the implementation of the nicotine policy.	ASAP	AD	Information provided	Completed/ Closed
27.11.2013		**No actions arising**				

Cheshire and Wirral Partnership NHS Foundation Trust

Board of Directors meeting Business Cycle 2013/14

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

No:	Agenda Item	Executive Lead	25/04/2013 - Seminar	29-May-13	26/06/2013 Seminar	24-Jul-13	25-Sep-13	30/10/2013 Seminar	27-Nov-13	18/12/2013 Seminar	29-Jan-14	26/02/2014 Seminar
1	Chair's announcements	Chair		√		√	√		√		√	
2	Chief Executive announcements	Chief Executive		√		√	√		√		√	
	Matters for Discussion /Board Action											
	Assurance Quality / Safety											
3	Receive Quarterly Infection Prevention Control Reports	Director of Infection Prevention and Control		Qtr 4 10/11		Qtr 1			Qtr 2		Qtr 3	
4	Director of Infection Prevention and Control Annual Report 2013/14 inc PEAT	Director of Infection Prevention and Control				√						
5	Receive Annual Mental Health Act Statement and CQC MHA Annual Report	Medical Director Compliance Quality and Regulation										
6	Safeguarding Children Annual Report 2013/14	Director of Nursing, Therapies and Patient Partnership				√						
7	Safeguarding Adults Annual Report 2013/14	Director of Nursing, Therapies and Patient Partnership					√					
8	Accountable Officer Annual Report inc. Medicines Management 2013/14	Medical Director Compliance Quality and Regulation				√					√	
9	Health and Safety Annual Report and Fire 2013/14 link certification	Director of Nursing, Therapies and Patient Partnership					√					
10	Receive Appraisal Annual Report	Medical Director of Effectiveness and Medical Workforce				√						
11	Implementation of Nicotine policy	Director of Nursing, Therapies and Patient Partnership				√			√			
12	Implementation of Francis II - 5 themed areas	Medical Director Compliance Quality and Regulation							√			

No:	Agenda Item	Executive Lead	25/04/2013 - Seminar	29-May-13	26/06/2013 Seminar	24-Jul-13	25-Sep-13	30/10/2013 Seminar	27-Nov-13	18/12/2013 Seminar	29-Jan-14	26/02/2014 Seminar
13	LD redesign	Director of Operations		√		√		√	√			
14	Community Services re-design	Director of Operations		√			√					
15	Trust Clinical Strategy	Director of Operations					√				√	
16	Trust Information strategy	Director of Finance										
17	Emergency Planning Annual Report 2013/14	Director of Nursing, Therapies				√						
18	Care Quality Commission Registration Report	Director of Finance							√			
Assurance Quality / Effectiveness												

No:	Agenda Item	Executive Lead	25/04/2013 - Seminar	29-May-13	26/06/2013 Seminar	24-Jul-13	25-Sep-13	30/10/2013 Seminar	27-Nov-13	18/12/2013 Seminar	29-Jan-14	26/02/2014 Seminar
18	National Annual Patient Survey Report 2013/14- Action Plan	Director of Nursing, Therapies and Patient Partnership				√						
19	Single Equality Scheme	Director of Nursing, Therapies and Patient Partnership					√					
20	Receive Research Annual Report 2013/14	Medical Director Effectiveness Medical Education and Medical Workforce					√					
	Experience											
21	Receive Quarterly Quality Reports	Medical Director Compliance Quality and Regulation		Qtr 4 12/13		Qtr 1			Qtr 2		Qtr 3	
22	Receive Learning from Experience Report	Director of Nursing, Therapies and Patient Partnership		Qtr 4 12/13			Qtr 1				Qtr 2	
	Strategy and Planning											
23	Annual Plan 2013/14	Director of Finance		√								
24	Health and Wellbeing Strategy	Director of Nursing, Therapies and Patient Partnership		√								
	Assurance Governance											
25	Appointment of Board Deputy Chair and Senior Independent Director	Chair					√					
26	BOD Business Cycle 2013/14	Chair		√		√	√		√		√	

No:	Agenda Item	Executive Lead	25/04/2013 - Seminar	29-May-13	26/06/2013 Seminar	24-Jul-13	25-Sep-13	30/10/2013 Seminar	27-Nov-13	18/12/2013 Seminar	29-Jan-14	26/02/2014 Seminar
27	Approve BOD Business Cycle 2013/14	Chair										
28	Review Risk impacts of items	Chair/All		√		√	√		√		f il+A1	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Quality Report

Quarter 3
October – December 2013

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

NHS England's leading director for mental health has commended CWP for its 'can do' ethos at the Trust's annual 'Good Practice' showcase
See page 7

Care • Well-being • Partnership

Contents

An explanation of terms used throughout this report is available on the Trust's internet:
http://www.cwp.nhs.uk/reports/1628-quality-reporting-glossar

INTRODUCTION

Welcome to CWP's third *Quality Report* of 2013/14.

The Trust produces these reports every quarter to update staff, service users, carers, the public, commissioners, internal groups, and external scrutiny groups on progress in improving quality across CWP's services, which the Trust is required to formally report on in its annual *Quality Account*.

CWP's *Quality Account* 2012/13 and first two *Quality Report* of 2013/14 are available on the Trust's internet site: http://www.cwp.nhs.uk/our-publications/reports/categories/431

Reporting on the quality of the Trust's services in this way enhances public accountability by strengthening the Trust's approach to listening and involving the public, partner agencies and, most importantly, acting on the feedback the Trust receives.

Quality in the NHS is split into three parts. It means different things to different people. Here is what it might mean to the Trust's service users:

Quality

Patient safety	Clinical effectiveness	Patient experience
Being protected from harm and injury	*Receiving care and treatment that will make me better*	*Having a positive experience*
Being treated in a safe environment	*Having an improved quality of life after treatment*	*Being treated with compassion, dignity and respect*

This report is just one of many reviewed by the Trust's Board of Directors. Other reports include:

- the three times yearly Learning from Experience report –
  reviews learning from incidents, complaints, concerns, claims and compliments, including *Patient Advice and Liaison Service* [*PALS*] contacts
- the quarterly Infection Prevention and Control report –
  reviews the management and clinical governance systems in place to ensure that people experience care in a clean environment, and are protected from acquiring infections
- the monthly Corporate Performance report –
  reviews the Trust's quality and safety performance by reporting on compliance in achieving key local and national priorities

Together, these reports give a detailed view of CWP's overall performance.
This *Quality Report* provides a highlight of what CWP is doing to continuously improve the quality of care and treatment that its services provide.

Executive Summary – Quality Headlines this Quarter

CWP has achieved its quarter 3 milestones for its four trustwide quality priorities for 2013/14. The common focus across all of the priorities is reducing health inequalities.
➲ see pages 5 – 6

The National Clinical Director for Mental Health in England has commended CWP for its 'can do' ethos at its recent annual 'Good Practice' showcase event.
➲ see page 7

Two of Wirral older people's mental health team's occupational therapists from Meadowbank ward, Springview Hospital, have won the first ever Ken Holt Memorial Award for 'life story work' at the National Dementia Care Awards. The award recognised the outstanding work that the ward has done in integrating life story work into clinical practice.
➲ see page 8

Wallasey and West Wirral adult mental health's community mental health nurse has won 'Story of the Month' for *NHS England*'s '6Cs Live'! The story was commended for showing determination and commitment to a vulnerable service user.
➲ see page 9

CWP has celebrated double success at the *NHS North West Leadership Academy* recognition awards. CWP's Clinical Service Manager for Wirral drug & alcohol services has won the NHS Partnership/ System Leader of the Year award. CWP's Medical Director for Quality has won a joint award for NHS Quality Champion/ Innovator of the Year.
➲ see page 14

CWP received 396 formal compliments about the quality of its services during the third quarter of 2013/14.
➲ see page 15

Performance against contractual quality requirements and quality incentive schemes for 2013/14 is on track.
➲ see pages 16 – 19

Quality priorities for 2013/14

CWP has set four **trustwide quality priorities** for 2013/14, which reflect the Trust's vision of "**leading 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**.

The Trust has made a commitment in its *Quality Account* to monitor and report on these in its quarterly *Quality Report*s. This year, the common focus across all the priorities is **reducing health inequalities to** help reduce avoidable variations in the quality of care and to improve outcomes.

Patient Safety priorities for 2013/14

Improve the safety, effectiveness, and efficiency of patient care and services, through the development of a dashboard to monitor safety and quality indicators during the transition and after the community mental health team and learning disability service redesigns

CWP has achieved the quarter 3 milestones for this quality priority, as detailed below:

- The clinical effectiveness and experience domains of the quality impact assessments for the community mental health team and learning disability service redesigns have been developed further:
  - *Triangle of Care* meetings for carer champions, covering mental health for inpatient settings, has been extended to include physical health and drug and alcohol teams. The full rollout of *Triangle of Care* for community teams is planned for quarter 4.
  - Care pathway patient experience measures and patient/carer outcome measures have been introduced.
  - The complex needs pathway and the dementia pathway both include 'Recovery Star', which ensures that care planning is collaborative and is meaningful to the person.
- Quality dashboards, measuring ongoing compliance against quality indicators, are reported to the Quality Committee every two months by the Service Directors and Clinical Directors representing each locality in CWP. An implementation plan is in place to ensure a quality dashboard is produced for each locality specialty by the end of March 2014.

Improve patient safety and experience through the development of priority Trust 'never events' and implementation of associated preventative, positive, and patient focused 'always events'

CWP has achieved the quarter 3 milestones for this quality priority, as detailed below:

- A pilot phase for the approved *always events*, incorporated into the current inpatient safety metrics and community safety metrics programmes, has been rolled out.
- The community safety metrics pilot phase included drug and alcohol teams, physical health teams, and district nursing teams.
- Quality dashboards have been enhanced to incorporate the results of the *always events*.
- Baseline and future compliance with the priority *always events* will be reported to the *Quality Committee* via the quality dashboards on an ongoing basis.

Clinical Effectiveness priority for 2013/14

Improve outcomes by implementing clinically effective practice through the development of evidence based care pathways, including transitional pathways

CWP has achieved the quarter 3 milestones for this quality priority, as detailed below:

- Care pathways for first episode psychosis, dementia, and complex needs are now available on the Trust's information systems and are being used. Adult attention deficit hyperactivity disorder, memory assessment, bipolar disorder, depression and obsessive compulsive disorder are in development for implementation before the end of quarter 4.
- Locality clinical and process pathways will be prioritised following agreement of the Trustwide and locality clinical strategies in January 2014.
- Physical health care bundles have been developed based on the inpatient care standards contained within the revised physical healthcare pathway. It is reported within the inpatient safety metrics.
- The *FallSafe* care bundle is in place across all wards. The Trust's *always events* framework includes falls standards. Together, these will inform the review of the Trust's falls policy and pathway by the end of quarter 4.

Patient Experience priority for 2013/14

Improve service user and carer experience, by developing patient/ carer reported outcome measures, and patient experience measures across care pathways – linked to Payment by Results

CWP has achieved the quarter 3 milestones for this quality priority, as detailed below:

- 'Recovery colleges' are using the short WEMWBS [Warwick-Edinburgh Mental Well-being Scale] to measure student outcomes. Patient reported outcomes are being collected by WEMWBS within West recovery colleges. WEMWBS are being piloted at East recovery colleges next quarter.
- The benefits of using 'Recovery Star' as a care planning tool are being considered in support of maintaining a recovery focus for all patients.
- *Operational Board* has approved the pilot of an IT solution to gather real time patient and carer experience from early in 2014. The pilot will be evaluated after a four week period and, subject to a positive outcome, plans will then be developed to rollout across the Trust.
- *Triangle of Care* meetings for carer leads have been re-launched across each of the Trust's localities to support ward staff with self assessments of how they involve carers and families in care planning and treatment of people with mental ill health.

Improving outcomes for service users by supporting recovery

CWP is committed to **improving outcomes** for its service users, so that the care and treatment that the Trust provides improves their **quality of life**, **social functioning** and **social inclusion**, self reported **health status**, and supports them in reaching their best level of **recovery**. Recovery is CWP's approach to **helping people to be the best they can and want to be**.

In each *Quality Report*, CWP reports on how its services are improving outcomes for service users by supporting recovery.

Focus on...
CWP's annual 'Good Practice' showcase

The *National Clinical Director for Mental Health in England* has commended CWP for its 'can do' ethos at its recent annual 'Good Practice' showcase event.

Impressive marketplace stalls were created by staff from mental health, learning disability, drug and alcohol, and physical health services, who came together to ***share and showcase good practice*** at the Trust's clinical effectiveness and leadership forum. Staff spoke about how much they enjoyed the event, how much they learnt, and how they have been inspired to take ideas back to their own work areas to make improvements.

Dr Geraldine Strathdee spoke at the event and spent time visiting the marketplace stalls. She observed how CWP works proactively with acute services, holding joint therapy sessions, and how the Trust uses information to ***embed learning*** and ***implement best practice***. Dr Strathdee commented on the "brilliant and impressive" services in the marketplace, showcasing mental health care at its best, with staff and service users stood side by side, proud of what they had jointly co-designed.

Examples of best practice, detailing the impact and next steps of CWP's projects, have been sent to Norman Lamb, Minister of State at the *Department of Health*.

> *"It was an absolute delight to meet so many inspiring professionals, stood side by side with service users, proud of what they had jointly co-designed and the positive recovery outcomes. CWP has an obvious passion for quality, recovery focussed patient care. In light of recent reports such as the Keogh Review, where the focus is on driving excellence in care; having a culture that nurtures innovation is very special."*
>
> ***Dr Geraldine Strathdee***

Focus on...
The 'Life Story' project

Two of Wirral older people's mental health team's occupational therapists from Meadowbank ward, Springview Hospital, have won the first ever **Ken Holt Memorial Award** for 'life story work' at the National Dementia Care Awards. The award recognised the outstanding work that the ward has done in integrating life story work into clinical practice.

"I am delighted that the judges chose Meadowbank ward, due to the clear commitment and passion shown by the team in using life story work to transform the support that individuals with dementia and carers receive. Their focus is rightly on the uniqueness of the person not dementia."

Anna Gaughan, Chief Executive – Life Story Network

Life story work is a technique designed to enable older adults to recognise their past, present, and future. Life story books are built into this work, to give a visual aid and reminder of important events or feelings. Here are a few of many positive outcomes the Life Story Book has brought:

- ***Enhanced quality of person centred care***
- ***Improved engagement*** in therapy and activities
- Encouragement of service users to reminisce and help in sustaining interactions
- Spontaneous discussions with service users who struggle to initiate conversation
- Helping care homes in getting to know residents transferred from hospital
- Settling of agitation and improvement in concentration
- Provision of comfort to service users, carers and families
- ***Collaborative care planning***

Patient, carer, staff experience

"Just to say THANK YOU to the OTs who have laboriously put together the Life History book for [patient]... Her book is giving her more pleasure than you would believe possible."
Community Occupational Therapist and Care Co-ordinator

"My family and I thought the Life Story Book was excellent... a great help when she returned to her Care Home, where we would sit and read it with my wife. Sadly my wife has recently passed away, but the book continues to be a source of comfort".
Husband and carer of a patient

"... I think this is excellent... I love looking back at the old pictures... I am very proud of my past. My boys will look forward to looking at this... What a lovely idea doing this for me, thank you."
Patient on Meadowbank

"I am incredibly proud of the work my staff have done in creating, designing, implementing, and producing these books. We are now training other areas in how to put a life story book together so that more people and their families can benefit from this person centred therapeutic tool."
Lead Occupational Therapist

Focus on...

Story of the month – NHS England's 6Cs Live!

Wallasey and West Wirral adult mental health's community mental health nurse has won Story of the Month for *NHS England*'s '6Cs Live'! The story was commended for showing ***determination*** and ***commitment*** to a vulnerable service user with a long history of mental illness whose condition had rapidly deteriorated, refusing treatment, leading them to become homeless.

The **improvement in quality of life** since hospital treatment and working in partnership with care providers has been outstanding. A number of positive outcomes have been achieved for the service user:

- ***Independent living*** in own flat
- ***Improved mental health and wellbeing***
- ***Increased confidence and self esteem***
- Willingly engaging with services
- Recognising the ***progress made*** and expressing thanks for all the work the community mental health nurse has done
- ***Built trust*** and ***improved communications*** with services
- Able to look forward to a ***stable future of recovery***

"....true compassion, care and commitment, over and above the call of duty, by advocating for and supporting [service user] to lead a better life. It has been a long process but the care shown over the last 18 months has really paid off... a real credit to our profession".
Peter Evans, Team Manager

"Despite an exceptional standard of entries this month it was clear to us that Jane's commitment to [service user] was both life changing and inspirational. Jane demonstrated compassionate care at its best".
Sam Sherrington, Head of Nursing and Midwifery Strategy, at NHS England

Improving patient and staff experience of pharmacy services

The Trust's pharmacists and pharmacy technicians ensure that service users receive **safe and effective medicines**, in a **timely** manner, **tailored** to their own individual pharmaceutical needs. Detailed below is a summary of how the team has facilitated this during the past quarter, as well as other quality updates and developments.

The pharmacy team continues to proactively participate in service user and carer groups by providing meaningful **advice and independent information on medicines** used in mental health. For example, the Early Intervention Team carer's group and **information sessions on medicines** were a success, with carers reporting that they found the sessions very informative. Also, a question and answer session on medicines for the 'coping with mood disorders course' was provided at the recovery college in Blacon.

"I would like to thank everybody for giving their valuable time. It was not only appreciated by myself but more importantly the carers themselves".
Community nurse,
Early Intervention Team

The team provides proactive **education around medication** to support clinical staff on the inpatient units and community teams. This is identified through staff requests for additional training as part of recommendations from incidents and from newly qualified staff or staff new to CWP. The points below highlight the quality outcomes obtained from such clinical support:

- The pharmacy team has delivered nicotine replacement therapy education and is supporting inpatient staff with nicotine replacement therapy products in preparation for the implementation of CWP going smoke free in February.
- An acute care consultant was supported when reviewing the use of sodium valproate for treatment of an inpatient.

Clinical Effectiveness

Research

CWP has now recruited over 700 people to research studies since April 2013. During quarter 3, the Trust commenced a further commercial study into long acting injectables and has already recruited most of the patients. The 'ATLAS' trial of antipsychotic treatment of very late-onset schizophrenia-like psychosis has now recruited most of the patients. CWP has also fully recruited to a dementia study looking at eyesight called 'PROVIDE'. CWP has completed a large number of feasibility questionnaires for industry, mostly looking at new dementia drugs – the Trust expects to hear in the new year if it has been successful.

The study of falls, which included two of CWP's dementia wards, has finished. This study was presented at the CWP research conference held in November. The final publication is expected to be available soon, and a meeting is planned in January where the study team will go through the findings with senior members of the Trust to plan how CWP can improve its ward environments in line with the findings.

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

This research project aims to improve mental health services and help to reduce the risk of similar incidents occurring in the future. The number of cases submitted to each category as a percentage of the registered cases required by the terms of the Inquiry for quarter 3 [October – December 2013] are:

Categories of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	Cases submitted as a percentage of registered cases	
Sudden unexplained death in psychiatric inpatients	-	*n* = 0
Suicide	100%	*n* = 13
Homicide	-	*n* = 0
Victims of homicide	-	*n* = 0

Clinical Audit

Featured below is a report on six Trust level clinical audits that have been reviewed and approved as part of the Trust's annual clinical audit programme. It includes the actions that have been identified in order to improve the quality of healthcare that CWP provides.

1. Advancing Quality in Mental Health and Learning Disability - Dementia and Psychosis

See page 19 for details of this monthly audit.

2. NHS Safety Thermometer

See page 14 for details of this monthly audit.

3. Patient safety metrics - inpatient and community

See page 5 for details of this monthly audit.

4. ECT re-audit 2013

The Trust is committed to providing high standards of care to service users undergoing electro convulsive therapy [ECT]. Therefore practice has to be measured against Trust policy, NICE guidelines and ECT accredited standards to ensure that service users receive high quality treatment and positive outcomes. As a result of this audit, the Trust will, by February 2014:

- Review training around ECT to ensure that all staff are aware of the legal requirements relating to consent for ECT therapy.
- Issue a bulletin to relevant staff, to remind staff to monitor and record side effects and to document reasons for continuing/withdrawing therapy where side effects occur.
- Explore if assessments and monitoring can be performed by suitably trained multi disciplinary team staff working in ECT suites.

5. Medicines management re-audit

The *Department of Health* requires that all NHS trusts establish, document and maintain an effective system to ensure that medicines are handled in a safe and secure manner that is accountable to the Trust Board. As a result of this audit, the Trust will, by March 2014:

- Develop medicines element of care pathways to include a prompt to ask about side effects.
- Remind teams of the correct procedure for the receipt of depot injections.
- Review the Trust policy on rapid tranquilisation.

6. Standard care letter template re-audit

The Trust's strategic risk register highlights the potential risk to patient safety due to inability to communicate in a timely manner with other partners in primary care, acute, social care etc. Following all routine outpatient appointments, a standard letter using the agreed template should be sent to the service user's GP. This re-audit has been identified within the corporate assurance framework as a control to inform quantification of the nature and degree of the risk. As a result of this audit, the Trust will, by February 2014:

- Consider if use of the discharge template and assessment templates should also be audited.
- Plan a Trustwide review of the quality of the content of clinic letters.
- Ensure that mechanisms are put in place so that locally issues are picked up directly with the doctor/s involved through appraisals.

NICE guidance and clinical effectiveness

Implementing *National Institute of Health and Care Excellence* [*NICE*] guidance:

- **enhances the effectiveness of clinical services** and
- **improves clinical outcomes**, and also **improves non-clinical outcomes** for patients, such as gaining employment or returning to education.

The Trust holds regular *Clinical Effectiveness network* meetings to monitor performance to ensure **adherence to best practice**. During quarter 3, CWP held two meetings. Presentations were received on *brain damage*; and also *Attention Deficit Hyperactivity Disorder*, from the respective *NICE* champions within the Trust. The table below demonstrates the Trust's compliance for the guidance it has been able to fully assess. CWP continues to work with its clinical leads in the Trust, and its commissioners, to further promote compliance with *NICE* guidance.

Type of *NICE* guidance	CWP's ability to deliver as at quarter 3			
	Full	Partial	Not	Total
Clinical Guideline	51	21	0	72
Public Health Interventions	30	9	0	39
Interventional Procedures	2	0	0	2
Technology Appraisal	16	0	0	16
Medical Technology	1	0	0	1
Cancer Service Guidelines	0	1	0	1
Patient Safety	2	0	0	2
Total	102 77%	31 23%	0 0%	133

Quality success stories

In addition to earlier success stories featured in the report, below is a summary of some of CWP's other success stories over the past quarter in **promoting quality** within the communities that the Trust serves, and in **improving the quality of the Trust's services.**

Patient Safety News

The *Care Quality Commission* [*CQC*] undertook an unannounced inspection of Eastway Assessment & Treatment unit, finding it to be **fully compliant** with all the **essential standards of quality and safety** inspected. The *CQC* commented that they were particularly impressed with the person centred approach to care and the involvement of service users and their families/ carers in care planning. They found records that provided detailed person centred information about patients' needs and welcomed the positive approach adopted to risk assessments.

The *Patient Safety First* campaign's ambition is to eliminate the avoidable harm associated with pressure ulcers across the NHS. With an estimated 180,000 newly acquired pressure ulcers developing each year [NHS Safety Thermometer 2012] and 91,810 patient safety incident reports received by the *National Reporting and Learning System* in 2011, this is one of the biggest **patient safety challenges** facing the NHS. CWP is contributing to national work in this important area of patient safety. The Trust's *Tissue Viability Specialist Nurse* and *Specialist Practitioner Community Student* attended the **UK annual wounds conference**. The general theme for this year focused on the management of pressure ulcers, supported by many seminars and workshops. The *CWP Tissue Viability Specialist Nurse* is an active member of the North West Tissue Viability Nurse Group. They presented a poster about the staging of pressure ulcers, which was designed by the group. The conference was well received by over 1,000 delegates this year, and it consisted of the largest exhibition of wound care companies in the UK.

Clinical Effectiveness News

AQuA
Advancing Quality Alliance
The Guardian Public Services Awards 2013
in partnership with HAYS Recruiting experts worldwide
WINNER

CWP participates in the ***Advancing Quality*** **[*AQ*] regional *CQUIN*** - see page 19 - which celebrated winning 'The Guardian' *Public Services Award 2013*. The programme scooped the title for the *Measuring Excellence* category, which awards initiative where excellence is recognised using data and grounded on a solid bed of evidence. Judges said that the programme had a strong ethos of transparency and shared learning and proved that using and measuring data is a means of really understanding what people need. The judges felt that *AQ* should win because it aims to tackle variations in care, cut readmissions, and save lives so that thousands of patients receive the right care at the right time and in the right place.

CWP celebrated double success at *The NHS North West Leadership Academy* recognition awards in November 2013. CWP's Clinical Service Manager for Wirral drug & alcohol services has won the **NHS Partnership/ System Leader of the Year** award. CWP's Medical Director for Quality has won a joint award for **NHS Quality Champion/ Innovator of the Year**.

Community physical health services continue to measure levels of harm free care using the **NHS Safety Thermometer** on a monthly basis on four outcomes:

- pressure ulcers
- falls
- venous thromboembolisms
- urinary tract infections in patients with catheters

This is a national *Commissioning for Quality and Innovation* goal, which aims to facilitate the delivery of harm free care over time. There has been an improvement from 92% at the end of 2012/2013, to 94% in November 2013.

The *Care Programme Approach Association* [*CPAA*] thanked staff from CWP for hosting a **national event** 'My Decision or Yours? Care Planning and Legal Frameworks'. The event was opened on behalf of CWP by the Trust's Associate Director of Safe Services, who reminded delegates that throughout the day, the focus should be on the person using mental health services at the centre of the co-ordination of their care, supported by recovery approaches to help people to be the best they can and want to be.

Patient Experience News and patient feedback

East Cheshire's drug and alcohol CWP volunteer of the year, and other recovery support volunteers, worked with service users to develop a questionnaire to obtain **service user feedback** of the physical and mental wellbeing effects of the 'Doob' drug. Service users have the opportunity to have their say on service delivery. The vast amount of personal lived experience, which is shared with people having similar problems, gives service users hope, just by their example of being there for them.

The CWP eating disorder service has introduced online guided self help for service users with Binge Eating Disorder and low risk Bulimia Nervosa funded by the CWP 'Dragons Den' scheme. Service user satisfaction questionnaires and feedback from focus groups set out the vision for the website. The self help programme using "Overcoming Binge Eating" is hoped to increase uptake in people seeking help and improve 'did not attend' rates and disengagement, by offering a **more flexible and accessible approach**.

Drug & Alcohol Services [West Cheshire] have listened to service users struggling to attend clinics at Aqua and Unity House due to transport. In response to **service user feedback**, the service has **improved access to weekly clinics** and made them available in Neston at Mellock Lane health centre and Frodsham health centre. Attendance rates have increased to 96%. Service users are also benefiting from the use of other facilities provided in the health centres. Further work has been developed alongside service users to improve successful drug and alcohol completions. A service user newspaper has been developed promoting groups and services provided.

245 service users responded to the national patient survey of "people's experiences of community mental health services". The *Care Quality Commission* published a report that indicates CWP has performed 'better' overall than other Trusts in key areas: medications, care co-ordinator and crisis care. The results will be used to help identify areas for improvement and will inform future planning.

In quarter 3, CWP formally received **396 compliments** from service users, and others, about their experience of the Trust's services. Below is a selection of the comments and compliments received for the specialties across the Trust:

"You have seriously helped me and made a difference in my life and in my recovery."
Adult mental health services

"Just wanted to say how much I appreciate all the help and support you and your team have given me in getting mum back home and settled in. It would have been difficult enough getting her home following her accident given her physical injuries but the dementia has made it doubly difficult and had I not had you to call on for help and advice I do not know how I would have managed. She is happy and content to be at home which is what I had promised I would try to do if at all possible but without the help of you and your team I don't think I could have achieved it. Not only was the practical help invaluable but the support and advice you have given me is very much appreciated and helped me to cope with all that needed doing… Once again I cannot thank you enough for everything you and your team have done for mum and I."
Physical health – CWP West

"Thank you for your smiles, concern and always being ready to listen. It has meant so much to us."
Child & adolescent mental health services

"I would like to express my extreme gratitude to the staff who have supported me through this difficult time and called the GP on my behalf. It makes such a difference and is such a relief to me that I have the level of support given by the staff."
Learning disability services

"I am so grateful to everyone who has provided me with support. I am finally living again, rebuilding my life after so many dark years, gaining back my confidence, and pride, and self respect."
Drug and alcohol services

Contract requirements – Quality improvement and innovation

CWP has certain **quality requirements and goals** which have been agreed with commissioners [those who buy the NHS services that the Trust provides] detailed in the Trust's contracts. These are monitored through the contract monitoring process, to ensure that the aim of **improving quality of care** is on track. This is monitored at quality meetings held jointly with commissioners to ensure all of the Trust's performance is on track.

Quality requirements

This part of the contract sets out the requirements of CWP's commissioners in regard to the quality of all the services it provides. CWP aims to build on its positive performance against these requirements in its contract last year. **Performance against contractual quality requirements for 2013/14 is on track.**

Commissioning for Quality and Innovation [CQUIN]

A proportion of CWP's income from its contracts in 2013/14 is conditional on achieving **quality improvement and innovation goals** agreed by CWP and its commissioners, through the *CQUIN* payment framework. The total *CQUIN* monies in 2013/14 is subject to achievement of certain milestones. Reporting against the quarter 3 milestones is currently underway. Quarter 2 milestones are in the process of being verified as achieved. Below details the progress against each of the schemes.

Trustwide schemes

- Safety thermometer
  Data is uploaded via the Information Centre web portal on a monthly basis.
- "Advancing Quality" – dementia and psychosis
  Ongoing reporting of compliance to commissioners.

Western Cheshire schemes

- Long term conditions: patient education programmes
  Development of a six month forward plan for development of a local education programme that includes joint working partner organisations, including detail of how the programmes will be delivered during 2014/15.
- Ageing well: planning and predicting health care needs
  Forward plans for activity during quarters 3 and 4 developed and baseline data provided regarding involvement of community teams in care planning when a patient is admitted to hospital.
- Chronic obstructive pulmonary disease [COPD] advanced service in the community
  Work is underway to provide an integrated care service [acute/ community] for patients with COPD, incorporating self management and a forward plan for 2014/15.
- Transition between childrens and adult services
  Progress with action plan developed within quarter 1 has been reported to the commissioners regarding service improvements to the current transition process.
- Mental and physical health care pathways
  Collaborative working continued with the Countess of Chester Hospital NHS Foundation Trust to implement and develop pathways in relation to urgent response, dementia care and delirium pathway.

East Cheshire schemes

- Long term conditions [LTC] quality, innovation, productivity and prevention [QIPP] programme
  Report submitted to the commissioners to provide an update in relation to ongoing work regarding:
  - *Infrastructure and needs assessment*
  - *Risk profiling*
  - *Improving coordination of care*
  - *Self management support [including shared decision making]*
- Transition across services
  Steering group established to oversee the implementation of an improved transition pathway for young people to adult services. Feedback gathered from young people via distribution of patient experience measure and focus groups; staff feedback was also gathered via a focus group.
- Psychiatric assessments
  Work underway to implement an enhanced liaison service, outcome measures to evidence efficacy identified and data collection commenced.

Vale Royal and South Cheshire schemes

- Long term conditions [LTC] quality, innovation, productivity and prevention [QIPP] programme
  Report submitted to the commissioners to provide an update in relation to ongoing work regarding:
  - *Infrastructure and needs assessment*
  - *Risk profiling*
  - *Improving coordination of care*
  - *Self management support [including shared decision making]*
- Transition across services
  Steering group established to oversee the implementation of an improved transition pathway for young people to adult services. Feedback gathered from young people via distribution of patient experience measure and focus groups; staff feedback was also gathered via a focus group.
- Physical health checks
  Process developed to offer health checks to patients who have not received their annual health check within 12 months and a brief intervention management/ health promotion scheme developed.
- Dementia baseline screening for people with Down Syndrome
  Steering group established to oversee the development of the service and training programme for staff in dementia. Baseline dementia screening offered to people with Down Syndrome over the age of 30. Training programme for staff commenced.
- Autism
  Training commenced with community mental health teams regarding autism awareness and reasonable adjustments for patients with a diagnosis of autism. Feedback about experiences of mental health services in relation to people with autism has been requested from adults with autism, their carers and staff who support them.

Wirral schemes

- Contract dataset
  Monthly contract datasets submitted, completeness, quality and configuration of datasets reviewed and action plans developed.
- Dementia
  Pathways developed in collaboration with Wirral University Teaching Hospital NHS Foundation Trust in relation to dementia care and specialist posts recruited to implement the pathway.
- Long term conditions
  Work continued in collaboration with all health and social care partners through the identified domain groups regarding service integration for patients with long term conditions.
- Innovation

Work underway with the following innovative ideas agreed during quarter 1:

- *In Sight, in Mind*
- *Healthy Lifestyle Group*
- *Recovery Peer Mentors*
- *Kidstime*
- *CAMHS Peer Mentor*

North West Specialised Commissioning schemes

- Optimising care pathways
  - *Tier 4 CAMHS – patient level data provided to illustrate number of days spent at each stage of the pathway, including any variance.*
  - *Eating Disorder Services – report completed detailing progress in implementing the care pathway.*
  - *Secure and step down services – reporting template submitted with patient level data to illustrate number of days spent at each stage of the pathway, including any variance.*
- Physical healthcare
  Progress reports submitted to the commissioner evidencing performance with specific physical health checks and, where necessary, including actions to improve performance.
- Care programme approach [CPA]
  Action plans developed to address any areas where issues have been identified in relation to CPA meetings.
- Literacy
  Update report provided to the commissioners including performance against targets, evidencing service user involvement and inclusive of an action plan to remedy areas where performance could be improved.
- Improving service user experience through innovative access to and for secure services
  Progress made with implementing technology to improve service user experience though innovative access to and for secure services.

Trafford Clinical Commissioning Group schemes

- Health Equality Framework
  Health equality framework tool implemented and baseline scoring undertaken.
- Health improvement strategies
  Action plans for each of the ten indicators have been developed and reported to commissioners.

Primary Care Mental Health Services schemes [commissioned by Wirral Clinical Commissioning Group]

- Access and equity
  Baseline established of referrals received by the service for patients aged 65 and over, with long term conditions, perinatal mental health needs and military veterans.
- Communication with Primary Care
  Baseline report provided of communication and engagement activities undertaken during the quarter including plans to deliver activities over the rest of the year.
- Maximising appointments available
  Baseline utilisation report provided to commissioners outlining utilisation of appointment slots.

Advancing Quality

Advancing Quality [*AQ*] is an ongoing regional *CQUIN*. It is a programme that was introduced in order to drive up **quality improvement** across the North West of England region. *AQ* is about giving the **best quality treatment** first time, every time. The programme applies a systematic approach to care, by measuring and monitoring interventions to ensure that they happen.

There is up to a six month time lag in reporting the data. **CWP is on track for achieving the stretch targets for dementia and psychosis for 2013/14**, as detailed in the table below.

Diagnosis area	Composite target April 2013 – March 2014	CWP compliance April 2013 – August 2013	Appropriate care target April 2013 – March 2014	CWP compliance April 2013 –August 2014
Dementia	83.64%	92.71%	50.00%	93.55%
Psychosis	88.19%	97.83%	58.88%	61.97%

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Report to:	**Board of Directors – meeting in public**
Date of meeting:	**24 January 2014**
Title of report:	**Learning from Experience report – Trimester 2 2013/14**
Action sought:	**For noting and approval**
Authors:	**David Wood, Associate Director of Safe Services** **Audrey Jones, Head of Clinical Governance** **Safe Services Department**
Presented by:	**Avril Devaney, Director of Nursing, Therapies and Patient Partnership**

Strategic objective/s that this report covers:
SO1 – Deliver high quality, integrated and innovative services that improve outcomes
SO2 – Ensure meaningful involvement of service users, carers, staff and the wider community
SO5 – To use and produce high quality information to enable effective decisions and improved care
SO6 – To sustain financial viability and deliver value for money
SO7 – To be recognised as a progressive organisation that is about care, wellbeing and partnership

Distribution

Version	Names/ Groups	Date issued
1	H Mannin to A Jones	18.12.2013
2	A Jones to D Wood	20.12.2013
3	D Wood to A Jones	26.12.2013
4	A Jones to Quality Committee	30.12.2013
5	A Jones to L Hulme for Board of Directors	22.01.2014

Executive director sign-off

Executive director (name and title)	Date signed-off
Avril Devaney, Director of Nursing, Therapies and Patient Partnership	22.01.2014

EXECUTIVE SUMMARY

1. Purpose of the report

This *Learning from Experience* report aggregates qualitative and quantitative analysis from key sources of staff and service user feedback, and other relevant sources of learning, covering the period from August 2013 – November 2013, **trimester 2** of 2013/14.

2. Key performance indicators

Performance indicator			2012/13		2013/14	
			T2	T3	T1	T2
Number of patient safety incidents reported			2183	1864	2437	2418
Severity (Increase in level of harm ⇧)	**Category A**		19	12	16	17
	Category B		14	23	33	30
	Category C		455	368	276	270
	Category D		1293	571	693	915
	Category E		402	890	1419	1137
Reports to external agencies	StEIS (externally reportable to NHS England)		33	35	49	43
	Medicines & Healthcare Regulatory Authority		139	132	198	160
	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations		10	6	10	5
	NHS Litigation Authority – NHSLA	Non clinical claims	7	5	7	9
		Clinical claims	1	0	0	2
	National Reporting and Learning System		1191	1071	1501	1074
Number of complaints			53	60	76	59
Acknowledgement of complaints within 3 days			75%	91%	99%	93%
Number of compliments			815	903	516	671

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

3. Analysis – key highlights

Follow up from the actions identified in trimester 1 of 2013/14 are outlined in Appendix A.

3.1 Incident reporting

All incidents involving patient safety are reported to the *National Reporting and Learning System* [*NRLS*]. CWP has achieved 100% compliance in meeting these reporting targets. Overall incident reporting has decreased by 0.8% in trimester 2. The lower harm categories of incidents continue to be the highest number of reported incidents, which is an internationally recognised standard so that it does not take incidents that cause harm to improve patient safety. The reporting of higher harm categories of incidents has remained at a similar level to those reported in trimester 1.

3.2 Falls incidents

There has been another overall decrease in falls incidents this trimester, from 234 to 203. The most frequently reported severity of falls has again been category E [near miss/ prevented] patient safety incidents. Management of known risks in relation to falls is now recorded on the Trust's incident reporting system. This includes acute physical health problems, prescription of 'as required' medication prior to the falls incident, and recording of low postural blood pressure prior to the incident. By continuing to monitor this data, an indication of the appropriate management of

falls risks can be gained on an ongoing basis. Additionally, a falls specialist nurse from *St Helen's and Knowsley Teaching Hospitals NHS Trust* was commissioned to undertake a review of falls within CWP. The review has included assessment of the environment on key wards which provide care for those at highest risk of falls to ensure that the risk of falls is further minimised. The recommendations of this independent review are being monitored by the Trust's *Patient Safety and Effectiveness Sub Committee*. This will link with a research project recently undertaken called "*Pedestrian Walkabout*". How this work is contributing to the mitigation of avoidable falls will be reported in the trimester 3 report.

4.3 Medicines incidents

There has been an overall decrease in the number of medication related incidents when compared with the previous trimester. There has been an increase in failure to administer incidents for CAMHS Tier 4 wards compared with last trimester. The modern matron, ward manager and pharmacist have agreed measures to reduce this, including education, allocation of a named nurse for each medicine round, reviewing timing of doses to streamline medicine rounds, and checks at the end of each medicine round and each shift to ensure no doses are missed.

4.4 Complaints, PALS, compliments

59 complaints were received under the NHS complaints procedure during the trimester, this is higher than the same trimester last year but a decrease of 17 complaints compared with last trimester. There is a downward trend in relation to PALS contacts, which is an expected decrease as a result of services dealing with concerns quickly and efficiently at a local level following advice provided by visits from the PALS Officer to services. Compliments for this trimester remain high, and have increased in relation to the previous report.

4.5 Security, violence and aggression incidents

This trimester, CWP's current position against the *No Force First* key core strategies and actions has been reviewed to facilitate a reduction in restrictive practices and to further promote the principles of recovery orientated systems of care that is person centred, promotes choice, respect, dignity, partnerships, self management and full inclusion. The baseline position will be used to set improvement targets. Restraint incidents this trimester have reduced by 15%, with a 1% decrease in service user injuries reported during restraint. Whilst post incident feedback to service users reduced by 4% this trimester, there was 100% compliance with policy, i.e. there were valid clinical reasons for this not taking place.

5. Summary of recommendations

The following highlights the recommendations identified as a result of the aggregated analysis undertaken on key sources of staff and service user feedback, and other relevant sources of learning.

	Recommendation	Action	By Whom	When
1	The Trust should be assured of consistency in the reporting of harm through the incident reporting process.	A deep dive will be undertaken to review incident reporting within the Trust, benchmarked against other Trusts similar to the profile of CWP.	Incidents team	31.03.2014
2	Strengthen the Root Cause Analysis (RCA) process for pressure ulcers.	Analyse the investigatory recommendations from RCAs of pressure ulcers and review recurrent themes.	Pressure ulcer action group	31.03.2014
3	All incident reporters should ensure that the correct sub category of incident is selected when reporting medication incidents.	This should be promoted through locality based working of the pharmacists. Reminders will also be included in the 'learning lessons, changes in practice' publication.	Locality pharmacists	28.02.2014
4	Reduce drug related	Ward nursing teams should	Ward nursing staff	Immediately

	Recommendation	Action	By Whom	When
	incidents from the category 'failure to administer'.	contact the on-call pharmacist if medication out of hours is not available on the ward.		
5	Reduce the number of controlled drug errors.	i. Assurance should be sought from the clinical specialties that all policies and procedures associated with controlled drugs are being adhered to. ii. Assurance should be sought that all nursing staff are aware of the controlled drug policy and procedures and that they are being adhered to.	Chief Pharmacist Modern matrons/ ward managers	Immediately Immediately
6	Reduce the number of medication incidents in relation to prescribing controlled drugs.	i. Feedback to prescribers on an ongoing basis to ensure their prescriptions and new prescription charts are legible and accurate. Practice issues to be fed back to prescribers on a quarterly basis at the locality teaching sessions. ii. Consultants should be reminded, via consultant manager meetings, to review prescribing errors with their supervisees during supervision. iii. Actions should be agreed around reducing such errors.	Pharmacy team/ prescribers	Immediately
7	Develop a system to ensure better capture of learning from complaints and to ensure learning is better disseminated across the organisation.	Actions/ recommendations from complaints investigations should be logged and monitored to ensure they are being implemented and that learning is taking place.	Head of clinical governance/ Complaints team	30.04.2014
8	Maximise all opportunities to seek and promote feedback from people who use the Trust's services.	To identify a joint working programme and more partnership working between the complaints/ PALS team with the communications and involvement team.	Complaints/ PALS team and communication and involvement team	31.03.2014
9	Future comparative monitoring and performance against improvement targets in relation to the 'No Force First' strategy.	A review data fields within the incident reporting system to reflect the new reporting needs of the 'No Force First' strategy	Safety & security lead/ Incidents team	28.02.2014

6. The Board of Directors is asked to:

- **Discuss** the findings and key analysis within the report.
- **Note** the recommendations identified, which will be monitored by Quality Committee.

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

RCA leads to communicate the incident reporting and investigation flowchart to relevant staff in localities, including investigating managers, general managers and clinical directors, to ensure clear understanding of roles, responsibilities and timescales for RCA processes.
The RCA leads have provided assurance that they have either attended or provided information for the locality governance meetings to ensure that the incident reporting and investigation flowchart has been disseminated. Individual support is offered to investigating managers for each investigation to ensure that they have a clear understanding of their role, responsibilities and timescales for the RCA process.
Modern Matron, CAMHS, to review missing patient incidents, individually, cumulatively and with the benefit of appropriate analysis, and discuss with ward management and the care team what, if any, changes to policies, procedures, and/ or practices might be required to ensure that effective care and treatment is being provided whilst minimising unnecessary risks.
The Modern Matron, CAMHS, is working in liaison with the clinical audit team as lead on the development of the Trustwide missing persons audit this year. CAMHS have developed an initial draft of the audit tool, which they are currently consulting with ward managers about before agreeing a final draft. In addition to this, whilst going through this process, CAMHS will continue to review any missing persons incidents as per the incident reporting and management policy, and will also link in with *Catch22* – an independent organisation who meet with the young people who have absconded.
- *Safe Services Department to ensure that unannounced visits review the use of seclusion.* - *Effective Services Department should include an audit on the clinical audit programme to re-audit the management of seclusion in quarter 4 of 2013/14.*
Unannounced visits review the use of seclusion where this has been highlighted as an issue/ key line of enquiry for the ward through triangulation. The inspection team then seeks to gain assurance that it is being appropriately and safely implemented in line with CWP policy. The re-audit of seclusion is included on the clinical audit programme for 2013/14. It is scheduled to be completed in February 2014.

Cheshire and Wirral Partnership NHS
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Document Reference (2013/14/95)

Report to:	**Board of Directors**
Date of meeting:	**29 January 2014**
Title of report:	**Community Service Improvement Programme – Six month evaluation**
Action sought:	**For discussion and approval**
Author:	**David Wood, Associate Director of Safe Services**
Presented by:	**Andy Styring, Director of Operations**

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
SO4 – Maintain and develop robust partnerships with existing and potential new stakeholders
SO5 – Improve quality of information to improve service delivery, evaluation and planning
SO6 – Sustain financial viability and deliver value for money
SO7 – Be recognised as a progressive organisation that is about care, well-being and partnership

Distribution

Version	Name(s)/Group(s)	Date Issued
1	D Wood to A Styring	17.01.2014
2	D Wood to L Hulme for Board of Directors	20.01.2014

Executive director sign-off

Executive director (name and title)	Date signed-off
Andy Styring, Director of Operations	20.01.2014

1. Purpose of the report

To provide the Board of Directors with an update on the continuous evaluation programme of the Community Service Improvement Programme [CSIP].

2. Background

During 2012/13, the Trust worked on a number of cost improvement programmes to generate over £13million worth of savings over the next three years. This was in response to *The Operating Framework for the NHS in England 2012/13* (Department of Health, 2012), requiring the NHS to make up to £20billion of efficiency savings by 2014/15 to invest in meeting demand, improving quality and securing sustainable change. The Trust's clinicians led a review of the delivery of services by its adult community mental health teams [CMHTs]. They were subject to consultation and used information from national and local evidence regarding the needs of the groups of service users accessing these services. The objectives of the CSIP were to ensure that:

> *Services are effective and efficient and that interventions deliver positive patient outcomes in the context of a recovery focused culture, within a defined financial envelope.*

In providing care and treatment to people who use the Trust's services using the new model which was adopted – **StAR: Stepped Approach to Recovery** – staff will continue to deliver evidence based interventions, use the framework of the Care Programme Approach [CPA], and the ethos of recovery that is unique to the individual.

3. Evaluation

3.1 At the 25 September 2013 meeting of the Board of Directors, a review of the quality impact three months following the CSIP implementation was received. This used the quantitative measures captured as part of the Trust's quality dashboard. As detailed in the last report, CWP commissioned an external review of the quality dashboard, undertaken by auditors PricewaterhouseCoopers LLP. This review was reported to the Trust's Quality Committee on 8 January 2014, and provided positive assurance about the quality dashboard's presentation, key performance indicator selection and calculations, and data quality. This quality dashboard information is collected on a continuous basis and is reported on by the locality Service and Clinical Directors to the Trust's Quality Committee every two months. Common trends across all teams will be identified and monitored through a process of longitudinal analysis [analysis over time]. The initial quality impact assessment for the evaluation of the CSIP identified that other measures would be incorporated in to the quality dashboard over time, specifically clinical outcomes for patients, care pathway adherence, and adherence to NICE guidelines. As this and more data and information is gathered, it will allow for better statistical analysis and early warning to detect emerging themes and trends. The Board of Directors therefore agreed to receive a further report, based on the quality dashboard quantitative measures, covering a more longitudinal period twelve months post the CSIP implementation.

3.2 Each locality has a CSIP implementation, monitoring and evaluation group which have project plans that are made available for the Trustwide CSIP group. A verbal update in relation to the impact of the service redesign is provided by service and clinical directors of each locality to the Trust's monthly Operational Board as a standing agenda item. This meeting is attended by a carer representative and has staff-side and Non Executive Director representation. These updates have demonstrated that the Trust has been flexible and responsive to any issues which have arisen requiring adjustments be made.

3.3 The previous report to the Board of Directors identified that a number of qualitative measures were in development as part of the Trust's Quality Account priorities for 2013/14, and therefore not reported in the three month evaluation. The Board of Directors therefore asked to receive an update on evaluation events that were scheduled for November and December 2013 that covered some of these qualitative areas. These events were designed to listen to people who use the Trust's services, carers of people use the Trust's services, and staff, to understand "how it feels". The facilitators to the days were identified as independent/ objective of each locality, co-ordinated by the Trust's research and effectiveness team. Unfortunately, these events have not been very well attended, with the number of participants not being either statistically representative, nor sufficient to be able to identify any issues or to formulate any meaningful themes, either within each locality or across the Trust. In CWP however, where events have been driven by the locality – in response to routine feedback and scheduled as part

of the locality's project plan – two events have been successfully held to seek people's views and experiences. The common theme related to the need for improved ongoing communication. It has therefore been recommended that each locality CSIP implementation, monitoring and evaluation group develop more robust plans to better engage people with the evaluation events, learning from CWP Wirral's approach, and ensure that ongoing communication is explored as a theme. A staff survey was produced in December 2013, specifically linked to the CSIP, which will also feed into these evaluation events. Based on the feedback received, locality action plans will be produced and combined so that the Trustwide CSIP group can develop plans to ensure that the model is fully embedded and sustainable. These evaluation events will be held during February 2014 and the outputs reported to the March 2014 meeting of the Board of Directors.

4. Recommendations to the Board of Directors

The Board of Directors is asked to:

- **Note** and **approve** the plans that have been identified to ensure better engagement with the CSIP evaluation events, which will include a staff survey and will also explore the theme identified from the events held in Wirral regarding ongoing communication.
- **Agree** to receive a further report in March 2014, detailing feedback received and Trustwide plans formulated to ensure that the StAR model is fully embedded and sustainable.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 13/14/96)

Report to:	**Board of Directors**
Date of Meeting:	**29 January 2014**
Title of Report:	**Strategic risk register and corporate assurance framework**
Action sought:	**For DISCUSSION and APPROVAL**
Author:	**David Wood, Associate Director of Safe Services** **Louise Hulme, Head of Corporate Affairs**
Presenting Executive:	**Dr Anushta Sivananthan, Medical Director – Quality**

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
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Distribution

Version	Name(s)/Group(s)	Date Issued
1	L Hume to D Wood	17.01.2014
2	D Wood to L Hulme for Board of Directors	20.01.2014

1. Purpose of the report

To apprise the Board of Directors of the current status of the corporate assurance framework and strategic risk register, as per the requirements of the Trust's integrated governance strategy.

2. Introduction

The following report indicates progress against the mitigating actions identified against the Trust's strategic risks, new risks that have been identified, and the controls, assurances in place that act as mitigations against each strategic risk. The Quality Committee is the designated committee for risk management operationally and last reviewed the strategic risk register at its meeting on 8 January 2014. The Audit Committee undertook an in-depth review of *The inability of staff to manage the occurrences of slips, trips and falls of patients, resulting in patient injury* strategic risk at its meeting on 7 January 2014 and agreed a target risk score. Its programme of detailed reviews help the Audit Committee in its reporting to the Board of Directors annually on its work and performance in the preceding year and to provide commentary in support of the annual governance statement, specifically dealing with the fitness for purpose of the corporate assurance framework and the completeness and embedding of risk management in the Trust.

3. Current status

3.1 Strategic risk register

Description of the risk	Residual risk rating Sep 2013	Residual risk rating Nov 2013	Residual risk rating Jan 2014	Risk score since last review	Summary risk treatment plan
Risk of harm to patients as a result of increased rate of stage 3/4 pressure ulcers being reported and evidence of recurring themes in RCA reports relating to pressure area care	20	20	20	↔	A review commenced on 8 July 2013 by CWP West to review the reporting and clinical management of pressure ulcers, in response to queries raised internally and externally regarding an increase in the reporting of pressure ulcers and the recurrence of themes in relation to their clinical management. The 29 October 2013 Audit Committee undertook a deep delve of the risk, controls and mitigations in place, length of time on the risk register, and impact of actions. This involved the Service Director presenting the risk and the actions and assurances in place. It was agreed that the Service Director will attend the Audit Committee again in 6 months time to assess the impact of the actions. The November Quality Committee also reviewed the current status of this risk, and referred the risk to the Patient Safety & Effectiveness Sub Committee to agree actions required to strengthen the risk treatment plan.

Description of the risk	Residual risk rating Sep 2013	Residual risk rating Nov 2013	Residual risk rating Jan 2014	Risk score since last review	Summary risk treatment plan
					The risk treatment plan will be reviewed at the February 2014 meeting of the Patient Safety & Effectiveness Sub Committee.
Adults, children and young people are not protected through safeguarding training and practice	**20**	**20**	**20**	↔	Concerns were raised by West Cheshire CCG regarding accuracy of training figures (June 2013), however the CCG has now indicated they are assured by the improvements made. The risk is reviewed by Quality Committee following receipt of safeguarding exception report every two months. Discussed at November Board of Directors - request that risk is re-modelled to reflect the focus of the risk on training. **Re-modelled risk approved at January 2014 Quality Committee. No changes to risk score. To re-model further or archive once receipt of all-year assurances from commissioners re compliance with safeguarding training targets.**
Risk of harm to patients due to lack of staff competency to manage changing physical conditions	**20**	**20**	**20**	↔	A review of physical healthcare training has been reported to the Quality Committee. Recommendations were identified to address the current/ ongoing strategic risk regarding the lack of staff competency to manage changing physical conditions, to be taken forward by a proposed physical healthcare network reporting to the Patient Safety & Effectiveness Sub Committee. **The physical healthcare network will report to the February 2014 meeting of the Patient Safety & Effectiveness Sub Committee to propose risk treatment plan moving forward.**
The inability of staff to manage the occurrences of slips, trips and falls of patients, resulting in patient injury	**20**	**20**	**20**	↔	FallSafe care bundle is in place across all wards. Patient Safety & Effectiveness Sub Committee has received and approved a report detailing a risk treatment plan to implement control measures to mitigate this risk to a target risk score. The report was in response to the findings of an external

Description of the risk	Residual risk rating Sep 2013	Residual risk rating Nov 2013	Residual risk rating Jan 2014	Risk score since last review	Summary risk treatment plan
					acute falls nurse specialist who undertook a review of falls prevention and management. The review found that, in general, CWP has a robust system in place for the management of slips, trips and falls however, sometimes locally these systems are not always fully implemented. Additionally, issues such as environmental improvements and training also need to be addressed at local level. **Responses to the findings of external review have been identified. Audit Committee undertook in-depth review of the risk at the January 2014 meeting. Risk score target of 15 agreed. Further update to come to May 2014 meeting to provide assurance of actions completed. Further update to come to Audit Committee regarding impact of actions and controls by September 2014.**
Lack of robust ligature management programme within the Trust may result in harm to patients with associated reputational and financial impact on the organisation	**15**	**15**	**20**	↑	Board approved the current capital programme in May 2013. An update report was provided to September 2013 and January 2014 Operational Board. Further action required is installation of door top alarm systems to en suite rooms. **The January 2014 Operational Board agreed to expedite the timeframes for completion of these installation works in response to regulation 28 report [August, September and October 2014 for the high, medium and low priority areas respectively]. It agreed to increase the likelihood score to 4 due to the known residual environmental risk, increasing the current residual risk score to 20.**

Description of the risk	Residual risk rating Sep 2013	Residual risk rating Nov 2013	Residual risk rating Jan 2014	Risk score since last review	Summary risk treatment plan
Risk of harm to patients due to CARSO risk assessment not being completed as per policy	**16**	**16**	**16**	↔	Completion of CARSO risk assessments included in patient safety metrics programme. The Quality Committee endorsed the appointment of a clinical expert champion for zero harm to help CWP achieve synergies in promoting safe and effective services through effective care planning and systems to prevent avoidable harm and unacceptable variations in healthcare experience – risk assessment is fundamental to this work plan. **Proposals in response to the clinical expert champion for zero harm were approved by the January 2014 meetings of the Quality Committee and Operational Board. Proposals are being presented to the January 2014 meeting of the Board of Directors for endorsement.**
Risk of harm to patients and staff due to staffing levels across inpatient services in the three localities	**16**	**16**	**16**	↔	A review was presented to the January 2014 meeting of the Operational Board by the Associate Director of Nursing [Mental Health] and DIPC, detailing the findings of the review team's consideration of staffing levels as identified by ward managers and modern matrons, use of bank staff and financial impact of this, and rostering issues. **Review was presented to Operational Board in January 2014 which approved, in principle, the operational recommendations. Review will be presented to March 2014 meeting of the Quality Committee to consider qualitative recommendations. Specific, immediate actions identified to be presented to January Board of Directors for discussion.**

Description of the risk	Residual risk rating Sep 2013	Residual risk rating Nov 2013	Residual risk rating Jan 2014	Risk score since last review	Summary risk treatment plan
Risk of not being able to deliver planned financial risk rating due to incomplete CIP plans resulting in potential breach of terms of authorisation and reputational damage	**16**	**16**	**16**	↔	Strengthening of financial infrastructure via recruitment of locality accountants and establishment of a performance and service redesign function to support tracking of CIP delivery. Board seminars in October and December 2013 considered financial projection and revised approach to CIP going forward. **Board to receive draft final projections in January 2014.**
Risk of not being able to deliver safe and effective services due to inadequate attendance on mandatory training. This may result in harm to patients, litigation claims and breach of legislation.	**16**	**16**	**16**	↔	A review of the Trust training strategy has been undertaken following corporate services review and follows planning priorities and links to response to Francis and Berwick reports and CWP always events framework. Revised mandatory employee learning programme presented to and approved by October 2013 Operational Board. Implementation plan in development which will be monitored to inform risk treatment plan on an ongoing basis. **Operational Board to receive a detailed review of this risk at the February 2014 meeting.**
Data quality may have an adverse impact on external (regulatory, contractual) monitoring and governance ratings and on effective internal decision making regarding service planning and development	**16**	**16**	**16**	↔	Action plan further to the contract query received from Wirral CCG re data quality was completed December 2013. The information strategy has been drafted but will not be finalised until the Trust's clinical strategy is approved in January 2014 and the Associate Director of Performance and Service Redesign takes up post in January 2014. Findings of an external audit regarding the processes and systems associated with development and presentation of the quality dashboard was reported to January 2014 Quality Committee. **Risk has been reviewed as part of Q3 Monitor quality governance self-assessment – returned to green. Outcome of Quality Account audit for 2013/14 [due May 2014] will be taken into consideration prior to reducing the risk score and archiving this risk.**

Description of the risk	Residual risk rating Sep 2013	Residual risk rating Nov 2013	Residual risk rating Jan 2014	Risk score since last review	Summary risk treatment plan
Risk of harm to patients, carers and staff as well as reputational and litigation risks due to a/ unable to show consistent investigation of incidents; b/ unable to show learning from actions of incidents, claims etc is cascaded; c/ unable to be assured investigations are carried out in a timely manner d/ inability to communicate in a timely manner with partners	**16**	**16**	**16**	↔	Score remains at 16 in response to regulation 28 report – response provided 18 January 2014 and action plan in place to be monitored by Quality Committee. Learning from experience report and always events performance will be monitored to inform risk treatment plan on an ongoing basis. Further work is now ongoing to further improve RCA processes, particularly following the CQC outcome 16 review which identified the need to close actions quickly so that there is assurance of learning from incidents being fed back. Service Directors have been asked to monitor the management of actions arising from root cause analysis investigations – SUI report to January 2014 Quality Committee identified a further increase in locality actions not being closed. **Performance against closure of RCA recommendations will be monitored more closely at the Compliance, Assurance and Learning Sub Committee.**
Risk of breach of Trust Terms of Authorisation/ Provider Licence as a result of external scrutiny	**20**	**15**	**15**	↔	The CQC visited Eastway on 27 September 2013 and found the unit fully compliant against all standards. The Monitor governance rating for the Trust has return to Green. This has not been affected by the two minor concerns following the CQC unannounced visit to Clatterbridge mental health services registered location. The current residual score therefore reflects these assurances. **This risk will be re-scored based on the emergent outcomes of the planned CQC visit programme, including the responsive visit to Bowmere mental health services registered location on 17 January 2014.**
Risk of adverse incident due to patient ID policy not being followed in inpatient areas	**15**	**15**	**15**	↔	This risk was identified following a clinical audit presented to April 2013 Patient Safety and Effectiveness Sub

Description of the risk	Residual risk rating Sep 2013	Residual risk rating Nov 2013	Residual risk rating Jan 2014	Risk score since last review	Summary risk treatment plan
					Committee, which highlighted low levels of compliance across some inpatient units in relation to adhering to patient identification policy. There has also been previous medication incidents linked to mis-identification. Internal audit report received at January 2014 Quality Committee indicating this not to be a significant risk. This will be monitored via incident reporting for evidence of improvement prior to archiving. **Learning from Experience report to continuously monitor this risk longitudinally. Quality Committee in January 2014 agreed to consider archiving this risk at its next meeting.**
Risk of harm to patients from receiving medicines that have not been stored within the manufacturers' product specification. In these circumstances this relates to adequate cold storage i.e. between 2-8 degrees Celsius	**12**	**12**	**12**	↔	This risk was identified following a visit to the pharmacy site as part of a tendering exercise. Confirmation that the majority of actions have been completed. **Discussed at January Quality Committee and proposed for archive. To discuss with Chief Pharmacist to confirm controls and archiving.**
Significant number of unconfirmed notes on CAREotes system which may result in harm to patients, risk of litigation and external scrutiny	**12**	**12**	**12**	↔	A report is generated monthly for all services to action. Discussed at August 2013 Patient Safety and Effectiveness Sub Committee. Nominations covering all localities/ specialities provided to Adrian Burke to the CAREnotes working group. **Working group to report back to Patient Safety and Effectiveness Sub Committee February 2014 – to consider for archive at this time.**
Risk of adverse clinical incident due to dual record keeping systems (electronic and paper)	**12**	**12**	**12**	↔	The Records and Information Governance Group is liaising with the Clinical Informatics Lead to correlate the clinical systems priorities with the dual record keeping risk. A revised dual record keeping action plan was presented to the December 2013 Patient Safety & Effectiveness Sub Committee. A compliance action regarding record keeping was identified by the CQC

Description of the risk	Residual risk rating Sep 2013	Residual risk rating Nov 2013	Residual risk rating Jan 2014	Risk score since last review	Summary risk treatment plan
					following its visit to Clatterbridge mental health services registered location, for completion end March 2014. **Patient Safety & Effectiveness Sub Committee will monitor progress of this action plan at its February 2014 meeting, escalating matters of concern re completion by the end of March to the Quality Committee.**
Risk of breach of Equality and Diversity legislation resulting in risk of reputational, financial loss and potential harm to staff and patients	**12**	**12**	**12**	↔	A review of the current risk in relation to this is underway. Awaiting assurance re Trust compliance re September 2013 Board update on Equality and Diversity Act progress. **Gaps in compliance identified, Associate Director of Nursing is interim senior lead. Assurance is being sought from the Workforce and Organisational Development Sub Committee re compliance on Equality and Diversity Act. Also, an equality and diversity officer is currently being recruited to.**
Reduction in quality of service provided as a result of service redesign, which may result in patient harm, increased burden on carers, increased complaints and litigations, and a negative impact on Trust reputation to patients, public and commissioners	**15**	**10**	**10**	↔	This risk has been re-modelled and current residual score remains 10. This follows September 2013 Quality Committee receiving quality dashboards presented by Service Directors with a view to continuing this at each Quality Committee meeting. The Board approved a paper detailing the quality impact of CSIP programme post implementation demonstrating, overall, no impacts on quality. A monthly verbal update is also provided to Operational Board regarding implementation of the CSIP programme and the LD service re-design. In November 2013, CQC requested assurance regarding impact of CSIP. Response provided, no further information requested. **The CQC reviewed this risk as part of the feedback from CQC monitoring visit re mental health: assessment and application for detention and admission visit [to Wirral]. No formal**

Description of the risk	Residual risk rating Sep 2013	Residual risk rating Nov 2013	Residual risk rating Jan 2014	Risk score since last review	Summary risk treatment plan
					action identified over and above on-going Trust identified actions. The CQC indicated a follow up visit in one year. Locality evaluations to reflect 6 month impacts being presented to January 2014 require further evaluations to take place as a result of small numbers of feedback – to be reported again to March 2014 meeting of the Board of Directors.
Risk of loss of income and capacity due to tariff being set at a level which does not allow CWP to compete in the marketplace	**9**	**9**	**9**	↔	Local and regional PbR groups in place – financial benchmarking data may be available to evaluate this risk. Need to include PbR project group into corporate governance structure, regularly reporting into Operational Board. **Consider for archive following progress with above risk treatment plan. To discuss with Director of Finance re archiving this risk – update will come to March 2014 Quality Committee.**

3.2 Corporate assurance framework

The corporate assurance framework outlining controls and assurances is available at appendix 1/ T drive.

4. Discussion

The following are significant updates since the last review of the strategic risk register and corporate assurance framework.

4.1 New risks

There have been no new risks added to the risk register.

4.2 Amended risk scores

One risk has had its residual risk score amended. This is:

Lack of robust ligature management programme within the Trust may result in harm to patients with associated reputational and financial impact on the organisation

This score has increased from 15 to 20 on the basis of the Quality Committee and Operational Board review of the risk, which considered that in response to known interim residual gaps to environmental mitigation of en suite doors, the likelihood score should be increased to 4. Operational Board received the ligature action plan at the January 2014 and agreed that actions be expedited as per the risk treatment plan above.

One risk has been re-modelled with no change to the residual risk score. This is:

Adults, children and young people are not protected through safeguarding practice
This risk has been re-modelled to:
Adults, children and young people are not protected through safeguarding training and practice

This risk has been re-modelled following discussion at the November 2013 meeting of the Board of Directors, where it was identified that that the basis of this risk is around training, particularly in physical health services, and therefore a need for the focus of the risk treatment plan to be more specific.

4.3 Archived risks
No risks have been archived.

4.4 Audit Committee review of the risk register
The Audit Committee undertook an in-depth review on the risk *The inability of staff to manage the occurrences of slips, trips and falls of patients, resulting in patient injury* at their meeting on 7 January 2014. The Medical Director for Quality and the Head of Clinical Governance attended the meeting to inform the Audit Committee of the progress to-date with this risk. Information was presented on the risk treatment plan in place which had been informed by the recommendations of an external expert in falls risk management, and a target risk score of 15 was presented and agreed. It was also agreed that a further presentation be made to May 2014 Audit Committee to provide assurance on completion of actions identified, and in October 2014 to assess the overall impact of the risk treatment plan.

The Audit Committee was advised by the Quality Committee to reconsider the next risk for in depth review and recommended that at their next meeting on 4 March 2014 that the risk of *Lack of robust ligature management programme within the Trust may result in harm to patients with associated reputational and financial impact on the organisation* be chosen for in-depth review, particularly in light of the increase in likelihood score to receive overall assurance regarding the risk treatment plan.

4.5 Current and further development of the risk register
Proposals have been agreed for an external/ objective facilitation at the February 2014 Board seminar, extended to senior managers as part of their risk management training, to inform the Trust's risk appetite, risk tolerance, and patient safety culture.

Work is continuing to improve the dynamism of the strategic risk register. This will be further aided by the external facilitation on risk tolerance and, consequently, the identification of target risk scores for all strategic risks. This will bring a more evidence based and strategic decision making approach to the archiving of risks in line with the delivery of the Trust's strategic objectives – but can only be objectively applied where the organisation has a more structured understanding of its risk tolerance.

5. Recommendations
The Board of Directors is required to **review, discuss** and **approve** the amendments that have been made to the strategic risk register and corporate assurance framework as recommended by the Quality Committee.

Appendix 1
Corporate assurance framework

Risk Owner	Risk Lead	Risk Type	Date Added	Description of the Risk	Source of Risk	Inherent Risk Score	Controls in place	Assurance	Gaps in controls	Impact	Likelihood	Residual Risk Rating	Target Risk Score	Actions required with responsibilities/timeframes	Date of review
Strategic Objective 1- Deliver high quality, integrated and innovative services that improve outcomes															
Anushta Sivananthan - Medical Director Quality	Maria Nelligan - Deputy Director of Nursing	Clinical Risk	20/01/2011	Risk of harm to patients due to lack of staff competency to manage changing physical conditions	Incident report	25	Inpatient physical healthcare collaborative Inpatient physical healthcare policy and pathway Training programme for inpatient staff on physical healthcare Health Action Plan/ CPA Bi monthly inpatient metrics Falls policy and pathway Falls risk assessment tool Falls and NA links via PCT to best practice MIAA Audit - Mandatory Training 2012/13 Clinical Audit Programme 2012/13 (CPA Audit - 31/07/12 Falls Audit - 31/08/2012 Inpatient and Community Safety Metrics - Monthly and On-going)	Protocol on physical observations Clinical Audit - Physical Health Audit 31/12/2012 Training reports to PSESC Inpatient safety matrix (ISM) Monitor Health Action Plan/CPA documentation Learning from Experience Report analysing incidents Agreed at Nov Quality Committee that physical healthcare training to be delivered by IPC team	CareNotes implementation of assessment tools current gaps in relation to new policy and pathway implementation	5	4	20		a) Ensure physical healthcare pathway is implemented trust wide in line with quality account targets Maria Nelligan- Deputy Director of Nursing by 30/04/2012 STATUS- Completed 08/06/2012 b) Ensure that physical health management is incorporated into mandatory training review Maria Nelligan- Deputy Director of Nursing by 01/10/2011 STATUS- Completed 01/10/2011 c) Ensure falls policy is ratified and implemented Anushta Sivananthan - Medical Director by 29/04/2011 STATUS- Completed 01/12/2011 d) Ensure compliance with NPSA falls rapid response alert Anushta Sivananthan - Medical Director by 29/07/2011 STATUS- Completed 01/12/2011 e) Review of physical healthcare pathway and discussion to take place regarding on-going funding/roll out of training Maria Nelligan- Deputy Director of Nursing/Anushta Sivananthan - Medical Director/Avril Devaney- Director of Nursing by 30/09/2012 STATUS- Completed by 30/09/2012 f) Addition of physical healthcare training as mandatory for inpatient staff Jane Tomlinson- Head of Learning & Development STATUS - Completed by November 12 WOD g) Confirmation of how physical healthcare training for inpatient staff is going to be delivered to be given to Trust Quality Committee Maria Nelligan- Deputy Director of Nursing/Anushta Sivananthan - Medical Director by November 12 Quality Committee STATUS- Completed h) Roll out a programme of physical healthcare training as part of mandatory training Maria Nelligan- Associate Director of Nursing [Mental Health]/ Andrea Hughes- Associate Director of Nursing [Physical Health] by 01/04/2013 STATUS-Outstanding- A review of physical healthcare training was reported to the Quality Committee. Recommendations were identified to address the current/ on-going strategic risk regarding the lack of staff competency to manage changing physical conditions, to be taken forward by a proposed physical healthcare network reporting to the Patient Safety & Effectiveness Sub Committee address. The physical healthcare network will report to the February 2014 meeting of the Patient Safety & Effectiveness Sub Committee to propose risk treatment plan moving forward.	20/02/2014

Risk Owner	Risk Lead	Risk Type	Date Added	Description of the Risk	Source of Risk	Inherent Risk Score	Controls in place	Assurance	Gaps in controls	Impact	Likelihood	Residual Risk Rating	Target Risk Score	Actions required with responsibilities/timeframes	Date of review
Avril Devaney - Director of Nursing Therapies & Pt Partnership	Andrea Hughes - Associate Director of Nursing and Therapies	Clinical Risk	01/12/2011	Adults, children and young people are not protected through safeguarding training and practice	External Recommendations	25	Suite of patient safety policies In place inc: Safeguarding Policy Safeguarding flow chart Review of datix incidents to identify potential safety risks Local safeguarding groups Staff training including MEL MIAA Audit - 2012/13 MIAA Audit - Effectiveness of Policy review group 2012/13 Clinical Audit Programme 2012/13 Safeguarding Adults Audit - 31/07/12 Safeguarding Children Audit - 31/07/12 Seclusion Audit - 31/07/12 Violence and Aggression Audit - 31/07/12 AWOL Audit - 31/07/12 Medicines Management Audit - 30/06/12 Inpatient and Community Safety Metrics	Learning from experience reports from safeguarding CSU self assessments compliance MIAA reports Clinical audits Inpatient safety matrix Service objectives regarding 100% access to supervision and 80% compliance with statutory and mandatory training. Quarterly mandatory training and patient experience reports to Operational Board Exception reporting to Quality Committee	The gap in control associated with the current mandatory employee learning risk, particularly the inability to report in ESR by CSU level and give accurate reports, applies to this risk also.	5	4	20		a) Ensure that the Trust Safeguarding policy is reviewed. Satwinda Lotay- Trust Safeguarding lead by 30/06/2012 STATUS- Completed 30/06/2012 b) Ensure that hotspot areas are identified and targeted training is arranged to enable the Trust to meet external targets on safeguarding training. Satwinda Lotay- Trust Safeguarding lead by 30/09/2012 STATUS- Completed c) Targets around training to be reviewed in Performance reviews and reported to Performance and Compliance Sub Committee and Operational Board. Louise Hulme- Planning & Performance Manager by 31/12/2012 STATUS- Completed and on-going. d) Pilot in the first instance a tool to evaluate the efficacy of safeguarding training to better demonstrate staff knowledge, understanding and adherence to trust policy and guidelines around safeguarding Andrea Hughes - Associate Director of Nursing & Therapies (Physical Health) by 31/03/2013 STATUS- Completed e) Each CSU to provide a training implementation plan to achieve 80% compliance by 31st March 2013 which will be monitored at Trustwide Safeguarding committee with exceptions reported to Quality Committee All General Managers by 31/03/2013 STATUS- Completed f) Safeguarding team to deliver bespoke training as agreed with General Managers to target services with low uptake rates.Safeguarding team STATUS- Action on-going and to link to action e) g) Learning and Development to support CSUs in the maintenance of an up to date accurate record of training achievement and compliance via ESR Learning & Development Team STATUS- Action on-going and to link to action e) h)To re-model once receipt of all-year assurances from commissioners re compliance with safeguarding training targets. STATUS - In progress - awaiting assurance. Discussion at November BOD requested that risk is re-modelled to reflect focus of risk on training - re-modelled risk approved at January Quality Committee. No change to current risk score. To re-model further or archive once receipt of all-year assurances from commissioners re compliance with safeguarding training targets.	08/01/2014

Risk Owner	Risk Lead	Risk Type	Date Added	Description of the Risk	Source of Risk	Inherent Risk Score	Controls in place	Assurance	Gaps in controls	Impact	Likelihood	Residual Risk Rating	Target Risk Score	Actions required with responsibilities/timeframes	Date of review
Anushta Sivananthan - Medical Director Quality	David Wood - Associate Director of Safe Services	Clinical Risk	11/05/2010	The inability of staff to manage the occurrences of slips, trips and falls of patients, resulting in patient injury.	Incident report	20	Falls policy and pathway in place, Falls Risk Assessment tool developed for older persons and service users who are known to have a risk of falls. Falls training needs analysis developed, Falls audit programme in place, Links with PCT falls co-ordinators Clinical Audit Programme 2012/13 Falls Audit - 31/08/2012 Inpatient and Community Safety Metrics - Monthly and on-going Additional equipment funding Falls Task and Finish group established June 2012	NRLS data shows the Trust is similar when compared to other Trusts in relation to falls Inpatient Safety Metrics NHSLA Level 2 compliance Quarterly incident reports show an increase in falls reported but a decrease in severity of falls highlighted as a safety priority within the Trust's Quality Account	There is limited data available in relation to falls management as to whether falls may have been prevented due to risk assessment and planning The Trust has had an increase in the number of category B falls in 12/13 and has had incidents in 13/14	5	4	20	15	a) Develop an action plan for the safety priority of reduction of inpatient falls by 10% as outlined within Quality Accounts. Ursula Martin- Associate Director of Quality, Compliance & Assurance by 31/08/2010. STATUS- Completed 31/08/2010 b) Undertake a falls audit to look at incidents of falls in Q1 2010 and look at whether any of these falls could have been prevented. Ursula Martin- Associate Director of Quality, Compliance & Assurance by 31/05/2011. STATUS: Completed 12/07/2011 c) On-going monitoring of falls incidents data through the quarterly learning from experience report triangulated with NPSA benchmark report. Ursula Martin- Associate Director of Quality, Compliance & Assurance by 30/03/2012. STATUS: On-going d) Falls reaudit 12 months post policy implementation. Ursula Martin- Associate Director of Quality, Compliance & Assurance by 28/09/2012. STATUS- Completed (incorporated into Inpatient Safety Metrics) e) Establish task and finish group to undertake RCA cluster analysis, incidents by bed days, environmental issues, incorporating benchmarking data. Ursula Martin- Associate Director of Quality, Compliance & Assurance first meeting by 31/08/2012. STATUS- Completed 31/08/12 f) Review falls assessment tool and falls intervention plan in use within the Trust and identify any further actions that the Trust can take in relation to reduction of inpatient falls. Falls collaborative Group by January 2013 (reporting to Jan 13 Quality Committee) STATUS- Completed g) Roll out Fallsafe Royal College Programme across 6 wards (older adult wards) for 3 months and ensure collection of carebundle data on falls. Ward Managers for 6 wards by end Jan 13. STATUS- Completed h) Evaluate Fallsafe Programme and report to Trust Quality Committee Falls collaborative Group by January 2013 (reporting to Jan 13 Quality Committee) STATUS- Completed i) Review high spec falls prevention and management equipment (smart floors, telehealth etc.) and look at whether to purchase this equipment. Falls collaborative Group by January 2013 (reporting to Jan 13 Quality Committee) STATUS- Completed j) Review Fallsafe wards at the end of the pilot (March 13) Ward Managers for 6 wards by end March 13. STATUS- Completed k) Develop a Never/Always event re falls. Falls collaborative Group by March 2013. STATUS: Completed. This action will be picked up as part of the Quality Account safety priority Always and Never Events. The Trust never/ always events framework was agreed at Sept Operational Board. l) Commission an external review to introduce an independent view to CWPs approach to management of falls and develop recomemndations. Medical Director Quality and Head of Clinical Governance 01/10/2014 STATUS: On track. Review completed - responses in development. Audit Committee undertook in-depth review of the risk at the January meeting. Risk target agreed. Further update to come to May 2014 meeting to provide assurance on actions to be completed. Further update to come to audit regarding impact of actions and controls by October 2014.	05/02/2014

Risk Owner	Risk Lead	Risk Type	Date Added	Description of the Risk	Source of Risk	Inherent Risk Score	Controls in place	Assurance	Gaps in controls	Impact	Likelihood	Residual Risk Rating	Target Risk Score	Actions required with responsibilities/timeframes	Date of review
Avril Devaney - Director of Nursing Therapies & Pt Partnership/A Styring- Director of Operations	J Critchley- Service Director West Cheshire	Clinical Risk	05/07/2013	Risk of harm to patients as a result of increased rate of Grade 3/4 pressure ulcers being reported and evidence of recurring themes in RCA reports relating to pressure care (resulting in concerns raised by commissioners)	Incident report	20	National standards in relation to pressure care being adopted in the Trust Nursing assessments Pressure ulcer Care Bundle in place Peer review process in place for all Grade 3/4 pressure ulcers to look at whether pressure ulcer could have been avoided RCA process undertaken on all avoidable pressure care serious incidents Rates of incidents reviewing through Learning from Experience reports	Safety thermometer reporting on pressure ulcers Incident rates/reporting via Learning from Experience	Internal//external feedback regarding increased rates of pressure incidents and recurring themes from RCA investigations	4	5	20		a) A review of pressure care to be undertaken and an update to be given to Quality Committee Julie Critchley- Service Director West Cheshire/Andrea Hughes- Associate Director of Nursing Physical Health STATUS- Outstanding- The November Quality Committee also reviewed the current status of this risk, and referred the risk to the Patient Safety & Effectiveness Sub Committee to agree actions required to strengthen the risk treatment plan. The risk treatment plan will be reviewed at the February 2014 meeting of the Patient Safety & Effectiveness Sub Committee.	20/02/2014
Andy Styring - Director of Operations	Service Directors and Clinical Directors - all localities	Clinical Risk	30/04/2013	Risk of harm to patients and staff due to staffing levels across inpatient services in the three localities.	Local Risk Register (AMH East)- other localities TBC	25	Staffing rotas in place- e rostering Temporary staffing systems in place On call system in place		Unannounced visits in East Cheshire have raised these issues. Patient Safety and Effectiveness Committee identified that there are similar issues across other inpatient areas in West and Wirral localities	4	4	16		a) Discuss at Quality Committee actions needed to address this issue on a Trust wide basis including a position statement on current staffing levels (safety and skill mix across all professional types, benchmarked against other trusts. Andy Styring- Director of Operations and Service Directors STATUS- Completed - position statement provided to October Operational Board. b) Clear protocol to be in place around vacancy control procedures during periods of service redesign which needs to incorporate an impact assessment process Avril Devaney- Director of Nursing Therapies and Patient Partnerships by end June 2013 STATUS- Completed c) Finance to review staffing establishments with service managers in East Cheshire following feedback from unannounced visits to Millbrook. Service Director East Cheshire/Deputy Director of Finance by Sept Quality Committee STATUS- On-track -to be considered as part of review (See action d) d) Establish a review team with external input and undertake a review to consider staffing levels identified by ward managers and modern matrons, use of bank and financial impact of this and rostering issues - Maria Nelligan to lead. STATUS - On track - Review presented to Operational Board in January 2014. Action plan to be presented to January Board of Directors.	29/01/2014

Risk Owner	Risk Lead	Risk Type	Date Added	Description of the Risk	Source of Risk	Inherent Risk Score	Controls in place	Assurance	Gaps in controls	Impact	Likelihood	Residual Risk Rating	Target Risk Score	Actions required with responsibilities/timeframes	Date of review
Anushta Sivananthan - Medical Director Quality	Dr. I Davison	Clinical Risk	05/07/2013	Risk of harm to patients due to CARSO risk assessment not being completed as per policy	Incident report	20	Clinical Management Policy Training in clinical risk management Summarised view of risk on Trust EPRS CAREnotes	Clinical audit process has been strengthened via Inpatient and Community Safety Metric Programme. Addressed via performance reviews Inpatient/Community Safety Metrics linked into Quality Dashboard work	Recurrent themes in SUI investigations that CARSO not updated Community Safety Metric results indicate that there are performance issues/gaps in assurance	4	4	16		a)Completion of CARSO risk assessments being considered as part of the Never/Always Events Framework, which will be approved Sept 13 at Operational Board Operational Board by 11/09/2013 STATUS- Completed. Consideration given to this for inclusion in Never/ Always Events Framework. Agreed to include this is CSM as oppose to Never/ Always Event Framework. b) October PSE to receive information on 4Ps approach to risk formulation, and information from CDs on other speciality approaches to risk management and any support required - training etc STATUS: Completed and feed back provided to Dec PSE - Clinical Directors will use 4Ps as an aide memoir. c) Appointment of an internal clinical advocate to act as a catalyst to help CWP achieve synergies in promoting safe and effective services through effective care planning and systems to prevent avoidable harm and unacceptable variations in healthcare experience - risk assessment to underpin this. Dr Anushta Sivananthan three year plan by 01/04/2014. STATUS: On track. Dr I Davidson appointed as clinical expert champion for zero harm. Initial proposals of the internal clinical advocate approved by January Quality Committee. Final proposals to be agreed at January 2014 Board of Directors.	29/01/2014

Risk Owner	Risk Lead	Risk Type	Date Added	Description of the Risk	Source of Risk	Inherent Risk Score	Controls in place	Assurance	Gaps in controls	Impact	Likelihood	Residual Risk Rating	Target Risk Score	Actions required with responsibilities/timeframes	Date of review
Avril Devaney - Director of Nursing Therapies & Pt Partnership	David Wood - Associate Director: Safe Services/ Service Directors	Clinical Risk	11/05/2010	Risk of harm to patients, carers and staff as well as reputational and litigation risks due to a/ unable to show consistent investigation of incidents; b/ unable to show learning from actions of incidents, claims etc is cascaded; c/ unable to be assured investigations are carried out in a timely manner d/ inability to communicate in a timely manner with partners	Incident report	20	Incidents and complaints policy Actions from SUIs logged on DATIX and closed down when completed CSU governance systems HASCAS investigation training for managers HASCAS investigation training for investigators HASCAS mentoring of investigators SUI quality group Follow up by MIAA audit of Incident Management and Reporting - 2012/13 Transfer of care included on Always/ Never event framework Updated Incident Policy and protocols in line with revised national policy and Duty of Candour legal and contractual requirements Improved process around SUI management	Learning from Experience reports and publications NHSLA level 2 compliance achieved Incident / Complaints Policies Actions Datix Module Triangulation meetings Weekly reports to all services to remind of status of live complaints and SUIs and to receive updates on progress to ensure performance monitoring	Issues raised with SUI management - insufficient number of investigators; quality of reports variable and RCA not completed within agreed timeframes CQC outcome 16 review identified the need to close actions quickly so that there is assurance of learning from incidents	4	4	16		a) Establish core group of lead investigators within CSUs to receive externally commissioned training. Val Mc Gee- Deputy Director of Operations by 30/04/2012. STATUS- Completed 30/04/2012 b) Streamline RCA process: Ursula Martin- Associate Director Quality, Compliance & Assurance by 29/06/2012. STATUS- Completed 29/06/2012 c) To plan and implement Investigation Managers Drop-in sessions. Kathy Richardson- Risk and Legal Services Manager by 30/09/2012. STATUS- Completed 30/09/2012 by Clinical Governance Department d) To develop and implement an Investigation Toolkit for RCA Investigators. Kathy Richardson- Risk and Legal Services Manager by 30/09/2012. STATUS- Completed 30/09/2012 by Clinical Governance Department e) Establish in house RCA training programme for additional investigators by 30/09/2012- revised action due to Risk and Legal Services Managers leaving f) Ensure that 4 in house RCA training session are facilitated prior to end March 2013. Ursula Martin- Associate Director Quality, Compliance & Assurance by 31/03/2012. STATUS- Completed- training in place, however 4 sessions were not in place. Sessions planned for 13/14 g) Recruit 2 RCA leads within the Clinical Governance Department on a fixed term contract to promote consistent investigation are undertaken, learning takes place and the Trust meet contractual requirements. Ursula Martin- Associate Director Quality, Compliance & Assurance by 30/11/2012. STATUS- Completed - Action was off track due to CSIP review (posts will be recruited from pool of individuals at risk). 3 posts have been funded for 12 months, one for each locality- 2 will be in post by 20th may and other post is currently being recruited. h) Undertake a review of unexpected deaths over a period of time, report findings and develop actions as appropriate Ursula Martin- Associate Director Quality, Compliance & Assurance by 28/02/2013. STATUS- Audit completed and reported to Patient Safety & Effectiveness Sub Committee, actions to be linked into suicide prevention audit and quality account priorities i) Identify medical leads to support RCA leads in each area whose role will be to ensure quality of reporting, adhere to timeframes and promote feedback of learning to services. Ursula Martin- Associate Director Safe Services by 28/06/2013. STATUS- Completed 28/06/2013 j) Training programme to be developed for RCA leads and medical leads. David Wood- Associate Director Safe Services by 31/07/2013. STATUS- Completed, two training sessions were held, 22 and 29 July, facilitated by external RCA provider bespoke to CWP needs k) Update Incident Policy and protocols in line with revised national policy and Duty of Candour legal and contractual requirements. David Wood- Associate Director Safe Services by 31/07/2013. STATUS: Completed. Policy revised by DW - approved by July Quality Committee. Further work is on-going to further improve RCA processes as part of zero harm proposals (see CARSO strategic risk) l) Implement recommendations/ actions from CQC outcome 16 review. STATUS - On track. Service Directors have been asked to monitor the management of actions arising from root cause analysis investigations. Performance will be monitored more closely at the Compliance, Assurance and Learning Sub Committee	16/01/2014

Risk Owner	Risk Lead	Risk Type	Date Added	Description of the Risk	Source of Risk	Inherent Risk Score	Controls in place	Assurance	Gaps in controls	Impact	Likelihood	Residual Risk Rating	Target Risk Score	Actions required with responsibilities/timeframes	Date of review
Andy Styring - Director of Operations	Val McGee - Deputy Director of Operations/Julie Critchley- Service Director, Julie Cottier - Service Director	Clinical Risk	13/08/2012	Reduction in quality of service provided as a result of service redesign, which may result in patient harm, increased burden on carers, increased complaints and litigations, and a negative impact on Trust reputation to patients, public and commissioners.	Risk Assessment	20	Annual planning process scopes out risks to Top 5 CIP plans Impact assessment process CIP steering group being convened- issues and risk logs in place for escalation purposes Consultation processes as part of service redesigns include patients, public, commissioners, OSC etc.	Impact assessments have been undertaken for community mental health 12/13 service redesign Board approval gained in July 12 for community services redesign Board approved report outlining CSIP quality impact post implementation- Sept 13 Bi-monthly reporting to Quality Committee Monthly verbal update to Operational Board (re. CSIP and LD redesign)	In November 2013, the CQC reviewed this risk as part of the feedback from CQC monitoring visit re mental health: assessment and application for detention and admission visit [to Wirral]. No formal action identified over and above ongoing Trust identified actions. The CQC indicated a follow up visit in one year.	5	2	10		a) Undertake an initial quality impact assessment of CMHT service redesign looking at safety, effectiveness and patient experience Anushta Sivananthan- Medical Director Quality, Compliance & Assurance/Ursula Martin- Associate Director of Quality, Compliance & Assurance/Adult Mental Health CSU General Manager and Clinical Directors by 31/08/2012 STATUS: Completed b) Develop quality indicators for monitoring of service changes in CMHT 12/13 Anushta Sivananthan- Medical Director Quality, Compliance & Assurance/Ursula Martin- Associate Director of Quality, Compliance & Assurance/Adult Mental Health CSU General Manager and Clinical Directors by 30/09/2012 STATUS: Completed and presented to Sept 12 Quality Committee c) Undertake a baseline of quality indicators for CMHT service redesign and present to the Board of Directors Anushta Sivananthan- Medical Director Quality, Compliance & Assurance/Ursula Martin- Associate Director of Quality, Compliance & Assurance by Jan 13 Board of Directors STATUS: Completed (March Quality Committee) d) Undertake a quality impact assessment of LD service redesign Anushta Sivananthan- Medical Director Quality, Compliance & Assurance/Ursula Martin- Associate Director of Quality, Compliance & Assurance/LD General Manager/Clinical Director by Jan 31/12/2012 STATUS: Completed e) Further develop Quality dashboard for inpatient and community teams Anushta Sivananthan- Medical Director Quality, Compliance & Assurance/Ursula Martin- Associate Director of Safe Services/Service Directors/Clinical Directors STATUS: Completed f) Receive feedback from Star Chamber processes with commissioners regarding impact assessment of CIP and link any feedback into quality impact assessment process. Anushta Sivananthan- Medical Director Quality, Compliance & Assurance/David Wood - Associate Director of Safe Services STATUS: Completed. g) Provide report to Board covering quality impact of CSIP 3 month post implementation. STATUS: Completed. Report provided and approved by Board in September 2013 h) Locality evaluations to be completed reflecting 6 month progress. Service Directors by Jan 2014 STATUS: In progress	29/01/2014

Risk Owner	Risk Lead	Risk Type	Date Added	Description of the Risk	Source of Risk	Inherent Risk Score	Controls in place	Assurance	Gaps in controls	Impact	Likelihood	Residual Risk Rating	Target Risk Score	Actions required with responsibilities/timeframes	Date of review
Andy Styring - Director of Operations	Val McGee - Deputy Director of Operations. Dan Allmark - Head of Estates	Clinical Risk	11/05/2010	Lack of robust ligature management programme within the Trust may result in harm to patients with associated reputational and financial impact on the Organisation	Risk Assessment/Incident Report	25	Estates capital programme Ligature prioritisation programme in place based on risk Mandatory Learning includes on Clinical Risk assessment and Observation CARSO review Q4 2012/13 MIAA Audit - Mandatory Training 2012/13 Clinical Audit Programme 2012/13 includes the following audits which are linked to the risks regarding ligature Therapeutic Observation Audit - 31/07/12 Clinical Risk Assessment Audit - 31/07/2012 Ligature Management Audit - 31/07/2012 Inpatient Safety Metrics - Monthly and On-going	Patient safety walkrounds may address outstanding estates issues if applicable Assurance given to Quality Committee that remedial work against 11/12 ligature programme given Report to exec directors regarding completion of ligature audits in Jan 11 All ligature risks have been RAG rated and funds have been pledged centrally for ligature remedial work 11/12 Update at Quality Committee given at May 13- capital programme paper went to Ops Board on 8 May. Scheme 2 agreed ligature remedial works of £300k. Scheme 7 has identified urgent works at Alderley. Agreement given to require door top alarm systems fitting in all refurbishment works	Recent SUIs in in-patient areas . Assurance required that action plans from incidents have been implemented Trust wide.	5	4	20		a) Ensure an action plan of how red/amber risks are going to be managed is discussed at exec directors meetings Steve Ferrington- Head of Estates by 28/02/2011 STATUS- Action completed 28/02/2011 b) Ensure that ligature management programme is reported to the Trust Health Safety and Well-being meeting regularly Steve Ferrington- Head of Estates by 11/05/2011 STATUS- Action completed 11/05/2011 c) Ensure that there is an on-going programme for ligature risk assessment and managed within the Trust Steve Ferrington- Head of Estates by 23/06/2011 STATUS- Action completed 24/06/2011 d) A final report of priorities for 11/12 capital programme to go to July Ops Board for sign off - outlining remedial risks Steve Ferrington- Head of Estates by 31/07/2011 STATUS- Action completed 31/07/2011 e) Following completion of actions relating to new policy, audit to be undertaken Val Mc Gee- Deputy Director of Operations by 29/02/2012 STATUS- Completed f) Embed clinical risk assessment and therapeutic assessment policies contained within MEL in clinical service Val Mc Gee- Deputy Director of Operations by 29/02/2012 STATUS- Completed g) Put a programme of ligature works in place for 2013, based on clinical risk Dan Allmark, Estates Manager by 31/03/2013 STATUS- Completed - Capital and Revenue programme agreed by Board - May 2013. h) Confirm progress against urgent works at Alderley and progress against ligature scheme Dan Allmark, Estates Manager by 18/09/2013 - DA due to report at Sept Quality Committee STATUS- Completed. Update provided to November Operational Board. i) Further action required regarding the door top alarm systems. To provide a further update to January Operational Board. Status- On track works identified for completion by end October 2014. Discussed at Quality Committee - due to high level of environmental risk, likelihood increased to 4 therefore overall risk score of 20. Ligature risk action plan approved at Operational Board to expedite urgent action.	15/01/2014
Quality	Ward Managers	Clinical Risk	30/04/2013	Risk of adverse incident due to Patient ID policy not being followed in inpatient areas	Clinical audit	20		Policy in place which meets national guidance . Revision of ISM to include patient ID commencing November 2013	Clinical audit presented to Patient Safety & Effectiveness meeting April 2013 highlighting non compliance with policy There have also been incidents due to medication wrongly administered	5	3	15		a) Review clinical audit data, looking at compliance at ward level and communicate this data to ward managers and matrons Clinical Governance Manager by 15th May 2013 STATUS- Completed b) Have patient ID as a local Never/Always event as part of quality account priority Associate Director of Safe Services by end June 2013 STATUS- Completed c) Further monitoring prior to archive. Decision re. archiving this risk due at March 2013 Quality Committee STATUS- On track	08/01/2014

Risk Owner	Risk Lead	Risk Type	Date Added	Description of the Risk	Source of Risk	Inherent Risk Score	Controls in place	Assurance	Gaps in controls	Impact	Likelihood	Residual Risk Rating	Target Risk Score	Actions required with responsibilities/timeframes	Date of review
Anushta Sivananthan, Medical Director Quality	Andrew Ellis, AMD Quality	Clinical Risk	11/05/2010	Risk of adverse clinical incident due to dual record keeping systems (electronic and paper)	Incident Report	16	Record keeping policy and strategy is implemented and monitored by the Trustwide Record Keeping Group, Information governance toolkit-green status, Annual record keeping audit CareNotes access by Social Services, Information sharing policy in place, Record keeping is a component of Root Cause Analysis in the event of an incident MIAA Audit - IT applications - Shared Heath Records 2012/13 Clinical Audit Programme 2012/13 Record Keeping Audit 03/12	Action plan from Trust Records Group Incident reporting analysed regularly Audit reports Minutes of Trust Records Group Assurance/action plan been developed by AMD Quality reporting through to Patient Safety & Effectiveness Sub Committee		4	3	12		a) Review Terms of Reference for Trust Records Meeting as part of the Trust governance review Andrew Ellis- AMD Quality (Chair of Trust Records Group) by 31/08/2010 STATUS- Completed 31/08/2010 b) Review the Trust records policy to ensure compliance with NHSLA standards Gill Monteith- Trust Records Group by 29/10/2010 STATUS- Completed 31/10/2011 c) Clinical informatics lead to work with IM&T to promote further development of carenotes - presentation to Quality Committee Andrew Ellis- AMD Quality (Chair of Trust Records Group)/Janet King- Associate Director of informatics by 28/02/2012 STATUS- Completed presentation was given to Patient Safety & Effectiveness Sub Committee June 12 d) Undertake a review where the Trust has dual record keeping systems and where the risks may be increased so that mitigations can be put in place Andrew Ellis- AMD Quality (Chair of Trust Records Group)/Janet King- Associate Director of informatics by 28/02/2012 STATUS- Completed- action plan developed by AMD Quality e) Give an update of the action plan developed to October Patient Safety & Effectiveness Sub Committee Andrew Ellis- AMD Quality (Chair of Trust Records Group)/Janet King- Associate Director of informatics by 31/10/2012 STATUS- Completed f) The policy is currently under review for NHSLA compliance purposes, and will be approved at Patient Safety & Effectiveness Sub Committee in October. AMD Quality (Chair of Trust Records Group)/Gill Monteith, Trust Records Manager by 31/10/2012 STATUS- Completed g) Give an update of the dual record keeping action plan to Patient Safety & Effectiveness Sub Committee AMD Quality (Chair of Trust Records Group)/Gill Monteith, Trust Records Manager by 30/06/2013. This item was deferred from June Patient Safety & Effectiveness Sub Committee - The revised Assurance Framework deferred from August PSE and will be received at October PSE STATUS: Completed. A revised dual record keeping action plan was presented to the December 2013 Patient Safety & Effectiveness Sub Committee. Patient Safety & Effectiveness Sub Committee will continue to monitor this action plan and to report exceptions to Quality Committee. h) February Patient Safety and Effectiveness Sub Committee to monitor progress, achievement required by end March 2014 as per response to CQC. Jo Watts, Head of Compliance by end March 2014. Status- On track	20/02/2014

Risk Owner	Risk Lead	Risk Type	Date Added	Description of the Risk	Source of Risk	Inherent Risk Score	Controls in place	Assurance	Gaps in controls	Impact	Likelihood	Residual Risk Rating	Target Risk Score	Actions required with responsibilities/timeframes	Date of review
Anushta Sivananthan - Medical Director Quality	Fiona Couper, Chief Pharmacist	Clinical Risk	05/07/2013	Risk of harm to patients from receiving medicines that have not been stored within the manufacturers product specification. In these circumstances this relates to adequate cold storage i.e. Between 2-8 degrees Celsius.	Visit to Lloyds pharmacy 27/6/13, Incident report	15	1.Daily fridge monitoring recorded 2. Fridge monitoring SOP in place that all staff should have read & signed up to.	1. Fridge monitoring records 2. Staff signature sheet against the fridge monitoring SOP	Visit on 27/6/13 to the pharmacy by Chief Pharmacist and Senior pharmacy Technician highlighted the daily fridge temperatures were being recorded however 5 of the 6 fridges reached maximum temperatures in excess of the expected 2-8 degrees Celsius. No temperature recording over weekends annotated on daily monitoring chart. No escalation of raised temperature to pharmacy manager nor a check made against the fridge temperature monitoring chart by a second person in the pharmacy. Lack of staff awareness about adherence to fridge monitoring procedures/policy.	3	4	12		a) Lloyds pharmacy to recall all affected medicines that have been issued to community teams/wards. STATUS - Completed June 2013 b) Lloyds pharmacy to compile report to be sent to chief pharmacist of all affected medicines along with names of patients. STATUS- Completed - The affected medicines list was compiled by the Lloyds team and the accompanying patient list was finalised by the CWP senior pharmacy technician. c)Chief Pharmacist reported to Superintendent pharmacist's office at Lloyds pharmacy head office - Shiraz Khan (regional quality manager for professional standards/governance) about my concerns regarding the expected standard of pharmacy practice, fridge storage arrangements, staff training, workflow in the pharmacy, adherence to procedures/instructions. STATUS: - Completed June 2013. This led to a meeting with Shiraz Khan to discuss further and resulted in an action plan being drawn up for the Lloyds pharmacy team to complete in light of the issues raised. Regular monthly meetings with Shiraz khan have taken place since June and the action plan is being progressed. d) Comms, medicine alert bulletin cascade to CWP staff about the issue with guidance on how to manage affected patients who have received affected doses. By chief pharmacist. STATUS: Completed June 2013 e) Datix incident completed in general for the incident – chief pharmacist STATUS: Completed June 2013 f) Further datix incidents to be logged for all affected service users (chief pharmacist). STATUS: On-going - Chief Pharmacist to confirm when complete g)Chief pharmacist to receive feedback from Shiraz Khan on actions following the incident and changes to practice implemented to prevent a reoccurrence. STATUS: On-going as part of action plan (see action c). Discussed at January Quality Committee and proposed for archive. To discuss with Chief Pharmacist to confirm controls and archiving.	31/01/2014
Andy Styring - Director of Operations	Service Directors- Clinical staff	Compliance Risk	22/02/2013	Significant number of unconfirmed notes on CareNotes system which may result in harm to patients, risk of litigation and external scrutiny	Local Risk Registers (All CSLs)	20	Carenotes training Supervision policies in place	Training reports Supervision reports Carenotes audits	Unconfirmed notes report extracted from carenotes- significant number of unconfirmed notes (including students)	3	4	12		a) Review CARE notes functionality to see if confirmed notes function can be disabled Adrian Burke, Clinical Informatics Lead by end March 2013 STATUS: Completed- CARE notes function cannot be disabled without considerable cost and disruption, therefore mitigations of alerts and monitoring will be in place b) Draft an alert regarding unconfirmed notes and circulate to all clinical staff. Agree whether students should be writing in clinical notes, given that there is a significant amount of unconfirmed student notes Adrian Burke, Clinical Informatics Lead by end March 2013 STATUS- Completed. Discussed at Aug 2013 PSE. Nominations covering all localities/ specialities to be provided to Adrian Burke to on the CARE notes working group by 30.8.13. c) Working group to report back to PSE February 2014. Adrian Burke, Clinical Informatics Lead by end March 2013 STATUS: On track	01/02/2014

Risk Owner	Risk Lead	Risk Type	Date Added	Description of the Risk	Source of Risk	Inherent Risk Score	Controls in place	Assurance	Gaps in controls	Impact	Likelihood	Residual Risk Rating	Target Risk Score	Actions required with responsibilities/timeframes	Date of review
Strategic Objective 2- Ensure meaningful involvement of service users, carers, staff and the wider community															
Strategic Objective 3- Be a model employer and have a caring, competent and motivated workforce															
Avril Devaney - Director of Nursing Therapies & Pt Partnership	R Nielsen - Associate Director of Workforce Development	Compliance Risk	11/05/2010	Risk of not being able to deliver safe and effective services due to inadequate attendance on mandatory training. This may result in harm to patients, litigation claims and breach of Legislation	Local Risk Registers (All CSLs)	20	Review of Mandatory Employee Learning Ongoing reporting of compliance via Workforce and Organisational Development Sub Committee ESR SSS Supervisor Self Serve (SSS) roll out allowing managers to directly book staff onto courses facilitating easier access and ability to generate and create reports on staff compliance re training 'Train the Trainer' course carried out for Trainers Increased E-Learning packages Internal Audit planned as part of 12/13 internal audit programme- Mandatory Training 2012/13. Implementation of behaviours related incremental pay progression scheme introduced on 1st September	NHSLA level 2 compliance achieved in 2010 Training reports provided to the Workforce and Organisational Sub Committee Monthly reporting to Board via Corporate Performance Report on Training as at April 12/13 Performance targets set for compliance to be achieved	Inability to report in ESR by CSU level and give accurate reports Additional training requirements identified outside of MEL may impact on Mandatory training performance e.g. CQUIN training requirements Uptake in numbers of trained staff - trust not meeting internal targets Aug 12- CSUs all reported downtime with the e-learning modules which impacted on ability to complete mandatory learning in a timely way.	4	4	16		a) Develop an integrated training plan for the Trust which identifies training for staff groups Roger Neilson- Associate Director of Workforce and Organisational Development by 30/06/2010 STATUS- Completed 30/06/2010 b) Report re CSU attendance following 12 months implementation Jane Tomlinson - Head of Learning & Development by 03/09/2012 STATUS: Completed c) Targets around training to be reviewed in Performance reviews and reported to Performance and Compliance Sub Committee and Operational Board Louise Hulme- Planning & Performance Manager by 31/12/2012 STATUS: Completed - MEL reviewed at all performance reviews d) Impact assessment of CQUIN schemes 12/13 regarding training to be undertaken to ensure there is no impact on the undertaking of MEL and report to June 12 Operational Board Ursula Martin- Associate Director of Quality, Compliance & Assurance by 30/06/2012 STATUS: Completed 30/06/2012 e) Desk top review of mandatory training to be undertaken for all staff groups with recommendations given back to training leads and Ops Board re frequency and delivery of training Anushta Sivananthan- Medical Director/ Avril Devaney - Director of Nursing Therapies & Pt Partnership/ Roger Neilson-Associate Director of Workforce & Organisational Development/Ursula Martin- Associate Director of Quality, Compliance & Assurance by 30/11/12 STATUS: Completed f) Further review of mandatory training to be undertaken following table top review and corporate services review (linking into planning priorities and responses to Francis and Berwick reports) and Always/ Never event framework. Maria Nelligan- Deputy Director of Nursing Mental Health and Director of Infection Control/Jane Tomlinson, Head of Learning & Development by 31/03/2013 STATUS: Off track but original timeframes revised to Feb 2014- Revised MEL programme presented and approved by October Operational Board. Implementation plan in development.Further update due at February 2014 Operational Board.	15/02/2014
Strategic Objective 4- Maintain and develop robust partnerships with existing and potential new stakeholders															
Strategic Objective 5- Improve quality of information to improve service delivery, evaluation and planning															

Risk Owner	Risk Lead	Risk Type	Date Added	Description of the Risk	Source of Risk	Inherent Risk Score	Controls in place	Assurance	Gaps in controls	Impact	Likelihood	Residual Risk Rating	Target Risk Score	Actions required with responsibilities/timeframes	Date of review
Tim Welch - Director of Finance	Anne Casey- Head of Performance and Information	Compliance Risk	11/05/2010	Data quality may have an adverse impact on external (regulatory, contractual) monitoring and governance ratings and on effective internal decision making regarding service planning and development	External Recommendations (PWC report)	20	Informatics strategy/policies outlining data quality roles and responsibilities Data quality roadshows for CSU support- run regularly throughout the year Informatics Strategy work plan KPMG action plan re-quality governance MIAA Audit - IT Applications 2012/13 MIAA Audit - Network Infrastructure 2012/13	ISC minutes and workplan progress Internal/external audit reports/actions plans IG toolkit audits and review-Green rating 12/13 (satisfactory rating) Clinical informatics group minutes Reports to Audit Committee	12/13 PWC audit of Quality Accounts highlighted issues re data quality Discrepancies between manually collected data held by CSUs and that collected via electronic clinical systems	4	4	16		a) Upgrade of CareNotes System Janet King Associate Director of Informatics by 13/12/2010 STATUS- Completed 13/12/2010 b) Develop a process for the prioritisation of clinical developments required for Carenotes and develop an action plan 10/11 to be reviewed annually Janet King Associate Director of Informatics by 13/12/2010 STATUS- Completed 13/12/2010 c) Commission a review of Carenotes to look at fitness for purpose of the system Janet King Associate Director of Informatics by 31/10/2012 STATUS- Completed and reported to Operational Board d) Develop a plan for auditing manual and electronic data captured for key compliance targets to ensure on-going review of 2 targets/quarter Janet King Associate Director of Informatics by 30/06/2012 (approved by Informatics Sub Committee) STATUS- Completed 30/06/2012 e) Convene a data quality task and finish group to review findings of PWC Quality Accounts audit and report any recommendations/actions to Operational Board Anushta Sivananthan - Medical Director by 30/09/2012 STATUS- Completed- An audit by PricewaterhouseCoopers of the Trust's Quality Accounts has led to a task and finish group being established in relation to data quality. The group have been tasked with reviewing the mandatory 7 day follow up of all service users discharged and a regular report is to be circulated to all CSUs. f) Following contracting round and annual planning process, review the Trust Information strategy Development of a task and finish group and review to be completed by 31/07/2013 STATUS: On Track - amended to 31/03/2014 following appointment of AD Performance and Servcie Redesign g) Audit Committee to commission an external audit of methodology and processes for development of Quality Dashboard Ursula Martin - Associate Director of Safe Services, Anne Casey -Head of Performance and Information, Louise Hulme - Head of Corporate Affairs by 31/08/2013 STATUS: Completed - External audit commenced August 2013 and concluded in October. Report received reviewed by Quality Committee in January 2014. To further review at end of Q3 (Jan 2014) for Monitor quality governance self assessment. h) Quality Account audit 2013/14 to be completed to inform archiving of risk David Wood - Associate Director of Safe Services, Anne Casey - Head of Performance and Information by 30/05/2014 STATUS- On track	31/01/2014
Strategic Objective 6- Sustain financial viability and deliver value for money															

Risk Owner	Risk Lead	Risk Type	Date Added	Description of the Risk	Source of Risk	Inherent Risk Score	Controls in place	Assurance	Gaps in controls	Impact	Likelihood	Residual Risk Rating	Target Risk Score	Actions required with responsibilities/timeframes	Date of review
Andy Styring - Director of Operations	Julie Critchley, Val McGee, Julia Cottier- Service Directors	Financial Risk	11/05/2010	Risk of not being able to deliver planned financial risk rating due to incomplete CIP plans resulting in potential breach of terms of authorisation and reputational damage	Local Risk Registers (All CSLs)	20	Budget statements CIP Profiling Annual plan outlining top CIP plans in place 12/13 Quarterly financial risk rating to Monitor Quarterly Performance Reviews address financial issues MIAA Audit - Financial Systems 2012/13	Impact assessment of service redesign as part of annual planning processes CPR reports on CIP monitoring performance at Board level on a monthly basis Regular monitoring via CIP steering group Monitor risk rating currently at 3 as per Quarter 4 11/12 Internal audit programme mapped to financial strategy Audit committee overview	Quality of CIP plans Impact of CIP for Community Care Western Care Cheshire (TCS) in the forthcoming years internal Financial modelling in month 1 qtr 1 12/13 indicate a FRR of 2	4	4	16		a) Ensure achievement of CIP plans continue to be monitored at Board of Directors and Operational Board Ros Francke - Director of Finance by 11/05/2010. STATUS- Completed 12/07/2011 b) Development and review of annual plans to include CIP. Andy Styring - Director of Operations by 03/05/2011 STATUS- Completed 03/05/2011. c) All clinical and corporate services to submit a structured financial recovery plan. Andy Styring - Director of Operations by 31/05/2012. STATUS- Completed 31/05/2012 d) Review Q1 performance against CIP plans and give position statement re Monitor Financial Risk Rating Ros Francke - Director of Finance by July 2012 Board of Directors. STATUS - Completed July 12 Board e) Convene a CIP Steering Group reporting to Operational Board.Val Mc Gee- Deputy Director of Operations by 31/08/2012. STATUS- Completed f) Convene CIP workshop for 13/14 CIP plans. Val Mc Gee- Deputy Director of Operations/ Louise Hulme- Head of Performance and Planning by 28/02/2013. STATUS- Completed g) Review requirement for central PMO function in the Trust to monitor annual planning and CIP Tim Welch- Director of Finance by end August 2013 STATUS- On Track h) Develop a process for efficiency impact assessment and scheme approval Rob Collins- Acting Deputy Director of Finance/Ursula Martin, Associate Director of Safe Services by end April 2013 STATUS- Completed- process developed, needs to be rolled out in localities (link to action g) i) Review financial position as part of annual planning process and financial assumptions to determine risk Tim Welch- Director of Finance by May Board of Directors STATUS- Completed j) Strengthening of financial infrastructure via recruitment of divisional accountants and establishment of (equivalent to a)PMO function to support tracking of CIP delivery Tim Welch- Director of Finance by 31/08/2013 STATUS- Off track, scheduled for Jan 2014 Board. Recruitment completed. October Board seminar considered financial projections and revised approach to CIP management. January 2014 Board to receive outline financial projects and plans.	29/01/2014

Risk Owner	Risk Lead	Risk Type	Date Added	Description of the Risk	Source of Risk	Inherent Risk Score	Controls in place	Assurance	Gaps in controls	Impact	Likelihood	Residual Risk Rating	Target Risk Score	Actions required with responsibilities/timeframes	Date of review
Tim Welch- Director of Finance Deputy Director of Operations Val Mc Gee		Financial Risk	11/05/2010	Risk of loss of income and capacity due to tariff being set at a level which does not allow CWP to compete in the marketplace	External Recommendations	12	Senior PbR project group and operational group Joint provider/commissioner PbR meeting covering 3 PCTs (commissioners) Links into regional finance group re PbR - will help with some benchmarking data PbR Clinical and operational leads established Annual reference costing exercise now reflects PbR clusters Overall financial controls around service line costs and planning MIAA Audit - Activity Recording / PbR 2012/13	Minutes of contact and PbR meetings GP commissioners being engaged via joint meetings Assurance against CQUIN 12/13 milestones to meet PbR timeframes	Local tariff rather than regional tariff - our costs may mean that Trust cannot demonstrate comparable tariffs with public/private sectors PbR does not cover all services (AOP) - national pilots on-going in other service areas.	3	3	9		a) Continue to monitor this through PbR and contract meetings Tim Welch- Director of Finance on-going STATUS- On-going b) Ensure regular updates are given to Operational Board re PbR Tim Welch- Director of Finance on-going STATUS- On-going - to include PbR project group within corporate governance structure, regularly reporting into Operational Board. Consider for archive following this. To discuss with Director of Finance re. archiving risk	31/01/2013
Strategic Objective 7- Be recognised as an open and progressive organisation that is about care, well-being and partnership															

Risk Owner	Risk Lead	Risk Type	Date Added	Description of the Risk	Source of Risk	Inherent Risk Score	Controls in place	Assurance	Gaps in controls	Impact	Likelihood	Residual Risk Rating	Target Risk Score	Actions required with responsibilities/timeframes	Date of review
Sheena Cumiskey - Chief Executive	David Wood, Associate Director: Safe Services	Compliance Risk	07/12/2011	Risk of breach of Trust Terms of Authorisation/ Licence as a result of external scrutiny	External Recommendations (CQC/KPMG/Local authority reports)	20	Integrated Governance framework Internal audit plan External audit of governance undertaken 11/12 Review of Corporate Governance completed and signed off and re audit done KPMG External scrutiny by other agencies Regular patient surveys MIAA reports on Assurance Framework MIAA Audit - Self-Certification and regulatory reporting 2012/13 MIAA Audit - CQC Compliance 2012/13 CQC follow up visit to Eastway - September 2103 judged compliance against all standards.	External audit of governance (KMPG) signed off as green and completed May 12 CSUs are performance monitored on key standards on a quarterly basis Regular meeting with Commissioners to review contractual performance CQC have re-inspected following initial learning disability special review inspection Outcome 16 action plan in place	CQC have raised 5 moderate concerns in relation to Eastway Assessment and Treatment Unit There have been 2 management reviews (Saddlebridge and Alderley) Significant concerns raised by commissioners in relation to Alderley Unannounced visit reports to inpatient units have highlighted major concerns CQC visit in October 2013 on outcome 16 found areas requiring improvement	5	4	15		a) Review business cycle of Quality Committee Dr Anushta Sivananthan, Medical Director by 04/04/2012 STATUS- Completed 04/04/2012 b) Review of custom reports of assurance framework and develop regular reporting to risk leads and owners Ursula Martin- Associate Director Quality, Compliance & Assurance by 13/07/2012 STATUS- Completed c) Triangulation meeting to increase membership to include CSU membership Anne Casey- Head of Performance & Information by 30/12/2011 STATUS- Completed 01/02/2012 d) Complete all the actions from KMPG external audit and ensure that a re-audit is undertaken Dr Anushta Sivananthan, Medical Director by 04/04/2012 STATUS- Completed 04/04/2012 e) Review Triangulation terms of reference to ensure the meeting is driven by the Board Assurance Framework Anne Casey- Head of Performance & Information by 31/07/2012 STATUS- Completed and reviewed at July Performance & Compliance Sub Committee f) Implementation of Eastway Action Plan and assurance to Trust Quality Committee Maria Nelligan- Acting Senior Clinical Lead Learning Disabilities/Deputy Director of Nursing by 31/03/2013 STATUS- Completed - CQC visit to Eastway on 27/9/13 resulted in compliance against all standards g) Implementation of Saddlebridge Action Plan and assurance to Trust Quality Committee Julia Cottier- Service Director East Locality by 31/03/2013 STATUS- on-going until closed. No exceptions reported to Sept Quality Committee. h) Implementation of Alderley Action Plan and assurance to Trust Quality Committee Maria Nelligan- Acting Senior Clinical Lead Learning Disabilities/Deputy Director of Nursing by 31/03/2013 STATUS- on-going until closed. Lead changed to Julia Cottier, Service Director CWP Wirral i) Develop action plans to focus on issues identified by CQC emerging during planned/ unannounced visits. David Wood- Associate Director of Safe Services 31/03/2014 STATUS- On track.	31/01/2014

Risk Owner	Risk Lead	Risk Type	Date Added	Description of the Risk	Source of Risk	Inherent Risk Score	Controls in place	Assurance	Gaps in controls	Impact	Likelihood	Residual Risk Rating	Target Risk Score	Actions required with responsibilities/timeframes	Date of review
Avril Devaney - Director of Nursing Therapies & Pt Partnership	Andrea Hughes- Associate Director of Nursing	Compliance Risk	11/05/2010	Risk of breach of Equality and Diversity legislation resulting in risk of reputational, financial loss and potential harm to staff and patients	Risk assessment (compliance with EPIT)	15	Trust Single Equality Scheme Single Equality Scheme E&D training Impact assessments of Trust policies External benchmarking – EPIT data	Patient & staff surveys Minutes of Operations Board Consultation with local communities and reported on EDS Trust policy approval system- Document Quality Group MEL includes E&D Equality Impact Assessments Minutes of Performance and Compliance Sub Committee	Training figures low data collection (MHMDS) not compliant with Equality Act Equality Impact assessments non compliant with act and guidance commissioners evaluation of our EPIT evidence was poor- implies poor readiness for compliance with the national Equality Delivery System corporate systems do not analyse by protected characteristic- i.e. complaints; patient experience; therefore we can not evidence that people with protected characteristics are not disadvantaged reporting of 'hate' related incidents needs to be developed so that we can understand by protected characteristic if any group is being disadvantaged	3	3	9		a) Develop Trust wide Equality strategy and action plan Chrissie Cooke- Programme Director by 31/07/2012 STATUS- Action update needed b) Publish Equality objectives as part of the equality act public sector duty Chrissie Cooke- Programme Director by 06/04/2012 STATUS- Completed 04/05/2012 c) Submit information to DH Equality Delivery System Chrissie Cooke- Programme Director by 30/03/2012 STATUS- Action update needed d) Publish information as part of equality act public sector duty Chrissie Cooke- Programme Director by 31/01/2012 STATUS- Completed 31/01/2012 e) A review of this risk is now underway to close gaps identified above Andrea Hughes Associate Director of Nursing Physical Health 31/03/2014 STATUS- update required following Board query regarding compliance with E&D Act 2010. Gaps in compliance identified to request assurance from Workforce and OD sub committee	31/01/2014

Description of the Risk	Source of the Risk	Inherent Risk	Residual Risk rating Jan 2013	Residual Risk rating March	Residual Risk rating May 2013	Residual Risk rating July 2013	Residual Risk rating Sept 2013	Residual Risk rating Nov 2013	Residual Risk rating Jan 2014	Jan	Summary Risk Treatment Plan (refer to actions on assurance framework for specific detail)	Date of review
Risk of harm to patients as a result of increased rate of Grade 3/4 pressure ulcers being reported and evidence of recurring themes in RCA reports relating to pressure care (resulting in concerns raised by commissioners)	Incident report	N/A	N/A	N/A	N/A	20	20	20	20	↔	A review commenced on 8 July 2013 by CWP West to review the reporting and clinical management of pressure ulcers, in response to queries raised internally and externally regarding an increase in the reporting of pressure ulcers and the recurrence of themes in relation to their clinical management. The 29 October 2013 Audit Committee undertook a deep delve of the risk, controls and mitigations in place, length of time on the risk register, and impact of actions. This involved the Service Director presenting the risk and the actions and assurances in place. It was agreed that the Service Director will attend the Audit Committee again in 6 months time to assess the impact of the actions. The November Quality Committee also reviewed the current status of this risk, and referred the risk to the Patient Safety & Effectiveness Sub Committee to agree actions required to strengthen the risk treatment plan. The risk treatment plan will be reviewed at the February 2014 meeting of the Patient Safety & Effectiveness Sub Committee.	20/02/2014
Adults, children and young people are not protected through safeguarding training and practice	External Recommendations	16	12	20	20	20	20	20	20	↔	Concerns were raised by West Cheshire CCG regarding accuracy of training figures (June 2013), however the CCG has now indicated they are assured by the improvements made. The risk is reviewed by Quality Committee following receipt of safeguarding exception report every two months. Discussed at November Board of Directors - request that risk is re-modelled to reflect the focus of the risk on training. Re-modelled risk approved at January 2014 Quality Committee. No changes to risk score. To re-model further or archive once receipt of all-year assurances from commissioners re compliance with safeguarding training targets.	05/03/2014

Description of the Risk	Source of the Risk	Inherent Risk	Residual Risk rating Jan 2013	Residual Risk rating March	Residual Risk rating May 2013	Residual Risk rating July 2013	Residual Risk rating Sept 2013	Residual Risk rating Nov 2013	Residual Risk rating Jan 2014	Jan	**Summary Risk Treatment Plan (refer to actions on assurance framework for specific detail)**	Date of review
Risk of harm to patients due to lack of staff competency to manage changing physical conditions	Incident report	25	20	20	20	20	20	20	20	↔	A review of physical healthcare training has been reported to the Quality Committee. Recommendations were identified to address the current/ ongoing strategic risk regarding the lack of staff competency to manage changing physical conditions, to be taken forward by a proposed physical healthcare network reporting to the Patient Safety & Effectiveness Sub Committee. The physical healthcare network will report to the February 2014 meeting of the Patient Safety & Effectiveness Sub Committee to propose risk treatment plan moving forward.	20/02/2013
The inability of staff to manage the occurrences of slips, trips and falls of patients, resulting in patient injury.	Incident report	20	20	20	20	20	20	20	20	↔	FallSafe care bundle is in place across all wards. Patient Safety & Effectiveness Sub Committee has received and approved a report detailing a risk treatment plan to implement control measures to mitigate this risk to a target risk score. The report was in response to the findings of an external acute falls nurse specialist who undertook a review of falls prevention and management. The review found that, in general, CWP has a robust system in place for the management of slips, trips and falls however, sometimes locally these systems are not always fully implemented. Additionally, issues such as environmental improvements and training also need to be addressed at local level. Responses to the findings of external review have been identified. Audit Committee undertook in-depth review of the risk at the January 2014 meeting. Risk score target of 16 agreed. Further update to come to May 2014 meeting to provide assurance of actions completed. Further update to come to Audit Committee regarding impact of actions and controls by September 2014.	07/01/2014

Description of the Risk	Source of the Risk	Inherent Risk	Residual Risk rating Jan 2013	Residual Risk rating March	Residual Risk rating May 2013	Residual Risk rating July 2013	Residual Risk rating Sept 2013	Residual Risk rating Nov 2013	Residual Risk rating Jan 2014	Jan	Summary Risk Treatment Plan (refer to actions on assurance framework for specific detail)	Date of review
Lack of robust ligature management programme within the Trust may result in harm to patients with associated reputational and financial impact on the Organisation	Risk Assessment/Incident Report	25	15	15	15	15	15	15	20		Board approved the current capital programme in May 2013. An update report was provided to September 2013 and January 2014 Operational Board. Further action required is installation of door top alarm systems to en suite rooms. The January 2014 Operational Board agreed to expedite the timeframes for completion of these installation works in response to regulation 28 report [August, September and October 2014 for the high, medium and low priority areas respectively]. It agreed to increase the likelihood score to 4 due to the known residual environmental risk, increasing the current residual risk score to 20.	15/01/2014
Risk of harm to patients due to CARSO risk assessment not being completed as per policy	Incident report	N/A	N/A	N/A	N/A	16	16	16	16		Completion of CARSO risk assessments included in patient safety metrics programme. The Quality Committee endorsed the appointment of a clinical expert champion for zero harm to help CWP achieve synergies in promoting safe and effective services through effective care planning and systems to prevent avoidable harm and unacceptable variations in healthcare experience – risk assessment is fundamental to this work plan. Proposals in response to the clinical expert champion for zero harm were approved by the January 2014 meetings of the Quality Committee and Operational Board. Proposals are being presented to the January 2014 meeting of the Board of Directors for endorsement.	29/01/2014

Description of the Risk	Source of the Risk	Inherent Risk	Residual Risk rating Jan 2013	Residual Risk rating March	Residual Risk rating May 2013	Residual Risk rating July 2013	Residual Risk rating Sept 2013	Residual Risk rating Nov 2013	Residual Risk rating Jan 2014	Jan	Summary Risk Treatment Plan (refer to actions on assurance framework for specific detail)	Date of review
Risk of harm to patients and staff due to staffing levels across inpatient services in the three localities.		N/A	N/A	N/A	16	16	16	16	16	↔	A review was presented to the January 2014 meeting of the Operational Board by the Associate Director of Nursing [Mental Health] and DIPC, detailing the findings of the review team's consideration of staffing levels as identified by ward managers and modern matrons, use of bank staff and financial impact of this, and rostering issues. Review was presented to Operational Board in January 2014 which approved, in principle, the operational recommendations. Review will be presented to March 2014 meeting of the Quality Committee to consider qualitative recommendations. Specific, immediate actions identified to be presented to January Board of Directors for discussion.	29/01/2014
Risk of not being able to deliver planned financial risk rating due to incomplete CIP plans resulting in potential breach of terms of authorisation and reputational damage	Local Risk Registers (All localities)	20	16	16	16	16	16	16	16	↔	Strengthening of financial infrastructure via recruitment of locality accountants and establishment of a performance and service redesign function to support tracking of CIP delivery. Board seminars in October and December 2013 considered financial projection and revised approach to CIP going forward. Board to receive draft final projections in January 2014.	29/01/2014
Risk of not being able to deliver safe and effective services due to inadequate attendance on mandatory training. This may result in harm to patients, litigation claims and breach of Legislation	Local Risk Registers (All CSLs)	20	16	16	16	16	16	16	16	↔	A review of the Trust training strategy has been undertaken following corporate services review and follows planning priorities and links to response to Francis and Berwick reports and CWP always events framework. Revised mandatory employee learning programme presented to and approved by October 2013 Operational Board. Implementation plan in development which will be monitored to inform risk treatment plan on an ongoing basis. Operational Board to receive a detailed review of this risk at the February 2014 meeting.	15/01/2014

Description of the Risk	Source of the Risk	Inherent Risk	Residual Risk rating Jan 2013	Residual Risk rating March	Residual Risk rating May 2013	Residual Risk rating July 2013	Residual Risk rating Sept 2013	Residual Risk rating Nov 2013	Residual Risk rating Jan 2014	Jan	**Summary Risk Treatment Plan (refer to actions on assurance framework for specific detail)**	Date of review
Data quality may have an adverse impact on external (regulatory, contractual) monitoring and governance ratings and on effective internal decision making regarding service planning and development	External Recommendations (PWC report)	20	16	16	16	16	16	16	16	↔	Action plan further to the contract query received from Wirral CCG re data quality was completed December 2013. The information strategy has been drafted but will not be finalised until the Trust's clinical strategy is approved in January 2014 and the Associate Director of Performance and Service Redesign takes up post in January 2014. Findings of an external audit regarding the processes and systems associated with development and presentation of the quality dashboard was reported to January 2014 Quality Committee. Risk has been reviewed as part of Q3 Monitor quality governance self-assessment – returned to green. Outcome of Quality Account audit for 2013/14 [due May 2014] will be taken into consideration prior to reducing the risk score and archiving this risk.	31/01/2014
Risk of harm to patients, carers and staff as well as reputational and litigation risks due to a/ unable to show consistent investigation of incidents; b/ unable to show learning from actions of incidents, claims etc is cascaded; c/ unable to be assured investigations are carried out in a timely manner d/ inability to communicate in a timely manner with partners	Incident report	20	16	16	16	16	16	16	16	↔	Score remains at 16 in response to regulation 28 report – response provided 18 January 2014 and action plan in place to be monitored by Quality Committee. Learning from experience report and always events performance will be monitored to inform risk treatment plan on an ongoing basis. Further work is now ongoing to further improve RCA processes, particularly following the CQC outcome 16 review which identified the need to close actions quickly so that there is assurance of learning from incidents being fed back. Service Directors have been asked to monitor the management of actions arising from root cause analysis investigations – SUI report to January 2014 Quality Committee identified a further increase in locality actions not being closed. Performance against closure of RCA recommendations will be monitored more closely at the Compliance, Assurance and Learning Sub Committee.	16/01/2014

Description of the Risk	Source of the Risk	Inherent Risk	Residual Risk rating Jan 2013	Residual Risk rating March	Residual Risk rating May 2013	Residual Risk rating July 2013	Residual Risk rating Sept 2013	Residual Risk rating Nov 2013	Residual Risk rating Jan 2014	Jan	Summary Risk Treatment Plan (refer to actions on assurance framework for specific detail)	Date of review
Risk of adverse incident due to Patient ID policy not being followed in inpatient areas	Clinical audit	N/A	N/A	N/A	15	15	15	15	15	↔	This risk was identified following a clinical audit presented to April 2013 Patient Safety and Effectiveness Sub Committee, which highlighted low levels of compliance across some inpatient units in relation to adhering to patient identification policy. There has also been previous medication incidents linked to mis-identification. Internal audit report received at January 2014 Quality Committee indicating this not to be a significant risk. This will be monitored via incident reporting for evidence of improvement prior to archiving. Learning from Experience report to continuously monitor this risk longitudinally. Quality Committee in January 2014 agreed to consider archiving this risk at its next meeting.	08/01/2014
Risk of breach of Trust Terms of Authorisation/ Provider Licence as a result of external scrutiny	External Report	20	20	20	20	20	20	15	15	↘	The CQC visited Eastway on 27 September 2013 and found the unit fully compliant against all standards. The Monitor governance rating for the Trust has return to Green. This has not been affected by the two minor concerns following the CQC unannounced visit to Clatterbridge mental health services registered location. The current residual score therefore reflects these assurances. This risk will be re-scored based on the emergent outcomes of the planned CQC visit programme, including the responsive visit to Bowmere mental health services registered location on 17 January 2014.	31/01/2014
Risk of harm to patients from receiving medicines that have not been stored within the manufacturers product specification. In these circumstances this relates to adequate cold storage i.e. Between 2-8 degrees Celsius.	Visit to Lloyds pharmacy 27/6/13, Incident report	N/A	N/A	N/A	N/A	12	12	12	12	↔	This risk was identified following a visit to the pharmacy site as part of a tendering exercise. Confirmation that the majority of actions have been completed. Discussed at January Quality Committee and proposed for archive. To discuss with Chief Pharmacist to confirm controls and archiving.	31/01/2014

Description of the Risk	Source of the Risk	Inherent Risk	Residual Risk rating Jan 2013	Residual Risk rating March	Residual Risk rating May 2013	Residual Risk rating July 2013	Residual Risk rating Sept 2013	Residual Risk rating Nov 2013	Residual Risk rating Jan 2014	Jan	Summary Risk Treatment Plan (refer to actions on assurance framework for specific detail)	Date of review
Significant number of unconfirmed notes on CareNotes system which may result in harm to patients, risk of litigation and external scrutiny	Local Risk Register (Informatics)	N/A	N/A	12	12	12	12	12	12	↔	A report is generated monthly for all services to action. Discussed at August 2013 Patient Safety and Effectiveness Sub Committee. Nominations covering all localities/ specialities provided to Adrian Burke to the CAREnotes working group. Working group to report back to Patient Safety and Effectiveness Sub Committee February 2014 – to consider for archive at this time.	01/02/2014
Risk of adverse clinical incident due to dual record keeping systems (electronic and paper)	Incident Report	16	12	12	12	12	12	12	12	↔	The Records and Information Governance Group is liaising with the Clinical Informatics Lead to correlate the clinical systems priorities with the dual record keeping risk. A revised dual record keeping action plan was presented to the December 2013 Patient Safety & Effectiveness Sub Committee. A compliance action regarding record keeping was identified by the CQC following its visit to Clatterbridge mental health services registered location, for completion end March 2014. Patient Safety & Effectiveness Sub Committee will monitor progress of this action plan at its February 2014 meeting, escalating matters of concern re completion by the end of March to the Quality Committee.	20/02/2014
Risk of breach of Equality and Diversity legislation resulting in risk of reputational, financial loss and potential harm to staff and patients	Risk assessment (compliance with EPIT)	15	12	12	12	12	12	12	12	↔	A review of the current risk in relation to this is underway. Awaiting assurance re Trust compliance re September 2013 Board update on Equality and Diversity Act progress. Gaps in compliance identified, Associate Director of Nursing is interim senior lead. Assurance is being sought from the Workforce and Organisational Development Sub Committee re compliance on Equality and Diversity Act. Also, an equality and diversity officer is currently being recruited to.	31/01/2014

Description of the Risk	Source of the Risk	Inherent Risk	Residual Risk rating Jan 2013	Residual Risk rating March	Residual Risk rating May 2013	Residual Risk rating July 2013	Residual Risk rating Sept 2013	Residual Risk rating Nov 2013	Residual Risk rating Jan 2014	Jan	Summary Risk Treatment Plan (refer to actions on assurance framework for specific detail)	Date of review
Reduction in quality of service provided as a result of service redesign, which may result in patient harm, increased burden on carers, increased complaints and litigations, and a negative impact on Trust reputation to patients, public and commissioners.	Risk Assessment	20	15	15	15	15	15	10	10		This risk has been re-modelled and current residual score remains 10. This follows September 2013 Quality Committee receiving quality dashboards presented by Service Directors with a view to continuing this at each Quality Committee meeting. The Board approved a paper detailing the quality impact of CSIP programme post implementation demonstrating, overall, no impacts on quality. A monthly verbal update is also provided to Operational Board regarding implementation of the CSIP programme and the LD service re-design. In November 2013, CQC requested assurance regarding impact of CSIP. Response provided, no further information requested. The CQC reviewed this risk as part of the feedback from CQC monitoring visit re mental health: assessment and application for detention and admission visit [to Wirral]. No formal action identified over and above on-going Trust identified actions. The CQC indicated a follow up visit in one year. Locality evaluations to reflect 6 month impacts being presented to January 2014 require further evaluations to take place as a result of small numbers of feedback – to be reported again to March 2014 meeting of the Board of Directors.	29/01/2014
Risk of loss of income and capacity due to tariff being set at a level which does not allow CWP to compete in the marketplace	External Recommendations	12	9	9	9	9	9	9	9	↔	Local and regional PbR groups in place – financial benchmarking data may be available to evaluate this risk. Need to include PbR project group into corporate governance structure, regularly reporting into Operational Board. Consider for archive following progress with above risk treatment plan. To discuss with Director of Finance re archiving this risk – update will come to March 2014 Quality Committee.	31/01/2014

Archive

Date of archive	Risk	Score	Rationale for archive	Were all actions complete
13th August 2012	CWP will be unable to meet the national (NHS) and regulatory (Monitor) standard for community information data set (CIDS) if deployment of community information system (CIS) in Community Care Western Cheshire (CCWC) does not achieve timescales or functionality project deliverables, causing the Trust to fail external metrics.	12	An options appraisal regarding this risk was discussed at July 12 Operational Board- it was agreed that no money would be invested and assurance given that the data could be collected manually if required. Recommend that this risk is archived	Develop an options appraisal regarding investment/cost benefit analysis to reduce implementation timescale to complete by March 2013 Janet King Associate Director of Informatics by 11/07/2012 STATUS- Completed 11/07/2012 Dependent of discussion at July 12 Operational Board- take forward recommendations and review project plan Janet King Associate Director of Informatics (timeframe to be determined) STATUS- Completed July Ops Board
14th August 2012	That the trust engages a medical locum who is not appropriately qualified; Is paid above the rate agreed at the time of booking; Is not competent to carry out/a fit person to carry out assigned duties; is not engaged in appraisal and revalidation	8	The processes in place were revisited by MIAA who reported 'significant assurance' on 25/06/12.	Actions identified from MIAA audit to be completed Chris Sheldon- Head of HR by 31/01/2012 STATUS- Completed Reaudit of process Chris Sheldon- Head of HR by 31/12/2012 STATUS- Completed Reinforcement of process by Medical Staffing Officer attending service line meetings Chris Sheldon- Head of HR by 30/03/2012 STATUS- Completed

4th September 2012	Inability to monitor compliance with NICE guidance due to lack of capacity	15	Discussed at Patient Safety & Effectiveness Sub Committee in August 12 and agreed that given the appointment of 20 NICE champions across mental health learning disabilities and 20 NICE champions across CCWC – it is suggested that capacity is less of an issue, has been addressed through realisation of the strategy, and the focus of the risk should be considered as the risk of patients possibly being denied an effective treatment – e.g. as above regarding the prescribing of memantine. This risk will be scoped out by the newly convened Clinical Effectiveness Network and reported to the Patient Safety & Effectiveness Sub Committee	a) Fund a Band 6 for CWP who will identify relevant publications to community care and key priorities within the publications and will rate compliance. Will source and identify necessary evidence and work with CSUs to develop/deliver action plans Dr Andy Cotgrove- Medical Director Effectiveness & Medical Education by 31/05/2011 STATUS- Completed 31/05/2011 b) Review need for ongoing funding for Band 6 Post Pat Mottram- Research & Effectiveness Manager by 31/03/2012 STATUS- Completed 31/03/2012 c) Provide update to patient safety and effectiveness committee on progress Pat Mottram- Research & Effectiveness Manager by 16/06/2011 STATUS- Completed 16/06/2011 d) Review NICE Publication Management Policy Pat Mottram- Research & Effectiveness Manager by 31/07/2011 STATUS- Completed 20/10/2011 e) Convene a Clinical Effectiveness Network meeting Dr Andy Cotgrove- Medical Director Effectiveness & Medical Education by 30/09/2012 STATUS- Completed first meeting in Sept 12

6th Jan 2013	Risk of harm to patients and staff that the Trust does not meet all legal requirements associated with Health and Safety regulations in relation to provision of first aid training, which could result in financial loss and reputational damage	12	The Trust has recruited a first aid trainer, developed an in house programme, which has recently been accredited. A training programme is in place to roll out first aid training to staff.	a) Determine whether this is still a risk for the Trust and review risk score Andrea Snagg- Head of Occupational Health by 30/07/2010 STATUS- Completed 03/03/2011 b) Address the training issues as a component of the mandatory training review Roger Neilson- Associate Director Workforce & Organisational Development by 31/01/2011 STATUS- Completed 31/01/2011 c) Review the first aid policy Andrea Snagg- Head of Occupational Health by 31/01/2011 STATUS- Completed 31/01/2011 d) Undertake an options appraisal to consider whether to employ a first aid/Basic Life support trainer and present to BDSC Ken Edwards- Safety & Security Lead by 30/04/2012 STATUS- Completed 30/04/2012 e) Recruit a first aid/Basic Life support trainer Ken Edwards- Safety & Security Lead by 30/04/2012 STATUS- Completed 30/04/2012 f) Deliver the BLS/first aid training programme and review impact of new post Ken Edwards- Safety & Security Lead by 31/10/2012 STATUS- Completed
6th Jan 2013	Risk of impact on financial & quality of care arising from lack of effective engagement with new commissioning arrangements	12	The Trust has developed links with new commissioning arrangements and plans are in place for agreeing the 13/14 contract.	a) Joint work being undertaken with PCTs an emerging consortia Sheena Cumiskey- Chief Executive- Ongoing STATUS- Action ongoing
22nd Feb 2013	Risk of harm to patients due to potential inability to apply safeguarding policies, procedures and processes	12	Reworded risk to read Adults, children and young people are not protected through safeguarding practice	Actions incorporated into revised risk

				formal group in the CWP governance structure Ken Edwards- Safety & Security lead by 24/06/2011 STATUS- Completed 24/06/2011 b) Develop a medical devices group assurance framework with actions that need to be undertaken and report to June 11 Pt safety and effectiveness group Ken Edwards- Safety & Security lead by 30/06/2011 STATUS- Completed 30/6/2011 c) Develop ongoing reporting against medical devices assurance framework to Pt safety and effectiveness group Ken Edwards- Safety & Security lead by 30/06/2011 STATUS- Completed 19/04/2012 d) Review Medical Devices policy and outline revised processes for procurement, monitoring, training etc. Ken Edwards- Safety & Security lead by 30/09/2012 STATUS- Completed Policy ratified 13/11/2012 e) Roll out contract with BCAS, ensuring that a medical devices inventory is developed and presented to the Medical Devices Sub Committee Ken Edwards- Safety & Security lead by 31/03/2012 STATUS- Completed f) Ensure that a medical devices training report is developed and presented to WOD/Medical Devices Group Ken Edwards- Safety & Security lead by 31/03/2012 STATUS- Completed g) Ensure that actions regarding resus equipment review are implemented Basic Life Support/First Aid Trainer/Ward Managers by 30/05/2013 STATUS- Completed and presented to June 13 Patient Safety and Effectiveness Sub Committee h) Ensure that follow up actions from MIAA audit are reviewed prior to archiving risk Ken Edwards- Safety & Security lead a by timeframes on annual plan (to
18th October 2013	Lack of robust governance around medical devices may result in harm to patients , breach of legislation and litigation claims	**15**	Confirmation received from Risk Lead that all actions have been completed. Any exceptions to be reported to Patient Safety and Effectiveness sub-committee who can escalate back to risk register should issues arise	

Archive

18th October 2013	Risk to patient safety due to inability to communicate in a timely manner with other partners primary care, acute, social care etc	15	Have included risk of inability to communicate within re-modelled risk.	All actions encompassed within re-modelled risk
18th October 2013	Possibility of Flu pandemic that would impact on all Trust services	12	Board. On-going monitoring of through Emergency Planning, reporting to Operational Board bi-monthly. No breaches re flu targets since targets set. Can escalate if targets at risk of breach.	a) Ongoing monitoring through Emergency Planning Sub Committee reporting to Operational Board. Ongoing promotion of flu vaccination programme- with targeted communications in the run up to flu season
18th October 2013	Risk of breach of contractual requirements and financial penalties due to SUI process not meeting prescribed timescales	16	This is a duplicated risk - breach of contractual requirements due to SUI process is covered in another strategic risk	All actions encompassed within re-modelled risk
12th November 2013	Non adherence to patients monies policy resulting in potential safeguarding issues.	12	Finance lead has confirmed that no outstanding actions from MIAA audit.	Finance lead has confirmed that no outstanding actions from MIAA audit.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document Reference (13/14/97)

Report to:	**Board of Directors**
Date of meeting:	**29 January 2014**
Title of report:	**Proposals to take forward the "zero harm" agenda within CWP**
Action sought:	**DISCUSSION and NOTING**
Author:	**David Wood, Associate Director of Safe Services**
Presenting Executive:	**Dr Anushta Sivananthan, Medical Director – Quality**

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
SO4 - Maintain and develop robust partnerships with existing and potential new stakeholders
SO5 – Improve quality of information to improve service delivery, evaluation and planning
SO6 - Sustain financial viability and deliver value for money
SO7 – Be recognised as a progressive organisation that is about care, well-being and partnership

Distribution

Version	Name(s)/Group(s)	Date Issued
1	D Wood to L Hulme for public meeting of the Board of Directors	17.01.2014

Executive director sign-off

Executive director (name and title)	Date signed-off
Dr Anushta Sivananthan, Medical Director – Quality	17.01.2014

1. Purpose of this report

This report provides the Board of Directors with an update on the strategic direction of the Trust's zero harm aspirations. In doing so, it details the tactical plans for the delivery of quality by tackling unwarranted risks and variation.

2. Background and introduction

One of the five expectations contained in The Mandate (Department of Health, 2012) from the Government to the NHS is an improvement in the provision of safer care by March 2015. The Government and the NHS Chief Executive have described the challenges posed by a number of recent highly public failures in the standards of care provided by the NHS as a "watershed moment" (Department of Health, 2013) and an opportunity to drive cultural change further and faster. The Trust responded to the Berwick (2013) root-and-branch review of patient safety in the English NHS by appointing a Clinical Expert Champion for Zero Harm. The champion subsequently developed proposals to help the Trust in making choices to help develop and deliver the right tactical steps towards the strategic goal of having an aspiration of zero harm that drives the Trust culture. Major cultural change is required for everyone in CWP to continuously improve quality and patient safety. Quality and patient safety is a crucial issue, it is the core business of any NHS organisation, therefore approaches to assessing and monitoring the quality of service provision must be adequately resourced. It is only through continuous improvement of systems that the Trust will make a difference in the quality of health and health care.

3. Tactics

The tactical steps to facilitate the delivery of the strategic goal of having an aspiration of zero harm that drives the Trust culture involves:

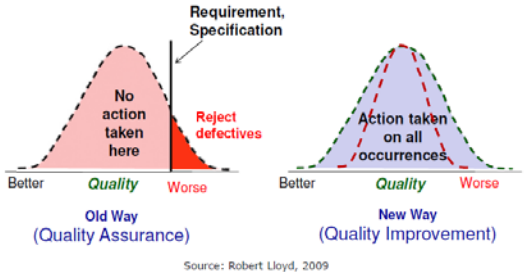
- Moving from process orientated reporting to outcome orientated reporting – recovery
  Full training in using clinical risk assessment, care planning and outcome measurement to deliver the best, sustainable outcomes.
- Increasing skills and capacity to intelligently analyse data at team, service and Trustwide levels
  Identification of variance:
  - *Promotion of positive variance.*
  - *Reduction/ elimination of harmful or inefficient/ unnecessary variance*.
- Promotion of what good quality healthcare looks like in each service and celebrate success in delivering good outcomes
  Link CWP internally across services and corporate functions.
  Learn from success internally and externally.
  Ensure sharing and celebration of success internally and externally.

The strategic goal of having an aspiration of zero harm that drives the Trust culture will facilitate:

- The delivery of quality orientated services, ethically and economically.
- Improvement in the health and well-being of local communities.
- Competitiveness – winning commissioned services.
- Keeping up with rapidly changing evidence bases.
- Meeting local demand in line with funding and commissioning models – being the best value money provider available.

3.1 Continuous improvement of systems to improve the quality of health and health care

There is local evidence from complaints and incident reviews demonstrating variations in health care experience, despite investigation, best intentioned action planning, and the hard work of individual frontline staff, management and governance systems. This is mirrored nationally – the Care Quality Commission's (2013) "The state of health care and adult social care in England 2012/13" similarly identifies variation in the delivery of patient safety and effective care. Research shows that the cultural change required to continuously improve quality and patient safety requires celebration of success and the promotion of good practice [by identifying, celebrating and building on evidence of success] to be as rigorous as identifying problems in practice and being intolerant of poor care delivery systems.



3.2 The agreed evidence based proposal

The Trust's Quality Committee [8 January 2014] and Operational Board [15 January 2014] has agreed the next steps required to meet the challenge of building a culture of zero harm and continuously improving the delivery of patient safety and effective care. It has been agreed to leverage the best out of existing systems, using the Trust's current investment in promoting, managing and governing Trust services. The Trust does not need or will gain additional value from setting up conflicting or additional management and governance structures. The proposal does, however, require some of the tactics to be resourced to create the skills and capacity to improve the ability of all staff to routinely use data. The proposal will ensure that future approaches continue to have a clear focus on the core business of the Trust, which is delivering safe, accessible, effective, sustainable, acceptable and affordable health care. The proposal entails:

3.2.1 *Appointment of a care planning and effective lead*
to re-invigorate care planning and reduce variation in its use – cost circa £55,000.

Care planning underpins all service delivery to those with health care needs. It is a vital part of preventing unwarranted avoidable risks and unacceptable variations in health care experience. This lead role will facilitate the delivery of effective care planning techniques.

3.2.2 *Celebrating success and promoting good practice*
by identifying, celebrating and building on evidence of success.

The cultural change required to continuously improve quality and patient safety requires this to be as rigorous as identifying problems in practice and being intolerant of poor care delivery systems.

3.2.3 *Support for meta-analysis*
to facilitate checking for variance, normalised deviance, and looking at what works well – cost circa £185,000.

Skills and capacity to undertake intelligent interrogation and analysis of data to check for variance and normalised deviance, as well as looking at works well, is a main component of the proposal that is required if the Trust is to work towards achieving a zero harm culture. Risk is reduced and healthcare is made more safe when such modern improvement methods are applied.

3.2.4 *Peer review of complex needs and supporting efficiency*
to reduce variation in length of stay on acute wards and manage peoples' stays in acute beds more effectively – cost circa £385,000.

The Complex Recovery, Advice and Consultation [CRAC] team supporting acute care and community teams to manage complex cases will continuously reduce admissions/ the need for acute beds, and will continuously improve successful outcomes for people using services.

3.2.5 *Organisational development*
Tying objectives for staff to Trust objectives, and training to deliver safe and effective care will build a culture of zero harm.

3.3 The benefits
The Trust's zero harm agenda will send a positive message to all people who use CWP's services, carers of people who use CWP's services, all people who work for CWP, and CWP's partners that the Trust is serious about investing in meeting the aspirational challenge of zero harm. Investment in meeting this challenge is an indicator of the Trust's appetite to engage with a number of tactical and strategic challenges being faced by all Trusts currently and for the future.

The predominant benefits are qualitative in nature, with evidence bases indicating links to financial efficiencies, which therefore assures affordability. At the individual level of the person using the Trust's services, reducing harm and improving outcomes cannot, ethically, be costed, however all of the below benefits are known to be cost effective and link to quality, innovation, productivity and prevention [QIPP] principles. They are also essential controls and assurances against the Trust's strategic objectives:

- Promotion of meaningful recovery.
- Promotion of safe and effective care and co-ordinated, patient centred outcome focussed care.
- Prevention of unwarranted avoidable risks and unacceptable variations in healthcare experience and clinical practice and recurrent learning themes.
- Reduction in error provoking situations and processes.
- Better prediction and forecasting to intelligently inform service improvement, service development, inform commissioning intentions, and support early warning processes.
- Improved effectiveness of inpatient care and assistance to community mental health teams and acute care in the management of complex cases, i.e. reduced admissions, better focussed admissions, better community support packages and therefore reductions in need for acute beds whilst promoting meaningful recovery and better quality and safety.

4. Conclusion/ Next steps
The implementation of the above tactical steps, towards the strategic goal of having an aspiration of zero harm that drives the Trust's culture, will facilitate achievement of the ideal of *interventions leading to the maximum number of people achieving good outcomes and positive recovery and the smallest number of people experiencing adverse outcomes*.

The Trust's Quality Committee has agreed that the proposal is a "productive investment" and addresses the strategic direction of the Trust's plans for the delivery of quality. The Trust's Operational Board has agreed the financial investment required to deliver this fundamental agenda. Given the cost to fund supporting peer review and effective challenge to manage complex cases across the CWP footprint, the Operational Board has asked that historical evidence be provided to the Trust's Business Development and Innovation Sub Committee that CRAC brings added value much cheaper than each acute care team and community mental health team replicating the equivalent work of the CRAC team.

All appointments will be recruited to with a view to being in post from 1 April 2014. An initial three year implementation plan will be developed for operation from 1 April 2014. This will be monitored by the Trust's Quality Committee to track delivery and benefits realisation.

5. Recommendation
The Board of Directors is asked to **endorse** the strategic direction of the Trust's zero harm aspirations and plans for the delivery of quality by tackling unwarranted risks and variation.

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Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 13/14/98)

Report to:	**Board of Directors**
Date of Meeting:	**29th January 2014**
Title of Report:	**NHS England Planning Guidance, changes to the Monitor strategic planning process and development of Monitor two year Operational Plan**
Action sought:	**FOR DISCUSSION & APPROVAL**
Author:	**Louise Hulme, Head of Corporate Affairs/ Company Secretary**
Presented by:	**Tim Welch, Director of Finance**

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

Distribution

Version	Name(s)/Group(s)	Date Issued
1	Operational Board	15th January 2014
2	Board of Directors	29th January 2014

Executive director sign-off

Executive director (name and title)	Date signed-off
Tim Welch, Director of Finance	8th January 2014

1. Purpose of the report

To provide the Board of Directors with an update on the recently published NHS England planning guidance '*Everyone Counts: Planning for Patient 2014/15 to 2018/19*' and changes to Monitor's annual planning/ strategic planning process for 2014/15 and beyond.

2. NHS England

NHS England recently published updated planning guidance. This document covers a five year period, 2014/15 to 2018/19 and sets out the strategic and operational priorities for NHS England and commissioners.

It reiterates NHS England's focus to meet the five domains of the Outcomes Framework and the government's mandate. It also outlines three additional priorities - improving health, reducing health inequalities and parity of esteem between services for mental health and physical needs - where it expects to see improvements.

NHS England highlights that delivering their longer term ambitions will require a change in the way health services are delivered and have outlined six models of care and organising principles for the future of health and care. They signal a shift in the approach in that the priority is on separating commissioning and provision of service based on different populations' needs and different pathways. This is on the understanding that different groups within the population have different needs and services need to be organised around that. The six transformational care models are:

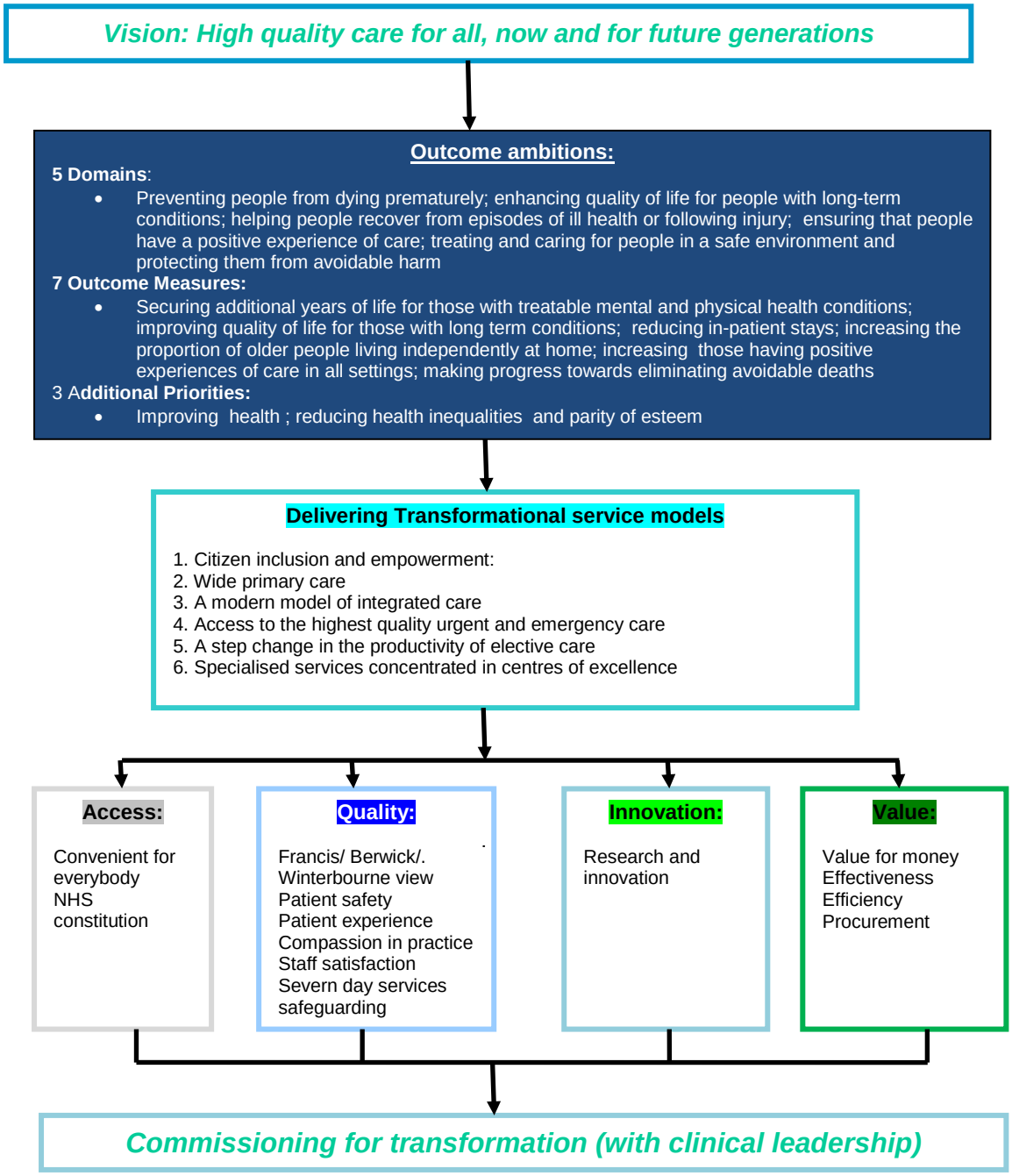
1. Citizen inclusion and empowerment
2. Wider primary care
3. A modern model of integrated care
4. Access to the highest quality urgent and emergency care
5. A step- change in the productivity of elective care
6. Specialised services concentrated in centres of excellence

Underpinning these transformational service models will be four core characteristics: quality, access, innovation and value for money. Commissioners must put these models and characteristics at the centre of their discussions with providers.

In the context of delivering these care models, the planning guidance explicitly highlights the need to find ways to raise the quality of care for all communities to the best international standards while closing a potential funding gap of around £30 billion by 2020/21. This will require a significant shift in the activity and response from the hospital sector to the community. The funding and implementation of the Better Care Fund is seen as having the potential to improve sustainability and raise quality.

As this guidance principally sets out the expectations for CCG plans, it will be crucial that as part of the 2014-15 contract negotiations CWP ensure that discussions are centred around these transformational service models, particularly the modern model of integrated care as this provides specific opportunities for the Trust to work together with other providers to develop *'care integrated around the patient.'* The full outline of the requirement for CCG plans are set out at appendix 2.

The flowchart below outlines the linkages between the NHS England strategic ambitions (the 5 domains, 7 outcome measures and 3 additional priorities) and their links to the transformational care models and their underpinning characteristics.



NHS England planning guidance '*Everyone Counts: Planning for Patient 2014/15 to 2018/19*'

3. Monitor

Monitor recently published details of the revised annual planning process. This is in line with the directive by NHS England and recent work on longer term planning with NHS England, the Local Government Association and The NHS Trust Development Authority. This was also in response to

Monitor's findings that there are significant opportunities to improve strategic planning processes across foundation trusts.

The revised approach will enable Monitor to have a greater focus on the strategic element of plans and to understand how foundation trusts intend to address the unique challenges in 2015/16 from both an operational and strategic point of view. The key changes are:

- Monitor will work with NHS England and the NHS Trust Development Authority to reconcile key commissioner and provider planning assumptions to highlight any Local Health Economies (LHEs) where there are major planning divergences; and

- Monitor will divide its annual plan review into two distinct phases, the first focused on **operational planning**, and the second focused exclusively on **strategic planning**.

Phase 1 – Two year operational and financial review - submission 4 April 2014 – *Monitor review April to May 2014*

The first phase of the Monitor review will assess the strength of foundation trusts' operational plans to address the two-year short-term challenge to 2015/16. These operational plans will require two year supporting financial projections and are intended to enable Monitor to understand the degree to which foundation trusts have started planning for, and have already begun implementing, transformational initiatives. These plans will need to include:

- the strength of the Trust's understanding of the challenges being faced over the next two years;
- the Trust's level of engagement with the key stakeholders within the LHE to assess the nature and scale of the challenge and plans to address the specific challenge faced in 2015/16;
- the congruence of commissioner and provider activity and revenue assumptions for 2014/15 and 2015/16;
- an assessment of the reasonableness of key assumptions in the plan, particularly in light of Monitor's accuracy of planning findings and efficiency assumptions
- the level of planned capacity in key services compared to the likely demand over the period to 2015/16; and
- the nature and robustness of Trust initiatives to ensure that high quality services continue to be delivered over the next two years to 2015/16.

Phase 2 – Five year strategic and sustainability review -submission 30 June 2014 – *Monitor review July to September 2014*

The second phase of the Monitor review will focus on the robustness of the Trust's strategies to deliver high quality patient care on a sustainable basis. Foundation trusts will be asked to present a five year plan with accompanying financial projections and with a particular focus on the degree to which each foundation trust has developed realistic transformational schemes and aligned its plans with those of other factors within the LHE.

This plan will need to include evidence of:

- the robustness of the Trust's strategic planning process;

- the trust's understanding of its local health economy and any likely financial gap based on its current configuration;
- the congruence of commissioner and provider activity and revenue assumptions over the coming five years;
- the strategic options, which may include transformational change to the current configuration if necessary, that the Trust believes are available to ensure sustainability of high quality services for patients;
- the Trust's chosen schemes and initiatives that should secure the Trust's long-term sustainability;
- the Trust's level of engagement and extent of alignment with the key stakeholders within the LHE to agree key initiatives; and the foundation trust board's self-assessment of the trust's longer term sustainability and the key points supporting its conclusions.

Guidance was issued by Monitor on 23rd December 2013 and set out further detail on the plan requirements and the template for completion.

To prepare for the first phase submission - the two year Operational Plan, a planning schedule has been developed with leads identified and timescales - see appendix 1. This set outs a practical guide to the detail required within the sections of the plan. The information underpinning the clinical strategies will provide much of the detail for this Operational Plan, particularly around the evidence of engaging with local health partners around priorities.

A further production schedule for the production of the Strategic Plan will be produced and provided to the February Operational Board.

The full guidance issued by Monitor can be found at the following link - http://www.monitor-nhsft.gov.uk/node/5552

5. Recommendations

It is recommended that the Board of Directors

- note the changes to the strategic planning process and the directives from NHS England and Monitor.

Appendix 1

Monitor Operational Plan 2014/15 and 2015/16- production schedule

Timeline:

First draft deadline: Friday 3rd February 2014

Board seminar: Wed 26th February 2014

Governor seminar (re. Monitor submission): Friday 28th February 2014

Final draft deadline: Friday 7th March 2014

Board sign off: Wed 26th March 2014

Submission to Monitor: Friday 4th April 2014

Section		Section lead (s)
	Executive Summary (to be completed at the end)	
	Operational Plan: the Short term challenge (to include): • evidence of collaborative work with LHE partners to define the extent of the short term challenges within the LHE • a summary of the extent of the agreed two year challenge.	Service Directors
	Operational Plan: Quality Plans (to include): • national and local commissioning priorities; • the foundation trust's quality goals as defined by its quality strategy and quality account; • an outline of existing concerns (CQC or other parties) and plans to address them; • the key quality risks inherent in the plan and how these will be managed; • an overview of how the board derives assurance on the quality of its services and safeguards patient safety (ref. Monitor	Associate Director: Safe Services

	Quality Governance Framework); • what the quality plans mean for the foundation trust workforce; • the foundation trusts' responses to Francis. Berwick and Keogh; • risks to delivery of key plans; • contingency that is built into the plan.	
	Operational Plan: Operational requirements and capacity (an assessment of the activity and demand pressures and the inputs needed to address these over next two years) **to specifically include:** • an assessment of the inputs needed(i.e. physical capacity, workforce and beds) over next two years based on expected activity levels; • an analysis of the key risks and how the trust will be able to adjust its inputs to match different levels of demand.	Service Directors Associate Director: Estates Associate Director: Safe Services Associate Director: Workforce
	Operational Plan: Productivity, efficiency and CIPs (to include): • identification of a robust programme of schemes; • description of CIP programme (highlighting difference between incremental and efficiency driven and those which are transformation in nature; • detail around planned transformation schemes, their state of implementation and any future schemes central to the delivery of the plan.	Service Directors Deputy Director of Finance
	Operational Plan: Financial Plan commentary (to include): • income, and the extent of its alignment with commissioner intentions/ plans; • costs; • capital plans; • liquidity; • risk ratings	Deputy Director of Finance Associate Director: Estates
	Appendices: For any items of commercial sensitivity or not for publication	
	Coordination and version control	Head of Corp Affairs/ CoSec

Appendix2

Fundamental elements of commissioner plans

		Fundamental	Key features to be demonstrated in plans
1	Outcomes	Delivery across the five domains and seven outcome measures	• your understanding of your current position on outcomes as set out in the NHS Outcomes Framework • the actions you need to take to improve outcomes
2		Improving health	• working with H&WB partners, your planned outcomes from taking the 5 steps recommended in the "commissioning for prevention" report
3		Reducing health inequalities	• identification of the groups of people in your area that have a worse outcomes and experience of care and your plans to close the gap • implementation of the 5 most cost effective high impact interventions recommended by the NAO report on health inequalities • implementing EDS2
4		Parity of esteem	• the resources you are allocating to mental health to achieve parity of esteem • identification and support for young people with mental health problems • plans to reduce the 20 year gap in life expectancy for people with severe mental illness
5	Patient services	New approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care	• how you will commission services so that patients and citizens have the opportunity to take control • how you will put real time patient and citizen voice at the heart of decision making • how you will include authentic citizen participation in the design of your plans • how you will promote transparency in local health services

		Fundamental	Key features to be demonstrated in plans
6	Patient services (continued)	Wider primary care, provided at scale	• your understanding of the potential contribution of primary care to delivery of your ambition • working with partners and the public to develop an integrated approach to primary and community services, with joint commissioning as appropriate • how you will enable primary care to operate at greater scale to improve access and continuity of care and to enable your urgent and emergency care network to function effectively
7		A modern model of integrated care	• what you are doing to ensure people with multiple long-term conditions and clinical risk factors are offered a fully integrated experience of support and care
8		Access to the highest quality urgent and emergency care	• how your strategic plan is in line with the vision set out in the Urgent and Emergency Care Review Phase One Report http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf • how you will you be ready to determine the footprint of your urgent and emergency care network during 2014/15, working with key partners and informed by a detailed understanding for your area of: a) patient flows; b) the number and location of emergency and urgent care facilities; c) the services they provide; and d) the most pressing needs for your population • how you will be ready in 2015/16 to begin the process of designation for all facilities within your network
9		A step-change in the productivity of elective care	• how you have considered your model of elective care for your local providers to achieve a 20% productivity improvement within 5 years, so that existing activity levels can be delivered with better outcomes and 20% less resource

		Fundamental	Key features to be demonstrated in plans
10	Patient services (continued)	Specialised services concentrated in centres of excellence.	• how your strategic plans address whether your providers are seeing and treating a sufficiently high enough volume of patients to meet specified clinical standards, in line with the need to concentrate specialised services in 15-30 centres of excellence, linked to Academic Health Science Networks • how your plans are ensuring that specialised services in your area are connecting actively to and maximising the opportunities of working with research and teaching
11	Access	Convenient access for everyone	• how you will deliver good access to the full range of services, including general practice and community services, especially mental health services in a way which is timely, convenient and specifically tailored to minority groups
12		Meeting the NHS Constitution standards	• that your plans include commissioning sufficient services to deliver the NHS Constitution rights and pledges for patients on access to treatment as set out in Annex B and how they will be maintained during busy periods
13	Quality	Response to Francis, Berwick and Winterbourne View	• how your plans will reflect the key findings of the Francis, Berwick and Winterbourne View Reports
14		Patient safety	• how you will address the need to understand and measure the harm that can occur in healthcare services, to support the development of capacity and capability in patient safety improvement • how you will increase the reporting of harm to patients, particularly in primary care and focused on learning and improvement

		Fundamental	Key features to be demonstrated in plans
15	Quality (continued)	Patient experience	• how you will set measureable ambitions to reduce poor experience of inpatient care and poor experience in general practice • how you will assess the quality of care experienced by vulnerable groups of patients and how and where experiences will be improved for those patients • how you will demonstrate improvements from FFT complaints and other feedback
16		Compassion in practice	• how your plans will ensure that local provider plans are delivering against the six action areas of the Compassion in Practice implementation plans • how the 6Cs are being rolled out across all staff
17		Staff satisfaction	• an in-depth understanding of the factors affecting staff satisfaction in the local health economy and how staff satisfaction locally benchmarks against others • how your plans will ensure measureable improvements in staff experience in order to improve patient experience
18		Seven day services	• that the action plans submitted by your providers (a requirement within the Service Development and Improvement Plan section of the NHS Standard Contract) give you confidence that they will be able to comply with all ten of the Seven Day Service Clinical Standards by 2016/17 • if not, how your strategic and operational plans are going to ensure these standards are being met for patients • how your strategic plans are addressing the need to provide consistently high quality urgent and emergency care services outside of hospital across the seven day week

		Fundamental	Key features to be demonstrated in plans
19		Safeguarding	• how your plans will meet the requirements of the accountability and assurance framework for protecting vulnerable people • the support for quality improvement in application of the Mental Capacity Act • how you will measure the requirements set out in your plans in order to meet the standards in the prevent agenda
20	Innovation	Research and innovation	• how your plans fulfil your statutory responsibilities to support research • how you will use Academic Health Science Networks to promote research • how you will adopt innovative approaches using the delivery agenda set out in *Innovation Health and Wealth: accelerating adoption and diffusion in the NHS*
21	Delivering value	Financial resilience; delivering value for money for taxpayers and patients and procurement	• meeting the business rules on financial plans including surplus, contingency and non-recurrent expenditure. • clear and credible plans for QIPP that meet the efficiency challenge and are evidence based, including reference to benchmarks • the clear link between service plans, financial and activity plans

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document Reference (2013/14/99)

Report to:	**Board of Directors**
Date of Meeting:	**29th January 2014**
Title of Report:	**Update and approval of CWP Clinical Strategies**
Action sought:	**For APPROVAL**
Author:	**Julia Cottier, Service Director, East, Julie Critchley, Service Director West, Suzanne Edwards, Acting Service Director, Wirral.**
Presented by:	**Andy Styring, Director of Operations**

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
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Distribution

Version	Name(s)/Group(s)	Date Issued
1		

Executive director sign-off

Executive director (name and title)	Date signed-off
Andy Styring, Director of Operations	19th January 2014

1. Purpose of the report

To update the Board of Directors on the progress of the CWP Clinical Strategies.

2. Content

At the meeting of the Board of Directors on 25th September 2013, the Board received and discussed the draft Clinical Strategies from CWP Wirral, CWP West Cheshire and CWP East Cheshire. These have been developed by the senior clinical leadership teams in localities.

The Board agree the following steps and proposed timetable for action:

- September to December 2013 services will consult further with key partners on the broad principles for service development and will develop greater detail to implement each element / strand of their clinical strategy
- To have presentation from Service Directors on detail of each strategy (plan on a page) at October 2013 Board Seminar, (to include lead governors at seminar discussions)
- October – December - further consultation, discussion and increasing level of detail developed in localities and across service specialities). Suggestion to have locality groups to be chaired by Service Directors and to include Non-Executive Directors and Governor representation on group along with other key stakeholders
- October – January – local groups will work in partnership to develop greater detail in plan and increase consultation. Consultation will take place internally and externally and with Health & Wellbeing Scrutiny Committee as appropriate
- Final draft of Clinical Strategies to be presented to the January 2014 Board for consideration and approval.
- Subject to formal approval at January Board then to be used to inform contract negotiations and drive CWP Annual Plan

Each locality has consulted as described within the attached papers and has continued to review and amend the strategy based upon their consultation outcomes.

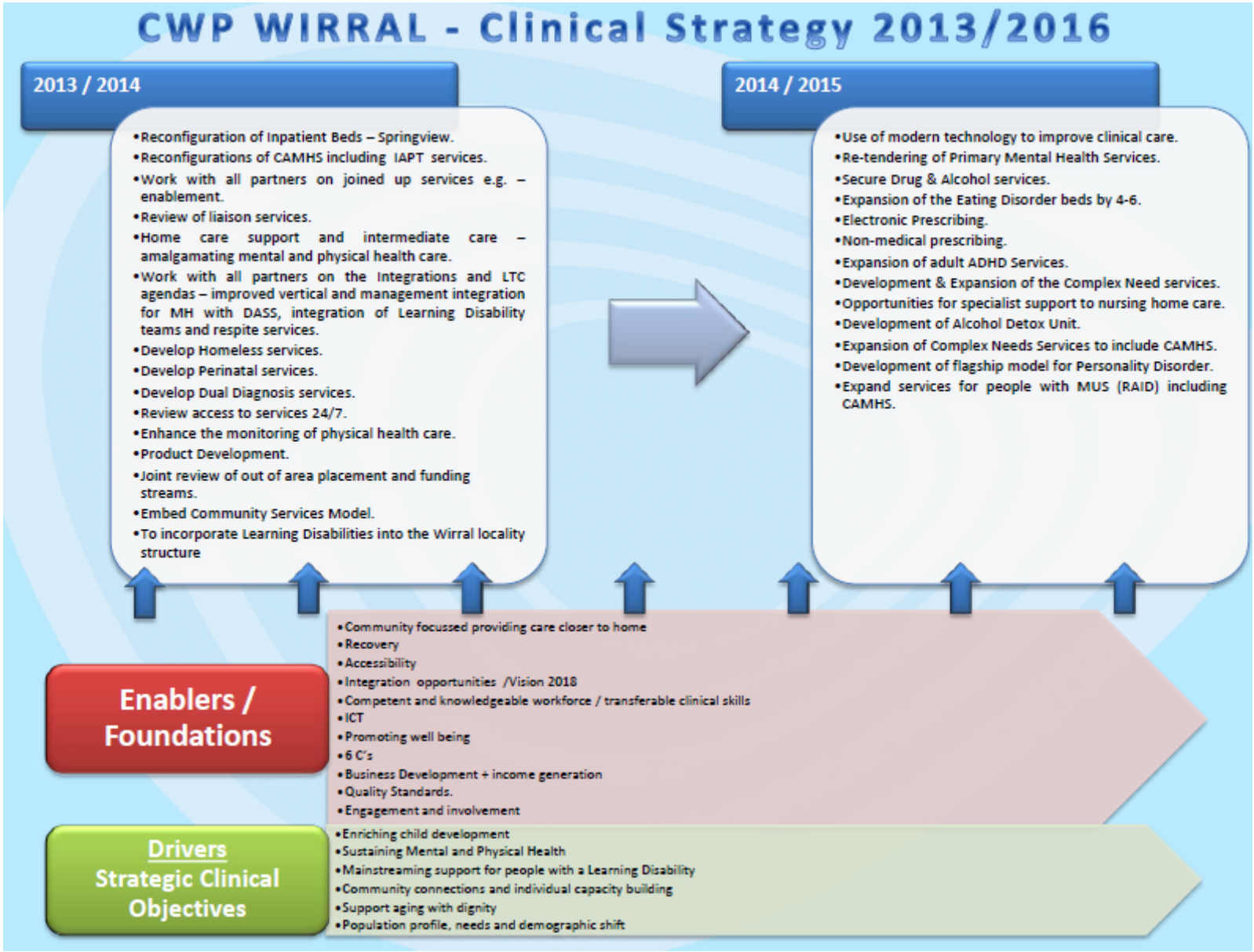
Each of the clinical strategies were presented to and discussed at the January 2014 meeting of the Operational Board. The Operational Board noted the progress in the development of the respective clinical strategies and gave approval to them being presented to the Trust Board of Directors for further discussion and final approval.

3. Recommendations to the Board of Directors

The Board of Directors is asked to note and approve the CWP Clinical Strategies and agree that the inform contract negotiations and drive the CWP annual planning submissions to Monitor.

4. Appendices

As set out below


CWP WIRRAL - Clinical Strategy 2013/2016
2013 / 2014
•Reconfiguration of Inpatient Beds – Springview.
•Reconfigurations of CAMHS including IAPT services.
•Work with all partners on joined up services e.g. – enablement.
•Review of liaison services.
•Home care support and intermediate care – amalgamating mental and physical health care.
•Work with all partners on the Integrations and LTC agendas – improved vertical and management integration for MH with DASS, integration of Learning Disability teams and respite services.
•Develop Homeless services.
•Develop Perinatal services.
•Develop Dual Diagnosis services.
•Review access to services 24/7.
•Enhance the monitoring of physical health care.
•Product Development.
•Joint review of out of area placement and funding streams.
•Embed Community Services Model.
•To incorporate Learning Disabilities into the Wirral locality structure
2014 / 2015
•Use of modern technology to improve clinical care.
•Re-tendering of Primary Mental Health Services.
•Secure Drug & Alcohol services.
•Expansion of the Eating Disorder beds by 4-6.
•Electronic Prescribing.
•Non-medical prescribing.
•Expansion of adult ADHD Services.
•Development & Expansion of the Complex Need services.
•Opportunities for specialist support to nursing home care.
•Development of Alcohol Detox Unit.
•Expansion of Complex Needs Services to include CAMHS.
•Development of flagship model for Personality Disorder.
•Expand services for people with MUS (RAID) including CAMHS.
Enablers / Foundations
•Community focussed providing care closer to home
•Recovery
•Accessibility
•Integration opportunities /Vision 2018
•Competent and knowledgeable workforce / transferable clinical skills
•ICT
•Promoting well being
•6 C's
•Business Development + income generation
•Quality Standards.
•Engagement and involvement
Drivers Strategic Clinical Objectives
•Enriching child development
•Sustaining Mental and Physical Health
•Mainstreaming support for people with a Learning Disability
•Community connections and individual capacity building
•Support aging with dignity
•Population profile, needs and demographic shift

(Appendix 1) CWP Wirral Clinical Strategy

1. Introduction

As agreed at Operational Board a paper was presented at Trust board on the 25th September 2013 for noting by the Board of Directors and approval of next steps. This paper provides an update as to the current position of CWP Wirral in its development and delivery of its clinical strategy and steps taken so far against the agreed actions. The report also provides detail on the specific strategic intentions and service developments detailed in the strategy for both 2013/14 and 2014/15.

2. Progress to Date on Agreed Board Actions

Action	Timescale	Completed	Commentary
Services will consult further with key partners on the broad principles for service development and will develop greater detail to implement each element / strand of their clinical strategy	September – December 2013	**Yes**	A "Clinical Strategy" event was organised and all stakeholders were invited to attend a "Market Style Event" allowing for discussion and interaction on each of the specific areas/strands with attendees. Feedback forms/comments were collected and incorporated in to the revised version Individual discussions with commissioners and key partners on the clinical strategy have taken place
Presentation from Service Directors on detail of each strategy (plan on a page) at October 2013 Board Seminar,	October 2013	Completed	
Further consultation, discussion and increasing level of detail developed in localities and across service specialities	October to December 2013	Ongoing	Each service area has widened its consultation to their specific groups Specific project teams are being established to progress detailed plans and/or develop business cases. Local forum for Wirral Governors to be arranged
Final draft of Clinical Strategies to be presented to the January 2014 Board for consideration and approval.	January 2014		
Subject to formal approval at January Board then to be used to inform contract negotiations and drive CWP Annual Plan	February – March 2014		

3. Progress to date on Strategic Aims and Service Developments

Strategic Aim/Service Development	Time Frame	CIP/QIPP	Dependency Factors/Issues	Progress to date
Reconfiguration of Inpatient Beds – Springview.	2013 - 2015	Yes	A review of inpatient bed use will need to be undertaken Trust wide, with consideration being taken on the development of pathways that will sit along acute care, but are designed to meet more complex/longer stay. Discussion with commissioners in relation to PbR 3rd Sector/Independent/joint provision of community crisis provision Review of home treatment teams within CWP	The beds have been temporarily closed since end of October 2013, to date all CWP patients requiring an inpatient bed have been accommodated within CWP. Further analysis will need to be undertaken to understand the sustainability of this, and the potential to generate income with any spare capacity. This will require a Trust wide review. Wirral Commissioners have funded the reprovision of 3 emergency respite beds for use by HTT – registered but awaiting formal opening date. A review of the function of the two home treatment teams (adult & older people's) and liaison is planned (commencing 13 January 2014) which will include a review of the out of hours pathway which cuts across both health and social care (DASS). A business case for the proposal of merging the two teams into one ageless functional HTT will be developed by end February 2014
Work with all partners on joined up services e.g. – enablement.		Yes	Work is ongoing with partners on Wirral to widen the service delivery model to include physical health services as appropriate	Continued discussions on tendering opportunities as they arise with Commissioners and response as appropriate (i.e. Healthy Children 0-19 service)
Review of liaison services.	2014/15	No		This work has been led by the CCG, and is due to be completed end of quarter 1 Also links to the review around access to services 24/7
Home care support and intermediate care – amalgamating mental and	2014/15	Yes	Wirral CCG is leading on a whole system change for Wirral – Vision 2018 which	CWP are leading on the Quality and Outcomes work stream and have senior clinical and management presentation on all of the other

Strategic Aim/Service Development	Time Frame	CIP/QIPP	Dependency Factors/Issues	Progress to date
physical health care.			is the response to demographic changes, increased demand, changing and costly technologies and the increasing cost of health and social care	work streams
Work with all partners on the Integrations and LTC agendas – improved vertical and management integration for MH with DASS, integration of Learning Disability teams and respite services.	2014/15	Yes (as part of Vision 2018 model this would be a level 2 QIPP	Vision 2018 Local Authority agreement MDT with WUTH and CT CCG and contractual obligations Adult and Older Peoples CMHTs Community Learning Disabilities	Full involvement from CWP in all domains of the project CWP scoping role and responsibilities within the MDT, and developing an understanding of the resource implications from CWP perspective. A review of community mental health services has been undertaken by the Local Authority with the recommendation that LA staff are seconded to CWP (mental health only). The development of a Learning Disability Commissioner and Provider Group – discussion within this group on joint health and social care learning disabilities teams with the final objective to second to CWP to replicate the Mental Health model
Develop Homeless Services	2013/14	No	Local Authority A range of 3rd sector organisations	CWP held Homeless workshop in August 2013. The aim was to get all partners to share their involvement with the homeless community and how we could work better together. The outputs of the workshop were sent to the CCG to help inform the strategic direction for the homeless services on Wirral. This has formed part of the commissioning intentions for 2013/14
Develop Perinatal Services	2013/14	No	Required additional funding to enhance the service however CCG have declined to fund any	Business case prepared by Women's and Children's QIPP only partially supported by CCG therefore status quo to remain within the existing agreed pathways and guidelines.

Strategic Aim/Service Development	Time Frame	CIP/QIPP	Dependency Factors/Issues	Progress to date
			medical input into the service. Additional midwife to be recruited by WUTH which will provide greater support for the pathway.	
Develop Dual Diagnosis Service	2013/14	No	Public Health and retendering of Drug and Alcohol Services	An initial meeting took place to look at enhancing current arrangements and MDT working across D&A and AMH. Action plan developed. Requested and received a new dual diagnosis report on report manager, to give client numbers/demographics. Planning to run joint review clinics in localities e.g. Highfield Centre to cut down on client travel, and to realise benefits of joint working. Senior clinical lead in the process of initiating forum for dual diagnosis link workers as per policy, with regular meetings, initially with band 7 staff across locality, to set up link people in each team. Still need to identify lead psychiatrist to provide clinical sessions for alcohol service clients with a dual diagnosis
Review access to services 24/7	2014/15	Yes	Local Authority Primary Care MH and Secondary Care Interface and current multiple providers Interface between home treatment team and liaison Inclusion of the Local Authorities Emergency Duty Team (EDT)	Project team to be established to look at a single point of access and assessment into CWP Wirral Services Project team established to develop a business case for an out of hours service that will combine liaison, home treatment, access and EDT.

Strategic Aim/Service Development	Time Frame	CIP/QIPP	Dependency Factors/Issues	Progress to date
Enhance the monitoring of physical health care	2014/15	No	Agreement with CCG	Forms part of the Service Development and Improvement Plan for 2014/15 contract with CCG. Protocols around Physical Health Care as part of the Commissioning intentions with the CCG i.e. Lithium
Product development		Yes		CAMHS – Next step cards/phone app development
Joint review of out of area placement and funding streams.		QIPP		As part of the LA review of CMHT's they are recommending the development of a review officer. The post holder will conduct a review of all out of area placements which CPN's and Social workers will undertake. New service developments may be an option depending on the outcome of the reviews. A similar process is taking place with regard to LD placements as part of the Winterbourne View recommendations. This is led by commissioners with input from CWP
To incorporate Learning Disabilities into the Wirral locality structure	January 2014	No		Completed
Embed the CSIP	2013-2014	Yes	Local Authority decision on secondment of mental health staff	Implemented April 2013. Ongoing monitoring and evaluation to ensure that the model and pathways are being implemented. Changes to the team structures will be required once a decision has been made with regards to the secondment of LA staff.
Use of modern technology to improve clinical care.	2014/15	Yes		Bid for monies submitted and is currently being developed.
Re-tendering of Primary Mental Health Services.	2014/15	No	Potential partnerships	No information on the service specification. CWP are working with the CCG to review pathways and interface between primary and secondary care.

Strategic Aim/Service Development	Time Frame	CIP/QIPP	Dependency Factors/Issues	Progress to date
Secure Drug & Alcohol services.	2014/15	No	Potential partnerships	Awaiting commencement of tendering process.
Expansion of the Eating Disorder beds by 4-6.	2014/15	Yes	NHS England and impact of commissioning arrangements for inpatient eating disorder services	Business case to be developed to review the options of developing Oaktrees and/or satellite ward.
Electronic Prescribing.	2014/15			Awaiting update
Non-medical prescribing.	2014/15	No	Places identified – awaiting confirmation of course	A number of practitioners have completed the prescribing module and are working to the guidelines. Further places at the university have been requested
Expansion of adult ADHD Services.	2014/15	Yes	The service needs to be embedded within localities, as the service currently has no capacity to expand, this would benefit all localities as they could develop services within their local areas/neighbours. CCG have voiced concerns at the cost of the current services	Awaiting feedback from Service and Clinical Directors on how to progress this. CWP Wirral is currently working with the CCG to review the existing pathways.
Development & Expansion of the Complex Need services.	October 2014	No	Links to Drug and Alcohol, ADHD, CJL and Personality Disorder Service	Service is currently only funded for 1 year, an evaluation programme has been developed and will be presented to the CCG
Opportunities for specialist support to nursing home care.	2014/15	Yes	Links to Wirral's Dementia Strategy and QIPP agenda Included in commissioning intentions	Yet to commence Included in commissioning intentions
Development of Alcohol Detox Unit.		Yes	Creation of capacity within the inpatient unit at	Currently in the process of drafting a plan to propose to utilise the 13 bedded unit at

Strategic Aim/Service Development	Time Frame	CIP/QIPP	Dependency Factors/Issues	Progress to date
			springview as a result of the inpatient redesign	Springview as a rapid access alcohol detox facility. There is a model of service delivery at Manchester, which serves all 3 of the Acute Manchester Trusts and has been very well evaluated. The service will arrange a visit early 2014 to look at utilising this model. In the meantime, the NMP role has been expanded in alcohol treatment in preparation for this to be a nurse led service. The Harm Reduction Unit will increase their ambulant detox provision and are developing in preparation, e.g. PGD for rectal diazepam, defibrillator, oxygen supply etc.
Expansion of Complex Needs Services to include CAMHS.	October 2014	No	Continuation of the service post October 2014	The current pilot has included a small cohort from CAMHS the outcome of this will feed into the evaluation.
Development of flagship model for Personality Disorder.	2014/15	No	Links with 3rd sector to further develop service user consultant model	Evaluation to link to complex needs service with the view that this will sit within that remit.
Expand services for people with MUS (RAID) including CAMHS.	2014/15	QIPP		Work yet to commence

4. Influencers on the Clinical Strategy

Since the initial development of the clinical strategy the Wirral Health and Social Care economy have come together in a combined approach to address the challenges set out in "A call to Action". The local financial challenge in Wirral in 2016/17 is suggested to be a 22% reduction in total spend across health and social care. This whole system approach will be overseen by the Vision 2013 Programme Board with a number of work streams that reflect the AQUA principles and include Financial and Populations Modelling, Quality & Outcomes, Secondary care clinical model, Primary Care clinical model, Integration, Communication and Workforce, Finance and Contracting, and IT and Information Governance. CWP will be represented at all of these groups and it will be necessary for the direction of the clinical strategy to dovetail with the principles and activities outlined within the groups.

The Clinical Commissioning Group have been clear in their position with regards to investment in further service developments with a clear message that there will be limited growth or opportunities for new monies. This means that some elements of the clinical strategy may only be aspirational, for example perinatal services, if there continues to be no opportunities for service development other than service redesign. Recent discussions with the commissioners regarding the deflator have resulted in a request to develop a business case for any ideas from the CCG. CWP Wirral have decided to concentrate on over performance and will submit business cases for CAMHS 16-19 services, Early Onset Dementia and Alcohol Acquired Brain Injury and Single Point of Access, as part of these cases there will be the opportunity to review and redesign for example the development of email access for advice from GPs to Consultants to reduce the number of referrals.

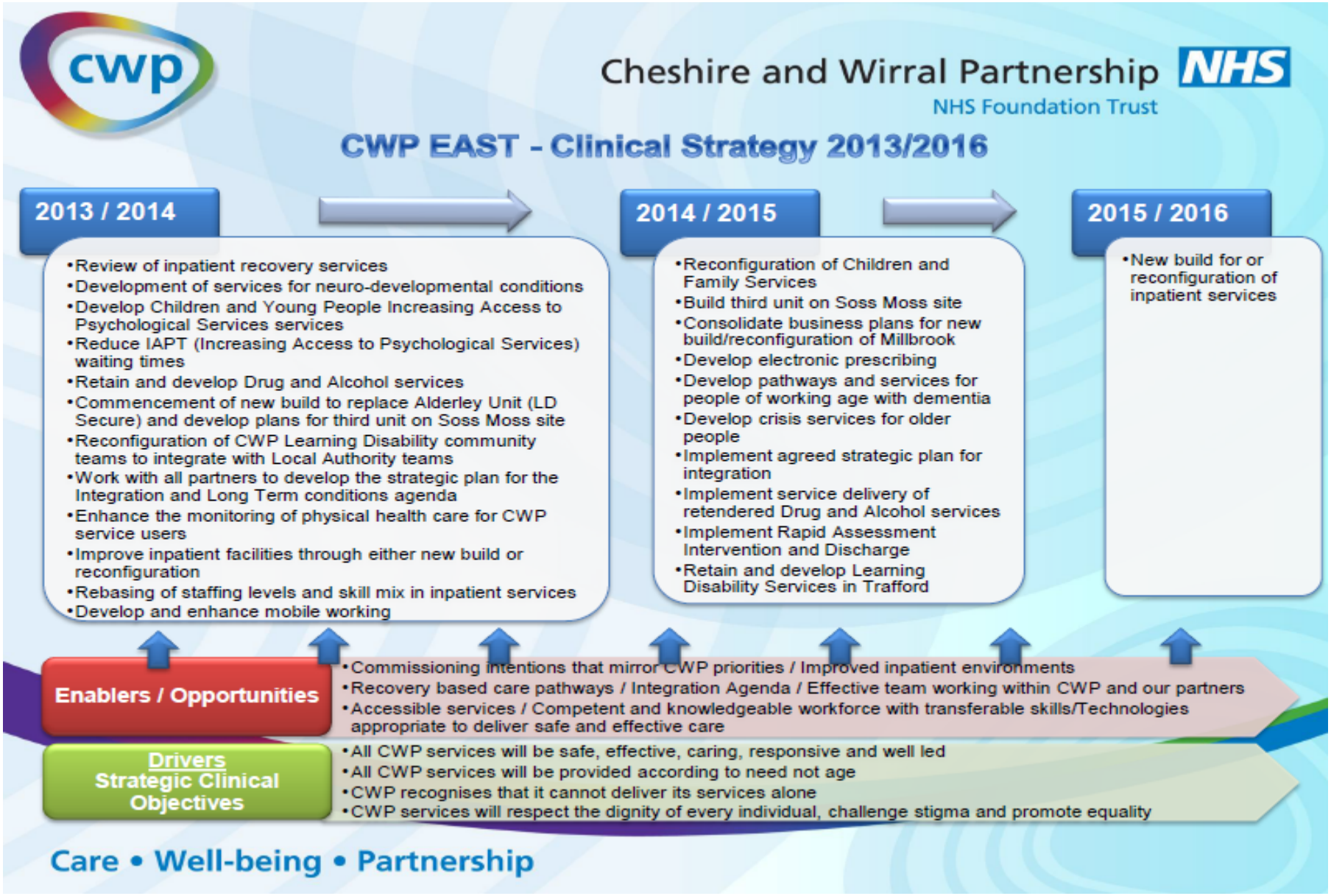
Greater partnership working with 3rd sector, voluntary and other organisations will be the vehicle to develop services and innovate, along with capitalising on the locality model within CWP. As well as relocating service provision such as psychological therapies into community settings and ensuring that robust pathways to voluntary and other organisations which have strong user led initiatives are developed. As part of our work with the 3rd Sector and Public Health we are engaged in a pilot around ABCD (Asset Based Community Development) initiative which will endeavour to understand all of the community assets on Wirral to develop community connectors to direct service users as part of their recovery to those community assets.

5. Cost Improvement Plans (CIP)

The clinical strategy will drive the CIP and the efficiencies required, some of these cannot be done in isolation of the other two localities or without our existing and/or new partners. Some of the efficiencies created will be QIPP following the focus on greater integration within health and social care, and some of the efficiencies will help release time for clinicians to spend greater face to face time with service users. Further detailed work is being undertaken with regards to CIP and associated impact assessments.

6. Conclusion

The clinical strategy will need to be dynamic and not static if CWP Wirral is to respond flexibly to the developing health and social care agenda, and will require regular review and refresh to ensure that it is fit for purpose.


Cheshire and Wirral Partnership NHS
NHS Foundation Trust
CWP EAST - Clinical Strategy 2013/2016
2013 / 2014
•Review of inpatient recovery services
•Development of services for neuro-developmental conditions
•Develop Children and Young People Increasing Access to Psychological Services services
•Reduce IAPT (Increasing Access to Psychological Services) waiting times
•Retain and develop Drug and Alcohol services
•Commencement of new build to replace Alderley Unit (LD Secure) and develop plans for third unit on Soss Moss site
•Reconfiguration of CWP Learning Disability community teams to integrate with Local Authority teams
•Work with all partners to develop the strategic plan for the Integration and Long Term conditions agenda
•Enhance the monitoring of physical health care for CWP service users
•Improve inpatient facilities through either new build or reconfiguration
•Rebasing of staffing levels and skill mix in inpatient services
•Develop and enhance mobile working
2014 / 2015
•Reconfiguration of Children and Family Services
•Build third unit on Soss Moss site
•Consolidate business plans for new build/reconfiguration of Millbrook
•Develop electronic prescribing
•Develop pathways and services for people of working age with dementia
•Develop crisis services for older people
•Implement agreed strategic plan for integration
•Implement service delivery of retendered Drug and Alcohol services
•Implement Rapid Assessment Intervention and Discharge
•Retain and develop Learning Disability Services in Trafford
2015 / 2016
•New build for or reconfiguration of inpatient services
Enablers / Opportunities
•Commissioning intentions that mirror CWP priorities / Improved inpatient environments
•Recovery based care pathways / Integration Agenda / Effective team working within CWP and our partners
•Accessible services / Competent and knowledgeable workforce with transferable skills/Technologies appropriate to deliver safe and effective care
Drivers
Strategic Clinical Objectives
•All CWP services will be safe, effective, caring, responsive and well led
•All CWP services will be provided according to need not age
•CWP recognises that it cannot deliver its services alone
•CWP services will respect the dignity of every individual, challenge stigma and promote equality
Care • Well-being • Partnership

(Appendix 2) CWP East Clinical Strategy

1. Introduction

As agreed at Operational Board a paper was presented at Trust board on the 25th September 2013 for noting by the Board of Directors and approval of next steps. This paper provides an update as to the current position of CWP East in its development and delivery of its clinical strategy and steps taken so far against the agreed actions. The report also provides detail on the specific strategic intentions and service developments detailed in the strategy for both 2013/14 and 2014/15.

2. Progress to Date on Agreed Board Actions

Action	Timescale	Completed	Commentary
Services will consult further with key partners on the broad principles for service development and will develop greater detail to implement each element / strand of their clinical strategy	September – December 2013	**Yes**	East Clinical Strategy has been shared with all clinical teams and clinical support colleagues Individual discussions with commissioners, key partners and PPI/Lived experience reps on the clinical strategy have taken place Presented at the Council of Governors seminar in December 2013 Presented at VR/South CCG public consultation events in October 2013 Arrangements made to present at service user fora in Feb 2014 (first available date given)
Presentation from Service Directors on detail of each strategy (plan on a page) at October 2013 Board Seminar,	October 2013	Completed	
Further consultation, discussion and increasing level of detail developed in localities and across service specialities	October to December 2013	Ongoing	Each service area has widened its consultation to their specific groups Specific project teams are being established to progress detailed plans and/or develop business cases.
Final draft of Clinical Strategies to be presented to the January 2014 Board for consideration and approval.	January 2014		

Subject to formal approval at January Board then to be used to inform contract negotiations and drive CWP Annual Plan	February – March 2014		

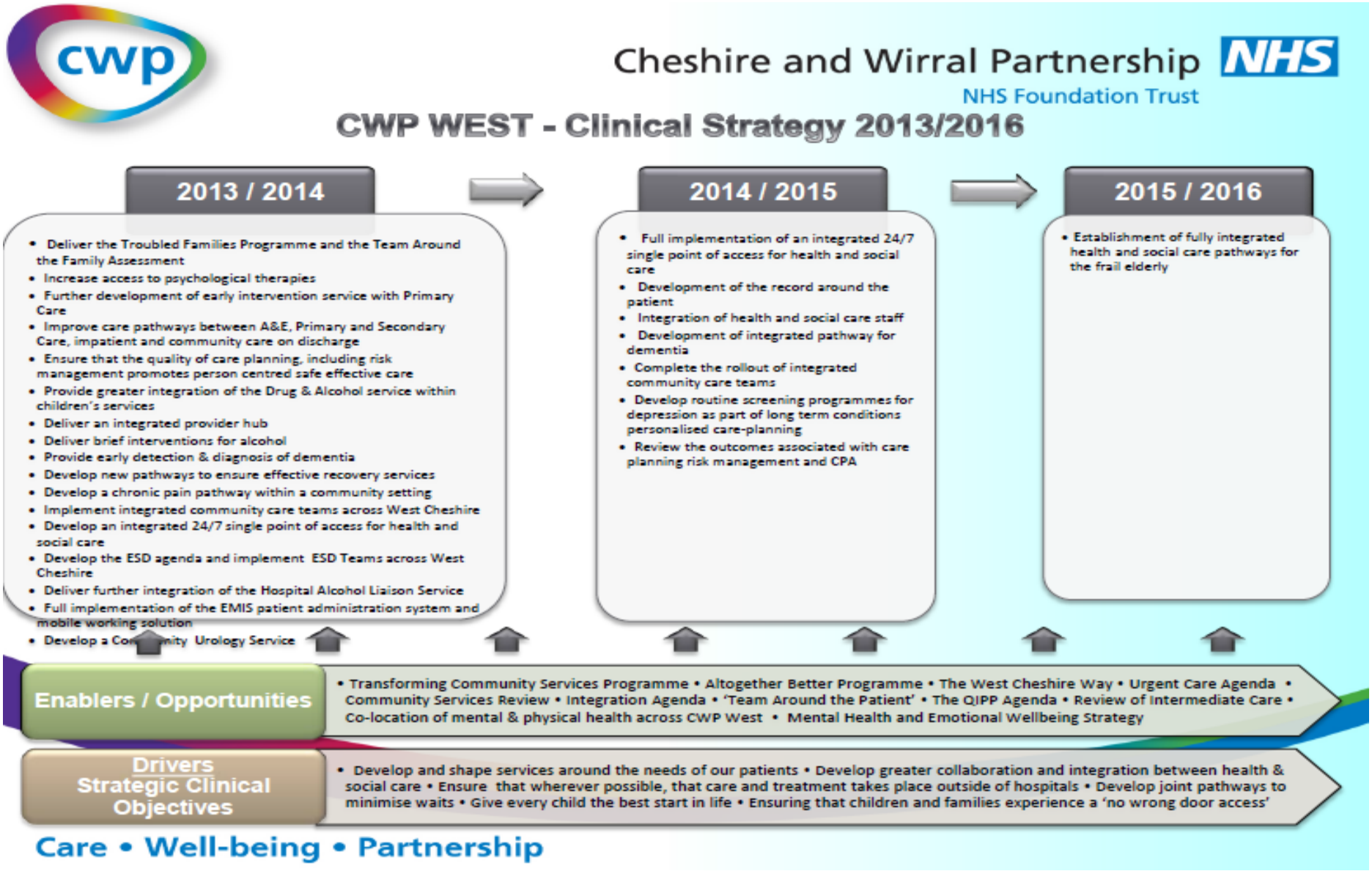
3. Progress to date on Strategic Aims and Service Developments

Strategic Aim/Service Developments	Time Frame	£	Dependency Factors	Progress to date
• Review of inpatient recovery services	2013 – 2014	Potential CIP		Ongoing – should be completed by March 2014
• Development of services for neuro-developmental conditions	2013-2014	Additional investment	Time limited funding from CCG	On track with milestones
• Develop Children and Young People Increasing Access to Psychological Services services	2013-2014	Additional investment	Trustwide project	On track with milestones
• Reduce IAPT (Increasing Access to Psychological Services) waiting times	2013-2014	Additional investment	Funding agreed to reduce waiting list – currently awaiting decision on ongoing funding to maintain waiting times	Underway (January 2014)
• Retain and develop Drug and Alcohol services	2013-14	Reduction in current contract values	Tendering process underway	Trafford – awaiting decision on award of contract for service delivery from April 2014 East – latest information is that service delivery will be from July 2014 (no tender documents received as yet)
• Commencement of new build to replace Alderley Unit (LD Secure) and develop plans for third unit on Soss Moss site	2013-14	Internal resources	Contractors	On track
• Reconfiguration of CWP Learning Disability community teams to	2013-14	Possible CIP	Joint project with LA – project lead only in place	Ongoing

Strategic Aim/Service Developments	Time Frame	£	Dependency Factors	Progress to date
integrate with Local Authority teams			until March 2014. LD Life Course project also happening in CEC footprint	
• Work with all partners to develop the strategic plan for the Integration and Long Term conditions agenda	2013-14	Health economy wide savings required	CCGs at different stages in implementation. Capacity issues	Ongoing
• Enhance the monitoring of physical health care for CWP service users	2013-14	?	CWP East and CCGs working together to agree roles and responsibilities. Recent incidents have led to reviews by teams	Ongoing
• Improve inpatient facilities through either new build or reconfiguration	2013-14	Investment required from capital programme	JV/Estates capacity. Future of ECT/use of site	Ongoing
• Rebasing of staffing levels and skill mix in inpatient services	2013-14	Potential investment required	Ward staffing review	Ongoing
• Develop and enhance mobile working	2013-14	Potential initial investment leading to CIP	Cultural shift required	Ongoing
• Reconfiguration of	2014-15	Potential	Commissioning	Project team being established

Strategic Aim/Service Developments	Time Frame	£	Dependency Factors	Progress to date
Children and Family Services		CIP/QIPP	intentions	
• Build third unit on Soss Moss site	2014-15	Income generation	Commissioner buy in	External consultant working with CWP to develop business case
• Consolidate business plans for new build/reconfiguration of Millbrook	2014-15	Possible CIP	Trustwide review of inpatient services/JV/capital programme	Ongoing
• Develop electronic prescribing	2014-15	Possible CIP	Trustwide programme	
• Develop pathways and services for people of working age with dementia	2014-15	QIPP	Commissioning Intentions	
• Develop crisis services for older people	2014-15	QIPP	Commissioning intentions	
• Implement agreed strategic plan for integration	2014-15	Health economy wide savings required	Commitment from all partners required	
• Implement service delivery of retendered Drug and Alcohol services	2014-15		Tendering process	
• Implement Rapid Assessment Intervention and Discharge	2014-15	QIPP	Commissioning intentions	Project teams in both CCG areas established. (CQUIN for 2013-14 to design model)

Strategic Aim/Service Developments	Time Frame	£	Dependency Factors	Progress to date
• Retain and develop Learning Disability Services in Trafford	2014-15		Tendering process	No tender documents as yet


Cheshire and Wirral Partnership NHS
NHS Foundation Trust
CWP WEST - Clinical Strategy 2013/2016
2013 / 2014
• Deliver the Troubled Families Programme and the Team Around the Family Assessment
• Increase access to psychological therapies
• Further development of early intervention service with Primary Care
• Improve care pathways between A&E, Primary and Secondary Care, impatient and community care on discharge
• Ensure that the quality of care planning, including risk management promotes person centred safe effective care
• Provide greater integration of the Drug & Alcohol service within children's services
• Deliver an integrated provider hub
• Deliver brief interventions for alcohol
• Provide early detection & diagnosis of dementia
• Develop new pathways to ensure effective recovery services
• Develop a chronic pain pathway within a community setting
• Implement integrated community care teams across West Cheshire
• Develop an integrated 24/7 single point of access for health and social care
• Develop the ESD agenda and implement ESD Teams across West Cheshire
• Deliver further integration of the Hospital Alcohol Liaison Service
• Full implementation of the EMIS patient administration system and mobile working solution
• Develop a Co nity Urology Service
2014 / 2015
• Full implementation of an integrated 24/7 single point of access for health and social care
• Development of the record around the patient
• Integration of health and social care staff
• Development of integrated pathway for dementia
• Complete the rollout of integrated community care teams
• Develop routine screening programmes for depression as part of long term conditions personalised care-planning
• Review the outcomes associated with care planning risk management and CPA
2015 / 2016
• Establishment of fully integrated health and social care pathways for the frail elderly
Enablers / Opportunities
• Transforming Community Services Programme • Altogether Better Programme • The West Cheshire Way • Urgent Care Agenda • Community Services Review • Integration Agenda • 'Team Around the Patient' • The QIPP Agenda • Review of Intermediate Care • Co-location of mental & physical health across CWP West • Mental Health and Emotional Wellbeing Strategy
Drivers
Strategic Clinical Objectives
• Develop and shape services around the needs of our patients • Develop greater collaboration and integration between health & social care • Ensure that wherever possible, that care and treatment takes place outside of hospitals • Develop joint pathways to minimise waits • Give every child the best start in life • Ensuring that children and families experience a 'no wrong door access'
Care • Well-being • Partnership

(Appendix 3) CWP West Clinical Stratgey

1. Background

The West Clinical strategy was developed in conjunction with clinical leads in each area of provision, it is based on the commissioning intentions and evidence based best practice along with population needs as described in the JSNA. The Altogether Better programme has been an additional driver as has the integration agenda across health and social care and internal integration of Physical and Mental health within CWP.

2. Current context

It is acknowledged that the clinical strategy cannot be a fixed document but will need to be iterative in nature to allow for changes in local needs and the national and local political and economic environment which will impact on commissioning. Therefore it is a document that is responsive to these changes and will reflect the current changing context of the NHS locally.

As expected CWP West clinical strategy is influenced by the local health and social care environment and has a number of partnership arrangement that are co-dependent on other organisations and their key aims and objectives. Partnership working and integration is a theme that runs through the strategy.

3. Update

The link to the table below gives an update on the progress against West Clinical Strategy detailing strategy, main achievements, targets, risks and mitigation and impact assessment for CIP.

T:\01. BoD Committees\Board of Directors\Meetings\140129\Open

Document Reference (2013/14)

Date of Meeting: 29-Jan-14

Title of Report: Corporate Performance Report (December 2013)
Open Board Version

Action sought: **DISCUSSION & APPROVAL**

Author: Anne Casey, Head of Performance and Information

Presented by: Tim Welch, Director of Finance/Deputy Chief Executive

Headlines from the CPR for Board Members to Note:

1. The Continuity of Services Risk Rating for December is 4, by way of historic comparison the Financial Risk Rating which was the previous monitor risk rating system and has now been replaced by the Continuity of Services Risk Rating is still shown , and was 3 for November.
2. The experience sheet demonstrates information at locality level. The commentary accompanying the data provides more
detail in relation to Experience.
3. The membership sheet details the range of activities which took place in-month.

Strategic Objective(s) that this report covers:

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

Version	Name (s)/Groups(s)
1	Tim Welch, Director of Finance/Deputy Chief Executive Avril Devaney, Director of Nursing, Therapies & Patient Partnership
2	Board of Directors

Executive Director

Tim Welch, Director of Finance/Deputy Chief Executive

Financial Executive Summary Data Month 9 (December 2013)

Key Messages :

The Trust's risk rating	4
Overall I&E position	£0.4m surplus
EBITDA performance	£5,652,000
Cash comment	No issues to report.
Capital expenditure comment	No issues to note.
Financial risks registered (where appropriate to comment)	No issues to report.

Section 1: Patient Feedback

No. complaints received	April	May	June	July	August	September	October	November				December			
								Red	Amber	Green	Concern	Red	Amber	Green	Concern
Corporate Support Services		**1**									**1**			1	
Corporate Support Services		1									1			1	
East Clinical Services	**9**	**6**	**12**	**13**	**6**	**7**	**9**			**3**	**3**		1	**5**	**6**
Adult Mental Health Services East	9	6	10	11	4	6	9			2	2			4	6
Child & Adolescent Mental Health Services East			1		1								1		
Drug & Alcohol Service East				1							1				
Learning Disabilities Services East				1						1				1	
Older Adults Mental Health Services East			1		1	1									
West Clinical Services	**16**	**10**	**11**	**18**	**15**	**15**	**13**		**6**	**5**				**7**	**9**
Adult Mental Health Services West	2	5	5	7	5	6	6		1	2				1	1
Child & Adolescent Mental Health Services West	4	2	1	4	4	3	1		1	1					4
Drug & Alcohol Service West	1					1			1						
Learning Disabilities Services West				1					1						
Older Adults Mental Health Services West				1			1							1	1
Physical Health Services West	9	3	5	5	6	5	5		2	2				5	3
Wirral Clinical Services	**2**	**4**	**5**	**3**	**3**	**3**	**6**		**1**	**2**			2	2	
Adult Mental Health Services Wirral	2	3	3	3	1	2	3			1			1	2	
Child & Adolescent Mental Health Services Wirral		1			1		1		1	1					
Learning Disabilities Services Wirral						1									
Older Adults Mental Health Services Wirral			2		1		2						1		
Total	**27**	**21**	**28**	**34**	**24**	**25**	**28**	**21**				**33**			

No. PALS contacts received	April	May	June	July	August	September	October	November		December	
								Total	Concerns	Total	Concerns
***Non CWP**	**6**	**5**	**1**	**5**	**8**	**3**	**4**	**6**	**1**	**7**	
*Non CWP	6	5	1	5	8	3	4	6	1	7	
Corporate Support Services	**0**	**1**	**2**	**1**	**1**	**2**	**0**	**0**	**0**	1	**1**
Corporate Support Services		1	2	1	1	2	0	0	0		1
East Clinical Services	**7**	**17**	**4**	**4**	**5**	**10**	**6**	**5**	**2**	**9**	**2**
Adult Mental Health Services East	7	12	4	4	4	8	5	5	2	6	1
Child & Adolescent Mental Health Services East		5			1	2	1	0	0	1	
Older Adults Mental Health Services East										2	1
West Clinical Services	**11**	**16**	**13**	**8**	**10**	**7**	**6**	**13**	**4**	**9**	0
Adult Mental Health Services West	9	11	4	4	7	2	2	6	3	6	
Child & Adolescent Mental Health Services West		1	1			2	2	1	0		
Older Adults Mental Health Services West						2	0	0	0		
Physical Health Services West	2	4	8	4	3	1	2	6	1	3	
Wirral Clinical Services	**5**	**6**	**3**	**11**	**6**	**3**	**4**	**5**	**1**	**4**	**2**
Adult Mental Health Services Wirral	3	5	3	8	5	2	1	3	1	3	2
Child & Adolescent Mental Health Services Wirral	1			3			2	1	0		
Drug & Alcohol Service Wirral	1	1					0	0	0		
Learning Disabilities Services Wirral					1	1	0	0	0	1	
Older Adults Mental Health Services Wirral							1	1	0		
Total	**29**	**45**	**23**	**29**	**30**	**25**	**20**	**29**	**8**	**30**	**5**

No. compliments received	April	Tim Welch,	June	July	August	September	October	November	December
Corporate Support Services	1	0	2	0	0	0	1	0	0
East Clinical Services	71	34	31	5	87	46	71	9	67
West Clinical Services	38	48	132	67	59	64	81	107	101
Wirral Clinical Services	7	14	42	11	83	16	11	36	42
Total	**117**	**96**	**207**	**83**	**229**	**126**	**164**	**152**	**210**
Exception outside response times for complaints	**2**	**3**	**2**	**1**	**1**	**4**	**3**	**1**	**2**

Experience - Although there has been a 36% increase in th number of complaints / concerns received it is important to note that there has been had a drop in the severity level of those reported. We have seen less red and amber complaints and an increase in green complaints and concerns being reported.
We have seen an increase of 3% in the overall number of PALS contacts received during December; attributable to the increase in time that the PALS officer is spending within the services.

Compared to November:
Red complaints remained at 0
Amber complaints have decreased from 7 to 3
Green complaints have increased from 10 to 15
Concerns have increased from 4 to 15

Second complaints:
We have received no second complaints during December.

Formal/Informal:
From 1st April 2012, as a team we are logging complaints as Formal/Informal including cases that are 'upheld', 'partially upheld' or 'not upheld'.
In relation to December's figures, 16 of the 33 complaints were recorded as formal. Of the 33 complaints, 2 were 'withdrawn', 7 were 'not upheld', 7 were 'partially upheld', 4 were 'upheld' and the remaining 13 are 'on-going'.

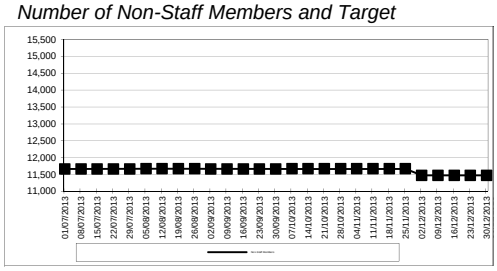
Complaints over agreed timescale:

GR-1013-002	AMH East	Un-agreed delay due to response letter being sent over timescale, without a new date being agreed.
AM-1113-001	Physical Health West	Un-agreed delay due to response letter being sent over timescale, without a new date being agreed.

Compliments
There has been an increase in the number of compliments received for December. This can be explained by the notable submission of compliments from Services in Eastern Cheshire in comparison with November's figures. West locality are still the highest service in regards to submission, however this can be explained by the physical health service encompassed in this area, which is not reflected in others.

Non-Staff Membership (Public and Service User & Carer constituencies)

Number of Non-Staff Members and Target

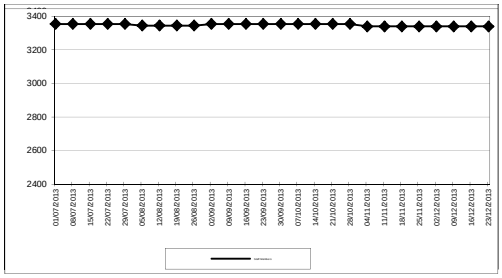


The Trust monitors the number of non-staff members (i.e.. general public and service user/carer members) and has an active recruitment programme to increase membership whilst targeting various groups including males, BME, Asian Youth, 11-15 yr age and SU/Carers.
Total current membership (including staff) is 14,809 at the end of December 2013).

Table - 1

Staff Membership

Number of Staff Members

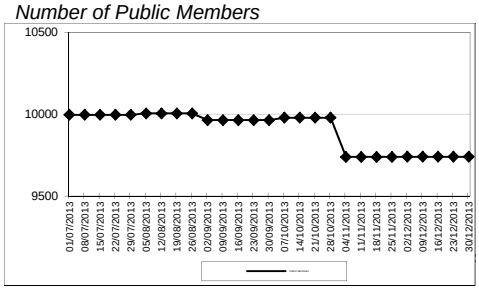


There will normally be little fluctuation in staff membership and variation will come through turnover and opting-out.
Total current staff membership is **3,339** at the end of December (2013).

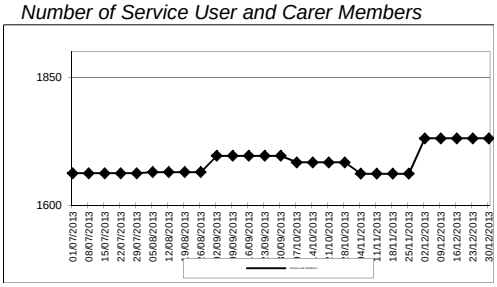
Table - 2

Breakdown of Non-Staff Membership

Number of Public Members



Number of Service User and Carer Members



Communication and Involvement Team
December 2013

Membership
At the end of December 2013, the Trust had 14,809 members

This can be broken down into the following constituencies:

Public –	9,739
Service User / Carer -	1,731
Staff -	3,339
Total	14,809

Involvement Representatives

Recruitment and Selection Interviews:
During December 2013, Involvement Representatives with lived experience of CWP services attended **7** recruitment and selection interviews across adult mental health, physical health and drug and alcohol services. Patients and carers are also routinely involved in the recruitment of staff in Child and Adolescent Mental Health Services and Learning Disability Services using methods appropriate and meaningful to them.

Meetings Events:
Involvement Representatives have also attended the following internal meetings:
1 x Recovery Action Group (RAG) West
1x Recovery Working Group West
Triangle of Care Meeting West
Benefits & Welfare Group
Challenging Stigma Meeting

Unannounced Visits:

Involvement representatives have attend **4** unannounced visits
Inpatient visits: 2 x Wirral
Community visits: 1 West & 1 East

CWP Inpatient Survey 2013
The findings from the Inpatient Survey (conducted in August) are being analysed and a report complied. The report will be shared with all CWP inpatient sites across the Trust to inform action plans.

Governors
This month the Council of Governors met on the 6th December as a full body.

The Governors continue to be ambassadors for the Trust by attending local Trust events and also representing the Trust the North West Governors forum and events held by the Foundation Trust Governors Association.

Volunteers
The Trust currently has **193** volunteers who are currently active or going through the recruitment process. A number of volunteers are placed in the recovery colleges helping service users to enrol and make them feel welcome and supported as well as co facilitating courses.
9 volunteers were recruited in December and 2 volunteers have been placed on a long term work placements and 6 short term work experience students have also been provided placements.

Volunteers also attended:
1 x Recovery Action Group (RAG) West
1 x Recovery Working Groups West

Equality and Diversity
The Trust Equality and Diversity Officer has been actively involved in the local community and in different activities relating to equality and diversity. During the last month CWP has linked up with the following organisations:
Stonewall
Gypsy & Travellers Voice Event
Wirral LGBT Network
Mermaids (Transgender).
Wirral LGBT Network
Irish Community Care Merseyside

Involvement Team Activity / Local Community Groups / Organisations
The Involvement Team continue to be actively involved in working with service users and carers including:

Direct contact in the Involvement Team office
At various meetings and task and finish groups across the Trust
Via email and the telephone
At local community events
Via the CWP Inpatient survey
Via Patient and Carers Stories

The Involvement Team continue to make links with local community organisations across the CWP footprint including the mental health forums across the localities. The wider team is also supporting the three integrated care project groups in West, Wirral and East. Attending events and meetings provides the Trust with the opportunity to develop better communication and also to promote the “challenging stigma” campaign.

Events attended: December 2014

External events and meetings attended / supported	No of Attendees	People Recruited
CWP Trust Induction	30	n/a
CWP Clinical Strategy Meeting Wirral	20	0
Heswall Day Centre Xmas Fair	80	1
Community Feedback Wirral	150	8
Bowmere Carol Concert	40	1
Healthwatch Winter Warmer Event Wirral	30	7
HLC Volunteers Event	20	11
Polish Xmas Event Wirral	40	0

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2013/14/101a)

Report to:	Board of Directors
Date of Meeting:	29 January 2014
Report:	Monitor Quarter 3 Submission
Action sought:	FOR DISCUSSION & APPROVAL
Author:	Anne Casey, Head of Performance and Information David Wood, Associate Director of Safe Services Andy Harland, Deputy Director of Finance Louise Hulme, Head of Corporate Affairs Jo Watts, Head of Compliance
Presented by:	Tim Welch, Director of Finance

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

Distribution

Version	Name(s)/Group(s)	Date Issued
1	Anne Casey to David Wood	20 January 2014
2	David Wood to Anne Casey	20 January 2014
3	Anne Casey to Louise Hulme	22 January 2014

Executive director sign-off

Executive director (name and title)	Date signed-off
Tim Welch, Director of Finance/Deputy Chief Executive	22 January 2014

1. Purpose of the report

The purpose of this report is to update and inform the Board of Directors on the Trust's position in relation to the key areas of Monitor's Risk Assessment Framework [Compliance Framework pre 1 October 2013] which require quarterly submissions. This includes:

- an updated assessment against Monitor's Quality Governance Framework, highlighting any outstanding actions.
- to request that the Board considers the content of the Quarter 3 submission and considers the declarations required in the submission to Monitor.

2. Summary

Monitor's *Risk Assessment Framework for 2013/14* (URL appended as appendix 1) sets out the approach Monitor will take to assess the compliance of NHS foundation trusts and to intervene where necessary. The Compliance Framework for 2013/14 was in place until the Risk Assessment Framework took effect on 1 October 2013. Monitor uses NHS foundation trusts' annual plans, in-year submissions and relevant third party reports to assign risk ratings for finance and governance.

Monitor uses these ratings to assess risk to compliance with the Authorisation, guide the intensity of monitoring and signal to the NHS foundation trust the degree of concern with the specific issues identified and evaluated.

Monitor requires NHS foundation trusts to report in-year, normally on a quarterly basis (dependent upon the outcome of its rating). The Board is required to submit three declarations along with its 'data' in the return.

The submission is split into the following areas; the Board is required to respond 'Confirmed' or 'Not Confirmed' to the following statements:

- For finance, that: The Board anticipates that the Trust will continue to maintain a Continuity of Services Risk Rating of at least 3 over the next 12 months. (One declaration required.)
- For governance, that: The Board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards. (Two declarations required.)
- Otherwise: The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per Compliance Framework page 16 Diagram 8 and page 58, and the Risk Assessment Framework page 21, Diagram 6) which have not already been reported. (One declaration required.)

3. Discussion

In relation to the Quality Governance Framework statement, in order to support the declaration made, the Board is asked to note the proposed quality standards rating – the evidence used to support this self assessment and also the areas for further development are detailed in the paper to Board entitled "*Monitor* Quality Governance Framework – self assessment". The Board is also asked to note that the Trust has met all Monitor performance targets and that the Trust received an inspection by the Care Quality Commission (CQC) on 14 November 2013, with outcomes 5 and 21 requiring action (minor concerns).

3.1 Finance

The Trust will be reporting an overall Continuity of Service Risk Rating of 4 and intends to sign the Governance Declaration which states 'The Board anticipates that the trust will continue to maintain a Continuity of Service Risk Rating of at least 3 over the next 12 months'. As reported last quarter Monitor no longer use the Financial Risk Rating metrics.

Monitor have also confirmed that we are no longer required to report on the supplementary Finance Risk Indicators in their previous format, and therefore there are no financial fails to report in our Q3 submission.

3.2 Governance

Monitor asks the Board to make **two** declarations in regard to governance. They also assess the targets and indicators outlined in in Appendix A of the Risk Assessment Framework (see appendix 2) and arrive at a weighted Governance Rating between red and green. The Trust's achievement of required targets and the Trust returning to compliance from the CQC's perspective has returned the Trust to a green governance risk rating.

Quality Governance Framework statement

Quality governance is the combination of structures and processes at and below board level to lead on trustwide quality performance including:

- ensuring required standards are achieved;
- investigating and taking action on sub-standard performance;
- planning and driving continuous improvement;
- identifying, sharing and ensuring delivery of best-practice; and
- Identifying and managing risks to quality of care.

The template for Q3 does not require the Trust to make a Quality Governance declaration per se unlike submissions during 2012/13. To support the Board in deciding which declaration it wishes to make a review of the Trust's position against the Quality Governance Framework has been undertaken for Q3. This information has been included to ensure the completeness of the information available for Board members. The usual sources of assurance in this regard are:

- A revised assessment against Monitor Quality Governance Standards
- The CQC Quality and Risk Profile (contained within the Corporate Performance Report - CPR)
- The Learning from Experience report
- The Quality report
- The Corporate Performance report (CPR) – both private board and public versions
- Internal and external audits
- Various specialist sources of assurance such as clinical audit, PLACE environmental reports, infection control, safeguarding etc.

All quality areas have now returned to green. This is as a consequence of receipt [Quality Committee meeting – 8 January 2014] of external audit assurance from work conducted during quarter 3 of 2013/14, regarding the robustness and effective use of the quality dashboard, which were previously rated as amber/ green pending assurance that there were no major omissions.

The overall assessment for Q3 is outlined below. The comprehensive assessment is detailed in the paper to Board entitled "*Monitor* Quality Governance Framework – self assessment".

Strategy		Q3 2013/14 self assessment (RAG) rating
1a	Does quality drive the trust's strategy?	GREEN
1b	Is the Board sufficiently aware of potential risks to quality?	GREEN
Capabilities and culture		
2a	Does the Board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?	GREEN
2b	Does the Board promote a quality-focused culture throughout the Trust?	GREEN
Processes and structure		
3a	Are there clear roles and accountabilities in relation to quality	GREEN

	governance?	
3b	Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	GREEN
3c	Does the Board actively engage patients, staff and other key stakeholders on quality?	GREEN
Measurement		
4a	Is appropriate quality information being analysed and challenged?	GREEN
4b	Is the Board assured of the robustness of the quality information?	GREEN
4c	Is quality information being used effectively?	GREEN

The RAG rating is explained below

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

<u>Performance against targets declaration</u>

The Board is required to make a declaration on the Trust's performance against Monitor's targets, stating whether the Trust can 'Confirm' or 'Not confirm' against the following statements:

- The Board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards; and
- The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per Compliance Framework page 16 Diagram 8 and page 58, and the Risk Assessment Framework page 21, Diagram 6) which have not already been reported.

The table below details the Trust's current performance and intended submission against the applicable targets set within Monitor's Risk Assessment Framework. The figures in brackets are figures for Quarter 2.

As assurance Board members should note that the definitions of the targets have been verified against the defined reporting construction within the 2013/14 Risk Assessment Framework. All figures provided have been sense checked by two team members.

Target	Threshold	Quarter 3 Performance	
Care Programme Approach (CPA) follow up within 7 days of discharge	>95%	96.80%	[98.34%]
Care Programme Approach (CPA) formal review within 12 months	>95%	95.7%	[96.52%]
Minimising delayed transfers of care	<=7.5%	2.00%	[0.99%]
Admissions had access to crisis resolution home treatment teams	>95%	98.50%	[97.75%]

Target	Threshold	Quarter 3 Performance
Meeting commitment to serve new psychosis cases by early intervention teams	>95%	132.30% [126.83%]
Data completeness: identifiers	>97%	99.30% [99.33%]
Data completeness: outcomes	>50%	86.40% [91.40%]
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	Achieved [Achieved]
Community care - referral to treatment information	50%	100% [100%]
Community care - referral information	50%	93.20% [97.28%]
Community care - activity information	50%	92.20% [93.18%]
Risk of, or actual, failure to deliver mandatory services	Yes/No	No
CQC compliance action outstanding (as at 31 December 2013)	Yes/No	Yes - CQC unannounced inspection on 14 November 2013 to Springview, Wirral. Outcome 5 "Meeting nutritional needs" and Outcome 21 "Records" rated as minor concerns. Action plan submitted to CQC in respect of action to address gaps in compliance. Actions scheduled to be completed by 31 March 2014.
CQC enforcement action within last 12 months (up to 31 Dec 2013)	Yes/No	No
CQC enforcement notice currently in effect (as at 31 December 2013)	Yes/No	No
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at 31 December 2013)	Yes/No	No
Major CQC concerns or impacts regarding the safety of healthcare provision (as at 31 December 2013)	Yes/No	No
Trust unable to declare ongoing compliance with minimum standards of CQC registration	Yes/No	No
Unable to maintain, or certify, a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements	Yes/No	No

Care Quality Commission

Springview mental health inpatient unit was inspected by the CQC on 14 November 2013, the following standards were inspected and compliance or non-compliance is indicated:

- Respecting and involving people who use services - Met this standard
- Care and welfare of people who use services - Met this standard
- Meeting nutritional needs - Action needed, minor concern
- Safeguarding people who use services from abuse - Met this standard
- Staffing - Met this standard
- Assessing and monitoring the quality of service provision - Met this standard
- Complaints - Met this standard
- Records - Action needed, minor concern

Where standards were not considered to have been met in the two areas above, they were considered to have a minor impact on people who use the service. The action needed for outcome 5, meeting nutritional needs, has been completed and this has been reported back to the CQC. The action needed for outcome 21, records, is in progress for completion by the end of March 2014, and this has been reported back to the CQC. At its quarterly meeting with the CQC, it was confirmed to the Trust that the CQC is satisfied with the action plan to address the minor concerns noted during inspection.

Results of any elections

An election was held on 23 December for two staff governor seats and two service user carer governor seats. The election was uncontested and Brian David Crouch was elected into one of the service user carer seats and will take up seat with immediate effect. The remaining staff governor seats and last service user carer seat are currently vacant.

One staff governor seat has been vacant since November 2012. An elections campaign is in development to look at improved promotion around the governor role and becoming a governor.

Iain Stewart has been appointed as a partnership governor representing Wirral Clinical Commissioning group as of December 2013. CCG appointed governors for the East Cheshire and West Cheshire CCGs will take up seat shortly.

Reports of changes of any directors or Board of Governors

As reported in the Q2 report, Dr Faouzi Alam took up post as Medical Director from the 1st October 2013.

Changes to the Council of Governors are as set out above.

Likely risk rating outcome

Based on the Trust's governance risk rating is expected to remain as green since the action required following the CQC inspection to Springview did not result in major concerns as per the thresholds contained in Monitor's guidance. The final report from the CQC inspection to Bowmere on 17 January is awaited and unlikely to be published before the end of January. From verbal feedback provided to the Trust, there are unlikely to be major concerns.

4 Recommendations to the Board of Directors

The Board is asked to **consider** and **confirm** its final intention in relation to the Quarter 3 submission to Monitor. If the Board is unable to verify its decision at the Board meeting, the Board should seek further clarification to inform their decision before the actual submission date 31 January 2014.

5 Appendices

Appendix 1: Monitor's Risk Assessment Framework 2013/14

http://www.monitor.gov.uk/raf

Appendix 2: Monitor quarterly submission template

Worksheet "Targets and Indicators"

Declaration of risks against healthcare targets and indicators for 2013-14 by Cheshire and Wirral Partnership

These targets and indicators are set out in the Risk Assessment Framework

Definitions can be found in Appendix A of the Risk Assessment Framework

NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

Key:

Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Quarter 2 Actual Performance	Quarter 2 Actual Achieved/Not Met	Quarter 3 Actual Performance	Quarter 3 Actual Achieved/Not Met	Any comments or explanations
Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	0.00%	Not relevant	0.0%	Not relevant	
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	0.00%	Not relevant	0.0%	Not relevant	
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	0.00%	Not relevant	0.0%	Not relevant	
A&E Clinical Quality- Total Time in A&E under 4 hours	95%	0.00%	Not relevant	0.0%	Not relevant	
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	0.00%	Not relevant	0.0%	Not relevant	
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	0.00%	Not relevant	0.0%	Not relevant	
Cancer 31 day wait for second or subsequent treatment - surgery	94%	0.00%	Not relevant	0.0%	Not relevant	
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	0.00%	Not relevant	0.0%	Not relevant	
Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	0.00%	Not relevant	0.0%	Not relevant	
Cancer 31 day wait from diagnosis to first treatment	96%	0.00%	Not relevant	0.0%	Not relevant	
Cancer 2 week (all cancers)	93%	0.00%	Not relevant	0.0%	Not relevant	
Cancer 2 week (breast symptoms)	93%	0.00%	Not relevant	0.0%	Not relevant	
Care Programme Approach (CPA) follow up within 7 days of discharge	95%	98.34%	Achieved	96.8%	Achieved	
Care Programme Approach (CPA) formal review within 12 months	95%	96.52%	Achieved	95.7%	Achieved	
Admissions had access to crisis resolution / home treatment teams	95%	97.75%	Achieved	98.5%	Achieved	
Meeting commitment to serve new psychosis cases by early intervention teams	95%	126.83%	Achieved	132.3%	Achieved	
Ambulance Category A 8 Minute Response Time - Red 1 Calls	75%	0.00%	Not relevant	0.0%	Not relevant	
Ambulance Category A 8 Minute Response Time - Red 2 Calls	75%	0.00%	Not relevant	0.0%	Not relevant	
Ambulance Category A 19 Minute Transportation Time	95%	0.00%	Not relevant	0.0%	Not relevant	
Clostridium Difficile -meeting the C.Diff objective	0	0	Not relevant	0	Not relevant	
MRSA - meeting the MRSA objective	0	0	Not relevant	N/A	Not relevant	No longer applicable under RAF
Minimising MH delayed transfers of care	<=7.5%	0.99%	Achieved	2.0%	Achieved	
Data completeness, MH: identifiers	97%	99.33%	Achieved	99.3%	Achieved	
Data completeness, MH: outcomes	50%	91.40%	Achieved	86.4%	Achieved	
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	0.00%	Achieved	N/A	Achieved	
Community care - referral to treatment information completeness	50%	100.00%	Achieved	100.0%	Achieved	
Community care - referral information completeness	50%	97.28%	Achieved	93.2%	Achieved	
Community care - activity information completeness	50%	93.18%	Achieved	92.2%	Achieved	

Risk of, or actual, failure to deliver Commissioner Requested Services	N/A	No	No		
CQC compliance action outstanding (as at 31 Dec 2013)	N/A	No	Yes	*CQC inspection on 14th November 2013 to Springview, Wirral. Outcome 5 "Meeting*	
CQC enforcement action within last 12 months (as at 31 Dec 2013)	N/A	No	No		
CQC enforcement action (including notices) currently in effect (as at 31 Dec 2013)	N/A	No	No		
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at 31 Dec 2013)	N/A	No	No		
Major CQC concerns or impacts regarding the safety of healthcare provision (as at 31 Dec 2013)	N/A	No	No		
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A	No	No		
Results left to complete		0	0		
Total Score		0	0		
Overide Rating (if any)					

Compliance Framework Indicative Governance Risk Rating

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document Reference (2013/14/101b)

Report to:	**Board of Directors**
Date of Meeting:	**29 January 2014**
Title of Report:	**Monitor Quality Governance Framework – self assessment**
Action sought:	**For APPROVAL and NOTING**
Author:	**David Wood, Associate Director of Safe Services** **Louise Hulme, Head of Corporate Affairs/ Company Secretary**
Presenting Executive:	**Tim Welch, Director of Finance**

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
SO4 - Maintain and develop robust partnerships with existing and potential new stakeholders
SO5 – Improve quality of information to improve service delivery, evaluation and planning
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SO7 – Be recognised as an open, progressive organisation that is about care, well-being and partnership

Distribution

Version	Name(s)/Group(s)	Date Issued
1	L Hulme to D Wood	19.01.2014
2	D Wood to L Hulme for Board of Directors	20.01.2014

Executive director sign-off

Executive director (name and title)	Date signed-off
Tim Welch, Director of Finance	20.01.2014

1. Purpose of the report

In April 2013, *Monitor* published 'Quality governance: How does a Board know that its organisation is working effectively to improve patient care?' The guidance is designed to support *Monitor*'s Quality Governance Framework. This forms part of the *Monitor* Risk Assessment Framework which replaced the Compliance Framework from Q3 2013/14. The guidance aims to help Boards understand what is required of a trust's internal assurance mechanism for assuring the organisation wide processes for governing quality, with a view to improve decision making and to support Boards in discharging their responsibilities to improve care for patients. This report details the quarter 3 *Monitor* quality governance self assessment and recommends a way forward for conducting an annual self assessment.

2. Annual *Monitor* quality governance self assessment – March 2014

Principally, the guidance sets out a series of questions for Boards to consider and to assess the assurance on quality governance systems and processes. These are:

1. *Engagement on quality* – does the Board provide a clear steer on the strategic and operational quality outcomes it expects the organisation to achieve?
2. *Gaining insight and foresight into quality* – how are you assured that the Board is receiving the right type and level of quality information?
3. *Accountability for quality* e.g. what are the key sources of assurance upon which you rely?
4. *Managing risks to quality* e.g. are your Board Assurance Framework and local risk registers effective in capturing the risks to quality with your Trust?

As part of the quarterly submission process to Monitor, the Board receives an updated quality governance self assessment, which enables a quarterly view on the Quality Governance Framework. However it is recommended that the Board undertakes a full annual assessment based on the Quality Governance Framework and guidance to enable further assurance to Board members and to further demonstrate the Trust's commitment to quality. The detail of the full assessment is available at *Appendix 2*.

It is proposed that the evidence for the annual overall assessment is collated and that Board members receive this at the March 2014 Board meeting to enable a discussion on assessing its position and to enable future benchmarking of progress on an annual basis.

3. Quarter 3 *Monitor* quality governance self assessment – October to December 2013

See *Appendix 1*. All quality areas have now returned to green. This is as a consequence of receipt [Quality Committee meeting – 8 January 2014] of external audit assurance from work conducted during quarter 3 of 2013/14, regarding the robustness and effective use of the quality dashboard, which were previously rated as amber/ green pending assurance that there were no major omissions.

4. Recommendations to the Board of Directors

The Board of Directors is asked to:

- **Discuss** and **approve** the quarter 3 Monitor quality governance self assessment, as per *Appendix 1.*
- **Note** the guidance of the Monitor Quality Governance Framework and guidance and **agree** that members of the Board undertake a full annual quality governance self assessment, as per *Appendix 2*.

5. References

http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-foundation-trusts/mandatory-

Appendix 1: *Monitor* Quality Governance Framework – self assessment quarter 3 2013/14

Following a review of *Monitor*'s Quality Governance Framework, the following self assessment has been completed. Below is a summary of each area, with a self assessment RAG rating. A comprehensive assessment is outlined in *Appendix 1.1*, detailing information used to formulate this assessment and areas that may required further development, with suggested actions.

Strategy		**Q3 2013/14 self assessment (RAG) rating**
1a	Does quality drive the trust's strategy?	GREEN
1b	Is the Board sufficiently aware of potential risks to quality?	GREEN
Capabilities and culture		
2a	Does the Board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?	GREEN
2b	Does the Board promote a quality-focused culture throughout the Trust?	GREEN
Processes and structure		
3a	Are there clear roles and accountabilities in relation to quality governance?	GREEN
3b	Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	GREEN
3c	Does the Board actively engage patients, staff and other key stakeholders on quality?	GREEN
Measurement		
4a	Is appropriate quality information being analysed and challenged?	GREEN
4b	Is the Board assured of the robustness of the quality information?	GREEN
4c	Is quality information being used effectively?	GREEN

The RAG rating is explained below:

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

Appendix 1.1 – Self assessment evidence as at Q3 2013/14

Quality area	Trust evidence	Self assessment	Actions from Q2 with update	Further actions for completion by end Q4 2013/14
1. Strategy				
1a: Does quality drive the Trust's strategy?	• Quality is embedded in the Trust's overall strategy. ▪ Overall vision '*Leading in partnership to improve health and well-being by providing high quality care'.* ▪ The Trust's vision and strategy comprises a number of Trust-wide quality goals covering safety, clinical effectiveness/ outcomes and patient experience which drive year on year improvement. ▪ Quality goals reflect local as well as national priorities, reflecting what is relevant to patient and staff – annual planning events and working with commissioners and other local scrutineers on development of quality priorities help identify priorities. ▪ Quality goals are specific, measurable and time-bound – outlined in quality section of annual plan. ▪ Overall Trust-wide quality goals link directly to goals in localities/ services (which will be tailored to the specific service) – as part of	**GREEN**	Update presentation of quality dashboard assurances from localities to Quality Committee, incorporating service development and improvement work as a consequence of trend analysis of quality information. **Associate Director of Safe Services in partnership with Service Directors** **COMPLETED**	Board of Directors is being asked to endorse the strategic direction of the Trust's zero harm aspirations and plans for the delivery of quality by tackling unwarranted risks and variation at January 2014 meeting. An initial three year implementation plan to be developed for approval at March 2014 Quality Committee. **Associate Director of Safe Services**

Quality area	Trust evidence	Self assessment	Actions from Q2 with update	Further actions for completion by end Q4 2013/14
	annual plan and clinical strategies • Quality goals are communicated as part of quality accounts, regular quality reporting, via Clinical Directors at Quality Committee, as part of clinical performance reviews. • Corporate performance report has quality section. • Quality dashboard routinely reported to Quality Committee.			
1b: Is the Board sufficiently aware of potential risks to quality	• The Board regularly assesses and understands current and future risks to quality and is taking steps to address them. Risks are aligned to annual plan and the assurance framework has been mapped to the strategic objectives for the Trust. • The Board regularly reviews quality risks in an up-to-date risk register and assurance framework. • The strategic risk register is supported and fed by quality issues captured in locality/ service risk registers - there is a process of escalation in place for 'red' rated risks on the clinical service risk registers to be considered for inclusion on the strategic risk register. • The risk register covers potential future external risks to	**GREEN**	Develop locality risk register process linked to new operational structures and review escalation processes via governance structures **Associate Director of Safe Services in partnership with Executive leads, Service Directors and Clinical leads** **IN PROGRESS** Consultation process in progress to update the Trust's integrated governance strategy – carry forward to end Q4 2013/14	No further actions.

Quality area	Trust evidence	Self assessment	Actions from Q2 with update	Further actions for completion by end Q4 2013/14
	quality (e.g. new techniques/ technologies, competitive landscape, demographics, policy change, funding, regulatory landscape) as well as internal risks- risks are aligned to the annual planning process, which looks at external risks. • There is clear evidence of action to mitigate risks to quality - actions on the risk register are monitored by the Safe Services Department. • Proposed initiatives are rated according to their potential impact on quality (e.g. clinical staff cuts would likely receive a high risk assessment) - there is an impact assessment in place for new service developments, which incorporates risk. • There is an appropriate mechanism in place for capturing front-line staff concerns. • Quality measures monitored before and after implementation through quality impact assessments.			
2. Capabilities and culture				
2a: Does the Board have the necessary leadership and skills knowledge to ensure delivery of the	• The Board is assured that quality governance is subject to rigorous challenge, including full NED engagement and review – NEDs chair Quality	**GREEN**	Agree senior manager risk management training, focusing on risk appetite, risk tolerance and patient safety culture, linked to strategic	No further actions.

Quality area	Trust evidence	Self assessment	Actions from Q2 with update	Further actions for completion by end Q4 2013/14
quality agenda?	Committee and Audit Committee. • Board development programme in place. • Board seminars in place which allow time to debate issues on quality and assurance. • Board members have attended training sessions covering the core elements of quality governance and continuous improvement.		avoidable harm agenda. **Associate Director of Safe Services in partnership with Chief Executive, Director of Nursing, Therapies and Patient Partnership, and Medical Director for Quality** **ON TRACK** Board seminar scheduled for 26 February 2014, training has also been extended to include human factors principles as a prequel to the strategic "zero harm" work to be approved by January 2014 Board.	
2b: Does the Board promote a quality-focused culture throughout the Trust?	• Quality Committee chaired by NED, attendance by Executive team and other NEDs. • The Board takes a proactive approach to improving quality (e.g. it actively seeks to apply lessons learnt in other Trusts and external organisations). • The Board regularly commits resources (time and money) to delivering quality initiatives - e.g. QIPP agenda discussions at Board. • The Board is actively engaged in the delivery of quality improvement initiatives (e.g. some initiatives led personally	**GREEN**	Ongoing actions from Q2 2013/14 self assessment **None**	Board of Directors is being asked to endorse the strategic goal of having an aspiration of zero harm that drives the Trust culture at January 2014 meeting. An initial three year implementation plan to be developed for approval at March 2014 Quality Committee. **Associate Director of Safe Services**

Quality area	Trust evidence	Self assessment	Actions from Q2 with update	Further actions for completion by end Q4 2013/14
	by Board members). CQUIN monies reinvested into QIPP. • NED involvement in unannounced visit schedule. • Staff are encouraged to participate in quality/ continuous improvement training and development - the Trust has reviewed its mandatory training, focusing on what training is required for which staff groups, underpinned by patient safety following Berwick review. • Staff feel comfortable reporting harm and errors (these are seen as the basis for learning, rather than punishment) - positive feedback from staff survey, which is reviewed at Operational Board level and National Reporting and Learning System data stating that CWP reports incidents in line with other Trusts in its benchmarked cluster. • Staff are entrusted with delivering the quality improvement initiatives they have identified (and held to account for delivery - link to annual plan). • Internal communications (e.g. monthly newsletter, intranet, notice boards) regularly feature articles on quality - quarterly			

Quality area	Trust evidence	Self assessment	Actions from Q2 with update	Further actions for completion by end Q4 2013/14
	quality report, three times per year learning from experience report.			
3. Structures and processes				
3a: Are there clear roles and accountabilities in relation to quality governance?	• Each and every Board member understands their ultimate accountability for quality - discussed at Board seminars and as part of the self assessment process and signed off by Board as part of the Annual Governance Statement. • The governance structure is in place within the Trust with committees/ sub committees with clear terms of reference, outlining roles and responsibilities in relation to quality. • Quality is a core part of main Board meetings, both as a standard agenda item and as an integrated element of all major discussions and decisions. • Quality performance is discussed in more detail each month by a quality-focused Board sub-committee. Quality Committee meets every two months but any issues requiring discussion in relation to quality are brought to Operational Board which meets monthly.	**GREEN**	Position statement and forward plan for corporate governance meetings structure to be developed, lining up: - key Trust strategies [including clinical strategies] - Trust operating/ escalation/ performance improvement framework - Corporate governance manual **Safe Services Department senior managers in partnership with Executive leads, Service Directors and Clinical leads** **IN PROGRESS** Consultation process in progress to update the Trust's integrated governance strategy – carry forward to end Q4 2013/14	

Quality area	Trust evidence	Self assessment	Actions from Q2 with update	Further actions for completion by end Q4 2013/14
3b: Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	• Boards are clear about the processes for escalating quality performance issues to the Board - Corporate Performance Report in place. • Process for escalation of risks to the Board are outlined in Integrated Governance Strategy. • Process for escalation of incidents to Board is outlined in Incident reporting and management policy - level 3 incidents reported to Board and actions followed up by Quality Committee. • Robust action plans are put in place to address quality performance issues (e.g. including issues arising from serious untoward incidents and complaints) - monitored by Compliance, Assurance and Learning Sub Committee. Actions from SUIs are monitored by Quality Committee. • Lessons from quality performance issues are well-documented and shared across the Trust on a regular, timely basis - communicated via lessons learned publication and learning from experience report. • There is a proactive clinical	**GREEN**	Position statement and forward plan for developing Trust operating/ escalation/ performance improvement framework. **Safe Services Department senior managers in partnership with Executive leads, Service Directors and Clinical leads** **IN PROGRESS** Consultation process in progress to update the Trust's integrated governance strategy – carry forward to end Q4 2013/14	Performance management systems to be further reviewed and plans identified to strengthen. **Associate Director of Performance and Service Redesign**

Quality area	Trust evidence	Self assessment	Actions from Q2 with update	Further actions for completion by end Q4 2013/14
	audit programme in place aligned to national audit priorities, contractual requirements and quality priorities identified by the Trust. • There is also scope for undertaken reactive audits/ re-audits linked to risks. • There is an internal audit programme in place, which links to quality. • An error reporting process is defined and communicated to staff. • There is a performance management system in place within the Trust as part of the Trust's Operating Framework.			
3c: Does the Board actively engage patients, staff and other key stakeholders on quality?	• Quality outcomes are made public (and accessible) regularly, and include objective coverage of both good and poor performance - quality report and learning from experience report presented to public Board. Inpatient safety metrics results presented on all inpatient wards for staff/ patients/ visitors to see. • The Board actively engages patients on quality, e.g. - Patient feedback is actively solicited, made easy to give and based on validated tools, e.g. surveys, patient stories,	**GREEN**	Development of implementation plan for real time patient experience agenda. **Director of Nursing, Therapies and Patient Partnership, Clinical Governance Manager, Involvement Manager in partnership with clinical teams** **COMPLETED** Implementation timeframes agreed at December 2013 Operational Board. Pilot in	Introduction of a patient experience sub committee, aligned to Learning from Experience reporting timeframes, to report to Quality Committee to strengthen receipt of assurances against patient experience domain of quality **Director of Nursing, Therapies and Patient Partnership, Head of Clinical Governance, Head of Communications and Involvement in partnership with clinical teams**

Quality area	Trust evidence	Self assessment	Actions from Q2 with update	Further actions for completion by end Q4 2013/14
	video diaries, PALS, real time patient experience (current pilot). - Patient views are proactively sought during the design of new pathways and processes - via surveys/ focus groups, attendance at annual planning events. - All patient feedback is reviewed on an ongoing basis, with summary reports reviewed regularly by the Board - learning from experience report looks at patient feedback via PALS/ complaints. - The Board regularly reviews and interrogates complaints and serious untoward incident data - via the learning from experience report quarterly and standing agenda items reviewing SUIs/ complaints. - The Board uses a range of approaches to 'bring patients into the Board room', e.g. patient stories. • Staff are encouraged to provide feedback on an ongoing basis, as well as through specific mechanisms – staff blog,		progress, full implementation March 2014.	

Quality area	Trust evidence	Self assessment	Actions from Q2 with update	Further actions for completion by end Q4 2013/14
	annual staff survey, training feedback. • The Board actively engages all other key stakeholders on quality, e.g. - Quality performance is clearly communicated to commissioners to enable them to make educated decisions via contract meetings, reports - Feedback from PALS and LINks is considered - LINks commentary on quality accounts, feedback from annual planning events, consultations on new service developments etc., PALS talkback. - For care pathways involving GP and community care, discussions are held with all providers to identify potential issues and ensure overall quality along the pathway - Trust working with clinical commissioning groups and via clinical networks. - The Board is clear about Governors' involvement in quality governance – with meetings structure in place. • Public consultation sought on			

Quality area	Trust evidence	Self assessment	Actions from Q2 with update	Further actions for completion by end Q4 2013/14
	service changes identified as part of annual plan priorities.			
4. Measurement				
4a: Is appropriate quality information being analysed and challenged?	• The Board reviews a monthly 'dashboard' of metrics outlined within the Corporate Performance report. • The Quality Committee reviews quality and safety metrics displayed in a quality dashboard. • Quality information can be analysed and challenged at the individual team level – as part of CAREnotes reporting and data quality/ control. • External assessment/ data delves take place as part of Quality Account auditing and external and internal audit programmes.	**GREEN**	Position statement and forward plan for developing Trust operating/ escalation/ performance improvement framework. **Safe Services Department senior managers in partnership with Executive leads, Service Directors and Clinical leads** **IN PROGRESS** Consultation process in progress to update the Trust's integrated governance strategy – carry forward to end Q4 2013/14	
4b: Is the Board assured of the robustness of the quality information?	• There are clearly documented, robust controls to assure ongoing information accuracy, validity and comprehensiveness: - roles and responsibilities in relation to data quality are outlined within the Trust's Data Quality Policy - Assurance on data quality given to Board via Information Governance Toolkit scores and independent review of	**GREEN**	A proposal regarding the management of business intelligence and information analysis functions to be discussed and implemented. **Associate Director of Safe Services/ Associate Director of Effective Services/ Associate Director of Operations: Estates & Facilities with Executive Team.** **COMPLETED**	No further actions.

Quality area	Trust evidence	Self assessment	Actions from Q2 with update	Further actions for completion by end Q4 2013/14
	Quality Account - Clinical audit programme driven by national audits, with processes for initiating additional audits as a result of identification of local risks (e.g. incidents) - Electronic systems are used where possible, generating reliable reports with minimal ongoing effort - Information can be traced to source and is signed-off by owners - gate keeping process in place within the Trust • There is clear evidence of action to resolve audit concerns: - Action plans are completed from audit (and subject to regular follow-up reviews) - Trustwide action plans monitored by Compliance, Assurance and Learning Sub Committee - Re-audits are undertaken to assess performance improvement		Appointment of Associate Director of Performance and Service Redesign – Report on output of external audit of the quality dashboard to assure the Trust regarding the methodology and assurance processes and data quality relating to quality dashboard development. Implementation of any resulting recommendations. **Associate Director of Safe Services/ Head of Performance and Information/ Audit Committee** **COMPLETED** Quality dashboard external audit reported to January 2014 Quality Committee provided assurance regarding data quality and key performance indicator specifications	
4c: Is quality information being used effectively?	• Information in quality reports is displayed clearly and consistently - ongoing development of Corporate	**GREEN**	A proposal regarding the management of business intelligence and information analysis functions to be	Board of Directors is being asked to endorse the strategic direction of the Trust's zero harm aspirations and plans for the

Quality area	Trust evidence	Self assessment	Actions from Q2 with update	Further actions for completion by end Q4 2013/14
	Performance reporting and quality dashboards. • Information is compared with target levels of performance (in conjunction with a R/A/G rating), historic own performance and external benchmarks (where available and helpful). • Information being reviewed is the most recent available, and recent enough to be relevant. • 'On demand' data is available/ sought for the highest priority metrics. • The Trust is able to demonstrate how reviewing information has resulted in actions which have successfully improved quality performance, e.g. inpatient safety metrics and care bundles continue to demonstrate sustained improvements.		discussed and implemented. **Associate Director of Safe Services/ Associate Director of Effective Services/ Associate Director of Operations: Estates & Facilities with Executive Team.** **COMPLETED** Appointment of Associate Director of Performance and Service Redesign	delivery of quality by tackling unwarranted risks and variation at January 2014 meeting. This includes support for meta-analysis. An initial three year implementation plan to be developed for approval at March 2014 Quality Committee. **Associate Director of Safe Services**

Appendix 2: *Monitor* quality governance self assessment guidance

Question:	Evidence Yes / No	Link to *Quality Governance Framework* domains
Engagement on quality: • ***Does the board provide a clear steer on the strategic and operational quality outcomes it expects the organisation to achieve?*** • ***Do you know that a quality culture exists across the different layers of clinical and non-clinical leadership? What is your evidence for this?*** • ***Does the board understand the effectiveness of the methods used by the trust for communicating to and involving staff, patients and stakeholders in the quality agenda?***		
1. The board has put in place a leadership development programme that: • reviews the skills and capabilities of the board in relation to quality governance; • demonstrates learning and impact on behaviours; • considers the skills of non-executive directors in relation to quality governance; • encourages and trains clinical leadership and non-clinical management to participating in setting the quality agenda; and • identifies and develops future leaders.		1A: Does quality drive the trust's strategy? 2A: Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? 2B: Does the board promote a quality-focused culture throughout the trust? 3C: Does the board actively engage patients, staff and other key stakeholders on quality?
2. The board encourages the development of an open and quality culture through: • a participative approach to staff and clinical engagement; • the investment of resource to promotion of the change; and • the use of quality walks, surveys and peer reviews.		2B: Does the board promote a quality-focused culture throughout the trust?
3. The board has developed its quality improvement strategy through: • the creation of systematic processes for engaging staff in development, communication and devising indicators; • involvement of commissioners, partners, patients; • analysis of the organisation's performance on key quality indicators; • directly linking the Quality Accounts with the quality improvement strategy.		1A: Does quality drive the trust's strategy? 2B: Does the board promote a quality-focused culture throughout the trust? 3C: Does the board actively engage patients, staff and other key stakeholders on quality?

4. The board applies good principles of effective staff engagement such as: • considering harder to reach staff; • actively considering how staff will be engaged in strategic and service development; • communicating data and information that the board receives to the relevant staff; • ensuring that staff know how to raise issues; and • seeking out and reviewing the results of staff feedback using regular 'local' staff surveys.		3C: Does the board actively engage patients, staff and other key stakeholders on quality?
5. The board uses the following principles to ensure effective engagement with the public: • uses public consultation to shape strategy and process design; • uses a wide variety of methods to engage a cross-section of the public; • promotes a culture of communication; and • feeds back the outcomes from engagement and consultation.		3C: Does the board actively engage patients, staff and other key stakeholders on quality?
6. The board uses patients to design improvements, and monitor whether they have the desired impact through an approach that includes: • capturing a broad range of patients and carers; • embedding patient engagement and involvement into the quality improvement programme; • including patients in service and process redesign; • ensuring engagement processes are user-friendly; • encouraging staff to take ownership by leading responses to patient engagement; and • ensuring patient feedback demonstrates impact.		3C: Does the board actively engage patients, staff and other key stakeholders on quality?
7. The board engages with commissioners and partners through: • proactive and early consultation; • ensuring that commissioners' views are considered in setting and monitoring quality goals; and • collaborating with local authorities and GPs on quality improvement strategies.		3C: Does the board actively engage patients, staff and other key stakeholders on quality?

Gaining insight and foresight into quality:

- ***How are you assured that the board is receiving the right type and level of quality information?***
- ***Have you compared the information you receive with other trusts of similar type and complexity?***
- ***Are the 'hard' facts and data consistent with what you are hearing and observing around your trust?***
- ***How are you assured that the data you use to inform decisions is robust and valid?***
- ***Could you name the best and worst performing services from a quality perspective within your trust and how these services compare with other trusts?***

8. The board uses a strategic integrated performance dashboard which includes: • quality, performance, activity and finance; • aligning performance scorecards to strategic goals; • expanding to ward- and service-level dashboards; • explanation for variances; • analyses and comments; • performance projection and trends; • risk analysis on achieving trajectory; and • overview summary of the impact on quality by division or service.		4A Is appropriate quality information being analysed and challenged? 4C Is quality information used effectively?
9. The board has a strategic approach to data quality which drives quality improvement with: • SMART objectives; • data quality metrics; and • data quality assurance and audit programme.		4B: Is the board assured of the robustness of the quality information?
10. The board benchmarks performance: • with comparable organisations where possible; • based on risk assessing greatest need; • using internal benchmarking and 'peer reviews'; and • analysing historical data.		4A Is appropriate quality information being analysed and challenged? 4C Is quality information used effectively?

Accountability for quality:

- ***What are the key sources of assurance upon which you rely?***
- ***Are you able to distinguish between assurance and reassurance?***
- ***Is there a clear trail of assurance underpinning the board statements and declarations?***
- ***Do you understand how quality governance assurance processes operate across the organisation's committee structure?***
- ***Do you understand the role that your audit functions have in supporting board assurance on quality governance?***

11. The board supports its Corporate Governance Statement on quality and quality governance through: • a clearly understood structure of assurance and baseline assessments supporting statements and declarations by the board; • utilising the internal audit function to provide an overview of the quality governance assurances; • mapping quality improvement strategies to the *Quality Governance Framework* to ensure visibility at the board and within the organisation as to how the trust's quality activities are aligned with the regulatory regime and the coverage provided by the audit and risk escalation processes.		1B: Is the board sufficiently aware of potential risks to quality? 2A: Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? 3A: Are there clear roles and accountabilities in relation to quality governance?
12. The board has effective supporting structures to enable the board to carry out its role efficiently by: • ensuring that the committee structures can demonstrate that the quality governance agenda is being adequately covered; • reviewing the tiers of supporting committees to ensure that they do not impede board assurance; • ensuring that clinical quality remains a core feature of mainstream reporting at board level; • reviewing the effectiveness of the role of the audit committee and other board committees to ensure that the systems and process are functioning effectively in relation to assurance; and • clearly setting out the roles and terms of reference of each committee and sub-committee in relation to assurance on quality governance.		1B: Is the board sufficiently aware of potential risks to quality? 2A: Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? 3A: Are there clear roles and accountabilities in relation to quality governance? 3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?
13. The board effectively uses audit functions to support quality governance assurance by: • developing a narrative assurance and escalation framework to provide a clear outline of audit and assurance of processes and controls; • using audit to conduct baseline assessments or specific elements of the *Quality Governance Framework* within the organisation; • using audit to review and provide independent assurance against the trust's self-assessment; and • ensuring that the internal audit and clinical audit work programmes are collaborative and cohesive and aligned to the quality governance agenda.		1B: Is the board sufficiently aware of potential risks to quality? 2A: Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? 3A: Are there clear roles and accountabilities in relation to quality governance? 3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?

Managing risks to quality: • ***Are your BAF and local risk registers effective in capturing the risks to quality with your trust?*** • ***How assured are you that patient safety incidents are being reported and dealt with correctly and escalated to the board appropriately?*** • ***How are you assured that efficiency programmes are not adversely impacting on the quality of patient care?***		
14. The board has taken steps to ensure that it can identify and address the risks to its quality objectives: • the BAF should be reviewed and if necessary revised quarterly; • the risk management frameworks explicitly outline the processes for local risk management and registers; • board members are aware of the risk escalation process at and beneath clinical unit level; • management and staff with responsibility for risk are supported by training; • local risk registers are supported by local audit and a centrally coordinated risk register library; and • there is an audit programme of regular review of the completion of local risk registers.		1B: Is the board sufficiently aware of potential risks to quality? 3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?
15. The board uses good practice to improve incident reporting by: • issuing clear guidance on risk categorisation of patient safety incidents and reporting; • staff trained and inducted on the importance of reporting incidents and the processes involved; • a duty to comply with the policy on incident reporting is set out in staff terms of employment; • using a tailored incident recording and reporting system to minimise manual reconciliation or manipulation; and • reporting increases in incident reporting to the board.		1B: Is the board sufficiently aware of potential risks to quality? 3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?
16. The board ensures that it understands the potential risks to quality as a consequence of CIPs by: • ensuring that development of CIP schemes begins at clinical unit management level and ownership is cascaded down to individual level; • informing staff that they should raise		1B: Is the board sufficiently aware of potential risks to quality?

concerns where they feel quality is being compromised as the result of cost improvements or efficiencies; • implementing a QIA to support the identification and mitigation of risks and ensuring this is linked to local risk registers; • carrying out post-implementation review of CIPs carrying a higher risk of impacting on quality; and • reporting CIPs at board with clear metrics showing the impact on quality of the efficiency programme.		