Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting of the Foundation Trust Board of Directors

Wednesday 26th March 2014 at 1.00pm

Romero Centre, Macclesfield

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
13/14/106	Apologies for absence	Receive apologies	Verbal	Chair	1 min (1300)
13/14/107	Declarations of interest	Identify and avoid conflicts of interest	Verbal	Chair	1 min (1301)
13/14/108	Minutes of the previous meeting held 29th January 2014	Confirm as an accurate record the minutes of the previous meetings	Written minutes	Chair	3 mins (1302)
13/14/109	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)
13/14/110	Board Meeting Business Cycle 2013/14 and draft Business Cycle 2014/15	Confirm that agenda items provide assurance that the Board is undertaking its duties	Written Report	Chair	2 mins (1310)
13/14/111	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	5 mins (1312)
13/14/112	Chief Executive's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	5 mins (1317)

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Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
Assurance: Quality/ Effectiveness/ Experience/ Safety					
13/14113	Q3 Infection Prevention and Control report	To receive the Q3 report	Written Report	Deputy Director of Nursing/ Infection, Prevention and Control	10mins (1322)
13/14/114	Review of health services for Looked after Children and safeguarding in Cheshire West and Chester	Review CQC findings	Written Report	Director of Nursing, Therapies and Patient Partnership	10 mins (1332)
13/14/115	Community Services Improvement Programme- progress with the continuous evaluation programme	To feedback from local evaluations	Written Report	Director of Operations	15 mins (1342)
13/14/116	Board Assurance Framework and Risk Register	To note current Board Assurance Framework and Risk Register	Written Report	Medical Director	10mins (1357)
13/14/117	Progress Report on the implementation of the Ward Nursing Staffing Review	To update on progress and current position	Written Report	Director of Nursing, Therapies and Patient Partnership	10mins (1407)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
Strategy and Planning					
13/14/118	Trust Operational Plan 2014/16 *(draft plan to follow 21/3/14)*	To approve the two year operational plan prior to submission to Monitor	Written Report	Director of Finance	30 mins (1417)
Performance					
13/14/119	Corporate Performance Report - February 2014	Review Trust performance	Written Report	Director of Finance	10 mins (1447)
Assurance: Governance					
13/14/120	Chair and Chief Executive division of responsibilities	To approve the division of responsibilities as set out in the Code of Governance	Written Report	Head of Corporate Affairs/ CoSec	5 mins (1457)
13/14/121	Information Governance Annual Report	Receive Information Governance Annual Report	Written Report	Director of Finance	10 mins (1502)
13/14/122	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	5 mins (1512)
13/14/123	Any other business	Consider any urgent items of other business	Verbal or written	Chair/ All	5 mins (1517)
13/14/124	Review of meeting	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and	Verbal	Chair/All	5 mins (1522)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
		management of time)			
13/14/125	Date, time and place of next meeting: Wednesday 28th May, 1.00pm at Redesmere, Trust Board HQ	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 29th January 2014
Redesmere, Countess of Chester Health Park, Chester,
commencing at 1.00pm

PRESENT	Mike Maier, Deputy Chair and Non-Executive Director Sheena Cumiskey, Chief Executive Avril Devaney, Director of Nursing, Therapies & Patient Partnership Lucy Crumplin, Non-Executive Director Ron Howarth, 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
IN ATTENDANCE	Andy Harland, Deputy Director of Finance Louise Hulme, Head of Corporate Affairs (inc. CoSec) Trish McCormack, General Manager, West (for 13/14/99) Val McGee - Service Director, Wirral (for 13/14/99) Jacqui Nevin, Clinical Director East (for 13/14/99) Mandy Skelding-Jones - Associate Director: Performance and Service Redesign Richard Harland, Service User/ Carer Governor Phil Jarrold, Service User/Carer Governor Stanley Mayne, Public Governor Rob Robertson, Public Governor Peter Wilkinson, Deputy Lead Governor, Public Governor
APOLOGIES	David Eva, Chair Dr Faouzi Alam, Medical Director Effectiveness & Medical Workforce Fiona Clark, Non-Executive Director Tim Welch, Director of Finance & Deputy Chief Executive

	MINUTES	ACTION
13/14/86	**WELCOMES AND APOLOGIES FOR ABSENCE** The Deputy Chair welcomed everyone to the meeting. Apologies were noted from David Eva, Chair, Dr Faouzi Alam, Medical Director, Fiona Clark, Non-Executive Director and Tim Welch, Director of Finance. It was noted that David Eva and Fiona Clark were representing the Trust at the funeral of the Lead Governor's husband who had sadly passed away recently. The meeting was quorate.	
13/14/87	**DECLARATIONS OF INTEREST** There were no interests declared.	
13/14/88	**BOARD MINUTES- MEETING OF 27TH NOVEMBER 2013**	

	The minutes of the meeting held on 27th November 2013 required the following amendments: p.8: To add working closely with Wirral University Teaching Hospitals, East Cheshire Hospital Trust and Public Health as part of the policy implementation. p.9: To refer to the policy to cover the whole organisation, but focus in on in-patients at present. Subject to the amendments, the minutes of the meeting held on 27th November 2013 were **approved** as a correct record.	
13/14/89	**MATTERS ARISING AND ACTION POINTS** Item 13/14/52: These issues have been covered by the 'zero harm' proposals which are later on the agenda. Action closed.	
13/14/90	**BOARD MEETING BUSINESS CYCLE 2013-14** The business cycle was noted. It was acknowledged that working is on-going to fully refresh the business cycles for 2014-15. These will be provided to the March 2014 Board meeting for approval.	
13/14/91	**CHAIR'S ANNOUNCEMENTS** The Chair informed the meeting that; **CWP Big Book of Best Practice** CWP has published its first Big Book of Best Practice. The guide features case studies from around the Trust which aim to demonstrate examples of leading clinical practice and facilitate the sharing of innovative ideas. The book is based on the annual CWP good practice showcase which was held late last year and was visited by NHS England's leading director for mental health, Dr Geraldine Strathdee. Downloadable copies are available from the CWP website. **Nicotine Management Policy** The new Nicotine Management Policy will be introduced from 3 February 2014. From this date smoking within CWP premises or grounds will not be permitted**.** CWP is committed to supporting patients, carers and staff through the changes associated with the new policy. Further details are available on the CWP website. **Engage** The 20th edition of Engage will be distributed in early February. In this edition, we are raising awareness of the courses on offer in the CWP Recovery Colleges and the latest new from across the Trust including CWP's success at the national Dementia Care Awards.	

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13/14/92	**CHIEF EXECUTIVE'S ANNOUNCEMENTS** Sheena Cumiskey informed the Board that the closed Board meeting discussed a recent review of ward staffing across the Trust lead by Maria Nelligan. This had been also been reviewed by the Operational Board. The Board have agreed for further work to be undertaken on this which will be presented at the March open Board meeting. Sheena Cumiskey informed the Board that the Trust has recently been successful in winning a tender to provide children and young people's IAPT services in partnership with Catch 22. Sheena Cumiskey advised that Bowmere Hospital had been visited by the CQC on the 11th of January 2014. All standards were compliant with the exception of outcome 21 on record keeping. The Trust was already aware of issues regarding compliance in this area. The Trust is now awaiting the draft report which is due next week.	
13/14/93	**QUARTER 3 QUALITY REPORT** Dr Anushta Sivananthan introduced the report and drew the Board's attention to the following items: • The Trust has achieved all Q3 milestones for the four quality priorities (the quality dashboard, the always/ never event framework, developing key care pathways and developing real time patient experience information). • Two Occupational Therapists at Meadowbank Ward have won the Ken Holt award at the national Dementia Care Awards. • Jane Brand, Mental Health Nurse in Wirral has won story of the month for 'NHS England's 6 Cs live!' • Eastway Unit is now fully compliant with all CQC essential standards following the CQC visit in September 2013 recognising the hard work by staff in ensuring improvements. Ron Howarth commented on the fact that Dr Anushta Sivananthan was also noted in the Quality Report having won a joint award for NHS Quality Champion/ Innovator of the Year. The Board the **resolved** to receive and **approve** the report.	
13/14/94	**LEARNING FROM EXPERIENCE REPORT-TRIMESTER 2** Avril Devaney introduced the report and highlighted that this report is a summary of the full report that is considered by Quality Committee. Avril Devaney highlighted the following items: • An overall decrease in the number of falls incidents. • Further work on the 'no force first' principles- CWP and several other Trusts in the north west have been successful in obtaining funding from the University of Central Lancashire to research the American model to assess whether it could be replicated in the UK	

	• Recommendations arising from the report are a deep dive review of incident reports to ensure the correct categorisation of incidents. This is not applicable to category A and B incidents but will focus on those assessed as category D and E Ron Howarth noted from the report that assurances following medications incidents were required immediately and queried whether these had been completed. Dr Anushta Sivananthan confirmed that this was the case. The Board the **resolved** to **note** the report	
13/14/95	**COMMUNITY SERVICES IMPROVEMENT PROGRAMME - 6 MONTH EVALUATION** Andy Styring introduced the report and reminded Board members of an earlier initial evaluation report presented at the September Board meeting which confirmed that the CSIP programme targets were being achieved but did not cover wider issues. Andy Styring informed that a number of evaluation events had taken place across the localities facilitated by the Research and Development team. Unfortunately there had been a low turn-out to the events and this made the data collected statistically invalid. As such the events will be rearranged to run again and further information about these will be reported to the March Board meeting. The exception to this was in the Wirral locality whereby an event was held that was successful and it is hoped that this can be replicated in West and East. A discussion ensured regarding ensuring a good response to the rearranged events. Andy Styring confirmed that the localities would be driving the rearranged events and would be encouraging service user, carer and governor involvement. The Board the **resolved** to **approve** the report.	
13/14/96	**BOARD ASSURANCE FRAMEWORK AND RISK REGISTER** Dr Anushta Sivananthan introduced the Risk Register and the Board Assurance Framework (BAF) and informed Board members that the Risk Register and the BAF is scrutinised by Quality Committee, Operational Board (via the CPR) and the Audit Committee through the in-depth review of individual risks. Dr Sivananthan highlighted that: • The score for the ligature risk *(Lack of robust ligature management programme within the Trust may result in harm to patients with associated reputational and financial impact on the organisation)* has been increased to 20. The key mitigations for this risk are the completion of the action plan to address environment risks which has now been expedited by Operational Board with the actions due for completion by August 2014. CQC are happy with the action taken to progress this. • The safeguarding risk has been re-worded following the November Board meeting. This is now *Adults, children and young*	

	people are not protected through safeguarding training and practice. This risk is due for archive once assurance has been received from the risk lead that all actions have been completed. • Audit Committee reviewed the risk -*The inability of staff to manage the occurrences of slips, trips and falls of patients, resulting in patient injury.* The Committee will receive a follow up report in May 2014 to confirm all actions have been completed. Ron Howarth commented that the Audit Committee had shared the view that there are too many red rated risks on the Risk Register and that there is potential to reduce these by combining several similar risks together. Dr Anushta Sivananthan confirmed that work is continuing in the Safe Services department to further improve the Risk Register. The Board the **resolved** to **note** the report.	
13/14/97	**CONTINOUS IMPROVEMENT PLANS FOR THE DELIVERY OF PATIENT SAFETY AND EFFECTIVE CARE** Dr Anushta Sivananthan introduced the report and informed the Board that following the Mid Staffordshire inquiries, the Berwick and Francis reports, the Trust is progressing a 'zero harm' ambition and as such plans have been developed to practically progress this agenda. Dr Sivananthan reported that Dr Ian Davidson is the Trust's 'Zero Harm' champion and is endorsing the proposals for the appointment of a care planning lead to invigorate care planning in the Trust. It is also proposed that support for meta-analysis is brought into the Trust to support with the interrogation of data and checking for variations. The final element of the proposal is to peer review complex needs services and to support efficiency to reduce variation in length of stay on acute wards and to manage stays in acute beds more effectively. Dr Sivananthan informed that the proposals set out a three year plan of continuous improvement, bringing forward quality improvements and ensuring value for money. Mike Maier queried whether the total costs have been factored into the Annual Plan for 2014-15. Dr Sivananthan confirmed this was the case, but that the plans are informing contract negotiations and there is a possibility of some CCG funding for some elements. Andy Styring commented on the importance of requesting CCG funding towards the proposals. Ron Howarth expressed his support to the proposals and requested confirmed of an evaluation at the end of the 3 year programme and whether the posts would be permanent or time limited. Dr Sivananthan advised that the care planning costs would be met recurrently however the other posts would be time limited initially. Dr Sivananthan confirmed that it is necessary to advertise these posts as the organization does not currently hold these skills. The Board the **resolved** to **approve** the report.	

13/14/98	**NHS ENGLAND PLANNING GUIDANCE, CHANGES TO THE MONITOR STRATEGIC PLANNING PROCESS AND DEVELOPMENT OF THE MONITOR TWO YEAR OPERATIONAL PLAN** Andy Harland, Deputy Director of Finance introduced the report and highlighted key points. These were: • NHS England have recently issued guidance that sets out their expectations for CCG plans developing key models of care and the contract negotiations should reflect these plans in line with these model. • There is a funding gap of £30m for 2014-16. • In line with the NHS England mandate, Monitor has revised their planning processes. Plans will be required in two submissions - a two year operational plan and a 5 year strategic plan for submission in April and June 2014 respectively. • Plans have been initiated internally to progress the two submissions including work to reflect the clinical strategies in the Monitor submissions. Sheena Cumiskey informed that part of the NHS England guidance sets out the plans for the Better Care Fund. CCGs have to submit their plans for the Better Care Fund monies to the Health and Well-being Boards in each locality. This will not greatly impact on CWP as it is focussing on moving patients from acute physical care to community services. This does impact on West locality and the potential for joint social care services in West Cheshire. The Board the **resolved** to **note** the report.	
(13/14/100)	**CORPORATE PERFORMANCE REPORT - DECEMBER 2013** Andy Harland introduced the report and highlighted the following areas: • The Continuity of Services risk rating is currently scored as a 4. • The number of public members in the Trust has decreased due to a data cleansing exercise. • Work is being undertaken to develop the CPR so it is more effective at analysing trends. The full CPR will be reported to the open Board meetings in the future once this work is completed. The Board the **resolved** to **approve** the report.	
(13/14/101)	**MONITOR QUARTER 3 SUBMISSION AND ASSESSMENT OF QUALITY GOVERNANCE** Andy Harland introduced the report requiring the Board's consideration of the declarations required as part of the Q3 submission.	

	The Board noted the quality governance assessment for Q3 and the plan for an overall annual quality governance assessment at the end of Q4. The Board the **resolved** to **approve** the declaration in respect of both governance declarations and in respect of the finance declaration (Dr Anushta Sivananthan left the meeting).	
13/14/99	**CWP CLINICAL STRATEGIES** (David Eva joined the meeting) Andy Styring introduced the report which had been deferred until later on the agenda. Andy Styring welcomed Val McGee, Service Director: Wirral, Jacqui Nevin, Clinical Director:East and Trish McCormack, General Manager: West to the meeting. Andy Styring reminded Board members that the clinical strategies for the localities have been in development for some time and have undergone a period of consultation which included a seminar with governors. The strategies have now been finalised and are being used to inform the current contract negotiations. The strategies will also underpin the operational and strategies plan submissions to Monitor. With regard to Wirral locality, Val McGee presented the strategy and highlighted the key areas for development which included: • Reconfiguration of inpatient beds • A review of liaison services • The development of perinatal Services • The development of dual Diagnosis Service • Enhancing the monitoring of physical health care • A review of access to services 24/7 • A review of our of areas placements and funding streams • Improving use of technology in clinical services and product development • Expansion of eating disorder beds Val McGee informed that 'Vision 2018' had been launched in Wirral during the development of the clinical strategy. CWP are leading on the quality and outcomes work stream. (Stephen McAndrew left the meeting) Trish McCormack presented the clinical strategy for West locality reminding Board members that the strategy has been based around the Altogether Better programme across the 4 work streams of starting well, living well, ageing well and urgent care. Trish McCormack highlighted the following key areas within the strategy: • Development of the early support strategy for troubled families. • School nursing improvements. • EMIS system rollout to primary care to be completed by March 2014. • Integrated SPA for physical health running from 8am-8pm. • Integrated community teams working closely with Cheshire West	

	and Chester Council. • Improving IAPT services. • Further development of the integrated provider hub and gaining an understanding of the financial implications of this. Ron Howarth queried the progress of the integrated teams in West Cheshire. Trish McCormack informed that two teams are fully integrated and others are planned shortly. They are arranged in a cluster model around the GP bringing together community matrons, district nurses, occupational therapists, mental health services and social care services. They are generally working with the older population and the risk stratification tool is being used to ensure patients are being prioritised according to the need. Jacqui Nevin presented the clinical strategy for East Cheshire and reminded the Board members of the nuances of the East locality covering two CCGs and two local authorities as Vale Royal is under Cheshire West and Chester. Jacqui Nevin highlighted the following key areas in the strategy: • A review of inpatient services due for completion by March 2014 • Development of services for neuro-developmental conditions • Children and young people's IAPT services • Increasing capacity with adult IAPT services • Retaining and further developing drug and alcohol services • Reconfiguring of community LD teams • Partnership working on long term conditions • Improving mobile technologies Trish McCormack informed the Board that the Learning Disability service also has a clinical strategy but this has been incorporated into the locality strategies. Andy Styring extended his thanks to the locality teams for their work in developing the strategies and commented on the potential for future governor involvement in working with partners as the clinical strategies roll out across localities. The Board the **resolved** to **approve** the report and the clinical strategies.	
13/14/102	**REVIEW OF RISK IMPACTS OF ITEMS DISCUSSED** There were no further risk areas identified.	
13/14/103	**ANY OTHER BUSINESS** There were no items of other business raised.	
13/14/104	**REVIEW OF MEETING** Board members were asked to complete the short on-line survey regarding meeting effectiveness.	

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	Comments were invited from the public gallery and a discussion ensued with members of the public gallery regarding partnership working and promoting CWP services to key stakeholders.	
13/14/105	**DATE, TIME AND PLACE OF NEXT MEETING** Wednesday 26th March, 1.00pm at Romero Centre, Macclesfield	

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Cheshire and Wirral Partnership NHS
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Action points from Board of Directors Meetings
26th March 2014

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
29.01.2014	13/14/95	**Community Services Improvement Programme- 6 month evaluation** Board to receive further CSIP evaluation report at March 2014 Board meeting to detail output from further evaluation events	March 2014	ASt	Scheduled report for March 2014 meeting. Clinical Services & Clinical Support information is going to be discussed at May Public Board.	Outstanding
29.01.2014	13/14/95	**Community Services Improvement Programme- 6 month evaluation** Governors to be informed of additional CSIP evaluation events	ASAP	ASt/ LH		Outstanding

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		√		√	√		√		√	

Cheshire and Wirral Partnership NHS Foundation Trust
Open Board of Directors meeting Business Cycle 2014/15

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

No:	Agenda Item	Executive Lead	30/04/2014 Seminar	28/05/2014	25/06/2014 Seminar	30/07/2014	24/09/2014	29/10/2014 Seminar	26/11/2014	18/12/2014 Seminar	28/01/2015	25/02/2015 Seminar	25/03/2015
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 13/14		Qtr 1 14/15			Qtr 2 14/15		Qtr 3 14/15		
4	Director of Infection Prevention and Control Annual Report 2013/14 inc PLACE	Director of Infection Prevention and Control				√							
5	Safeguarding Children Annual Report 2013/14	Director of Nursing, Therapies and Patient Partnership				√							
6	Safeguarding Adults Annual Report 2013/14	Director of Nursing, Therapies and Patient Partnership				√							
7	Accountable Officer Annual Report inc. Medicines Management 2013/14	Medical Director Compliance Quality and Regulation				√							
8	Health and Safety Annual Report and Fire 2013/14 link certification	Director of Nursing, Therapies and Patient Partnership					√						
9	Receive Appraisal Annual Report 2013/2014	Medical Director of Effectiveness and Medical Workforce				√							
10	Implemtation of service redesign programmes	Director of Operations					√						√
11	Implemetaton of Trust Clinical Strategy	Director of Operations					√						√
12	Emergency Planning Annual Report 2013/14	Director of Nursing, Therapies and Patient Partnership				√							
13	Avoidable / Zero Harm reporting (quarterly)*TBC*												
14	Ward Staffing update						√						√
15	Care Quality Commission Registration Report	Director of Finance							√				

16	Approve Integrated Governance Framework	Medical Director Compliance Quality and Regulation											√
Assurance Quality / Effectiveness													
17	National Annual Patient Survey Report 2013/14- Action Plan	Director of Nursing, Therapies and Patient Partnership				√							
18	Single Equality Scheme	Director of Nursing, Therapies and Patient Partnership					√						√
19	Receive and Approve Quarterly Monitor returns (to include licence compliance and quality governance assessment)	Director of Finance	Q4 13/14			Q1 14/15		Q2 14/15			Q3 14/15		
20	Strategic Risk Register and Assurance Framework	Medical Director Compliance Quality and Regulation		√		√	√		√		√		√
21	Receive Research Annual Report 2013/14	Medical Director Effectiveness Medical Education and Medical Workforce					√						
Experience													
22	Receive Quarterly Quality Reports	Medical Director Compliance Quality and Regulation		Qtr 4 13/14		Qtr 1 14/15			Qtr 2 14/15		Qtr 3 14/15		
23	Receive Learning from Experience Report	Director of Nursing, Therapies and Patient Partnership	Trimester 3 (13 /14)				Trimester 1 (14/15)				Trimester 2 (14/15)		
Strategy and Planning													
24	Monitor Operational Plan 2015-2017	Director of Finance											√
25	Monitor Strategic Plan 2014-2019	Director of Finance			√								
Assurance Governance													
26	Appointment of Board Deputy Chair and Senior Independent Director	Chair					√						
27	CEO /Chair Division of Responsibilities												√
28	BOD Business Cycle 2014/15	Chair		√		√	√		√		√		√
29	Approve BOD Business Cycle 2015/16	Chair											√
30	Review Risk impacts of items	Chair/All		√		√	√		√		√		√

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document Reference (2013/14/113)

Report to	**Trust Board of Directors**
Date of Meeting	**26th March 2014**
Title of Report	**Director of Infection Prevention and Control (DIPC) Board Report Quarter Three (October – December 2013)**
Action sought	**For Noting**
Author	**IPC Clinical Nurse Specialists, Maria Nelligan, Director of Infection Prevention & Control**
Presented by	**Maria Nelligan, Director of Infection Prevention & Control**

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

Distribution

Version	Name(s)/Group(s)	Date Issued
V1	Infection Prevention & Control Sub Committee	30th January 2014

Executive director sign-off

Executive director (name and title)	Date signed-off
Sheena Cumiskey, Chief Executive	2014

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4. Recommendations 5

1. The purpose of the report

The purpose of this Director of Infection Prevention and Control (DIPC) quarterly report, quarter three, 2013/2014, is to provide an update to the Board of Directors in line with the requirements of the Department of Health, Health and Social Care Act 2008 (revised 2010) and the National Commissioning Board. This report will demonstrate the performance outcomes and operational work carried out by the Infection Prevention and Control Team during quarter three, which will include as a minimum:

- Outbreaks and Incidents for the three pathways;
- CWP HCAI data which is reported to CWP performance, Public Health England and the Clinical Commissioning Group (CCG) monthly;
- Relevant new documents;
- Trends

2. Outbreaks and Incidents

2.1 Inpatients Services Pathway

For the Mental Health contract the Health Care Associated Infections (HCAI's) that are required to be reported are Clostridium difficile and Metaicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia, Both these HCAIs are reported by exception only. There were no incidents of Clostridium difficile infection or MRSA bacteraemia in inpatient mental health services between September and December 2013. In addition there were no outbreaks of e.g. diarrhoea and/or vomiting to report in inpatient mental health services during this quarter.

Service user involvement
The Infection Prevention and Control (IPCT) participated in the Trust's Involvement Event in early October. One of the Clinical Nurse Specialists for Infection Prevention and Control gave a presentation on the importance of service user involvement in the IPC audit programme and how service user input informs future practice and development. Following this event several involvement representatives have indicated that they wish to participate in future inpatient IPC audits. This is an excellent opportunity for the IPCT to further strengthen and develop their links with service users and involvement representatives.

Inoculation injuries amongst service users
During the period this report covers the IPCT have provided guidance, support and immunisation services to CAMHS inpatient services following inoculation injuries sustained by service users during the sharing of items used in deliberate self-harm. Intervention by the IPCT has reduced the risk of harm to the service users concerned and supported the staff in the areas concerned.
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2.2 Community Services Pathway

Surveillance
The Clinical Commissioning Group for Western Cheshire have ambitions set for 2013/14 by the National Commissioning Board in collaboration with the Department of Health (2012), Public Health England and the Care Quality Commission regarding essential standards.

The 2013-2014 ambitions set for MRSA bacteraemia has changed for 2013/14, with a ZERO tolerance for any avoidable or preventable infections. During Q3 there have been 2 MRSA bacteraemias in relation to the Western Cheshire CCG footprint. Neither has had CWP provider service input and Post Infection Reviews (PIRs) have been completed on both. These have been reported to the Director of Infection Prevention & Control (IPC) and the IPC Sub committee as exceptions. One of the cases is unavoidable and the other is to be disputed to Public Health England (PHE) as health care provision was provided by other acute organisations and has become a repatriated case.

For Clostridium difficile Toxin infections and for performance reporting, this ambition has been set at forty eight for year 2013/14, a reduction of 13% from fifty five for year 2012/13. Quarter 3, October to December 2013 inclusive, continues to show a reduction in figures which falls below the ambition level. Maximum figures up to and including Q3 are expected to be 36; in reality the figure sits at 19 which excludes expatriated cases.

The community pathway are responsible for the surveillance of all community infections including MRSA bacteraemia and C.difficile infections, but also include the emergence of multi resistance gram negative organisms, particularly Escherichia coli and Klebsiella in urine infections. Reporting also includes the number of referrals from the Countess of Chester Hospital (COCH) for MRSA pre-operative patients requiring decolonisation and treatment in line with the existing contract. The community IPC Clinical Nurse Specialist (CNS) reports on a monthly basis to the performance team for the commissioning group and to the IPCSC bi monthly. This includes those figures for MSSA and E.coli bacteraemia, although no RCA is carried out on these cases. Through surveillance it has been noted that trends in e coli urinary tract infections is seasonal, with higher numbers in the summer months. The E.coli urine isolates in November and December has been recorded as the highest since surveillance began in April 2013, however it must be noted that this has not been in conjunction with an increase in gram negative infections nationally. Public Health North West/England are aware of these emerging and increasing gram negative organisms, and work is ongoing with the community IPCT.

The above information is summarised in the table below:

Data for months October to December 2013				
		October 2013	**November 2013**	**December 2013**
MRSA bacteraemia	Apportioned to non-acute trust and received care from CWP	0	0	0
MRSA bacteraemia	Apportioned to non-acute trust and did not receive care from CWP	0	1	1
MRSA decolonisation	Number of patients decolonised who are referred to the service	4	3	5
Clostridium difficile	Apportioned to non-acute trust and received care from CWP	0	0	0
Clostridium difficile	Apportioned to non-acute trust and did not receive care from CWP	2	6	3
E Coli bacteraemia	Actual	15	14	10
MSSA bacteraemia	Actual	2	5	2
MRSA infections	Actioned	8	8	7
ESBL infections	Actioned (total resistance)	28 (10, 35.7%)	36 (11, 30.5%)	37 (13, 35%)

Education events have taken place with GPs, and Non-Medical prescribers over this quarter with emphasis on the antibiotic strategy and competencies documents. An alert is also going to be cascaded to all GPs in relation to inaccurate diagnostics and prescribing, particularly in relation to care homes and repetitive sampling after initial treatments.

Surveillance shows that where initially treatment has not been successful, treatment is changed to sensitivity in over 90% of cases in response to communications from the community IPCT.

Safety Matrix

The 10 week catheter pathway has been edited in response to the safety matrix and new guidance, and will be incorporated into operational policy and best practice. All catheterised patients are assessed in conjunction with the community nursing teams regarding patient self care information and MRSA screening.

The community IPCT are involved in supporting and advising the tissue viability service in relation to the Pressure Ulcer and Wounds safety matrix and care bundles in relation to colonisation and infections.

Aseptic Non Touch Technique (ANNT) training has again taken place over this quarter with community nursing and podiatry services in support of the High Impact Interventions and NICE CG 139.

2.3 Health Protection & External Services Pathway

The third quarter of the year has seen eight care homes and a local community hospital closed due to outbreaks of gastrointestinal illness. Norovirus was confirmed by samples submitted to the laboratory in 4 homes; no causative organism was identified for the remaining outbreaks. All care homes have received updated information to ensure prompt action is taken in response to potential outbreaks of gastrointestinal illness and an educational session provided for attendees of the Care Home Infection Prevention and Control Link Forum.

Care Homes continue to require support and guidance regarding the management of Vancomycin Resistant *Enterococci* (VRE) in patients having been screened and then discharged from the local acute hospital while all results received related to residents of care homes are followed up with the staff to ensure appropriate care and management is in place. IPC training sessions continue to be provided on a regular basis at Tarporley War Memorial Hospital and topic specific training has also been delivered to care homes in response to identification of specific organisms ie MRSA, highlighting to staff the importance of IPC precautions.

Local schools and nurseries have continued to be supported during outbreaks of gastrointestinal illness with provision of specialist advice and support to ensure effective cleaning procedures have been enforced following contamination of the school environment. This has involved close liaison with school /nursery managers to promote best practice across the Western Cheshire locality related to infection control in the educational environments. Follow up educational sessions have been provided for the schools involved promoting effective hand hygiene and awareness of infection prevention and control procedures, supported by colleagues in school health services. Specialist advice has also been provided for a school having particular issues due to long term continence problems with identified children, which has resulted in the need for provision of extra facilities at the school.

Provision of IPCl advice and support has been provided directly to four GP practices in relation to Care Quality Commission compliance and this area of work continues to be a high priority amongst the Practice Nurse Infection Prevention and Control Link forum. This forum continues to be well supported facilitating access to appropriate specialist knowledge and current issues.

3. Staff Seasonal Flu Vaccination Campaign

The Infection Prevention and Control Team provided significant support to this year's campaign as outlined below:

- Facilitated immunisation training to new immunisers and mandatory updates to existing immunisers.
- Five staff trained as immunisers and between them administered approximately 500 vaccines to staff in core clinics and also in local clinics across all localities.
- Immunisations to service users in inpatient settings were also given by the IPCT most notably in the East Locality.
- Administration and data input during clinics

A full report will go to Operational Board in March 2014

4. Recommendations

The Board of Directors is asked to note the DIPC Quarter three report for 2013/14.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document Reference (2013/14/114)

Report to:	**Trust Board of Directors**
Date of Meeting:	**26th March 2014**
Title of Report:	**CQC Review of Health Services for Children Looked After and Safeguarding in Cheshire West and Chester.**
Action sought:	**For Noting**
Author:	**Andrea Hughes Associate Director of Nursing and Therapies**
Presented by:	**Avril Devaney, Director of Nursing Therapies and Patient Partnerships**

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 an open, progressive organisation that is about care, well-being and partnership

Distribution

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

Executive director sign-off

Executive director (name and title)	Date signed-off
Avril Devaney	18th March 2014

1. Purpose of the report

This report is to inform the Board of Cheshire & Wirral Partnership NHS Foundation Trust's (CWP) response to the findings of the recent Care Quality Commission (CQC) review of health services in Children Looked After and Safeguarding in Cheshire West and Chester. It focuses on the key findings and outcomes for CWP, its partnerships and our response.

2. Summary

The CQC undertook a review of health services in safeguarding and looked after children services in Cheshire West and Chester on 20 – 24 January 2014.

It focused on the experiences and outcomes for children within the geographical boundaries of the local authority area and the effectiveness of health providers serving that area including Clinical Commissioning Groups (CCGs) and the NHS England Area Team.

The review also considered arrangements for the health related needs and risks for children placed out of area.

The review was conducted under Section 48 of the Health and Social Care Act 2008 and also checked that healthcare organisations were working in accordance with their responsibilities under section 11 of the Children Act 2004.

The last inspection of health services for safeguarding and looked after children's services took place in November 2010 as a joint inspection with Ofsted. The overall effectiveness of the safeguarding services was judged as inadequate and recommendations from that inspection were covered in this review. The improvement notice placed on the local authority by the Department of Education following the 2010 inspection was lifted in December 2012 following a re-inspection by Ofsted which rated safeguarding arrangements as adequate.

CQC used a range of methods to gather information including document review, interviews, focus groups and visits. In total the review took into account the experiences of 75 children and young people.

The report follows the child's journey reflecting the experiences of children and young people or parents/carers under the following headings

- Early help
- Children in Need
- Child protection
- Looked After Children

The review also considered how well led the health services are in relation to safeguarding and looked after children under the following areas

- Leadership and Management
- Governance
- Training and Supervision

The CQC report was published on 27 February and contains 22 recommendations for provider services, the two CCGs and NHS England Cheshire Warrington and Wirral Area Team.

Of the 22 recommendations, 15 apply to CWP. An additional 21 areas for improvement have been identified by the CCG in response to the themes identified within the review, where improvement could be made, but were not the subject of recommendations, 12 of which apply to CWP

An action plan addressing the recommendations is required within 20 days of receipt of the report

The CWP approved action plan has been forwarded to the CCG who will collate the overall response for submission to CQC.

3. Key Findings

Parents and foster carers were very positive about the work and support they received from a range of health professionals including health visitors, therapists and community nurses. This included the work of community psychiatric nurses, school health nurses and the CAMH service. Areas they identified for improvement included a more timely response from CAMHs staff following contact.

Young people active in the Children in Care Council valued the regular participation opportunities provided and see that their views are listened to and acted on. They reported no issues in accessing CAMHs but did highlight areas around the quality of relationships and the transition between services at ages 16 and 19 which CWP need to give consideration to.

Early Help - Health and social care give a high priority to health promotion, and are working to ensure local services are young person friendly and have appropriate facilities. Engagement and leadership by health professionals in Team around the Family (TAF) is evident, several recommendations relate to further developing practice in the supporting this approach.

Children in Need – The review found that almost all CAMHs teams had lengthy waiting lists, particularly for assessment and review of young people with attention deficit hyperactivity disorder (ADHD). Action is required to ensure there is capacity for a more timely response to need in these services and also to the young person's substance misuse service.

The review highlights the need to further develop information sharing and risk management in relation to young people who self-harm or are at risk of child sexual exploitation.

However, the review commented that CAMH services respond well to young people in crisis to prevent their admission to hospital and to ensure that they receive services in the most appropriate setting.

Exemplary practice was noted in the work of a specialist learning disability CAMHs worker.

Child Protection – Health staff are generally aware of the child protection process and benefit from good support by named safeguarding professionals. Good practice by mental health professionals was highlighted. Whilst the review noted that reports and attendance at child protection conferences had improved, and is well supported by supervision, there is room for improvement in the scrutiny of referrals from adult mental health and engagement by CAMHS and adult mental health professionals in child protection case conferences.

The impact of delays for young people being seen by CAMHs requires closer scrutiny, especially when a child has a child protection plan.

Looked after Children - The appointment of additional Child in Care specialist nurses in CWP was recognised as being an important lever in raising the quality and enabling greater consistency in the delivery of statutory health assessments. High performance in meeting key performance indicators has been sustained. The report recommended that practice needs further development to embed smarter care planning. Children in Care specialist nurses were able to demonstrate good work in supporting care leavers.

Leadership and Management - The review found strong effective leadership underpinned by improvement driven senior health managers, designated and named professionals. Strong commitment to involving and learning from the views of children and young people was evidenced by the work of CAMHs. A high propriety is given to partnership working, the report states that reviewers found open, mature, supportive and challenging working relationships between health organisations and other partners. Engagement with the LSCB is good.

Governance – Good governance between all partners across the health and social care economy was found. Performance reporting requires a stronger focus on the impact and outcomes of the work delivered. Health professionals are appropriately engaged in work to learn lessons from child deaths. Practice learning reviews have been effective in promoting greater awareness of risk and have highlighted the need for new approaches to strengthen managing risk when young people present with complex emotional, mental health and behavioural needs.

Quality assurance of children's health assessments and individual health plans has been strengthened, however the review indicates that further work is required in this area and notes that the work of the specialist child in care nurses is not yet formally quality assured.

Training and Supervision – CWPs corporate safeguarding team is well used and valued by frontline staff. Joint closer working arrangements and training with adult mental health staff is required to fully embed "Think Family". Adult mental health training and supervision arrangements require further review and development.

Next Steps

The CWP action plan will be incorporated within the CWP overarching CQC action plan monitored by Compliance, Assurance & Learning and escalation to Quality Committee as required.

The Trust wide Safeguarding Group will maintain operational oversight.

The action plan will be sent to all Service Directors and General Managers for information and implementation as appropriate.

The learning will be shared across the Trust as part of a special lessons learnt publication to be produced in April re: recent CQC visits.

4. Recommendations to the Board of Directors

To note the key findings of the CQC Review of Health Services for Children Looked After and Safeguarding in Cheshire West and Chester, and the next steps outlined above.

The full review report can be found at:
http://www.cqc.org.uk/sites/default/files/media/documents/20140227_clas_cheshire_west_and_chester_final_report

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document Reference (2013/14/115)

Report to:	**Board of Directors**
Date of meeting:	**26 March 2014**
Title of report:	**Community Service Improvement Programme – progress with the continuous evaluation programme**
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	18.03.2014
2	D Wood to L Hulme for Board of Directors	19.03.2014

Executive director sign-off

Executive director (name and title)	Date signed-off
Andy Styring, Director of Operations	19.03.2014

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].

1. 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 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.

3.2 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. The Board of Directors agreed to receive a further report, based on the quality dashboard quantitative measures, covering a more longitudinal period twelve months post the CSIP implementation.

3.3 The same report to the 25 September 2013 meeting of 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. It was reported to the 29 January 2014 Board of Directors meeting that these events had not been very well attended. Each locality CSIP implementation, monitoring and evaluation group was subsequently asked to develop more robust plans to better engage people with the evaluation events. An update on progress was provided to the Trust's Operational Board on 19 February 2014 and it was agreed that to allow sufficient time to adequately respond to and present the information from the consultation events, that the 26 March 2014 meeting of the Board of Directors would receive progress before receiving a final report at the May 2014 Board of Directors meeting in public. The progress and feedback from each locality is provided below.

3.4 <u>CWP East</u>

Since the implementation of the improvement programme, feedback has been routinely provided via team meetings, team manager meetings and through spending time with community mental health teams and speaking with carers and people using services. Based on this feedback, a review was conducted to identify issues and discuss and develop solutions. This review included five service users, one carer, and seven staff sharing their perceptions and experiences of the service, by means of an informal interview. Two carers also sent in written comments. Consideration is being given to repeating this element of the review in order that wider and more representative views are sought,

possibly by hosting an event akin to that undertaken in CWP Wirral. This will ascertain if there has been any change as a result of changes that will be proposed using current feedback that has been received, which will be reported to the Board of Directors meeting in public in May 2014. Initial feedback can be grouped in to the following themes:

- Variable awareness of change.
- Continuity of personnel.
- Receiving regular and planned support.
- Being able to access care from a named person rather than a service.
- The definition of a good service being one that offers support rather than necessarily facilitating progress to independence.
- Effects of service changes on service delivery including offering support, facilitating progress to independence and recovery.

Aforementioned, to respond to and address these themes, a number of service redesign options are being considered to produce the flexibility for efficient and effective service delivery that will create a seamless service whereby the people using services continuity and consistency for the whole of their recovery journey. Additionally, consideration will be given to ensuring that staff have the appropriate support and skills to effectively manage change personally and with the people that they work with and support.

3.5 CWP West

The next CSIP event for CWP West as part of ongoing evaluation is planned to take part across two days in March and April. In March, there will be three targeted 'day one' events for people and carers of those using services – these events are scheduled for 24 March [Chester], 26 March [Ellesmere Port] and 28 March [Vale Royal]. A specific invitation will be sent by mail to people who are currently engaged in services and have attended a clinic appointment [either practitioner led/ medical] in the last two months. In addition, care co-ordinators will be asked to encourage people who use services to attend. There is time as part of the 'day one' events for staff to also drop in and give their feedback. The 'day two' events will take place in April. This will be a much wider event and will be held in a large venue – and will be facilitated similar to the events held in CWP Wirral. This will seek to achieve co-production with people and carers of those using services, and also staff, on what is working well and what the service needs to more of and less of, culminating in the production of an action plan. The service will link with voluntary sector so that there is some 'market stall' type of event at lunchtime as well as raising awareness so that they can encourage any service users and carers to attend. Additionally, medical staff from Chester have met with the Clinical Director for CWP Wirral to exchange information on what is working well in both areas and they have agreed that a visit from CWP West to CWP Wirral will take place in March.

3.6 CWP Wirral

Ongoing feedback has been gained from the staff and people/ carers of people who use services in CWP Wirral since the implementation of the CSIP. Based on this, two events were held to facilitate a constructive and managed process for seeking out people's views and experiences whilst at the same time identifying solutions, co-produced and owned by all those involved. 'Day one' was broken in to three groups – people and carers of those using services, and the leadership team. 'Day two' brought the three groups together to discuss and develop solutions. The events were facilitated by people from outside of the locality, namely personnel from the Trust's learning and development team and a lived experience facilitator external to CWP [for the group comprised of people and carers of those using services]. Support was also sought from CWP's patient and carer recovery leads. Specific support was received from members of the Wirral Mental Health Forum in the planning and format of the days. As part of 'day two', people and carers of those using services worked on specific areas around recovery, which was facilitated by the Trust's patient and carer recovery leads. Staff and managers reviewed internal processes and issues that had been identified. Feedback can be grouped in to the following themes:

- Variable awareness and engagement with the change process.
- Uncertainty regarding whether the CSIP implementation was following the agreed process.
- Variable information provision to people and carers of those using services and their understanding of the impact that the changes would have on their care.
- Some people using services had not noticed any changes in their care package or level of input from services.
- The requirement for improved communication with staff and people/ carers of those using services.

A number of pledges were then collectively identified for achievement through a series of task and finish groups, with a further evaluation day scheduled for early in the second part of the year to revisit these pledges. These pledges will look at:

- Better communication with people and carers of those using services.
- Improved continuity of care and consistency.
- Better use of the community support worker and peer mentor.
- Better involvement of people and carers of those using services in planning their care.
- Better continuous information giving regarding changes.

4. Recommendations to the Board of Directors

The Board of Directors is asked to:

- **Note** and **approve** the progress with the plans identified to ensure better engagement with ongoing CSIP evaluation events.
- **Agree** to receive a further report at the Board of Directors meeting held in public in May 2014, detailing feedback received and locality/ Trustwide plans formulated to ensure that the StAR model is fully embedded and sustainable.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document Reference 2013/14/116

Report to:	**Trust Board of Directors**
Date of meeting:	**26 March 2014**
Title of report:	**Strategic risk register/ corporate assurance framework update**
Action sought:	**For DISCUSSION & APPROVAL**
Author:	**David Wood, Associate Director of Safe Services** **Louise Hulme, Head of Corporate Affairs**
Presenting Executive:	**Dr Anushta Sivananthan, Medical Director (Quality, Assurance & Compliance)**

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 partnership with existing and potential new stakeholders
SO5. Improve quality of information to improve service delivery, evaluation and planning
SO6. To sustain financial viability and deliver value for money
SO7. To 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 Hume to D Wood	14.03.2014
2	D Wood to L Hulme for Board of Directors	19.03.2014

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. Summary

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 5 March 2014. The Audit Committee undertook an in-depth review of the *Risk of harm to patients due to lack of staff competency to manage changing physical conditions* strategic risk at its meeting on 8 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 Nov 2013	Residual risk rating Jan 20134	Residual risk rating March 2014	Risk score since last review	Summary risk treatment plan
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)	**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 2013 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 was provided to**

Description of the risk	Residual risk rating Nov 2013	Residual risk rating Jan 20134	Residual risk rating March 2014	Risk score since last review	Summary risk treatment plan
					the February 2014 meeting of the Patient Safety & Effectiveness Sub Committee. In the absence of the risk owner to present this, it has been referred to the Quality Committee Chair who will update the Board of Directors with an assurance report that has been received from the risk owner.
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 have received assurance from 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, with request that risk is re-modelled to reflect the focus of the risk on training. Quality Committee to consider further re-modelling following assurance from CCGs re compliance with safeguarding training targets (with the exception of West – potential financial adjustment (across both contracts): £100,000 at year end for non-achievement against 80% thresholds). **Re-modelled risk approved at January 2014 Quality Committee with no change to risk score. Quality Committee agreed at its March 2014 meeting further re-model the risk to reflect the action plan received following the CQC inspection of safeguarding that took place week commencing 20 January 2014.**
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 reported to the February 2014 meeting**

Description of the risk	Residual risk rating Nov 2013	Residual risk rating Jan 20134	Residual risk rating March 2014	Risk score since last review	Summary risk treatment plan
					of the Patient Safety & Effectiveness Sub Committee to propose risk treatment plan moving forward and the 4 March 2014 meeting of the Audit Committee subsequently undertook an in-depth review and agreed a target risk score of 15 to be achieved by January 2015.
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 and 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 15 agreed. Further update to come to May 2014 meeting to provide assurance of actions completed. Action plan being implemented by a task and finish group and is reviewed routinely by the Patient Safety and Effectiveness Sub Committee.**
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**	**20**	**20**	↔	Board approved the capital programme in May 2013. Updates provided to September 2013 Quality Committee and November 2013/ January 2014 Operational Boards. Further action agreed regarding the en suite door top alarm systems and clinical risk management of dressing gown cords. **The January 2014 Operational Board agreed to expedite the timeframes for**

Description of the risk	Residual risk rating Nov 2013	Residual risk rating Jan 20134	Residual risk rating March 2014	Risk score since last review	Summary risk treatment plan
					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. Also discussed at January 2014 Quality Committee – due to high level of environmental risk, likelihood increased to 4 therefore overall risk score of 20. High priority areas to be fully completed by August 2014 when risk score will be re-visited. This has also been agreed with CQC.
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 community safety metrics programme. The Quality Committee has endorsed the 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 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. Zero harm final proposals agreed at January 2014 Board of Directors. Recruitment to posts now underway and three year implementation plan in development for approval at May 2014 meeting of the Quality Committee.**

Description of the risk	Residual risk rating Nov 2013	Residual risk rating Jan 20134	Residual risk rating March 2014	Risk score since last review	Summary risk treatment plan
Risk of harm to patients and staff due to staffing levels across inpatient services in the three localities	**16**	**16**	**16**	↔	Position statement prepared by the Associate Director of Nursing [Mental Health] and DIPC on current staffing levels, including safety and skill mix across all professional types, benchmarked against other trusts presented to Operational Board in October 2013. Agreement to 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. **Review was presented to Operational Board in January 2014 which approved, in principle, the operational recommendations. Review was noted at March 2014 meeting of the Quality Committee for qualitative recommendations. Specific, immediate actions identified were presented and approved by January 2014 Board of Directors. Further update report being presented at March 2014 meeting of the Board of Directors.**
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**	↔	A further action has been identified regarding strengthening of financial infrastructure via recruitment of locality accountants and establishment of a performance and 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. **January and February 2014 Board received outline financial projects and plans. Locality accountants meeting weekly with Service Directors to identify CIP for 2014/16.**
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 and approved by October 2013 Operational

Description of the risk	Residual risk rating Nov 2013	Residual risk rating Jan 20134	Residual risk rating March 2014	Risk score since last review	Summary risk treatment plan
					Board. Implementation plan in development which will be monitored to inform risk treatment plan on an ongoing basis. **Implementation plan in development which will be monitored to inform risk treatment plan on an ongoing basis. Operational Board to continue to monitor until end March 2014 with a view to re-modelling.**
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**	↔	The information strategy has been drafted but will not be finalised until the Trust's clinical strategy is approved in January 2014 and Associate Director of Performance and Redesign advises of way forward. An external audit regarding the processes and systems associated with development of the quality dashboard reported to January 2014 Quality Committee – with positive assurance. Action plan further to the contract query received from Wirral CCG was completed December 2013. **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. In the interim, Quality Committee received a paper at 05.03.2014 meeting regarding current status.**
Risk of adverse clinical incident or regulatory action due to dual record keeping systems (electronic and paper) and quality of recording	**12**	**12**	**16**	↑	The Records and Clinical Systems Group is correlating clinical systems priorities with the dual record keeping risk – also tying into review of system effectiveness and functionality. A revised dual record keeping action plan was presented to the December and February 2013/ 2014 Patient Safety & Effectiveness Sub Committee meetings, for completion end March 2014. **Escalated to risk score of 16 following CQC visits to Springview in Nov 2013 and Bowmere in Jan 2014 which highlighted minor concern in respect of**

Description of the risk	Residual risk rating Nov 2013	Residual risk rating Jan 20134	Residual risk rating March 2014	Risk score since last review	Summary risk treatment plan
					outcome 21 (records). Target risk score will be proposed at the April 2014 Patient Safety and Effectiveness Sub Committee.
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**	↔	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 root cause analysis 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 was fed back as a recommendation. Service Directors have been asked to monitor the management of actions arising from root cause analysis investigations. **Performance against closure of RCA recommendations will be monitored more closely at the Compliance, Assurance and Learning Sub Committee – to review improvements at April 2014 meeting.**
Risk of breach of Trust Terms of Authorisation/ Provider Licence as a result of external scrutiny	**15**	**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. **Recent CQC visits to Springview and Bowmere have identified improvements required in relation to outcome 21 (records). Action plan implementation in progress, scheduled completion date end March 2014. The risk score will be re-modelled at that point with suggested target risk score.**

Description of the risk	Residual risk rating Nov 2013	Residual risk rating Jan 20134	Residual risk rating March 2014	Risk score since last review	Summary risk treatment plan
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 [Physical Health] is interim senior lead. Assurance is being sought from the Workforce and Organisational Development Sub Committee.**
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	**10**	**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 three months 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 ongoing Trust identified actions. The CQC indicated a follow up visit in one year. Full locality evaluations to reflect impacts of the CSIP being presented to May 2014 Board of Directors.**

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 been re-modelled and has had its residual risk score amended as a result. This is:

Risk of adverse clinical incident due to dual record keeping systems (electronic and paper)
This risk has been re-modelled to:
Risk of adverse clinical incident or regulatory action due to dual record keeping systems (electronic and paper) and quality of recording
This risk has been re-modelled following the two most recent Care Quality Commission unannounced visits conducted at Springview in November 2013 and Bowmere Hospital in January 2014, which highlighted minor concerns in respect of outcome 21 (records). Consequently, the risk has been re-scored, resulting in an increase in the likelihood of the issue. The risk is currently scored as 16 having previously been scored as 12. An updated 'quality of record keeping action plan' was submitted to the Patient Safety and Effectiveness Sub Committee in February 2014, which outlined development plans in relation to clinical systems. This includes a review of system effectiveness and functionality. A target risk score will be agreed at the April 2014 meeting of the Patient Safety and Effectiveness Sub Committee once the closure of the actions required for Care Quality Commission assurance purposes at the end of March 2014.

4.3 Archived risks

Four risks have been archived. These are:

Significant number of unconfirmed notes on CAREnotes system which may result in harm to patients, risk of litigation and external scrutiny
This risk has been archived on the basis of Patient Safety and Effectiveness Sub Committee receiving assurance regarding there being no risk of harm to patients and no risk of litigation, rather it is an individual performance issue.

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
This risk has been archived on the basis of the completion of actions and improved contract monitoring with the provider.

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
This risk has been archived on the basis that there are no immediate actions regarding this risk and anything arising can be escalated back to the risk register by the PbR group reporting into Operational Board if necessary.

Risk of adverse incident due to Patient identification policy not being followed in inpatient areas
This risk has been archived on the basis of the assurance provided by the internal audit locality governance report to the January 2014 Quality Committee, information provided by the risk owner, and ongoing systems in place to monitor this risk, i.e. via the learning from experience report.

4.4 Audit Committee review of the risk register

The Audit Committee undertook an in-depth review on the strategic risk *Risk of harm to patients due to lack of staff competency to manage changing physical conditions* at their meeting on 4 March 2014.

The Deputy Director of Nursing attended and advised the Committee of the status of the risk and the controls and assurances in place and mitigating actions being implemented.

The Audit Committee has requested that at their next meeting in May 2014, they undertake a scenario testing exercise relating to the risk around terms of authorisation/ licence conditions based on findings from the Eastway inspection findings in 2012. This is to include understanding of the likelihood of the scenario occurring again, understanding the causal triggers or conditions, and understanding the early warnings systems that could mitigate this.

4.5 Current and further development of the risk register
The current review of the strategic risk register is continuing to demonstrate more active management. Further work is planned to further improve the dynamism of the risk register. This includes:

- All risks on the risk register to have an identified risk target score by April 2014 – informed by the risk session provided to the Board seminar on 26 February 2014.

- Work to continue around strengthening the use of the Datix incident reporting and management system to report routinely on the local and strategic risk registers and corporate assurance framework, with a plan for a short pilot to test functionality and then a full export to Datix. It is anticipated that this will be completed by July 2014.

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	12	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 and will report on action plan on ongoing basis. Audit Committee has agreed target risk score of 15 following in-depth review of mitigations, including changes to Essentials 1 training including new physical health training will be implemented from March 2014. It is anticipated that the risk target of 12 will be achieved by March 2015.	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: Action completed and under ongoing review through contract monitoring processes. i) To re-model to reflect the action plan received following the CQC inspection of safeguarding that took place week commencing 20 January 2014. Safe Services Department by end April 2014. **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	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 recommendations. Medical Director Quality and Head of Clinical Governance 01/10/2014 **STATUS: Completed. Review completed. Audit Committee undertook in-depth review of the risk at the January 2014 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.** **m) Falls task and finish group to implement action plan arising from external review findings** **STATUS: On track - Action plan being implementation and was reviewed by February 2014 Patient Safety and Effectiveness Committee. All actions due for completion by May 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 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 was scheduled for review at the February 2014 meeting of the Patient Safety & Effectiveness Sub Committee and March 2014 meeting of the Quality Committee however there was no service representation at the meeting to provide assurance. This risk has been referred to Quality Committee Chair to seek assurances.**	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 - In progress. Review presented to and recommendations agreed by Operational Board and Board of Directors in January 2014. Lead being identified to progress programme.**	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 agreed at January 2014 Board of Directors. Recruitment to supporting posts now underway.**	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, next review April 2014 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. Interim reports provided to January and March Board of Directors. Further evaluation to be provided to May Quality Committee and then to be provided to May Board of Directors and subsequent Council of Governors.**	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

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. An updated quality of record keeping action plan was submitted to Patient Safety & Effectiveness Sub Committee in Feb 2014 outlining further developments required to the clinical systems, this includes a review of system effectiveness and functionality. A target risk to the April 2014 Patient Safety & Effectiveness Sub Committee meeting.**	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
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 March 2014 Operational Board. January corporate performance report identified improvements in MEL compliance trustwide. To continue to monitor until end March 2014 with a view to re-modelling.**	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- Ongoing. Recruitment completed. October Board seminar considered financial projections and revised approach to CIP management. January and February 2014 Board received outline financial projects and plans. Locality accountants meeting weekly with Service Directors to identify CIP for 2014/16.**	29/01/2014
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. Action plans in progress to achieve full compliance. Continuing to report into Quality Committee.**	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. Equality and diversity officer is currently being recruited to.**	31/01/2014

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document Reference 2013/14/117

Report to:	**Trust Board of Directors**
Date of Meeting:	**26th March 2014**
Title of Report:	**Progress Report on the implementation of the Ward Nursing Staffing Review**
Action sought:	FOR DISCUSSION & Noting
Author:	Maria Nelligan, Associate Director of Nursing & Therapies (MH) Anne Casey Interim Programme Manager
Presented by:	Maria Nelligan, Associate Director of Nursing & Therapies (MH) and DIPC Anne Casey Interim Programme Manager

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 an open, progressive organisation that is about care, well-being and partnership

Distribution

Version	Name(s)/Group(s)	Date Issued
1	Andy Styring	17/3/14
2	Avril Devaney	17/3/2014
3		

Executive director sign-off

Executive director (name and title)	Date signed-off
Avril Devaney, Director of Nursing, Therapies and Patient Partnership	19th March 2014

1. Introduction

A Ward Nursing Staffing Review was completed from October to December 2013 resulting in an in-depth report being submitted to CWP Operations Board on January 2014. The recommendations from that report were twofold firstly relating to staffing establishments and secondly relating to a programme of continuous improvement which includes practice and workforce issues. This report details the staffing requirements identified in the Ward Nurse Staffing Review and progress to date.

The objective of the Ward Nurse Staffing Review was to review existing nursing ward establishments and practices to ensure that they were fit for purpose and to make recommendations on areas that require enhancement. This is in line with the national agenda following the recommendations of Francis (2013) and the government's response summarised in the National Quality Boards (2013) guidance.

1.1 Background

In October 2013 the Operations Board received a paper setting out the Trusts current position in relation to the mental health wards staffing, vacancies and skill mix. This led to the Associate Director of Nursing & Therapies (MH) leading the review of ward staffing levels on behalf of the Board. The areas covered within the review included both qualitative and quantitative data and the review methodology followed the Telford Model using a consultative approach based on professional judgement. To prevent bias quantitative data was also used to aid triangulation.

The review team was interprofessional and included representatives from nursing, compliance, governance, human resources, research and finance. A core team from the review group met with representatives from each ward including the Ward Manager, Modern Matron, Consultant Psychiatrist and Allied Health Professionals in order to discuss issues that are impacting on ward staffing on a shift by shift basis. The areas covered included the structure of the multi-disciplinary team and how the team works on a day-to basis, the nursing skill mix and RN to patient ratios, therapeutic interventions, aspirational roles and training needs, documentation and paperwork, gate-keeping, assessment and discharge planning, environmental issues, impact of incidents, lean ways of working and efficiencies, impact of routine and ad-hoc additional work such as ECT, RCA's and investigations etc. The core team challenged the ward representatives on areas of practice and assumptions in order to support the resulting conclusions and recommendations.

The data examined for each ward included current ward MDT establishments, rosters, skill mix ratios, bank usage, sickness, incidents, uptake of education, occupied bed days, re-admission rate, length of stay and supervision/appraisal compliance. Benchmarking from the National Bed Enquiry (2000) and Boardman (2007), NICE guidelines, CQC essential standards and contractual service specifications were also considered.

A reference group made up of Associate Directors, Service Directors and staff side provided the review team with an opportunity to consult and seek advice. This group was chaired by a Clinical Director. Consultation with Merseycare NHS Trust also took place as they had completed this work previously.

To underpin the data gathered and the issues raised within individual ward review meetings Focus Groups with patients took place. The core review team also sought additional information from Clinical Service Manager's and General Manager's where appropriate.

The review team analysed the information gathered and made recommendations to the Board relating to recommended staffing levels and continuous improvement of clinical and workforce practices.

1.2 National context

Considerable discussion has taken place regarding the impact nursing staffing levels have on the quality of patient care. Francis (2013), Berwick (2013) and Keogh (2013) highlight the negative impact on patient outcomes where staffing levels are not sufficient and high profile cases such as Mid Staffordshire Hospital are but one. Research demonstrates that there are better outcomes for patients in terms of safety and quality where there is a high Registered Nurse ratio. Little research exists for mental health; however the principles are transferable across the nursing disciplines. It is recognised that staff shortages have an impact on patients and staff and compromise care directly and indirectly. Recurrent shortages of staff impact on the stress and wellbeing of staff leading to higher sickness and greater dependency on bank, reducing continuity of care and impacting on substantive workload. This has an impact on the quality of care delivered to patients and the cost effectiveness of the wards.

Patients have a right to be cared for by the appropriately qualified and experienced staff in a safe environment. The National Quality Board (NQB) (2013) published guidance which sets out the expectations for all Trusts Boards to "take full responsibility for the quality of care provided to patients and as a key to quality take a full and collaborative responsibility for nursing and care staffing, capacity and capabilities." Pg 5

It is envisaged that commissioners will actively seek assurances from Boards with regards to the staffing establishment and the competency and skills of the workforce. Some have started to ask for this information already in contract monitoring meetings. Staffing data will also be part of the CQCs Intelligent Monitoring of NHS Providers.

The right number and skill mix of staff alone will not ensure high quality patient care is delivered, this also depends on a range of factors such as leadership; management; culture of a team and on the ward; level of educational training to staff. The more positive the experience of staff within a Trust the better the outcomes for patients in the organisation. Staff engagement has many significant associations with patient satisfaction, mortality and infection rates. The proportion of staff working in well-structured teams receiving well-structured appraisals and experience supportive leadership from line managers are all linked to patient mortality (NQB2013).

Being listened to, respected and treated with the compassion and dignity they deserve has a huge impact on the patients experience of care and contributes to higher quality of care, it is vital that leaders and managers at every level create supportive caring cultures in teams and within our organisation as a whole.

1.3 CWP current arrangements

Ward staffing currently consists of substantive staff hours supplemented by bank staff that are used to backfill shortfalls in substantive staff availability due to sickness vacancies and secondments. In addition, bank staff are required to meet the additional needs of patients with complex needs and support peak in workflows.

In the past 2 years the dependency on the bank has increased by 29% from 92 WTE in 2010-11 to 119 WTE in 2012-13. Minimum staffing has generally been achieved with the combination of substantive and bank staff. However ensuring fundamentals of care are maintained is often at the expense of staff and indirect care tasks for example *"the first thing to go is breaks, then going home on time, then activities for patients, then record keeping"* Ward Managers 2013 of services.

To prevent this occurring, the staffing establishments need to be reset to meet the needs of patients and staff. That is, nurses must have the capacity to increase time spent with service users to provide direct care, they must have the capacity to fulfil indirect care requirements and they must be able to take breaks, undertake supervision and education.

1.4 Methodology of the Ward Nursing Staffing Review

In the absence of a specific staffing tool for mental health a literature review of current practice in this area was undertaken. The Telford Model a consultative approach (whereby a Ward Manager provides their professional opinion on ward staffing required) is well recognised as a key tool in this area this was chosen for the review. To strengthen this approach the MDT (including consultant psychiatrists) and Modern Matron were also interviewed to ensure a rounded profile for each ward was established (which will be held locally at ward level). The Ward Nursing Staffing Review meetings took place following Octobers Operational Board and were completed on 19th December 2013.

To address any potential bias, triangulation of data was used before reaching a conclusion on the required new staffing establishments, this data included:

- Staff to occupied bed days
- Nurse per bed day
- Incidents
- Bank demand
- Vacancies
- Sickness
- Findings form CWP internal unannounced visits
- Findings from the Activity Follows Productives

2. Analysis of current bank usage

Bank usage of greater than 5 WTE is deemed as high as this equates to more than one member of bank staff on each shift throughout the course of a week. Bank staff provide valuable support to wards to mitigate staffing shortfalls however it is acknowledged that high use of bank can have an impact on continuity of care and delivery of quality outcomes.

High bank to substantive staff ratios have been found to have a negative impact on substantive absence and workload (Hurst & Smith, 2010), there is also anecdotal evidence that bank staff feel less supported when the bank to substantive staff ratio is high, leading to bank staff choosing to work in alternative areas, further depleting resources within the wards with the greatest shortfall. Therefore reducing bank demand should have a positive impact on substantive sickness and workload.

3. Recommended staffing establishments from the review

3.1 Headroom

When setting nurse establishments it is important to include headroom (NQB, 2013). Headroom is the collective term for planned and unplanned staff absence from the ‘numbers’ on the ward for example annual leave, sickness, mandatory training etc. Currently headroom within the rostered areas of the Trust is set at 22% - this is made up of 14% annual leave (agenda for change average), 5% sickness and 3% essential training. Finance have advised that historically no consistent headroom has been applied to ward budgets therefore the staffing establishments on core business wards do not incorporate standard headroom. Newly commissioned wards have headroom built into contracts; this may be higher than the Trust 22% as other headroom such as maternity leave should be within these.

Both annual leave and essential training headroom, totalling 17% are currently built into roster templates. Sickness headroom is separate from the roster template as it is not prudent to have staff in post ‘in case’ of sickness. It would be prudent to set aside a bank budget of 5% of the staffing establishment to manage sickness headroom.

Setting required staffing levels must be supported with demonstrably efficient rosters, in particular relating to annual leave, in order to realise the expected benefits of such an investment.

3.2 Required staffing levels

It was evident from the Ward Nursing Staffing Review that Ward Managers have a realistic expectation in relation to staffing their wards and are familiar with flexing staffing levels in response to patient

needs on a day to day basis. As part of the review Ward Managers were challenged with regard to the establishments they felt they needed to meet standards on a shift by shift basis and consensus was met with the Multi Disciplinary Team at the end of the interview. The concluded establishments were then reviewed in light of the quantitative data collated and queries checked with services managers.

The recommended ward establishment was calculated by identifying the clinical hours needed shift by shift and then incorporating headroom. The recommended increase in ward establishments is presented below:

This breaks down as follows by locality:

Role	East WTE	West WTE	Wirral WTE	Trust Total WTE
RNB6	3.2	3.2	5.8	**12.2**
RNB5	-1.7	3.9	0.6	**2.8**
CSW	15.8	17.2	10	**43**
Resource Manager	6	7.3	4	**17.3**
Advanced Practitioner	3	1	3	**7**
Total	**26.3**	**32.6**	**23.4**	**82.3**

As indicated in the table above the review concluded that an additional 58 WTE ward nurses (15 WTE RN and 43 WTE CSW) would be needed to meet the needs of the wards to deliver ongoing quality standards.

Bank demand for the 21 wards for the 12 month period within the review was 118 WTE and West locality already have 2 RNs and 3 CSW's as a cost pressure within their establishments. For this period the vacancies ran at an average total of 60 WTE giving an additional staffing demand, excluding vacancies, of 63 WTE. Therefore the number of nursing WTE recommended by this review is on a par with the current bank usage.

However this does not take into account the need for sickness backfill. As previously discussed it is recommended that a bank budget of 5% of the establishment is set aside to manage sickness headroom. This would equate to 27 WTE if fully utilised.

The review identified the need for advanced practitioners to meet clinical gaps and improve physical health standards and resource managers to release ward manager from administration to increase clinical time with patients. These roles were supported by the reference group and total 7WTE and 17.3 WTE respectively as agreed by the Boards.

3.3 Skill mix and RN to patient ratio

The Royal College of Nursing (RCN, 2010) suggests a registered to non-RN ratio of 60:40 alternatively the Safe Staffing Alliance (2013), a group of senior nurses, believes RN-to-patient levels should never fall below 1:8 during the day. In areas of higher acuity where there is a higher number of staff per patient the RN to patient ratio would be more appropriate for example manager with 16 beds requires 8 staff on days but due to the nature of the ward needs 4 RN's and 4 CSW's per day shift, then the registered to non-registered would be 50:50 but the RN to patient ratio would be 1: 4 and the overall staff to patient ratio would be 1:2 – this is a more appropriate measure than the 50:50 in these circumstances. The proposed uplifted establishment would ensure that CWP wards have the minimum daytime RN to bed ratio of 1:8 would be met at all times. Although not all wards would achieve the 60:40 RN to CSW ratio the overall staffing levels on those wards would be sufficient.

With regards to the skills and competencies of RNs the review has recommended that for some wards an increase in the number of band 6 RNs with enhanced skills and competencies in complex assessment, and care planning on wards for people with dementia and eating disorders is required.

In addition, as recommended in the report, a number of the clinical support worker roles should be recruited as band 1 and 2 apprentices.

3.4 Requirements of the NQB for publishing Staffing Levels

NHS Employers advises that following the guidance developed by the NQB, from April 2014, all hospitals will be required to publish staffing levels on a ward-by-ward basis together with the percentage of shifts meeting safe staffing guidelines. This is mandatory and will be done on a monthly basis. By the end of the year this will be done using models approved independently by NICE. Until then the trust will publish details of staffing levels using a model agreed by ward managers, e-rostering, governance and the associate director of nursing and therapies (MH).

The NQB (2013) suggests that an escalation policy and contingency plans help provide clarity at times of increased pressure and when staffing capacity and capability cannot be met on a shift by shift basis. A escalation policy is being developed via the Ward Managers Task Group and will include actions to be taken, the people who should be involved in the decisions in short, medium and long term staffing shortages and outline the contingency steps where capacity problems cannot be resolved. Therefore this escalation policy will aid the trust in pro-actively responding to staffing problems and ensure that staff are supported and confident in raising concerns.

3.5 Discussion

It was evident to the review team that the clinical teams were committed to delivering quality care to patients. In the reviews the 6c were evident in the discussion and examples given by the clinical teams. They were also realistic in their expectations regarding resources in the current economic climate. To reach recommended establishments the review went through requirements for patients and staff shift by shift with the ward teams.

Whilst the Trust has continued to maintain safe staffing levels through the use of bank to continue in this way is not sustainable. Many of the bank staff are existing substantive staff working extra hours, this may be good for patient continuity but is not so good for the health and wellbeing of staff. Alternatively a consistent staff team is needed to successfully develop therapeutic engagement with patients and to establish a cohesive team within a therapeutic environment.

It is essential that the programme of continuous improvement is implemented in parallel and following the recruitment of substantive staff. The establishing of well-resourced teams will provide the environment to embrace change, without this approach there is not the capacity, nor resilience, within the existing teams to deliver the change programme required.

3.6 Implementation of the review

The Director of Operations is the lead executive for the implementation of the reviews recommendations. He has commissioned a steering group and a Programme Manager (interviews 20th of March) to take this forward. In the meantime an Interim Programme manager has been identifies and is working with the Associated Director of Nursing (MH) and Services Directors. As an interim measure targeted recruitment initiatives have also been introduced where there is a significant shortfall. The Associate Director of Nursing (MH) has established a Ward manager's task group to take forward the reviews practice issues the group is supported by the Heads of Clinical Governance and Compliance. An Inpatient Bed/Ward Review Programme Manager post has been created to project-manage the implementation of the Comprehensive Review of Ward Staffing Establishments

2013. The post will be responsible for the delivery of the programme and the associated benefits realisation to ensure that the Trust provides bed based services which meet the needs of the population and ensures resources are managed both effectively and efficiently. This will include modelling the financial implications of the recommendations to increase staffing numbers.

- The Trust has identified a staff member to temporarily act into this role whilst recruitment occurs.
- A Programme Board and Project Team are in the process of being set up.
- The recommendations from the Comprehensive Review of Ward Staffing Establishments 2013 have been reviewed and actions allocated accordingly to the Programme Board, Project Team, Ward Managers Task Group, CWP Education, Acute Care Networks and Senior Managers.

4. Summary

This reports sets out the requirements for Trusts in relation to staffing wards. It also provides an overview on how the recommendations from the comprehensive ward staffing review will be implemented.

The board is asked to note the report.

5. References

National Quality Board (2013) How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability. NHS England

Boardman J and Parsonage M (2007) Delivering the Governments Mental Health Policies: Service Staffing and Costs. Sainsbury Centre for Mental Health.

RCN (2010) Guidance in safe nursing staffing levels in the UK. RCN London

Keogh (2013) Review of the quality of care provided by 14 hospital Trusts in England overview report. NHS England

Berwick D (2013) A promise to learn, a commitment to act: Improving the safety of patients in England. Department of Health

Cavendish C (2013) The Cavendish Review: An independent review into healthcare assistants and support workers. Department of Health

Document Reference (2013/14)

Date of Meeting: 26-Mar-14

Title of Report: Board of Directors
Public 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 finance risk rating for February is 4.
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
1	Avril Devaney, Director of Nursing, Therapies and Patient Partnership
2	Operational board
2	Board of Directors

Executive Director

Tim Welch, Director of Finance/Deputy Chief Executive

Key Messages :

The Trust's risk rating	4
Overall I&E positionc Year to Date	£2.2m surplus
EBITDA performance	£7,694,000
Cash comment	No issues to report.
Capital expenditure comment	No issues to note.
Financial risks registered (where appropriate to comment)	No issues to report.

Patient Experience — Data Month 11 (February 2014)

Section 1: Patient Feedback

No. complaints received	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	January Red	January Amber	January Green	January Concern	February Red	February Amber	February Green	February Concern
Corporate Support Services		**1**						**1**	1								
Corporate Support Services		1						1	1								
East Clinical Services	**9**	**6**	**12**	**13**	**6**	**7**	**9**	**6**	12		**3**	**4**			**3**	**4**	**2**
Adult Mental Health Services East	9	6	10	11	4	6	9	4	10		3	2			3	3	1
Child & Adolescent Mental Health Services East			1		1				1								1
Drug & Alcohol Service East				1				1				1					
Learning Disabilities Services East				1				1	1							1	
Older Adults Mental Health Services East			1		1	1						1					
West Clinical Services	**16**	**10**	**11**	**18**	**15**	**15**	**13**	**11**	16		**2**	**4**	**2**		**5**	**12**	**4**
Adult Mental Health Services West	2	5	5	7	5	6	6	3	2		1	1			2	3	2
Child & Adolescent Mental Health Services West	4	2	1	4	4	3	1	2	4						1	1	1
Drug & Alcohol Service West	1					1		1				1					
Learning Disabilities Services West				1				1							1		
Older Adults Mental Health Services West				1			1		2							1	
Physical Health Services West	9	3	5	5	6	5	5	4	8		1	2	2		1	7	1
Wirral Clinical Services	**2**	**4**	**5**	**3**	**3**	**3**	**6**	**3**	4		**1**	**3**		**1**	**1**	**5**	
Adult Mental Health Services Wirral	2	3	3	3	1	2	3	1	3		1	3			1	5	
Child & Adolescent Mental Health Services Wirral		1			1		1	2									
Learning Disabilities Services Wirral						1											
Older Adults Mental Health Services Wirral			2		1		2		1					1			
Total	**27**	**21**	**28**	**34**	**24**	**25**	**28**	**21**	**33**			**19**				**37**	

No. PALS contacts received	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	January Total	January Concerns	February Total	February Concerns
***Non CWP**	**6**	**5**	**1**	**5**	**8**	**3**	**4**	**6**	**7**	**6**	**1**	**3**	
*Non CWP	6	5	1	5	8	3	4	6	7	6	1	3	
Corporate Support Services	**0**	**1**	**2**	**1**	**1**	**2**	**0**	**0**	1				
Corporate Support Services		1	2	1	1	2							
East Clinical Services	**7**	**17**	**4**	**4**	**5**	**10**	**6**	**5**	**9**	**24**		**9**	**1**
Adult Mental Health Services East	7	12	4	4	4	8	5	5	6	22		9	1
Child & Adolescent Mental Health Services East		5			1	2	1	0	1	2			
Older Adults Mental Health Services East									2				
West Clinical Services	**11**	**16**	**13**	**8**	**10**	**7**	**6**	**13**	**9**	**16**	**3**	**29**	**2**
Adult Mental Health Services West	9	11	4	4	7	2	2	6	6	12	2	23	1
Child & Adolescent Mental Health Services West		1	1			2	2	1		1			
Older Adults Mental Health Services West						2						1	
Physical Health Services West	2	4	8	4	3	1	2	6	3	3	1	5	1
Wirral Clinical Services	**5**	**6**	**3**	**11**	**6**	**3**	**4**	**5**	**4**	**11**	**2**	**3**	
Adult Mental Health Services Wirral	3	5	3	8	5	2	1	3	3	8	2	2	
Child & Adolescent Mental Health Services Wirral	1			3			2	1		3		1	
Drug & Alcohol Service Wirral	1	1											
Learning Disabilities Services Wirral					1	1			1				
Older Adults Mental Health Services Wirral							1	1					
Total	**29**	**45**	**23**	**29**	**30**	**25**	**20**	**29**	**30**	**58**	**5**	**44**	**3**

No. compliments received	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	January	February
Corporate Support Services	1	0	2	0	0	0	1	0	0	1	0
East Clinical Services	71	34	31	5	87	46	71	9	67	44	93
West Clinical Services	38	48	132	67	59	64	81	107	101	124	43
Wirral Clinical Services	7	14	42	11	83	16	11	36	42	5	49
Total	**117**	**96**	**207**	**83**	**229**	**126**	**164**	**152**	**210**	**174**	**185**
Exceptions outside response times for complaints	**2**	**3**	**2**	**1**	**1**	**4**	**3**	**1**	**2**	**4**	**5**

Experience

There has been an increase in the number of complaints/concerns (formal/informal) received for February compared to January. We have seen a decrease of 24% in the overall number of PALS contacts received during February. When looking at identifiable trends in regards to complaints received this month, the increase is across all levels of complaint. This includes a new Red complaint in relation to our older peoples services in Wirral, which was initially logged through the PALS service. When looking at further trends, physical health West have seen an increase in their Green complaints.

Compared to January:

Red complaints have increased from 0 to 1
Amber complaints have increased from 6 to 9
Green complaints have increased from 11 to 21
Concerns have increased from 2 to 6

Second complaints:

We have received four second complaint during February, which are explained in more detail below;

AM-0214-004	**Physical Health West**	Complaint was re-opened following contact from another Trust who requested information from CWP for their response.
AM-0713-002	**AMH West**	Complaint was re-opened by service user following initial withdrawal of concerns.
GR-0214-011	**AMH East**	Complaint was re-opened following contact from son who remains concerned surrounding clinical care.
AM-0913-005	**AMH East**	Complaint was re-opened following contact from PHSO regarding case review.

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 February's figures, 24 of the 37 complaints were recorded as formal. Of the 37 complaints, 2 were 'withdrawn', 3 were 'upheld', 4 were 'not upheld,' 4 were 'partially upheld,' 2 were 'closed without response' and the remaining 22 are 'on-going'.

Complaints over agreed timescale:

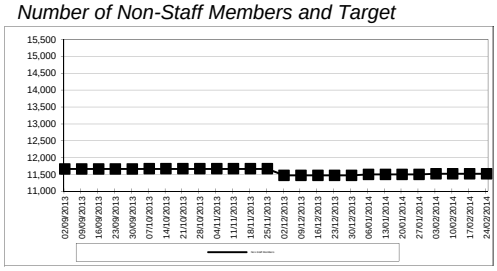
AM-0713-007	**AMH West**	Agreed extension due to difficulties in reaching service user to provide verbal response as requested.
AM-1213-002	**AMH West**	Unagreed extension to timescales due to investigation being delayed within service.
GR-1213-008	**AMH Wirral**	Agreed extension due to difficulties in making contact to feedback response.
GR-0114-004	**AMH Wirral**	Agreed extension due to the need to speak with professional involved to fully respond.
GR-0114-005	**AMH Wirral**	Unagreed extension as new response date not agreed while consultant change was requested.

Compliments

There has been a slight increase in the number of compliments received for February. We are currently awaiting submission from mental health services in West, this will be included within next month's figures.

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

Number of Non-Staff Members and Target

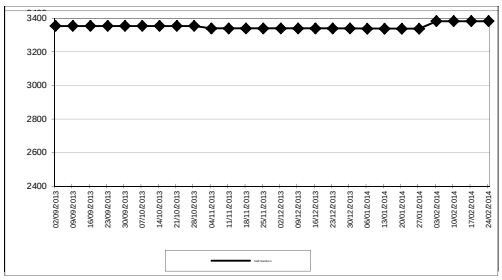


The Trust monitors the number of non-staff members (i.e. general public and service user/carer members) and has an active recruitment programme to increase membership whilst targeting various groups including males, BME, Asian Youth, 11-15 yr age and SU/Carers.
Total current membership (including staff) is 14,897 at the end of February 2014).

Table - 1

Staff Membership

Number of Staff Members

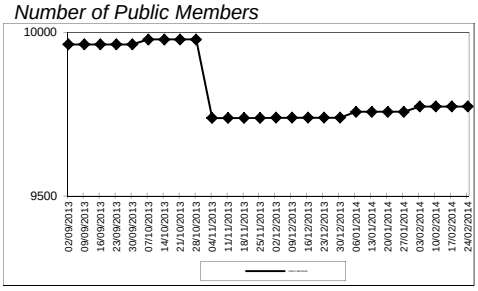


There will normally be little fluctuation in staff membership and variation will come through turnover and opting-out.
Total current staff membership is **3,382** at the end of February (2014).

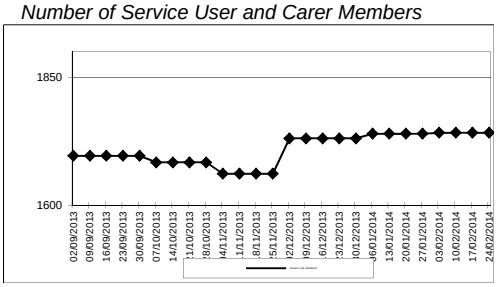
Table - 2

Breakdown of Non-Staff Membership

Number of Public Members



Number of Service User and Carer Members



Communication and Involvement Team
February 2014

Membership
At the end of February 2014, the Trust had 14,897 members

This can be broken down into the following constituencies:

Public –	9,773
Service User / Carer -	1,742
Staff -	3,382
Total	14,897

Recruitment and Selection Interviews:
During February 2014, Involvement Representatives with lived experience of CWP services attended **20** 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 Activities:
Involvement Representatives have also attended the following internal meetings:
1 x Recovery Action Group (RAG) West,
1 x Recovery Implementation Group (RIG) Trustwide
2 x Triangle of Care Meeting West & East
Benefits & Welfare Group
Quality Committee
Peer Support Training
Launch of Triangle of Carer Event
Recruitment & Selection Training
1 x IMROC Meeting London

Unannounced Visits:

Involvement representatives have participated in **4** unannounced visits
Inpatient visits: 1 Wirral & 1 West
Community visits: 1 West & 1 East

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

Governors
This month, Governors have met within their sub committees of the Council of Governors, and they have also been involved in the Annual Planning process. Governors continue to be ambassadors of the Trust liaising with the associated networks of people including the Foundation Trust Governors Association.

The Governors have attended the following:
Triangle of Care Launch event
PLACE Visit
East Cheshire Mental Health Forum

Volunteers
The Trust currently has **194** 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.

At the beginning of January, the Trust started its first peer support training programme which is an 8 week course for service users with long term mental health conditions to use their lived experiences to help others by becoming peer support volunteers. The training for the peer support volunteer roles has gone very well and ended 5th March, The first cohort of delegates are service users with lived experience of inpatient services. The vision is to offer this course again to include community services so that we will have peer support volunteers in all areas of mental health.

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

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: February 2014

External events and meetings attended / supported	No of Attendees	People Recruited
CWP Staff Induction	30	n/a
Cradle to Grave Event, Great Sutton	30	5
Wirral Mind Art Project	10	0
Healthwatch East 1st Anniversary Event	50	5

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document Reference (2013/14/120)

Report to:	**Trust Board of Directors**
Date of Meeting:	**26th March 2014**
Title of Report:	**Code of Governance - Division of Responsibilities – Chair and Chief Executive**
Action sought:	**To note**
Author:	**Louise Hulme, Head of Corporate Affairs/ Company Secretary**
Presented by:	**Louise Hulme, Head of Corporate Affairs/ Company Secretary**

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 an open, progressive organisation that is about care, well-being and partnership

Distribution

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

Executive director sign-off

Executive director (name and title)	Date signed-off
Sheena Cumiskey, Chief Executive	18th March 2014

1. Purpose of the report

To inform the Board on the requirements in the Monitor NHS Foundation Trust Code of Governance in relation to the division of responsibilities between the Chair and the Chief Executive

2. Summary

The Monitor NHS Foundation Trust Code of Governance sets out the requirement for the division of responsibilities for the Chair and the Chief Executive to be set out in writing and approved by the Board of Directors.

3. Content

The responsibilities of the Chair are as follows:

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

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

The responsibilities of the Chief Executive are as follows:

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

4. Recommendations to the Board of Directors

That the Board of Directors approves the division of responsibilities as set out in the Monitor NHS Code of Governance for Foundation Trusts and that this is reviewed on an annual basis.

5. References

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document Reference ()

Report to:	**Records & Information Governance Group/Board of Directors**
Date of Meeting:	**24th January 2014**
Title of Report:	**Annual Information Governance Report**
Action sought:	**FOR DISCUSSION & APPROVAL**
Author:	**Gill Monteith, Trust Records Manager**
Presented by:	**Audrey Jones, Clinical Governance Manager**

Strategic Objective(s) that this report covers:
- Deliver high quality, integrated and innovative services that improve outcomes
- Be a model employer and have a caring, competent and motivated workforce
- Maintain and develop robust Partnerships with existing and potential new stakeholders
- Improve quality of information to improve service delivery, evaluation and planning
- Sustain financial viability and deliver value for money.

Distribution

Version	Name(s)/Group(s)	Date Issued
1.0	Records & Information Governance Group	24th January 2014

Executive director sign-off

Executive director (name and title)	Date signed-off
Tim Welch, Director of Finance, Senior Information Risk Owner. Faouzi Alam, Medical Director, Caldicott Guardian	

Information Governance Annual Report 2013/14

1. Purpose of the report

To brief the Records & Information Governance Group and the Board of Directors on information governance resources, governance, issues, risks and improvement plans undertaken in 2013/14 and planned for 2014/15 and to seek approval for the 2013/14 annual Information Governance Toolkit submission.

2. Summary

The planned Information Governance Toolkit (IGT) submission for 2013/14 achieves a "satisfactory/green" rating and an overall score of 95%, an increase of 2% from base line June 2013 submission. The Trust scored 93% (unsatisfactory/red) for the June 2013 IGT submission. This was as a the result of dropping from level 2 (satisfactory/green) to level 1 (unsatisfactory/red) for clinical coding accuracy for secondary diagnosis. A robust action plan was developed and the Trust scored 94% (satisfactory/green) for the October 2013 IGT submission. A Mersey Internal Audit Agency (MIAA) coding audit in October 2013 showed that secondary diagnosis accuracy was 10.2%. The requirement for the IGT level 2 is 75%. The Trust temporarily employed a qualified clinical coder during January and February 2014 to quality check the secondary diagnosis codes. MIAA undertook a further audit in early March 2014 ready for the March 2014 IGT submission. The preliminary report has stated that compliance is showing at 98% for primary diagnosis and 89.8% for secondary diagnosis which is a rise of 79.6%. This has resulted in the overall submission rising from 94% to 95%. All other areas of the toolkit are compliant and level 2/3. See appendix A for the planned March 2014 IGT submission which will be 95% (green/satisfactory).

Mersey Internal Audit Agency are currently undertaking an annual assessment of the Trust's IGT scores and supporting evidence. See appendix B for the terms of reference.

Analysis of information governance incidents indicates that mis-directed post accounts for almost a third of incidents reported. As a result, the need to check patient details i.e. correct addresses has been emphasied in staff briefings and information governance face to face training delivered. Incidents of lost records continue to be of concern and staff have been reminded of the need to use the case note tracking system correctly. Incidents of mis-directed faxes have reduced dramatically. None of the incidents reported required external notification to the Department of Health, Information Commissioner's Office or Monitor.

3. Information Governance Briefing

Information governance is the framework of organisational culture, communication, policies and procedures which ensure the security, validity, availability and accuracy of its clinical and corporate information. It is driven by a framework of legislation, national and international standards and good practice guidelines and is particularly impacted by the rate of technological change which requires the compliance framework in which the Trust operates to be regularly updated.

Compliance with information governance standards is annually assessed through the completion of the Information Governance Toolkit, hosted by NHS Information Centre

The information governance toolkit submission is examined by the Trust's regulators: The Care Quality Commission (CQC) include the toolkit assessment in the Trust's Quality & Risk Profile (QRP), while the foundation trust regulator, Monitor, consider the toolkit when assessing the foundation trust's governance risk rating.

4. Information Governance 2013/14 and 2014/15

Review of Information Governance Workplan 2013/14

A key priority for the 2013/14 work plan was to develop a robust action plan to address the failure to achieve a satisfactory IGT score for clinical coding. A mandated field for secondary diagnosis was introduced onto the Carenotes system in May 2013. The requirement to collect and record secondary diagnosis was communicated to all medical staff and secondary diagnosis performance was added to the weekly data quality dashboards.

Mersey Internal Audit Agency undertook a clinical coding audit in October 2013. The draft report showed that the accuracy of secondary diagnosis coding was 10.2%. The IGT requirement for level 2 is 75%. The Trust temporarily employed a qualified clinical coder during January and February 2014 to quality check the secondary diagnosis codes. MIAA agreed to undertake a further audit in early March 2014 ready for the March 2014 IGT submission. The preliminary report has stated that compliance is showing at 98% for primary diagnosis and 89.8% for secondary diagnosis which is a rise of 79.6%. This has resulted in the overall submission rising from 94% to 95%. A clinical coding policy has been developed and will be considered at the Records & Clinical Systems Group (RCSG).

The targets in the 2013/14 information governance work plan have largely been met. The compliance team have refreshed all policies which have been uploaded to the toolkit. The Trust scored 94% (satisfactory/green) for the October 2013 IGT submission.

The following annual audits have all been undertaken:

- Patient survey
- Staff survey
- Data protection audit (transfers of data outside of UK)
- Corporate records audit

Information asset owners undertook their annual reports for the SIRO during January 2014. This included all transfers of hardcopy and digital person identifiable and sensitive information being identified, mapped and risk assessed.

The ICT Acceptable Usage Policy *(AUP*) has been reviewed and as a result ICT will be implementing the following configuration changes:

- Network password length will be increased from a minimum of 6 characters to 8 characters, in line with a recent audit undertaken by MIAA.
- Client Firewalls will be activated when a Trust mobile device is connected to third party networks.

These measures are anticipated to be implemented by the end of March 2014.

A priority for this year has been to develop Quality dashboards, ensuring the data which populates the dashboards is of the highest quality. The quality dashboards measure on-going compliance against quality indicators and enable managers within localities to review performance and target areas of improvement required. These are reported to the Quality Committee every two months by the Service Directors and Clinical Directors representing each locality in CWP.

Information Governance Toolkit 2013/14

To achieve a satisfactory/green Information Governance Toolkit (IGT) rating, ALL requirements must achieve at least level 2.

Information Governance Annual Report 2013/14

In recent years, following national guidance, Mersey Internal Audit Agency (MIAA) have completed an annual IG Toolkit review of scores and evidence uploaded to the toolkit. The last report detailed that the Trust were not meeting the level 2 requirements or the score could not be substantiated in 5 cases at the time of the review, this was largely due to actions being underway but not completed or reported to committee, including the clinical coding concerns. However MIAA gave a **significant assurance** opinion on the information governance toolkit evidence.

A robust action plan was developed which outlined that carenotes would be developed with a mandated field to collect secondary diagnosis data and a clinical coding policy would be developed to outline the requirements for the collation of diagnosis data. The policy and requirement to collect and record secondary diagnosis would be communicated to all medical staff by the end of May 2013. Clinical coding was added to the weekly data quality dashboards, a coding policy has been developed and the Trust temporarily employed a qualified clinical coder during January and February 2014 to quality review the secondary diagnosis codes. The preliminary report has stated that compliance is showing at 98% for primary diagnosis and 89.8% for secondary diagnosis which is a rise of 79.6%. This has resulted in the overall submission rising from 94% to 95%.

In addition to the above MIAA made the following recommendations:

- As part of the improvement cycle to broaden the scope of and formalise in-house auditing and compliance checking regimes which are supported by external assurances (such as MIAA report)
- The Trust need to consider how it will manage the inherent risks as staff leave, change roles and internal processes adapt, to ensure that on-going Information Governance processes are not disrupted, undermined or compromised leading to breaches of legislation, NHS policy or procedures.
- Consideration for further enhancement of the evidence collation and validation process should be given as there were instances were the evidence provided was not relevant, immediately available or did not meet the criteria for all levels of the scores declared.

The above recommendations were incorporated into the 2013/2014 work plan and were driven as part of the corporate governance meeting review and corporate service redesign. A number of work programmes have been completed to address the recommendations made. Such improvements have strengthened the evidence collation and provide sufficient assurance that the trust is able to manage any inherent risks relating to changes within the workforce or work processes. The evidence collation process has been significantly refreshed during the last quarter to ensure that evidence is contemporaneous and meets the requirements of the toolkit.

MIAA are undertaking a further review of the Trust's IGT scores and evidence. See appendix B for the terms of reference.

See appendix A for the planned March 2014 IGT submission which should be 95% (green/satisfactory).

Information Governance Work Plan 2014/15
The focus of the Trust's work plan for 2014/15 will be the maintenance of all level 3 information governance toolkit requirements and the improvement of scores at level 2 to level 3.

The Trust will continue to progress the work to increase the quality of clinical coding.

Policies and Procedures – policy review remains an on-going process and will be reviewed in line with clinical pathway development and in line with the clinical effectiveness strategy. Policies will also be in reviewed in line with the new policy review process to ensure they are clear, concise and easily accessible to all staff.

Awareness and Training – while the majority of information governance training is delivered through e-learning, requests for greater choice in delivery, and significant under-reporting from the national NLMS system, resulted in a number of face to face sessions which meet the requirements of the toolkit being undertaken. The use of a handbook for manual completion has also been used. Additional training opportunities were very well received and a choice of training methods will continue to be offered in 2014/15.

Upgrade to ICT Disaster Recovery facilities and Backup systems – after a review of the existing ICT Disaster Recovery (DR) facilities and Backup systems, ICT intend to implement upgrades to those systems to strengthen DR facilities and reduce return of service recovery times. MIAA recently undertook an audit of the Trust ICT DR and backup facilities and have stated that proposed upgrades would deliver significant assurance for ICT service continuity. Subject to resourcing, the upgrades are anticipated to be completed by June 2014.

Data quality – this remains a key focus for the Trust, monitoring through the production of a weekly data quality dashboard, performance reviews, and a suite of data quality reports available on demand and on subscription have seen the Trust maintain its compliance with regulatory targets. Good data quality is a pre-requisite for the right patient information being available at the right time to all staff involved in providing care, effective reporting of Payment by Results and more outcome-focussed targets. Targeted action programmes are implemented to support staff in enhancing and maintaining data quality. This will also triangulated as part of the learning from incidents and feedback from compliance checks.

See appendix C for 2014/2015 work plan.

Review of Information Governance Incidents 2013/14

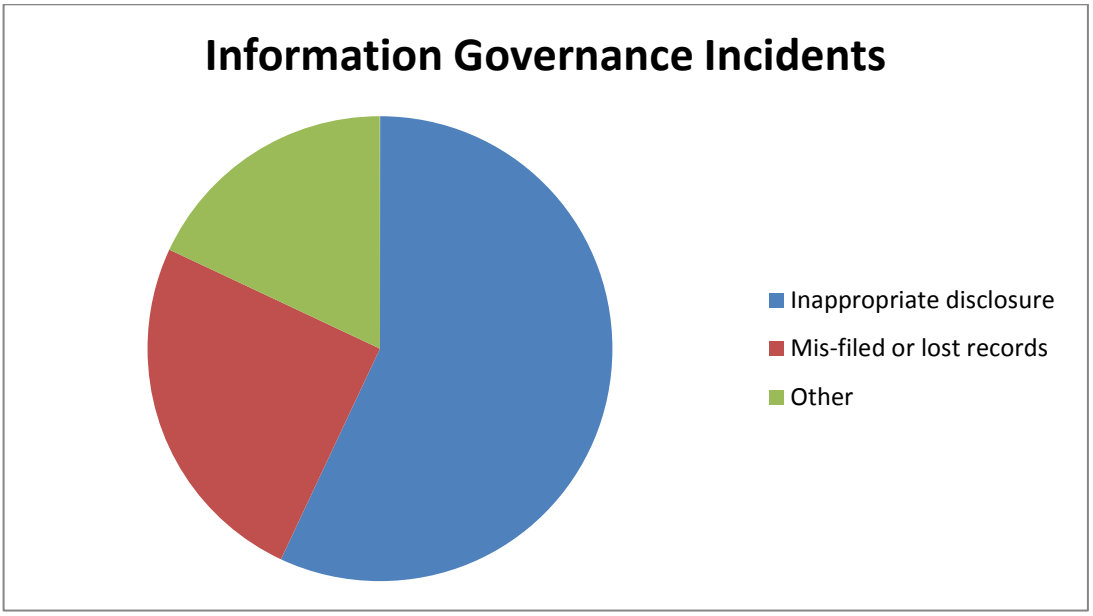
Data on information governance incidents and near misses were provided for the first 3 quarters of 2013/14 as reported on the Trust's Datix risk and incident reporting system. Overall information governance incidents have decreased significantly compared to the first 3 quarters of the previous year. There were 80 information governance incidents reported in 2013/14 compared to 106 the previous year which is a decrease of 26%.

Of the 80 incidents reviewed, incidents of inappropriate disclosure (eg wrongly addressed, wrongly delivered, sent to wrong email, information left on view, disclosure of PID in attachments, verbal disclosure) accounted for over 50% of incidents (45 in total). There were also 19 incidents of lost or mis-filed records reported which is an increase of 15.3% compared to the previous year. Other incidents reported were `potential breaches' or near misses, these included a lost smart card, information left on photocopies, boxes with records in left in corridor, information found in car parks and confidential waste bins not emptied.

Incidents of mis-directed faxes have reduced dramatically with only 1 reported compared with mis-directed faxes accounting for the second highest cause of information governance incidents in the previous year.

None of the incidents reported required external notification to the Department of Health, Information Commissioner's Office or Monitor.

Fig 1. Information Governance Incidents



Analysis of the incidents indicates inappropriate disclosure (e.g. wrongly addressed, wrongly delivered, sent to wrong email, information left on view, disclosure of PID in attachments, verbal disclosure) accounted for over 50% of incidents. As a result, the need for staff to be vigilant has been emphasied in staff briefings and information governance face to face training delivered. Incidents of lost records continue to be of concern and staff have been reminded of the need to use the case note tracking system correctly.

Information Risk Management Approach
CWP has access to a number of sources of information, guidance and assurance concerning information governance. NHSIC (Information Centre) maintains a comprehensive library of exemplar materials supports the information governance toolkit and provides guidance on ethics and the health and social care record guarantees. The Information Commissioner's Office provides guidance on the Data Protection and Freedom of Information Acts and the Environmental Information Regulations.

Audit opinions are provided by both external and internal audit and the Trust incorporates mandatory information governance audit within its annual audit programme.

CWP takes a risk-based approach to information governance – evaluating incidents and being appraised of potential gaps in assurance. It should be noted that compliance with the requirements of the information governance toolkit does not necessarily imply that there are no areas of risk within an organisation, the toolkit cannot accommodate every eventuality and therefore organisations are urged to consider their level of risk in collecting, processing, disclosing and disposing of data. The Compliance, Assurance and Learning sub committee are responsible for monitoring overall compliance with Information Governance principles and in turn escalate any risks to Quality Committee or Operational Board.

Lesson learned from investigations and reviews are incorporated into training materials, communication notices and policy as appropriate.

Assessment of Information Governance Arrangements
Information governance arrangements have been reviewed during 2013/14 firstly against the latest version of the information governance toolkit, and then against guidance released throughout the

year. Incident analysis shows a lower number of information governance incidents and near misses reported compared to the previous year, this together with maintaining a "satisfactory/green" information governance toolkit rating supports the case that **current information governance arrangements within Cheshire & Wirral Partnership are appropriate and fit for purpose**.

5. Recommendations to the Records & Information Governance Group/Board of Directors

a. That the Board approves the statement that current information governance arrangements are fit for purpose
b. That the Board approves the submission of the 2013/14 information governance toolkit.
c. That the Board the information governance work plan for 2014/15

6. References

1. Information Governance Toolkit
https://nww.igt.connectingforhealth.nhs.uk/

Information Governance Annual Report 2013/14

Appendices

A. Cheshire & Wirral Partnership Information Governance Toolkit Planned Submission – March 2014

Req No	Description	Status	Attainment Level
Information Governance Management			
10-101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	Confirmed Complete	Level 3
10-105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	Confirmed Complete	Level 3
10-110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	Confirmed Complete	Level 2
10-111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	Confirmed Complete	Level 3
10-112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	Confirmed Complete	Level 3
Confidentiality and Data Protection Assurance			
10-200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	Confirmed Complete	Level 3
10-201	Staff are provided with clear guidance on keeping personal information secure and on respecting the confidentiality of service users	Confirmed Complete	Level 3
10-202	Personal information is only used in ways that do not directly contribute to the delivery of care services where there is a lawful basis to do so and objections to the disclosure of confidential personal information are appropriately respected	Confirmed Complete	Level 3
10-203	Individuals are informed about the proposed uses of their personal information	Confirmed Complete	Level 3
10-205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	Confirmed Complete	Level 3
10-206	There are appropriate confidentiality audit procedures to monitor access to confidential personal information	Confirmed Complete	Level 3
10-207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	Confirmed Complete	Level 2
10-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	Confirmed Complete	Level 3
10-210	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	Confirmed Complete	Level 3
Information Security Assurance			
10-300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	Confirmed Complete	Level 3

10-301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	Confirmed Complete	Level 3
10-302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	Confirmed Complete	Level 3
10-303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	Confirmed Complete	Level 3
10-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	Confirmed Complete	Level 3
10-305	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	Confirmed Complete	Level 3
10-307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	Confirmed Complete	Level 3
10-308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	Confirmed Complete	Level 2
10-309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	Confirmed Complete	Level 3
10-310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	Confirmed Complete	Level 3
10-311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	Confirmed Complete	Level 3
10-313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	Confirmed Complete	Level 3
10-314	Policy and procedures ensure that mobile computing and teleworking are secure	Confirmed Complete	Level 2
10-323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	Confirmed Complete	Level 2
10-324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	Confirmed Complete	Level 2
Clinical Information Assurance			
10-400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	Confirmed Complete	Level 3
10-401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	Confirmed Complete	Level 3
10-402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	Confirmed Complete	Level 3
10-404	A multi-professional audit of clinical records across all specialties has been undertaken	Confirmed Complete	Level 3
10-406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	Confirmed Complete	Level 3

Secondary Use Assurance			
10-501	National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as standards develop	Confirmed Complete	Level 3
10-502	External data quality reports are used for monitoring and improving data quality	Confirmed Complete	Level 3
10-504	Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained	Confirmed Complete	Level 3
10-506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	Confirmed Complete	Level 3
10-507	The Completeness and Validity check for data has been completed and passed	Confirmed Complete	Level 3
10-508	Clinical/care staff are involved in validating information derived from the recording of clinical/care activity	Confirmed Complete	Level 3
10-514	An audit of clinical coding, based on national standards, has been undertaken by a NHS Classifications Service approved clinical coding auditor within the last 12 months	Confirmed Complete	Level 3
10-516	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national standards	Confirmed Complete	Level 2
Corporate Information Assurance			
10-601	Documented and implemented procedures are in place for the effective management of corporate records	Confirmed Complete	Level 3
10-603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	Confirmed Complete	Level 3
10-604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	Confirmed Complete	Level 3

B Mersey Internal Audit Agency Information Governance Toolkit Assessment Terms of Reference

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C Information Governance work plan 2014/2015

IGT work plan 1415v2.doc