Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting of the Foundation Trust Board of Directors

Wednesday 28th May 2014 at 1.30pm

Boardroom, Redesmere

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
14/15/01	Apologies for absence	Receive apologies	Verbal	Chair	1 min (1330)
14/15/02	Declarations of interest	Identify and avoid conflicts of interest	Verbal	Chair	1 min (1331)
14/15/03	Minutes of the previous meeting held 26th March 2014	Confirm as an accurate record the minutes of the previous meetings	Written minutes	Chair	3 mins (1332)
14/15/04	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 (1335)
14/15/05	Business Cycle 2014/15	Confirm that agenda items provide assurance that the Board is undertaking its duties	Written Report	Chair	2 mins (1340)
14/15/06	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	5 mins (1342)
14/15/07	Chief Executive's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	5 mins (1347)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
Assurance: Quality/ Effectiveness/ Experience/ Safety					
14/15/08	Board Assurance Framework and Risk Register	To note current Board Assurance Framework and Risk Register	Written Report	Medical Director	10mins (1352)
14/15/09	Q4 Infection Prevention and Control report	To receive the Q4 report	Written Report	Deputy Director of Nursing/ Infection, Prevention and Control	10mins (1402)
14/15/10	Quality Report Q4	To receive the Q4 report	Written Report	Medical Director	10 mins (1412)
14/15/11	Learning From Experience Report	To receive the Learning from Experience report	Written Report	Director of Nursing, Therapies and Patient Partnership	15 mins (1422)
Strategy and Planning					
14/15/12	Update on development of the 5 year Strategic Plan	To update the Board on progress with development of the 5 year strategy	Verbal	Director of Finance	10 mins (1437)
Assurance: Governance					
14/15/13	Monitor Quality Governance and Provider Licence self-assessment 2013/14	To note the results of the self-assessment for compliance	Written Report	Director of Finance	10 mins (1457)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
14/15/14	Approve Integrated Governance Framework including revised Corporate Governance Structure	Approved revised framework	Written Report	Medical Director	10 mins (1507)
14/15/15	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	10 mins (1517)
14/15/16	Any other business	Consider any urgent items of other business	Verbal or written	Chair/ All	5 mins (1527)
14/15/17	Review of meeting	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair/All	5 mins (1532)
14/15/18	Date, time and place of next meeting: Wednesday 30th July, 1.00pm at Romero Centre, Macclesfield	Confirm arrangements for next meeting	Verbal	Chair	2 mins (1537)

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Minutes of the Board of Directors Meeting
Wednesday 26th March, Romero Centre, Brooklands Avenue, Macclesfield
commencing at 1.00pm

PRESENT	David Eva, Chair Dr Faouzi Alam, Medical Director Effectiveness & Medical Workforce Fiona Clark, Non-Executive Director Lucy Crumplin, Non-Executive Director Avril Devaney, Director of Nursing, Therapies & Patient Partnership Mike Maier, Deputy Chair and Non-Executive Director Stephen McAndrew, Non-Executive Director and Senior Independent Director Dr Anushta Sivananthan, Medical Director Compliance, Quality & Assurance Andy Styring, Director of Operations Tim Welch, Director of Finance & Deputy Chief Executive	
IN ATTENDANCE	Julie Critchley, Service Director Cheshire West Locality Louise Hulme, Head of Corporate Affairs (inc. CoSec) Maria Nelligan, Deputy Director Nursing (for item 13/14/117)	
APOLOGIES	Sheena Cumiskey, Chief Executive Ron Howarth, Non-Executive Director	
	MINUTES	**ACTION**
13/14/106	**WELCOMES AND APOLOGIES FOR ABSENCE** The Chair welcomed everyone to the meeting. Apologies were noted. The meeting was quorate.	
13/14107	**DECLARATIONS OF INTEREST** There were no interests declared.	
13/14/108	**BOARD MINUTES- MEETING OF 29th January 22014** The minutes of the meeting held on 29th January 2014 were **approved** as a correct record.	
13/14/109	**MATTERS ARISING AND ACTION POINTS** 13/14/95 - Action Completed. 13/14/95 - Action Completed.	
13/14/110	**BOARD MEETING BUSINESS CYCLE 2013-14 AND 14/15** The business cycles for 2013/14 and 2014/15 were noted.	

13/14/111	**CHAIR'S ANNOUNCEMENTS** The Chair informed the meeting that; Norman Lamb, the Minister of State for Care and Support visited the integrated care team Princeway Health Centre in Frodsham. The Minister spent time meeting the team, followed by a round table discussion about integrated care in Cheshire. There will be another Tea and Talk session for governors, members, staff and the public on Thursday 24th April at the Stein Centre, Wirral. Details are available on the website The Trust has appointed new locality clinical directors, Rashmi Parhee, for Wirral locality, Mahesh Odiyoor, West locality, and Matthew Howard, East locality. The Chair extended a warm welcome to the new clinical directors.	
13/14/112	**CHIEF EXECUTIVE'S ANNOUNCEMENTS** Tim Welch, Deputy Chief Executive informed the Board that: The CQC have recently undertaken an unannounced visit to Greenways. This had been a positive visit and the unit was fully compliant with all standards. We are now awaiting the final draft report and this will be circulated to Board members once received. Health and Well-being Boards are responsible for the Better Care Fund and plans are now at the final stage with submission due on 4th April 2014. CWP are fully involved in this going forward. There will be no dramatic changes in 2014/15 but moving further ahead, the Better Care Fund should reflect a community focus on delivery of services. Avril Devaney, Director of Nursing, Therapies and Patient Partnership has received an Honorary Masters from University of Chester in recognition of her work in health services.	
13/14/113	**Q3 Infection Prevention and Control (IPC) report** Maria Nelligan introduced the report highlighting the key points. There have been no outbreaks or incidents in Q3. The IPC team have been working with involvement reps to enhance service user and carer involvement in the IPC programme going forward. Maria Nelligan reported that there had been two MRSA incidents in West Cheshire; however these were not related to CWP services. Work is ongoing in care homes regarding prevention and reactive work against infections in the community. This service is due to be re-tendered in the coming weeks. There is a need to consider whether CWP wish to re-tender for this service.	

	Regarding the annual flu campaign, Maria Nelligan informed that a report is due to be provided to April Operational Board setting out the detail around the operational delivery of the campaign. Maria Nelligan extended her thanks to the IPC team for their work in delivering the vaccination programme to staff and patients during last campaign. Stephen McAndrew queried whether there was outcome data from the flu campaign to try and identify if there have been any reduction in number of flu cases. Maria Nelligan informed that this was not available at this time but confirmed there have been no inpatients with influenza at any time. There are cases of flu amongst community patients, but this information is not collected. Stephen McAndrew commented that it would be good to see outcomes from the campaign. Maria Nelligan informed that discussions are ongoing to look at how the campaign is presented and the need to identify outcomes from the campaign. The 2012 campaign was more successful than in 2013 so there is additional learning to build in from this too. Fiona Clark queried the support to local schools. Maria Nelligan confirmed that this is in place via the health protection pathway. More details will be provided on this work in the Q4 report. The Board **resolved** to **approve** the report.	
13/14114	**REVIEW OF HEALTH SERVICES FOR LOOKED AFTER CHILDREN AND SAFEGUARDING IN CHESHIRE WEST AND CHESTER** Avril Devaney presented the report provided to the Board for information. Board members were reminded that a CQC review was undertaken in January 2014. This was the first review of this type under the new regime. Following the inspection, the local authority was given an inadequate rating, partly due to the response to health assessments for looked after children. An action plan has been developed and is now in final draft form. This will be provided to the CQC. Drawing attention to the report, Avril Devaney advised that the next steps with this process were outlined on back page of the report. The monitoring of actions will be undertaken via the Trust-wide Safeguarding Group reporting to Quality Committee and any learning will be cascaded through the organisation. The Board noted the acknowledgement of the CWP CAMHS nurse noted as exceptional within the report. David Eva queried the length of time for people in CAMHS to get an IAPT appointment and whether this is actually an issue for commissioners, regardless of how we reconfigure systems to try and improve waiting times. Avril Devaney commented that this is the case and this review has focussed attention on this issue for CAMHS services. The Board **resolved** to **approve** the report.	

13/14/115	**COMMUNITY SERVICES IMPROVEMENT PROGRAMME - PROGRESS WITH THE CONTINUOUS EVALUATION PROGRAMME** Andy Styring presented the report and updated the Board on the CSIP evaluation process. The January Board of Directors agreed to undertake evaluations in east and west Cheshire localities based on those already undertaken in Wirral. These evaluations are still to take place. The West Cheshire events will take place this week with a further two evaluation events in April 2014. East Cheshire locality is still to confirm dates but these will be finalised shortly. David Eva queried who would attend the evaluation session and whether they would involve governors. Andy Styring advised that it would be CMHT service users mainly attending, however governors are welcome to attend if they wish to and that the Service Directors will offer this opportunity to governors should they wish to be involved. Andy Styring apologised for the delay in finalising the locality evaluations, however this was due to practical issues and the view taken by the Operational Board was that it was better to take more time to properly arrange these events in order to enable a fuller evaluation to take place. Dr Anushta Sivananthan commented that a range of issues had been looked at during the events, these included how timely reviews are, ensuring care plans are in place and patient safety and experience issues. Fiona Clark queried how the Board would be assured that services are better. Dr Faouzi Alam commented that outcome measures are needed for individuals and that this is a developing picture. Tim Welch commented that the premise is that the Trust wants to continuously improve services, but there is a need to improve the ways we capture and report outcomes. The Board noted that a further report would be provided to the May 2014 Board meeting. The Board **resolved** to **note** the report.	
13/14/116	**BOARD ASSURANCE FRAMEWORK AND RISK REGISTER** Dr Anushta Sivananthan introduced the report which set out the updates to the strategic risk register and the board assurance framework and reminded Board members that scrutiny of this report had been undertaken in the March Quality Committee. Dr Anushta Sivananthan advised that no new risks had been added to the strategic risk register. The dual recording keeping risk has been re-scored to reflect the recent CQC inspection and reported that the IT enabled workstreams are now progressing improvements in this area.	

	Dr Anushta Sivananthan advised that 4 risks had been archived. These were the risks around unconfirmed entries on care-notes, the pharmacy risk around medicine temperatures, the PBR tariff risk and the patient ID policy risk. The Board were updated on the current work to identify target risk scores and timeframes for achievement for all risks. The Board **resolved** to **approve** the report.	
13/14/117	**PROGRESS REPORT ON THE IMPLEMENTATION OF THE WARD NURSING STAFFING REVIEW** The Chair welcomed Maria Nelligan to the meeting to present the report. Maria Nelligan reminded Board members that the ward staffing review had been undertaken in two phases. This involved looking at minimising bank usage as part of sustainability plans and the need to look at the staffing skills mix and culture across in-patent areas. The Board were advised that work has started to recruit to the new posts. A programme board is being established to oversee all of the work streams. This is supported by a recently appointed programme manager. The programme board will report progress on delivery to the Board. Maria Nelligan advised that by the end of June 2014, the Board will receive six monthly staffing reports on ward staffing capacity and capability. These reports will require the Board to consider and discuss staffing levels in public and agree any actions required. The report must also be available on the Trust website and accessible on NHS choices. Staffing levels on all wards must be published by the end of June 2014. This must include information on planned staffing levels split by registered and non-registered staff, their specific roles and the Trust's actual staffing levels on a shift by shift basis. NHS England will be asking all Trusts to complete two benchmarking surveys to identify their progress towards this in April and May 2014. From the end of June 2014, monthly reports to the Board will be provided setting out staffing levels. These will include information on any shortages and any impact on quality of patient care. They will also include information on risk, any required actions and mitigations. Maria Nelligan reported that Andy Styring is the Executive sponsor for work due to operational focus. Avril Devaney, Director of Nursing will provide the reports to the Board. David Eva queried the cost implications of increased staffing levels and whether the finances are in place and have they been factored into the financial projections for 2014/15. It was confirmed that a significant proportion of the cost of the new staff would be covered by the current spend on bank staff. A discussed ensued on whether HR process could be expedited to enable the Trust to get people into post quickly especially in light of the	

	fact that other Trusts could potentially be competing for the same staff. This may be a particular issue in east Cheshire. Maria Nelligan informed of the developments around the enhanced training for healthcare assistants and the development of a career pathway for these roles. Work is already ongoing around developing team and ward manager training to support with improving the clinical and leadership focus. Dr Anushta Sivananthan expressed disappointment regarding the National Quality Board (NQB) focus on nursing staff only rather than multi-disciplinary staff given CWP's focus on developing wider multidisciplinary teams. Maria Nelligan informed that the CWP review included the full multi-disciplinary teams and looked at staffing numbers across all clinical disciplines. Lucy Crumplin commented that the review has highlighted to the Board the reliance on bank staff, and requested assurance that this practice has shifted. Avril Devaney commented that the drive is to enable the Board to be more informed about what is happening in inpatient areas. The six monthly reports will highlight the progress being made. Tim Welch commented that bank staff usage is currently being covered recurrently so this resource is available to fund the increased staffing levels. The programme board needs to set out the optimum service level models going forward. There will be a need to look at any further investment requirements for 15/16 planning. Avril Devaney commented on the need to ensure that the information is presented in a meaningful way for members of the public and staff. Andy Styring commented that the presentation of the information also needs to indicate what the optimum levels are, what the required staffing levels are and what is supernumerary, to ensure understanding what safe care levels are. The Board **resolved** to **approve** the report.	
13/14/118	**TRUST OPERATIONAL PLAN 2014/16** Tim Welch introduced the draft Trust Operational Plan document and advised that this is a Trust template incorporating the information required for the Monitor submission in order to provide a more useful plan for the Trust. Tim Welch reminded the Board that this submission forms part 1 of the two submissions required to Monitor this year. The Operational Plan sets out the Trust's plans for 2014-16 with the Strategic Plan setting out the 5 year picture with the outer three year detail and assessments. The Strategic Plan will be presented to the Board in June 2014. The Operational Plan 2014/16 will be submitted to Monitor on 4th April 2014. Any Board members wishing to add comments are welcome to do so ahead of the deadline.	

	The Board **resolved** to **approve** the Trust Operational Plan 2014/16 and the delegated responsibility to submit the Plan to Monitor on behalf of the Board of Directors.	
13/14/119	**CORPORATE PERFORMANCE REPORT - FEBRUARY 2014** Tim Welch introduced the report and requested any questions or comments. There were no further questions as these had been discussed during the closed meeting. The Board **resolved** to **approve** the report.	
13/14/120	**CHAIR AND CHIEF EXECUTIVE DIVISION OF RESPONSIBILITIES** Louise Hulme introduced the report to inform the Board of 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. It was confirmed that this document reflects the delegated responsibilities as set out the in Corporate Governance Manual. The Board **resolved** to **approve** the report.	
13/14/121	**INFORMATION GOVERNANCE ANNUAL REPORT** Tim Welch introduced the report which presented performance around information governance and the IG toolkit submission. It was identified that IG performance has improved significantly but that there is a continued need to continue to improve further. Tim Welch reminded Board members that they are required to approve the statement of assurance that IG arrangements are fit for purpose and advised that external assurance had been obtained to verify processes in place. The Board **resolved** to **approve** the report.	
13/14/1222	**REVIEW OF RISK IMPACTS OF ITEMS DISCUSSED** There were no further risk areas identified.	
13/14/123	**ANY OTHER BUSINESS** Dr Anushta Sivananthan reported on the Health Minister Jeremy Hunt's policy launch on reducing patient safety incidents. The Board received and approved the Trust's zero harm approach in January 2014 so the Trust is well placed to support the government initiatives.	

13/14/124	**REVIEW OF MEETING** It was agreed that the meeting had undertaken the required business effectively. The Chair invited comments from the public gallery on any observations they wished to share.	
13/14/125	**DATE, TIME AND PLACE OF NEXT MEETING** Wednesday 28th May 2014, 9.30am, Trust Boardroom, Redesmere.	

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Action points from Board of Directors Meetings
28th May 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~~ June 2014	ASt	Locality evaluations underway - Board to receive evaluation report at June meeting.	Outstanding
26th March 2014 - No Actions Arising						

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

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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
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(Document Reference 2014/15/08)

Report to:	**Board of Directors – meeting in public**
Date of meeting:	**28 May 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	15.05.2014
2	D Wood to L Hulme for Board of Directors	16.05.2014

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 7 May 2014. The Audit Committee, at its May 2014 meeting, undertook a scenario testing exercise relating to the risk around terms of authorisation/ licence conditions based on findings from the Eastway inspection findings in 2012. 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 Jan 2014	Residual risk rating March 2014	Residual risk rating May 2014	Risk score since last review	Summary risk treatment plan
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 with recommendations identified to address the risk which is being taken forward by a physical healthcare network reporting to the Patient Safety & Effectiveness Sub Committee. **The physical healthcare network reported to the February 2014 meeting 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. Patient Safety and Effectiveness Sub Committee to continue to receive assurances on progress towards target risk score from the network group.**
Lack of robust ligature management programme within the Trust may result in harm to patients with associated	20	20	20	↔	Board approved the capital programme in May 2013. Updates provided to September 2013 Quality Committee and November 2013/ January 2014 Operational Boards.

Description of the risk	Residual risk rating Jan 2014	Residual risk rating March 2014	Residual risk rating May 2014	Risk score since last review	Summary risk treatment plan
reputational and financial impact on the organisation					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 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. May 2014 Quality Committee received assurances that all actions on track for completion by August 2014 as agreed.**
Adults, children and young people are not protected through practitioners not implementing safeguarding practice and principles	**20**	**20**	**16**		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-**

Description of the risk	Residual risk rating Jan 2014	Residual risk rating March 2014	Residual risk rating May 2014	Risk score since last review	Summary risk treatment plan
					model the risk to reflect the action plan received following the CQC inspection of safeguarding that took place week commencing 20 January 2014. Risk has been remodelled considering the positive outcome of the West Cheshire CQC inspection of safeguarding for looked after children. Training is currently at 90% compliance Trustwide and attendance has been at 80% and over for the last 12 months. In addition there is continuous monitoring of safeguarding practice through the Trust's unannounced compliance visits, safety metrics programmes, CQC visits, and practice audits. The Trust is providing the monthly safeguarding assurance framework to each CCG for both adult and children's services. Target risk score of 12 will be suggested to the next Trustwide safeguarding meeting.
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	**20**	**20**	**16**	↓	The risk treatment plan was provided to the February 2014 meeting of the Patient Safety & Effectiveness Sub Committee and March 2014 meeting of the Quality Committee. Risk owner did not present the risk treatment plan, assurance report requested by Quality Committee Chair to assure the Board of Directors. A pressure ulcer action group has been established to take forward actions to reduce the risk to an acceptable target risk. Audit results are demonstrating that the care being delivered is evidence based and standards have improved. **The Board of Directors received the assurance report via the Quality Committee at the March 2014 meeting. This detailed the risk score has been re-modelled to 16 to reflect improvements. A risk target score of 12 aspiration for achievement by November 2014.**
The inability of staff to manage the occurrences of slips, trips and falls of patients, resulting in patient	**20**	**20**	**16**	↓	FallSafe care bundle is in place across all wards. Patient Safety and Effectiveness Sub Committee has approved a risk

Description of the risk	Residual risk rating Jan 2014	Residual risk rating March 2014	Residual risk rating May 2014	Risk score since last review	Summary risk treatment plan
injury					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. Initial risk score target of 15 agreed, however has been remodelled by the risk owner and 12 is achievable. Action plan is being implemented by a task and finish group and is reviewed routinely by the Patient Safety and Effectiveness Sub Committee. Risk re-modelled to 16 to reflect progress.**
Risk of harm to patients due to CARSO risk assessment not being completed as per policy	**16**	**16**	**16**	↔	Completion and quality 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 CPA/ effective lead underway – who will look at developing care plan training and**

Description of the risk	Residual risk rating Jan 2014	Residual risk rating March 2014	Residual risk rating May 2014	Risk score since last review	Summary risk treatment plan
					guidance. Recent data quality report indicates a 90% CARSO completion rate. Further assurance needed on quality of CARSO assessments prior to re-modelling. The main priority is ensuring services reach and sustain over 99% completion rates. Audit on a case by case basis in September 2014 where no completed CARSO summary to understand what might be the individual clinician or managerial issues preventing completion. Further development of guidance on the CARSO summarised review of risk will be rolled out as feedback from frontline staff continues to come in and it becomes routinely used. This will ensure all staff are supported in understanding how to use it best to promote safety, quality and recovery in CWP services.
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. Ward staffing review presented to and recommendations agreed by Operational Board and Board of Directors in January 2014 and an update**

Description of the risk	Residual risk rating Jan 2014	Residual risk rating March 2014	Residual risk rating May 2014	Risk score since last review	Summary risk treatment plan
					provided in March 2014. Programme lead now identified. Publication of staffing establishment levels on website from 1 April 2014. Target risk score to be identified.
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 (MEL) programme presented and approved by October 2013 Operational Board. Implementation plan in development which will be monitored to inform risk treatment plan on an ongoing basis. **Further update provided to March 2014 Operational Board. 2014 corporate performance reports have identified improvements in MEL compliance Trustwide. To request assurance from next Workforce and Development Sub Committee that improvements have been achieved with a view to re-modelling and a target risk score identified. Education CWP Sub Group is being established which will take over the oversight of this risk from June 2014.**
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 – awaiting Associate Director of Performance and Redesign advice 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 was reviewed as part of Q3 Monitor quality governance self-assessment – returned to green. Quality Committee**

Description of the risk	Residual risk rating Jan 2014	Residual risk rating March 2014	Residual risk rating May 2014	Risk score since last review	Summary risk treatment plan
					received a paper at 05.03.2014 meeting regarding current status in relation to data quality indicators. Awaiting independent auditor sign off of Quality Account for 2013/14. Once completed, risk to be remodelled and a target risk identified.
Risk of adverse clinical incident or regulatory action due to dual record keeping systems (electronic and paper) and quality of recording	**12**	**16**	**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 outcome 21 (records). An updated assurance framework and target risk to be identified at the June 2014 Patient Safety & 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 scrutinised at the Compliance, Assurance and Learning Sub Committee – exceptions to be reported to Quality Committee. Incident reporting and management policy currently under review. This is due for completion in July 2014 to focus on improvements to process and**

Description of the risk	Residual risk rating Jan 2014	Residual risk rating March 2014	Residual risk rating May 2014	Risk score since last review	Summary risk treatment plan
					improving staff training. Also ongoing work around improving the process around interface incidents and ensuring actions arising/ learning points are clear.
Risk of breach of Trust 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 completed end March 2014. Assessment of compliance against provider licence reviewed for 2013/14 due to report to May 2014 Board of Directors. Audit Committee undertaking an in-depth review of this risk at their next meeting. To identify target risk score by end May 2014.**
Risk of not being able to deliver planned financial risk rating due to incomplete CIP plans resulting in potential breach of terms of authorisation and reputational damage	**16**	**16**	**12**	↓	Strengthened 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. March 2014 Board approved Operational Plan including 2014/15 CIP plans. Improved process now in place including weekly updates on CIP plans to Executive Team. Risk re-modelled to take account of improvements to process. To identify target risk score by end May 2014.**

Description of the risk	Residual risk rating Jan 2014	Residual risk rating March 2014	Residual risk rating May 2014	Risk score since last review	Summary risk treatment plan
Risk of breach of Equality and Diversity (E&D) 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 in progress. Awaiting assurance re Trust compliance re September 2013 Board update on Equality and Diversity Act progress. **Equality and diversity officer has been recruited to and responsibility for E&D assigned to Associate Director of Nursing (Physical Health) to increase visibility. To confirm archiving of this risk with new E&D officer once in post.**
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 June 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

Four risks have been re-scored (one of which has also had its risk description re-modelled), these are:

Adults, children and young people are not protected through safeguarding training and practice
The description of this risk has been re-modelled to the following description:
Adults, children and young people are not protected through practitioners not implementing safeguarding practice and principles
This is to reflect the themes arising from the CQC inspection of safeguarding that took place week commencing 20 January 2014, rather than the risk specifically focussing on training. The risk has been re-scored from 20 to 16. This is due to the impact score reducing from 5 to 4. This reflects the positive outcome of the West Cheshire CQC inspection of safeguarding for looked after children and the updated, more comprehensive risk treatment plan identified in section 3.1 above to assure re matters of safeguarding practice.

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
This risk has been re-scored from 20 to 16. This is due to the likelihood score reducing from 5 to 4. This reflects an assurance report received by the Board of Directors from the risk lead (Service Director, CWP West) who identified that community nursing has a robust system in place to monitor the quality of care provided in the community in relation to pressure ulcer management and that audit results are demonstrating that care being delivered is evidence-based and standards have improved. This risk will continue to be closely monitored by the Quality Committee.

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
This risk has been re-scored from 16 to 12. This is due to the likelihood score reducing from 4 to 3. This risk has been re-scored due to the improved process now in place around identification and delivery of CIP schemes.

The inability of staff to manage the occurrences of slips, trips and falls of patients, resulting in patient injury
This risk has been re-scored from 20 to 16. This is due to the impact score reducing from 5 to 4. This is on the basis of assurances received that the “FallSafe” programme is having an impact as reflected by incident reporting figures and a reduction in the associated levels of harm.

4.3 Archived risks

No risks have been archived.

4.4 Audit Committee review of the risk register

At its May 2014 meeting, the Audit Committee undertook 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 was to understand the likelihood of the scenario occurring again, understand the causal triggers and/ or conditions, and understand the early warnings systems that could mitigate this. Assurance was received that early warning frameworks are in place as far as reasonably practical.

At the July 2014 meeting, the Audit Committee will be receiving assurances from the strategic risks that it has previously reviewed, including the ‘pressure ulcers’ risk and the ‘falls’ risk.

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, as demonstrated by the adjustments to a number of risk scores and also each risk having significant updates to their risk treatment plans. Further work is planned to further improve the dynamism of the risk register. All risks on the risk register will have an identified risk target score by June 2014. This is in line with the continuing work to strengthen the use of Datix to report routinely on the local and strategic risk registers and corporate assurance framework, which is due for completion 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
(available on T drive)

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/15/09)

Report to	Board of Directors
Date of Meeting	May 2014
Title of Report	Director of Infection Prevention and Control (DIPC) Board Report Quarter Four (January – March 2014)
Action sought	For Noting
Author	IPC Clinical Nurse Specialists
Presented by	Maria Nelligan, Director of Infection Prevention & Control

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
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
V1	Board of Directors	May 2014
V1	Infection Prevention & Control Sub Committee	8 May 2014
V2	DIPC	16 May 2014

Executive director sign-off

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

Contents

1. The purpose of the report

The purpose of this Director of Infection Prevention and Control (DIPC) quarterly report, quarter four, 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 four, which will include as a minimum:

- Outbreaks and Incidents
- HCAI data which is reported to CWP performance, Public Health England and the Clinical Commissioning Group (CCG) monthly;
- IPC Guidance
- Trends

2. Inpatients Services Pathway - Incidents and Development

For the Mental Health contract the Health Care Associated Infections (HCAI's) that are required to be reported are Clostridium difficile and Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia, both these HCAIs are reported by exception only. There were no incidents of Clostridium difficile infection or MRSA bacteraemia reported to the IPCT in inpatient mental health services between January and March 2014.

During the period this report covers there was one outbreak of diarrhoea and vomiting on Juniper Ward in Bowmere Hospital. A total of six service users were affected. There were no reported cases amongst staff members. Whilst a causative organism was not identified the presenting symptoms were strongly suggestive of an illness viral in origin. The ward was closed for the relatively short period of time of three days which demonstrates excellent adherence to infection control standards by all the ward and facilities staff. In accordance with best practice a post outbreak review meeting was held to identify areas of good practice and also to reflect on any areas of development.

2.1 Service user involvement and IPC Procedure

Building on work in 2013 with service users in the West Locality, during Q4, IPCT have facilitated sessions for service users at the recovery colleges in Macclesfield and Crewe. Topics covered include IPC awareness hand hygiene and its links to general health and wellbeing. These sessions have been positively evaluated by participating service users and ensures the infection control message is being spread beyond the inpatient units. Collaborative working has started with the recovery colleges to provide further learning opportunities for service users in 2014/15.

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2.2 Community Services Pathway

The Clinical Commissioning Group for Western Cheshire have a HCA's ambitions set for 2013/14 by the National Commissioning Board (NQB) 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 is ZERO tolerance for any avoidable or preventable infections. During Q4 there has been 1 MRSA bacteraemia in the Western Cheshire CCG footprint. This case did not have any CWP provider service input and Post Infection Review (PIR) was completed within the designated time frame. This has been reported to the Director of Infection Prevention & Control (IPC) and the IPC Subcommittee as an exception.

The ambition set for Clostridium difficile toxin infections and for performance reporting has been set at 48 for year 2013/14.This is a reduction of 13% from 55 for 2012/13. During the period this report covers 4 cases were identified. This demonstrates a reduction in figure, falling below the ambition levels. Maximum figures up to and including Q4 are expected to be 48; in reality the figure sits at 35 which is INCLUSIVE of Welsh and repatriated 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. 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 a root cause analysis is not carried out on these cases. An alert has been cascaded to all GPs in relation to inaccurate diagnostics and prescribing, particularly in relation to care homes and repetitive sampling after initial treatments. This information will be cascaded through CWP via the Physical Health in Mental Health Network.

2.3 Prevention of MRSA and Catheter Care

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.

2.4 Preventing Pressure Ulcers

The community IPCT continue 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.

2.5 Health Protection & External Services Pathway Incidents and Development

The fourth quarter of the year has seen six care homes closed due to outbreaks of gastrointestinal illness. Astrovirus was confirmed by samples submitted to the laboratory from 1 home; no causative organism was identified for the remaining outbreaks. Close monitoring of a number of other homes along with a local hospice and community hospital prevented closure and facilitated awareness of appropriate assessment processes. All care homes have received updated information to ensure prompt action is taken in response to potential outbreaks of gastrointestinal illness and follow up educational sessions provided for Care Homes having been affected by outbreaks. Homes have also been supported regarding cases of Clostridium difficile ensuring appropriate advice and management of cases in line with national guidance. The March meeting of the IPC Care Home Forum received good feedback following an educational session around hand hygiene.

A number of local nurseries have been supported during outbreaks of childhood infectious disease including hand, foot and mouth disease and cases of scarlet fever. This has included support for a nursery which had a case of possible meningitis allowing appropriate management of concerns from staff and parents of children attending the nurseries.

GP practices continue to be supported to ensure compliance related to Care Quality Commission Registration requirements 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 by IPCT facilitating access to appropriate specialist knowledge and current issues including attendance at the most recent meeting by the immunisation and screening coordinator from NHS England.

Support has been provided at the request of Public Health England (PHE) in relation to ongoing work in partnership with the local authority looking at the incidence of tattoo practices potentially exposing clients to the risk of blood borne virus. Additional support was also requested by PHE in the management of an outbreak affecting a high number of guests following a wedding reception at a local venue.

3. Carbapenemase-producing Enterobacteriaceae (CPE)

In February 2014 Public Health England (PHE) wrote to all Chief Executives of acute NHS Trusts requesting implementation of the recommendations of the recently published Carbapenemase-Producing Enterobacteriaceae (CPE) tool kit.

Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. However, these organisms are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. Carbapenems are a valuable family of antibiotics normally reserved for serious infections caused by drug-resistant Gram-negative bacteria (including Enterobacteriaceae). Carbapenemases are enzymes that destroy carbapenem antibiotics, resulting in resistance.

It is important to emphasise that this tool kit is presently designed for the use of acute NHS Trusts only. However, the CWP Infection Prevention and Control Team, in conjunction with Mental Health Trusts across the North West, have sought clarification from PHE regarding the development of a tool kit for non acute care settings. We have been advised that the tool kit is presently under development and publication is anticipated during 2014/15.

Whilst the tool kit remains in development CWP has the following processes in place to assure the Board regarding the management of CPE in any CWP care settings:

- In the event of a service user in an inpatient or community setting becoming symptomatically unwell with a CPE infection. Their care would be transferred to an acute NHS Trust for appropriate treatment which would include intra-venous antibiotics.
- CPEs are and identified alert organism and as such Microbiology are expected to inform the IPCT if such an organism is identified in a specimen submitted from a CWP inpatient or community setting.
- In the event of an outbreak of CPE this would be managed in accordance with the CWP policy IC6 Contingency Plans for the control of infectious outbreaks/incidents.
- CWP Pharmacy department conduct quarterly surveillance of antibiotic prescribing for in-patients, GP out of hours service and community matrons. The results of this surveillance are reported to the Infection Prevention and Control Sub Committee and Medicine Management Group. The trust currently have an annual compliance rates of 97% (community and out of hours) and 96% (Mental Health (MH) in-patients) for appropriate antimicrobial prescribing.

4. Recommendations

The Board of Directors is asked to note the DIPC Quarter 4 report for 2013/14.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Quality Report

Quarter 4
January – March 2014

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

Wirral drug & alcohol service steered a project to support street drinkers with chronic physical and mental health problems by setting up CWP's first controlled drinking room in a local *YMCA*. Alan Briggs, volunteer, and Thomas Cuddy, engagement worker are pictured above.
See page 6

Care • Well-being • Partnership

Contents

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

INTRODUCTION

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

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

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

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

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

Quality

Patient safety

Being protected from harm and injury

Being treated in a safe environment

Clinical effectiveness

Receiving care and treatment that will make me better

Having an improved quality of life after treatment

Patient experience

Having a positive experience

Being treated with compassion, dignity and respect

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

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

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

Executive Summary – Quality Headlines this Quarter

CWP has achieved its quarter 4 milestones for its four trustwide quality priorities for 2013/14. The common focus across all of the priorities is reducing health inequalities.
➲ see page 5

The Wirral drug & alcohol service has steered a project to support street drinkers with chronic physical and mental health problems by setting up CWP's first controlled drinking room in a local *YMCA*.
➲ see page 6

Wirral memory assessment service was accredited as excellent by the Royal College of Psychiatrists in the final report of the memory service national accreditation programme.
➲ see page 7

CWP's Mental Health Act team manager and Mental Health Act Administrator have successfully developed and delivered a 5-week Mental Health Act training programme to *East Cheshire Police*.
➲ see page 8

Wirral home treatment team has invested in staff by enhancing their physical health skills.
➲ see page 8

CWP received 656 formal compliments about the quality of its services during the final quarter of 2013/14.
➲ see page 9

Performance against contractual quality requirements and quality incentive schemes for 2013/14 is on track.
➲ see page 10

Quality priorities for 2013/14

CWP has set four **trustwide quality priorities** for 2013/14, which reflect the Trust's vision of "**leading in partnership to improve health and well-being by providing high quality care**". They are linked to the Trust's strategic objectives, and reflect an emphasis on **patient safety**, **clinical effectiveness** and **patient experience**.

This year, the common focus across all the priorities is **reducing health inequalities to** help reduce avoidable variations in the quality of care and to improve outcomes:

Patient Safety priorities for 2013/14

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

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

Clinical Effectiveness priority for 2013/14

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

Patient Experience priority for 2013/14

Improve service user and carer experience, by developing patient/ carer reported outcome measures, and patient experience measures across care pathways

The Trust has **achieved** each of the priorities. Details of how are detailed in its Quality Account 2013/14.

Improving outcomes for service users by supporting recovery

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

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

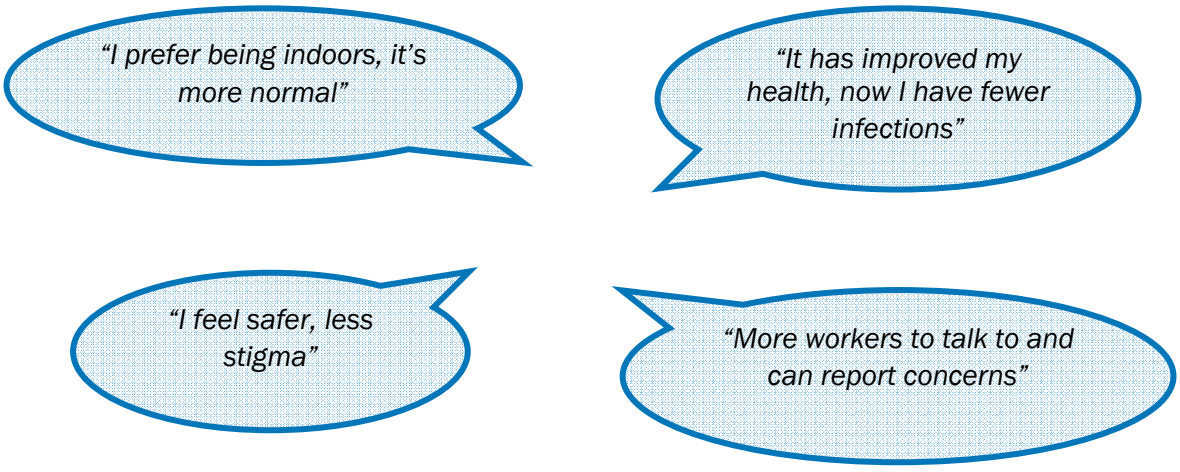
Focus on...
CWP's first controlled drinking room

Wirral drug and alcohol service has steered a project to support street drinkers with chronic physical and mental health problems by setting up a controlled drinking room in a local *YMCA* (*Young Men's Christian Association*). The controlled drinking room is a **safe** place to drink alcohol and provides **help and treatment for vulnerable people** who were excluded from other services due to anti-social behaviour.

CWP's Engagement Team has reported that 1097 people accessed the controlled drinking room since July 2013. The project evaluation demonstrated many benefits – improving social functioning and quality of life for people with prolonged alcohol misuse:

- Reduced alcohol consumption, less street drinking with fewer drunk and disorderly charges
- Positive activities engaged, improved daily routine and sense of belonging
- 95 referred to other services and support networks
- 44 now engaged with CWP services with access to alcohol detoxification programmes
- Harm reduction and medical care provided for people with physical health problems
- Nutritional advice and food provided encouraged healthy eating
- Fewer intoxicated people thus improved social behaviour

Service user experience has been captured. 100% reported they had reduced their alcohol consumption. Here are a few examples of what they said:



Focus on...

Memory services national accreditation programme

Wirral memory assessment service was **accredited as excellent** by the *Royal College of Psychiatrists* in the final report of the *Memory Service National Accreditation Programme*.

The service confidently outlined the **team's successes**. Some of the positive aspects mentioned in the report are listed below:

- Joint shared protocols with GPs and primary care
- Early evening and Saturday morning appointments available
- 5 accessible satellite clinics offered
- Opportunities for patients/ carers to be involved with research
- Routine feedback/ satisfaction surveys
- The service was described as 'caring', 'sensitive', 'considerate' and 'always accessible'
- Promotes staff training, provides consistent supervision
- Provides education to GPs
- Access to full time dementia advisor

Improving patient and staff experience of pharmacy services

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

The pharmacy team continues to proactively participate in service user and carer groups by providing meaningful **advice and independent information on medicines** used in mental health. For example, in February, pharmacists participated in the Lime Walk House carer group. The main topics of discussion included information on antipsychotic medicines, how they work and future developments. Carers reported that they would like pharmacists to attend future sessions.

CWP helped to facilitate the psychiatry and neurology clinical pharmacy diploma weekend with Liverpool John Moores University which was attended by 35 post graduate pharmacists. The final session of the weekend was a presentation from a CWP patient and carer and was found highly informative and entertaining by everyone. Pharmacists received positive feedback on the quality of the speakers and knowledge shared.

A CWP pharmacist has contributed to a briefing published in the *Pharmaceutical Journal* for representing the *College of Mental Health Pharmacy* for the medicines optimisation work with the *Royal Pharmaceutical Society*.

Quality success stories

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

Patient Safety News

Jan Devine, Mental Health Act Team Manager, and Lynsey Evans, Mental Health Act Administrator designed, developed and delivered a 5-week Mental Health Act training programme for *East Cheshire Police*. It was received very well from Police Officers, who commented on how useful the training and guides were. Inspector Jez Taylor said, "They have done an excellent job. Overall, I was really impressed by Jan and Lynsey and the input certainly got a healthy debate going". A **positive outcome** was that a case conference was held between professionals and the local police inspector to discuss the appropriateness of people on Section 136 and a management plan was agreed for future incidents.

Wirral Home Treatment Team has invested in staff by enhancing physical health skills of their NMPs (Nurse Medical Prescribers). Further improved practice led to increased changes to medications and the start up of short term courses. The NMPs follow the service user from the home setting into an acute care admission by enabling them to complete the physical health screen on admission, and they instigate the medicines reconciliation for writing up the prescription card on admission, permitting a more seamless service with less transition points. Feedback from patients is wholly appreciative of the rapid review and treatment changes.

Clinical Effectiveness News

homeless link
WE REPRESENT AND SUPPORT ORGANISATIONS WORKING WITH HOMELESS PEOPLE IN THE UK

The *Homeless Link* organisation has publicised the innovative and effective work that **Wirral Drug and Alcohol Service** has done to improve the outcomes for homeless people with dual diagnosis needs. The specialist team, which manages 300 to 400 dual diagnosis service users, worked in partnership with psychological services and found that meaningful work can be done with service users with substance misuse. There have been real positive outcomes achieved, for example:

- Mental health diagnosed with mental health nurse input
- Improved dietary intake
- Hostel accommodation found
- Registration with GPs
- Residential detox programmes arranged and further rehabilitation programmes completed

Jane Brand, 6Cs Live! 'Story of the Month' winner of **Wallasey & West Wirral adult mental health service** was personally invited as a guest to the Healthcare and Innovation Expo in March 2014 by Jane Cummings, Chief Nursing Officer, *NHS England*. Jane Brand showcased her work on the *'Compassion in Practice'* exhibition stand and shared her experiences in **improving care for people using 6Cs**.

Patient Experience News and patient feedback

A service user who has regularly accessed inpatient services wrote to CWP providing encouraging feedback on the massive improvement in practice experienced when they accessed the **Home Treatment Team** and **Brackendale ward**. They felt they were **listened to** and their **privacy and dignity were respected**, this made them feel **comfortable** and **supported**. The service user suggested further areas for improvement and is working with the team to put them into practice. They thanked staff for their support in enabling them to have a meaningful and fulfilling life.

"The team came out very quickly to assess me and they asked me how I could be helped, they helped me take some responsibility and placed me at the centre of my own care."
Adult Mental Health service user

CWP's **harm reduction unit** was mentioned in January's *Nursing Standard Magazine* for promoting *Alcohol Concern*'s 'Dry January Campaign'. Pledge boards displayed where staff and service users signed up to cutting out alcohol in January.

Helen Parkinson, nurse specialist and Andrew Jolley, clinical support worker said, *"Even social drinkers regularly consume more than the recommended daily amount of alcohol, which can increase your risk of vascular diseases, such as heart attack, stroke and kidney disease. Make sure you know what the recommended limits are and stick to them."*

In quarter 4, CWP formally received **656 compliments** from service users, and others, about their experience of the Trust's services. Below is a selection of the comments and compliments received for the specialties across the Trust:

"I think this has been the most positive experience I have had regarding my mental health. All the Doctors and Nurses have been kind and helpful."
Adult mental health services

"Thank you for the many kindnesses and care and compassion you showed to (service user). He so appreciated everything you did for him."
Physical health – CWP West

"Thank you so much for all you have done over the past six months. We will endeavour to continue with the good work with (service user) for years to come, we have hope for the future."
Child & adolescent mental health services

"Staff attitude is helpful and welcoming, they try to accommodate requests if possible. The atmosphere is relaxed and happy."
Learning disability services

"They are life savers, without their help, I think, no sorry, I know I would be dead. They bend over backwards to help and you are welcome any day."
Drug and alcohol services

Contract requirements – Quality improvement and innovation

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

Quality requirements

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

Commissioning for Quality and Innovation [CQUIN]

A proportion of CWP's income from its contracts in 2013/14 is conditional on achieving **quality improvement and innovation goals** agreed by CWP and its commissioners, through the *CQUIN* payment framework. The total *CQUIN* monies in 2013/14 is subject to achievement of certain milestones.

Reporting against the quarter 4 milestones is currently underway. Quarter 3 milestones have now been verified as achieved.

Advancing Quality

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

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

Diagnosis area	Composite target April 2013 – March 2014	CWP compliance April 2013 – August 2013	Appropriate care target April 2013 – March 2014	CWP compliance April 2013 –August 2014
Dementia	83.64%	89.88%	50.00%	52.89%
Psychosis	88.19%	98.02%	58.88%	93.06%

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/14/11)

Report to:	**Board of Directors – meeting in public**
Date of meeting:	**28 May 2014**
Title of report:	**Learning from Experience report – Trimester 3 2013/14**
Action sought:	**For noting and approval**
Authors:	**David Wood, Associate Director of Safe Services** **Audrey Jones, Head of Clinical Governance** **Safe Services Department**
Presented by:	**Avril Devaney, Director of Nursing, Therapies and Patient Partnership**

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

Distribution

Version	Names/ Groups	Date issued
1	A Jones to D Wood	20.05.2014
2	D Wood to L Hulme for Board of Directors	20.05.2014

1. Purpose of the report

This *Learning from Experience* report aggregates qualitative and quantitative analysis from key sources of feedback from people who use the Trust's services, staff, and other relevant sources of learning, covering the period from December 2013 – March 2014, **trimester 3** of 2013/14.

Performance indicator			2012/13	2013/14		
			T3	T1	T2	T3
Number of patient safety incidents reported			1864	2437	2418	2514
Severity (Increase in level of harm ⇧)	**Category A**		12	16	17	11
	Category B		23	33	30	33
	Category C		368	276	270	409
	Category D		571	693	915	786
	Category E		890	1419	1137	1220
Reports to external agencies	StEIS		35	49	43	79
	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations		6	10	5	10
	NHS Litigation Authority – NHSLA	Non clinical claims	5	7	9	2
		Clinical claims	0	0	2	0
	National Reporting and Learning System		1071	1501	1074	1055
Number of complaints			60	76	59	85
Acknowledgement of complaints within 3 days			91%	99%	93%	95%
Number of compliments			903	516	671	864

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

3. Analysis – key highlights

Follow up from the actions identified in trimester 2 of 2013/14 are outlined in *Appendix A*.

3.1 Incident reporting

All incidents involving patient safety are reported to the *National Reporting and Learning System* [*NRLS*]. CWP has achieved 100% compliance in meeting these reporting targets. Overall incident reporting has increased by 4% in trimester 3. The reporting of higher harm categories [categories A and B – those requiring formal review using root cause analysis methodologies as per the Trust's contractual arrangements] has remained at a similar level to those reported in trimester 2 [overall decrease of 3 incidents. The lower harm categories of incidents continue to be the highest number of reported incidents, which is an internationally recognised standard, so that it does not take incidents that cause harm to improve patient safety.

3.2 Falls incidents

There has been another overall decrease in falls incidents this trimester, from 203 to 195. The most frequently reported severity of falls has again been category E [near miss/ prevented] patient safety incidents. Following an independent review of falls across the Trust, a falls task and finish group has recently been developed to implement and oversee the following recommendations: a review the environment of wards (lighting, flooring, decoration, signage) which may be contributing to the increase risk of falls; to review CWP policy *Prevention and management of slips, trips and falls* which will include a review of the risk assessment used; and further development of competencies.

3.3 Medicines incidents

Data from this trimester demonstrates that *Adult Mental Health Services East* continues to make improvements to practice as a result of previous incident reporting. *Adult Mental Health Services West* has reported an expected increase in the number of incidents, the main contributor being one

ward having a strong focus on medication safety and documentation – a high level of reporting has been encouraged and the incidents reported have been analysed and used to show where practice requires improvement. For *Adult Mental Health Services Wirral*, a review of an increase in medicines incidents has resulted in the development of a unit wide prescription checking action plan – this is addressing training needs for staff. *Physical Health West*, *Learning Disability Services*, *Drug & Alcohol Services* and *CAMHS* have reported a similar number of incidents to last trimester.

3.4 Complaints, PALS, compliments

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

3.5 Security, violence and aggression incidents

Reported incidents of physical intervention within inpatient areas have decreased overall by 18% to 329 incidents. Reporting of physical intervention holds used by staff demonstrated that 40% of all incidents were managed using newly introduced/ approved training techniques, whilst 28% of incidents were managed by staff using 'guiding' techniques that promote autonomy and self direction. When comparing restraint position data, the use of level 4 holds has decreased by 3% to 60% overall, which is line with the new 'Closing the Gap' strategy. This strategy identifies actions which, when fully met, are designed to reduce the use of restrictive practices and further promote the principles of recovery oriented systems of care such as person centred care, choice, respect, dignity, partnerships, self-management, and full inclusion.

4. Summary of recommendations

The following highlights the recommendations identified as a result of the aggregated analysis undertaken on key sources of feedback from people who use the Trust's services and staff, and other relevant sources of learning.

	Recommendation	Action	By Whom	When
1	Ensure there is a joined up approach to learning from recommendations from different types of investigations.	To review the coding for recommendations/ actions after the completion of investigations.	Incidents Team/ Quality Surveillance Support Managers	30.07.2014
2	CWP policy GR1 Incident reporting and management policy to be updated.	Updated policy to be approved by the Quality Committee.	Head of Clinical Governance	02.07.2014
3	Establish the extent of additional learning/ benefit of undertaking comprehensive root cause analyses subsequent to completion of local root cause analysis of pressure ulcer incidents.	An analysis of immediate learning which has been identified from pressure ulcer local root cause analyses needs to be undertaken on a cohort of investigations previously undertaken. This will then be compared with comprehensive root cause analyses subsequently undertaken for the same incidents. Following analysis, an interim report [a] will be presented to the next Patient Safety & Effectiveness Sub Committee. A further report [b] will be completed once the work has	Head of Clinical Governance/ Clinical Services Manager for Ageing Well	a. 15.08.2014 b. 31.10.2014

	Recommendation	Action	By Whom	When
		been completed which will set out recommendations for consideration by the Trust and commissioners.		
4	Review the increase in 'failure to administer' incident reports in trimester 3	A clinical alert should be issued to ensure that: - Reporters are aware of the correct sub-category of incident to select, including the differentiation between failure to administer and non-adherence to policy/ procedures. - The ward nursing team contact the pharmacy team [or the on-call pharmacist if out of hours] if a medication is not available on the ward. - Mechanisms are in place to reduce the number of non-administrations when the medication is available on the ward.	Medicines Management Team	Immediately
5	Review medicines incidents reporting.	The Medicines Management Team should provide an update for the next Learning from Experience report on the contents of the medicines incidents plan and how this is being implemented and monitored for effectiveness.	Medicines Management Team	01.08.2014
6	Further link the 6Cs to existing assurance systems by embedding them into the Trust's unannounced compliance visits process.	Future reports from unannounced compliance visits after July 2014 to include a selection on findings from review of the 6Cs.	Head of Compliance/ Head of Clinical Governance	01.08.2014
7	Explore learning and actions in response to feedback regarding communication issues.	The complaints team to provide a report regarding communication issues for the Trust's 'values group'.	Incidents Manager	01.07.2014
8	Early warning signs from incidents, complaints and claims need to be identified so that more prompt action can be taken.	Review associated themes and learning from sources of feedback on a real time basis.	Quality Surveillance Support Managers	31.08.2014
9	Maximise all opportunities to seek and promote feedback from staff, through the process of raising of concerns.	Develop a process to ensure all opportunities are maximised to learn wherever staff raise concerns and to report on this feedback consistently.	Associate Director of Nursing [Physical Health]/ Associate Director of Safe Services/ Head of	01.08.2014

	Recommendation	Action	By Whom	When
			Human Resources	

5. The Board of Directors is asked to:

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

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

The incidents team should undertake a deep dive into the reporting of the level of harm incidents Trustwide, benchmarked against other trusts where applicable, to identify if there are any areas of under reporting or over reporting.
This work is ongoing, initial work has been undertaken to review incidents within CWP. Contact has been made with 2 other local mental health trusts to benchmark the reporting of level of harm. Part 4 of the report above includes an update to reflect the next steps required.
▪ All incident reporters should ensure that the correct sub category of incident is selected. The pharmacy team will promote this during their locality based working and a reminder will be included in the learning lessons and changes in practice publication. ▪ The pharmacy team will remind the ward nursing teams to: - Contact them [or the on-call pharmacist if out of hours] if a medication is not available on the ward. - Ensure that they implement mechanisms to reduce the number of non-administrations when the medication is available on the ward.
This recommendation has been carried forward to the next report to ensure sufficient time to embed these recommendations fully into practice.
▪ The Accountable Officer for controlled drugs [Chief Pharmacist] should gain assurances from the clinical specialties that all policies and procedures associated with controlled drugs are being adhered to. ▪ Modern matrons and ward managers should ensure all nursing staff are aware of the controlled drug policy and procedures [contained within the Medicines Policy MP1] and that they are being followed appropriately.
The Accountable Officer is still awaiting further assurances from services that all policies and procedures associated with controlled drugs are being adhered to. Follow up of this action will be transferred to the action schedule of the Patient Safety & Effectiveness Sub Committee.
The complaints and incidents team should develop a system to ensure better capture of learning from complaints and to ensure learning is better disseminated across the organisation. Actions/ recommendations from complaints investigations should be logged and monitored to ensure they are being implemented and that learning is taking place.
▪ The complaints team's processes now ensure that the recommendations/ actions are included in the investigation report to ensure potential learning is not lost. ▪ As of April 1 2014, all actions in relation to the outcome of complaints investigations are recorded within an Excel spreadsheet so that all recommendations are captured. ▪ Work is currently being developed within the Datix incident reporting system to develop it to better capture the actions/ recommendations and learning from the investigation outcome of complaints. ▪ Ongoing developmental work to the Learning from Experience report will ensure learning is captured so that this can be disseminated throughout the organisation. ▪ Processes will be strengthened as part of the review of the complaints policy to facilitate locality feedback from complaints within their specialities to the individual teams involved. The Safe Services Department will ensure that all localities are made aware of Trustwide learning and learning from other localities.
The complaints, incidents and PALS team should identify a joint work programme with the communications and involvement team to ensure that the Trust is maximising all opportunities to seek and promote feedback from people who use its services.
A meeting is scheduled for later in May 2014 to explore a programme of joined up working. A report will be submitted to the next Quality Committee.
The Safety and Security Lead, in conjunction with the incidents team, should review data fields to reflect the new reporting needs of the No Force First strategy and CWP policy to ensure future ability to comparatively monitor and set improvement targets.
This recommendation has been carried forward for the next trimester as Datix developmental work has not commenced yet.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document Reference (2014/15/13)

Report to:	**Board of Directors**
Date of Meeting:	**28 May 2014**
Title of Report:	**i. *Monitor* Quality Governance Framework standards – self assessment** **ii. *Monitor* NHS provider licence criteria – self assessment**
Action sought:	**For APPROVAL and NOTING**
Authors:	**David Wood, Associate Director of Safe Services** **Louise Hulme, Head of Corporate Affairs/ Company Secretary**
Presenting Executive:	**Tim Welch, Director of Finance**

Strategic Objective(s) that this report covers *(delete as appropriate):*
SO1 - Deliver high quality, integrated and innovative services that improve outcomes
SO2 - Ensure meaningful involvement of service users, carers, staff and the wider community
SO3 - Be a model employer and have a caring, competent and motivated workforce
SO4 - Maintain and develop robust partnerships with existing and potential new stakeholders
SO5 – Improve quality of information to improve service delivery, evaluation and planning
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	D Wood to L Hulme	07.04.2014
2	L Hulme to D Wood	19.05.2014
2	D Wood to L Hulme for Board of Directors	19.05.2014

Executive director sign-off

Executive director (name and title)	Date signed-off
Tim Welch, Director of Finance	21.05.2014

1. Purpose of the report

In February 2013, *Monitor* published guidance to respond to the statutory consultation on the new NHS provider licence and provided the final standard licence conditions. The guidance was designed to inform providers of NHS services of how *Monitor* will main regulate providers of NHS services.

In April 2013, *Monitor* published 'Quality governance: How does a Board know that its organisation is working effectively to improve patient care?'. The guidance is designed to support *Monitor*'s Quality Governance Framework. This forms part of the *Monitor* Risk Assessment Framework which replaced the Compliance Framework from quarter 3 of 2013/14.

This report details:

- The quarter 4 *Monitor* NHS provider licence criteria self assessment and recommends a way forward for conducting an annual self assessment for the forward year [2014/15].

  The licence contains obligations for the Trust that allows *Monitor* to fulfil its duties. Since it enables *Monitor* to continuously oversee the way that CWP is governed, this assessment aims to help the Board in confirming the accuracy of requirements and rules that CWP is required to comply with as a license holder.

- The quarter 4 *Monitor* quality governance self assessment incorporating the end of year [2013/14] annual self assessment.

  This assessment aims to help the Board understand what is required of its internal assurance mechanism for assuring the organisation wide processes for governing quality, with a view to improve decision making and to support Boards in discharging their responsibilities to improve care for patients.

2. Quarterly and annual self assessments

2.1 Quarter 4 *Monitor* quality governance self assessment – end of year 2013/14 self assessment

See *Appendix 1*. All quality areas remain at green for quarter 4 and therefore at 2013/14 year end. The previous quarterly positions, received previously by the Board, are also detailed.

2.2 Quarter 4 *Monitor* NHS provider licence criteria self assessment – end of year 2013/14 self assessment

See *Appendix 2.* There is self assessment evidence detailed against selected *Monitor* NHS provider licence criteria [*Appendix 2.1*] where either a review of position is required or the criteria requires the Trust to "comply or explain".

All conditions are rated as Green, with the exception of one rated as Amber: Condition/ licence provision G6. This is rated as Amber/ Green due to residual risks in relation to the strategic risk *"Risk of breach of Trust Terms of Authorisation/ Licence as a result of external scrutiny"* described within the corporate assurance framework. This risk requires a full review and remodelling to ensure it articulates the actual current residual risk/s, following on from the Audit Committee review of this risk on 1 May 2014 and assurance received that early warning frameworks are in place, as far as reasonably practical, to mitigate this risk. It is anticipated that upon completion of this, this condition will be rated as Green. This will be undertaken by the next scheduled receipt of the strategic risk register at the Board of Directors meeting in public on 30 July 2014.

The full licence criteria [*Appendix 2.2*] is provided for information. In quarter 1 the Board will be asked to acknowledge these licence provisions as they apply at the start of 2014/15 alongside the self assessment of the selected criteria.

3. Recommendations to the Board of Directors

The Board of Directors is asked to:

- **Discuss** and **approve** the quarter 4 2013/14 and full year 2013/14 *Monitor* quality governance self assessment, as per *Appendix 1.*

- **Discuss** and **approve** the 2013/14 *Monitor* NHS provider licence criteria self assessment, as per *Appendix 2*, and **agree** that members of the Board undertake a full annual self assessment for the forward year 2014/15 alongside the quarter 1 self assessment.

Appendix 1.1: *Monitor* Quality Governance Framework – annual self assessment 2013/14

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

		Self assessment (RAG) rating 2013/14			
Strategy		**Q1**	**Q2**	**Q3**	**Q4/ year-end**
1a	Does quality drive the trust's strategy?	GREEN	GREEN	GREEN	GREEN
1b	Is the Board sufficiently aware of potential risks to quality?	GREEN	GREEN	GREEN	GREEN
Capabilities and culture					
2a	Does the Board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?	GREEN	GREEN	GREEN	GREEN
2b	Does the Board promote a quality-focused culture throughout the Trust?	GREEN	GREEN	GREEN	GREEN
Processes and structure					
3a	Are there clear roles and accountabilities in relation to quality governance?	GREEN	GREEN	GREEN	GREEN
3b	Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	GREEN	GREEN	GREEN	GREEN
3c	Does the Board actively engage patients, staff and other key stakeholders on quality?	GREEN	GREEN	GREEN	GREEN
Measurement					
4a	Is appropriate quality information being analysed and challenged?	GREEN	GREEN	GREEN	GREEN
4b	Is the Board assured of the robustness of the quality information?	AMBER/ GREEN	AMBER/ GREEN	GREEN	GREEN
4c	Is quality information being used effectively?	GREEN	GREEN	GREEN	GREEN

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

Appendix 1.2: Self assessment evidence against *Monitor* Quality Governance Framework as at Q4 2013/14 and year end position

Quality area	Trust evidence	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2014/15
1. Strategy				
1a: Does quality drive the Trust's strategy?	• Quality is embedded in the Trust's overall strategy. ▪ Overall vision '*Leading in partnership to improve health and well-being by providing high quality care'.* ▪ The Trust's vision and strategy comprises a number of Trust-wide quality goals covering safety, clinical effectiveness/ outcomes and patient experience which drive year on year improvement. ▪ Quality goals reflect local as well as national priorities, reflecting what is relevant to patient and staff – annual planning events and working with commissioners and other local scrutineers on development of quality priorities help identify priorities. ▪ Quality goals are specific, measurable and time-bound – outlined in quality section of annual plan. ▪ Overall Trustwide quality goals link directly to goals	**GREEN**	Board of Directors is being asked to endorse the strategic direction of the Trust's zero harm aspirations and plans for the delivery of quality by tackling unwarranted risks and variation at January 2014 meeting. An initial three year implementation plan to be developed for approval at March 2014 Quality Committee. *In January 2014, the Board of Directors approved a 3-5 year investment in staff so that they can deliver best care. This will be achieved through a number of continuous improvement programmes which will improve patient safety and effective care. The Trust's 'Zero Harm' goal is to reduce avoidable harm and embed a culture of patient safety in CWP.* **Associate Director of Safe Services** **COMPLETED**	Board of Directors to endorse the Trust's quality improvement priorities, developed by Medical Director for Quality and Associate Director of Safe Services, as part of annual report (Quality Account). **Medical Director for Quality and Associate Director of Safe Services**

Quality area	Trust evidence	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2014/15
	in localities/ services (which will be tailored to the specific service) – as part of annual plan and clinical strategies • Quality goals are communicated as part of quality accounts, regular quality reporting, via Clinical Directors at Quality Committee, as part of clinical performance reviews. • Corporate performance report has quality section. • Quality dashboard routinely reported to Quality Committee.			
1b: Is the Board sufficiently aware of potential risks to quality	• The Board regularly assesses and understands current and future risks to quality and is taking steps to address them. Risks are aligned to annual plan and the assurance framework has been mapped to the strategic objectives for the Trust. • The Board regularly reviews quality risks in an up-to-date risk register and assurance framework. • The strategic risk register is supported and fed by quality issues captured in locality/ service risk registers – there is a process of escalation in place for 'red' rated risks on	**GREEN**	Develop locality risk register process linked to new operational structures and review escalation processes via governance structures. *Consultation process completed to update the Trust's integrated governance strategy, which includes a number of enhancements such as more robust risk treatment plans, clearer means of escalation and de-escalation of risks and a judgment framework linked to risk tolerance.* *Additionally, internal audit overall assessment has*	No further actions.

Quality area	Trust evidence	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2014/15
	the clinical service risk registers to be considered for inclusion on the strategic risk register. • The risk register covers potential future external risks to quality (e.g. new techniques/ technologies, competitive landscape, demographics, policy change, funding, regulatory landscape) as well as internal risks – risks are aligned to the annual planning process, which looks at external risks. • There is clear evidence of action to mitigate risks to quality – actions on the risk register are monitored by the Safe Services Department. • Proposed initiatives are rated according to their potential impact on quality (e.g. clinical staff cuts would likely receive a high risk assessment) – there is an impact assessment in place for new service developments, which incorporates risk. • There is an appropriate mechanism in place for capturing frontline staff concerns. • Quality measures monitored before and after		*concluded that there is an effective system of internal control to manage the principle risks identified by the organisation.* **Associate Director of Safe Services in partnership with Executive leads, Service Directors and Clinical leads** **COMPLETED**	

Quality area	Trust evidence	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2014/15
	implementation through quality impact assessments.			
2. Capabilities and culture				
2a: Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	• The Board is assured that quality governance is subject to rigorous challenge, including full NED engagement and review – NEDs chair Quality Committee and Audit Committee. • Board development programme in place. • Board seminars in place which allow time to debate issues on quality and assurance. • Board members have attended training sessions covering the core elements of quality governance and continuous improvement.	**GREEN**	Agree senior manager risk management training, focusing on risk appetite, risk tolerance and patient safety culture, linked to strategic avoidable harm agenda. *Board seminar took place on 26 February 2014 with training extended to include human factors principles which was a prequel to the strategic "zero harm" work approved by January 2014 Board.* **Associate Director of Safe Services in partnership with Chief Executive, Director of Nursing, Therapies and Patient Partnership, and Medical Director for Quality** **COMPLETED**	No further actions.
2b: Does the Board promote a quality focused culture throughout the Trust?	• Quality Committee chaired by NED, attendance by Executive team and other NEDs. • The Board takes a proactive approach to improving quality (e.g. it actively seeks to apply lessons learnt in other Trusts and external organisations). • The Board regularly commits	**GREEN**	Board of Directors is being asked to endorse the strategic goal of having an aspiration of zero harm that drives the Trust culture at January 2014 meeting. An initial three year implementation plan to be developed for approval at March 2014 Quality Committee.	No further actions.

Quality area	Trust evidence	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2014/15
	resources (time and money) to delivering quality initiatives – e.g. QIPP agenda discussions at Board. • The Board is actively engaged in the delivery of quality improvement initiatives (e.g. some initiatives led personally by Board members). CQUIN monies reinvested into QIPP. • NED involvement in unannounced compliance visit schedule. • Staff are encouraged to participate in quality/ continuous improvement training and development – the Trust has reviewed its mandatory training, focusing on what training is required for which staff groups, underpinned by patient safety following Berwick review. • Staff feel comfortable reporting harm and errors (these are seen as the basis for learning, rather than punishment) – positive feedback from staff survey, which is reviewed at Operational Board level and National Reporting and Learning System data stating that CWP reports incidents in line with other Trusts in its benchmarked cluster.		*In January 2014, the Board of Directors approved a 3-5 year investment in staff so that they can deliver best care. This will be achieved through a number of continuous improvement programmes which will improve patient safety and effective care. The Trust's 'Zero Harm' goal is to reduce avoidable harm and embed a culture of patient safety in CWP.* **Associate Director of Safe Services** **COMPLETED**	

Quality area	Trust evidence	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2014/15
	• Staff are entrusted with delivering the quality improvement initiatives they have identified (and held to account for delivery – link to annual plan). • Internal communications (e.g. monthly newsletter, intranet, notice boards) regularly feature articles on quality – quarterly quality report, three times per year learning from experience report.			
3. Structures and processes				
3a: Are there clear roles and accountabilities in relation to quality governance?	• Each and every Board member understands their ultimate accountability for quality – discussed at Board seminars and as part of the self assessment process and signed off by Board as part of the Annual Governance Statement. • The governance structure is in place within the Trust with committees/ sub committees with clear terms of reference, outlining roles and responsibilities in relation to quality. • Quality is a core part of main Board meetings, both as a standard agenda item and as an integrated element of all major discussions and	**GREEN**	Position statement and forward plan for corporate governance meetings structure to be developed, lining up: - key Trust strategies [including clinical strategies] - Trust operating/ escalation/ performance improvement framework - Corporate governance manual *Review of integrated governance strategy includes a number of enhancements such as more robust risk treatment plans linked to strategic objectives, clearer means of escalation and de-escalation of risks and a judgment framework linked to risk tolerance,*	Workshop re roles and accountabilities in relation to quality governance to be held with the staff that form the new clinical and professional structure that has been implemented at locality level, since these roles have overall responsibility for the delivery of care within each locality. **Medical Director for Quality and Associate Director of Safe Services supported by Safe Services Department senior managers**

Quality area	Trust evidence	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2014/15
	decisions. • Quality performance is discussed in more detail each month by a quality focused Board sub committee. Quality Committee meets every two months but any issues requiring discussion in relation to quality are brought to Operational Board which meets monthly.		*underpinned by a fit for purpose corporate meetings structure.* **Safe Services Department senior managers in partnership with Executive leads, Service Directors and Clinical leads** **COMPLETED**	
3b: Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	• Boards are clear about the processes for escalating quality performance issues to the Board – Corporate Performance Report in place. • Process for escalation of risks to the Board is outlined in Integrated Governance Strategy. • Process for escalation of incidents to Board is outlined in Incident reporting and management policy – level 3 incidents reported to Board and actions followed up by Quality Committee. • Robust action plans are put in place to address quality performance issues (e.g. including issues arising from serious untoward incidents and complaints) – monitored by Compliance, Assurance and Learning Sub Committee.	**GREEN**	Performance management systems to be further reviewed and plans identified to strengthen. *Corporate reporting format is under review and will be refined. It will include locality key performance indicators, which are currently being developed. It will also include clearly defined escalation requirements. Terms of reference are in development for the performance reviews, which will integrate the process into the formal governance structures of the Trust.* **Associate Director of Performance and Redesign** **IN PROGRESS**	No further actions.

Quality area	Trust evidence	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2014/15
	• Lessons from quality performance issues are well-documented and shared across the Trust on a regular, timely basis - communicated via lessons learned publication and learning from experience report. • There is a proactive clinical audit programme in place aligned to national audit priorities, contractual requirements and quality priorities identified by the Trust. • There is also scope for undertaken reactive audits/ re-audits linked to risks. • There is an internal audit programme in place, which links to quality. • An error reporting process is defined and communicated to staff. • There is a performance management system in place within the Trust as part of the Trust's integrated governance strategy.			
3c: Does the Board actively engage patients, staff and other key stakeholders on quality?	• Quality outcomes are made public (and accessible) regularly, and include objective coverage of both good and poor performance – quality report and learning from experience report presented to	**GREEN**	Introduction of a patient experience sub committee, aligned to Learning from Experience reporting timeframes, to report to Quality Committee to strengthen receipt of assurances against patient	The Trust has signed up to the Care Connect pilot which is a platform for patients' active engagement in relation to sharing of experiences, asking questions and reporting problems. An

Quality area	Trust evidence	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2014/15
	public Board. Inpatient safety metrics results presented on all inpatient wards for staff/ patients/ visitors to see. • The Board actively engages patients on quality, e.g. - Patient feedback is actively solicited, made easy to give and based on validated tools, e.g. surveys, patient stories, video diaries, PALS, real time patient experience (current pilot). - Patient views are proactively sought during the design of new pathways and processes - via surveys/ focus groups, attendance at annual planning events. - All patient feedback is reviewed on an ongoing basis, with summary reports reviewed regularly by the Board – learning from experience report looks at patient feedback via PALS/ complaints. - The Board regularly reviews and interrogates complaints and serious untoward incident data – via the learning from		experience domain of quality. *Initial meeting to discuss proposed terms of reference scheduled for 27 April 2014.* **Director of Nursing, Therapies and Patient Partnership, Head of Clinical Governance, Head of Communications and Involvement in partnership with clinical teams** **IN PROGRESS**	implementation plan needs to be developed for this pilot. **Associate Director of Safe Services, Associate Director of Effective Services, Head of Clinical Governance, Head of Communications and Involvement**

Quality area	Trust evidence	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2014/15
	experience report quarterly and standing agenda items reviewing SUIs/ complaints. - The Board uses a range of approaches to 'bring patients into the Board room', e.g. patient stories. • Staff are encouraged to provide feedback on an ongoing basis, as well as through specific mechanisms – staff blog, annual staff survey, training feedback. • The Board actively engages all other key stakeholders on quality, e.g. - Quality performance is clearly communicated to commissioners to enable them to make educated decisions via contract meetings, reports - Feedback from PALS and local Healthwatch organisations is considered - Healthwatch commentary on quality accounts, feedback from annual planning events, consultations on new service developments etc., PALS talkback.			

Quality area	Trust evidence	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2014/15
	- For care pathways involving GP and community care, discussions are held with all providers to identify potential issues and ensure overall quality along the pathway - Trust working with clinical commissioning groups and via clinical networks. - The Board is clear about Governors' involvement in quality governance – with meetings structure in place. • Public consultation sought on service changes identified as part of annual plan priorities.			
4. Measurement				
4a: Is appropriate quality information being analysed and challenged?	• The Board reviews a monthly 'dashboard' of metrics outlined within the Corporate Performance report. • The Quality Committee reviews quality and safety metrics displayed in a quality dashboard. • Quality information can be analysed and challenged at the individual team level – as part of CAREnotes reporting and data quality/ control. • External assessment/ data	**GREEN**	Position statement and forward plan for developing Trust operating/ escalation/ performance improvement framework. *Review of integrated governance strategy includes a number of enhancements such as clearer means of escalation and de-escalation of risks and a judgment framework linked to risk tolerance.*	Corporate Performance report is currently being reviewed to strengthen its content and presentation to facilitate more robust analysis and challenge of quality information. This will include pull through of information from the quality dashboard – meeting scheduled for 7 May 2014. **Associate Director of Performance and Redesign**

Quality area	Trust evidence	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2014/15
	delves take place as part of Quality Account auditing and external and internal audit programmes.		**Safe Services Department senior managers in partnership with Executive leads, Service Directors and Clinical leads** **COMPLETED**	
4b: Is the Board assured of the robustness of the quality information?	• There are clearly documented, robust controls to assure ongoing information accuracy, validity and comprehensiveness: - roles and responsibilities in relation to data quality are outlined within the Trust's Data Quality Policy - Assurance on data quality given to Board via Information Governance Toolkit scores and independent review of Quality Account - Clinical audit programme driven by national audits, with processes for initiating additional audits as a result of identification of local risks (e.g. incidents) - Electronic systems are used where possible, generating reliable reports with minimal ongoing effort	**GREEN**	None.	No further actions.

Quality area	Trust evidence	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2014/15
	- Information can be traced to source and is signed off by owners – gate keeping process in place within the Trust • There is clear evidence of action to resolve audit concerns: - Action plans are completed from audit (and subject to regular follow-up reviews) – Trustwide action plans monitored by Compliance, Assurance and Learning Sub Committee - Re-audits are undertaken to assess performance improvement			
4c: Is quality information being used effectively?	• Information in quality reports is displayed clearly and consistently – ongoing development of Corporate Performance reporting and quality dashboards. • Information is compared with target levels of performance (in conjunction with a R/A/G rating), historic own performance and external benchmarks (where available and helpful). • Information being reviewed is	**GREEN**	Board of Directors is being asked to endorse the strategic direction of the Trust's zero harm aspirations and plans for the delivery of quality by tackling unwarranted risks and variation at January 2014 meeting. This includes support for meta-analysis. An initial three year implementation plan to be developed for approval at March 2014 Quality Committee. *In January 2014, the Board of*	No further actions.

Quality area	Trust evidence	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2014/15
	the most recent available, and recent enough to be relevant. • 'On demand' data is available/ sought for the highest priority metrics. • The Trust is able to demonstrate how reviewing information has resulted in actions which have successfully improved quality performance, e.g. inpatient safety metrics and care bundles continue to demonstrate sustained improvements.		*Directors approved a 3-5 year investment in continuous improvement programmes which will improve patient safety and effective care. This included appointment to 'quality surveillance' analytical roles – recruitment has been completed.* **Associate Director of Safe Services**	

Appendix 2.1: Self assessment evidence against *Monitor* NHS provider licence criteria as at Q4 2013/14

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

Licence reference	Licence provision	Self assessment	Q4 response	Further actions for completion by end Q1 2014/15
1. General provisions				
G2	Has Monitor given any direction regarding setting or limiting conditions within the Provider Licence?	**GREEN**	No.	No further actions.
G4(1)	Is the Trust aware of any reason why a newly appointed Governor or an appointed Governor is unfit to be a Governor?	**GREEN**	No.	No further actions.
G4(2)	Is the Trust aware of any reason why a newly appointed Director or a Director in post is unfit to be a Director?	**GREEN**	No.	No further actions.
G5	Has Monitor issued new guidance relating to the provider licence in the quarter?	**GREEN**	No.	No further actions.
G6	Executive to consider any new licencing risks identified in the quarter – update of Board Assurance Framework for Board approval?	**AMBER/ GREEN**	The current corporate assurance framework includes a strategic risk in relation to "Risk of breach of Trust Terms of Authorisation/ Licence as a result of external scrutiny" to inform risk treatment plan on an ongoing basis.	This strategic risk requires a full review and remodelling to ensure it articulates the actual current residual risk/s, following on from the Audit Committee review of this risk on 1 May 2014 and assurance received that early warning frameworks are in place, as far as reasonably

Licence reference	Licence provision	Self assessment	Q4 response	Further actions for completion by end Q1 2014/15
				practical, to mitigate this risk. **Associate Director of Safe Services/ Head of Corporate Affairs**
G6(3)	Publication of Annual Governance Statement (AGS)?	**GREEN**	No action in Q4.	The AGS is published as part of the Annual Report and Accounts 2013/14 in July 2014.
G7	Consider CQC registration status in quarter – note cancellations and registrations (G7(2))?	**GREEN**	Trust Board location to be amended to Redesmere.	Head of Compliance to update statement of registration with change to Trust Board location.
G9	Consider whether Commissioner Requested Services have not been amended?	**GREEN**	No.	No further actions.
G9(12)	Have the contractual requirements to activities or any mandatory services been amended?	**GREEN**	No.	No further actions.
2. Pricing				
P1(4)	Have any services been sub contracted?	**GREEN**		
3. Choice and competition				
C1(3)	Are clear systems in place for notifying individual patients about choice re '18 week' breaching when arranging alternative care?	**GREEN**	N/A.	
4. Integrated care				
IC1	Are there any service changes that require staff/ public consultation (need to be cognisant of Public Interest)?	**GREEN**	Not at this time.	

Licence reference	Licence provision	Self assessment	Q4 response	Further actions for completion by end Q1 2014/15
5. Continuity of services				
CoS1	Have any contract variations been completed to service specifications [if Yes action required CoS1(4)]?	**GREEN**	There were no specific contract variations for changes to the service specifications in quarter 4. As part of the 2014/15 contract negotiations which take place during quarter 4, all service specifications should be reviewed and any changes agreed with the commissioners will have been included as part of the 2014/15 contract at sign off. Service specifications for NHS Wirral CCG, NHS East Cheshire/ South Cheshire and Vale Royal CCGs have been reviewed and agreed by all parties. A review is still required for West Cheshire mental health and physical health services and the smaller contracts as part of the 2014/15 negotiations	To complete contract specification work as per Q4 response.
CoS2	Have any assets been disposed of that would impact on the ability to provide 'Commissioner Requested Services'?	**GREEN**	No.	
6. NHS Foundation Trust conditions				
FT1	Has the Constitution been amended? Publication of the Annual Report and Accounts in accordance with Monitor requirements – once published requires submission to Monitor with 28 days.	**GREEN**	Constitution amended in 2013/14 to reflect changes agreed at the 2012 Annual Members Meeting and Health and Social Care Act changes. Revised version provided to Monitor in accordance with requirements and published on website.	
FT4(8)	Submit to Monitor audited Corporate Governance	**GREEN**	N/A.	Due for sign off at June 2014 Board meeting.

Licence reference	Licence provision	Self assessment	Q4 response	Further actions for completion by end Q1 2014/15
	Statement following Board approval in Q1 by 30 June 2014.			

Appendix 2.2: Full list of *Monitor* NHS provider licence criteria

Availble on T drive.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/15/14)

Report to:	Board of Directors – meeting in public
Date of Meeting:	28 May 2014
Title of Report:	Integrated governance strategy
Action sought:	To approve
Authors:	David Wood, Associate Director of Safe Services
Presented by:	Dr Anushta Sivananthan,Medical Director (Compliance, Quality & Assurance)

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	D Wood to L Hulme for Board of Directors	16.05.2014

1. Purpose of the report

This report provides the integrated governance strategy, incorporating the Trust's meetings structure, approved by the Quality Committee on 7 May 2014, for the endorsement of the Board of Directors.

2. Background

As an integrated governance strategy, i.e. spanning clinical governance, risk management, performance management, and across clinical and corporate support services, it was important that the current iteration of the integrated governance strategy be consulted on widely. A number of interdependencies were also taken into consideration in reviewing the strategy, these include:

- Changes to the performance management framework for the Trust from early 2014, including locality key performance indicators and performance reviews.
- A review of the Trust's patient safety culture, including its risk appetite and tolerances, which was the subject of the February 2014 Board seminar.

As such, the strategy was subject to a two month consultation to ensure a seamless approach. The strategy was circulated for consultation on 13 January to the:

- Quality Committee membership.
- Audit Committee membership.
- Operational Board membership.

These groups have a direct impact on the successful operation, management and scrutiny of the principles articulated in the integrated governance strategy.

3. Key areas of the strategy that have been reviewed

- Introduction of a target risk score, to ensure a systematic approach to the active management and subsequent archiving of risks.
- Introduction of risk treatment plans, to bolster controls and assurances against risks, thereby mitigating residual risk and closing gaps in assurance.
- Greater clarity regarding inherent, residual and target risks so that there is a common language around risk management.
- Clearer means of escalation of risks within clinical service structures and to corporate level.
- Ensuring that locality and strategic risks underpin and drive all of the Trust's operating activities and strategic decision making, in conjunction with the Trust's strategic objectives and locality/ specialty clinical strategic objectives.
- More consistent and routine use of the risk grading matrix to ensure that there is a common understanding of how risk should be judged.
- Use of this internal judgement framework to ensure more consistent application of tolerance to risk and a systematic approach to its escalation and de-escalation.
- Strengthening of the Trust's meetings structure, e.g.
    - Introduction of the innovation agenda to the business and development sub committee, so that Dragon's Den innovation pitches are not one off events, rather innovation is a routine activity.
    - Introduction of a compliance, learning and assurance group, to close gaps following removal of the learning from experience group from the corporate meetings structure and limitations of the current performance and compliance sub committee.

4. Conclusion

The changes to the integrated governance strategy formalise the enhanced arrangements that have been introduced by the Trust's Safe Services Department that have been in place in 'shadow' format during the latter half of the year. The assurance provided by these enhanced arrangements has been recognised through the work of the Trust's internal auditors in relation to the requirements of the Annual Governance Statement. Significant assurance has been received that there is an effective system of internal control to manage the principal risks identified by the organisation.

5. Recommendation

The Board of Directors is asked to **endorse** the integrated governance strategy.

Integrated Governance Strategy

Lead executive	Medical Director
Author / contact number	Associate Director of Safe Services - 01244 393134

Type of document	Strategy
Target audience	All CWP staff
Document purpose	The integrated governance strategy combines the risk management strategy and performance management framework into one document. This will ensure that effective systems can be implemented without unnecessary duplication and the Trust can monitor and deliver its strategic objectives, delivered via the integrated governance model.

Document consultation		
AMH – Wirral	Yes	Jan Pye; Rashmi Parhee; Jose Ferran; Geraldine Swift; Joanne Hurley; Neal Fenna; Linda Friend; Iain Wells; June Thornton; Polly Nash
AMH – West	Yes	Joanne Knowles; Joy Fenna; Daniel Carlson; Dave Appleton; Colin White;
AMH – East	Yes	Sally Sanderson; Jane Tyrer; Kate Chapman; Karen Millard; Laura Draper; Mark Grey; Nichola Spinney; Jenny Jones;
D&A services	Yes	Jane Newcombe; Pauline Forrester; Susan Griffiths; Angela Davies; Linda Johnstone;
CAMHS	Yes	Carys Jones; Karen Phillips; Gwen Jones; Catherine Phillips; Toby Biggins; Iris Batman; Carole Winstanley
LD services	Yes	Jan Patton; Janet Lomas; Jean Brennan; Sarah Evans; Susan Rawson; Christina Theobald; Alison Woodhouse;
CCWC services	Yes	Cathy Hones; Sally Kass; Helen Thornley-Jones
Corporate services	Yes	Abiola Allinson; Chris Sheldon; Fiona Couper; Gill Monteith; Jane Manton; Audrey Jones; Jo Watts; Jenny Gillison; Lyn Ellis; Martin Dowler; Pat Mottram; Tracey Battison; Veena Yadav; Alison Wood; Melysa Cureton; Karen Herbert; Joanna Rogerson; Jan Devine; Sally Bestwick; Amanda Miskell; Lynn Barton; Helen Pilley; Ken Edwards; Helen Davies; Jen Adams
Other	Yes	Review of meetings / governance structure undertaken with wide consultation with Executive Directors, Associate Directors, Clinical Directors and General Managers
Staff side	Yes	Dave Donal; Terry Unwin;

Approving meeting	Quality Committee	5-Mar-14
Original issue date	Apr-03	
Implementation date	Mar-14	
Review date	Mar-16	

CWP documents to be read in conjunction with	HR6	Mandatory Employment Learning (MEL) policy

Training requirements	Yes - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA)

Financial resource implications	No - None specifically there may be resulting financial implications as a result of adopting this strategy i.e. resources to reduce / mitigate risk

Equality Impact Assessment (EIA)

Initial assessment	Yes/No	Comments
Does this document affect one group less or more favourably than another on the basis of:		
• Race	No	
• Ethnic origins (including gypsies and travellers)	No	
• Nationality	No	
• Gender	No	
• Culture	No	
• Religion or belief	No	
• Sexual orientation including lesbian, gay and bisexual people	No	
• Age	No	
• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
N/A		
Is the impact of the document likely to be negative?	No	
• If so can the impact be avoided?	N/A	
• What alternatives are there to achieving the document without the impact?	N/A	
• Can we reduce the impact by taking different action?	N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted.		

If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.

Was a full impact assessment required?	No	
What is the level of impact?	Low	

Document change history

Changes made with rationale and impact on practice
1. Introduction of a target risk score.
2. Introduction of risk treatment plans.
3. Greater clarity regarding inherent, residual and target risks.
4. Clearer means of escalation of risks within clinical service structures and to corporate level.
5. Introduction of an internal judgement framework.

External references

References
1. DH (2006). The Integrated Governance Handbook. London, Department of Health, Crown Copyright.

Content

1. Introduction

The Integrated Governance Handbook, produced by the Department of Health and developed in February 2006, describes integrated governance as *'systems, processes and behaviours by which Trusts lead, direct and control their functions, in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations'*.

Integrated governance in Cheshire and Wirral Partnership NHS Foundation Trust (CWP) is therefore about the integration of clinical and corporate governance, clinical and non-clinical risk management, and performance management / improvement / escalation processes in order to give the Board of Directors and key internal / external stakeholders assurance regarding the quality and safety of the services that the Trust provides.

This ensures that effective systems are implemented without unnecessary duplication and the Trust can monitor and deliver its strategic objectives, which are as follows:

- Deliver high quality, integrated and innovative services that improve outcomes;
- Ensure meaningful involvement of service users, carers, staff and the wider community;
- 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;
- Be recognised as a progressive organisation that is about care, well-being and partnership.

2. Implementation of the integrated governance model

The delivery of this integrated governance strategy relies on having:

- Robust internal (corporate) assurance mechanisms and quality governance arrangements – this is delivered through the direct and indirect assurance provided through the corporate meetings structure to the Board and to external stakeholders, i.e. regulators, commissioners, external scrutineers, partner organisations and patient groups;
- Assurance mechanisms through the use of external and internal (independent) audit and seeking to review benchmarking / peer review data, where available;
- Robust links to the Trust's Operating Framework to describe the accountability arrangements and the actions that will be taken should risk / performance issues be judged as requiring escalation.

2.1 Organisational risk management structure detailing all those committees and groups which have some responsibility for risk

The Trust's corporate meetings structure is shown in appendix 1.

The committees of the Board are responsible for overseeing strategic risks outlined within the strategic risk register and corporate assurance framework. The Quality Committee reviews the strategic risk register at each meeting, as the committee with 'overarching responsibility for risk'. The Quality Committee will refer any risks to the Operational Board as appropriate, particularly where there are identified resource requirements to address the risk(s).

The Audit Committee is responsible for oversight and internal scrutiny of risk systems and processes within the organisation, and discharges these functions through the use of internal and external auditors. The internal audit plan is developed in collaboration with the strategic risk register. In addition, at each Audit Committee meeting there is an in-depth review undertaken on a selected strategic risk, the controls and assurances in place, mitigations identified, and the impact of these on the residual risk rating and outstanding controls and assurances ahead of reaching the target risk rating. In summary, this committee provides additional assurance on risk management processes and systems for the Board of Directors.

Both committees will escalate to the Board of Directors any risks where controls are not sufficiently impacting (positively) on the residual risk rating towards achieving the target risk score.

There must be approved, documented terms of reference for the high level committee(s) with overarching responsibility for risk. The terms of reference for these, i.e. the Quality Committee, Operational Board and Audit Committee are outlined in appendix 2 respectively.

Terms of references within the governance structure must include a description of:

- Duties;
- Who the members are, including nominated deputies where appropriate;
- How often members must attend;
- Requirements for a quorum;
- How often meetings take place;
- Reporting arrangements into the high level risk committee(s);
- Reporting arrangements into the Board from the high level risk committee(s).

2.2 How the board or high level risk committee(s) review the organisation-wide risk register

The corporate assurance framework is utilised by the Board of Directors as a planned and systematic approach to the identification, assessment and mitigation of the risks that could hinder the Trust achieving its strategic objectives. The assurance framework document contains information regarding internal and external assurances that strategic objectives are being met.

Where risks are identified, mitigations and subsequent action plans are mapped against them. The assurance framework is used to develop the risk register that is scored using a 5x5 matrix of impact and likelihood, see appendix 3 for risk matrix. This matrix adapted from the internationally recognised Australian and New Zealand standard (AS NZS 4360:2004), which is widely used within the NHS. This is a 5x5 matrix, in which score for impact or consequence of the risk is multiplied by the score for likelihood of recurrence. The total score generated is known as the risk rating.

In addition to the escalation of risks via the Quality and Audit Committees, the Board of Directors is also required to receive the full corporate assurance framework document and the strategic risk register a minimum four times yearly for review.

The approved strategic risk register includes the following:

- Source of the risk (including, but not limited to, incident reports, risk assessments, locality risk registers, and external recommendations);
- Description of the risk;
- Identified risk owner and risk leads;
- Risk score detailing inherent score (gross - before the application of controls), residual score (net - after the application of controls) and target (tolerable) score;
- Controls, assurances and risk treatment plan to address gaps;
- Date of review.

Each risk is linked to a Trust strategic objective and has an Executive lead responsible for receiving assurance that the actions required to mitigate the risk are completed at local, operational or strategic level.

2.3 Process for the management of risk locally, which reflects the organisation-wide risk management strategy / how risks are escalated through the organisation

Risk is managed at all levels, both up and down the organisation.

As well as having a strategic risk register, each locality has its own risk register(s), with the accountable officers for risk management being the Locality Clinical Director and Service Director of each locality as appropriate. The locality risk register must be reviewed within the local governance structure. Meetings within the corporate meetings structure or other meetings such as task and finish groups may maintain a risk log but in doing so should at each meeting consider whether those risks that are logged represent a hindrance to the Trust achieving its local strategic objectives or Trustwide strategic objectives – the process of local management of risk and escalation should be followed as per Table 1.

Risks can be managed and monitored within a locality but must be elevated appropriately, dependent on the severity of the risk. This is outlined below:

Table 1: Local management of risk and escalation

Score	Grade	Local management of risk and escalation
Risk Rating 1-6 'Green'	**Low - moderate**	**Risk can be managed within localities via agreed governance structures** – individual / team must escalate to Team Manager
Risk Rating 8-12 'Amber'	**High**	**Risk can be managed within localities via agreed governance structures** – General Manager must escalate to Service Director and Locality Clinical Director
Risk Rating 15-25 'Red'	**Extreme**	**Risk is escalated to Safe Services Department for consideration for inclusion on the strategic risk register – those risks scoring 15 or more when modelled for their Trustwide impact are included and a risk treatment plan agreed** – Service Director or Locality Clinical Director to inform Safe Services Department. Safe Services Department to escalate to relevant Executive(s) to agree Trustwide impact, with management in line with corporate assurance framework processes if risk score remains red.

The top five risks on locality risk registers are reviewed at quarterly performance reviews. This involves Executive scrutiny of the local risk register and seeking assurance from the locality managers that appropriate controls are identified and implemented to address and reduce risk.

2.4 Assignment of management responsibility for different levels of risk within the organisation / authority levels for managing different levels of risk within the organisation

The integrated governance strategy sets out the responsibility and roles of each level of leadership in the organisation in relation to handling and managing risk.

At an executive level, the Chief Executive has delegated operational responsibility for oversight of risk management processes to the Medical Director (Quality), but each Executive Director is accountable for managing the strategic risks that are related to their portfolio. Executive Directors, as strategic 'risk owners', can discharge accountability to 'risk leads' within their portfolio, e.g. Associate Directors / senior managers.

At a locality level, Locality Clinical Directors and Service Directors are the accountable officers for the local risk register process and must manage risks as outlined in section 2.3. Locality Clinical Directors and Service Directors, as local 'risk owners', can discharge accountability to 'risk leads' within their portfolio, e.g. General Managers / Clinical Service Managers / Modern Matrons. As per section 2.3, any red rated local risks must be escalated to the Safe Services Department, for consideration to include on the strategic risk register. The Head of Compliance will receive an automated notification from the Trust DATIX system outlining that a risk has been red rated. The Head of Compliance will highlight the risk to the appropriate Executive Director for consideration of inclusion on the strategic risk register; the Executive Director should consider the following factors:

- The impact of the risk on the organisations ability to achieve strategic objectives;
- The nature of the risk (i.e. risks that could cause serious harm to people who use services);
- Does the risk treatment plan provide adequate assurance to mitigate the impact of the risk;
- If this risk is a locality based risk or affects one or more services.

The Executive Director will indicate those risks that should be escalated to the strategic risk register; such decisions will then be reported to the next Quality Committee for approval.

2.5 How all risks are assessed?

There are five steps to risk assessment as defined by the Health & Safety Executive, which the Trust has adapted, thus.

The approved strategic / locality risk register includes the following:

- Source of the risk (including, but not limited to incident reports, risk assessments, locality risk registers, and external recommendations);
- Description of the risk;
- Identified risk owner and risk leads;
- Risk score detailing inherent score (gross - before the application of controls), residual score (net - after the application of controls) and target (tolerable) score;
- Controls, assurances and risk treatment plan to address gaps;
- Date of review.

The process for assessing and recording risk both at a strategic and locality level within the Trust is as follows:

Step 1 - Identify the hazards / risks

This may be via a concurrent or reactive process (risk identified as a result of an incident for example) or via a proactive process (risk identified via a service development initiative / clinical strategic priority). The source of the risk must be identified and recorded on the relevant (strategic / locality) risk register.

Step 2 - Describing the risk and looking at current controls and assurances in place

Controls and assurances are recorded on the risk register and this helps determine the inherent (gross score) current residual risk score and target (tolerable) score (step 3).

Step 3 - Scoring the risk using 5x5 impact and likelihood

The risk is scored using the matrix in appendix 3.

Step 4 - Record of findings and actions

Actions are identified and implemented to reduce the risk to an acceptable level (as it is recognised that all risks can be practicably be eliminated). An acceptable level of risk will be determined on a case by case basis (using the Trust's risk tolerance methodology) to formulate the target risk score.

Step 5 - Reviewing the risk at regular intervals

Locality risk registers are reviewed monthly at the local governance meetings to ensure that risks are being monitored / managed. The strategic risk register is reviewed as a minimum four times per year by the Board of Directors and at every meeting of the Trust's Quality Committee which meets every two months. Outside of these meetings, where a new risk is identified or current risk controls are identified as not bringing about the desired degree of mitigation (i.e. occurrence of a further incident relating to a risk that is being managed) the Executive lead would identify the risk and ensure this is recorded on the strategic risk register and is escalated to the next Board of Directors meeting and Quality Committee.

2.6 How risk assessments are conducted consistently

There is not an exhaustive list of risk assessments however all risk assessments would usually follow their accompanying template, e.g. there is a stress risk assessment tool for stress, however where guidance is required to ensure a consistent approach to robustly conducting risk assessments for where there is not an accompanying tool, the Trust has also developed a generic risk assessment tool.

2.7 Risk awareness training for senior managers

As part of the Board of Directors development, there is regular risk management training to the Board of Directors and senior managers as part of the Trust's Training Needs Analysis (TNA).

Trust-wide risk awareness training sessions will be delivered as part of the mandatory employee learning programme and can be booked through the booking processes for training, outlined within Trust policy Mandatory Employee Learning (MEL) policy.

The process for recording attendance for the Board is via the Head of Corporate Affairs recording attendance and forwarding to Learning & Development Services (LDS) so that this can be recorded on the Trust's Electronic Staff Record (ESR) system. For all other attendees who must have risk awareness training, the recording of attendance is completed by LDS once the individual attends the learning event and signs the attendance register. LDS collates the sheets (either locally or through the trainer sending the documentation to LDS). The individual's learning record is updated by LDS to 'completed' or 'Did Not Attend' (dependent on the action) on ESR.

Follow-up of non attendance of Board members is undertaken by the Head of Corporate Affairs and, where a Board member has not been able to attend the planned seminar on risk management, they will be booked onto one of the other senior managers risk awareness sessions planned as part of the Mandatory Employee Learning (MEL) programme.

Follow-up of non attendance for all other senior managers who must have risk awareness training (other than Board members) is undertaken as per the processes outlined within Trust policy Mandatory Employee Learning (MEL) policy.

2.8 Risk acceptance

No organisation can achieve its strategic objectives without taking risk. Each organisational strategic objective in the corporate assurance framework features risks which the organisation is engaging with at any one time, which is indicative of the Trust's risk appetite. The risk tolerance is indicated by a target risk score in the corporate assurance framework, which is the level of risk that the organisation can accept.

As part of annual business planning cycle processes, including considering an integrated governance strategy that incorporates local, regional and national strategic context, commissioning intentions, and horizon scanning information, the Board of Directors in accepting new risks to organisational strategic objectives will assess (through its receipt, review and approval of the corporate assurance framework) its appetite for the risk(s). Where the risk appetite scores 2 – 5, then the risk will be added to the corporate assurance framework, risk treatment plan identified, and a target risk rating allocated. As per the descriptions below, the assessment of the target risk will predominantly be influenced the likelihood score.

Risk Appetite	Assessment	Description
1	Zero	Organisation is **not willing to accept under any circumstances risks that may** result in reputation damage, financial loss, or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / people who use the Trust's services.
2	Low	Organisation is **not willing to accept (except in very exceptional circumstances)** risks that may result in reputation damage, financial loss, or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / people who use the Trust's services.
3	Moderate	Organisation is **willing to accept some risks in certain circumstances that may** result in reputation damage, financial loss, or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / people who use the Trust's services.

Risk Appetite	Assessment	Description
4	High	Organisation is **willing to accept risks that may** result in reputation damage, financial loss, or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / people who use the Trust's services.
5	Very high	Organisation **accepts risks that are likely** to result in reputation damage, financial loss, or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / people who use the Trust's services.

2.9 Escalation framework (incorporating judgement and accountability framework)

The integrated governance strategy describes risk "events" and the management and escalation of these risks. However, as an integrated governance framework that not only considers risk but clinical governance and performance issues, consideration must also be given to the escalation of such "issues" that the organisation will be required to judge the significance of at any one time to inform means of escalation, for example to the Executive Team. The National Patient Safety Agency (NPSA) describes these in terms of the following domains:

- Impact on the safety of patients, staff or public;
- Quality / complaints / audit;
- Human resources / organisational / development / staffing / competence;
- Statutory duty / inspections;
- Adverse publicity / reputation;
- Business objectives / projects (including locality key performance indicators);
- Finance, including claims;
- Service / business interruption;
- Environmental impact.

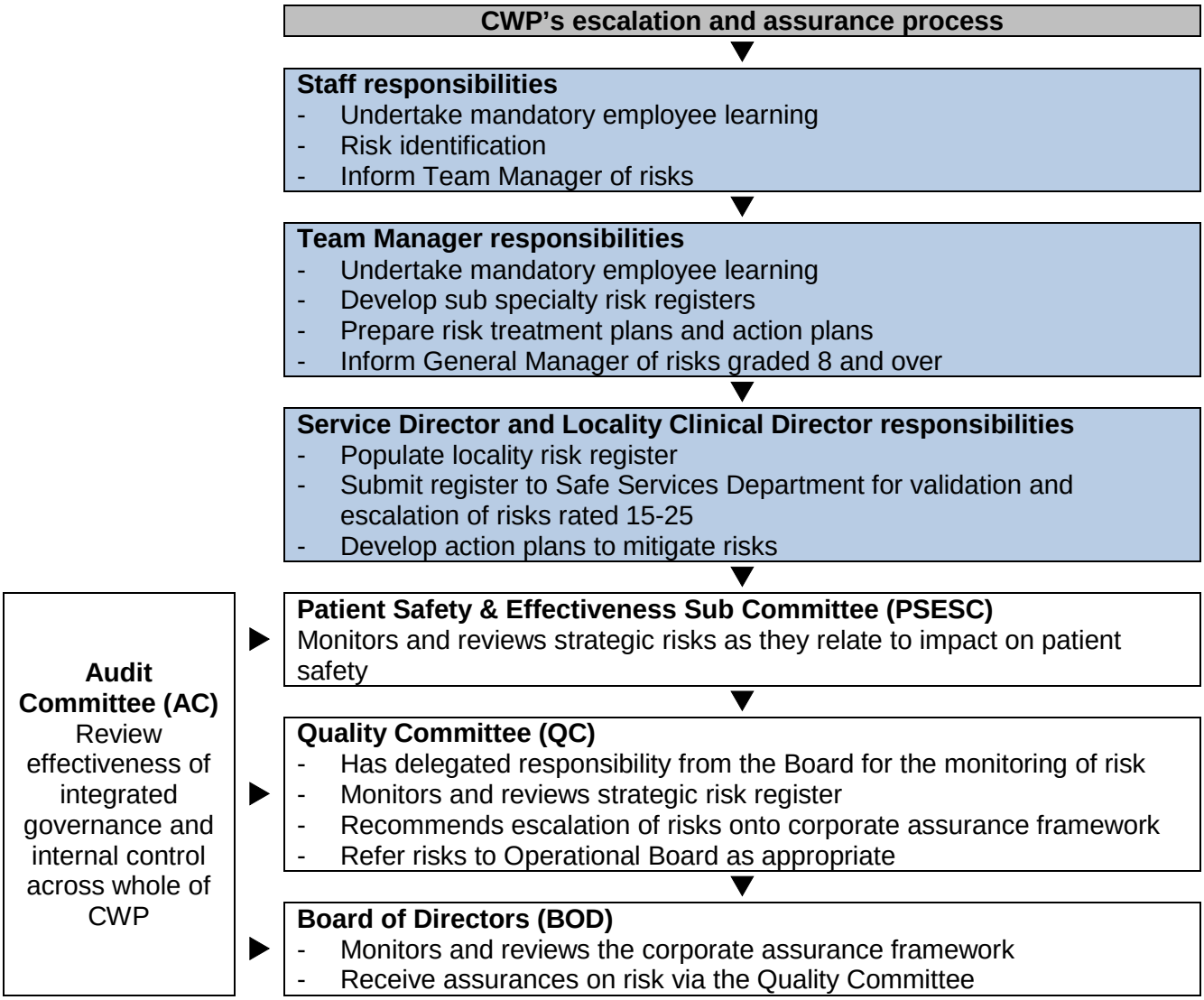
2.9.1 Early warning frameworks

Early warning frameworks are in place to identify the potential for deteriorating standards in the quality of care related to the above domains. For example, the quality dashboard incorporates a set of indicators that, taken together, give an indication of how well an individual team or service is functioning. It provides an early warning, pre-empting more serious concerns and enabling action to be taken before things go wrong. It offers a simple method to enable clinical management staff to assess the risk of deteriorating performance and to benchmark against others. Other frameworks / reports are reviewed by the Trust's Board of Directors to give a detailed view of CWP's overall performance, including:

- **The three times yearly Learning from Experience report** – reviews learning from incidents, complaints, concerns, claims and compliments, including *Patient Advice and Liaison Service* (*PALS*) contacts;
- **The quarterly Infection Prevention and Control report** – reviews the management and clinical governance systems in place to ensure that people experience care in a clean environment, and are protected from acquiring infections;
- **The monthly Corporate Performance report** – reviews the Trust's quality and safety performance by reporting on compliance in achieving key local and national priorities;
- **The quarterly Quality Report** – provides a highlight of what CWP is doing to continuously improve the quality of care and treatment that its services provide.

2.9.2 Escalation

Clear, transparent and consistent use of evidence based means of assessing / judging these issues is essential to inform when and how to (including who to) escalate. Application of a consistent methodology also ensures means of applying on-going judgements to inform eventual de-escalation. The risk rating matrix (appendix 3) provides criteria for scoring the risk associated with the above domains, and the significance of the risk. This facilitates the judgement of risk events or issues and whether they present as triggers for escalation. The following flowchart describes CWP's escalation and assurance process:



2.9.3 Trust meetings structure – reporting, responsibility, assurance mechanisms, escalation and accountability

The escalation framework is reliant on an effective Trust meetings structure (see appendix 1) which links through to the corporate assurance framework, underpinned by Monitor's quality governance requirements and the Care Quality Commission's requirements for registration. This provides the Board with assurance about how the organisation is able to identify, monitor and escalate and manage concerns, which may include identifying consequences to ensure performance management where assurance is not provided, in a timely fashion at an appropriate level.

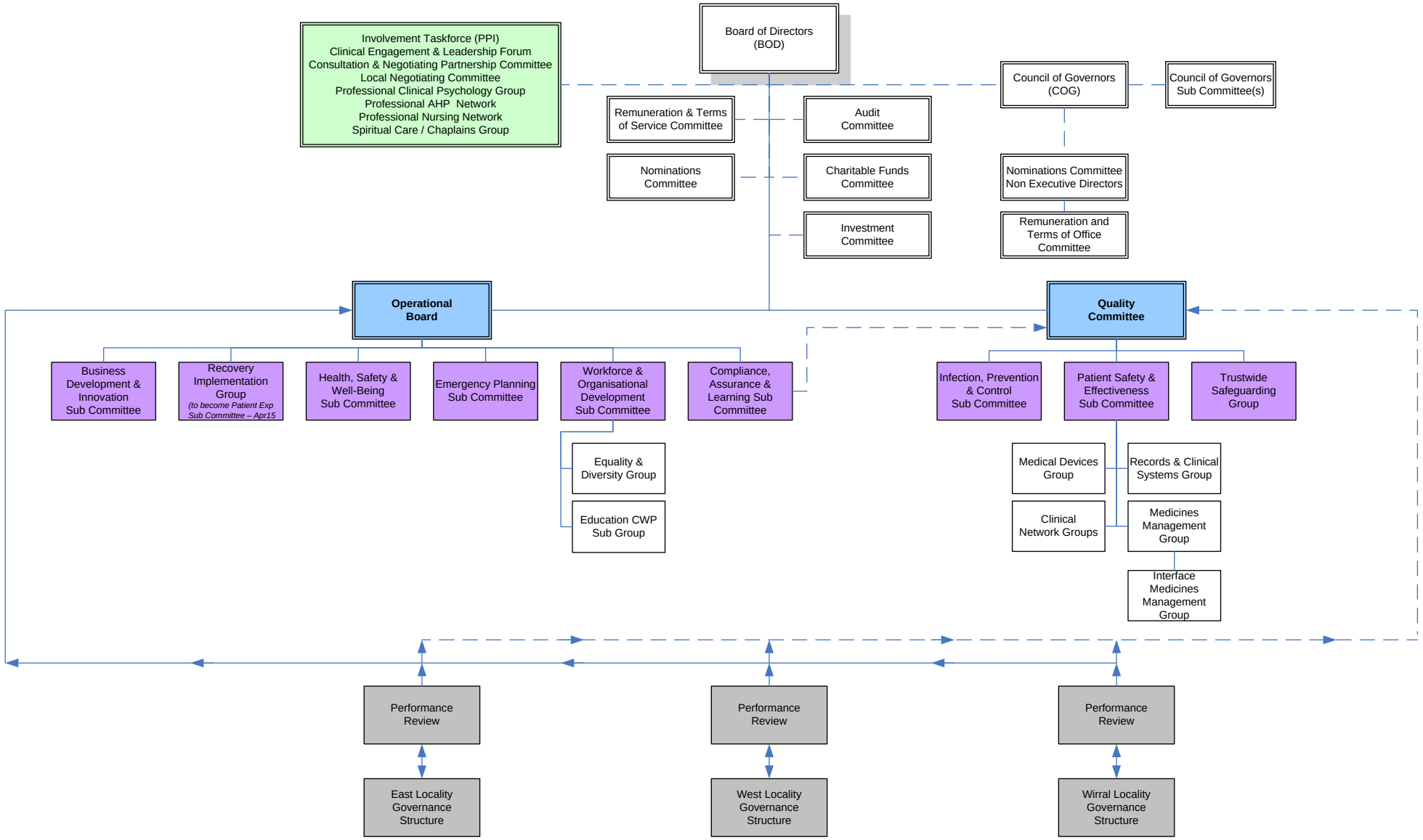
The Trust's strategic plan is implemented, monitored and assured by the Trust's meeting structure which has delegated responsibility from the Trust Board. The structure monitors compliance through performance indicators, a comprehensive audit programme, the monitoring of associated risks and through other mechanisms of assurance. The table below demonstrates the reporting and accountability mechanisms.

These are supported by clear terms of reference (ToR) (the most recent ToR are available via the corporate governance manual) and responsibilities (appendix 1).

	Trust Board Committees	Sub Committees	Groups	Task & Finish Groups
Reporting to	Trust Board	Board Committees	Committees	Groups
Reviewed	Annually against ToR	Annually against ToR	Annually against ToR	On establishment
Type	- Quality Committee - Audit Committee - Operational Board - Remuneration and Terms of Service Committee - Charitable Funds Committee - Nominations Committee - Investment Committee	- Business Development and Innovation Sub Committee (BDISC) - Health, Safety and Wellbeing Sub Committee (HSWSC) - Emergency Planning Sub Committee (EPSC) - Workforce and Organisational Development Sub Committee (WODSC) - Infection, Prevention and Control Sub Committee (IPCSC) - Patient Safety and Effectiveness Sub Committee (PSESC) - Compliance, Assurance and Learning Sub Committee (CALSC) - Trustwide Safeguarding Group - Recovery Implementation Group (RIG)	- Medicines Management Group (MMG) - Equality and Diversity Group - Clinical Network Groups - Records and Clinical Systems Group (RCSG) - Medical Devices Group - Education CWP Sub Group - Performance Reviews	ToR devised on inception
Membership	- Non-Executive Directors (NED) - Executive Director - Senior Managers - Senior Clinicians	- Executive Directors - Senior Managers - Staff - Representatives	- Various Staff	- Various Staff
Responsible for	- Strategy - Assurance - Monitoring progress, including identification of consequences - Devising plans	- Providing assurance - Implementing plans - Performance management of groups, including identification of consequences	- Operational activity delivery	- Specific delivery of work streams

	Trust Board Committees	Sub Committees	Groups	Task & Finish Groups
Assurance Mechanisms (up to Board)	- Minutes - Action Log - Action Plans - Audit - Risk Registers	- Minutes - Action Logs - Action Plans - Audit - Risk Registers - Detailed reports	- Minutes - Action Log - Audit - Detailed reports	- ToR - Minutes - Action plans
Escalation of risks	- To Trust Board through Risk Registers, minutes, detailed reports and audit	- To sub committee via minutes, risk registers, detailed reports, audit	- To committees reporting progress, risks, and quality	- Report risks

Appendix 1 – Trust meetings structure



Appendix 2 - Responsibility of committees

Operational Board

The Operational Board is responsible for ensuring that the decisions of the Board of Directors are implemented, monitoring the operational performance of the Trust and steering early development of policy, strategy and business case proposals prior to full discussions at the Board of Directors.

To view the full term of reference click here

Quality Committee

The Quality Committee is responsible for ensuring that the strategic priorities for quality improvement are identified, implemented and monitored. The Quality Committee is the committee responsible for monitoring strategic risks within the organisation.

To view the full term of reference click here

Audit Committee

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

To view the full term of reference click here

Appendix 3 - Risk rating matrix

			IMPACT		
likelihood of occurrence	**Catastrophic (5)**	**Major (4)**	**Moderate (3)**	**Low (2)**	**Minimal (1)**
Almost certain (5)	25	20	15	10	5
Likely (4)	20	16	12	8	4
Possible (3)	15	12	9	6	3
Unlikely (2)	10	8	6	4	2
Rare (1)	5	4	3	2	1

Some examples of scoring the impact of risks are outlined below:

	1	**2**	**3**	**4**	**5**
Descriptor	**Minimal**	**Low**	**Moderate**	**Major**	**Catastrophic**
Injury to staff or patient	Minor injury or illness, with / without first aid treatment	NPSA reportable Police reportable (Violent & Aggressive acts)	Injury up to 24hrs hospital treatment required (except major injuries)	Major injuries Long term incapacity / disability requiring extensive rehabilitation	Death or incident causing such harm that they place a patient or staff members life in jeopardy
Patient experience / complaints	Concerns raised / referral to PALS with agreed local resolution	Green complaint	Amber complaint	Red complaint	Detrimental recommendation following referral to external regulator
Litigation	None / minor out of court settlement	Civil Litigation – without defence Litigation cost <£50k	Civil / Criminal Litigation without defence costs of £50k - £500k	Civil / Criminal Litigation without defence cost £500k - £1m	Litigation cost >£1m
Service / Business continuity	Partial loss of service – short recovery	Partial loss of service – long recovery	Partial loss of service – cannot recover Complete loss of service – short recovery	Complete loss of service – long recovery	Complete loss of service – cannot recover
Staffing / Capacity	Short term low staffing level temporarily reduces service quality (less than 1 day)	On-going low staffing level reduces service quality	Late delivery of key objective / service due to lack of staff / capacity	Uncertain delivery of key objective / service due to lack of staff / capacity within organisation	Non delivery of key objective / service due to lack of staff / capacity within organisation

	1	2	3	4	5
Descriptor	**Minimal**	**Low**	**Moderate**	**Major**	**Catastrophic**
Financial (Loss)	Less than £1k	More than £1k but less than £25k	More than £25k but less than £100k	More than £100k but less than £1m Drop in financial risk rating	More than £1m unrecoverable financial loss by end of financial year. Drop in financial risk rating
Inspection / Self-assessment	Minor recommendations Minor non-compliance with standards	Recommendations given. Non-compliance with standards	Critical report Challenging recommendations. Non-compliance with standards	Enforcement Action. Severely critical report. Major non-compliance with standards	Successful prosecution. Query de-authorisation with Monitor
Adverse Publicity / Reputation	Local media – Short term. Minor effect on staff morale	Local media – Long term. Significant effect on staff morale	National Media less than 3 days	National Media more than 3 days Questions in Parliament	Public enquiry Prolonged national media attention

Measures of Likelihood are outlined below:

	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not