Cheshire and Wirral Partnership NHS
NHS Foundation Trust

AGENDA - Meeting of the Trust Board of Directors held in Public

Wednesday 25th July 2018 at 1.30 pm

Boardroom, Redesmere, Countess of Chester Health Park

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/26	Apologies for absence	Receive apologies:	(Verbal)	Chair	**1.30 (1 mins)**
18/19/27	Declarations of Interest	Identify and avoid conflicts of interest	(Verbal)	Chair	**1.31 (2 mins)**
18/19/28	Meeting Guidelines	To note	(Written)	Chair	**1.33 (1 mins)**
18/19/29	Minutes of the previous meeting • 24th May 2018 – Extraordinary meeting • 30th May 2018	Confirm as an accurate record the minutes of the previous meetings	(Written)	Chair	**1.34 (5 mins)**
18/19/30	Matters arising and action points	Provide an update in respect of ongoing and outstanding items to ensure progress	(Written)	Chair	**1.39 (5 mins)**
18/19/31	Board Meeting business cycle 2018/19 (revised)	To approve and note.	(Written)	Chair	**1.44 (5 mins)**

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/32	Chair's announcements	Announce items of significance not elsewhere on the agenda	(Verbal)	Chair	**1.49 (10 mins)**
18/19/33	Chief Executive's announcements *(including overview of items discussed in closed meeting)*	Announce items of significance not elsewhere on the agenda	(Verbal)	Chief Executive	**1.59 (20 mins)**
Quality of Care					
18/19/34	Monthly Ward Staffing Up-date • Six monthly report – Nov 17 – April 18 • Monthly reports – May and June 2018	To note the ward staffing reports	(Written)	Director of Nursing, Therapies and Patient Partnership.	**2.19 (5 mins)**
18/19/35	Guardian of Safe Working – Quarterly Report	To note	(Written)	Medical Director, Effectiveness, Medical Education and Medical Workforce	**2.24 (5 mins)**
Strategic Change					
18/19/36	CWP Rehabilitation Strategy	To note	(Written)	Director of Operations / Dr Amrith Shetty	**2.29 (20 mins)**
Operational Performance, Finance and Use of Resources					
18/19/37	Board Performance Dashboard	To note performance	(Written)	Director of Finance	**2.49 (5 mins)**
18/19/38	Integrated Governance Framework	To approve	(Written)	Medical Director Compliance, Quality and Assurance.	**2.54 (5 mins)**
18/19/39	Strategic Risk Register	To review and note	(Written)	Medical Director Compliance, Quality and Assurance	**2.59 (5 mins)**

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/40	GDPR Action Plan	To approve	(Written)	Medical Director, Effectiveness, Medical Education and Medical Workforce	**3.04 (5 mins)**
18/19/41	CQUIN – Food Services	To note	(Written)	Director of Operations	**3.09 (5 mins)**
Governance and Regulation					
Governance and regulation: Assurance and escalation reports from Board Sub-committees (discussion by exception only)					
18/19/42	Liverpool Community Health Independent Review Report (Kirkup)	To note	(Written)	Medical Director Compliance, Quality and Assurance	**3.14 (10 mins)**
18/19/43	Infection, Prevention and Control Annual Report	To note	(Written)	Director of Infection, Prevention and Control	**3.24 (5 mins)**
18/19/44	Health and Safety Annual Report	To note	(Written)	Director of Nursing, Therapies and Patient Partnership.	**3.29 (5 mins)**
18/19/45	Medical Appraisal Annual Report and Annual Declaration	To note	(Written)	Medical Director, Effectiveness, Medical Education and Medical Workforce	**3.34 (5 mins)**
18/19/46	Quality Committee Chair's report and terms of reference: • July 2018	Review Chair's Report and any matters for note/ escalation and approve terms of reference.	(Written)	Chair of Quality Committee	**3.39 (5 mins)**

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/47	Audit Committee Chair's report: • July 2018	Review Chair's Report and any matters for note/ escalation	(Written)	Chair of Audit Committee	**3.44 (5 mins)**
Closing Business					
18/19/48	Any other business other business	Consider any urgent items of other business	(Verbal)	Chair	**3.49 (5 mins)**
18/19/49	Questions from observers or members of the public. *(relating to specific items on the agenda)*	To encourage openness and transparency	(Verbal)	Chair	**3.54 (10 mins)**
18/19/50	Review of risk impacts of items discussed	Identify any new risk impacts	(Verbal)	Chair/ All	**4.04 (2 mins)**
18/19/51	Key messages for communication	Agree items of particular importance to communicate to staff, governors or other key stakeholders	(Verbal)	Chair	**4.06 (5 mins)**
18/19/52	Review of meeting performance	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	(Verbal)	Chair/All	**4.11 (5 mins)**
18/19/53	Date, time and place of next meeting: • **FRIDAY 28th September 2018 – 1:30pm – Location TBC**	Confirm arrangements for next meeting	(Verbal)	Chair	**4.16 (Close)**

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting Attendees' Guidance, January 2016

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

Before the meeting

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

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

At the meeting

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

Attendance

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

After the meeting

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

Standards

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

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

UNCONFIRMED Minutes of the Board of Directors Meeting
Thursday 24th May 2018
Board Room, Redesmere at 12:00 noon.

PRESENT	Mike Maier, Chair Dr Jim O'Connor, Non-Executive Director Lucy Crumplin, Non-Executive Director Sheena Cumiskey, Chief Executive Avril Devaney, Director of Nursing, Therapies and Patient Partnership David Harris, Director of People and Organisational Development Edward Jenner, Non-Executive Director Dr Anushta Sivananthan, Medical Director, Quality, Compliance and Assurance Rebecca Burke-Sharples, Non-Executive Director Tim Welch, Director of Finance Ann Pennell, Non-Executive Director	
IN ATTENDANCE	Suzanne Christopher, Corporate Affairs Manager (mins) (SCh)	
APOLOGIES	Dr Faouzi Alam, Medical Director Andrea Campbell, Non-Executive Director Andy Styring, Director of Operations	
	MINUTES	**ACTION**
18/19/01	**APOLOGIES AND ABSENCE** The Chair welcomed all to the meeting. The meeting was quorate. Apologies were noted as above.	
18/19/02	**DECLARATIONS OF INTEREST** There were none declared.	
18/19/03	**CHAIR'S ANNOUNCEMENTS** The Chair confirmed that announcements would be deferred to the usual board meeting scheduled for the following week.	
18/19/04	**CHIEF EXECUTIVE ANNOUNCEMENT** The Chief Executive confirmed that announcements would be deferred to the usual board meeting scheduled for the following week.	
18/19/05	**PROVIDER LICENCE COMPLIANCE – REVIEW AND DECLARATIONS (G6&CoS7 AND FT4)** Tim Welch confirmed that there is a requirement for the Trust to complete the self-declarations included in the agenda pack on an annual basis. Quarterly declarations are presented to Board for consideration and review. Earlier in the week the annual declarations were reviewed by the Audit Committee. which recommended that the Board approve these for submission to NHSI. The Board of Directors **noted and approved** the declarations for submission.	

18/19/06	**STATUTORY REGISTERS – DIRECTORS AND GOVERNORS** The Chair confirmed that the registers are presented to Board to note. Suzanne Christopher confirmed that the Governor's register of interests had been further up-dated following the agenda pack being issued. At the time of the meeting only one declaration remained outstanding (Iain Stewart). The team will continue to chase. **ACTION** – Chairman and Lead Governor to contact Iain Stewart in writing to review his recent attendance at the Council of Governors. The Board of Directors **noted** the registers.	**SCh / MM**
18/19/07	**CHIEF EXECUTIVE / CHAIR – DIVISION OF RESPONSIBILITIES** The Chair introduced the paper and advised that the duties of the Chairman and Chief Executive are reviewed on a yearly basis. No questions were raised by the Board. The Board of Directors **approved** the division of responsibilities.	
18/19/08	**AUDIT COMMITTEE – ANNUAL REPORT** Edward Jenner introduced the report. The report was taken as read and questions were invited. Lucy Crumplin raised a question in respect of the External Audit section of the report – section D – second paragraph – regarding no significant deterioration in the trend of the Trust's experience of such incidents. Lucy requested that in terms of a comparator, that this be benchmarked to provide the relevant context. **ACTION** – Request Philip Leong (MIAA) to provide benchmarking information as above. The Board of Directors **noted** the Audit Committee Annual Report.	**SCh / EJ**
18/19/09	**ANNUAL REPORT AND ACCOUNTS – 2017/18** Tim Welch introduced the item and requested that the Board consider the following:- 1. Any comments about the documents in terms of factual accuracy 2. Consider the assurance process Tim advised that further to the papers being issued to the Board members, that the documents had also been reviewed by the Audit Committee on the 22nd May 2018. The Audit Committee requested three amendments to the Annual Report and Accounts as follows:- • Inclusion that Dr James O'Connor is also the Trust Deputy Chair • Reference to the Scrutiny Committee of the Council of Governors • Paragraph by way of explanation to the Statement of Comprehensive Income.	

	Further to the Audit Committee meeting, the Trust also received feedback from some Stakeholders which was now included. An SBAR had been provided to the Board ahead of the meeting to outline the above amendments. Each report was then reviewed separately. <u>Annual Report</u> Ann Pennell requested that a small amendment be made to the Lead Governor statement welcoming her to the Trust – to include reference to 'Social Care'. Mike Maier requested a change to the order of the wording in the Remuneration Report to better explain and reflect the changes to Board Members pay. **ACTION** – for the above amendments to be made to the Annual Report and Accounts 17/18 prior to submission to the NHSI portal. <u>Quality Report</u> Dr Anushta Sivananthan advised the Board that the Quality Committee and Board have received assurance throughout the year which is reflected in the Quality Report. Dr Anushta Sivananthan provided assurance to the Board in response to some of the feedback received from Commissioners to date. In respect of the CQUIN for Wound Care Assessment, the Trust is not financially penalised. The CQUIN is based on point prevalence and does not focus on continuous improvement. The Trust also reports on Pressure Ulcers and if required, deals with these accordingly through the Zero Harm group and Quality committee. In respect of the comment on reduction of beds, the Trust closely monitors this extremely important target and this will continue to be monitored as part of our Quality Assurance. The Chief Executive commented that this also forms part of our monthly dashboard which is reviewed at Board. Tim Welch confirmed for the understanding of Board members that the Trust is required to include verbatim feedback from partners within the Quality Report and, therefore, does not have a formal right of reply. Rebecca Burke-Sharples raised a query in relation to the 'tone' around one of the feedback comments in respect of waiting times for CAMHS services. Dr Anushta Sivananthan advised that the information that the Trust had provided was correct and that this will also be picked up via the Care Groups and our Performance Dashboard. <u>Financial Accounts</u> Tim confirmed that the presentational change in respect of the Statement of Comprehensive Income had been referenced to the Board earlier in the week as stated earlier in the meeting. No questions were raised by Board members in respect of the Financial Accounts.	**SCh**

	ISA 260 Tim Welch confirmed that the final version of the ISA 260 had now been received by the Trust. Referring to page 5 of the document, Tim provided the following summary: Financial Statements • The Auditors have provided a clean opinion. • Minor presentation work was required which is now all complete. • There are no unadjusted audit differences. • All recommendations from last year have all been completed and are now closed. Value for Money • The Auditors have provided a clean opinion. Quality Report • A limited opinion assurance is provided by the Auditors. Due to the complexity of how the Quality Accounts are externally audited , this is the highest rating achievable. . • Dr Anushta Sivananthan reported that the Quality Report is also scrutinised by NHS Improvement. A discussion followed in respect of the indicator chosen by Governors which the auditors are not required to audit, but do so on behalf of the Governors. It was felt that some reflective learning was required in respect of how the Trust can support the Governors to choose their indicator to ensure this gives them something viable to audit. No further questions were raised by Board members. The Board of Directors **noted** the ISA 260 and **approved** the Annual Report and Accounts 2017/18 for submission to NHSI on the basis of the recommendation of the Audit Committee and pending the suggested amendments above. The Chairman thanked all those involved in producing the Annual Report and Accounts for their efforts. Tim Welch re-iterated his thanks to both the Finance Team and the Safe Services Team for all their hard work.	
18/19/10	**ANY OTHER BUSINESS** None	
18/19/11	**QUESTIONS FROM OBSERVERS OR MEMBERS OF THE PUBLIC** No observers present.	
18/19/12	**REVIEW OF EFFECTIVENESS OF MEETING** All agreed the meeting was effective.	
18/19/13	**DATE, TIME AND PLACE OF NEXT MEETING** Wednesday 30th May 2018, Boardroom, Redesmere (Closed Board – 9:30am, Open Board – 1:30pm).	

Signed

Mike Maier, Chair

Date:

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

UNCONFIRMED Minutes of the Public Board of Directors Meeting
Wednesday 30th May 2018
Boardroom, Redesmere commencing at 1.30pm

PRESENT	Mike Maier, Chair Dr Jim O'Connor, Non-Executive Director Lucy Crumplin, Non-Executive Director Sheena Cumiskey, Chief Executive David Harris, Director of People and Organisational Development Edward Jenner, Non-Executive Director Dr Anushta Sivananthan, Medical Director, Quality, Compliance and Assurance Rebecca Burke-Sharples, Non-Executive Director Andy Styring, Director of Operations Ann Pennell, Non-Executive Director Gary Flockhart, Associate Director of Nursing and Therapies (MH & LD) (on behalf of Avril Devaney) Andy Harland, Deputy Director of Finance (on behalf of Tim Welch)	
IN ATTENDANCE	Suzanne Christopher, Corporate Affairs Manager (mins) Jodie Denrico, Acting Head of Communications and Engagement	
APOLOGIES	Avril Devaney, Director of Nursing, Therapies and Patient Partnership Tim Welch, Director of Finance Andrea Campbell, Non-Executive Director Dr Faouzi Alam, Medical Director	
	MINUTES	**ACTION**
18/19/01	**APOLOGIES AND ABSENCE** The Chair welcomed all to the meeting. The meeting was quorate. Apologies were noted as above.	
18/19/02	**DECLARATIONS OF INTEREST** There were none declared.	
18/19/03	**MEETING GUIDELINES** The meeting guidelines were noted.	
18/19/04	**MINUTES OF PREVIOUS MEETINGS** The minutes of the meeting held on the **28th March 2018** were reviewed:- • Amendments to the attendance list – to add in Rebecca Burke-Sharples and Ann Pennell • Page 3 – correction to the job title of Linda Johnstone The minutes of the Board meeting held on the **28th March 2018** were **approved** as a correct record.	
18/19/05	**MATTERS ARISING AND ACTION POINTS** 29/11/17 – WRES Up-date – schedule for July Open Board 17/18/92 – CCICP's future reporting to the Board: this is now included on	

	the Board business cycle - Close 17/18/99 – Paper was presented to Operational Board and the matter is monitored via the bed reports. Up-date to July's Open Board. 17/18/118 – further work is being undertaken and this will be reported to the June Board.	
18/19/06	**BOARD MEETING BUSINESS CYCLE** The 2018/19 business cycle was reviewed and **approved**.	
18/19/07	**CHAIR'S ANNOUNCEMENTS** The Chair announced the following: **Five year forward view – Trust Strategy** The strategy is now live and published on the Trust website. The strategy sets out the Trust objectives to 2023. **Mental Health Awareness Week** Last week was Mental Health Awareness Week, and this year the theme was 'stress'. A series of pop-up events were held **NHSmail migration** The process is now completed, and the Board expressed its thanks to our IT colleagues for all their efforts in ensuring a smooth process with minimal disruption.	
18/19/08	**CHIEF EXECUTIVE ANNOUNCEMENTS** The Chief Executive summarised the matters discussed in Closed Board as follows:- The Board : • Received an up-date and assurance in respect of the Thorn Heys Short Stay Respite Services on the Wirral. • Heard about the progress made in regards to the NHSmail migration and thanked staff for their considerable work to make the process as smooth as possible. • Considered the up-date on SUI's. • Approved the forward plan on Health Informatics Strategy. • Received an up-date on the tendering processes for Substance Misuse Services in the West and East. • Approved the MoU for Cheshire East Partnership Board. • Approved the development of Care Groups Approvals Panel. • Heard that the Trust is on track with its financial plan at month 1 of this financial year. The Chief Executive also provided an up-date to the Board with regards to the Liverpool Community Health Independent Review Report, also known as the Kirkup Report. The report was undertaken to look into events within that Trust over a period of time. CWP have now been issued with a copy of the report and the Executive team are currently reviewing the findings of the report and will use the outcomes to inform our Governance review. The outcome of this work will then form part of the business cycle for Operational Board that will report into the Quality Committee and the	

	Board in order that we can assess ourselves against the themes. An up-date will be provided to June Operational Board and July Board of Directors. The Chief Executive summarised the themes of the Report for the Board members. It was also noted that NHS England and NHS Improvement are currently considering ways of closer partnership working. Whilst they will remain two statutory organisations, they are considering some single integrated teams. There is suggestion that the regions will also be re-organised with the North region being reconfigured into the north west and the north east.	
18/19/09	**LEARNING FROM EXPERIENCE REPORT – EXECUTIVE SUMMARY** Gary Flockhart introduced the report covering December 2017 to March 2018 and highlighted: • Overall reduction in the number of incidents. • Overall incidents reported by CWP remain in the middle range. Seven areas identified for recommendations: • The quality improvement initiative regarding self-harm is now incorporated. • Mortality task and finish group is now complete. • The learning from deaths review led by the Consultant Nurse is now complete. • The Medication Safety Officer has linked with the safe services department and actions have now been achieved. • Routine review of staff accident incidents is now included in the business cycle. • • Business cycle for each sub-committee to include at least one publication a year to assist with practice development will form part of the corporate meetings review being undertaken by the Medical Director and the Associate Director of Safe Services. The Recommendations made from Trimester 3 analysis were as follows:- • The Safe Services Department to develop an accessible learning from deaths web page. • The Head of Clinical Governance to allocate investigation managers to outstanding investigations to ensure CWP continues to contribute to the national LeDeR programme. • Further analysis to be undertaken by the Safe Services Department and the Care Groups to streamline complaints categories and themes. In order to strengthen ward to board assurance, the Quality Committee has agreed to a new approach of seeking assurance of Learning from Experience which is detailed in the report and an up-date will be provided to the next Quality Committee. Dr James O'Connor commented that via Quality Committee it is apparent that there appeared to be an increase in the activity of complaints and incidents around Central and East compared to other areas. Dr O'Connor	

	advised that he had discussed this with the Head of Clinical Governance and work will be undertaken to rationalise that in order to seek assurance and consider analysis of the data following localities moving to Care Groups. Edward Jenner queried the accuracy of the graphic included in Table 2.1. This will be corrected for the next report. Andy Styring commented that with the formation of the Care Groups, CAMHS T4 seems to appear in several groups. This will need to be corrected also. The Board of Directors **approved** the report and endorsed the recommendations.	
18/19/10	**QUALITY IMPROVEMENT REPORT** Dr Anushta Sivananthan introduced the paper advising that the report covers the final trimester of last year and reported on the highlights as follows:- Croft Ward – East – Pilot Project using pharmacy technicians to administer medication. This has been implemented by other Trusts and is around care hours per day and considering best allocation of duties to free up clinical time. Dr James O'Connor asked if this method is proven to reduce medication errors. It was confirmed that this will be monitored, but that a reduction in medication errors has been evident at other Trusts. Care Planning - It was commented that there has recently been training (with a team approach) provided to staff teams. This approach is building confidence within the team and staff are feeling more able to formulate better care plans for patients. Patients are also recognising and feeling the benefits of this. Quality and Bed Management Hub – This is in relation to ward to ward transfers, which happen for a number of reasons. The Trust uses 'sleeping-out' arrangements to accommodate patients when there is no bed available on the preferred ward. This can have an impact on Care Plans and so we are currently considering ways to reduce this where possible. Further detail is provided within the full report for the Board members. The report has also been reviewed at Quality Committee. The NEDs commented on the quality of the report and congratulated the team on the work undertaken. The Board of Directors **noted** the report.	
18/19/11	**QUARTERLY INFECTION PREVENTION CONTROL REPORTS** Gary Flockhart presented the report on behalf of Victoria Peach. The report relates to quarter 4 and has previously been to the Infection Prevention and Control Sub-Committee. During quarter 4 there has been one case of MRSA. A post infection	

	review has been completed by the IPC team along with the Countess of Chester which concluded the episode was unavoidable. There have been no cases of Clostridium Difficile. There was a brief closure of the Millbrook unit due to an outbreak of diarrhoea and vomiting. The outbreak was confirmed to be Norovirus. Two audits have been undertaken within the reported period with minor suggestions for improvement. The IPC team have developed an IPC e-learning package for staff to access across the organisation to assist with improving compliance rates. The flu campaign saw an increase of 14% this year compared to last year for participation rates. One concern has been raised in respect of safety devices. Up-dates will be provided to the IPC sub-committee. There is on-going work in respect of Sepsis, especially within the Community teams. Assurance has been received to confirm that IPC activity and performance is being managed in accordance with national guidance. Lucy Crumplin raised a question relating to the safe disposal of sharps and if any other Trusts were fully complaint in this area. It was commented that the inference appears to be that nobody is as yet compliant. Dr James O'Connor commented that the programme that the Trust has introduced has had a major impact and congratulated all those involved. The Board of Directors **noted** the report.	
18/19/12	**MONTHLY WARD STAFFING UPDATE** Gary Flockhart introduced the report which covered data for March and April 2018. During this period the Trust achieved staffing levels of over 95% for registered staff and clinical support workers on both day and night shifts. Therefore, we have a degree of assurance that we have capacity across the board. This also means we are not using temporary staffing to cover periods of leave. This report does not include AHP's, but will do with effect from June. The Board of Directors **noted** the report.	
18/19/13	**SPEAK UP GUARDIAN – F2SU REPORT – 2017-2018** Gary Flockhart introduced the paper which has also been presented to Quality Committee and Operational Board. Reporting to these committees and to Board is all helping to raise the profile of this initiative. An up-date was provided on the following areas:-	

	Key Work streams from 17/18 The majority of this work was achieved by Andrea Hughes, prior to her leaving her post here at CWP. • We have an agreed a Board Champion which is Rebecca Burke-Sharples. • There is increased access to information on the internet, including how to raise and escalate concerns. • We have a number of ambassadors in place across the Trust. • All reports are submitted to the National Guardian. • All concerns reported in this period were investigated. Benchmarking work has been undertaken against other Trusts and against National figures. CWP currently sits in the middle of the table. In terms of moving the process forward, we continue to promote the initiative internally and externally. Gary reported that he has also agreed to be the Speak Up Guardian for the Grosvenor GP Surgery. The team are also looking further developing an App. We also wish to increase the number of ambassadors. Edward Jenner raised a query in relation to the number of people who feel secure in raising concerns and asked if any trends have already been identified. A discussion took place regarding how people may interpret this question and the variety of reasons that may exist in terms of how people chose to answer this particular question. Dr James O'Connor commented that there is a clear shift in terms of people reporting incidents and the further introduction of the App will no doubt also make a significant difference. Dr Anushta Sivananthan commented that the Trust needs to further improve on how we feedback following incidents and capture the appropriate learning. The Board of Directors **noted** the content of the report and **agreed** the 18/19 plans.	
18/19/14	**CENTRAL AND EAST REDESIGN – CONSULTATION UP-DATE** The Chief Executive reminded the Board of the recent consultation process for adult and older people's services in Central and Eastern Cheshire. The consultation has run over the last 12 weeks and has now concluded. Sheena reflected that this has been a very useful process to help inform the system's plans. Dr Anushta Sivananthan explained that the process has been led by Commissioners of Vale Royal, South and East CCG's. As part of this process 7,000 consultation documents were sent out. Engagement events were held in a variety of settings with the aim of including a wide spread of our populations. This has brought Mental Health issues to the fore. The	

	team have also posted questions from the consultation on our website along with the answers we have been able to provide. All consultation documentation has also been made available via the Trust web pages. The process will now be subject to an independent review by the University of Chester. Dr James O'Connor commented that access to community services such as those being proposed is clearly the way forward for the patients of that area. This should be a very positive move. It was acknowledged that the process has provided a real richness of patient and carer feedback and provided a vital opportunity for people to help shape how services need to be going forward. Andy Styring noted that no decisions have yet been made as it is the consultation process that will inform the plans going forward. The Board of Directors **noted** the verbal up-date.	
18/19/15	**STRATEGIC RISK REGISTER AND CORPORATE ASSURANCE FRAMEWORK** Dr Anushta Sivananthan introduced the report. As at May, the Trust has three red risks and five amber risks. Four risks are also currently in scope. In terms of those in scope, up-dates were provided as follows:- • Not achieving safeguarding obligations – this risk has now been modelled as a new risk and has a full treatment plan. • The transition to Care Groups risk is currently being modelled and will be scheduled for approval at the next Quality Committee. • Lloyds Pharmacy contract – options are currently being considered and a report is due to come to July board. A risk treatment plan is now in place. • Corporate Governance Team are still in business continuity mode. This will be time limited risk and is still in scope and a plan is being developed. • Acute Care Bed Capacity Risk – this relates to people who may have to wait longer than 4 hours. Short term plans are being worked up and the risk treatment plan will consider longer term plans. However, the Trust has avoided having to send anyone outside the Trust for an acute bed. The Performance and Redesign team risk has now been re-scored with the level reducing. The risk of potential loss of Trust income relating to CQUIN targets has now been archived given the more robust process that is now established. The Cyber-attack risk has been discussed as part of this meeting and plans are now in place.	

	The Board of Directors **noted** the risk register.	
18/19/16	**BOARD PERFORMANCE DASHBOARD** Andy Harland introduced the paper. All priority projects are now aligned to Care Groups and the new patient safety KPI's have been approved by the quality committee. The dashboard reflects April performance. Following review of the operational performance dashboard, it was agreed that the following indicators would be escalated to the Board for oversight and discussion: • CQUIN Performance • Bed Pressures • Capacity % staff vacancies David Harris advised that a paper is due to be presented to Operational Board in June to consider the vacancy question. This will also be reported to Board via the Chair's report or a separate report depending on the decision taken at Operational Board. Despite our success with the flu campaign, we have seen the biggest spike in coughs and colds this winter for a number of years. David also brought the Board's attention to the turnover rates and advised that the NHSI Retention programme had now reached phase 3. NHSI are now looking to include all mental health Trusts and we have agreed to be part of the programme. Therefore, turnover will now also be included in the dashboard for monitoring. The Board of Directors **noted** the dashboard.	
18/19/17	**APPRENTICESHIP SUMMARY REPORT** David Harris introduced the report. When the Apprenticeship Levy came in, it presented two challenges; 1. How do we pay for it – which we subsequently resolved as the Trust was awarded the funding and continues to be, and 2. How do we make best use of the resource? We have had great success which is down to Louise Kitchener and Sandra Johnston (Education Team). The team focused on business administration, health care support workers and management qualifications. To date the Trust has in excess of 40 staff on apprenticeship programmes. Relationships have been built with external partners and with Care Groups. Our next focus will now be on clinical roles. Lucy Crumplin enquired as to how many of the 40+ were existing staff / new staff. David Harris confirmed that the majority are existing staff, but	

	as more and more of the clinical roles become available, this will be a way of attracting new staff. Dr James O'Connor enquired about retention of these staff going forward. David Harris advised that the feedback so far has been very positive and as the majority are existing staff there should be no issue with retention. Dr Anushta Sivananthan asked if the programme would be extended to people who have accessed our services and if a process exists in order to take that forward. David Harris confirmed that this is an area that they wish to explore further. The Board of Directors **noted** the report and **endorsed** the recommendation.	
18/19/18	**AUDIT COMMITTEE CHAIRS REPORT** <u>Audit Committee – Chair's Report</u> Edward Jenner advised that most of the meeting held on 1st May 2018 concentrated on compliance issues and a review of the draft reports ready for year end which were then presented to Board on 24th May 2018. One correction was noted to the Chair's report of the Audit Committee to amend "limited assurance" to "significant assurance" for the Information Governance Review. <u>Audit Committee Review of Effectiveness</u> The report was taken as read. The Board of Directors **noted** the Chair's Report and Effectiveness Review.	
18/19/19	**Quality Committee Chair's Report** <u>Quality Committee - Chairs Report</u> Dr James O'Connor presented the Chair's report of the Quality Committee held on the 9th May 2018. The Committee reviewed its effectiveness. The quality dashboard is currently being further developed and an example of how it might work is being brought to the next Quality Committee meeting. <u>Terms of Reference</u> It was noted that item 2 should say "minimum of 3". The Board of Directors **noted** the Chair's report and **approved** the Terms of Reference.	
18/19/20	**ANY OTHER BUSINESS** None.	

18/19/21	**QUESTIONS FROM OBSERVERS OR MEMBERS OF THE PUBLIC** None.	
18/19/22	**REVIEW OF RISK IMPACTS OF ITEMS DISCUSSED** No risks identified.	
18/19/23	**KEY MESSAGES FOR COMMUNICATION** The Chair commented that he would draft a Chair's report of the items discussed at the board meeting to be sent to the Governors.	**MM**
18/19/24	**REVIEW OF MEETING PERFORMANCE** The meeting was agreed as effective.	
18/19/43	**DATE, TIME AND PLACE OF NEXT MEETING** **Board of Directors (public)** Wednesday 25th July at 1.30 pm Boardroom, Redesmere	

Signed

Mike Maier, Chair

Date:

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Action points from Board of Directors Meetings
May 2018

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
28/03/2018	17/18/118	**SAFER STAFFING** Consider what workforce indicators could be combined with the safer staffing report to provide a more triangulated picture. Exec Team to discuss and come up with a proposed way forward.	May 2018	Exec Team		Open
28/03/2018	17/18/120	**GUARDIAN OF SAFE WORKING HOURS QUARTERLY REPORTS** Report to be more assurance focused, with the mandated element of the report featuring as an appendix. Dr Alam to discuss with Dr Porter for the next scheduled report.	July 2018	FA		Open

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

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

10	**Research Annual Report**	Medical Director Effectiveness, Medical Education and Medical Workforce	Quality Committee							✓				
11	**Medical Appraisal Annual Report and annual declaration of medical revalidation**	Medical Director Effectiveness, Medical Education and Medical Workforce	Operational Board				✓							
Finance and Use of Resouces/ Operational Performance														
12	**Operational Plan/ Board performance dashboard (incorporating Operational and Quality dashboard)**	Director of Finance	Operational Board/ Quality Committee		✓		✓	✓		✓		✓		✓
13	**Chair's Report of the Operational Board**	Chief Executive	Operational Board		✓		✓	✓		✓		✓		✓
14	**Annual Report, Accounts and Quality Account**	Director of Finance	Audit Committee (Quality Committee for QA)		✓									
15	**Health and Safety Annual Report and Fire and link certification**	Director of Nursing, Therapies and Patient Partnership	Operational Board				✓							
Well-led (leadership and improvement capability)														
16	**Board Assurance Framework**	Medical Director Compliance, Quality and Assurance	Quality Committee		✓			✓				✓		✓
17	**Learning from Experience Report, inc Learning from Deaths (executive summary)**	Director of Nursing, Therapies and Patient Partnership	Quality Committee		✓			✓				✓		
18	**Quality Improvement Report**	Medical Director Compliance, Quality and Assurance	Quality Committee		✓					✓				
19	**Integrated Governance Framework**	Medical Director Compliance, Quality and Assurance	Quality Committee					✓						
20	**CQC Community Patient Survey Report (themes and improvement plan)**	Director of Nursing, Therapies and Patient Partnership	Quality Committee					✓						

21	**NHS Staff survey (themes and improvement plan)**	Director of People and OD	Operational Board											✓
22	**Equality Act Compliance inc. WRES**	Director of Nursing, Therapies and Patient Partnership	Operational Board					✓						
23	**Guardian of Safe Working quarterly report**	Medical Director Effectiveness, Medical Education and Medical Workforce	Operational Board		✓		✓			✓		✓		
								Governance						
24	**Provider Licence Compliance**	Director of Finance	Audit Committee		✓					✓				
25	**CQC Statement of Purpose**	Medical Director Compliance, Quality and	Quality Committee							✓				
26	**Information Governance Toolkit**	Medical Director Effectiveness, Medical Education and Medical Workforce	Operational Board											✓
27	**Register of Sealings**	Director of Finance	Audit Committee					✓						
28	**CEO/ Chair Division of Responsibilities**	Chair	N/A		✓									
29	**Corporate Governance Manual**	Director of Finance	Operational Board									✓		
30	**Chair's Report of the Audit Committee**	Non Executive Director	Audit Committee		✓		✓	✓		✓		✓		✓
31	**BOD Business Cycle**	Chair	N/A											✓
32	**Terms of reference of Quality Committee and Operational Board**	Non Executive Director/ CEO	Quality Committee/ Operational Board		✓									
32	**Review risk impacts of items**	Chair/ All	N/A		✓		✓	✓		✓		✓		✓
33	**AOB (including matters that are NOT commecial-in-confidence)**	Chair/ All	N/A		✓		✓	✓		✓		✓		✓

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Quarterly Report of the Guardian of Safe Working Hours
Agenda ref. no:	18.19.34
Report to (meeting):	Trust Board of Directors
Action required:	Information and noting
Date of meeting:	25/07/2018
Presented by:	Dr Sumita Prabharakan

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

REPORT BRIEFING

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

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

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

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

Assessment – *analysis and considerations of options and risks*
Detailed information can be found in the attached report as directed by NHS Employers. During the reporting period we had 28 doctors working under the terms and conditions of the 2016 contract. There were considerable vacancies related to HENW posts not being filled, maternity leave, LTFT and higher trainees completing training. We have received no exception report during the reporting period and there have been no issues raised regarding safe working hours.

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

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

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1 2	Guardian of Safe working Hours Report to the Trust Board for the period April – June 2018

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Safer Staffing Six Monthly Review
Agenda ref. no:	18.19.34
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	25/07/2018
Presented by:	Avril Devaney

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

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*
This report has been produced to provide Board members with details of the findings of the Safer Staffing six month review, covering November 2017 – April 2018, in line with NHS England and the National Quality Board [NQB] requirements. The information in this report is based on meetings with staff members, safer staffing group meetings, desk top review, and analysis of data.

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

In January 2014, the Operational Board and Board of Directors received and approved a paper setting out the Trust's current position in relation to ward staffing, vacancies, skill mix and areas for improvement following a comprehensive review led, on behalf of the Board, by the Associate Director of Nursing & Therapies (MH). Since the initial review there have been eight, six monthly follow up reviews (including this one). Additionally, monthly reports have been provided to the Board of Directors from June 2014 onwards. In order to comply with NHS England and NQB requirements these reports and the Trust's performance are also published on CWP and NHS Choices websites.

Assessment – *analysis and considerations of options and risks*

The safer staffing review considers findings outlined in the following areas:

- Processes and Procedures (planned staffing verses actual staffing, E-rostering, Temporary Staffing and Unify data)
- Evidence based tools (Dashboards, Care hours per patient day (CHPPD) and In-patient quality audit tool)
- Leadership (Recruitment and retention and Supervision)
- Multi- disciplinary team (MDT) (Role and responsibilities)
- Time factors (Training and Environmental
- Openness and transparency including Escalating Concerns
- Future planning
- Summative findings (right staff, right skills and right place and time)

The presiding theme is that we have the right clinical staff and maintain ward establishments for the delivery of safe care; however as clinical services change and develop further work is required to review the ward skill mix in particular in relation to the use of clinical roles across the MDT and physical health needs.

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

The Trust Board are asked to approve the recommendations and approach to future work streams as set out in appendix 1: "Six Monthly Safer Staffing Review"

Who/ which group has approved this report for receipt at the above meeting?	Avril Devaney
Contributing authors:	Gary Flockhart and Marjorie Gould

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Operational Board	18.07.2018

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

Appendix no.	Appendix title
1	Safer Staffing Six Monthly Review

SAFER STAFFING REPORT

PERIOD OF REVIEW NOVEMBER 2017 – APRIL 2018

1.0 INTRODUCTION

The National Quality Board (NQB) sets out the expectation that a Safer Staffing report is submitted bi-annually to an organisation's Executive Board. Implicit in this is that the Executive Board holds ultimate responsibility in guaranteeing that organisationally there is 'capacity and capability to provide high quality care'[1]. The aims that the NQB require to be addressed are

- that processes are in place to enable staffing establishments to be met on a shift-to-shift basis
- evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability
- that clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns
- that a multi-professional approach is taken when setting nursing, midwifery and care staffing establishments
- that nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties
- that Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review
- that NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift
- that providers of NHS services take an active role in securing staff in line with their workforce requirements.

This six month Safer Staffing review report to the Board concentrates on the above for the period November 2017 through to April 2018. The Trust Board are requested to note the contents of this report, and critically approve the recommendations.

[1] The National Quality Board (2013) How to ensure the right people, with the right skills, are in the right place at the right time A guide to nursing, midwifery and care staffing capacity and capability https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

The findings and recommendations have been derived from appraisal of data (Appendix 1), staff views (clinical and managerial) as well as receiving specific project updates including the Hurst In-Patient Safer Staffing Tool. No one method enabled a qualitative overview and thus analysis using all domains was critical in evaluating the current position around safer staffing to ensure an accessible, responsive and quality health care provision.

Overall the identified findings demonstrated a staffing establishment that was sufficient to meet the Safer Staffing requirements. The reduced maintenance of staffing establishments were owing to unplanned absences such as sickness, human resource factors and the intensity of clinical care demands such as increased numbers of therapeutic observations. Increased demands were addressed by mainly using existing ward staff and temporary (Bank) staffing; on the whole staff shortages were filled via Bank rather than Agency. This was considered positive as it permitted greater staff familiarity with CWP systems and processes.

The reflective discussions also highlighted that clinical and management teams jointly strived to maintain care standards at times of intense staffing pressures and proactively tried to come up with creative solutions in the absence of any flexibility within establishments such as increased use of twilight shifts and the involvement of the broader MDT to support care delivery.

There were some variations in resources; included in this was the distribution and role responsibility of Resource Managers across the CWP in-patient footprint. There were recruitment contrasts for Registered Nurses (RN) and the composition of MDTs resulting in a need to formulate care and prescribe treatments based on resources available; the lack of adult in-patient psychology has relied on broader MDT treatment formulation. There was an emerging theme of increased hospital detentions in mental health that reflected a rising national trend[2]. There was also consideration around increased physical health needs of those accessing CWP services. This is a developing agenda for CWP to ensure rounded care delivery to meet the needs of people with mental health conditions and co-morbid physical health issues.

As an employer CWP has a diverse workforce and who are generally able to actively recruit. There was a perception that this is proving more challenging within East Cheshire and further exploration and understanding of this is needed. Additionally the development of new care models and redesign across CWP in-patient service may also provide an opportunity to examine and address this. There is a

[2] Care Quality Commission (January 2018) Mental Health Act The Rise in the use of the MHA to detain people in England http://www.cqc.org.uk/sites/default/files/20180123_mhadetentions_report.pdf

dedicated recruitment team around staffing processes (including temporary staffing). The Safer Staffing review highlighted that there is a positive opportunity for nursing personnel to be further involved in job fairs and the Consultant Nurses will support this as active recruitment drives to encourage nursing engagement from other areas will contribute to CWP sustainability and development of staff. This proposal, the new methods of developing a nursing workforce (MSc Nursing Degree, Advanced Nurse Practitioners and Trainee Nursing Associates) and Professional Advisors has been undertaken in the past 6 months to maintain a responsive workforce. Developments have also included planned working with CWP Education around recruiting 3rd Year student nurses via a CWP Nurse Recruitment event.

To facilitate in-depth understanding of these issues discussion has been presented under themed headings presented in the NQB (2013) report *How to ensure the right people, with the right skills, are in the right place at the right time A guide to nursing, midwifery and care staffing capacity and capability.*

2.0 PROCESSES AND PROCEDURES

2.1 PLANNED STAFFING VERSES ACTUAL STAFFING

Ward staffing was proactively planned through the use of the electronic roster system and mainly completed by Resource Managers. The majority of the Resource Manager posts are a cost pressure as they are, in the main, not established funded posts but they enable ward managers' to focus on their individual wards providing visible clinical leadership. There are occasional exceptions where Ward Managers complete the duty rotas, for example Crook Lane where there is no allocated Resource Manager.

The annual leave for ward staff was advance planned for the year however given capacity and the build-up of annual leave (such as from sickness), led to an accumulation of leave needing to be taken in month 11 and month 12 of the financial year which can have a knock on effect on staff availability. Ward Managers and Resource Managers monitor this across the full annual period to decrease this risk and any subsequent impact this may have.

Staffing establishments per shifts (days and nights) were predetermined and implicitly clear for each clinical area; with respect to establishments per shift, most areas meeting any deficits in daily establishment through utilising their own staff to cover. This was mainly through Bank use or on other occasions the use of temporary staff; on the whole Overtime and Agency was only used to ensure the safety of the clinical area through safe staffing numbers as a last resort. From reports Agency use was not disproportionate and although Eastway detailed that they

used Agency more often this was because the staff team seemed to have facilitated a staff group of Bank and Agency staff that were familiar with the client group's needs.

There has been no universal review of establishments across the in-patient areas in this 6 month period however the formation of the new care groups across CWP will consider this moving forward.

There was discussion and clarification with Resource Managers in terms of where planned staffing becomes actual staffing. The consensus was that 'actual' was the time at which staff arrived for the start of the duty period. However, it was only as discussions progressed that it was highlighted that a ward's actual staffing may not necessarily be static. This was due to the need for cross cover on other wards to redress unplanned staffing deficits or an increased level of care needs/acuity. If staff are moved for only a proportionate number of hours this is not immediately or consistently reflected in the actual data as part of shifts are not recorded in the safer staffing return nor are periods of cover from the ward manager or the wider MDT. In addition to base line establishments ward managers will also use a professional judgement approach in relation to ensuring safer staffing requirements are met. The approach to safer staffing is considered as a unit wide response and resource allows flexibility and response to ensure wards are safely staffed.

2.2 E ROSTERING

E Rostering is actively used and classifies completed rosters within one of three domains (Stormy, Cloudy or Clear) on the basis of Safety, Effectiveness, Budget, Fairness and Unavailability to reflect a rota's staffing capability. Strength of the E Rostering process is the capability of audit. Currently Version 10 of E Roster is in use and has been subject to MIAA internal audit and the audit recommendations will be considered and actioned as necessary.

2.3 TEMPORARY STAFFING

Reports indicated that much of the shift cover to address any staffing establishment shortfalls arose from wards using their own staff to work extra hours. Additionally, it was reported this process was a result of team commitment and flexibility and having client familiarity and maintaining a ward skill set. There were reports of generally being able to access staff from the nurse Bank and additionally highlighted that this had led to recruitment from the Bank into permanent posts. There was a reliance on temporary staff usage to maintain establishments

and to ensure adequate cover as a result of unplanned absence (for example sickness, emergency leave). There were periods where fill rates for Clinical Support Workers (CSW) were covered by Registered Nurses (RN) and although a cost pressure the principle held was the need to balance this and maintaining safe clinical care. This was a priority for all teams and there was awareness of how to escalate concerns via the bleep holder, Head of Clinical Services and on call system(s).

When unexpected deficits occurred across units there was a consequential need for staff to be relocated elsewhere for safety across the clinical area rather than having a singular ward view as previously highlighted.

Nevertheless, risk assessment processes were employed to weigh unit needs, specific ward commitments and unplanned absences. This, therefore, resulted in a planned safe fill rate deficit in one area to maintain a critical safety level in another. It was identified that staff highlighted that they understood the rationale for establishments to be balanced so as to maintain safe and effective staffing but conversely this impacted on the broader therapeutic interventions leading to prioritisation of high risk, high need treatments and interventions. This is not unreasonable when the overriding principle has had to be safety and effectiveness of care. Where possible members of the MDT were called upon to deliver care reinforcing a team based approach.

2.4 UNIFY

Monthly reports are generated per area to facilitate regular oversight by Ward Managers and Heads of Clinical Service of fill rates for RNs and CSW's across the day and night period. In the main fill rates were mainly over 95% as demonstrated below.

3.0 EVIDENCE BASED TOOLS

3.1 DASHBOARDS

To inform the safer staffing clinical discussions conversational focus was on throughput, occupancy, care and clinical demands. This assisted review of staffing establishment needs in consideration of individual ward profiles. It was noted from discussions that there was a perception of more complex length of stays, increased placement requests to enable safe discharge and increased levels of detention under the Mental Health Act (1983/20017). This is reflected in the changing trends nationally around hospital detentions. In January 2018 the CQC reported that there was a 40% increase in the use of the Mental Health Act with the act being applied to different groups than previously, including those with dementia and personality disorders.[3]

3.2 CARE HOURS PER PATIENT DAY (CHPPD)

The monitoring of staff to patient ratio by means of Care Hours per Patient Day was commenced in April 2018. This will facilitate staff-to-client ratio discussions and comparison at the next six monthly safer staffing discussions. At this juncture it is a process that has just been implemented and the Board is asked to note this with a view to a reported analysis in the next bi-annual report submission. In October 2017 CWP engaged in a national CHPPD pilot and provided feedback to the national programme that it would be beneficial if Allied Health Professionals (AHPs) be included within data capture. AHP staff are included in the CHPPD data and the data has started to be available within the Trust's Locality Data Packs.

3.3 IN-PATIENT QUALITY AUDIT TOOL

[3] CQC (2018) Mental Health Act The Rise in the use of the MHA to detain people in England http://www.cqc.org.uk/sites/default/files/20180123_mhadetentions_report.pdf

As the Board is aware some significant work on the quality of care, staff to client dependency and evaluations around direct to indirect care ratios has been completed using the In-patient Quality Audit Tool devised by Dr Keith Hurst (reported in the previous 6 month report). It has been discussed with the Trust's lead practitioner for this process that a repeat audit is completed within the CAMHS Wards. A summative decision was that this is feasible but ought to be considered towards the end of the year so as to enable the recommended changes and agreed actions to be realised. As part of the developments in this area the in-patient nurse consultants are taking forward quality audit improvement work.

The quality inspection component of the Hurst Tool has been completed on a staged approach the only two wards yet to be completed are Bollin and Eastway scheduled to be undertaken in August and September 2018. A recognised strength of having used this audit tool is that all the wards audited achieved the successful quality audit score of 70% or above; this is required by the national team to participate in the programme. Further analysis of the data and information obtained will be completed over the next six months. Eastway and Bollin will also have had their quality audits completed. Thereafter a rolling programme of re-audit will commence to measure and summarise changes.

There was consideration to whether the evidence based tool might be of use in measuring pharmacy provision but after wider consultation and consideration the tool was not adaptable for this use.

4.0 LEADERSHIP

4.1 RECRUITMENT & RETENTION

There were excellent examples of creative approaches to staffing being employed across the Trust, such as the recruitment of a housekeeper role and pharmacy technicians to facilitate care delivery and make best use of staff capabilities. Furthermore as the national picture for ensuring physical health within mental health is prioritised there has been the recruitment of Adult Registered Nurses within some in-patient wards thereby broadening the staffing establishment profile and expanding the skill base within the clinical team (Oaktrees, Cherry and latterly Meadowbank).

Recruitment has been fundamental to staffing sustainability and there is a dedicated CWP recruitment team. This six month review highlighted that it would be proactive for nursing cohorts to engage with and support the planned approach to recruitment of 3rd year students.

It was highlighted through the discursive parts of the safer staffing review that the ability to retain staff post qualifying and on completion of their preceptorship was a challenge with a proportion leaving for promotion or to other areas within CWP as part of career expansion. This led to further staffing pressures some of which has previously been discussed in terms of sustained recruitment within in-patients. However, staff moving on for these reasons and still remaining within CWP was perceived as positive overall.

4.2 SUPERVISION

Supervision is a crucial component in the delivery of quality care to enable reflective practice and it is a compliance measure within the safer staffing process; compliance targets are 85% or above. Compliance rates are reported and monitored at a service and ward level, moving forward the reports will be generated aligned to care groups. The six month data reflected variable rates of compliance however during the review meetings there was a clear commitment to try to achieve this target.

An area of good practice highlighted by some wards so as to achieve supervision compliance was identifying each week those staff that were due supervision. This was then included as part of the weekly objectives that could be diarised. It is, however, recognised that it is not only about compliance in the supervision process but ensuring a staff group who experience quality supervision 'to support and enhance practice for the benefit of clients'[4] and thereafter enable self-evaluation of practice and areas of development. To address this it is planned to complete a reflective event around supervision at the July Service Improvement Forum for In-patients that will contribute to the next bi annual review.

5.0 MULTI-DISCIPLINARY TEAM (MDT)

5.1 ROLES AND RESPONSIBILITY

The composition of each MDT across the Trust varies not only in terms of each team but also between local areas. There is access to broader psychological provision with the acute in-patient

[4] CWP (2017) HR22 Supervision Policy
http://nww.cwp.nhs.uk/Documents/PoliciesandProcedure/HR22%20Supervision%20policy%20Issue%206.pdf

wards in East Cheshire with access to an Art Therapist that is not available within other areas. All wards had Occupational Therapy (OT) provision and there was consensus that this role was well integrated in wards not only in establishment but in that OT staff contribute to areas of care delivery at times of high levels of clinical need e.g. therapeutic observations.

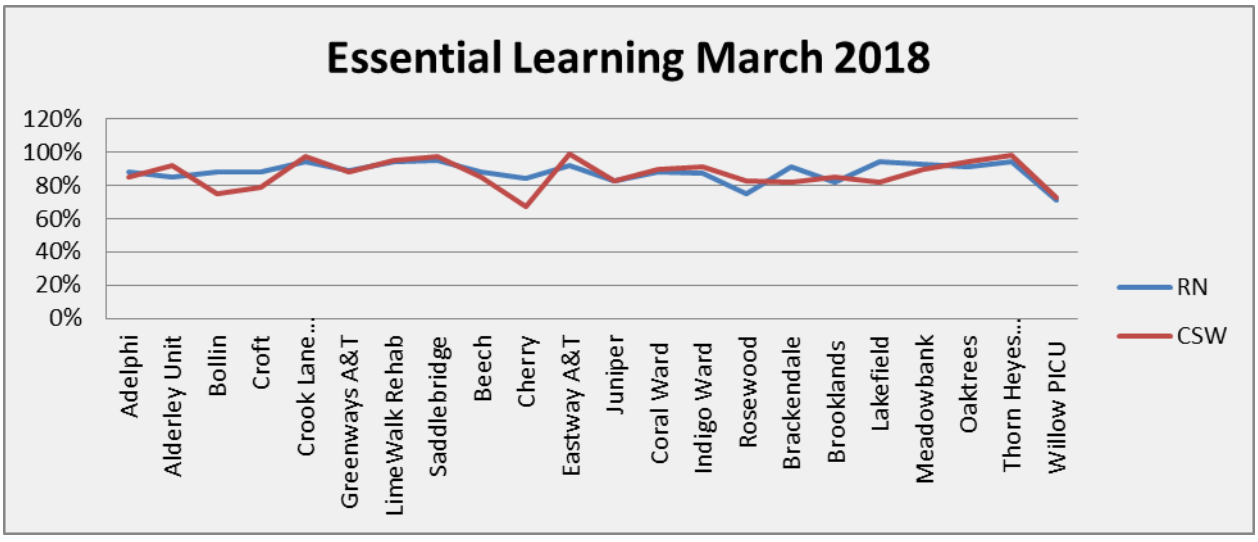
There was agreement on the need to maintain differing responsibilities of MDT members with a presiding sense of needing to work together. It was aspirational for areas that did not have access to a dedicated psychologist that they would wish access to this to assist in the delivery of comprehensive MDT reflective practice and formulation.

It was highlighted in discussions that ward managers on occasions had been required to be included in the staffing numbers to maintain daily establishment. The data did not reflect this as data is only captured when it is a full shift that someone is working in the daily establishment; this means that direct care by the ward managers is not submitted to Unify and therefore not included in fill rates.

6.0 TIME FACTORS

6.1 TRAINING

The data reflected that compliance with training was generally good as illustrated in the March 2018 chart below.



There are occasions however that at times of increased clinical need staff were withdrawn from mandatory training. However, an area of flexibility in attaining training compliance was where staff completed their e-learning in addition to rostered shifts whereupon this time could be

claimed back as it was able to be evidenced. It was recognised during the discussions that this would need robust oversight to minimise the risk of disproportionate amounts of time owing building up. There are also education facilities in the 3 localities where staff can access computers and attend sessions.

6.2 ENVIRONMENTAL

On review there were environmental challenges in terms of ensuring that staff were able to ensure gender requirements were met in relation to mixed sex accommodation. Some wards had greater capacity to achieve this than others. The clinical areas were all able to ensure maintenance of an individual's safety, privacy & dignity. Needs were met through increased observations and a short stay in the area until another bed could be allocated. Where there are incidents of potential breach these are datixed and reviewed by Matrons, Service Managers and reported to the Associate Director of Nursing for Mental Health and Learning Disability to determine whether the breach was justified or not.

7.0 OPENNESS AND TRANSPARENCY

Staffing levels are detailed per day on the ward entrance. Ongoing reviews of establishments were completed based on acuity and therapeutic observations to ensure safe and effective high quality care and any changes were aligned to clinical demand. An area of focus has been in relation to physical health care (led by the Consultant Nurse for Infection Prevention and Control) reviewing physical health in mental health. Appraisal of this and any subsequent recommendations and its finding will be reflected into the In-patient bed based care review. A summary of the work is outlined in appendix 2.

Ward staff openly discussed their views around safer staffing. There was no specific or formal request for increased staff but there was a sense that staff would welcome a review of establishments, the opportunity to have a broader MDT on all wards, including psychological therapies to assist in clinical formulation. This work has already commenced through the inpatient redesign project to explore whether the current configuration of inpatient wards is right to assist staff delivery of the best care. This piece of work continues to progress with the aim that it will be completed in September 2018.

Whilst there were some variations in the way Resource Managers carried out their role there was positive feedback that the role enabled ward managers to focus on the components of clinical care, staff proficiencies and MDT functioning.

7.1 Escalating concerns

Where wards have concerns around staffing levels these are raised direct to the modern matrons and heads of clinical services to provide a co-ordinated response to resolve; relocating resource from another ward for example.

Where it is not possible to resolve locally, capacity within the wider system can also be utilised; relocating resource from another locality for example.

Where there are ongoing concerns that are not resolvable these can be further escalated and a co-ordinated Trust response to support mitigation of concerns will be enacted. For example this has included a temporary reduction in beds on Adelphi ward to ensure safe staffing levels could be achieved. This was a temporary period from October 2017 during which time staffing levels were able to be addressed and the ward was able to return to full bed numbers in April 2018.

8.0 FUTURE PLANNING

8.1 An ongoing focus on the functionality of staffing establishments to ensure safe effective care is essential. It would be pragmatic to wait until, work that is being scoped around service redesign is completed given it is appraising acute in-patient pathways. This includes options around clusters, simulation modelling and capability in order to be responsive in care delivery, maintaining staff proficiency and taking into account physical health needs within the mental health in-patient settings.

8.2 A review of the Community (Physical Health) nursing workload is being completed to identify areas of quality improvement work that can be agreed. The Associate Director for Nursing for Physical Health will oversee the safer staffing response to NQB guidance which will be reported in the next safer staffing 6 monthly report.

8.3 The in-patient quality audit tool by Dr Keith Hurst will continue with the two wards (Eastway and Bollin) having their quality audit completed with the potential for a full re-audit of both CAMHS wards to review the impact and progress of recommendations made in the initial review.

8.4 The Trainee Nurse Associate and Nurse First Masters programme is continuing and the ongoing management and evaluation of this can continue to inform workforce planning. In January 2018 the Trust also employed 5 Trainee Advanced Clinical Practitioners and are looking ahead to recruiting a further 8 for commencement in September 2018.

8.5 As part of the 24/7 project there is a Band 6 Bleep Holder to hold supernumerary status. There will need to be further consideration of how this might be achieved in terms of staffing establishments.

8.6 CHPPD has commenced and will inform safer staffing for the next bi-annual report. This will include allied health professionals.

8.7 As part of the Specialist Mental Health Care Group the Mental Health Placed Based services are in the process of appraising and strengthening clinical services within the community (a summary of which is outlined in Appendix 3).

8.8 A pilot project is being considered using the Effective, Safe, Compassionate and Sustainable Staffing (ESCaSS)[5] workforce tool within CAMHS (scoping meeting to take place in July 2018).

9.0 SUMMATIVE FINDINGS

9.1 RIGHT STAFF

The presiding theme is that we have the right clinical staff and maintain ward establishments for the delivery of safe care. A thorough review and development of the MDT is considered to have improved psychological input within the acute in patient areas.

The resource manager role is a non-clinical role and this review found that this role was vital in the rostering process, the timeliness around fill rates and staffing in the short, medium and long term. There were, however, variations in roles and responsibilities of Resource Managers across the services and this will be taken forward.

[5] National Collaborating Centre for Mental Health (2018) **National Collaborating Centre for Mental Health. Effective, Safe, Compassionate and Sustainable Staffing (ESCaSS) for Mental Health Guide** London: National Collaborating Centre for Mental Health

There was consensus that having the ability to recruit in a timely manner was essential and that there was no disconnect with corporate teams such as Finance and People Services. Staffing in a timely manner was critical to safe and responsive care needs. Additionally proactive recruitment, flexible work patterns such as twilight shifts and the use of the MDT at times of acute clinical activity was fundamental in the safe maintenance of care.

The ability to have the Band 6 nurses maintaining supernumerary status when rostered as a Bleep Holder has proved challenging and further review to achieve this is underway.

9.2 RIGHT SKILLS

In general staffing establishments are maintaining levels of proficiency through mandatory training and there is a mechanism in place for new staff to be skilled up with pre-booked training dates being allocated. Newly qualified staff have preceptorship and this is essential to embedding skills. Furthermore, supervision and retaining experienced staff is central to safer staffing and is seen as a priority.

The development of a wider staffing skill set has commenced. This has included the recruitment of Adult Registered Nurses in Physical Care into mental health wards and there is a programme of work taking place to ensure quality care in the mental health settings around physical health (as set out in Appendix 2).

9.3 RIGHT PLACE AND TIME

The ability to meet staffing requirements is planned by way of e-rostering, the use of temporary staffing and at times agency staff. Short term and unplanned absences have proved challenging in terms of capability to cover shifts and appraisal of the data and narrative discussions reflect this. All areas rely on their permanent staff working Bank and some of the areas that this has been critical where familiarity with clients' early warning signs and positive behaviour plans is critical to safe care.

On occasion staff do not always work on the ward where they were originally identified to work having to be transferred out to wards where there was a greater clinical need. The discussions indicated that this was understood and appreciated to deliver priority care. What was highlighted was that in addressing absences at short notice there was a limited ability to deliver

some of the planned therapeutic treatments with clients and this had also led to MDT involvement in the day to day care management at times of high need.

BOARD ARE ASKED TO CONSIDER AND AGREE THE FOLLOWING RECOMMENDATIONS

10.0 RECOMMENDATIONS

10.1 Develop a mechanism to capture the degree to which ward managers work as part of the daily staffing establishment.

10.2 To undertake a review of the Resource Manager role to strengthen it and reduce variations.

10.3 During the introduction of the Band 6 Supernumerary Bleep Holder to assess any impact on ward staffing.

10.4 To enhance active recruitment drives as a recurrent feature of the safer staffing process.

10.5 Ongoing review of establishments and the monitoring of fill rates and the maintenance of narrative dialogue with staff and managers to gain insight into local and specific staffing influences.

APPENDIX 1

Month and Year of Data	Locality	Ward	Day				Night				Fill Rate			
			Registered midmives/nurses		Care Staff		Registered midmives/nurses		Care Staff		Day		Night	
			Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)
Nov-17	East	Adelphi	1233	1164	1119	1070.5	701.5	701.5	1150	1085.5	94.40%	95.67%	100.00%	94.39%
Dec-17	East	Adelphi	1245.5	1069	1289	1154	727.5	705.5	1253	1077.5	85.83%	89.53%	96.98%	85.99%
Jan-18	East	Adelphi	1503.5	1289	1266	1156	809.5	775	1453.5	1208	85.73%	91.31%	95.74%	83.11%
Feb-18	East	Adelphi	1202	1107.5	1222	1084.5	690	690	1046.5	977.5	92.14%	88.75%	100.00%	93.41%
Mar-18	East	Adelphi	1361.5	1246.5	1487	1268.5	784	726.5	1270.5	1190	91.55%	85.31%	92.67%	93.66%
Apr-18	East	Adelphi	1465.5	1256	1296	1207	694.5	660	1261.5	1204	85.70%	93.13%	95.03%	95.44%
Nov-17	East	Alderley Unit	1055	985	1369	1352.5	690	632.5	690	706	93.36%	98.79%	91.67%	102.32%
Dec-17	East	Alderley Unit	1128.5	1094.8	1397.5	1286.5	713	609.5	713	770.5	97.01%	92.06%	85.48%	108.06%
Jan-18	East	Alderley Unit	1080	1112.5	1361	1204.5	713	575	713	801.5	103.01%	88.50%	80.65%	112.41%
Feb-18	East	Alderley Unit	920	890	1307.5	1221.5	644	552	655.5	736	96.74%	93.42%	85.71%	112.28%
Mar-18	East	Alderley Unit	1032	975.5	1451	1373	713	621	713	805	94.53%	94.62%	87.10%	112.90%
Apr-18	East	Alderley Unit	1070	965.5	1543.5	1494.5	713	690	770.5	782	90.23%	96.83%	96.77%	101.49%
Nov-17	West	Beech	1267	1289	1150	1121.5	701.5	697.5	681	654.5	101.74%	97.52%	99.43%	96.11%
Dec-17	West	Beech	1326	1314.5	1007.5	936.5	713	704.5	701.5	701.5	99.13%	92.95%	98.81%	100.00%
Jan-18	West	Beech	1359	1303.5	1113	1113	697.5	697.5	722.5	678.5	95.92%	100.00%	100.00%	93.91%
Feb-18	West	Beech	1227	1202.5	1034.9	1007.4	656	644.5	644	639	98.00%	97.34%	98.25%	99.22%
Mar-18	West	Beech	1401.65	1352.65	1003.5	955.5	713	713	743	731.5	96.50%	95.22%	100.00%	98.45%
Apr-18	West	Beech	1483	1469.5	854	844	747.5	747.5	649	632.5	99.09%	98.83%	100.00%	97.46%
Nov-17	East	Bollin	1272	1170	1323	1230.5	655.5	664.5	1368.5	1204	91.98%	93.01%	101.37%	87.98%
Dec-17	East	Bollin	1269.04	1174	1268	1176.25	730.5	712	1426	1292.5	92.51%	92.76%	97.47%	90.64%
Jan-18	East	Bollin	1297	1270	1421	1366.5	701.5	671	1280.5	1185	97.92%	96.16%	95.65%	92.54%
Feb-18	East	Bollin	1127.5	1088	1292.5	1190.5	669	636.5	1056.5	1022	96.50%	92.11%	95.14%	96.73%
Mar-18	East	Bollin	1308.5	1202	1517.5	1358	733.5	726	1315	1211.5	91.86%	89.49%	98.98%	92.13%
Apr-18	East	Bollin	1393.5	1316.5	1391.5	1293	732	674.5	1334	1307	94.47%	92.92%	92.14%	97.98%
Nov-17	Wirral	Brackendale	1105	1116	933.5	933.5	678.5	667	678.5	690	101.00%	100.00%	98.31%	101.69%
Dec-17	Wirral	Brackendale	987.5	966	1045	1033	713	713	713	701.5	97.82%	98.85%	100.00%	98.39%
Jan-18	Wirral	Brackendale	880	884	1139	1139	729.5	706.5	713	678.5	100.45%	100.00%	96.85%	95.16%

Feb-18	Wirral	Brackendale	900	896.5	1011	1012	644	644	632.5	632.5	99.61%	100.10%	100.00%	100.00%
Mar-18	Wirral	Brackendale	1080.5	1058.5	1063	1028	713	713	713	713	97.96%	96.71%	100.00%	100.00%
Apr-18	Wirral	Brackendale	1065.5	1066.5	971	910.5	678.5	678.5	701.5	690	100.09%	93.77%	100.00%	98.36%
Nov-17	Wirral	Brooklands	1026.5	1026.5	1114.5	1114.5	621	621	1104	1104	100.00%	100.00%	100.00%	100.00%
Dec-17	Wirral	Brooklands	898.5	852.5	1207.5	1207.5	644	609.5	1092.5	1069	94.88%	100.00%	94.64%	97.85%
Jan-18	Wirral	Brooklands	1030	1007	1278.5	1278.5	770.5	713	1006.5	983.5	97.77%	100.00%	92.54%	97.71%
Feb-18	Wirral	Brooklands	788	765.04	1230.5	1219	632.5	563.5	920	920	97.09%	99.07%	89.09%	100.00%
Mar-18	Wirral	Brooklands	949.15	945.15	1233.5	1176	675.5	675.5	912	912	99.58%	95.34%	100.00%	100.00%
Apr-18	Wirral	Brooklands	949	888.5	1118.5	1118.5	688	607	719.5	707.5	93.62%	100.00%	88.23%	98.33%
Nov-17	West	Cherry	1168.75	1105.25	1239.5	1210.5	644	632	1068.5	1057	94.57%	97.66%	98.14%	98.92%
Dec-17	West	Cherry	1362.25	1311.29	1288.5	1232	684	666	1101	1090.5	96.26%	95.62%	97.37%	99.05%
Jan-18	West	Cherry	1207.75	1177.75	1454.5	1446.5	670.5	628	1230.5	1223	97.52%	99.45%	93.66%	99.39%
Feb-18	West	Cherry	903	903	1483.5	1483.5	531.5	531.5	1173	1173	100.00%	100.00%	100.00%	100.00%
Mar-18	West	Cherry	1148.5	1148.5	1280	1314.5	575.5	575.5	1104	1104	100.00%	102.70%	100.00%	100.00%
Apr-18	West	Cherry	1016.25	1016.25	1445	1433.5	717.5	717.5	1162	1162	100.00%	99.20%	100.00%	100.00%
Nov-17	West	Coral	989.5	936.5	1317.5	1317.5	632.8	632.8	770.5	770.5	94.64%	100.00%	100.00%	100.00%
Dec-17	West	Coral	905.5	894	1358	1358	586.5	586.5	901.5	901.5	98.73%	100.00%	100.00%	100.00%
Jan-18	West	Coral	1032.3	1020.8	1364.5	1364.5	669	669	874	874	98.89%	100.00%	100.00%	100.00%
Feb-18	West	Coral	740	739	1321.5	1321.5	598.5	577.5	949	949	99.86%	100.00%	96.49%	100.00%
Mar-18	West	Coral	1276.5	1276.5	1150	1150	586.5	586.5	954.5	954.5	100.00%	100.00%	100.00%	100.00%
Apr-18	West	Coral	1389	1375	951.5	951.5	563.4	563.5	1012	1012	98.99%	100.00%	100.02%	100.00%
Nov-17	East	Croft	1200	1114.95	1860	1468.5	690	560.5	1380	1266.5	92.91%	78.95%	81.23%	91.78%
Dec-17	East	Croft	1227	1194.65	1922	1267.5	713	529	1426	1393.5	97.36%	65.95%	74.19%	97.72%
Jan-18	East	Croft	1242	1143	1565.5	1487.5	713	607	1426	1388	92.03%	95.02%	85.13%	97.34%
Feb-18	East	Croft	1093.5	980	1414	1411	644	575	1288	1259.5	89.62%	99.79%	89.29%	97.79%
Mar-18	East	Croft	1227	1028.5	1531	1610	713	691.5	1380	1340.5	83.82%	105.16%	96.98%	97.14%
Apr-18	East	Croft	1177.5	1160.5	1448	1514.5	690	667	1322.5	1329.5	98.56%	104.59%	96.67%	100.53%
Nov-17	West	Eastway A&T	1041	1041	1082.5	1058	609.5	609.5	806	806	100.00%	97.74%	100.00%	100.00%
Dec-17	West	Eastway A&T	835	812	1136	1136	616.5	605	786	774.5	97.25%	100.00%	98.13%	98.54%
Jan-18	West	Eastway A&T	712.75	689.75	1344.5	1328.5	598	598	855.5	855.5	96.77%	98.81%	100.00%	100.00%
Feb-18	West	Eastway A&T	929.5	923.5	1046.5	1046.5	479.5	479.5	830	830	99.35%	100.00%	100.00%	100.00%

Mar-18	West	Eastway A&T	892.5	892.5	1127	1127	590.5	590.5	870.5	870.5	100.00%	100.00%	100.00%	100.00%
Apr-18	West	Eastway A&T	812.8	801.3	1512.5	1512.5	661.5	661.5	890.5	890.5	98.59%	100.00%	100.00%	100.00%
Nov-17	East	Greenways A&T	1132.5	958.35	1725	1607.5	690	667	1035	1012	84.62%	93.19%	96.67%	97.78%
Dec-17	East	Greenways A&T	1197	1084	2001	1666	713	736	1288	1184.5	90.56%	83.26%	103.23%	91.96%
Jan-18	East	Greenways A&T	1272	1042.5	2139	1746	713	736	1426	1207.5	81.96%	81.63%	103.23%	84.68%
Feb-18	East	Greenways A&T	1057	986	1932	1519.5	644	667	1288	1092.5	93.28%	78.65%	103.57%	84.82%
Mar-18	East	Greenways A&T	1217	998.5	2139	1828.5	713	632.5	1426	1449	82.05%	85.48%	88.71%	101.61%
Apr-18	East	Greenways A&T	1170	974.5	1817	1805.5	690	563.5	1380	1403	83.29%	99.37%	81.67%	101.67%
Nov-17	West	Indigo	1088.5	1040.5	897	897	542.5	531	874	845	95.59%	100.00%	97.88%	96.68%
Dec-17	West	Indigo	900.5	854.5	1086.5	1086.5	598	586.5	897.5	895.5	94.89%	100.00%	98.08%	99.78%
Jan-18	West	Indigo	1063	1051.5	1068	1010.5	648	647	843	796	98.92%	94.62%	99.85%	94.42%
Feb-18	West	Indigo	950.5	919	1010	992	492	469	792	784.5	96.69%	98.22%	95.33%	99.05%
Mar-18	West	Indigo	1134.5	1116	908.5	903.5	658	646.5	830.5	766	98.37%	99.45%	98.25%	92.23%
Apr-18	West	Indigo	1233.95	1191.45	739.5	696.5	542	542	874.5	828.5	96.56%	94.19%	100.00%	94.74%
Nov-17	West	Juniper	1396.5	1379.5	967	932.5	685.5	685.5	724.5	724.5	98.78%	96.43%	100.00%	100.00%
Dec-17	West	Juniper	1392	1398	1034.5	977	663.5	652	951.1	933.6	100.43%	94.44%	98.27%	98.16%
Jan-18	West	Juniper	1306	1294.5	1186	1151.5	724	724	955	909	99.12%	97.09%	100.00%	95.18%
Feb-18	West	Juniper	1168.5	1136	1242	1230.5	713.5	710.5	906	896	97.22%	99.07%	99.58%	98.90%
Mar-18	West	Juniper	1164.5	1134	1122.5	1112	713	713	862.5	832	97.38%	99.06%	100.00%	96.46%
Apr-18	West	Juniper	1368.2	1322.2	1007	987.5	701.5	701.5	689.8	683.8	96.64%	98.06%	100.00%	99.13%
Nov-17	Wirral	Lakefield	1034	1034	1012	977.5	667	667	701.5	667	100.00%	96.59%	100.00%	95.08%
Dec-17	Wirral	Lakefield	1105.5	1105	1049	1025.5	690	690	908.5	885.5	99.95%	97.76%	100.00%	97.47%
Jan-18	Wirral	Lakefield	1151	1135.5	874.5	874.5	724.5	724.5	1012	1012	98.65%	100.00%	100.00%	100.00%
Feb-18	Wirral	Lakefield	996	996	897.5	897.5	632.5	632.5	862.5	862.5	100.00%	100.00%	100.00%	100.00%
Mar-18	Wirral	Lakefield	1204.5	1193	1012	1000.5	747.5	713	897	874	99.05%	98.86%	95.38%	97.44%
Apr-18	Wirral	Lakefield	1098.5	1098.5	1023.5	1023.5	736	657.5	793.5	782	100.00%	100.00%	89.33%	98.55%
Nov-17	East	LimeWalk Rehab	1104.5	1087.5	1035	1077.5	690	540.5	690	774.5	98.46%	104.11%	78.33%	112.25%
Dec-17	East	LimeWalk Rehab	1051	911	1069.5	1006.5	713	568	713	711	86.68%	94.11%	79.66%	99.72%
Jan-18	East	LimeWalk Rehab	1154	920.5	1069.5	1047.5	713	621	713	656.5	79.77%	97.94%	87.10%	92.08%
Feb-18	East	LimeWalk Rehab	1024	947.5	963	922	644	540.5	644	694.5	92.53%	95.74%	83.93%	107.84%
Mar-18	East	LimeWalk Rehab	1093.5	1035.5	1023.5	1008.5	713	671	713	731	94.70%	98.53%	94.11%	102.52%

Apr-18	East	LimeWalk Rehab	1062.5	1057.5	1000.5	1039.5	690	621	690	695	99.53%	103.90%	90.00%	100.72%
Nov-17	Wirral	Meadowbank	1141	1140.5	1520	1497	747.5	782	1107	1061	99.96%	98.49%	104.62%	95.84%
Dec-17	Wirral	Meadowbank	1098.5	1086.5	1387.5	1355.5	724.5	724.5	1138.5	1127	98.91%	97.69%	100.00%	98.99%
Jan-18	Wirral	Meadowbank	1081	1069.5	1771	1770.5	805	782	1334	1334	98.94%	99.97%	97.14%	100.00%
Feb-18	Wirral	Meadowbank	780.5	757.5	1403	1403	655.5	575	1311	1244	97.05%	100.00%	87.72%	94.89%
Mar-18	Wirral	Meadowbank	917.5	906	1644.5	1621.5	586.5	574.5	1391.5	1368.5	98.75%	98.60%	97.95%	98.35%
Apr-18	Wirral	Meadowbank	1175.5	1095.5	1524	1520	621	540.5	1434	1184.5	93.19%	99.74%	87.04%	82.60%
Nov-17	Wirral	Oaktrees	1256	1213	724.5	724.5	540.5	540.5	753.5	753.5	96.58%	100.00%	100.00%	100.00%
Dec-17	Wirral	Oaktrees	1174.5	1170.5	1323.5	1307	724.5	724.5	397.5	352.5	99.66%	98.75%	100.00%	88.68%
Jan-18	Wirral	Oaktrees	1228	1203	1275	1252.5	839.5	851	425.5	391	97.96%	98.24%	101.37%	91.89%
Feb-18	Wirral	Oaktrees	1160	1150	977	977	690	690	307.5	307.5	99.14%	100.00%	100.00%	100.00%
Mar-18	Wirral	Oaktrees	1179	1124	1198	1187.5	713	713	346.5	276	95.34%	99.12%	100.00%	79.65%
Apr-18	Wirral	Oaktrees	1361	1377	1215.5	1207	690	655.5	345	310.5	101.18%	99.30%	95.00%	90.00%
Nov-17	West	Rosewood	1028.5	1024.35	1523	1523	517.5	517.5	816.5	816.5	99.60%	100.00%	100.00%	100.00%
Dec-17	West	Rosewood	958.3	945.3	1389	1389	542	520.5	827.5	804.5	98.64%	100.00%	96.03%	97.22%
Jan-18	West	Rosewood	915.25	914.75	1401.5	1390	609.5	609.5	837	837	99.95%	99.18%	100.00%	100.00%
Feb-18	West	Rosewood	868.5	868.5	1372	1372	522.75	522.75	744.5	744.5	100.00%	100.00%	100.00%	100.00%
Mar-18	West	Rosewood	960.5	960.5	1322.5	1322.5	506	506	897	897	100.00%	100.00%	100.00%	100.00%
Apr-18	West	Rosewood	861.25	872.75	1421.5	1421.5	593.5	616.5	616.5	616.5	101.34%	100.00%	103.88%	100.00%
Nov-17	East	Saddlebridge	1039	994	1345.5	1265	690.5	587	678.5	778	95.67%	94.02%	85.01%	114.66%
Dec-17	East	Saddlebridge	998.5	914.5	1234.5	1173	678.5	544.5	747	745.5	91.59%	95.02%	80.25%	99.80%
Jan-18	East	Saddlebridge	993	932.5	1293.5	1305.5	655.5	625	805	828	93.91%	100.93%	95.35%	102.86%
Feb-18	East	Saddlebridge	917.5	850	1196	1140	563.5	540.5	747.5	770.5	92.64%	95.32%	95.92%	103.08%
Mar-18	East	Saddlebridge	1098.5	987.5	1296	1281.5	724.5	678.5	713	708	89.90%	98.88%	93.65%	99.30%
Apr-18	East	Saddlebridge	1077.5	999	1357	1345.5	644	644	793.5	793.5	92.71%	99.15%	100.00%	100.00%

Nov-17	Wirral	Willow PICU	1056	989.5	877.5	866.5	724.5	701.5	678	666	93.70%	98.75%	96.83%	98.23%
Dec-17	Wirral	Willow PICU	918.5	907	943.5	909	667	655.5	770.5	747.5	98.75%	96.34%	98.28%	97.01%
Jan-18	Wirral	Willow PICU	1028.5	973.5	991	935	724	724	713	701	94.65%	94.35%	100.00%	98.32%
Feb-18	Wirral	Willow PICU	931.5	913	901	900	644	644	655	655	98.01%	99.89%	100.00%	100.00%
Mar-18	Wirral	Willow PICU	1018	1006.5	845.5	822.5	724.5	712.5	655.5	632.5	98.87%	97.28%	98.34%	96.49%
Apr-18	Wirral	Willow PICU	806.5	783.5	908.5	920	759	759	724.5	724.5	97.15%	101.27%	100.00%	100.00%

APPENDIX 2

Physical Health in Mental Health – the right staff , the right skills in the right place and time

Physical health problems such as heart disease, respiratory disease, diabetes, swallowing difficulties, and malnutrition are under-recognised and sub-optimally treated among people with severe mental illnesses (Lawrence and Kisely 2010; McIntyre et al 2007). Delays in accessing care as a result of late identification by staff working in inpatient units can lead to poorer treatment outcomes contributing to the excess morbidity and mortality rates**.**

Patients and service users admitted to hospital with a mental health issue are becoming increasingly likely to also have complex physical health needs. Therefore, it is essential that staff in mental health settings meet patients' physical as well as mental health care needs.

Care Quality Commission (CQC 2017) recommend regular assessment of the physical health needs of patients with appropriate follow up including screening and intervention and monitoring of outcomes and the employment of medical, nursing and pharmacy staff and other healthcare professionals with the necessary skills and knowledge to oversee and deliver aspects of physical healthcare. This includes competent use of the equipment and correct interpretation of the results obtained.

One solution to consider is to develop new care models and building flexible teams across traditional boundaries, ensuring they have the full range of skills and expertise to respond to service user needs in different settings that can focus on improved outcomes for service users. This includes a range of mental health and physical health nurses, allied health professionals and advanced practitioners.

A mapping exercise has also taken place across all inpatient facilities looking at access to Allied Health Professional (AHP) services and its implications in timely care provision. There exists within care groups, an variation in accessibility to AHP and this impacts not only the physical health treatment received by our patients but can also increase length of stay.

A recommendation through the Safer Staffing Report would be a review of the inpatient workforce to prepare for the future, to develop new care models and flexible teams utilising a range of staff crossing all professions including nursing and therapies. Strong clinical leadership across all staff groups including AHPs can be used to drive improvements in service delivery and enhance the quality of care for patients using the service.

Current projects and recommendations

- Workforce Planning Group meeting in August to progress the inpatient redesign work and discuss planning future workforce skill mix and care modelling requirements
- Consideration of new roles and team structures on inpatient wards including associate nurses, advanced practitioners and a mix of registered general nurses and mental health or learning disability nurses.
- A mapping exercise has taken place across all inpatient facilities looking at access and variations to AHP services and its implications to care and treatment provision for our inpatients. This will be discussed at the workforce planning group.
- A review of patient physical health assessment forms to reduce duplication of work and appropriateness of forms, to help release time for care.
- Development of existing physical health improvement leads forum to promote physical health and share physical health innovation and expertise.

References

Care Quality Commission (2017) Brief guide: Physical healthcare in mental health settings https://www.cqc.org.uk/sites/default/files/20170612_briefguide-physical_cal_healthcare_mental_health_settings.pdf accessed 21.05.18

Lawrence D, Kisely S (2010). 'Inequalities in healthcare provision for people with severe mental illness'. Journal of Psychopharmacology, vol 24, no 4, suppl, pp 61–8.

McIntyre RS, Soczynska JK, Beyer JL, Woldeyohannes HO, Law CWY, Miranda A, Konarski JZ, Kennedy SH (2007). 'Medical comorbidity in bipolar disorder: re-prioritizing unmet needs'. Current Opinion in Psychiatry, vol 20, no 4, pp 406–16.

APPENDIX 3

Appendix for Safer Staffing paper – Specialist Mental Health: Place Based services

Overview

This appendix to the safer staffing update will seek to provide a position statement with specific reference to the services that fall within the Specialist Mental Health: Place Based portfolio and particularly focusing upon Community Mental Health Teams (CMHT). It will detail the current position together with the steps currently being undertaken to ensure that services and the workforce are positioned to respond to the *safer staffing* agenda by ensuring *the right staff, the right skills* and *the right place.*

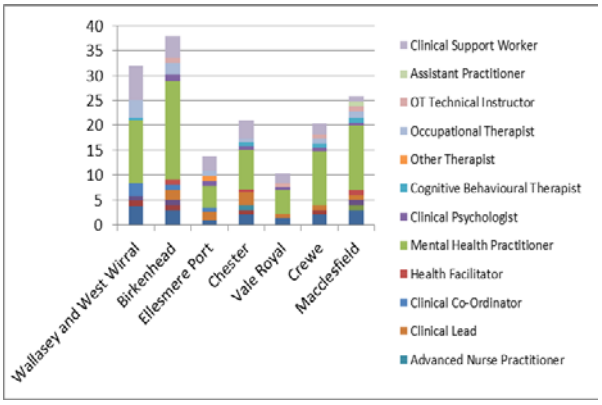
Background

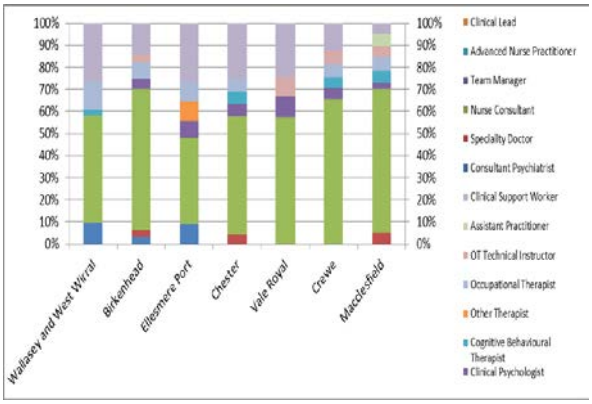
One of the Trust's key priorities is the Transformation of Mental Health Services with its signature quality initiative programme focusing upon the Responsive Care in Communities programme which seeks to ensure a Trust wide approach to the delivery of specialist mental health services that reduces unwarranted variation in practice, quality, experience and outcome of both physical and mental health and supports the delivery of place based care that uses the assets and skills of the local community to deliver integrated care. Taken in the context of an aging workforce and increasing difficulties in the recruitment of key roles it is imperative that this work programme takes an innovative approach to the development of new roles for both registered and non-registered staff that uses the assets and skills of the local community to integrate care delivery.

It should be noted that there are considerable interdependencies with the wider redesign of specialist mental health services, including the programme of work being done across Central and Eastern Cheshire to ensure that services are safe and sustainable; clinically effective and accessible whilst providing a good service user experience within the current financial envelope.

Current Position

CMHTs continue to operate as multidisciplinary teams, although the structure and composition of those teams varies significantly across the Trust's footprint. The table below illustrate the current composition of the teams for adults of working age – both in terms of the number of staff and proportionally.





It is evident that there is considerable variation across teams with regard to the types and mix of roles within teams without any agreed rationale for this. It is also worthy of note that those teams that are currently facing the greatest degree of challenge have the greatest proportion of qualified and least support staff. This variation is also evident within Older Peoples CMHTs with roles and functions having developed as a response to local demand, commissioning arrangements and clinical pathways.

The CMHT workforce is starting to routinely develop and utilise advanced skills and roles within clinical practice. Particular examples include the development of Non-Medical Prescribers, Advanced Practitioner roles, [although to date these positions are generally held by nurses], and the new Nursing Associate role. Historically, there has been little consistency across the organisation with regard to the development of these roles – particularly the Advanced Practitioner, and how the advanced skills are utilised to their optimum, Recent training positions have sought to address this and have been developed in a considered manner with the vision for services and the desire to address '*the right staff, the right skill, the right place*' agenda in mind.

Right Staff

An audit completed across CMHTs revealed a limited number of people who held advanced skills and a number of those lack current experience in their use – particularly the use of psychological interventions.

The current review of community services entails a clinically-led review of the current Care Clusters to ensure that they are NICE concordant together with the identification of the skills required to undertake each intervention and that it is delivered by the *right person, with the right skills in the right place* throughout the clinical journey. This will support services to identify an appropriate skill mix and optimise their capability, enabling recruitment and training and development to be considered planned way that maximises teams' capability through the use of innovative roles.

Evidence based approaches to caseload management, for example Choice and Partnership Approach (CAPA) are also being explored to ensure that workforce capability (capacity and skill) is available in right place to meet demand.

Right Skills

There is already a recognition (due to differing commissioning arrangements) that there are gaps in relation to the monitoring of peoples' physical health and wellbeing as well as access to psychological interventions [including interventions around personality disorder]. There is also recognition that there are training needs within the wider workforce resulting in the involvement of Education CWP and Organisational Development to support this.

Although very much in its infancy, progress is already being made towards addressing the clinical gaps utilising new roles with the Nursing Associate and new Advanced Practitioner roles being a clear example of how Specialist Mental Health: Place Based services are seeking to ensure that there is a robust approach to meeting the physical health needs of service users.

Right Time

It is important to recognise that the wider redesign of health and care systems impact upon the delivery of care within CMHTs too as the move to deliver Place Based care that addresses the needs of local populations' gains momentum.

Whilst the move towards integrated models of delivery is at different stages across the organisation, there is a unilateral acknowledgement of the need to develop increased links with Primary Care services – either through closer working practices or the development of new roles, to provide earlier intervention, reduce duplication and unnecessary consultations/ contacts and to address the mental health needs of people with other long term health conditions. Several 'pilot' programmes are in progress across the organisation trialling models with the aim of providing earlier support and intervention for the local populations.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Ward Daily Staffing Levels May and June Data 2018
Agenda ref. no:	18.19.34
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	25/07/2018
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

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

REPORT BRIEFING

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

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

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

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

Assessment – *analysis and considerations of options and risks*

During May 2018 the trust achieved staffing levels of 97.5% for registered nurses and 95.8% for clinical support workers on day shifts and 96.5% and 100% respectively on nights. During June 2018 the trust achieved staffing levels of 96.8% for registered nurses and 95.1% for clinical support workers on day shifts and 97.6% and 95.8% respectively on nights.

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

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

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

The Board of Directors are recommended to note the report.

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Gary Flockhart, Associate Director of Nursing [MH and LD] Avril Devaney, Avril Devaney, Director of Nursing, Therapies and Patient Partnership	18/07/2018 18/07/2018

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

Appendix no.	Appendix title
1	Ward Daily Staffing May 2018
2	Ward Daily Staffing June 2018

	Ward	Day				Night				Fill Rate				Safe Staffing was maintained by:
		Registered		Care Staff		Registered		Care Staff		Day		Night		
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	
East	Adelphi	1227.5	1107	1506	1341	747.5	736	1295.5	1192	90.2%	89.0%	98.5%	92.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Alderley Unit	973.5	921.5	1621.5	1501	713	655.5	883.5	861.5	94.7%	92.6%	91.9%	97.5%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Bollin	1331.5	1230.8	1366	1262	733.5	704.5	1322.5	1209.5	92.4%	92.4%	96.0%	91.5%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Croft	1189.5	1099.5	1523.55	1401	713	644	1357	1424.7	92.4%	92.0%	90.3%	105.0%	MDT supported the nursing staffing levels.
	Greenways A&T	1097.5	967	2139	1828.5	713	621	1426	1460.5	88.1%	85.5%	87.1%	102.4%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.
	LimeWalk Rehab	1142.5	1205.25	1069.5	1002	713	592.5	713	749	105.5%	93.7%	83.1%	105.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Saddlebridge	1012	1004.5	1437.5	1416.5	678.5	678.5	793.5	793.5	99.3%	98.5%	100.0%	100.0%	
Wirral	Brackendale	1018	1022	1109.5	1089.5	713	690	713	701.5	100.4%	98.2%	96.8%	98.4%	
	Brooklands	1015.5	993.5	1130	1189	757	746	866	866	97.8%	105.2%	98.5%	100.0%	
	Lakefield	1161.5	1140.5	1173	1127	707.5	673	954.5	976.5	98.2%	96.1%	95.1%	102.3%	
	Meadowbank	1321	1321	1325	1313.5	694	694	1387	1387	100.0%	99.1%	100.0%	100.0%	
	Oaktrees	1353	1376.5	1103	1112	665	653.5	402.5	425.5	101.7%	100.8%	98.3%	105.7%	
	Willow PICU	1037	1037	867.5	714.5	747.5	736	678.5	678.5	100.0%	82.4%	98.5%	100.0%	Cross cover arrangements.
West	Beech	1613	1598.5	900.5	900.5	739.5	739.5	757.5	748.5	99.1%	100.0%	100.0%	98.8%	
	Cherry	1156.5	1156.5	1583.5	1572	809	809	1119.5	1119.5	100.0%	99.3%	100.0%	100.0%	
	Eastway A&T	929.5	898.5	1589	1566	655.5	621	1108.5	1097	96.7%	98.6%	94.7%	99.0%	Ward manager actively worked within the daily staffing numbers. Cross cover arrangements.
	Juniper	1476.9	1449.9	963	961.5	701.5	690	759	758	98.2%	99.8%	98.4%	99.9%	
	Coral	1309	1286	1141	1118	605.9	583	877.5	877.5	98.2%	98.0%	96.2%	100.0%	
	Indigo	1191	1158	866.5	839	629.5	675.5	757.5	791	97.2%	96.8%	107.3%	104.4%	
	Rosewood	988.9	989	1477.75	1454.75	587.5	587.5	713	701.5	100.0%	98.4%	100.0%	98.4%	
	Trustwide	23544.8	22962.45	25892.3	24709.25	14023.9	13530	18885	18818.7	97.5%	95.8%	96.5%	100.0%	

	Ward	Day				Night				Fill Rate				Safe Staffing was maintained by:
		Registered		Care Staff		Registered		Care Staff		Day		Night		
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	
East	Adelphi	1260.5	1082	1373.5	1268.5	723.5	712	1132	1132	85.8%	92.4%	98.4%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Alderley Unit	983	921.5	1438.5	1393	690	644	865	931.5	93.7%	96.8%	93.3%	107.7%	Non mandatory staffing activity was cancelled. Cross cover arrangements.
	Bollin	1265.5	1229.5	1457.5	1337	690	678.5	1322.5	1262	97.2%	91.7%	98.3%	95.4%	Nursing staff working additional unplanned hours. Cross cover arrangements. Ward Manager actively worked within the daily staffing numbers when required.
	Croft	1155	994	1452	1423	690	621	1242	1267	86.1%	98.0%	90.0%	102.0%	MDT supported the nursing staffing levels. Cross cover arrangements.
	Greenways A&T	902.5	833.5	2162	1897.5	690	529	1519	1345.5	92.4%	87.8%	76.7%	88.6%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.
	LimeWalk Rehab	1096.5	1127	1035	960.5	690	722.5	690	597.75	102.8%	92.8%	104.7%	86.6%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Saddlebridge	994	922	1288	1276.5	609.5	609.5	759	747.5	92.8%	99.1%	100.0%	98.5%	Cross cover arrangments
Wirral	Brackendale	1055.5	1044	985	973.5	724.5	713	655.5	655.5	98.9%	98.8%	98.4%	100.0%	
	Brooklands	1103	1097.5	1109	1076	701	629	814	847	99.5%	97.0%	89.7%	104.1%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Lakefield	1009	1009	1031	1031	682.5	682.5	874	701.5	100.0%	100.0%	100.0%	80.3%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Meadowbank	1006	1025.5	1363	1024.5	552	609.5	920	770.5	101.9%	75.2%	110.4%	83.8%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Oaktrees	1198	1174.5	1249.5	1249.5	690	667	345	299	98.0%	100.0%	96.7%	86.7%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Willow PICU	1004	992.5	799	776	695.5	683.5	655.5	655.5	98.9%	97.1%	98.3%	100.0%	
West	Beech	1498.5	1456	881	793.5	678.5	678.5	690	649	97.2%	90.1%	100.0%	94.1%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Cherry	1168	1168	1311	1311	690	690	989	978	100.0%	100.0%	100.0%	98.9%	
	Eastway A&T	894.5	894	1610.5	1571	523	523	1158	1138.5	99.9%	97.5%	100.0%	98.3%	
	Juniper	1340	1269	937.5	879	751	751	649	649	94.7%	93.8%	100.0%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Coral	1235	1235	1020	1020	614	602.3	941	941	100.0%	100.0%	98.1%	100.0%	
	Indigo	1037.5	1018	1065.5	1006	633.5	622	880.5	795.5	98.1%	94.4%	98.2%	90.3%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Rosewood	982.25	970.75	1435	1435	579.25	579.25	628.5	628.5	98.8%	100.0%	100.0%	100.0%	
	Trustwide	22188.25	21463.25	25003.5	23702	13297.75	12947.05	17729.5	16991.75	96.8%	95.1%	97.6%	95.8%	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Quarterly Report of the Guardian of Safe Working Hours
Agenda ref. no:	18.19.35
Report to (meeting):	Trust Board of Directors
Action required:	Information and noting
Date of meeting:	25/07/2018
Presented by:	Dr Sumita Prabharakan

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

REPORT BRIEFING

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

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

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

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

Assessment – *analysis and considerations of options and risks*
Detailed information can be found in the attached report as directed by NHS Employers. During the reporting period we had 28 doctors working under the terms and conditions of the 2016 contract. There were considerable vacancies related to HENW posts not being filled, maternity leave, LTFT and higher trainees completing training. We have received no exception report during the reporting period and there have been no issues raised regarding safe working hours.

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

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

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1 2	Guardian of Safe working Hours Report to the Trust Board for the period April – June 2018

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Guardian of Safe working Hours Report to the Trust Board for the period April 2018 – June 2018

Report Author: Dr Sumita Prakhabaran
Guardian of Safe Working Hours

Date of report: 19th July 2018

Executive summary

The following report is the quarterly report to the Trust board and details the quarter April 2018 – June 2018.

There has been no exception reported during the reporting period. There have been no highlighted areas of concern regarding safe working or access to educational and training opportunities.

Introduction

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

High level data

Number of doctors in training (total): 42
(60 placements in total with HENW and maternity/LTFT vacant posts accounted)

Number of doctors in training on 2016 TCS (total): 28

Amount of time available in job plan for guardian to do the role: 0.5 PAs per week

Admin support provided to the guardian (if any): No admin support

Amount of job-planned time for educational supervisors: 0.25 PAs per trainee

a) Exception reports (with regard to working hours)

During the reporting period there were 28 doctors working under the TCS of the 2016 contract. **We had no exception reported regarding working hours and no exceptions reported regarding access to training/education reported at the time of preparation of the report.**

There is currently a mixed economy of contracts on individual rotas and this pattern will persist for several years as trainees progress onto the new contracts. For this reason there will continue to be a requirement on the trust to conduct traditional hours monitoring exercises for those rotas and trainees.

b) Work schedule reviews

There have been no formal work schedule reviews requested or completed.

c) Locum bookings

Vacancies stood at April 2018 as follows: 18 vacancies

i) Bank

Internal locum/bank work has varied across rota and site. Cost for the period April-June 2018 inclusive is as follows according to the information given to me to prepare this report:

Higher Trainee: £20,364 (see below narrative)

1st on call rota: £9,424.50

The information provided to me to complete this report indicates the following locum shifts over the reporting period:

Higher Trainee: 34 – from locum doctor report used to inform payroll and Central/East rota

1st on call rota: 24 – from locum doctor report used to inform payroll

In addition to the locum usage stated above there have been 8 shifts whereby the Consultant on call has stepped down as a higher trainee and 5 shifts when the higher trainee has stepped down to cover the 1st on call rota out of hours.

Reasons for locum usage and step down into the first on call rota are recorded as sickness.

Locum usage within the 2nd on call rota is related to vacancy, LTFT and placement numbers in general when populating a 1 in 10 rota.

ii) Agency

During the reporting period there has been no agency usage to cover 1st or 2nd on call rotas.

d) Vacancies

Trust wide data for vacancies for all doctors in training irrespective of contract:

Total Placements in CWP	
F1	8
F2	6
GPST1/2	5
CT1/2/3	23
ST4/5/6	18
Total	60

e) Fines

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

Summary

We currently have 28 doctors working under the terms and conditions of the 2016 contract. There are considerable vacancies related to HENW posts not being filled, maternity leave, LTFT and higher trainees completing training.

We have received no exception report during the reporting period and there have been no issues raised regarding safe working hours or access to educational and training experiences.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	CWP Rehabilitation Strategy Update
Agenda ref. no:	18.19.36
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	25/07/2018
Presented by:	Andy Styring/ Dr Amrith Shetty

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

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*
The purpose of this paper is provide a brief update to the rehabilitation services strategy and detail the key areas that the service is focussing on.

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

The strategy for Rehabilitation Services within Cheshire and Wirral Partnership NHS Foundation Trust has been developed following the Trust wide review of Rehabilitation services which was undertaken in 2015. In December 2016, a further update was presented to the Operations Board reflecting the progress made.

Assessment – *analysis and considerations of options and risks*

Since the Trust Wide Rehabilitation review, some progress has been made in terms of bringing together the different components of the rehabilitation service into one functional network of services.

The recent national focus on rehabilitation services provides CWP further opportunities to enrich some of the work that the service is already undertaking but also to engage other stakeholders in wider discussions about improving the outcome and experience for this group of service users.

Appendix 1 details the progress that has been made in relation to the rehabilitation strategy and outlines the next steps for the strategy.

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

CWP Board of Directors are requested to
Note the contents of the paper and the progress made in relation to the strategy

Who/ which group has approved this report for receipt at the above meeting?	Dr Anushta Sivananthan
Contributing authors:	Suzanne Edwards Dave Jones

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
35T	35T	35T

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

Appendix no.	Appendix title
1	Rehabilitation Strategy Update

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Operational Plan 2018/19- delivery indicators dashboard [June data]
Agenda ref. no:	18.19.37
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	25/07/2018
Presented by:	Tim Welch, Director of Finance/Deputy Chief Executive

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

REPORT BRIEFING

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

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

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

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

The operational plan delivery indicators dashboard in appendix 1 reflects the review of the metrics that has been undertaken with lead officers to ensure that the focus of monitoring the delivery of the Operational Plan and the Trust's strategic objectives is in line with the revision of the Operational Plan 2017/19 and highlights areas for improvement.
All priority projects have been aligned to Care Groups and there are three new projects identified this year (two are enabling projects).

Assessment – *analysis and considerations of options and risks*

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

The dashboard reflects month 3 (June) performance and there are 11 indicators off track.
SO1: 1.2 Patient experience
SO1: 1.3 Clinical Effectiveness
SO1.1.4/5/6/7/8 Patient Safety Indicators
SO3: 2.1 Capacity
SO3: 2.2 Competence
SO3: 3.3/6/9/10/12 Priority Projects, with the ADHD Priority Project remaining as red rated, further detail is available in the full PSO report.

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

- Safeguarding training is not achieving the required compliance level across three of the four care groups, resulting in the trust as a whole not achieving 80% compliance with safeguarding training, September Operational Committee will receive an update report from the CYP Care Group.
- Operational committee continuous improvement report is being redeveloped to facilitate a monthly refresh of data/ performance for the previous month and a primary data cut for the most recent month (to allow early indication of any potential performance issues). The KPIs reviewed by Operational Committee are being reviewed in partnership with the Heads of Operations on behalf of their respective care groups.

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

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

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

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Tim Welch	18/07/2018

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

Appendix no.	Appendix title
1	June 2018 Board Operational Plan Dashboard.

2	Operational Plan 2017/18 – Delivery Indicators/ Board KPIs

Appendix 1: Trust Dashboard

	Indicator	Outturn 2017/18	Target or Thresholds for escalation	Apr-18	May-18	Jun-18	Q1	Q2	Q3	Q4	Year End	General Comment
Strategic Objective 1 – Quality												
SO1: 1.8	Patient Safety: Reduction in the severity of harm (by 20%) sustained by those people accessing CWP services that cause harm to themselves	121 (10 per month)	97 (10 per month)	8	9	14	31					The quarter one number of severe self-harm incidents is off track overall (target <30) following the first two months of the quarter demonstrating improvement. The first quarter was acting as a baseline for quality improvement work for the year ahead, the previous three months' performance will be plotted using annotated run charts to identify improvement and enabling work.
SO1: 1.2	Patient experience: Demonstrable increase in the uptake of the Friends and Family Test (FFT) each quarter	Average 201 (per month)	330 per month	305	287	249	841					The new FFT system went live for Mental Health services (excluding IAPT) in May. Work is being undertaken to progress the development for IAPT & Physical Health services FFT feedback.
SO1: 1.3	Clinical Effectiveness: Demonstrable improvement in the Trustwide average bed occupancy rate, excluding leave, for working age adult wards	93.30%	Improvement to 85% by KH03's month 12 (December 2017)	95.95%	92.40%	92.40%	93.58%					
SO1: 1.4	Patient Safety: Total % inpatient deaths subject to a case record review	100%	100%	100.00%	N/A	N/A	100%					
SO1: 1.5	Patient Safety: Total number of inpatient deaths subject to a case record review identifying that there may have been a problem in the care provided	3	2 in 2018/19 (1 in any month)	1	0	N/A	1					Inpatient death following non-fixed ligature incident (Apr-18). A level 3 investigation is in progress. April and Q1 outturn will be reviewed retrospectively on completion of level 3 investigation.
SO1: 1.6	Patient Safety: Total % deaths reported by and to the Trust (including inpatient deaths) subject to a case record review	18%	15%	* 36%	* 42%	*24%	* 34%					* Includes only CAREnotes and PCMIS data in the denominator - Amber rating reflects this position. The Q1 outturn will be reviewed and adjusted in July 2018 when system updates have taken effect.
SO1: 1.7	Patient Safety: Total number of deaths (including inpatient deaths) subject to a case record review identifying that there may have been a problem in the care provided	4	3 in 2018/19 (1 in any month)	0	0	0	0					
Strategic Objective 2: People and OD/ Approach to workforce												
SO3: 2.1	Capacity: % of staff vacancies (Contracted)	5.00%	equal to or below baseline 5.31%	-6.35%	-7.97%	-8.51%	-8.51%					Our time to recruit is reducing - 68.3 working days overall (including approval time) in April 18 down to 60.9 working days in June 18. There remains a backlog and we also have continued increased demand – 17-18 demand was 25% higher on 16-17 recruitment activity and that activity remains high in Q1 18/19. We continue to concentrate on transactional work, prioritising medical, clinical and business critical A&C roles as agreed at Ops Committee in June 18. .
SO3: 2.2	Competence: % of staff receiving annual appraisal (via new proposed framework)	97.6%	100.0%	94.01%	91.48%	89.14%	89.14%					Windows for appriasal are three months for the bandings. Therfore we expect to see a decline in performance before they start to improve again. Care Groups reported at Operational Committee that the switch to Care Groups with changes in reporting lines has led to a drop in completion rates actions are being taken to improve compliance.

SO3: 2.3	% staff absence due to sickness	5.89%	Above annual plan (appendix 3) projection for 3 months	5.15%	4.71%	5.24%	5.24%						
SO3: 2.4	Staff, in month, Turnover rate (as a percentage)	0.91%	3 consecutive months where the turnover rate is 25% above the planned rate	0.98%	0.79%	0.78%	0.78%						

Operational Performance / Priority areas												
SO3: 3.1	100% of the 13 NHSI operational performance targets achieved (including waiting times)	100%	100%	78.0%	100.00%	100.00%	100.00%					
SO3: 3.2	100% Contractual targets met	324 (98.1%)	100%	96.3%	95.3%							This indicator reports a month behind, therefore June and Q1 position will be reported in Septemeber report 3 West PH, 4 West MH, 10 Wirral (3 for over performance), and 1 East
	CQUIN performance quarterly review		100%									This indicator reports position following CCG feedback on CQUIN quarterly submissions .
Trust Priority Projects												
Care Group: Neighbourhood Care												
SO3: 3.3	Single Model for Integrated Care	N/A	Delivery of Key Milestones									
Care Group: Specialist mental Health												
SO3: 3.7a	Redesign Adult OP MH services - Responsive Care in Communities	N/A	Delivery of Key Milestones									
SO3: 3.7b	Redesign Adult & Older peoples MH services - Bed based	N/A	Delivery of Key Milestones									
SO3: 3.8	Early Intervention Trust Wide Review	N/A	Delivery of Key Milestones									Complete
SO3: 3.10	Wirral All Age Disability	N/A	Delivery of Key Milestones									
Care Group: Children Young People & Families												
SO3: 3.5	Children and Young Families Prevention/ Early interventions:	N/A	Delivery of Key Milestones									
SO3: 3.4	0-19 Starting Well Service Implementation	N/A	Delivery of Key Milestones									
Care Group: Learning Disabilities & Nuero Developmental (LD&ND)												
SO3: 3.6	Transforming Care - LD	N/A	Delivery of Key Milestones									
SO3: 3.9	ADHD	N/A	Delivery of Key Milestones									Further detail is available in the PSO report
Enablers												
SO3: 3.11	People& OD Strategy	N/A	Delivery of Key Milestones									
SO3: 3.12	Health Informatics	N/A	Delivery of Key Milestones									Further detail is available in the PSO report
SO3: 3.13	Quality Improvement Strategy	N/A	Delivery of Key Milestones									
SO3: 3.14	Communications & engagement	N/A	Delivery of Key Milestones									Milestones being developed
Strategic Objective 6: Financial Planning												
SO6: 1	Use of resources	1	Use of Resources [UoR]	2	2	1	1					Further detail is available in Finance Report

Appendix 2: Trust Dashboard Reporting Framework

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

SO1: 1.6	Patient Safety: Total % deaths reported by and to the Trust (including inpatient deaths) subject to a case record review	KPI escalation via Learning from Experience report	18%	Learning from Experience report Every 4 months	May August January April	Quality Committee	Tabular	Avril Devaney/ Jim O'Connor	Lisa Parker	
SO1: 1.7	Patient Safety: Total number of deaths (including inpatient deaths) subject to a case record review identifying that there may have been a problem in the care provided	3 (improvement by year end)	4	Learning from Experience report Every 4 months	May August January April	Quality Committee	Tabular	Avril Devaney/ Jim O'Connor	Lisa Parker	

SO3: 2.1	Capacity: % of staff vacancies	5.00%	5.00%	Any 3 consecutive months where we are above the baseline for staff vacancy rate by 10%	By exception	People and OD subcommittee	Chairs escalation	Dave Harris	Viv Williamson	Risk 11 – staffing (rated red 20)
SO3: 2.2	Competence: % of staff receiving annual appraisal (via new proposed framework)	100% of available eligible cohort	97.6%	Any quarter in which each of the three months the appraisal rate is below the baseline position	Quarterly	People and OD subcommittee	Performance against plan chart or variance from plan	Dave Harris	Hayley Rigby	Risk 11 – staffing (rated red 20)
SO3: 2.3	% staff absence due to sickness	5.30%	5.89%	Any 3 consecutive months where we are above the monthly baseline set out in the annual plan.	By exception	People and OD sub committee	Variance from target trend line	Dave Harris	Chris Sheldon	Risk 11 – staffing (rated red 20)
SO3: 2.4	Staff , in month, Turnover rate		0.91%	3 consecutive months where the turnover rate is 25% above the planned rate	By exception	People and OD sub committee	variance from plan	Dave Harris	Gill Kelly	
Operational Performance / Priority areas										
SO3: 3.1	100% of the 13 NHSI operational performance targets achieved (including waiting times)	100%	100%	Any occasion where the compliance with any monitor target is missed for 3 consecutive months	By exception	Operational Board	Achievement trend line	Andy Styring/ Tim Welch	Service Directors	Risk in scope re. IAPT delivery
SO3:3.2	100% Contractual targets met	100%	Avg 98.1%	Any occasion where the same target for any contractual KPI is missed	By exception	Operational Board	Achievement trend line	Andy Styring/ Tim Welch	Service Directors	Risk in scope re. IAPT delivery
	CQUIN Achievement of milestones	(100% of CQUIN Milestones achieved)		Report quarterly on CCG confirmed achievement against milestones	By exception	Operational Board	written report	Andy Styring/ Tim Welch	Service Directors	Risk 14 Financial performance/ CIP delivery (rated red 16)
Op Plan ref	**Indicator**	**Target or Thresholds for escalation**	**Base line**	**Reporting and Frequency**	**Reporting Months**	**01/04/2017**	**01/05/2017**	**Executive Sponsor**	**Project Lead**	**Risk Register/ CAF ref**
SO3: 3.3	Priority project 1: Children and Young Families Prevention/ Early interventions:	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	April - March	Operational Board	Delivery of Key Milestones	Avril Devaney and Dave Harris	Val Sturgess	Risk 13 – tendering of services (rated amber 12)
Care Group: Neighbourhoods										

SO3: 3.3	Single Model for Integrated Care (Improved Place Based Care)	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Dave Harris	Karen Moore	
Care Group: Specialist Mental Health Services										
SO3: 3.7a	Redesign Adult & Older peoples MH services- responsive care in the community	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Nush Sivananthan & Faouzi Alam and Dave Harris	Sally Sanderson	
SO3: 3.7b	Redesign Adult & Older peoples MH services- Bed Based	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Nush Sivananthan & Faouzi Alam and Dave Harris	Suzanne Edwards	
SO3: 3.8	EI Review & delivery			Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Faouzi Alam	Trish McCormack	
SO3: 3.10	Wirral All Age Disabilities	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Andy Styring	Trish McCormack	
Care Group Children & Young People										
SO3: 3.5	Children and Young Families Prevention/ Early interventions:	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Avril Devaney	Fiona Pender	
SO3: 3.4	0-19 Starting Well Service Implementation	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Avril Devaney	Val Sturgess	
Care Group: Learning Disabilities & Nuero Developmental										
SO3: 3.6	Transforming Care - LD Care Model	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone	Monthly	Operational Board	Delivery of Key	Andy Styring	Mahesh Odiyoor	
SO3: 3.9	ADHD	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Andy Styring	Mahesh Odiyoor	
ENABLERS										
SO3: 3.11	People & OD Strategy	N/A	Delivery of Key Milestones		Monthly	Operational Board	Delivery of Key Milestones	Dave Harris/ Faouzi Alam	Jane Woods	
SO3: 3.12	Health Informatics	N/A	Delivery of Key Milestones		Monthly	Operational Board	Delivery of Key Milestones	Tim Welch	Jane Thomas/ Mandy Skelding-Jones	
SO3: 3.13	Quality Improvement Strategy				Monthly	Operational Board	Delivery of Key Milestones	Anushta Sivananthan	Hayley Cavanagh	

SO3: 3.14	Communication & Engagement	N/A	Delivery of Key Milestones		Monthly	Operational Board	Delivery of Key Milestones	Avril Devaney	Kathrine Wright	
Strategic Objective 6: Financial Planning										
SO6: 1	Use of resources	Use of Resources [UoR] score of 3 or 4	Plan	Monthly	April - March	Trust Board		Tim Welch/ Edward Jenner	Andy Harland	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Integrated governance framework review
Agenda ref. no:	18.19.38
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	25/07/2018
Presented by:	Dr Anushta Sivananthan, Medical Director (Executive Lead for Quality)

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

REPORT BRIEFING

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

This report presents the outputs of a review of CWP's governance and assurance arrangements. Applying integrated governance handbook principles (DH, 2006) this review represents the work to strengthen and streamline our governance arrangements to free up capacity to support the delivery of care and systems working. There are eight less meetings to support this aim. The main driver for the review has been to ensure we have fit for purpose and flexible governance arrangements that can respond to changing priorities and risks. This review is timely, in acting as a mitigating action against the current strategic risk of "potential for ineffective control and management of risks and inattention on business as usual associated with the transition to the Trust's clinician-led operational (Care Group) structure as part of CWP Forward View strategy". The report sets out a reviewed framework (including Trust meetings structure) for approval. In the spirit of continuous improvement, the effectiveness of the new arrangements will be reviewed after six months, to assure the Board that the improvements made are having a positive impact on managing the burden on the Board agenda, providing assurance, and facilitating an improvement ethos.

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

To achieve good governance requires regular challenge of complex committee structures and ensuring an interlink of committee structures into an effective and non-repetitive whole (DH, 2006). The current review of our governance and assurance arrangements is in response to a review, strategically, of the external environment, culminating in development of the CWP Forward strategy. In conjunction with a review of the Care Group meeting structures as part of Care Group approval processes, this will ensure that our ongoing and developing work in partnership across systems is integrated within the committee framework.

Assessment – *analysis and considerations of options and risks*

This review has been the result of a comprehensive and considered consultation process:

- Meetings held by the Medical Director (Quality) and AD Safe Services with subsidiary committee chairs to review the current operation of their meetings December 2017 and January 2018).
- Meeting to discuss Care Group governance, held between the ADs and representatives from the Care Group senior clinical and managerial team (March 2018).
- Meetings held by the Medical Director (Quality) and AD Safe Services with the ADs of Operations, who fed back recommendations about the Care Group meeting infrastructural interface with the Trust meetings structure, and also experiences of their capacity issues with ensuring representation across the whole of the current Trust meetings structure (June 2018).
- Discussion of assurance arrangements and the 'intelligent' information requirements of Boards at the Board seminar (June 2018).
- Walkthrough of the proposals with NED representatives from the Quality Committee (July 2018).

Appendix 1 details the revised integrated governance framework. A summary of the main changes are:

- Board of Directors is now the approving meeting of the integrated governance framework – to reflect that all Trust meetings are established by and should exist to serve the Board.
- Recognition of the Operational Board as an executive committee and clarity of the status of other committees of the Board and their reporting lines.
- Update to the Trust meetings structure, in particular (i) strengthening the sub committee infrastructure that supports the Operational Committee to enable it to be more effective and to provide more robust assurance to the Board of Directors (ii) recognising that E&D underpins all of our governance arrangements, the current E&D Group will continue with a task and finish brief, but both POD and PACE sub committees will have greater, substantive responsibilities for oversight.
- Update to reflect the transition to the Care Group clinician-led operational structure.
- Updated narrative around the management of risk and escalation processes, including 'ward to Board assurance' processes.
- Updated terms of reference of the Operational and Quality Committees, to reflect their duties in not only seeking/ providing assurance, but also in assuring the Board that in their operations they are supporting the development of capability building in relation to quality improvement.

Next steps are for sub committee terms of reference to be reviewed by the chairs and their submission to the Medical Director (Quality) and AD Safe Services before approval – to ensure all Trust meetings are aligned, through integrated governance, with the corporate assurance framework. Additionally, the Safe Services Department will attend sub committee meetings on a regular basis to offer constructive challenge regarding the "systems, processes and behaviours" elements of integrated governance.

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

The Board of Directors is asked to **approve** the integrated governance framework at Appendix 1 and **agree** to receive a report to review the impact of the changes in six months' time.

Who/ which group has approved this report for receipt at the above meeting?	Board of Directors – business cycle requirement
Contributing authors:	David Wood, Associate Director of Safe Services

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	18/07/2018

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

Appendix no.	Appendix title
1	Integrated governance framework (version 10)

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document level: Trustwide (TW)
Code: FR1
Issue number: 10

Integrated Governance Framework

Lead executive	Medical Director, Executive Director Lead for Quality
Authors details	Associate Director of Safe Services

Type of document	Policy
Target audience	All CWP staff
Document purpose	The integrated governance framework combines the high level risk management and performance management frameworks into one. This is to ensure that effective governance systems can be implemented, without unnecessary duplication, and the Trust can monitor and deliver its strategic objectives.

Approving meeting	Board of Directors	25-July-18
Implementation date	July 18 followed by an annual compliance review	

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

Document change history	
What is different?	1. Minor changes have been made in relation to the contents page, job titles, regulatory title changes, formatting, page numbering, cross referencing within the document. 2. Update of terms, roles, responsibilities and accountabilities as they relate to the Trust's clinician-led operational structure which are responsible for developing new models of care (Care Groups) 3. Updated narrative around the role of Operational Committee. 4. Updated narrative around the management of risk and escalation processes, including 'ward to Board assurance' processes. 5. Updated Trust meetings structure. 6. Updated Terms of Reference.
Appendices / electronic forms	No amendments since previous review.
What is the impact of change?	Amendments provide greater clarity with regards to how this framework interfaces with the new operational structures, but will not significantly impact upon current processes.

Training requirements	No specific requirements.

Financial resource implications	No

External references

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	

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Comments
- 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?		
Is the impact of the document likely to be negative? - If so can the impact be avoided? - What alternatives are there to achieving the document without the impact? - Can we reduce the impact by taking different action?	No N/A N/A 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	

Content

1. Introduction

The Integrated Governance Handbook, produced by the Department of Health (2006), remains relevant in the current and emerging care system landscape, describing 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 framework 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 engagement groups;
- Assurance mechanisms through the use of external and internal (independent) audit and seeking to review benchmarking/ peer review data, where available;
- Robust accountability arrangements that ensure actions will be taken should risk/ performance issues be judged as requiring escalation.

2.1 Corporate meetings structure

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

The committees of the Board, comprising non-executive, executive and integrated committees, are responsible for overseeing strategic risks outlined within the strategic risk register and corporate (Board) 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 Committee as appropriate, particularly where there are identified resource requirements to address the risk/s. The Operational Committee also reviews risks referred by its sub groups, and monitors and reviews Care Group risk registers.

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, the Audit Committee receives the strategic risk register and corporate assurance framework on a quarterly basis to enable them to undertake periodic reviews of risk treatment processes for individual risks on an escalation/ enquiry basis. In summary, this committee provides additional assurance on risk management processes and systems for the Board of Directors.

The committees of the Board 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 Committee 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 reviews 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 that multiplies an impact score by a likelihood score, see appendix 3 for risk matrix. The total score generated is known as the risk rating.

In addition to the escalation of risks via the committees of the Board, 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;
- 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 seeking and 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 throughout the organisation at all levels, both up and down the organisation.

As well as having a strategic risk register, each Care Group has its own risk register/s which document speciality/ sub specialty risks identified by service line business and governance meetings, and locality risks identified by locality based governance meetings, with the accountable officers for risk management being the Strategic Clinical Director and Associate Director of Operations. The Care Group risk register must be monitored and reviewed by the Quality, Governance & Effectiveness meeting within the clinical services 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 local/ place based objectives/ deliverables or Trustwide strategic objectives – the process of local management of risk and escalation should be followed as per Table 1. Additionally, corporate departments may also maintain departmental risk registers or risk logs, which are reviewed at least annually by the Medical Director (Executive Lead for Quality) and the Associate Director of Safe Services. The same process of escalation as described in Table 1 applies.

Risks can be managed and monitored at a clinical and corporate level, but must be escalated appropriately, dependent on the severity of the risk. This scheme of delegation is outlined below:

Table 1: Management of risk and escalation

Score	Grade	Clinical service management of risk and escalation	Corporate management of risk and escalation
Risk Rating 1 – 6 'Green'	**Low – moderate**	**Risk can be managed within clinical services via agreed governance structures** – individual/ team must escalate to Team Manager	**Risk can be managed via corporate services risk registers and/ or via risk log of meetings within the Trust meetings structure**
Risk Rating 8 – 12 'Amber'	**High**	**Risk can be managed within clinical services via agreed governance structures** – Head of Operations must escalate to Associate Director of Operations and Strategic Clinical Director	**Risk can be managed via corporate services risk registers and/ or via risk log of meetings within the Trust meetings structure**
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** – Associate Director of Operations or Strategic 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.	**Risk is escalated to Quality Committee 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** – Quality Committee agrees Trustwide impact, with management in line with corporate assurance framework processes if risk score remains red

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 framework 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 Care Group level, Strategic Clinical Directors and Associate Directors of Operations are the accountable officers for the risk register process and must manage risks as outlined in section 2.3. Strategic Clinical Directors and Associate Directors of Operations, as local 'risk owners', can discharge accountability to 'risk leads' within their portfolio, e.g. Heads of Operations/ Heads of Clinical Services/ 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 Clinical Governance will receive an automated notification from the Trust Datix system outlining that a risk has been red rated. The Head of Clinical Governance 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 organisation's ability to achieve strategic objectives;
- The nature of the risk (i.e. risks that could cause serious harm to people who access services);
- Does the risk treatment plan provide adequate assurance to mitigate the impact of the risk;
- If this risk is a place 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/ Care Group 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/ Care Group) 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 not 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

Care Group risk registers are reviewed monthly at the Quality, Governance & Effectiveness 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, both bespoke and as part of the Trust's Training Needs Analysis (TNA).

Trustwide 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 Education CWP 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 Education CWP once the individual attends the learning event and signs the attendance register. Education CWP collates the sheets (either locally or through the trainer sending the documentation to Education CWP). The individual's learning record is updated by Education CWP 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, where appropriate 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 framework 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 access 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 access 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 access the Trust's services.
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 access 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 access the Trust's services.

2.9 Escalation framework (incorporating judgement and accountability framework)

The integrated governance framework 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 local key performance indicators);
- Finance, including claims;
- Service/ business interruption;
- Environmental impact.

2.9.1 Early warning frameworks

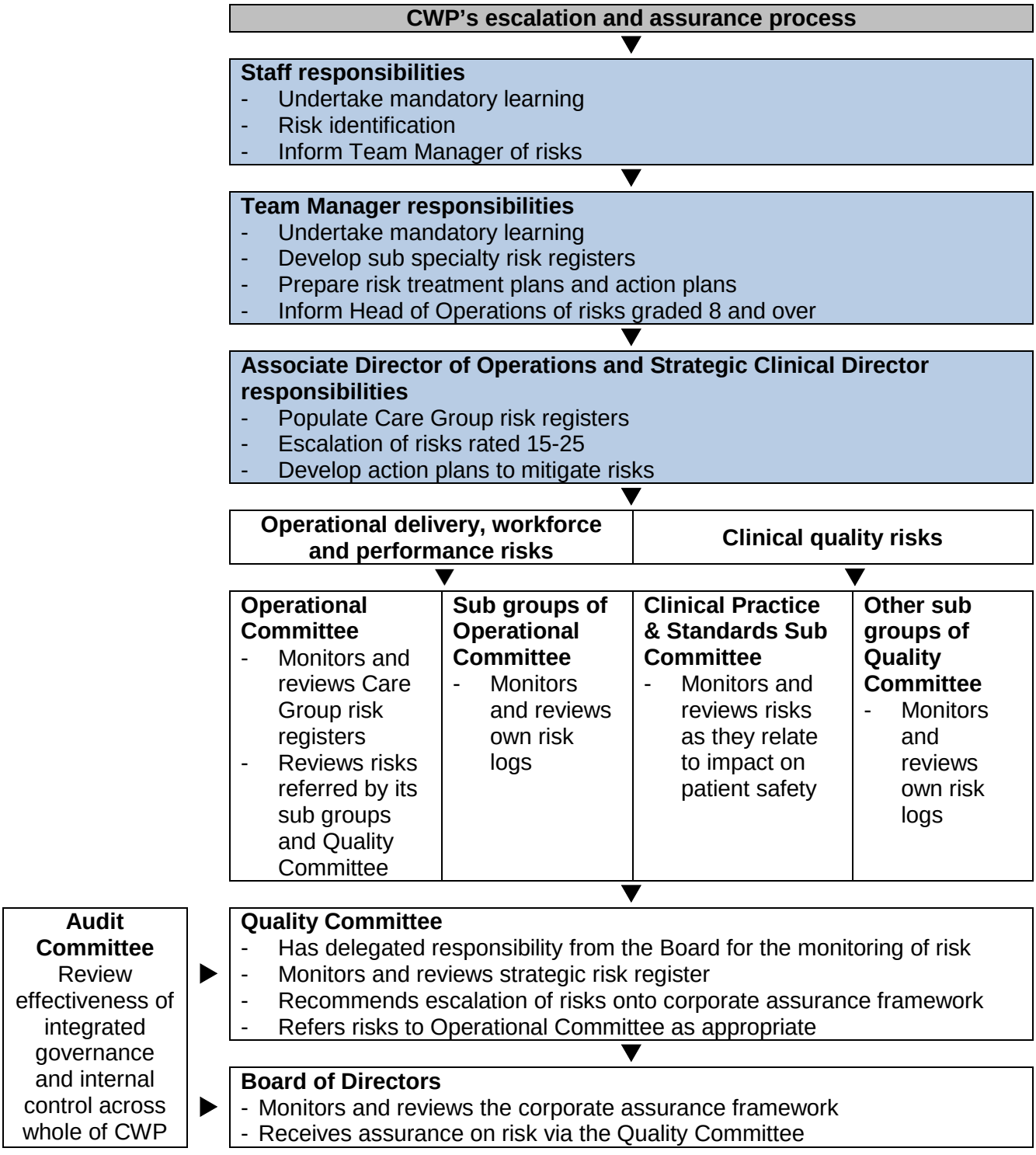
The Board achieves 'ward to board assurance' by applying the integrated governance framework, which is designed to support the improvement to safety and quality on a continuous basis. In

describing the Trust's escalation and assurance process, setting out the key responsibilities of individuals and key supporting committees, and being underpinned by the use of information and measurement, the framework enables and assure that safety and quality can be progressed and monitored at all levels from the 'ward to board'. 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 corporate performance dashboard and quality assurance dashboard incorporates sets 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 three times yearly Quality Improvement 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 ongoing 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 regulatory requirements. This provides the Board with assurance about how the organisation is able to identify, monitor, 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 healthcare quality improvement programme, the monitoring of associated risks, and through other mechanisms of assurance. The table below demonstrates the reporting and accountability mechanisms.

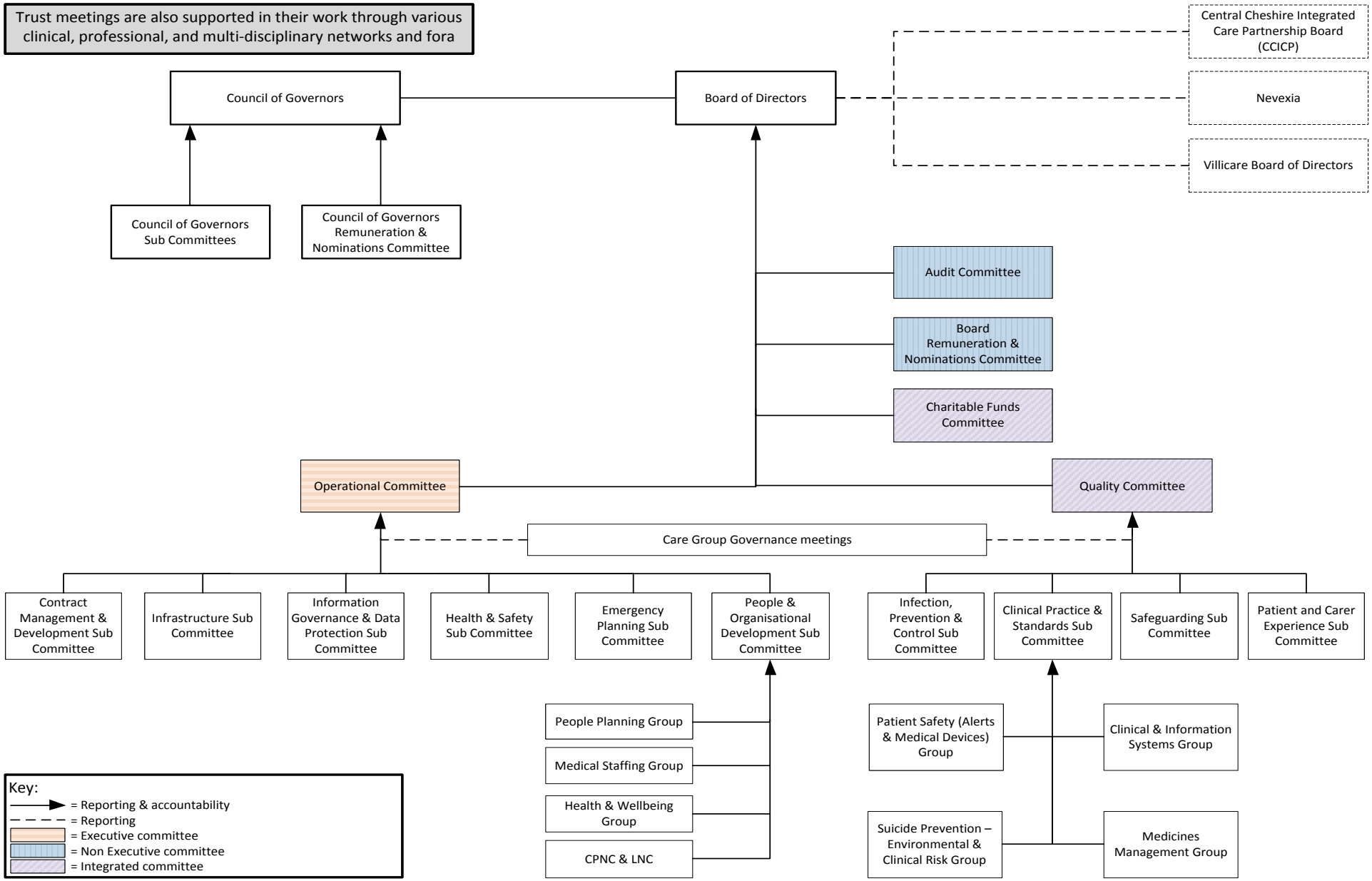
These are supported by clear terms of reference (ToR) (the most recent ToR are available via the corporate governance manual) and responsibilities (appendix 1).

	Committees of the Board			Subsidiary Committees and Groups		
	Quality Committee	**Operational Committee**	**Other Committees of the Board**	**Sub Committees**	**Groups**	**Task & Finish Groups**
Reporting to	Board			Board Committees	Sub Committees	Groups
Reviewed	Annually against ToR			Annually against ToR	Annually against ToR	On establishment
Membership	- Non-Executive Directors - Executive Directors - Senior Managers - Senior Clinicians	- Executive Directors - Senior Managers - Senior Clinicians	- Non-Executive Directors (for Non-Executive Committees) - Non-Executive Directors and Executive Directors (for integrated committees)	- Executive Directors - Senior Managers - Staff representatives	- Various staff	- Various staff
Responsible for	- Strategy - Assurance - Monitoring progress, including identification of consequences - Devising plans	- Strategy - Assurance - Monitoring progress, including identification of consequences - Devising plans	- Assurance - Monitoring progress, including identification of consequences	- Providing assurance - Implementing plans - Performance management of groups, including identification of consequences	- Operational activity delivery	- Specific delivery of work streams
Assurance mechanisms	- Minutes - Action Log - Action Plans - Assurance/ improvement reports - Risk Registers	- Minutes - Action Log - Action Plans - Assurance/ improvement reports - Risk Registers	- Minutes - Action Log - Action Plans - Assurance/ improvement reports	- Minutes - Action logs - Action plans - Assurance/ improvement reports - Risk registers	- Minutes - Action log - Assurance/ improvement reports	- ToR - Minutes - Action plans
Escalation of risks	- To Board through strategic risk register, minutes, Chair's reporting, detailed assurance/ improvement reports	- To Quality Committee through strategic risk register - To Trust Board through minutes, detailed assurance/ improvement reports	- To Board, via minutes and detailed assurance reports	- To sub committee via minutes, risk registers, detailed assurance reports	- To committees, reporting progress, risks, and quality	- Report risks

It is recognised that there will be times when urgent decisions are required outside of scheduled meetings. Such decision making authority by the Chair of the meeting on behalf of the group will only be used when an urgent decision is required and there are no alternatives (e.g. the matter will not wait until the next meeting of the committee/ sub committee and cannot be managed in another way without introducing unwarranted risk). Anyone putting forward an item for Chair's action should ensure that the issue has been supported by key individuals and groups in the usual way.

To ensure transparency, any urgent decisions will be submitted, along with relevant supporting papers, to the next regular meeting for formal endorsement and documentation in the minutes. If decisions have an immediate impact on the wider membership of the group or an immediate impact on practice, the members will be informed as soon as is practicable.

Appendix 1 – Trust meetings structure



Appendix 2 – Responsibility of committees

Operational Committee

The Operational Committee is responsible for ensuring that governance, assurance and improvement systems operate effectively and thereby underpin clinical care:

Assurance

Receiving assurance on performance through the lens of:

- People
- Clinical services
- Clinical support services
- Finance

Improvement

Overseeing delivery of strategic priorities as described in the CWP Forward View, in order to assure the Board of Directors that there is sustainable leadership, governance and improvement capability to deliver better outcomes for populations the Trust serves.

Operational Committee is the formal route to support the Chief Executive in effectively discharging their responsibilities as Accountable Officer.

The agenda for Operational Committee meetings will be structured to allow time for strategic debate and discussion of current and future issues affecting the Trust and the wider health care system.

Quality Committee

The Quality Committee is responsible for:

Assurance

Receiving assurance on organisational quality governance and current performance regarding quality of care.

Improvement

Ensuring that that the strategic priorities for quality improvement are identified, implemented and monitored, to support future planning including responding proactively to new care delivery models.

The Quality Committee has delegated responsibility from the Board of Directors for oversight of the integrated governance framework, has overarching responsibility for risk, and therefore for monitoring strategic risks within the organisation.

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.

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 De-authorisation by Regulator
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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Corporate assurance framework and strategic risk register – update report
Agenda ref. no:	18.19.39
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	25/07/2018
Presented by:	Dr Anushta Sivananthan, Medical Director (Executive Lead for Quality)

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	Yes
All strategic risks	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	Yes
As per report	

REPORT BRIEFING

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

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

As at July 2018, the Trust has 3 red and 5 amber rated strategic risks. There are 2 risks currently in-scope, both rated as amber.

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

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

Assessment – *analysis and considerations of options and risks*

New risks/ risks in-scope – two previous risks in-scope remain in scope, as follows:

- *Risk of inability to fulfil corporate governance responsibilities due to capability within the corporate affairs team.* The initial risk severity was mitigated by invoking business continuity processes. Additional capacity has since been secured (25 June 2018) on a rolling basis to cover long term absence, whilst an interim Head of Corporate Affairs has been secured (2 July 2018) for a six month period to cover fixed term absence.
- *Due to pressures on acute care bed capacity, there is a risk that people who require admission may have to wait longer than 4 hours for a bed to be allocated.* The Quality Committee has asked that mitigation of the risks of sleeping out on other wards due to high bed occupancy are included in the modelling of this risk. The centralised bed management hub continue to monitor the impact of this risk, a decision will be taken regarding escalation of this formally to the strategic risk register at the next review in September 2018.

Amended risk scores or re-modelled risks

Risk 8 – *Risk of deficiencies in ICT infrastructure* will be re-modelled ahead of the September 2018 Quality Committee to capture the specific deficiencies in the EMIS infrastructure (source: Care Group risk register).

Risk 4 – This risk has been revised to be described as *Potential for ineffective control and management of risks and inattention on business as usual associated with the transition to the Trust's clinician-led operational (Care Group) structure as part of CWP Forward View strategy* to be more specific about the risk/s requiring treatment. An in-depth presentation was provided to July 2018's Quality Committee meeting, outlining the full risk treatment plan that has now been developed (further updated at the July 2018 Care Group task and finish group).

Risks 10 and 12 – Following the Performance & Redesign Team moving into recovery phase (risk 10 – archived) and subsequent discussions at a governance workshop held with Care Groups in July 2018, risk 12 has been revised to be described as *Potential for adverse impact on the effectiveness of service delivery, evaluation and planning due to infrastructural, technical and capability gaps in using measurement for improvement.* A rapid improvement workstream has been established to develop the risk treatment plan.

Risk 11 – *Risk that the CWP workforce may not have sufficient capability to deliver place-based, person-centred care.* This risk now also reflects the current medical vacancies within the Trust and describes plans to mitigate against the pressures, to ensure effective recruitment processes are established and to minimise the impact on service delivery. The current situation is being reviewed on a weekly basis.

Archived risks

Risk that the medicine supply contract with Lloyds Pharmacy will not be extended from 18 May 2018, for a further twelve months, due to an increase in the price schedule. The immediate risk to the medicine supply was mitigated further to risk treatment overseen by the executive team and Operational Board. An options appraisal to ensure future maintenance of the medicine supply is scheduled for review by Operational Board in July 2018. Any emerging risks will be escalated and further considered by Quality Committee in September 2018.

Exceptions – there are three overdue risk treatment actions to report, as follows:

- Risk 3 – *Risk of cyber-attack*
  The May 2018 Operational Board and Board meetings approved engagement principles and investment plan for health informatics. Work plans are now being drawn up which will then complete this outstanding action.
- Risk 4 – *Potential for ineffective control and management of risks and inattention on business as usual associated with the transition to the Care Group structure as part of CWP Forward View strategy*
  The mitigating action to produce robust internal and external communications to ensure that all staff and stakeholders understand the new structures. It has been identified that further multi-channel communications are required, these have been increasing latterly and remain in progress.
- Risk 5 – *Risk of not achieving safeguarding contractual obligations and subsequent reputational impact, due to increased inspectoratory burden and acute increase in the volume of multiagency case reviews*
  The mitigating action to complete a service review is progressing, however the outcome is awaited. In the meantime, a Band 6 x 0.5 post has been uplifted to Band 7 x 0.6 for a fixed term whilst this review is being completed to close the identified interim capability gaps.

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

Review, **discuss** and **approve** the amendments made to the corporate assurance framework.

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Quality Committee	04/07/2018

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

Appendix no.	Appendix title
1	Strategic Risk Register

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	GDPR action plan.
Agenda ref. no:	18/19/40
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	25/07/2018
Presented by:	Dr Faouzi Alam, Medical Director & Caldicott Guardian

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

REPORT BRIEFING

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

This report provides an update to the Board of Directors on progress with GDPR implementation. The GDPR became directly applicable as law in the UK from 25 May 2018. The UK Data Protection Act 2018 (DPA18), which fills in the gaps of the GDPR, also came into force on 25 May 2018. Achievement of compliance with the new Data Protection legislation is overseen by the Trust's Records & Information Systems Group (RISG) including the action plan, any variance or risk is escalated to the Trusts Patient Safety and Effectiveness sub-committee.

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

The Trust's GDPR GROUP, as sub-group of RISG, has been managing preparations for GDPR and the National Data Guardian (NDG) and CQC data security review recommendations for two years. The first briefing paper containing a copy of the Trust's NDG/CQC/GDPR action plan was presented to the Board of Directors on 28/09/16. The work has been methodical and incorporated into scheduled reviews of policies, procedures and fair processing notices. Updated position papers were submitted to the Board of Directors on 26/07/17 and 28/03/18. Organisations (data controllers) must be able to demonstrate compliance with the GDPR principles and in particular that they have appropriate technical and organisational measures in place. For the Trust, the principle demonstrations of compliance are: **1) IGTK Level 2 with many areas achieving level 3. 2) Extensive review of existing policies, procedures and fair processing notices associated with IG which have been updated to reflect specific requirements of GDPR and 3) Significant review of the Information Asset Register to incorporate data flow mapping and the legal basis for processing data. 4) Review of all contracts.**

Assessment – *analysis and considerations of options and risks*

Just prior to the 25 May 2018, the Information Commissioner (IC) stated that it was highly unlikely that any large organisation would be fully GDPR compliant on 25th May 2018. The IC stated that GDPR implementation would be a work in progress for all organisations. Significant progress for GDPR compliance has been made by CWP since March 2018. Information Governance Alliance national guidance, including an implementation checklist, has been added to the Trust's GDPR group action plan with clear ownership assigned and delivery timeframes added. See Appendix 1 for updated action plan. **1) Privacy notices.** The public privacy notice was reviewed and published prior to 25 May 2018. The staff privacy notice was distributed to staff with April payslips. **2) Privacy Impact Assessment**. The PIA, which is required for all new systems or significant projects has been updated and now includes a risk matrix. **3) Data Protection Officer.** It has been agreed that the role of Data Protection Officer (DPO) will sit with the Records & Information Governance Manager which has been publicised within the privacy notices. **4) Roll out across the organisation.** Several communications to staff took place in the weeks leading up to 25 May 2018 to advise of the key changes within the new Data Protection legislation. **5) Significant review of the Information Asset Register.** Annual data flow mapping returns from Trust areas have been incorporated into the information asset register with the GDPR requirement to log the legal basis for processing data being added. **6) Review of all contracts to ensure GDPR compliance.** The contracts team communicated with clinical providers, and the procurement team communicated with non-clinical providers in April to advise that contract variations to incorporate GDPR will be required.

The following areas are potential risks for the Trust.

Review of all contracts to ensure GDPR compliance. 1) There is no central point for all contracts within the Trust. Whilst the contracts and procurement teams have made significant progress in communicating with all suppliers, ascertaining where logs are held for each contract, it is a very large piece of work to review all existing contracts and this will be ongoing. **There may be locally agreed contracts which the contracts and procurement teams are not aware of. 2) The teams are not resourced to support this additional work but are working closely with the DPO to agree processes and implement the elements they can. The impact is likely to be that timescales are longer than would be ideal. .** More work will be required in these areas and this involve colleagues from across the organisation in particular finance and the services. This will continue to be monitored within the work plan.

Overall the Board of Directors should feel assured that the Trust has made good progress with GDPR implementation. A further action plan progress report will be submitted to the September 2018 Board of Directors.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
• .Board to note update.

Who/ which group has approved this report for receipt at the above meeting?		Dr Faouzi Alam, Medical Director & Caldicott Guardian
Contributing authors:		Gill Monteith, Information Governance Manager
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Dr Faouzi Alam, Medical Director & Caldicott Guardian	18/07/2018

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1	Updated GDPR action plan July 2018 v12

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	CQUIN 1b, Healthy food for staff, visitors and patients
Agenda ref. no:	18.19.41
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	25/07/2018
Presented by:	Director of Operations

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

REPORT BRIEFING

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

To inform the Board of facilities initiatives relating to CQUIN 1b, Healthy food for staff, visitors and patients.

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

CWP Facilities team are committed to providing all elements as outlined within the healthy food CQUIN, Although the original guidance for the Health and Wellbeing CQUIN did seek a report at public facing board level, this requirement was not included for 2017/18 in the national NHS England updated guidance, however we have now had confirmation from local CCG's that they do require report regarding compliance with standards to go to public facing board.

Assessment – *analysis and considerations of options and risks*

Below is a summary of all initiatives:

Initiative 1

Standard required – The banning of price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS) 1. The majority of HFSS fall within the five product categories: pre-sugared breakfast cereals, soft drinks, confectionery, savoury snacks and fast food outlets;

Response – CWP FULLY ACEHIVED

Initiative 2

Standard Required – The banning of advertisement on NHS premises of sugary drinks and foods high in fat, sugar and salt (HFSS);

Response – CWP FULLY ACHIEVED

Initiative 3

Standard Required – The banning of sugary drinks and foods high in fat, sugar and salt (HFSS) from checkouts;

Response – CWP FULLY ACHIEVED

Initiative 4

Standard Required – Ensuring that healthy options are available at any point Inc. for those staff working night shifts (Vending). CWP have achieved all elements of initiatives above

Key areas for noting:

- 70% of drink lines stocked must have less than 5g sugar per 100ml - *CWP have implemented all required changes and 100% of drinks sold are non-sugar sweetened, with the exception of fresh juice drinks and these meet the standard for less than 5g per 100ml*
- 60% of all confectionery lines to not exceed 250kcal **-** *100% of confectionery sold is under 205KCAL*
- 60% of pre packed sandwiches and packaged meals to be less than 400kcal and not exceed 5g saturated fat per 100g - *CWP work with national supplier on a roll and 90% of our sandwich range is below 400KCAL*
- *Vending - 80% of drinks lines stocked must be sugar free*
- *Vending - 80% of confectionery and sweets do not exceed 250 kcal.*
- *Vending - We have also instructed our suppler to use the green heart symbol developed by Uvenco on all machines trust wide. (Uvenco are a nationally recognised supplier and are signed up to the CQUIN Targets)*

In regards to initiative 2 the following are key ares for improvement that we have made within this reporting period:

- *Quorn tasting day - promotion of alternative healthy protein, we now offer Quorn as a regular menu choice within the Oasis Cafe at Bowmere Hospital.*
- *Change for life – snack swap information available at till points*
- *CWP offer a full hot choice food service at our Oasis cafe at Bowmere hospital, we have made the decision within 2017 to change the food service working with our partner Apetito to ensure that the food choices we offer are consistent and meet all nutritional guidelines, we can now accurately inform customers of food content to the gram, using Apetito's Nutridata information, this is produced using a Camden approved Laboratory.*
- *Lunch time walking groups are linked with the Countess of Chester Health Park site walks*
- *We are working with Wirral Community Trust to support their Health & Wellbeing agenda via the Oasis Cafe at St Catherine's, they have a weekly fresh fruit and Veg Stall within their reception are and CWP aim to offer a similar service within 2018.*

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

The Board is asked to:

- **Review** and **discuss** the internal audit report, its findings and the local management responses identified.
- **Identify** (any) further local management action required.
- **Comment** on the organisational development and enabling actions identified and **agree** any further actions required.

Who/ which group has approved this report for receipt at the above meeting?	Operational Board
Contributing authors:	D.Pearson / J.Pidcock

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Operational Board	36T

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

Appendix no.	Appendix title
36T	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	CWP response to the Kirkup Report
Agenda ref. no:	18.19.42
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	25/07/2018
Presented by:	Dr Anushta Sivananthan, Medical Director (Executive Lead for Quality)

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

REPORT BRIEFING

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

This paper sets out CWP's robust approach to responding to the independent Kirkup Report, commissioned by NHS Improvement and published in January 2018, which highlighted some systemic concerns following a review of widespread failings relating to Liverpool Community Health Trust (LCT) between November 2010 and December 2014.

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

The Kirkup Report has been subject to wide media attention and is currently being considered across the sector. It describes how widespread failings can happen if warning signs are overlooked, particularly where Boards and senior staff are inexperienced and where there is inadequate scrutiny – in LCT's case due to the nature of the services they provided being regarded by scrutineers as low risk (those services included adult care, child and adolescent care, community dentistry, prison healthcare and public health). The consequence was "avoidable harm" to patients over several years and impacts on the well-being of staff who tried to raise concerns.

Assessment – *analysis and considerations of options and risks*

The review looked into the issues at LCT (i.e. provider level) but also the oversight by the NHS Trust Development Authority, NHS England and commissioners. There will be additional areas for CWP to consider in addition to findings relevant at the provider level, as the response of these (and other) scrutineers are published in due course.

In the main, the report outlines LCT's failure "in its duty to provide safe and effective services". The criticisms of LCT spanned the organisation from 'ward to Board' and this is where CWP, in welcoming the opportunity to learn from and strengthen its own systems in relation to external recommendations, is committed to proactively seeking assurance. During June and July 2018, CWP thoroughly considered the Kirkup Report, through a multilateral approach via the Trust's committee structure to identify any implications for CWP, providing assurance that inter-related impacts have been recognised and understood. An assurance level (using the recognised classifications of 'no', 'limited', 'moderate' 'substantial' and' high' assurance) has been identified by comparing and contrasting areas of learning applicable to CWP and the assurances available.

Theme	CWP assurance level	Thematic areas for further improvement
Organisation and leadership	**High**	▪ Strengthen organisational performance reporting to the Board ▪ Development of a Board development programme aligned to the Trust's QI strategy
Patient services and patient care	**High**	▪ Strengthen assurance systems for compliance with NICE guidance ▪ Improve risk assessment and formulation training ▪ Streamline incident reporting processes
Staff	**High**	▪ Strengthening visibility of trends or patterns in workforce data, including the NHS Staff Survey ▪ Improving approaches to whole-person staff wellbeing ▪ Strengthening HR policies and processes to be more person-centred
Financial – stability, oversight and governance	**High**	▪ Review of the quality impact assessment (QIA) template ▪ Capability building in undertaking QIAs

The thematic areas for further improvement identified will be led by the appropriate leads. The Board should be assured that each of these areas were and are already in progress, reflecting the 'high' assurance rating, and are being monitored by the relevant subsidiary committees. Completion of these areas will be reported in trimester 2's Learning from Experience report to the Board.

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

The Board of Directors is asked to **discuss** and **note** CWP's response to the Kirkup Report, and **approve** that the feedback on progress and completion of thematic areas for further improvement be reported back to the Board of Directors via the trimester 2 Learning from Experience report.

Who/ which group has approved this report for receipt at the above meeting?	Sheena Cumiskey, Chief Executive & Dr Anushta Sivananthan, Medical Director
Contributing authors:	David Wood, Associate Director of Safe Services

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	18/07/2018

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

Appendix no.	Appendix title
1	https://improvement.nhs.uk/documents/2403/LiverpoolCommunityHealth_IndependentReviewReport_V2.pdf

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

INFECTION PREVENTION & CONTROL

ANNUAL REPORT

2017 - 2018

Illustration created by the young people from Ancora House

for Hand Hygiene day in May 2017

Document Reference (2017 -2018)

Report to: Board of Directors
Date of Meeting: 25th July 2018
Title of Report: Infection Prevention and Control (IPC) Annual Report 2017-2018
Action sought: For Approval
Author: Julie Spendlove, Nurse Consultant, Head of IPC
Presented by: Victoria Peach

Strategic Objective(s) that this report covers:

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

Distribution

Version	Name(s)/Group(s)	Date Issued
V1	Infection Prevention & Control Sub Committee	18th April 2018
Final	Quality Committee - For approval	4th July 2018

Executive director sign-off

Executive director (name and title)	Date signed-off
Sheena Cumiskey, Chief Executive	July 2018

CONTENTS

1. Introduction

The purpose and content of this annual report is to provide an overview of the Infection Prevention and Control (IPC) activities from April 2017 to 31st March 2018. The report will highlight service achievements, compliance and progress made against the priorities outlined in the Infection Prevention and Control Sub Committee (IPCSC) work programme.

High standards of infection prevention and control are crucial to reduce and help prevent infection and infection risks, in all health care facilities across Cheshire and Wirral Partnership NHS Foundation Trust (CWP). To support this, the IPC Integrated Service, which consists of the CWP Infection Prevention and Control Team (IPCT) and Cheshire West and Chester (CWaC) IPCT colleagues, continues to work hard to prevent all avoidable infections and reduce the risk of resistant organisms across our Health & Social Care footprint.

The team use the CWP values in all areas of their work on a daily basis.

We encourage communication with our staff by being visible in the localities, having link practitioners, providing newsletters and attending key meetings.

We provide person – centred care.

We have the courage to challenge ANY behaviour that puts our services user, carers, visitors or staff at risk.

We are dedicated to maintaining competences required in relation to preventative IPC practice.

We are compassionate in all our contact with patients, carers and colleagues.

We are committed to preventing ANY avoidable infection.

Below is a brief summary of the IPCT highlights and achievements, and how we continue to raise the profile of both CWP and the IPC Integrated Service.

- **No** preventable Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections within our provider services
- **No** preventable Clostridium Difficile Toxin (CDT) infections within our services
- **Collaborative** working with Public Health England (PHE) on local Public Health issues and antimicrobial stewardship.
- **Achieving** a zero number of identified cross infection cases in service users or staff (excluding small round structured virus outbreaks or influenza)
- **National** conference speakers and poster presentations for SIXTH consecutive year
- **National** Education Professional and Development Committee secretary role for the Infection Prevention Society (IPS)
- **Active** members of national Mental Health IPS Special Interest Group
- **North West** IPS Education Officer role for second year of a two year term.
- **North West** IPS Deputy Communications Officer role
- **Regional** conference speakers and poster presentations at regional conferences,
- **North** West IPS and PHE meetings hosted at CWP, raising our profile for IPC
- **Ongoing** succession planning and developmental opportunities within the team including tissue viability, sepsis awareness, tuberculosis.
- **Innovative** role out of sepsis awareness across the Trust
- **Increased** visibility of tissue viability and development of training aids for inpatient ward areas

- **Successful** IPC study days both internal in November 2017 (CWP) and external in March 2018 (CWAC).

2. Summary of Director of Infection Prevention and Control (DIPC) reports to the Board of Directors (BoD)

In addition to the annual report the DIPC delivers a quarterly report produced by the Nurse Consultant. During 2017/18, the Board received concise reports in accordance with the business cycle, which highlighted areas of good practice and areas requiring development. The approval and any recommendations from the Board are communicated directly to the DIPC.

3. Care Quality Commission (CQC)

The CQC assess IPC standards against the Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance (Department of Health, 2015). The IPC assurance framework for 2017/18 demonstrates full compliance with these standards and also includes Water Safety and Antimicrobial Stewardship.

4. Infection Prevention and Control (IPC) governance arrangements

The IPCT has a high profile within Clinical Services and Support Services across the CWP footprint and also provides support to the Cheshire and Merseyside Public Health England (PHE) Team, Public Health in Cheshire West and Chester Council (CWAC), Western Cheshire Clinical Commissioning Group (CCG), Vale Royal CCG and Clinical Support Units (CSU). Internal governance is provided through the IPC subcommittee.

4.1 Infection Prevention and Control subcommittee (IPCSC)

The IPCSC reports directly to the Quality Committee (QC), and is chaired by the DIPC or Nurse Consultant. Meetings take place four times per year, and all CWP services and localities are represented. The quarterly meetings align with the quarterly reports required in July, November and January. An annual report will produced each year for the QC meeting in May. A recent review of the effectiveness of these meetings has provided very positive feedback.

4.2 The IPC Integrated Service

The structure of the IPC team enables an efficient service and response across the three localities and other CWP teams for mental health, learning disabilities and harm reduction services. The DIPC has overall accountability for the IPCT, which is led by the Nurse Consultant and supported by a lead nurse, a specialist nurse and two locality IPC nurses, one of whom also supports tissue viability across all the inpatient wards. In line with the Five Year Forward View, the team is looking at ways to integrate and work alongside the newly formed Care Groups. This will evolve during 2018-2019.

5.0 CWP's commitment to IPC 2016 -2020

This document is a working strategy until 2020. The commitment supports the person centred framework and the on-going IPC achievements to reduce and prevent avoidable healthcare-associated infections. The Board of Directors receives regular progress reports on the initiatives that are in place. The key objectives and plans for monitoring improvement are highlighted within the commitment and this is supported by the IPCSC work programme and assurance framework.

This commitment supports effective and meaningful infection prevention and control practice of all employees within CWP. It also ensures that effective measures for prevention and control of infection are integrated into the trust core business, planning and delivery.

5.1 IPC Link Groups

Modern Matrons and IPC link practitioners throughout CWP are supported by the IPCT to deliver the IPC agenda locally. IPC link practitioner groups are well established in each locality. These groups meet on a quarterly basis and provide an excellent opportunity to cascade and disseminate key IPC

guidance and updates to operational staff. An education element is also incorporated to promote continuing professional development (CPD).

The IPCT held their 14th annual IPC study day in November 2017 with in excess of 40 members of staff attending from a wide variety of CWP services. As in previous years this event provided an excellent stage for learning and networking with colleagues. The IPCT were able to secure the support of several speakers to provide an engaging and thought-provoking event, and look forward to facilitating this event again in November 2018. The topics presented included PLACE; Sepsis; Antimicrobial Resistance; Bare below the Elbow; Urosepsis; Flu Vaccination; IPC in Mental Health.

5.2 Refurbishments and New Builds

The IPCT provide advice and support during refurbishments and new builds across the trust, including advice for primary care premises to ensure compliance with national guidance and the audit programme. The IPCT continue to work in collaboration and partnership with CWP Estates in relation to any plans and works carried out within CWP, ensuring compliance with Hospital Building Note 00-09.

5.3 Safe systems to prevent needle stick and exposure incidents

The team review all incidents to reduce risk and promote good practice in relation to needle stick injuries (NSI) and have provided training and posters to all staff to support safer processes. Exposure incidents are potentially high risk, and preventative training and resources are ongoing.

5.4 Inoculation Incidents 2017 - 2018

		CWP East	CWP Physical Health West	CWP West	CWP Wirral	Total
2017/2018	**Inoculation Injuries: Needle stick incidents, bites & scratches**	9	14	10	5	**38**
2016/2017	**Inoculation Injuries: Needle stick incidents, bites & scratches**	9	12	8	1	**30**
2015/2016	**Inoculation Injuries: Needle stick incidents, bites & scratches**	4	5	16	7	**32**

There has been an increase in the number of inoculation incidents across the Trust some of which have been caused during or after venepuncture, use of insulin pens, incorrect use of safety devices and on occasions via scratches and bites.

It has been established that the use of safety sharps are not widely used across CWP, as legislated by the Health and Safety Executive (HSE) in 2013. However they are in use in some areas.

Trusts are required to substitute traditional, unprotected medical sharps with a ‘safer sharp’ where it is reasonably practicable to do so. CWP are not currently fully complaint with the regulations, as such CWP is at risk of being served an improvement notice by the HSE. Any subsequent non-compliance following an improvement notice can result in prosecution.

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

5.5 Outbreaks

All IPC incidents and outbreaks are routinely reported to the IPCSC and QC, ensuring relevant information and good practice is shared and action plans developed where required. A focus of the IPCT is to prevent outbreaks and if they do occur, to reduce the impact of the outbreak on service users and staff. This is achieved by monitoring environmental cleaning standards, hand hygiene and by ensuring staff can identify a potential outbreak which is addressed during Essential Learning.

	Central and East	West	Wirral
Number of outbreaks	2	5	1
Outbreak cause	Diarrhoea and vomiting x 2 (1 confirmed Norovirus)	Diarrhoea and vomiting x 4 Confirmed Influenza B x 1	Confirmed Influenza B
Average number of patients affected per ward	7	3	6
Average number of staff affected per ward	5	1	3
Average number of days ward closed	4	4 (2 wards not closed just observed)	5

In order to learn from experience, post-outbreak meetings are held for CWP inpatient areas within 5 working days of the end of an outbreak. These meetings include clinical service managers, modern matrons, ward managers, temporary staffing, occupational health, practice education facilitator and facilities manager where appropriate. Learning from these outbreaks is given as feedback to the teams and used with in future training.

Influenza B has been widely circulating nationally this flu season and this has affected some of our wards. In the main it has presented in our patients as low grade respiratory illnesses with associated chest infections in some cases. Both Influenza A and Influenza B have been isolated, from swabs taken from our patients, on all 3 localities. On 2 occasions the IPCT closed wards to admissions to restrict the spread of the virus. When a ward is closed due to Influenza it needs to remain closed for 5 days after the last patient started with symptoms.

In March 2018 a decision was made, in conjunction with the senior management team, to close Millbrook Unit in Macclesfield, due to a severe outbreak of diarrhoea and vomiting that started on Adelphi ward and also affected Bollin ward. The decision to close the whole unit was made to prevent further spread onto Croft ward. A total of 18 patients and 14 staff were affected and a specimen of faeces, that had been collected, was reported as a confirmed Norovirus by the virology laboratory.

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

5.6. Hand Decontamination

IPCT continues to actively promote hand hygiene, via observational activities in the workplace, trust induction, Essential 1 Learning and at all other events and opportunities.

The IPCT continue to work closely with colleagues from the Facilities Department and the main Trust supplier for hand hygiene products to ensure cost effective and appropriate hand hygiene facilities are accessible to all CWP staff, patients and visitors.

6. Education

6.1 Induction and Essential Learning (EE1)

The IPC team have facilitated 12 Induction sessions during 2017-2018 and 84 EE1 sessions (Essential Education). This has resulted in 2620 staff having received IPC and hand decontamination training. Overall 78% of clinical staff (including domestic staff) received IPC training in year and 78% of non-clinical staff received training giving a CWP compliance rate of 78%. This is below the expected compliance rate for mandatory training; care groups and services will be providing assurance to future Infection Prevention and Control sub-committee regarding local strategies for improvement.

The team strive to improve compliance by providing extra sessions, targeting low compliance areas and attending key clinical meetings. Throughout the period of this report, the IPC sessions consistently scores “good” or “excellent” in feedback from participants.

As compliance to IPC training is lower this year than previous years and the IPCT have developed an e-learning package that also incorporates ANTT (Aseptic Non touch technique). This will be available from June 2018 and can be completed by clinical staff bi-annually; therefore they only have to attend face to face training once every 2 years. The aim of this is to improve compliance due to increased accessibility to the training and will be evaluated for next year’s annual report.

240 staff received immunisation and vaccination training either face to face or via e-learning. 85 of these staff attended a half day flu vaccinator’s update that was introduced during 2017/18.

6.2 Continuing Professional Development of the IPC team during 2017 - 2018

In addition to the completion of organisational training requirements, the IPC team attends relevant local, national workshops and conferences, including national and regional Infection Prevention Society (IPS) conferences.

All IPCT members hold recognised infection prevention and control qualifications at BSc level and the lead and specialist nurses are all in the process of completing their MSc programmes.

Two members of the team have undertaken the CWP Leadership Course; one has completed and the other due to complete later this year.

One of the IPCT secretaries is undertaking an NVQ Business and Admin Management.

A member of the team has just completed their BSc (Hons) Nursing

7. IPC Audits

During the period this report covers, the team carried out audits on all inpatient clinical areas, community based clinics across all localities, health centres, children's centres and two GP practices**.** All inpatient areas have achieved above the compliance score of 93% during 2017/18.

All 17 areas in East locality, inpatient or community scored between 93 – 100%, which is a pass.

In the Wirral locality, 11 areas passed with scores between 93-100% and one clinic area failed with a score of 90%, as it needed new curtains and replacement work surfaces due to damage. This work is being undertaken by Estates.
In the West Mental Health and Learning Disability, 14 areas were audited; 13 passed with scores between 93-100% and one area failed with 66%. This building is not CWP property and so the action plan and feedback has been directed to the landlord.

Within the Physical Health West, 13 clinical areas were audited including 2 GP practices. 8 passed with scores between 94 – 98%. 2 premises do not belong to CWP and therefore any actions have been forwarded to the landlord.

Of the 3 remaining areas that failed, one was newly acquired by CWP, Willaston Surgery, and their score was 90%. Actions included aligning their IPC practices to CWP expectations in particular around hand hygiene products, waste disposal and sharps disposal.

The remaining 2 premises scored 89% and 90% with the main issues being dusty areas, stained chairs and not replacing sharps bins.

The Children's centres have been visited by the IPCT team and visual checks have been completed. They will be added to the audit programme for 2018 – 2019 for a full IPC audit.

Results are reported back to the ward manager, modern matron, clinic manager, estates and facilities managers, and the IPCSC where areas of good practice are highlighted and appropriate actions regarding areas of concern is reviewed and documented on the risk register if necessary. Improvement requirements will be reviewed within three months of the audit by the IPCT.

8. Service User Involvement

IPC nurses are involved In the Recovery Colleges by presenting sessions that aim to show how the principles of IPC can be used to maintain aspects of personal health

9. Health Care Associated Infection (HCAI)

During 2017 – 2018 there were no cases of Clostridium Difficile Infection within CWP.

There was, however, one case of MRSA Blood Stream Infection reported to the IPCT. This was a community acquired specimen. A 'community acquired specimen' is a blood culture that is taken from a patient's blood sample within 48 hours of admission to hospital and is a national definition.

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

9.1 Quality Premium - Gram Negative Blood Stream Infections (GNBSI)

There is a national ambition to reduce healthcare associated gram-negative blood stream infections by 50% by March 2021. This is supported by the Quality Premium for Clinical Commissioning Groups

(CCG), which has also set a reduction ambition of 10% in all E. Coli blood stream infections reported at CCG level, by 2019.

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

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

A full evaluation of the improvement plan will take place during Q2 2018 -19 and reported in the Q2 DIPC report.

10. Surveillance and Zero harm

The key items for community services are the surveillance and identified risks associated with Pressure Ulcers, Wounds and Urinary Catheters.

All patients with stage two or above wounds in community Physical Health services are screened for MRSA.

The Community Care Teams hold their own database of patients, with Urinary and Suprapubic Catheters in the community where patients are in receipt of community nursing. The IPCT offers advice and guidance where appropriate and support the teams to consider the suitability of the catheterisation and to consider a trial without catheter. The nursing teams are advised to use the 10 week catheter pathway, which has recently been updated.

Aseptic Non-Touch Technique (ANTT) training is provided via e-learning and will be incorporated into the new IPC e-learning package for 2018/2019.
Inpatient MH services have shown an increase in the number of patients requiring support for tissue viability, which is inclusive of self-harm wounds, cuts and post-operative surgical sites. This could be due to the increased visibility of and access to the IPC / Tissue Viability Nurse working within the IPCT. The IPC nurses continue to be visible across the three localities, and have had numerous face to face interactions with staff and service users throughout the year and approximately 270 telephone contacts across all localities.

10.1 Catheter Associated Urinary Tract Infection (CAUTI)

The IPCT continue to support the Trust response to the implementation of NICE guidance EPIC 3 (2014) and CQC requirements with regards to Catheter Associated Urinary Tract Infections. This has included the continuing monitoring of all catheterised patients in the community setting with CWP input, on average 250 patients, and offering support through product masking, training, staff meetings, communications, and updating the 10 week catheter pathway.

10.2 Skin-Tunnelled Central Catheter (Hickman) and Peripherally Inserted Central Line (PICCs)

The IPC service works collaboratively with other healthcare providers across the Western Cheshire footprint on the development of guidance and competencies to support these devices, based on national guidance including NICE and EPIC 3. Patient information leaflets have been developed and are in use, providing support and advice to both patients and carers.

11. Sepsis

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

Key Aims for the Sepsis Care Improvement Programme (SCIP).

- To minimise delay for CWP patients with signs of sepsis, in accessing acute care, by having a high level of awareness and a simple but effective process that enables the recognition of the early signs of sepsis.
- To improve awareness of sepsis across all of our services through a programme of education for all patient facing staff.

A Pilot Programme has been completed using an in-patient elderly setting and the GP Out of Hours Service. The pilot ran for three months, concluding on 8th January 2018. A period of evaluation has now been completed and final changes are being made to the pathways and education package based on feedback, before a phased roll out of the programme across the trust.

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

A Sepsis update newsletter has been circulated and Sepsis information continues to be included in mandatory EE1 IPC Training. Sepsis resources have been purchased, and resource packs put together for the roll out. Following this roll out the work will be made available to all other community teams.

11.1 Sepsis Success Stories

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

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

12. Tissue Viability

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

- Standardisation of a CWP wound dressing formulary for all inpatient areas across the organisation resulting in cost effective prescribing of dressings
- Development of a protocol for hiring pressure relieving equipment, in collaboration with a ward manager in the Wirral locality, saving the organisation £23,000
- High visibility across all the localities in the organisation to highlight the importance of recognising wound infection and the subsequent costs associated with incorrect prescribing of antibiotics in the fight against AMR
- Ensuring best practice is communicated to all staff via positive role modelling and in house presenting and teaching sessions

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

13. Influenza Immunisation Activity

Members of the IPCT completed training to support the annual staff influenza vaccination campaign during 2017/18. The team has worked in partnership with the Workforce Wellbeing team to deliver the vaccine across all localities**.** CWP reached a total of 72% of face to face staff vaccinated, which was an improvement of 14.2% on the previous year.

For 2018/19, the national CQUIN targets for Health & Wellbeing of Staff in the NHS continue and the flu immunisation target for all Trusts will be 75% of all face to face staff to be vaccinated for flu by the end of February 2019. The IPCT will support the Workforce Wellbeing team again in their delivery and will also support with the immunisation update training.

14. Antimicrobial Resistance (AMR) Strategy and CWP work

AMR has risen over the last 40 years and the inappropriate use of antimicrobials is a key contributor. The consequences of AMR include increased treatment failure for common infections and decreased treatment options where antibiotics are vital. Antimicrobial stewardship is crucial in combating AMR and is an important element of the UK Five Year Antimicrobial Resistance Strategy.

AMR remains a high priority within the Trust and antimicrobial stewardship represents an organisational and system-wide approach to promoting and monitoring the prudent use of antimicrobials by:

- optimising therapy for individual patients;
- preventing overuse and misuse; and
- minimising the development of resistance at patient and community levels.

PHE aims to reduce AMR by 50% by 2020 and their framework for action includes driving an understanding of the issue and willingness to act, changing key behaviours around prescribing and infection control, testing and evaluating appropriate methodologies in landing a new and serious issue with the public and demonstrating action on antimicrobial resistance.

Towards the end of 2017, a national public health campaign ‘Keep Antibiotics Working’, was promoted across the organisation to all staff including prescribers, in the form of training, presentations and posters. The campaign aim has been to motivate people to change their behaviour relating to the use of antibiotics, without deterring those who need antibiotics.

Within CWP, we continue to raise awareness and knowledge amongst our staff through education and training, to help promote these key messages, both internally with their patients but also for themselves and their families. The IPCT work closely with the medicines management teams across the localities in the monitoring of prescribing to improve compliance in line with the current antimicrobial formulary.

14.1 Inpatient Services antibiotic audit 2017/18

Antibiotic prescribing on the inpatient wards is audited and compliance to prescribing reported quarterly into the IPCSC. The most common infections treated on the CWP inpatient wards are urinary tract infections, respiratory infections and skin infections. Prescribers should prescribe according to the West Cheshire CCG (WCCCG) Antimicrobial Prescribing Guidelines.

449 antibiotic forms were collected during 2017/18. 374 prescriptions were written by CWP medical staff and 75 from other providers prior to admission.

272 of these prescriptions complied with the WCCCG guidelines; 36 were prescribed according to sensitivities following laboratory culture and 20 on the advice of a microbiologist. This demonstrates

an actual compliance rate for CWP medical prescribers, prescribing correctly to guideline formulary, as 90%.

Whilst this is an improvement of 6% from 2016/17, this was discussed at the medicines management group and further collaborative work with pharmacy, IPCT and the medical teams will commence in Q1 of 2017/18 to improve this figure.

Annual Prescribing data - April 2017 - March 2018		Wirral	West	East	Total	% audit compliance
Total number of prescriptions issued		136	154	159	449	
Allergies documented on medication chart	Yes	134	153	158	445	
	No	2	1	1	4	99%
Indication of prescription Noted	Yes	112	124	143	379	
	No	24	30	16	70	84%
Follows antimicrobial formulary/micro advice	Formulary	78	91	103	272	61%
	Sensitivities	9	12	15	36	8%
	Microbiology Advice	13	4	3	20	4%
	Commenced by other provider	18	26	31	75	17%
	Other	18	21	7	46	10%
Indication of stop date on medication chart	Yes	77	98	88	263	
	No	59	56	71	186	59%
Indication of length of course on medication chart	Yes	111	124	136	371	
	No	25	30	23	78	83%
Indication of long term prophylaxis on medication chart	Yes	6	9	1	16	
	No	130	145	158	433	4%
Indication of stop date on care notes	Yes	49	34	25	108	
	No	87	120	134	341	24%
Indication of length of course on care notes	Yes	84	63	85	232	
	No	52	91	74	217	52%
Indication of long term prophylaxis on care notes	Yes	5	22	5	32	
	No	131	132	154	417	7%

14.2 West Physical Health antibiotic prescribing 2017/18

Antibiotic prescribing activity in CWP West Physical Health is primary care based and as such is a different healthcare setting to secondary care mental health. Prescribers follow current NHS West Cheshire CCG antibiotic guidelines. Prescribing is reviewed using online ePACT data from the NHS Business Services Authority (NHSBSA). The prescribers are:

- The Urgent Treatment Centre (UTC) (Out of Hours service) – A mix of medical (GP) and nurse independent prescribers (NMP)
- Community Matrons – nurse independent prescribers (NMP) based in the community.

The UTC antibiotic benchmarking is currently measured against one local and two national measures:

- Local: compliance with NHS West Cheshire CCG antibiotic formulary
- National: compliance with recommendations to keep prescribing of cephalosporins, quinolones and co-amoxiclav as low as possible to prevent development of C.difficile infection, and antibiotic resistance in line with national targets
- National: work on the Bloodstream Infections Quality Premium to reduce inappropriate antibiotic prescribing for urinary tract infections (UTIs) in primary care by achieving a 10% (or greater) reduction in the Trimethoprim : Nitrofurantoin prescribing ratio

CWP has maintained a 99% compliance with formulary.

Cephalosporin, quinolone and co-amoxiclav prescribing for UTC GPs have averaged 11.55%, while the NMPs averaged 5.5%. The quality premium is 10%.

The trimethoprim: nitrofurantoin ratio for UTC GPs is 0.53 for the GPs and 0.17 for the NMPs. This is well below the West Cheshire CCG baseline of 0.951, which in turn is well below national average.

15. Estates Department Report

Estates department activity is essential in delivering the IPC agenda, and is delivered under the principles outlined in two main documents:-

1. Health Building Note 00-09 and covers the importance of a clean, safe environment for all aspects of Healthcare.

2. The Department of Health (DH) Health Technical Memorandum (HTM) 04-01 (2016), Safe water in healthcare premises.

The Estates department manages Water Safety to HTM 04-01 with the implementation of a Water Safety Plan, Operations Manual, and a Water Safety Group.

For CWP this Water Safety Group is covered via our monthly Statutory Standards Departmental meetings where Legionella is discussed and reviewed and the quarterly Infection Prevention and Control Sub Committee meeting (IPCSC). Both meetings consist of a variety of personal with a range of competencies. We also engage with an independent Water Safety Authorising Engineer who gives expertise and guidance to our policies and procedures.

15.1 Legionella compliance with legislation

The control of legionella is covered by the legal requirements of the Health & Safety at Work Act 1974 concerning risks from exposure to legionella and guidance on compliance with the relevant parts of the Management of Health and Safety at Work Regulations 1999.

Legionella is managed and controlled by the estates department, which continues to employ the services of ZetaSafe Ltd, who provide professional monitoring software for statutory legionella temperature monitoring. The department also employs various contractors to undertake legionella risk assessments on Trust properties where required. There is a three monthly review of test results, control measures and procedures to ensure compliance with current legislation and these results are published at the Infection Prevention Control Sub Committee.

Estates Operational Service continually undertake statutory legionella temperature monitoring tests throughout the Trust estate, during April 17' – March 18' a total of 19,755 temperature tests were undertaken. The annual test result report records an overall compliance level of 95.95% which is above the department's target of 90%. Tests recorded not meeting the required standard was 4.05% and therefore automatically triggered remedial work to ensure compliance moving forward.

15.2 Capital programme Works

Whilst the capital programme only includes limited projects, specifically aimed at addressing IPC, all new build and major refurbishment projects are designed in full accordance with the latest Building Regulations, and British Standards together with the latest HTM guidance specifically in relation to Infection Prevention and Control and with consideration to the IPC audits.

All projects, both new builds and refurbishment, include advice from the IPC team which reflects the latest Health Building Note 00-09 (Department of Health, 2013) which states 'the infection prevention

and control (IPC) team should be consulted throughout every stage of a capital project and their views taken into account.'

During the financial year 17/18 the following finances were invested in the built environment:

- Capital Programme 17/18 = £1.98M

- Environmental /IPC/ Place Work Plan – Funded from Revenue = £184k

The main IPC achievements in 2017/18 were:

- Upgrade of community Staff kitchens and toilet facilities at Stein Centre
- Development of the Birch Centre – the new Wirral CAMHS outpatient facility at Stein Centre.
- Extension and upgrade of en-suite showering facilities at Willow Ward
- Phase 1 of inpatient bed (anti ligature) replacement programme
- Commencement of two storey extension to Bowmere
- Completion of Delamere RC environmental upgrades
- Cyclical decoration and flooring replacement programme informed by IPC audits and environmental work plan.

Estates service have also agreed a recurring planned replacement programme for ward based washing machines, dryers , dishwashers and EBME equipment in order to enable finance to plan for this recurring expenditure and avoid periods of downtime when these facilities are unavailable to wards due to breakdown.

15.3 Physical Health West capital and operational revenue programme

In response to CWP IPC audits of Physical Health West properties, a further £50k was invested from the minor works budget to address specific action points.

16. Facilities Service and Waste Report

16.1 Facilities management Service Report

CWP operational cleaning services are led via the Estates & Facilities services structure and the Facilities management team are responsible for implementing the trusts cleaning strategy.

The Facilities Management (FM) function has teams in each locality that report through a structure of managers and supervisory staff members, who are responsible for the co-ordination of services and monitoring of standards in all trust areas in line with National Standards of Cleanliness (2007).

CWP Facilities services are predominantly provided in-house, this helps to ensure that services provided by the FM team are linked to the needs of clinical services. There are a number of locations within CWP that are outsourced. This is only where operationally and commercially practical and there are robust monitoring systems in place to ensure the quality of service provided is the same as the in house team.

16.2 Monitoring Arrangements for CWP in house cleaning service

Within 2017 – 2018 the EFM service has undertaken a review of existing internal processes to establish what improvements can be made to ensure that we have improved level of robustness and evidence based assurance on the standards of internal environment and cleanliness within CWP's inpatient areas and clinical areas - including community premises.

Current systems for ensuring that CWP's internal environments continue to meet the required standards and are fit for purpose; however the following actions/amendments are being implemented as a result of the review:

- Revision of training process for cleaning staff and supervisors to ensure that standards required align with the requirements of the National Patient Safety Agency National Standards of Cleanliness (2007).

- Weekly electronic reports from domestic supervisors to Head of Facilities based on daily inspection logs highlighting any failures or corrective actions required. These reports will also be shared with ward mangers as required.

- Dashboard of compliance will be produced - based on the above weekly reports this will form a quarterly report that will be submitted to IPCSC, providing both evidence and assurance on cleanliness standards. IPCSC terms of reference will reflect these changes and include increased focus on Facilities Management and the overall Environmental Work-plan.

- Specific actions reported to IPCSC will link to the Environmental Work-plan which forms the basis of the Trusts revenue expenditure programme for internal environments including decoration and flooring programmes.

To monitor compliance in relation to cleaning standards, CWP operate a monitoring system that covers all 49 factors as set out in the National Standards of Cleanliness 2007 approved code of practice.

The overall targets and achievements for cleanliness for all CWP areas for period 2017 - 2018 are listed below (again based on NSC risk ratings):

RISK LEVEL	TARGET RESULT (as set out by National Patient safety agency)	CWP Result
High Risk	95%	98.8%
Significant Risk	85%	95.15%
Low Risk	75%	98.30%

This information is taken from an average of all paper audits completed within 2017-2018

The Facilities management team cleanliness monitoring is supported by monthly Modern Matron walk-rounds that are attended by a senior member of the FM team to undertake a joined up approach with clinical services and address any issues patients or clinicians have with the Facilities services including the environment, this is then actioned by the relevant departments.

CWP FM attend all inpatient IPC audits, areas for action are addressed mostly at the time of audit all other actions are done immediately following the inspection. The facilities team continue to have a good working relationship with all members of the IPC team, taking collaborative approach to ensuring CWP's environments meet all required standards.

Important Note:
The facilities management team within 2018 – 2019 intend to create a specialist team, from within existing resources, to support a rolling deep clean programme across all inpatient areas. The programme of deep cleans will be informed by IPC audits and clinical service requirements and it is envisaged that this rolling programme will enable a deep clean of all inpatient areas twice per year on average. This is to provide further assurance and enable FM team to be more reactive in the event of outbreaks or incidents.

Further investment is required on cleaning equipment and technology to ensure that CWP premises are at the required standard, we will be working with our finance colleagues to produce a formal investment plan in cleaning equipment for each ward to maintain and ultimately improve standards.

16.3 Waste Management

The roll out of shared waste and recycling bins has continued at a further three Trust locations during 2017/18. The CWP recycling waste project has been successful in the Birch Centre and Vale house in Cheshire and has resulted in waste recycling and segregation figures to increase to an average 98%.

Central recycling points are situated in high concentration staff areas across CWP. Staff are encouraged to participate in recycling and separating all items of general waste at source.

The WARPIT reuse portal project for surplus assets has had another successful year with over 700 staff members claiming items for their teams and services. The efficient recycling system has supported a number of projects in 2017 /18 including providing Willaston Surgery with a complete fit out of recycled, good quality, wipe clean furniture in November. The CAMHS and LD relocations at the Stein in Wirral have also benefited from recycled furniture from WARPIT. This helps encourage staff to contribute to the Trust's environmental objectives through recycling and reuse by claiming items that are surplus and save valuable budget monies which can be utilised elsewhere.

16.4 Waste auditing

The CWP Waste audit system is designed to assess compliance with the requirements of Department of Health guidance document Safe Management of Healthcare Waste and to also ensure that waste segregation standards meet the requirements for waste handling and storage.

The home patient referral guidance on Community Clinical waste was approved by IPC SC in 2017 and uploaded onto the IPC home page for ease of access for Community Nursing Staff wanting to set up home patients for clinical waste collections.

A programme of 6 monthly waste audits is undertaken twice yearly by Domestic community supervisors. The Waste audits submitted by Facilities domestic supervisors are underpinned by a Waste Audit Schedule maintained by the Waste Manager which also notes any issues or incidents and solutions or outcomes. The waste audit tool covers; Waste provision overview; Segregation procedure; Types of waste produced; Personal protective equipment; Bin sizes and condition; Storage.

Waste audits form part of the planned programme of waste management and any issues or outstanding actions is followed up by the Waste Manager or members of Trust Facilities team. The Infection prevention and Control Team are included in any communications.
Where appropriate a full pre- acceptance waste audit is carried out by the Waste Manager to assess all types of waste and disposal methods. Thereafter audits are completed as part of the cleanliness monitoring by domestic supervisors at all sites. Audits are saved onto the Environment and Waste system and issues followed up within 24 hrs with appropriate actions logged on the Audit Schedule.

Summary of waste audit findings 2017

- Inappropriate waste disposal – packaging and paper towels disposed of in clinical waste bins
- Not displaying posters correct disposal procedures
- Sharps bins temporary aperture closure not in use leaving bin open.
- Storage of items in non-appropriate non patient areas (Waste holds)
- Unlocked bins in outside areas
- Waste Compounds not secured

- Contractor issues- missed collections and non-delivery of sharps bins

17. Patient-led Assessment of the Care Environment (PLACE)

The PLACE assessments cover the following areas:

- General Environment condition
- Environment cleanliness
- Food & Hydration – including – Quality/Taste/Temperature
- Privacy & Dignity
- Dementia friendly assessment

Overall the inspections this year have been excellent; the inspection teams are made up of trust volunteers, Trust governors and external agencies for example Health Watch. Any areas that received a fail or qualified pass were added to the Facilities department action plan, any areas that required input from the Estates management team have been added to Micad for addressing or reported to capital projects team for adding onto their work plan. Please see 2017 PLACE report attached for further information.

18. Conclusion

Infection prevention and control remains a priority for CWP. The IPCSC and IPCT continue to maintain and improve on the application, conservation and development of IPC standards. The Trust is committed to working towards excellence in IPC practice to help prevent avoidable infections in our patients including wound and urinary tract infections. When infection does occur, this is recognised early and treated appropriately in line with local antimicrobial guidance. AMR remains a high priority within the Trust and antimicrobial stewardship represents an organisational and system-wide approach to promoting and monitoring the prudent use of antimicrobials.

This report highlights the partnership working and continuous improvements within IPC during 2017/18 and the key priorities for 2018/19.

19. Work Priorities for 2018/19

- Maintain compliance and assurances with the Health and Social care Act (2015)
- Promote hand hygiene week in May 2018
- Deliver a quality IPC Education event to CWP staff in November 2018
- Roll out sepsis triage tool and e-learning across CWP
- Review and implementation of safety devices
- Actively support the staff influenza campaign to achieve 75% uptake in face to face staff
- Undertake a Trustwide mattress audit
- Implement new IPC e-learning module incorporating ANTT
- Improve compliance to anti-microbial prescribing

20. Recommendations

The Board is asked to approve the Infection Prevention and Control Annual Report for 2017/18 and the work priorities for 2018/19.

21. Appendices

Appendix One

Glossary for IPC AR.doc

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Health, Safety and Fire Annual Report 2017/2018
Agenda ref. no:	18-19-44
Report to (meeting):	Board of Directors
Action required:	Information and Noting
Date of meeting:	25/07/2018
Presented by:	Avril Devaney

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	
35T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	
35T	

REPORT BRIEFING

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

The Health, Safety and Fire annual report aims to inform Operational Board, Health and Safety Subcommittee and the local Health and Safety Groups of measures in place to manage Health & Safety and Fire matters in Cheshire and Wirral Partnership NHS Foundation Trust.

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

The HSE (Health and Safety Executive) is the enforcing authority for workers in England, Scotland and Wales. It is recognised that Great Britain is a safe place to work, gains have been made in safety and the focus is shifting onto health and keeping people well.

Assessment – *analysis and considerations of options and risks*

CWP is fully committed to developing the highest standards of health and safety practice and fire safety. This report details arrangements in place to monitor and maintain those standards.

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

For Information and noting.

Who/ which group has approved this report for receipt at the above meeting?	Associate Director of Nursing, therapies and patient partnership
Contributing authors:	Senior Health and Safety advisor

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Health and Safety Sub-Committee	26.06.2018
2	Operational Board	18.07.2018

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

Appendix no.	Appendix title
1	Health, Safety and Fire Annual Report 2017/2018

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Contents

List of Figures

List of tables

1. Purpose of the report

The Health and Safety Executive is the enforcing authority for workers in England, Scotland and Wales and also for patients/ service users in Scotland and Wales.

The Health and Safety Executive (HSE) have recently published 'Helping Great Britain work well'. Dame Judith Hackett, Chair of the HSE stated 'We have an unprecedented opportunity to keep building a 21st century, world class occupational health and safety system that will help Great Britain work well. If we can all come together to help achieve these things, maintain the gains made in safety and seize the opportunity to give health the same priority, it will help improve productivity, keep business costs down, help keep workers safe and well and protect members of the public'

It is recognised that Great Britain is a safe place to work and the focus is shifting onto health and keeping people well. To provide a focus for this important work, HSE has set out six new strategic themes that will bring a renewed emphasis on improving health in the workplace, as well as building on the highly successful track record on safety.
The six themes include Acting together, Tackling ill health, Managing risk well, Supporting small employers, Keeping pace with change and Sharing our success.
HSE have advised that priority areas for Inspectors will be falls from height, health risks from respirable silica dust exposure, the duty to manage asbestos and the Construction industry.

This annual report will set out measures in place to manage health and safety in the Trust and the effectiveness of those measures in the context of the above strategic themes.

2. Management of Health & Safety in CWP

CWP is fully committed to developing, promoting and monitoring the highest standards of health and safety practice. CWP acknowledges its obligations to comply with statutory responsibilities laid down in the Health and Safety at Work etc. Act 1974 (HASAW). This Act provides a legislative framework to promote and encourage high standards of health and safety at work. The HASAW also requires organisations to have a signed statement of intent in relation to Health and Safety; this is reviewed and signed by the Chief Executive every 2 years and is due for review in August 2018. CWP also has responsibilities under numerous Regulations that govern health and safety practice at work including the Management of Health and Safety at Work Regulations 1999 and the Workplace (Health and Safety) Regulations 1992.

The Senior Health and Safety Advisor provides update reports in accordance with the business cycles for the Health and Safety Sub Committee (HSSC), the Patient Safety and Effectiveness Sub Committee (PSESC) and has responsibility as the Chair of the Medical Devices Group, Medical Devices Liaison Officer, CAS Officer and more recently, display screen equipment and workplace assessments.
There have been three policies reviewed this year,

- GR40 - Central Alerting System Policy
- CP 50 - Policy for the administration and use of Oxygen
- CP59 - Medical Devices and Equipment Policy

The Health and Safety function has specific responsibility to achieve compliance with the following areas of safety management within the Organisation.

- Implementation, coordination and management of the Cardinus workstation assessment and training programme Trust wide including identification of workstation corrective equipment.
- Advising managers, staff, Occupational Health (now Workforce Wellbeing Hub), Human Resources and Safety Representatives on matters of health and safety at work.
- Completing risk assessments and workplace assessments in conjunction with managers and staff to ensure safe systems of work are followed and modifications are in place as required to maintain safety of employees and others.

- Management of and reporting on the Central Alerting System (CAS) and dissemination of relevant alerts to leads in the organisation for their action; This includes Estates and Facilities Alerts and Notifications, Medicines and Healthcare Products Regulatory Agency, NHS England Patient Safety Alerts and NHS Improvement notices.
- Preparing reports for various subcommittees assurance with input from the leads for each alert open with actions required by the Trust.
- Chair of the Medical Devices Group, joint management and co-ordination of the Medical Devices and Equipment contract including monitoring procedures for ensuring that governance requirements are met, medical device equipment is safe to use and available when required and that the contract represents value for money.
- Reporting to the Health and Safety Executive (HSE) incidents which fall within the definitions of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations)
- Reporting relevant adverse incidents involving medical devices and single use equipment to the Medicines and Healthcare Products Regulatory Agency (MHRA).
- Reporting adverse estates and facilities incidents to the Department of Health for national sharing and learning lessons.
- Completing Health, Safety and Security Assessments for buildings and identifying safety requirements for new services.
- Liaising with external organisations for work placements for young person's / apprentices and carrying out safety assessments prior to the placement including completion of assessment templates, provision of details of employer liability insurance.

3. Health and Safety Meetings for 2017-2018

A proposal was prepared by the Senior Health and Safety Advisor for approval at Operational Board in March 2016. This proposal outlined reduction of frequency of meetings of the Trust wide Subcommittee to ensure that when it did meet that there would be better attendance and focus on the Trust wide issues and statutory responsibilities. This coincided with the developments in the People and Organisational Sub Committee where greater focus was being placed on wellbeing. The emphasis for the pilot was that local safety issues could be debated in the locality and specific issues would inform the content of the Chairs Summary reports for inclusion on the Operational Board agenda.
The proposed frequency of the Trust wide meetings was twice a year, this was piloted for one year. The local Health and Safety meetings were to continue with a Chairs summary report (instead of all local minutes) being submitted to the Operational Board as per agreed business cycle. A generic business cycle and generic terms of reference were prepared for the West, the Wirral and Central & East Groups giving the localities the ability to include other issues pertinent to their localities

The People and Organisational Development Department launched a Workforce Wellbeing group which incorporated the wellbeing factors from the Health, Safety and Wellbeing Subcommittee. The terms of reference for this group were reviewed by Operational Board as part of the Health and Safety meetings review in March 2016.

The pilot was effective and local groups continued to meet discussing and resolving local issues. It was agreed during the pilot that the local health and safety group minutes would be added to the Trust wide Health and Safety Subcommittee agenda rather than the local chairs summary reports. It has also now been agreed that an exception report for the local groups will be submitted for information to the Operational Board.
In December 2017, it was agreed by the subcommittee that the Trust wide meeting would take place three times per year

There have been a total of 20 locality health and safety meetings held during 2017-2018 (Table 1), 11 statutory standards meetings and also two Trust wide subcommittee meetings. Figure 1 below identifies themes; topics and issues raised and discussed at the locality meetings.

Table 1-Local Health and Safety Group meetings 2017-2018

Health and Safety Group	West	Wirral	Central & East	Estates
Number of meetings held	5	3	6	6

Figure 1- Topics and issues raised and discussed at the locality Health and Safety meetings

4. Cardinus Workstation Assessments and Training Programme

Since 1992 following the European Safety Directive, the Display Screen Equipment Regulations have been in force in the United Kingdom. The legislative requirement is for employees who use computers at work to carry out training and an assessment of their workstation.

Cheshire & Wirral Partnership NHS Trust has invested in Cardinus Workstation Safety Plus, a health & safety on-line training programme and self-risk assessment questionnaire for computer workstations.

All staff with an email address received an email invite to take part in the on-line training and assessment programme. The programme commenced in 2015 following a successful pilot within Infrastructure services.

The programme takes approximately 30-40 minutes to complete and includes valuable information regarding safe use of the computer and information that can help to minimise risks and improve comfortable working. There are also video-based exercises to prevent musculoskeletal problems.

The Senior Health and Safety Advisor and the Medical Device and Safety Officer have been responsible for the set up and roll out of this new programme which has been hugely successful.

Currently (at time of writing report) there are 1,947 staff that have completed the training and assessment programme which equates to 81% of those invited (Figure 2). Further information to encourage a greater uptake will be published in CWP Essentials and via Safety assessments with ward and team managers. Training from the company will be delivered to key staff in the Estates department to enable streamlined reporting to line managers so assessments may be reviewed in appraisals/ supervision sessions.

An online 'catalogue' of workstation standard and corrective equipment has been produced showing images, codes and suppliers.

The Procurement team have secured a supplier who can offer standard and corrective workstation equipment for our users at very competitive prices.

Originally 42.98% of staff who have completed the training and assessment were classed as high risk and this has now reduced to 20.81% with interventions (Figures 3 & 4).

Users classed as low risk at the first assessment totalled 509 and this has now increased to 1261 users showing that training and interventions have reduced the risks from high and medium to low risk (Figures 3 & 4).

Following the delivery of further training for key staff in Estates, the system can be used to generate individual reports for staff and managers if required.

There will be a requirement in the next year to ensure that all the NHS.net email addresses are successfully cross referenced with the Cardinus system.

Figure 2 - Cardinus workstation users with completed training records

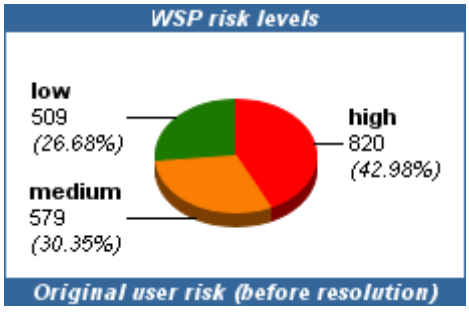


Figure 3 - Cardinus workstation user risk level before interventions

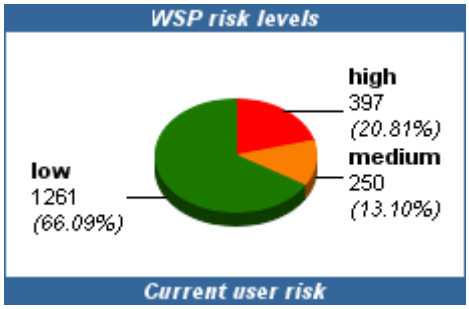


Figure 4 - Cardinus workstation current user risk following intervention

5. RIDDOR- (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995) (As amended April 2012)

As a result of the report by Lord Young 'Common Sense, Common Safety', improvements to 84% of Health and Safety Legislation was recommended, RIDDOR being one of them- The law now requires for injuries requiring more than **seven days** incapacitation to be reported to the Health and Safety Executive (HSE) as opposed to injuries resulting in three days absence previously.
Reporting and recording is a legal requirement, the reports made to the HSE informs the enforcing authorities about deaths, injuries, occupational diseases and dangerous occurrences so they can identify where and how risks arise and whether they need to be investigated. This allows HSE and Local Authorities to target their work and provide advice about how to avoid work related deaths, injuries, ill health and accidental loss.
For the period April 2017 - March 2018 there was a slight increase of RIDDOR reports made from the previous year. 11 incidents were reported to the HSE for this period.
In 2016-2017, there were 9 incidents that required reporting compared to 18 during the previous year (2015-2016). A downward trend was observed over the five years prior to 2017-2018 (Table 2).

For 2016-2017, CWP have recorded the lowest reportable number of RIDDOR incidents since 2004 when the Senior Health and Safety Advisor commenced reporting RIDDOR incidents to the HSE.

There had been a marked reduction in RIDDOR incidents relating to manual handling injuries over several years from seven requiring reporting to HSE in 2008 to one incident requiring reporting during 2012-2013; This figure rose in 2013-2014 to six incidents, with no identified reason, however, Since 2014 the number of reportable incidents has again decreased to one per year.

The number of Violence/Physical assault incidents to be reported to HSE decreased from 20 incidents during 2012-2013 to nine incidents during 2013-2014; however, this rose slightly to 12 incidents for 2014-2015. During 2015- 2016, this figure again fell to five reports during the reporting period and has remained at five incidents reported for 2016- 2017.
There has however been an increase to nine incidents recorded for 2017-2018. There were two occasions when two staff were injured in the same incident.
Further details will be reported in the annual security report which will be prepared by the Local Security Management Specialist.

Figure 5 displays the highest three categories of incidents requiring notification to the HSE since 2011. The Senior Health and Safety Advisor has requested that the resource managers contact her when any member of staff is on sick leave following any incidents to ensure with their support CWP complies with the Regulations.

CWP have not received any visits or interventions from the Health and Safety Executive for the reporting period.

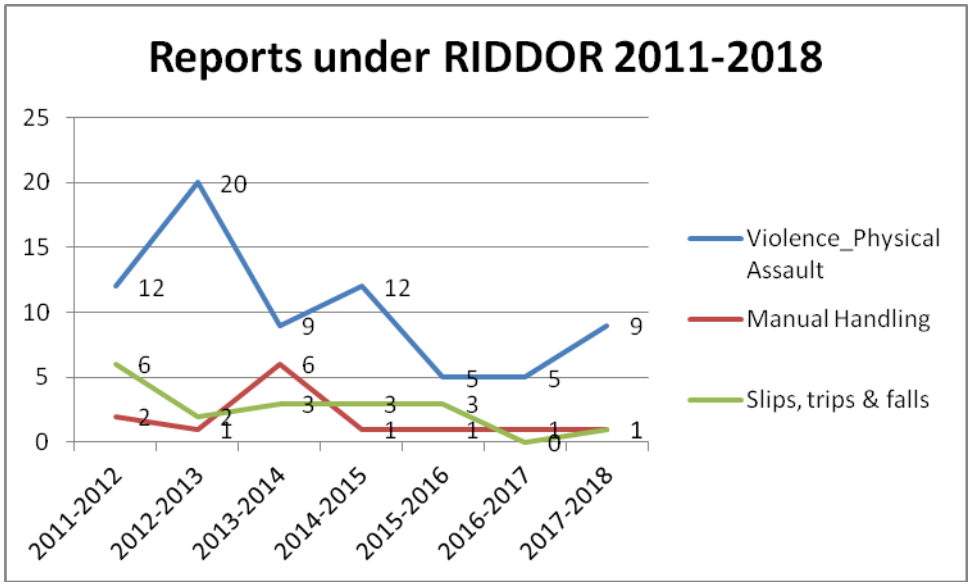


Figure 5 - RIDDOR reports made to the HSE 2011-2018 (Highest three categories reported)

Table 2 - RIDDOR reported incidents for CWP annually since 2007

Year	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018
Reports	29	37	30	28	20	26	21	18	11	9	11

Table 3 - Classification of RIDDOR reports to the Health and Safety Executive since 2011

Classification of incident	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2007-2018
Violence / Physical Assault	12	20	9	12	5 ↓	5 ↔	9 ↑
Manual Handling	2	1	6	1	1	1↔	1↔
Slips, trips and falls	6	2	3	3	3		1↑
Struck by an object		1		1		1	
Exposure			1				
Cuts		1	1		1		
Twisting injury (knee) (wrist)		1		1			
Collision			1			1	
Distress following incident					1	1	
Total	**20**	**26**	**21**	**18**	**11**	**9**	**11**

6. Central Alerting System (CAS)

The Central Alerting System superseded the Safety Alert Broadcast System and is an electronic cascade system developed by the Department of Health.
It is a key means by which to communicate and disseminate important safety and device alerts information within the NHS.
The CAS facilitates distribution of safety alerts, Medical Device Alerts, NHS England and NHS Improvement Patient Safety alerts, emergency alerts, drug alerts, public health alerts, field safety notices, Dear Doctor letters, Chief Medical Officer Messages and Estates and Facilities alerts including electrical safety notifications.

All alerts are sent to one nominated person in each Trust, known as the CAS Officer (CWP Senior Health and Safety Advisor) for them to action and disseminate appropriately throughout the organisation. The system of dissemination has been established within CWP for the alerts and this is reviewed annually. The Central Alerting System Policy was reviewed in 2017.
The National Patient Safety Alerting System (NPSAS) was launched by NHS England to strengthen the rapid dissemination of urgent patient safety alerts to healthcare providers via the Central Alerting System (CAS).
NHS England produced their first Patient Safety Alerts during December 2013 and by March 2018, NHS England and NHS Improvement had produced 53 Patient Safety Alerts.

The system was launched for alerting the NHS to emerging patient safety risks. The system allows for timely dissemination of relevant safety information to providers, as well as acting as an educational and implementation resource. It builds on the best elements of the former National Patient Safety Agency (NPSA) system. The system is known as the National Patient Safety Alert System (NPSAS)

It is a three-stage system, based on that used in other high risk industries and is used to disseminate patient safety information at different stages of development, to ensure newly identified risks can be quickly highlighted to providers.

The system allows rapid dissemination of urgent information, as well as encouraging information sharing between organisations and providing useful education and implementation resources for use by providers.

Alerts are issued in up to three stages, each denoted by a letter (W, Re and D) although all stages may not be issued as an alert.

6.1 Stage One Alert: Warning (W)

This stage 'warns' organisations of emerging risk. It can be issued very quickly once a new risk has been identified to allow rapid dissemination of information. Trusts will be asked to consider if immediate action is required and to develop an action plan to reduce risk of a similar incident occurring. Organisations are asked to share learning from their investigations and locally developed good practice.

6.2 Stage Two Alert: Resource (Re)

This alert may be issued some weeks or months after the stage one alert, and could consist of:

- sharing of relevant local information identified by providers following a stage one alert;
- sharing of examples of local good practice that mitigates the risk identified in the stage one alert;
- access to tools and resources that help providers implement solutions to the stage one alert; and
- access to learning resources that are relevant to all healthcare workers and can be used as evidence of continued professional development.

6.3 Stage Three Alert: Directive (D)

When this stage of alert is issued, organisations will be required to confirm they have implemented specific solutions or actions to mitigate the risk. A checklist will be issued of required actions to be signed-off in a set timeframe. These actions will be tailored to the patient safety issue
Every alert issued to NHS Trusts has a set completion date to ensure all of the actions required are completed within a specific timeframe.

6.4 Supply Distribution Alerts

A new type of alert has been issued via the CAS system since 2016. This new alert concerns supply disruption – affecting medical devices and clinical consumables – and are issued by the Department of Health.

The supply disruption team at the Department of Health already have routes for contacting NHS organisations in relation to small scale and low impact supply problems - these arrangements will continue. A Supply Disruption Alert will only be issued through CAS in the event of a significant supply disruption event with potential for widespread and severe impact on patient safety and outcomes. CWP have received 2 Supply Distribution Alerts, but no action was required.

6.5 Field Safety Notices

A 'field safety notice' (FSN) is an important communication about the safety of a medical device that is sent to customers by a device manufacturer, or their representative. The actions are referred to as field safety corrective actions. There are approximately 50 Field Safety Notices published each year. If the manufacturer does not receive adequate responses, the MHRA may produce a Medical Device Alert via the CAS system.

6.6 Reporting and Monitoring

- Patient Safety Alerts with actions required are monitored by the Patient Safety Effectiveness Sub Committee, by way of a prepared report by the CAS Officer; this Subcommittee is chaired by the Trust's Medical Director.
- Reports are prepared as per the Business Cycle for the Health and Safety Sub Committee which is chaired by The Director of Nursing, Therapies and Patient Partnership.
- A report was also produced for the bi-monthly Compliance and Assurance Learning Sub Committee which has now ceased operating.
- CAS reports are also an agenda item on the Medical Devices Group and all the Locality and Estates Health and Safety meetings.
- The Head of Clinical Governance is supplied with a monthly status report for sharing with the Commissioning Groups.

Since 2013, electrical alerts relating to notices for High and Low voltage equipment have been received from the Energy Networks Association (ENA) by the Department of Health Estates and Facilities Team. They have been issued in the format of Estates and Facilities Notifications (EFN's). The decision was made to utilise CAS to deliver this information to those responsible for the safety of electrical systems within healthcare organisations. All alerts are notified to our Authorised Engineer (Electrical). This arrangement resulted in a sharp increase in alerts received via the CAS function from 91 to 177 during the initial year of operation.

Monthly CAS data is published by NHS England, showing all responses to alerts due for completion and identifies if Trusts do not sign off alerts by the deadline date. Patient safety alerts and notices are issued by NHS England and NHS Improvement.

All NHS Trusts are monitored on their alert responses and actions by the Care Quality Commission.

Table 4 demonstrates a summary of all alerts received by the CAS officer during 2017-2018 and the originator E.G MHRA, NHS Improvement.

Table 4 - Summary of alerts received by CWP - April 2017- March 2018

All alerts received by CAS Officer	104
Medical Device Alerts (MHRA)	45
NHS Improvement Estates and Facilities Alerts	51
NHS Improvement Patient Safety Alerts	7
CAS Helpdesk Team Notification	1
DH Supply Disruption	0
Alerts with 'No action required'	33
Alerts with 'Action required- Ongoing' (at 31.03.18)	1
Alerts with 'Action complete'	70
Total	**104**

At the end of the reporting period (31.03.18), CWP had 1 alert open with actions required or their relevance to the Trust being assessed.
A total of 71 alerts required actions throughout the year compared to 103 the previous year.
The process for acknowledgement of alerts has been reviewed and the standard operating procedure is in place for business continuity purposes.
Contingency plans have been put in place in the absence of the CAS Officer and 2 deputies are now allocated this role.

Figure 6 shows a marked increase in total number of alerts received during 2013-2014 and this was due to the publication of Estates and Facilities Alerts and Notifications relating to electrical equipment originating from the Department of Health.

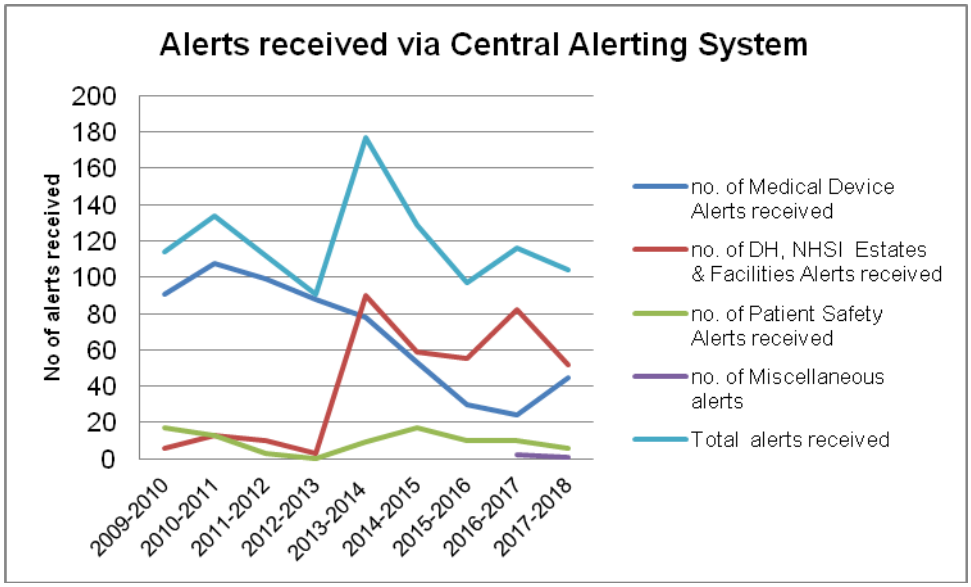


Figure 6 - Alerts received via the Central Alerting System

7. Medicines and Healthcare Products Regulatory Agency (MHRA)

The MHRA is the government agency responsible for ensuring that medicines and medical devices work, and are acceptably safe. The MHRA is an executive agency of the Department of Health. Adverse incidents relating to medical device failure or malfunction should be reported to the MHRA.
There have been no incidents recorded relating to medical devices that needed reporting to the MHRA.
The MHRA are now responsible for hosting the CAS site since April 2018.

8. Medical Devices and Equipment

There has been an ongoing internal review of the existing processes and contracts involved in the management of all medical devices and equipment.

One external provider services and maintains all medical devices and equipment with the exception of anesthetic machines and Thymatron ECT machines which require more specialised providers.
The medical device maintenance and servicing contract is the responsibility of the Estates and Facilities Department and is managed day to day by the Medical Device and Safety Officer and the Senior Health and Safety Advisor.
During 2017, a tender process was commenced for the management of medical devices. Five companies were invited to present for the contract. The service provider subsequently changed on April 1 2018 with a significant cost saving. The contract will remain under review to ensure best practice, customer satisfaction and value for money.
Physical health trainers within Education CWP work closely with the Medical Devices personnel in order to develop and maintain a programme to standardise medical devices equipment. CWP now having an in house Procurement Department has assisted greatly in the implementation of this programme.

- We currently have 1900 pieces of equipment which are managed by our external provider.
- We also have contracts to service specialised ECT equipment and for the anaesthetic machines.
- The Estates Department also manages the contract for servicing patient lifting equipment such as beds, hoists and slings.

The Medical Devices group meeting is held every three months and has membership from clinical areas within the Trust. The information from this group feeds into the Patient Safety Effectiveness Subcommittee.

9. Manual Handling

HSE developed and published an information sheet giving advice to employers in the health and social care sector in 2012. This guidance covered the requirements of the Lifting Operations and Lifting Equipment Regulations (LOLER) 1998 and how they applied to the health and social care Sector. The Guidance showed which types of equipment were considered as lifting devices and which were not, the risks associated with each type of equipment and the law in relation to statutory checks required. Advice was also published by the HSE concerning the use of hoists and slings by staff and what factors should be considered prior to each use of the equipment to help reduce risk of injury, this information is cascaded to staff via training sessions

9.1 Servicing of Equipment

The contract for the servicing, testing and checking of all hoists, slings and adjustable baths is with an external provider who also checks bedrails. The contract applies to inpatient areas and is managed and monitored by CWP Estates department, any issues and concerns are reported via Medical Devices Group and are monitored in the management of Statutory Standards within the Estates department.

9.2 Training

Manual handling training is accessible to all staff via Education CWP as part of the Essentials Framework, EE1 for inpatient staff on identified wards and EE2 for West Physical Health staff which is role specific. This training includes the safe methods of moving and handling, safe use of bed rails and also covers slips, trips and falls. For all non-clinical staff, manual handling training is via e-learning and is a mandatory, once only requirement and compliance with this was 97% at year end. Bespoke training sessions have been delivered to different staff teams at the request of team managers.

Simulated manual handling training has been introduced into the Emergencies in Mental Health Inpatient Settings training day which is a full day of different scenarios of simulated incidents and in which staff are placed in groups and given a scenario to manage which is visually recorded and played back to the staff group as part of their feedback. These scenarios allow staff to receive training that is as close to 'real life' as possible but in a controlled environment. Staff feedback has been very positive.

9.3 Training venues

Manual handling people movement training continues to be delivered at Churton House, Chester. The training venue provides greater space for the storage and practical use of the equipment during training sessions and enhances the learning environment for staff. The feedback from staff following training has been extremely positive.

The training for East Cheshire staff continues to be delivered at Millbrook Unit, in the old Complex Assessment and Rehabilitation (CARS) unit. Staff feedback continues to be very positive as they now do not have any travel or experience parking issues compared to when the training was held at Ropewalks.

10. Estates Department

There are requirements under Health and Safety Law to control the risks from exposure to asbestos, control of risks associated with Legionella, management of electrical safety, safe work at height for employees and delivery of other safety specific training.
All measures required for the control of exposure to asbestos and control of Legionella are managed by the Estates department. Estates activity risk assessments for many related tasks including work at height are available for staff and staff receive training in safe systems of work. All training reports and personal development are carried out as part of the staff appraisal process.
There is a compliance section on the Estates Intranet page for ease of reference for all CWP staff.

The Estates Department has a training group meeting that ensures all relevant maintenance staff receive training required according to their area of work, for example, Asbestos Awareness training, Safe Work at height and electrical safety training. The Estates Health and Safety Group develop and review any new risk assessment documents and update the local risk register.

The Estates Statutory Standards and Compliance group are responsible for ensuring that all CWP premises are designed and maintained in accordance with all relevant legislative requirements, each statutory standard has an identified lead within the estates department.
Specific standards include asbestos management, legionella management, electrical and gas safety LOLER (Lifting Operations and Lifting Equipment Regulations) and fire safety management. The Estates department also leads on the Environmental Ligature Management plans and programme.

The asbestos register is held and managed in accordance with the Control of Asbestos Regulations 2012. The register is held within the estates department and updated regularly when in situ asbestos is routinely inspected or where known asbestos is removed. The database covers all premises either owned or occupied by the Trust including former CWP West Physical Health Services premises. During 2017 relevant information has been input into the MICAD IPR Asbestos module (Internet Property Register) (IPR) to enable improved controls.

The Trust has a policy for the control of risks of legionella and water safety; in implementing this policy the Trust uses as a general source of practical guidance, the Health and Safety Commission's Approved Code of Practice (ACoP) L8 Legionnaires' disease –The control of Legionellae bacteria in water systems 2013, made with the consent of the Secretary of State under Section 16 of the Health and Safety at Work etc. Act 1974.

With regard to the detailed practical guidance of implementing this policy, Estates Department use the detailed technical advice on design, maintenance, operation and management of water systems given in the Health and Safety Commission guidance section of the L8 ACoP and the NHS Estates two documents entitled "Health Technical Memorandum 04 01, The Control of Legionellae, hygiene, “safe” hot water, cold water and drinking water systems” Part A: Design, installation and testing and Part B: Operational management. Health Technical Memorandum 04 now supersedes Health Technical Memorandum 2027 and Health Technical Memorandum 2040.

All the above management is in full compliance with the regulations and covers water quality. The governance arrangements are reported on a quarterly basis to the Infection Prevention and Control Subcommittee with an internally agreed compliance level of 92%.

The policy for the Control of Contractors has been reviewed and meets all the requirements of the revised CDM Regulations Construction (Design and Management) Regulations 2015.

Estates and Facilities Infrastructure Services are currently working towards implementation of the premises assurance model standards (PAM). Nominated competent persons have been identified as the lead for electrical safety, statutory standards, legionella etc. and these compliance arrangements are clearly communicated on the Estates Intranet page

11. Fire Safety

All CWP premises have a Fire Risk Assessment as required by The Regulatory Reform (Fire Safety) Order 2005 (RRO) and all have been reviewed during the year starting 1 April 2017– 31 March 2018. Those premises which required work or change have been issued with an amendment to the Fire Risk Assessment ensuring all premises have an up to date assessment. A schedule of actions detailing any such work has been passed to the Estates Department for action. There is a monitoring system in place to ensure any such work in this schedule is complete. Buildings that are not the responsibility of CWP who house members of Trust staff will be informed by letter of their obligations.

11.1 Fire Evacuation Exercises

CWP now have in place a programme for carrying out fire drills in all in patient units. The Modern Matrons have been issued with a timetable with two dates per year per in patients Unit. The Fire Advisors attend the drills and both oversee and direct the evacuation drills. This continues to produce very positive results with both management and staff benefitting from the procedures.

Following the exercise, staff must complete a written document relating to the drill as evidence for the enforcing authority (Fire Brigade) that drills have taken place. The law only requires one drill per year to be carried out as against the two that CWP complete.

All non -in patient units carried out at least one fire drill during the year.

11.2 Fires

It has been reiterated during all fire safety training sessions to ensure service users do not have ignition sources on the wards and staff have been supported to better understand and use policies available to them.

Table 5 Location of fires

Premise	Location	Cause
Springview	Fire in bedroom	Ignition source
Millbrook	Fire in bathroom	Ignition source
Greenways	Smouldering paper	Ignition source
1829 Building	Electrical wiring	Short circuit

The number of fires reported onto DATIX has reduced from five the previous year to four for this year.

Three were due to ignition sources and one due to electrical wiring.

All fires were contained in room of origin and all procedures and actions carried out quickly and efficiently.

11.3 Cause of Unwanted Fire Signals (False Alarms)

The number of false alarms has reduced from 43 recorded in 2016 – 2017 to 27 during 2017 – 2018 and the causes are listed in Table 6

Table 6 Causes of unwanted fire signals

Cause of unwanted fire signal	Number
Steam in bedrooms	5
Activation of fire detector-cause unknown	9
Insects inside detectors	1
Hairdryer	1
Smoking	1
Service user throwing glitter into detector	1
Fault on system	2
Smoke from cooking	2
Faulty toaster	2
Activation of fire call point by service user	2
Activation of fire call point by use of deodorant	1
TOTAL	**27**

11.4 Fire Training

The Trust Fire Advisors have delivered Trust mandatory training and have also carried out specific training for Fire Wardens, Competent Person (Fire) and bleep holders. The plan is to carry out further Competent Person (Fire) training as there have been numerous staff changes. Table 7 identifies courses carried out with number of staff completions.

Table 7 - Fire training course completions

Course name	Staff completions
Fire Warden (Hospitals)	11
Fire Warden (Offices and Clinics)	43
Competent person (Fire)	2
Hospital Bleep Holder Training	2

11.5 Garrett Handheld Metal Detectors

This year saw the introduction of the Garret Handheld Metal Detectors on nominated wards. The devices are hand held metal detectors (wands) for staff use to detect metal objects in a person's clothing. There have been positive reports from staff on wards about this device in the ongoing effort to reduce the number of ignition sources in our in-patient areas.

11.6 Fire Dampers (Estates and Facilities Alert)

The alert was issued which required all NHS Trusts to ensure all fire and smoke dampers should be suitable and tested on a regular basis. It also required for the integrity of all fire partitions, compartments and fire stopping to be the approved standard.

A programme of work was developed by CWP Estates to ensure these matters were addressed. The work is still ongoing with 82% of the requirements having been completed. The remainder will be completed by July 2018.

11.7 Fire Safety Data Returns following the Grenfell Tower fire

Following the Fire at Grenfell Tower, all NHS Trusts were required to complete fire safety data returns to NHS Improvement and the Cabinet Office. The initial review of the incident related to identification of external cladding and as a consequence the data required related to type and location of cladding, the number of two storey plus buildings and the number of in patient units amongst other information. CWP complied with the request within the deadline.

12. Health, Safety and Security Assessments

The Senior Health and Safety Advisor has been monitoring the effectiveness of the measures and processes in place to prevent harm to staff by carrying out health, safety and security assessments in different areas and monitoring incidents on a daily basis that are reported on the Datix system.
All in-patient areas are assessed on an annual basis. Health Centres and Physical Health clinics and resource centres will be assessed every 2 years.
The Local Security Management Specialist role sits in Education CWP, the security element of the assessments requires review by the LSMS in line with the requirements of NHS Protect.
100 Health and Safety Law posters were obtained and have been issued to Departments that did not have the new version of the poster displayed. The poster allows for details of specialist contacts within the Trust and Staff Side Representative Contact names to be displayed.

Documentation was prepared for new services. The Children's centres which joined CWP early in 2018 will be included in the timetable for assessments.
The main themes identified during the health safety and security assessments are identified in figure 7

Figure 7- Health Safety and security assessments themes identified

13. Priorities for 2018-2019

1. All policies which the Health and Safety function have responsibility for will be reviewed and updated as required.

2. Coordination between the Medical Devices and Safety Officer and Senior Health and Safety Advisor will continue in maintaining and monitoring the external contract for servicing and maintenance of medical devices. A review of current outsourced arrangements will be undertaken to establish whether any efficiency gains are possible.

3. A replacement programme for Automatic External Defibrillators (AED) was commenced in 2017 to replace the current models as consumables such as pads for the current models in use will become obsolete in the following two years. 18 defibrillators were replaced. This programme will continue in 2018.

4. Management of the Cardinus Workstation Safety Assessment and Training Programme will continue. With further training, reports can be compiled for teams / wards as requested by managers.

Workstation corrective equipment is standardised, updated on the intranet and available through the procurement department. A programme of email address exchanges will be required now that CWP has migrated to the NHS.net email system.

5. The Senior Health and Safety Advisor will continue to work in conjunction with ward and resource managers and the incidents team to identify incidents where staff may be injured whilst at work, offer support to staff and ensure reports are made to the HSE as appropriate.

6. Support will continue to be available to managers in supporting staff back to work and carrying out workplace and risk assessments. Assistance will also continue with Access to Work Assessments.

7. Liaison will continue with colleges to ensure young persons and apprentice assessments are completed

8. Health, safety and security assessments will continue and any corrective actions implemented.

9. Local Health and Safety meetings will continue and exception reports will be prepared for the Operational Board. Consideration will be given to the restructuring 'local' health and safety groups within CWP in line with the four care groups Specialist Mental Health, Children, Young people and Families, Transforming Care for people with LD and NDD and Neighbourhood Based services.

10. The Trust wide Health and Safety Committee will continue to meet three times per year- The agenda will be prepared by senior health and safety advisor and Estates business support assistant.

11. The current E learning package will be reviewed as much of the original content has been removed from the package.

12. A review of the locality health and safety meetings will take place to ensure they capture all four care groups

14. Recommendations

The Operational Board is asked to note the contents of this report.

15. References

Helping Great Britain work well, HSE 2016

The Health and Safety at Work etc. Act 1974 (HASAW)

The Management of Health and Safety at Work Regulations 1992 (as amended)

Workplace (Health and Safety) Regulations 1992

RIDDOR- Reporting of Injuries, Diseases & Dangerous Occurrences Regulations 1995 (as amended 2012)

Governance and Risk Policies- Cheshire and Wirral Partnership NHS Foundation Trust

Clinical Practice Policies - Cheshire and Wirral Partnership NHS Foundation Trust

Work with Display Screen Equipment 1992 (as amended 2002)

LOLER- Lifting Operations and Lifting Equipment Regulations 1998

Health Technical Memorandum – Firecode

The Regulatory Reform (Fire Safety) Order 2005

Control of Substances Hazardous to Health 1988 (as amended 2009)

Control of Asbestos at Work Regulations 1987 (as amended 2012)

Health and Safety Commission Approved Code of Practice L8 Legionnaires' disease –The control of Legionellae bacteria in water systems 1991 (as amended 2013)
Health Technical Memorandum 04.01 Part A and Part B

Work at Height Regulations 2005 (as amended 2015)

Construction (Design and Management) Regulations 1994 (as amended 2015)

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Medical Workforce Annual Report 2017-18
Agenda ref. no:	18.19.45
Report to (meeting):	Board
Action required:	Discussion and Approval
Date of meeting:	25/07/2018
Presented by:	Dr Faouzi Alam

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

REPORT BRIEFING

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

Each year designated bodies are required to complete an Annual Organisational Audit (AOA) on appraisal and revalidation in order to gain an understanding of the progress made during the last year, and assure Responsible Officers and Executive Boards as well as NHS England that systems for evaluating doctors fitness to practice are in place, functioning, effective and consistent.

Following the AOA, designated bodies are required to produce a status report and review their organisation's developmental needs in this area. PODSC initially receives this report and hopefully approves it for submission to the Board. The Chief Executive is asked to receive this status report and complete a statement of compliance for submission to NHS England by 28 September 2018.

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

Doctors, medical appraisers and the medical appraisal team found it particularly challenging during the 2017-18 appraisal year to meet timeframes, due to diminishing resource and competing demands. Appraisals continued to take place and every doctor due to be appraised was, but there was an increase in the number of appraisal meetings which were delayed or appraisals signed off beyond the 28 day timeframe. However, at a time when the medical workforce is so stretched by vacancies, we believe that meaningful conversations and quality outputs are preferable to rushed meetings and poor documentation. Appraisal is sometimes the only chance the doctor will have to truly reflect on how the last year has been, their aspirations for the next, and beyond.

Assessment – *analysis and considerations of options and risks*

13 recommedations for revalidation were made to the GMC between 1/4/17 and 31/3/2018
One recommendation was made to defer a decision for 12 months, pending the receipt of patient feedback for a doctor recently appointed.

We have 32 medical appraisers. Systems for assuring the quality of appraisals have been tightened up along with regular opportunities for appraisers to share good practice.

CWP's Responsible Officer is responsible for 108 doctors in total. Of these, 3 were not appraised due to extended absence and 1 had an appraisal meeting which took place but due to the sudden serious illness of the appraiser, was not signed off in time and thus is not considered by NHS England to be "complete."

Medical recruitment remains a challenge, both locally and nationally.

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

The Board is asked to approve the accompanying report (Appendix 1) and the Chief Exectitve requested to sign the Statement of Compliance for return to NHS England via the Medical Appraisal & Revalidation Manager.

Who/ which group has approved this report for receipt at the above meeting?		PODSC
Contributing authors:		Rachel McLoughlin, Sarah Carroll
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	PODSC	16/07/2018

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1	Medical Workforce Annual Report 2017-18
2	NHS England Statement of Compliance

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

APPENDIX 1

Medical Workforce Annual Report 2017-18

This appendix contains a more detailed analysis on:

1. Recommendations made to the GMC regarding CWP's doctors' fitness to practice
2. Arrangements for and outcomes of medical appraisal
3. Arrangements for and outcomes of responding to concerns expressed about doctors
4. A review of last year's action plan
5. A plan of action for the forthcoming year

The Director of Medical Workforce post was created during the year and Dr Rachel McLoughlin appointed in October 2017. As a team we have benefitted from a new perspective and the appraisal and revalidation links she has formed with other local trusts which has allowed us to review some of our ways of working.

1. Recommendations to the GMC on Fitness to Practice

At 31 March 2018 CWP had 108 doctors for whom Dr Alam is the Responsible Officer (RO):
89 consultants, 12 SAS doctors and 7 doctors on temporary /short term contracts. This excludes medical trainees from Health Education England and GPs doing sessions in CWP where the bulk of their work is within primary care.

13 recommendations to revalidate were made to the GMC between 1/4/2017 and 31/3/2018. Most were former Clinical Directors from the first phase of revalidation in 2013. All recommendations were completed on time. The RO's own revalidation recommendation was made by his Responsible Officer.

2. Appraisal

a. Activity levels of appraisal

Setting a timely appraisal is the responsibility of the individual doctor, supported by early allocation of the appraiser by the Medical Appraisal & Revalidation Manager (MARM.) Ensuring the outputs are completed and signed off within 28 days of the meeting is the joint responsibility of the doctor and appraiser. The appraisal team monitor the process and issue prompts along the way.

In 2017-18 103 doctors were appraised and the outputs (the appraisal summary, PDP and appraiser assurances) signed off. 3 doctors had an incomplete or missed appraisal approved by the RO (2 maternity leave, 1 sick leave.) One doctor's appraisal was categorised as missed altogether; the appraisal meeting took place on time but the appraiser had a serious illness and did not return to work until after the cut off point for completion of the outputs (28 April 2018.)

The criteria for the categorisation of appraisal was very slightly amended for 2017-2018 by NHS England. They are quoted below and taken from this year's Annual Organisation Audit (AOA) which was submitted earlier in the year. As the changes are minimal, year on year comparisons are largely accurate.

1.4.17 - 31.3.18 criteria	2014-15	2015-16	2016-17	2017-18
Category 1A - Appraisal meeting took place in the 3 months preceding the agreed appraisal due date, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March.	76	33	75	57
Category 1B - The appraisal meeting took place between 1 April and 31 March, the outputs were agreed & signed-off by the appraiser and the doctor, but one or more of the following apply: - the appraisal did not take place in the window of three months preceding the appraisal due date; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting. However, in the judgement of the responsible officer the appraisal was satisfactorily completed.	17	40	26	46
Category 2 - the appraisal has not been completed as a 1a) or 1B) but the responsible officer has given approval to the postponement or cancellation of the appraisal.	5	10	6	4
Category 3 - the appraisal has not been completed according to the parameters above and the responsible officer has not given approval to the postponement or cancellation of the appraisal.	0	0	0	1

There has been an increase in the number of Category 1B appraisals. We believe this is due to two factors; reduced admin resource in the appraisal office and the shortage of doctors. Colleagues have taken on extra duties to cover gaps, and quite rightly, priority has been given to clinical work. However this chimes with discussions at the Appraisal Lead network that meaningful conversations and quality outputs are preferable to rushed meetings and poor documentation. We will, of course, continue to aim for a larger number of appraisals to be fall into Category 1A in the coming year.

Our experience from previous years, supported by data, continues to identify a very small number of practitioners who appear to struggle with the organisational tasks associated with appraisal. A plan is in place incorporating increased monitoring and proactive support.

b. Appraisers

One medical appraiser training session took place during the appraisal year. We now have 32 appraisers allowing us to share the load more evenly. Appraisers should see only 3-4 doctors a year as each appraisal takes approximately 5 hours in total (pre-reading the supporting evidence, the appraisal meeting itself and the documentation of outputs.)

The Medical Appraisers Peer Group is led by the Director of Medical Workforce and the minutes feed into the People and Organisational Development Sub-Committee. Appraisers are required to attend at least once a year; this is monitored as part of appraiser feedback. The purpose of the group is to

provide peer support to appraisers, share good practice, aspire to consistency amongst appraisers and to receive updates and feedback from the NHS England North West appraiser network events. In recognition of the time demands on all doctors we have implemented changes to make appraiser meetings more accessible, including increasing the number and rotating between all localities.

c. Quality Assurance of Appraisal

Assurance around the quality of information gathered for appraisal:

The appraisal team continue to source and upload governance information to doctors' electronic portfolios. We are aware this is an extra burden on the departments who provide it and are grateful for their on-going support.

We continue to review the information required for appraisal, consistent with national guidance, particularly the Pearson Review (2017) which recommended medical appraisal should be a process which is supportive, adds value and is not overly burdensome for doctors.

At medical appraisal training this year we have stressed the benefits and satisfaction a well-planned appraisal can bring. A skilful, enquiring appraiser is essential, as is the doctor's provision of thoughtful reflections on his/her performance, challenges and aspirations.

Random review of portfolios have been carried out prior to some appraisal meetings. We plan to build on this next year. It is a new quality assurance measure and the Medical Appraisal Policy has been updated to include it.

Assurances around the quality of the appraisal discussion and the appraisal summary:

Rolling review of appraisal summaries (approximately 1/3rd each year) to provide assurance that the appraisal outputs are complete and to an appropriate standard using a quality assurance tool. This also acts as a process of continuous improvement as the DoMW reviews 2-3 appraisals from each of 9-10 doctors.). In May/June each year appraisers receive general feedback to highlight the main themes, their attendance at the appraiser peer group meetings and feedback from the doctors they have met with. 30% of appraisers will also receive tailored feedback.

We have begun discussing the importance of clearly identifying the doctor's "revalidation-readiness" in appraisal outputs, including highlighting gaps and plans to address these, along with a review of last year's PDP.

Audit of timelines of process of appraisal – maintained by the MARM.

An increasing number of doctors are seeing the advantage of meeting with a colleague outside of their own psychiatry specialty. (Doctors cannot have more than 3 consecutive appraisals with one appraiser.) This brings a completely different perspective to the appraisal discussion and mostly it has been welcomed after some initial hesitancy.

Acknowledgement of work outside of CWP is also more consistently discussed. Moving forward the emphasis will be on the provision of evidence to support these activities.

d. New developments during 2017-18

We have discontinued sourcing and uploading previous pharmacy data as it was not an indicator of a doctor's practice. Instead there are plans to ask for more meaningful reflections on prescribing habits.

Report Manager data from Carenotes, set up many years ago specifically for medical staff appraisals, is no longer sourced and uploaded by the appraisal office. As clinical services had changed and evolved it became less and less accurate. One report will not fit all. Reflections by doctors on their workload would be more helpful to appraisers unfamiliar with the doctor's role.

After discussion at the North West appraisal leads network we have changed the process by which 360 feedback is shared. It is now sent to the doctor's line manager (rather than the appraiser) for initial feedback, allowing greater triangulation of any support/actions required.

Delays in the conclusion of the investigative process after an SUI can lead to a delay before reflections on actions can be incorporated into portfolios. Clearly identifying when SUI processes produce learning which applies specifically to an individual doctor can be problematic. Where there is more than one consultant in the same team or two doctors with the same initials, it can take a time to establish which doctor the learning is for. If the doctor's appraisal meeting takes place whilst this is in progress, there is no triangulation of information. We have previously suggested that where individual learning is identified, the name of the staff member is included in incident review reports, (at least whilst they remain internal documents) so that both the Clinical Director, the appraisal office and the doctor him/herself, are clear who the learning is for. If this cannot happen we would continue to press for a better system than we currently have.

Doctors are also encouraged to reflect on general learning points and themes identified for their team.

Doctors have been reminded about the need to register interests and gifts, both as part of their appraisal documentation and on the CWP intranet. Following an MIAA audit, we have broadened this to include situations where a doctor has a nominal role in a business but where no financial benefit is received.

The Medical Appraisal Policy has been reviewed with increased emphasis on the importance of early identification of difficulties in providing sufficient data and the postponement of face to face meetings to allow this to be addressed.

e. Completion of 2016-17 action plan

Recommendation	Action	Responsibility	Timeframe	Outcome
1 Ensure appraisals completed in timely fashion.	Early allocation of appraisers; issue prompts pre and post-appraisal; escalate to RO/AMD when necessary.	MARM, AMD	March 2018	Achieved as much as possible within reduced resource and doctors increased workloads
2 Implement recommendation of the Pearson Review – reducing the burden on doctors.	Consider which supporting evidence could be taken out of appraisal (quality not quantity.)	RO, AMD, RO	December 2017	Achieved and on-going. Data removed and emphasis on quality reflections.
3 Implement recommendation of the Pearson Review – involve patients and families more in revalidation.	Adapt the friends and families survey to request feedback on any aspect of their treatment which was particularly good/requires improvement. Feedback	AMD, MARM	December 2017	F&FT cannot currently be used by appraisal office due to poor identifiers but work is on-

	to individual doctors.			going. See g. below for involvement of patients in QA.

f. Medical recruitment

This continues to be difficult and at the time of reporting, the psychiatry of old age is particularly challenging. Three old age posts have been advertised at least twice with no interest at all. The DoMW has met with the Resourcing Manager to think about what, if any, additional strategies could be put in place to attract doctors to CWP. Where possible, medical cover has been reconfigured and funding used differently to try fill existing medical vacancies (eg consultant funding used to support and develop SAS doctors in locum consultant posts; part time consultant funding used to create full time staff grade cover where there was known interest.)

We had intended to implement a 3 phase interview process for medical staff. However a combination of insufficient applicants, the need to urgently interview and appoint applicants who have offers from other employers and the lack of infrastructure resources to support the process, mean this planned change has not been possible.

g. Appraisal action plan for 2018-19

Recommendation	Action	Responsibility	Timeframe	Outcome
Establish a QA panel to benchmark and quality assure appraisal output	Panel meet annually to mark appraisal outputs from a selection of appraisers against QA tool & feedback to them. Panel includes a volunteer.	DoMW MARM	May/June 2019	Increased consistency of appraisal & outputs to benchmark and guide on-going quality improvement. Inclusion of a patient representative in appraisal and revalidation processes.
Implementation of Responsible Officer Action Group (ROAG) to consider the appraisal outputs over the previous 5 years for doctors due a revalidation recommendation in the forthcoming year.	Set up system to record and highlight data over 5 year period Set up meetings of RO, DoMW & MARM in time to examine evidence and make recommendations to GMC	MARM MARM	January 2019	Clear assurance process to map and monitor evidence over previous 5 years re fitness to practice**.**
Increased collaboration with neighbouring trusts to share best practice with periodic audits. MC, MCT & NWB	Liaison with other trusts & consideration of all audit recommendations for implementation in CWP	DoMW, MARM	March 2019	Sharing of best practice, adaptation of processes, calibration.

3. Concerns Involving Doctors

One internal investigation has been undertaken within CWP. Actions from this are in progress.

During the year there has been an emphasis on Clinical Directors dealing more appropriately with local concerns about a doctor's practice at the earliest possible opportunity, implementing an action plan if appropriate and confirming discussions and agreements in writing to the doctor. This is intended to prevent minor concerns escalating and will also ensure the supporting evidence is there if more formal action needs to be taken in future.

Quarterly meetings with the GMC Employer Liaison Service have continued. They allow helpful, informal discussions with a GMC colleague and the sharing of information in both directions. No doctors were formally referred to the GMC in 2017-18.

In January 2018 NHS Resolution (formerly the National Clinical Advisory Service – NCAS) delivered a 2 day Maintaining High Professional Standards case investigator workshop. Funding for the training and external venue was c.£8.5k via SIFT. Doctors who were interested in becoming medical investigators attended, along with those who intended to express an interest in a medical management position in the new structure. Remaining places were taken by HR colleagues. Feedback was excellent. The training was high calibre and additionally facilitated networking between medical staff and the HR managers with whom they would work on an investigation.

Potential medical managers were targeted to increase understanding and knowledge of managing doctors in difficulties. Nine now have CD responsibilities and two have senior medical educational roles; as such it's unlikely they will also have time to investigate doctors out of their immediate care group. In total there are 17 doctors who have trained to undertake medical investigations.

There are plans to feedback learning from investigations to all medical investigators and NHS England expects annual updates to be provided for them. A funding stream will need to be identified if the MHPS updates cannot be provided within the trust's existing contract with Hill Dickinson.

Recommendations

1) The Board is asked to approve this report.

2) The Chief Executive is asked to complete the NHS England Statement of Compliance for return to the Medical Appraisal and Revalidation Manager.

DR FAOUZI ALAM
Responsible Officer
8 June 2018

Appendix 2

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Statement of Compliance

Version number: 2.0

First published: 4 April 2014

Updated: 22 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Publications Gateway Reference: 03432

NB: The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Designated Body Statement of Compliance

The Cheshire and Wirral Partnership NHS Foundation Trust Board can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Yes

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

   Yes:

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

   Yes

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Yes

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

Yes

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

Yes

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

Yes

Signed on behalf of the designated body by the Chief Executive

Official name of designated body: Cheshire & Wirral Partnership NHS Foundation Trust

Name: Sheena Cumiskey Signed: _ _ _ _ _ _ _ _ _ _

Role: Chief Executive Date: _ _ _ _ _ _ _ _ _ _

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

CHAIR'S REPORT – QUALITY COMMITTEE 4 JULY 2018

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

- **Integrated governance framework review**
  The Quality Committee received a reviewed integrated governance framework and Trust meetings structure for comment. To achieve good governance requires regular challenge of complex committee structures and ensuring that there is an interlink of these structures into an effective and non-repetitive whole. The current review of our governance and assurance arrangements is in response to a review, strategically, of the external environment, culminating in development of the CWP Forward strategy. The review has been the result of a comprehensive and considered consultation process, led by the Medical Director (Quality) and Associate Director of Safe Services, which commenced in December 2017. The proposals represent our work to strengthen and streamline our governance arrangements, further they will free up capacity to support the delivery of care and systems working.
  The Board is asked approve the revised integrated governance framework being presented at today's meeting. Next steps are for all sub committee terms of reference to be reviewed by the chairs and respective membership, then submission to the Medical Director (Quality) and Associate Director of Safe Services before approval. This is to ensure that all Trust meetings are achieving alignment, through integrated governance, with the corporate assurance framework.

- **Strategic risk register – Care Group transitional risk**
  The risk associated with the transition to Care Groups has been defined and was approved by Quality Committee as "potential for ineffective control and management of risks and inattention on business as usual associated with the transition to the Trust's clinician-led operational (Care Group) structure as part of CWP Forward View strategy". The Quality Committee also received an in-depth review of the full risk treatment plan.
  The CWP Forward View transition task and finish group will continue to refine and monitor the full risk treatment plan.

- **Sexual safety on mental health wards**
  A driver diagram to outline the quality improvement work CWP is undertaking to ensure that we are doing all that we can to meet our responsibility to ensure that inpatients and staff are safe from sexual harassment and sexual violence was approved by the Quality Committee. This work is also a national driver – the CQC are working with NHS Improvement to develop national guidelines that promote the safety of people using or working in healthcare services and ensuring that their privacy and dignity are maintained. As part of this developmental work, the CQC hosted an event in April 2018 with the National Mental Health Nurse Directors Forum to explore improvements to sexual safety on mental health wards, which CWP contributed to. CWP is responding early to this driver.
  A governance framework was agreed that includes the Quality Committee overseeing delivery of agreed outputs and progress against the ambition of this quality improvement work.

- **Primary care streaming model – clinical, operational and financial risk plan**
  The Quality Committee was apprised of the current progress in mitigating, with all stakeholders, the current clinical, operational and financial risks associated with the primary care streaming model. The Quality Committee had previously requested resolution by 04.07.2018. Unfortunately, there has been a lack of response to the risks from Betsi Cadwaladr University Local Health Board (regarding streaming, triage and treatment of patients registered with GPs from Wales).
  The Quality Committee discussed the unresolved inappropriate management of clinical risks and commissioning arrangements for people registered with GPs in Wales. Due to the safety critical risks to patients and CWP (potential patient safety incidents and child protection considerations), it was agreed that the Medical Directors from CWP and the Countess of Chester Hospital NHS Foundation Trust will work to resolve this issue as soon as practicable in conjunction with system partners.

Lucy Crumplin
Non Executive Director/ Vice Chair of Quality Committee

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

QUALITY COMMITTEE

Terms of Reference

1. Constitution

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

2. Duties

The Quality Committee is responsible for:

Assurance
Receiving assurance on organisational quality governance and current performance regarding quality of care.

Improvement
Ensuring that that the strategic priorities for quality improvement are identified, implemented and monitored, to support future planning including responding proactively to new care delivery models.

The Quality Committee has delegated responsibility from the Board of Directors for oversight of the integrated governance framework, has overarching responsibility for risk, and therefore for monitoring strategic risks within the organisation.

The Quality Committee's duties can be categorised as:

Assurance

a) Monitoring and reporting on the Trust's delivery of integrated governance, exercising oversight of the systems and escalating any matters of concern as appropriate. Specifically:
   - Receiving and reviewing the corporate strategic risks (including those referred from other committees which are concerned with quality matters) allocated to the Quality Committee, monitoring progress made in mitigating those risks, identifying any areas where additional assurance is required and escalating to the Board of Directors as agreed by Quality Committee members.

b) Receiving assurance, via assurance reports and via a quality assurance dashboard, on organisational quality of care, aligned to the national "Single Oversight Framework", across the domains of safe, effective, caring and responsive services.

c) Seeking assurances that the Trust complies with external regulations and standards of quality and governance, including Care Quality Commission registration requirements.

d) Receiving assurance on the clinical and quality impact of the delivery of:
   - the key priority projects identified as part of the CWP Forward View/ Trust strategy (routine reporting of activity);
   - all current services (exception reporting of real/ near-real time issues);
   - quality schedules (including CQUINs) of the Trust's contracts with commissioners; and
   - efficiency programmes.

e) Review of the Trust's Quality Account and recommending its approval to the Board of Directors.

f) Receiving reports from the Board of Directors and Operational Board for information, context, assurance and/ or action as appropriate.

g) Approving the terms of reference and membership of its reporting sub committees and overseeing the work of those sub committees, receiving reports from them for consideration and action as necessary and routinely receiving the Chair's reports of their meetings. These meetings are:
   - Infection Prevention & Control Sub Committee
   - Clinical Practice & Standards Sub Committee

- Safeguarding Sub Committee
- Patient & Carer Experience Sub Committee

Improvement

h) Identifying the strategic priorities in relation to quality improvement as per the Trust's Quality Improvement strategy, including:
   - Quality improvement priorities required on an annual basis as part of the regulatory Quality Account, and oversight of the implementation of these.
   - Oversight of future planning, in conjunction with Care Group representatives, ensuring capacity to respond proactively to new models of care delivery.

i) Receiving and monitoring service-level quality performance improvement plans as identified as exceptions from the quality assurance dashboard.

j) Ensuring that the Trust is responding and improving to learning identified in implementing the patient safety agenda throughout the Trust. This includes:
   - Updates from patient safety initiatives, including thematic reports and quality improvement initiatives identified as an output of implementing the Trust's safety management system.
   - Oversight of serious incident management processes, including the mortality review (learning from deaths) agenda, response to Regulation 28 reports and oversight of identified quality improvement initiatives.
   - Learning from complaints and claims processes.
   - Receipt of assurance in relation to whether the Trust is learning from internal experience (including from complaints and claims) and learning from external experience and recommendations, past harm and integrating best practice, through receipt of the Learning from Experience report and Quality Improvement report.

k) Ensuring that the Trust is responding and improving to learning identified in implementing the clinical effectiveness agenda throughout the Trust. This includes:
   - Updates from clinical effectiveness initiatives, including quality improvement initiatives identified as an output of implementing the Trust's service improvement and effectiveness work programme.
   - Through service-level outcome reporting, identification of priority NICE/ evidence based guidelines and standards incorporated into improvement work.
   - Oversight of priority quality improvement projects, identified as part of the implementation of the Quality Improvement strategy, to tackle unwarranted variations in clinical care.

l) Ensuring that the Trust is responding and improving to learning identified in implementing the patient and carer experience agenda throughout the Trust. This includes:
   - Updates from improvement work co-ordinated by the Lived Experience, Volunteering and Engagement Network.
   - Receipt of assurance in relation to whether the Trust is learning from patient and carer experience initiatives, through receipt of the Learning from Experience report and Quality Improvement report.
   - Receipt of the annual CQC community mental health survey (and quality of care issues from analysis of the NHS Staff Survey via Operational Board) to inform themes and quality improvement work for endorsement by the Board of Directors.

3. Membership

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

i. Non Executive Director (Chair)
ii. Two additional Non Executive Directors (one of whom shall be Vice Chair)
iii. Chief Executive (Accountable Officer)
iv. Medical Director (Quality)
v. Medical Director (Effectiveness and Medical Staffing)
vi. Director of Finance
vii. Director of Nursing, Therapies & Patient Partnership
viii. *Director of Operations

ix. *Director of People & Organisational Development
x. [+]Associate Director of Nursing & Therapies (Mental Health)
xi. [+]Associate Director of Nursing & Therapies (Physical Health)/ Director of Infection Prevention and Control (DIPC)
xii. ** Strategic Clinical Directors
xiii. ** Associate Directors of Operations
xiv. Associate Director of Safe Services
xv. Associate Director of Effective Services
xvi. Associate Director of Patient & Carer Experience
xvii. [+]Head of Clinical Governance
xviii. [+]Head of Quality Assurance & Improvement
xix. [+]Clinical Champion for Quality Improvement

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

[+]responsive attendance based on agenda

(otherwise, core members)

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

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

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

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

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

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

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

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

4. Accountability and reporting arrangements

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

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

The Chair's report will also be circulated to the meeting of the Board in public, Audit Committee and Operational Board for information.

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

5. Frequency

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

6. Authority

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

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

7. Monitoring effectiveness

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

8. Administration

The Committee shall be supported administratively by a member of the corporate affairs/ board support team, whose duties in this respect will include:

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

9. Review

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

Date reviewed by Committee	4 July 2018
Date approved by Board of Directors	25 July 2018 (pending)
Review date	As per 2019/20 business cycle

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

CHAIRS REPORT
AUDIT COMMITTEE – 3 July 2018

The following is a summary of issues discussed and any matters for escalation from the 3 July 2018 meeting of the Audit Committee:

Internal Audit Progress Update
Two recently finalised audits were identified to the Audit Committee. These were:

- Fit and Proper Persons – Significant Assurance
- Both Managing Conflicts of Interest – Partially Compliant Assurance Opinion

Both reviews are agreed with Trust Management and Exec Sponsors. These will be shared with and reported to the Audit Committee following the pending sign off by the Trust's Operational Board. MIAA are in the process of developing an agreed schedule for sign off of all audit reports aligned to Audit Committee.

The Committee was briefed on forthcoming audits; Insight Trust 17-18 Assurance Framework and Internal Charter were discussed.

External Audit Update
A Technical update was provided with recent sector updates.

Strategic Risk Register
The Committee reviewed and discussed the changes to the risk register.

Healthcare Quality Improvement Plan
An overview of the delivery to date of the healthcare quality improvement programme was provided. The report has been approved by the Patient Safety & Effectiveness group and is included on the Quality Committee agenda on the 4th July for approval by Committee members.

Governance Matters
The Audit Committee noted the minutes and/or chair's reports from the Quality Committee and the Operational Board. There were no matters for escalation.

The Committee discussed and agreed that moving forward there will a standing item on the Audit Committee Agenda for any matters that need escalating to the Board of Directors.

Rebecca Burke-Sharples
Deputy Chair of Audit Committee

11th July 2018