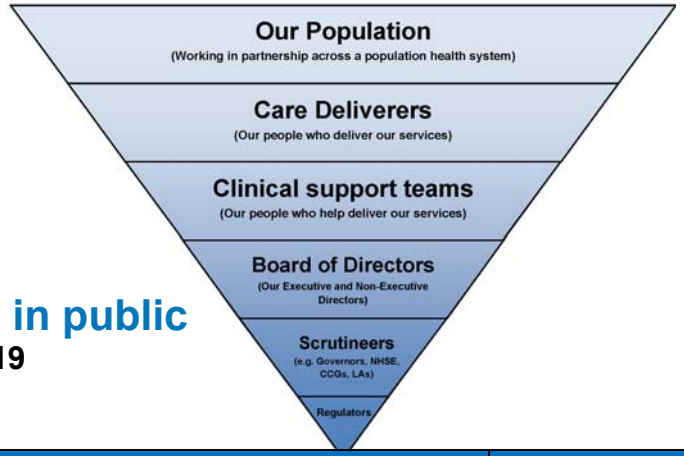

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

#cwpQI

Board of Directors, meeting held in public

At 1.30pm on Wednesday 25 September 2019
At the Boardroom, Redesmere

Ref	Title of item	Format	Presented by	Time
	ASSURANCE			
	Committee Governance			
19/20/64	Welcome, apologies and quoracy	Verbal	Chair	1.30pm (3 mins)
19/20/65	Declarations of interest			
19/20/66	Minutes of previous public meeting held on: • Wednesday 31 July 2019	Paper		1.33pm (5 mins)
19/20/67	Matters arising and action points	Paper		
19/20/68	2019/20 cycle of business	Paper		1.38pm (2 mins)
19/20/69	Chair's Announcements	Verbal		1.40pm (10 mins)
19/20/70	Chief Executive's Announcements	Verbal	Chief Executive	1.50pm (10 mins)
	Reporting from Committees and Matters of Governance			
19/20/71	Audit Committee: • Chair's report of the Audit Committee held 17 September 2019	Paper	Audit Committee Chair	2.00pm (5 mins)
19/20/72	Quality Committee: • Chair's Report of the Quality Committee held 11 September 2019	Paper	Quality Committee Chair	2.05pm (5 mins)

Ref	Title of item	Format	Presented by	Time
19/20/73	2018/19 Annual Reports (for noting only) • Health, Safety and Fire *(received at Operational Committee June 2019)* • Safeguarding adults and children *(received at Quality Committee July 2019)*	Papers	Director of Nursing, Therapies and Patient Partnership	2.10pm (5 mins)
	Operational Performance and Risk			
19/20/74	Board dashboard: Month 5 2019/20	Paper	Director of Business and Value	2.15pm (10 mins)
19/20/75	Board assurance framework and strategic risk register	Paper	Medical Director	2.25pm (10 mins)
19/20/76	NHS I/E Single Oversight Framework 2019/20	Paper	Director of Business and Value	2.35pm (10 mins)
	Quality of Care			
19/20/77	Safer Staffing: ward staffing: July and August 2019	Papers	Director of Nursing, Therapies and Patient Partnership	2.45pm (10mins)
19/20/78	Guardian of Safe Working Q1 2019/20 *(to be tabled)*	Paper	Medical Director	2.55pm (10 mins)
19/20/79	Learning from Experience: executive summary report: edition 1	Paper	Director of Nursing, Therapies and Patient Partnership	3.05pm (10 mins)
	10 minute break			
19/20/80	Quality Report: edition 1	Paper	Medical Director	3.25pm (10 mins)
19/20/81	Equality and Diversity annual report 2018/19	Paper	Director of Nursing, Therapies and Patient Partnership	3.35pm (15 mins)
	STRATEGY AND IMPROVEMENT			
	Strategy			

Ref	Title of item	Format	Presented by	Time
19/20/82	Place based working: • Cheshire East and Cheshire West Partnerships' Five Year Plans	Paper	Medical Director/ Chief Executive	3.50pm (10 mins)
19/20/83	West Cheshire Integrated Care Partnership • Terms of reference • Business plan	Paper	Chief Executive	4.00pm (10 mins)
	Any other business			
19/20/84	Any other business	Verbal	Chair/ All	4.10pm (5 mins)
19/20/85	Matters for referral to any other groups			
19/20/86	Matters impacting on policy and/ or practice			
19/20/87	Review risk impact of items discussed			
19/20/88	Three things to communicate			
19/20/89	Review the effectiveness of today's meeting https://www.smartsurvey.co.uk/s/CWPmeetingsurvey/			
CLOSE [4.15pm]				
Date, time and venue of the next meeting: **Wednesday 27 November, 9.30am, Boardroom, Redesmere**				

Version No	1	Date issued	

Quality Improvement Hub

Cheshire and Wirral Partnership NHS Foundation Trust

#cwpQI

DRAFT - Minutes of Board of Directors Meeting – held in Public

At 1:00pm on Wednesday 31 July 2019
At Boardroom, Redesmere

Present	Mike Maier	Chairman
	Sheena Cumiskey	Chief Executive
	Avril Devaney	Director of Nursing, Therapies and Patient Partnership
	Dr Anushta Sivananthan	Joint Medical Director, Quality, Compliance and Assurance
	David Harris	Director of People and Organisational Development
	Suzanne Edwards	Acting Director of Operations
	Rebecca Burke-Sharples	Non-Executive Director
	Andrea Campbell	Non-Executive Director
	Lucy Crumplin	Non-Executive Director
	Edward Jenner	Non-Executive Director
	Dr Jim O'Connor	Non-Executive Director
In attendance	Louise Brereton	Head of Corporate Affairs
	Suzanne Christopher	Corporate Affairs Manager (minutes)
	Gavin Williams	Community Nurse – CLDT Wirral
	Robert Waites	Health Facilitator - CLDT Wirral
	Helen Nellist	Public Governor
	Dr Mahesh Odiyoor	Strategic Clinical Director: LD, NDD and ABI
	Jane Woods	Deputy Director of People and Organisational Development
	Jodie D'Enrico	Head of Communications, Marketing and Public Engagement
Apologies	Andy Styring	Director of Operations
	Tim Welch	Director of Finance (after item 19/20/48)
	Dr Faouzi Alam	Joint Medical Director, Effectiveness, Medical Education and Medical Workforce & Caldicott Guardian

Ref	Title of item	Action
	Meeting governance	
19/20/39	**Welcome, apologies and quoracy** The Chair welcomed all to the meeting. The meeting was confirmed as quorate. Apologies were noted as above. Item 19/20/48 was taken as the first item. Further to this item, T Welch left the meeting.	
19/20/40	**Declarations of interest** None declared.	

Ref	Title of item	Action
19/20/41	**Minutes of the previous meeting held 22 May 2019 & 29 May 2019.** The minutes of the meeting held 22 May 2019 were **approved** as an accurate record. The minutes of the meeting held 29 May 2019 were **approved** as a correct record, with the following amendments:- • Item 19/20/25 – bullet point 2 – amend to – "*The staffing levels were safe as additional staff have assisted. However, this is not reflected in this report as it does not include AHP staffing and others who provide care for periods within a shift."* • Item 19/20/29 – addition to note the positive staff report.	
19/20/42	**Matters arising and action points** L Crumplin queried the progress made in respect of additional crisis beds (item 19/20/30 – 29th May 2019). S Edwards confirmed that the beds will be available from September 2019. There were no open actions included on the action log.	
19/20/43	**2019/20 Cycle of Business** The business cycle for 2019/20 was noted.	
19/20/44	**Chair's announcements** The Chairman announced the following: **Changes to ECT services** From Monday 5 August all Electro-Convulsive Therapy (ECT) services will be provided at our Bowmere Hospital site in Cheshire. This move is in line with the outcome of the public consultation on the redesigning of specialist mental health services in Eastern Cheshire, South Cheshire and Vale Royal. **Parliamentary Awards 2019** Wednesday, 10 July saw our three regional NHS Parliamentary Award winners head down to London for the National Parliamentary awards ceremony at Westminster. The Board congratulated our North-West regional winners: Director of Operations, Andy Styring; Next Step Cards and Clinical Support Worker, Stephanie John. **Outstanding celebration at CWP Recognition Awards** The third CWP Recognition Awards event was held recently at Ellesmere Civic Hall. The evening was a great opportunity to reflect on some of the Trust's achievements from the past year and to celebrate and recognise our colleagues and partners. The Board of Directors congratulated all the nominees and winners.	

Ref	Title of item	Action
	Chair and Chief Executive of the NMC visit CWP The Trust recently welcomed Philip Graf, Chair of the NMC and Andrea Sutcliffe, Chief Executive and Registrar of the NMC, to listen to CWP nurses reflect on their experiences in delivering care. Our visitors also heard from those who receive care as well as our partners. **A celebration of PRIDE** M Maier advised that he had recently attended a Crewe Pride celebration at Delamere Resource Centre on the 13 June 2019. The day was a wonderful example of the Trust's commitment to equality, diversity and inclusivity. A further launch event for Chester was held at Redesmere on Friday 26 July. **Save the Date: Person-Centred event and farewell to Avril Devaney** As Board Members are aware, Avril Devaney will be retiring after 17 years as Director of Nursing, Therapies and Patient Partnerships. Avril will be saying farewell at our person-centred event on 6 September, which will be held at Sycamore House. **Farewell to Lucy Crumplin** The Board of Directors also acknowledged that today's meeting would be the final Board meeting for Non-Executive Director, Lucy Crumplin, who is stepping down from her position with the Trust at the completion of her second three-year tenure. Huge thanks were offered to Lucy for all her efforts and contributions during her time with the Trust. **BAME Staff Network Meeting** It was reported that the first meeting was held on Friday 19 July 2019 - Sycamore House, Ellesmere Port. The Board of Directors **noted** the above updates.	
19/20/45	**Chief Executive's announcements** S Cumiskey updated on the following: **PRIDE** S Cumiskey reflected on the recent PRIDE events and commented what an honour it had been to participate. The Trust was able to celebrate and invite a wider set of partners to the event ahead of the celebrations scheduled to take place in Chester on the 10th August 2019. During the launch event at Redesmere, colleagues also had the opportunity to listen to an inspirational talk from Jessica Lynn, who described her life, her experiences and the challenges she has faced to be the person she wished to be. This reflected very much the work that CWP are trying to take forward through our networks and how we enable people to be the best they can be and make that experience real for them. S Cumiskey also provided an overview of the items discussed during the Closed Board Meeting as follows:	

Ref	Title of item	Action
	• The Board began their meeting with a patient story, which had been drawn together by the PALS team. The story described an individual's journey to change their relationship with food and the support CWP had provided to assist them in that process. The individual reflected on how, over time, some of the stigmas that were associated with their experience appeared to be breaking down. Board Members felt proud of the individual and what they had been able to achieve. This was a very positive way to begin the closed session. • Board Members discussed developments with regards to provider collaborates and the commissioning of specialised mental health services. • The Operational Committee Chair's report was received, and outlined how the Committee is reducing risk in respect of bed pressures. The Committee also acknowledged the efforts of staff to work in quite difficult circumstances. • A report was received in regards to the Trust's serious and untoward incidents and Board Members reflected on the learning from those. • An overview was provided regarding how the Trust plans to develop the Performance Team to better support the work of Care Groups. • It was reported that the Trust is on track to achieve its financial targets for this year. • A detailed presentation and lengthy discussion was held regarding how to further develop the Trust's capability to deliver the best possible care that meets the needs of the population. The Board of Directors **noted** the above summary.	
	Reporting from Committees and Matters of Governance	
19/20/46	**Audit Committee:** • Chair's report of the Audit Committee held on 9 July 2019 R Burke-Sharples introduced the item, reporting as Vice Chair of the Committee and as Chair of the meeting held on 9 July 2019. The Trust's new auditors, Grant Thornton, had attended the meeting for the first time. Committee members welcomed them to the Trust, and as is usual practice, held a private meeting with the internal and external auditors ahead of the formal meeting. This provided an opportunity to meet with the Partner and Senor Manager of Grant Thornton who will be providing support to the Trust going forward. During the formal meeting, Grant Thornton provided an overview of how they propose to deliver services to CWP over this financial year. The letter of engagement was approved by Committee Members.	

Ref	Title of item	Action
	The Audit Committee had also received the Speak Up Guardian Annual Report, which included a great deal of detail. The Audit Committee considered the processes in place to ensure the initiative is effective and endorsed the report to the Board of Directors. R Burke-Sharples outlined the governance processes for the report to be presented at Audit Committee, Quality Committee and the Board of Directors. The Board of Directors **noted** the Chair's report of 9 July 2019.	
19/20/47	**Quality Committee:** • Chair's Report of the Quality Committee held 3 July 2019 Dr J O'Connor introduced the item. Board Members were informed of a recent regulation 28 notification, and acknowledged that this was quite unusual for the Trust. The notice concerned the timing of assessments for patients suffering from depression. A response has been sent to the Coroner and a further update is scheduled for the Quality Committee. The recent external audit had raised some issues regarding EIT and CHEDs data. The matter was appropriately escalated to be considered in detail. A progress report will be provided to the September Quality Committee Meeting. A number of annual reports were received at the last Quality Committee meeting, which have been commended to the Board of Directors. The Board of Directors **noted** the Chair's Report of 3 July 2019. *Dr J O'Connor left the meeting*	
	Operational Performance	
19/20/48	**Board Dashboard Development** *This item was taken as the first item on the agenda.* *James Partington (Quality Surveillance Specialist) joined the meeting.* T Welch introduced the item and reminded colleagues that last December's Board Seminar considered the Board Dashboard. As part of that discussion, the Board agreed a number of KPI's to be included in the dashboard going forward. J Partington provided a presentation to Board Members that outlined the role of the quality surveillance team, the process to review the current dashboard and proposals for the new dashboard based on the discussions held in December. It was noted that data does exists for the metrics identified by Board Members in December. It was, therefore, agreed that the 20 metrics identified at the December 2018 Board Seminar	

Ref	Title of item	Action
	will now be progressed and can continue to be shaped over time. Board Members provided feedback in regards to the suggested format and expressed their preference for this to follow a similar appearance to the Quality Committee Dashboard. A discussion was held in regards to the definition of 'deep dive' and what that means against each of the identified metrics. Board Members also referenced the need to be clear on acceptable tolerances and understanding the root cause of trends. D Harris advised that in light of work now undertaken regarding the People and OD Strategy, there may now be additional metrics to add to the dashboard. D Harris agreed that tolerances need to be confirmed and agreement reached in regards to who will hold responsibility for the interpretation of the data. D Harris expressed his support for the approach being considered. Dr J O'Connor acknowledged James's comment during the presentation that the Quality Surveillance Specialists had also considered additional metrics and asked that these be shared with Board Members for further consideration. **ACTION** – J Partington to work up the 20 metrics agreed in December and share thoughts on additional metrics with Board Members for further consideration. S Edwards commented that work is already taking place within -Care Group that is supported by the Quality Surveillance Specialist. It is, therefore, important to ensure this work is joined up and not a duplication of data. The Board of Directors **noted** the presentation and **approved** the suggested way forward. *J Partington left the meeting.*	**J Partington**
	Quality of Care	
19/20/49	**Safer Staffing (May - June 2019)** *V Peach (Associate Director of Nursing – Physical Health) joined the meeting.* A Devaney introduced the item. Two reports were presented, the monthly safer staffing report and the six monthly safer staffing report. A Devaney highlighted the main sections of the monthly report as follows: The report is required to be presented to Board on a monthly basis to outline the percentage fill rates on inpatient wards. Staffing on Bollin Ward continues to be a challenge, although improvement has been noted. The service has managed to maintain the identified safeguards. Occupational Therapy also continue to support along with the Modern Matron and Clinical	

Ref	Title of item	Action
	Service Manager. Board Members were asked to note the report. The Board of Directors **noted** the monthly safer staffing report. V Peach introduced the six monthly safer staffing report. It was noted that in addition to the monthly fill rate reports, the Trust is required to provide six monthly reports as part of its obligations to the National Quality Board (NQB). The report considered Inpatient Services, IAPT, Specialist Mental Health, Learning Disability Services, Community Nursing and Community CAMHS. During this reporting period it is noted that the skills mix across the Trust has been enhanced with the inclusion of Nurse Associates. The Trust also continues to recruit to training nurse associate posts. The organisation has also continued to invest in advancing its staffing mix through role redesign, enhancing clinical roles, and broadening clinical capability through multi-disciplinary working. Some areas have also recruited in advance of need to support the succession planning process. A focus remains on the need to enhance clinical supervision. Training is also being considered to ensure any impact on time for direct care is minimised. Regular reports are provided to the People and Organisational Development Sub Committee. The report outlines that there is evidence to support that concerns are escalated appropriately to enable responsive solutions and to address areas of challenge. It is evident that both systems and processes are responsive. Board Members were asked to note the report and approve the suggested way forward. Dr A Sivananthan commented how helpful the report was, with an emphasis of focusing on the right care, at the right time, and in the right place, rather than just considering numbers of staff. R Burke-Sharples commended the efforts regarding the support to preceptorships and the flexible methodology being used. S Edwards commented that the report is useful to identify how the Trust is supporting staff to ensure time is dedicated to direct care. Thanks were offered to the acknowledgement of All Age Disability Services being included in this report going forward. Work is ongoing to ensure staff in these areas are supported accordingly. The Board of Directors **noted** the report.	
19/20/50	**Freedom to Speak up Guardian 2018/19 Annual Report** V Peach introduced the item. The report was taken as read and the following areas highlighted; It was noted that the report is now inclusive of a Board of Directors declaration. Thanks was offered to Board Members	

Ref	Title of item	Action
	for the completion of the self-assessment tool, and assurance was provided that all outcomes on that tool were completed by the end of the year. Quality Assurance processes have been developed to ensure appropriate scrutiny of cases. The profile of the Freedom to Speak up Guardians has also been raised through additional engagement with staff who may be more isolated. The policy has been reviewed and is available to all staff via the intranet. It was noted that the number of concerns reported has increased. This is not a significant change, and it is evident that this growth is also in line with the increase in awareness. There is also evidence to show that people across the Trust are in touch with the Freedom to Speak Up team. The method of collating data has also changed, which has impacted on the figures for this reporting year. Learning is captured, discussed and considered as part of the People and Organisational Development Sub-committee. The report also outlined the plans for 2019/20. A Campbell queried the increased concerns raised in West (table 3 of the report) whilst all other areas appear to have remained consistent. V Peach provided assurance that the increase is not related to one particular service and is related to the step change in recording methods (i.e. a team concern involving 8 people used to be counted as one, it will now be counted as 8 concerns). A Campbell also queried the narrative below table 4 regarding the reasons for complaints. V Peach advised that this related to more of the low level concerns often in respect of people not having the confidence to raise concerns themselves, and so instead using the Freedom to Speak Up process. A Devaney noted this as a point regarding accessibility and the need to further understand. As a Trust there is a need to explore any barriers that currently prevent individuals from coming forward. It was suggested that this should be included in the aims for the following year. E Jenner queried if the organisation is confident that of those individuals who have spoken up, that they have been protected in the process. A Devaney confirmed that that was the case and feedback has been actively sought in terms of the same. R Burke-Sharples reflected that the same conversation formed part of Audit Committee discussions. It was noted that some individuals appear to be accessing the Speak-Up process rather than other more appropriate avenues. The Board of Directors **noted** the report.	
19/20/51	**Medical Appraisal 2018/19 Annual Report** *Rachel Mcloughlin (Consultant Psychiatrist) joined the meeting.* R Mcloughlin introduced the item, outlining key issues and highlights from the report. Board Members were advised that the medical appraisal is now well established with high rates of	

Ref	Title of item	Action
	compliance. The process will continue to be reviewed to monitor compliance and consider further improvement. A quality assurance panel has also been piloted in year to consider the output of appraisals. This has been well received and also enabled appraisers to receive individual feedback. A Responsible Officer Assurance Group has also been introduced. The Group review all information submitted by the Doctor for revalidation to ensure this is consistent with GMC requirements. Doctors also now receive individual 'thank you' letters to confirm their revalidation and thank them for their contribution to the process and efforts for the Trust during the year. Board Members were advised that the following three areas will form the focus of this year's work programme: • Development of improved workforce planning / succession planning processes. • Piloting of a new electronic leave system • Individual meetings with all Clinical Directors to understand how we assist them to be as effective as possible in their role. D Harris noted the drive, focus and commitment that Rachel has brought to this role. Board Members thanked Rachel for her efforts to date. Dr A Sivananthan noted the feedback process to appraisers and how helpful this was, focusing on quality of appraisals as well as compliance rates. The Board of Directors **approved** the report and **agreed** for the Chief Executive to sign the Statement of Compliance on behalf of the Board of Directors. *R Mcloughlin left the meeting.*	
19/20/52	**Infection, Prevention and Control 2018/19 Annual Report** V Peach introduced the item. The report was taken as read and the key achievements highlighted for 18/19. It was noted that the Trust had demonstrated full compliance with Infection, Prevention and Control (IPC) requirements, and the following areas were highlighted: • Effective links have continued between the IPC control team and Modern Matrons / Link Practitioner on each of the Wards. • There has been a significant decrease (50%) in the number of inoculation incidents across the Trust since the implementation of safety devises during 2018/19. • A continued area of challenge relates to the use of scalpels within podiatry. There is currently no other devise that is safer and able to get close to the skin. The	

Ref	Title of item	Action
	team are currently working with procurement to consider this further. • 80% compliance has been achieved for essential learning. The training will now be delivered as part of the one stop training day, and compliance will continue to be monitored and improved. • Effective working relationships with Estates and Facilities has enabled audits to be carried out and prompt actions to be taken. • A sepsis awareness programme has been rolled out across the Trust. • Also involved in the flu campaign for staff – achieving a 60% compliance rate (aiming for 80% next year). • Cleanliness audits remain positively above target. • Waste auditing has been undertaken and all actions have been completed. The Policy is due to be updated this year. • PLACE visits have been very successful, and assisted the Trust in improving the environment for patients. D Harris commented that staff compliance with the flu vaccine was disappointing for last year. This was no reflection on the efforts of the campaign, but instead this appears to be around people's willingness to have the vaccine It was noted that this was discussed at length during a recent Execs meeting. The September CELF session will focus entirely on the flu campaign; expectations of the Trust, individual responsibilities and accountability. The Team were congratulated on a number of areas of their work during the year. It was clear the amount of work that is undertaken by the team, and they were thanked for their efforts. The Board of Directors **noted** the report. *V Peach left the meeting.*	
19/20/53	**Medicines Management 2018/19 Annual Report** Dr A Sivananthan introduced the item, advising that the report had been discussed in detail at the most recent Quality Committee. The report provided a summary of the activity and progress that has been made by the Medicines Management Group and the Pharmacy Team against the group's annual business cycle and the pharmacy team's quality improvement priorities. The report outlined the structure of the medicines management group and how they provide assurance in regards to prescribing methods. Sections of the report also form part of the evidence provided in others forms of Trust assurance, such as the learning from experience report. The report outlined the three areas for quality improvement:	

Ref	Title of item	Action
	1. Quality Improvement for High Risk Medicines Across All Care Settings. QI work is taking place with prescribers and nurses running clinics. 2. Stopping the over use of psychotropics in Learning Disability services. Teams have worked hard to review patients who are prescribed these meds. This has also been positively embraced by General Practice. 3. Targeted electronic referrals to community pharmacy. CWP are the first to do this, and involves sharing a holistic view of the person, rather than just their medication needs. A pharmacy technician has also been utilised to support prescribing. This has reduced medicine waste and enhanced nursing time. S Edwards commented that opportunities exist to consider how we use those models of care within crisis services. Board members commented on the standard of the report and the quality of the work being undertaken. The Board of Directors **approved** the annual report.	
19/20/54	**Data Protection 2018/19 Annual Report** *Gill Monteith (Trust Records and Information Governance Manager) joined the meeting.* G Monteith introduced the item, the report was taken as read and key achievements were highlighted. Board Members were advised that GDPR came into force with effect from May 2018. At the same time the UK data protection Act was also introduced. GDPR applies across Europe, whilst the UK data protection Act applies only to the UK, but compliments the GDPR principles. A working group was formed of the Information and Governance Sub-Committee. Their focus was to ensure compliance with the data protection act and GDPR regulations. Work was undertaken in regards to privacy notices, impact assessments, health record timeframes, asset registers and contract repository to ensure compliance with the new requirements. All work has now been completed and assurance provided of compliance. Questions were raised regarding the approach adopted to review our processes in line with the regulations and to ensure we are efficient in our processes. It was confirmed that a QI approach was adopted to establish the systems required. Further work will take place to review the 'flow' of information to avoid duplication or repetition. S Cumiskey expressed her thanks to Gill and the team for all their efforts to ensure the Trust is compliant. The Board of Directors **approved** the annual report.	

Ref	Title of item	Action
	Strategy	
19/20/55a	**People Strategy 2019/2022** D Harris introduced the item, providing a presentation to Board Members to update on progress to date in regards to the People and Organisational Development Strategy. It was noted that the strategy should always be evolving and adapting. Also part of this session is to invite feedback from Board Members to influence the shape and direction of this as it is implemented. The strategy will also be continually reviewed and discussed on a monthly basis as part of the People and Organisational Development Sub-Committee agenda. A review has already taken place to consider the areas of focus for this year, a large proportion of which will fall under the remit of the People and OD Services. D Harris provided an overview of the content and background to the strategy, governance arrangements and people planning. Board Members were also provided with the NHS Interim People Plan for information. D Harris provided a summary of the main points included in the Interim People Plan and then outlined each of the strategic priorities in turn. *Strategic Aim 1 - Contribution - To ensure we each have the capability (capacity, confidence and competence) to make our own unique contribution.* Discussion took place in regards to :- • How people new to the organisation contribute • How we engage with people who have lived experience to become employees of CWP • How we link this strategy to the Involvement strategy • Greater emphasis on how we connect with our local communities • Being creative in regards to the positions we offer • Including more detail about the culture of CWP and what engages and motivates the people who work for us *Dr J O'Connor returned to the meeting.* *Strategic Aim 2 – Development - To ensure we each develop the competence (knowledge, skills, behaviours) we need to deliver outstanding, person-centred care.* Discussion took place in regards to :- • The profile of CWP leaders and managers • The ability of managers to hold confident conversations • Supporting people to express their confidence (extroverts and introverts) • Change to language – 'education' to 'learning'	

Ref	Title of item	Action
	Strategic Aim 3 - <u>Wellbeing</u> - To create a workplace which helps each of us to enjoy positive physical and mental well-being and so be the best we can be. Discussion took place in regards to :- • Change to language – 'recognition and reward' to 'celebration and appreciation' • Ensuring links made between wellbeing and development (supporting people through transformation) • Considering environmental issues and impacts of this on individuals *Strategic Aim 4 - <u>Policies, Processes and Systems</u> - To provide policies, processes and systems that help (not hinder) each of us to deliver outstanding, person-centred care.* • Consideration of Policies and procedures to ensure these are values based and supporting managers to have confident conversations • Consider the overarching view of all policies and processes to help and enable staff • Consider the quality of processes (such as appraisal etc.) • Consider the impact on teams following investigation processes • Consider Board assurance processes in regards to staff safety issues • Ensuring policies allow the organisation to understand individual thought processes D Harris advised that the Governance Structure is also being considered in regards to the reporting mechanisms of the People and Organisational Development Sub-Committee and if this should become a direct committee of the Board. Further consideration will need to be given to the reporting cycle of the committee before proposals can be made to Board Members. *E Jenner left the meeting approx. 4pm.* A discussion also took place regarding the future skills required by the organisation and the people planning approach to support that, as well as the need to review the services we provide and how they are provide in the future, possibly with support of partners. It was recognised that the future of people planning needs to be driven by the needs of the populations CWP serves. The Board of Directors **noted** the presentation and **approved** the strategy. Thanks were offered to David Harris and his team.	
19/20/55b	**Learning Lessons to improve our people practices**	

Ref	Title of item	Action
	D Harris introduced the item, advising that a high level assessment of the Trust's current investigation and disciplinary processes had taken place against a set of recommendations recently issued by NHSI. The recommendations followed an unfortunate case reported at a London Trust relating to disciplinary proceedings of a staff member. The purpose of the report to the Board of Directors was to provide early sight of progress. The initial high level assessment has confirmed that processes within CWP appear satisfactory. However, these can be improved. Possible areas for improvement are likely to relate to training and the need for sufficient capacity and competence regarding investigations, with a greater oversight at Board level. A more detailed assessment will now be undertaken and will be reported to the Board of Directors with clear recommendations in due course. S Edwards offered support to this process and suggested the use of case studies to help inform the process. A Devaney commented that the NMC also issue guidance regarding what constitutes a good investigation, which may be helpful to also consider. It was noted that all processes need to also ensure kindness and compassion at all stages. The Board of Directors **noted** the report.	
19/20/56	**Quality Improvement Strategy 2019/20 implementation** Dr A Sivananthan introduced the item advising that the SBAR provides an update to Board Members regarding progress. Implementation of the QI strategy is now well underway, two cohorts of experts have been trained and the third cohort is planned for the autumn. The first senior manager's cohort has also now taken place. It is hoped that the majority of Band 8a staff and above will be trained by the end of March 2020. The Board of Directors **noted** the report.	
19/20/57	**Care Group development review process** S Cumiskey introduced the item on behalf of the Director of Finance, Tim Welch. Processes have now been established to further develop the maturity metrics. Care Groups have also been asked to reflect on the approval process and identify areas for further work. Support will continue to be provided via the Effective Services Team, and the work is scheduled to be completed by the end of September. The outcome will be presented to the October Board Seminar. The focus of the session will be to review the work undertaken by care groups to date, consider their self-	

Ref	Title of item	Action
	assessments, and identify areas for further improvement and support to allow care groups to be the best they can be. The session will also consider future engagement arrangements between the Board of Directors and Care Groups, and give thought to the required assurance processes. This will also involve a review of the Trust's financial standing orders and associated amendments to the Corporate Governance Manual regarding delegated authority to Care Groups and links to the Audit Committee to support assurance processes. The Board of Directors **noted** the recommendations.	
	Closing Business	
19/20/58	**Any other business** There were no further items of business. The Chair invited those observing the meeting to comment on the afternoon's proceedings. Questions :- Robert Waites - Health Facilitator - CLDT Wirral – raised the following questions:- How accessible have the vaccines been to staff? D Harris advised that a number of measures have been established to ensure the vaccine can be accessed by staff across the Trust. However, the feedback shows that there appears to be a large number of staff who are unwilling to accept this. As discussed during the meeting, further evaluation of this will take place at the September CELF. How can lived experience advisors be included in recruitment processes to add value? A Devaney advised that the current Trust strategy allows for the involvement of lived experience volunteers in processes such as recruitment. The staff member was advised to link with Cathy Walsh – Associate Director of Patient and Carer Experience. R Waites also commented on recent changes in their work environment, moving to a hot desking approach, but raised the question of how this impacts on the experience of students. Board Members will reflect on this suggestion. A further suggestion was made in regards to the principles applied to easy read materials for patients, being applied to all policies for staff. The Board of Directors welcomed this suggestion, and will consider this further.	
19/20/59	**Matters for referral to any other groups** There were no matters to refer or escalate to other groups.	
19/20/60	**Matters impacting on policy and/ or practice**	

Ref	Title of item	Action
	There were no matters identified impacting on policy and/or practice.	
19/20/61	**Review risk impact of items discussed** There were no further items to add to the risk register.	
19/20/62	**Key messages for communication** The various annual reports presented during today's meeting were noted by Board Members, along with the efforts of staff to ensure Trust compliance. All were thanked for their contribution. S Cumiskey also offered thanks on behalf of the Board of Directors to both Lucy Crumplin and Avril Devaney, for whom this would be their last board meeting. Lucy Crumplin steps down from her post as Non-Executive Director and Avril Devaney is to retire from her positon as Director of Nursing, Therapies and Patient Partnership at the end of September. S Cumiskey thanked both for their contribution to the Trust, with a special thanks to Avril for her 17 years of service as the Director of Nursing. Board Members reflected on the work of Avril during her time with the Trust and highlighted her kind, compassionate and person centred approach to all that she has been involved in. All thanked her for her efforts and commitment.	
19/20/63	**Review of meeting performance** All agreed the meeting had been effective. Board members were encouraged to complete the online meeting survey to enable continuous improvement at Board level.	
CLOSE		
Date, time and venue of the next meeting: **Wednesday 25 September 2019, 9.30am, Boardroom, Redesmere**		

Cheshire and Wirral Partnership NHS Foundation Trust
Open Actions Action Schedule

Meeting date	Meeting date	Group/ Ref	Action	By Whom	By when	Status
			No actions arising from meeting held 29/5/19			
	31.07.2019	19.20.48	**Board Dashboard Development:** J Partington to work up the 20 metrics agreed in December and share thoughts on additional metrics with Board Members for further consideration.	TW/JP	Sept 2019	Closed - revised board dashboard included in September meeting agenda

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Board of Directors
Business Cycle 2019/20 (Public Meeting)

	Item	Lead	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Assurance	Chair and CEO report and Announcements	MM/SC		✓		✓	✓		✓		✓		✓
	Review minutes of the previous meeting	MM		✓		✓	✓		✓		✓		✓
	ICP Board/s (minutes)	SC		✓		✓	✓		✓		✓		✓
	Receive Chair's Report of the Quality Committee	JOC		✓		✓	✓		✓		✓		✓
	Receive Chair's Report of the Audit Committee	EJ		✓		✓	✓		✓		✓		✓
	Freedom to speak up six monthly report	AD				✓			✓		✓		
	Six monthly Infection Prevention Control Report	Director of IPC							✓				
	Director of Infection Prevention and Control Annual Report Inc. PLACE	Director of IPC				✓							
	Safeguarding Adults and Children Annual Report and six monthly report	AD				✓					✓		
	Accountable Officer Annual report Inc. Medicines Management	AS				✓							
	Monthly Ward Staffing update (monthly and six monthly reporting)	AD		✓		✓	✓		✓		✓		✓

Item	Lead	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Research Annual Report	FA					✓						
Medical Appraisal Annual Report and annual declaration of Medical revalidation	FA				✓							
Operational Plan/Board performance dashboard (incorporating Operational and Quality Dashboard)	TW		✓		✓	✓		✓		✓		✓
Annual Report, Accounts and Quality Account	TW		✓									
Health and Safety Annual Report and Fire and Link Certification	AD				✓							
Board Assurance Framework	AS		✓			✓				✓		✓
Learning from Experience report, Inc. Learning from Deaths	AD		✓			✓				✓		
Integrated Governance Framework	AS									✓		
Equality and Diversity responsibilities inc. WRES and WDES	AD		✓		✓	✓						
Guardian of Safe Working quarterly report	FA		✓		✓			✓		✓		
Provider Licence Compliance	TW		✓					✓				
CQC Statement of Purpose	AS							✓				

	Item	Lead	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Data Protection and Security toolkit	FA											✓
	GDPR compliance annual review	FA				✓							
	Register of Sealings	TW					✓						
	Register of Interests (Directors and Governors)	MM		✓									
	Self-certification statements	TW		✓									
	Corporate Governance Manual	TW							✓				
	Fit and Proper Persons annual assurance	DH					✓						
	Terms of Reference and effectiveness reviews: • Quality Committee • Audit Committee • Operational Committee	JOC/SC		✓		✓							
	Review risk impacts of items	MM/SC		✓		✓	✓		✓		✓		✓
	CEO/Chair Division of Responsibilities	MM/SC		✓									
	BOD draft Business Cycle 20/21	MM/SC											✓
	AOB (including matters that are NOT commercial in-confidence	MM/SC		✓		✓	✓		✓		✓		✓

	Item	Lead	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
IMPROVEMENT	Quality Improvement report/ strategy implementation	AS				✓			✓				✓
	CQC Community Patient Survey Report (themes and improvement plan)	AD							✓				
	NHS Staff Survey (themes and improvement plan)	DH											✓
	People and OD strategy inc. workforce planning)	DH		✓							✓		

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STANDARDISED CHAIR'S REPORT

CHAIR'S REPORT DETAILS	
Name of meeting:	Audit Committee
Chair of meeting:	Edward Jenner
Date of meeting:	17 September 2019

(ESCALATION) Quality, clinical care, other risks identified that require escalation

Internal audit:

- A recent audit on Health roster attained moderate assurance. Audit Committee assessment of the audit suggested that the opinion may have been closer to a limited assurance. As the majority of actions are due for completion by end of October 2019, the Committee has invited colleagues join the November meeting to provide assurance on delivery of the action plan.

- An audit undertaken on Consultants' pay/ increments demonstrated some findings that led the Committee to a limited assurance opinion. As such, the Committee has requested further assurance regarding the follow-up action to this audit, to be received at the November meeting.

- A discussion on the proposed deferral of clinical supervision audit scheduled in the 2019/20 plan concluded that the audit should remain in the plan, but adopting a focus on supporting the implementation of the new policy.

(ASSURANCE) Matters discussed/decision:

Internal Audit

- MIAA provided an update in respect of the assurances, key issues and progress against the Internal Audit Plan for 2019/20. The completed audits above were discussed. The cyber essentials audit was also discussed which provided positive assurance on progress against action.
- The Committee was reminded of ongoing audits due for completion and those forthcoming, conflicts of interest, access to services – waiting times, and ward quality sport checks.

- Details of future events and benchmarking were noted by the Committee.

Anti-fraud

- A progress report was provided. There were no matters for escalation.

External Audit

- Grant Thornton provided an update on their recent work as incoming auditors. A relationship meeting will be held later in September to discuss the 2019/20 audit plan.

Procurement/ Tender Waivers

- The Committee received a report setting out some practical changes to the tender waiver process, including a revised tender form. The changes were approved by the Committee and will form part of a suite of changes within the Corporate Governance Manual due for review by the Committee in November 2019.

(IMPROVEMENT) Achievements:

2018/19 Quality Account audit – Early intervention in psychosis indication (EIP)

The Committee received an overview of the work undertaken in the performance and information team in responding to the recommendation in the ISA 260 regarding the EIP indicator. This included assurance regarding improved methodology for data verification in clinical services generally.

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STANDARDISED CHAIR'S REPORT

CHAIR'S REPORT DETAILS	
Name of meeting:	Quality Committee
Chair of meeting:	Dr J O'Connor, Non-Executive Director
Date of meeting:	11/09/2019

(ESCALATION) Quality, clinical, care, other risks identified that require escalation:

A 'comprehensive' quality impact assessment (following on from a 'high level' quality impact assessment received by the June 2019 Operational Committee) was presented to assure mitigation of, as far as practicable, the care and quality impacts of the phased reduction in bed numbers on Bollin ward. This is being supported by opening additional beds on Juniper and Lakefield wards and crisis beds in the community in East Cheshire - and is part of the ongoing strategic risk treatment plan in relation to the redesign of mental health services in Central and East Cheshire. The Quality Committee approved the quality impact assessment, subject to the addition of ensuring it looks at the impact of training attendance deficits and how we sustain the competence of our staff.

The Trust is currently responding to a Regulation 28 report, issued to a number of partner organisations, to respond to the Coroner's concerns regarding the effectiveness of discharge processes and communication. This will be provided by the deadline of 18 September 2019.

(ASSURANCE) Matters discussed:

A nicotine management task and finish group has been established to respond to feedback received from the outputs of the CQC's Mental Health Act monitoring visits - to build staff confidence in applying the Trust's policy.

Assurance was received on progress with implementing continuous improvement plans in relation to the Green Light Toolkit standards, incorporating the NHS Improvement 'learning disability standards for NHS trusts'. Care groups are working towards achieving the 'best' self-assessment rating, which the Quality Committee will review again in January 2020.

Assurance was received on progress with the delivery plan for building sustainable quality improvement capability in line with the quality improvement strategy. Assurance was also provided, via a video presentation from one of the Trust's physical health teams (Ellesmere Port community care team) on how quality improvement was being practically applied in occupational therapy - as well as examples of practical application set out in edition 1 of the Quality Improvement report.

(IMPROVEMENT) Achievements:

A presentation was delivered by the pharmacy team, demonstrating interventions provided and, as a result, positive outcomes achieved as a result of pilot work in Wirral and West Cheshire that has used workforce remodelling within CMHTs to increase pharmacy support and advice to the MDT. Quality Committee was in support of spreading this model to build pharmacy capability in all CMHTs across CWP.

The safe services team presented on a 'zero harm' ambition to eliminate unwarranted restrictive practices, recognising the significant improvements made by all clinical and clinical support services since 2014. With the establishment of national incident reporting criteria this year, CWP's comparative performance can be tracked with greater confidence - however whilst reporting remains at near zero, to achieve an ambition of not requiring the use of unwarranted restriction, CWP will progress with its continuous improvement plans to become a more trauma informed organisation by using a positive behaviour support approach. Realising this ambition will be achieved through organisational development (cultural) work, in particular by building the capability of our staff through developing co-produced training, which will be compliant with new national standards that apply from April 2020.

Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Reporting against Strategic Objectives Dashboard - September 2019
Agenda ref. no:	19.20.74
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	25/09/2019
Presented by:	Tim Welch, Director of Business and Value

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
Services that are responsive to people's needs	Yes
Well-led services	Yes
Which NHSI 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*

The Board of Directors requested the development of a dashboard to support Reporting against Strategic Objectives, to be launched in September 2019. This SBAR accompanies the first version of this dashboard.

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

Proposals for the new dashboard were discussed in the July Board of Directors meeting. In that meeting, it was agreed that:

- The style would be similar to the style already used for the Quality Assurance Dashboard taken to Quality Committee. This has an emphasis on time series analysis using statistical process control charts including upper and lower control limits reflecting the natural variation within the data. Initially, and in contrast to the Quality Assurance Dashboard which uses exception reporting based on agreed tolerance thresholds, all metrics will be reported.
- The content would be those metrics that were agreed at the December 2018 Board meeting, accepting that some metrics may not yet be in production and more are likely to follow as the product matures.

Assessment – *analysis and considerations of options and risks*

This is the first iteration of the new dashboard. All those who contributed were given the chance to see how their data were being presented and given an opportunity to influence both the presentation of the metrics, and the comments relating to their data. The author would like to thank People Information for being the deliverers of the most complete and thoroughly explained elements of the dashboard and hopes to achieve similarly high quality contributions from all providers to future dashboards.

The charts highlight two recent achievements: the good progress that has been made in analysing deaths through case record reviews (the 'morbidity and mortality' metric) and the 'supervision compliance' metric reached a high point in the month before last. There are no causes for concern based on most recent data. There are some useful comments explaining high or low points in the historical data which may have implications for lessons to be learned for the future.

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

The Board of Directors is invited to comment on this first iteration of the dashboard and indicate any direction they would like future iterations to take.

Who/ which group has approved this report for receipt at the above meeting?		Click here to enter text.
Contributing authors:		James Partington
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Board of Directors	18/09/2019

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	Reporting against CWP Strategic Objectives Dashboard September 2019 (powerpoint file)

Reporting Against Strategic Objectives

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

September 2019

Quality Surveillance Analysis Team

Helping people to be
the best they can be

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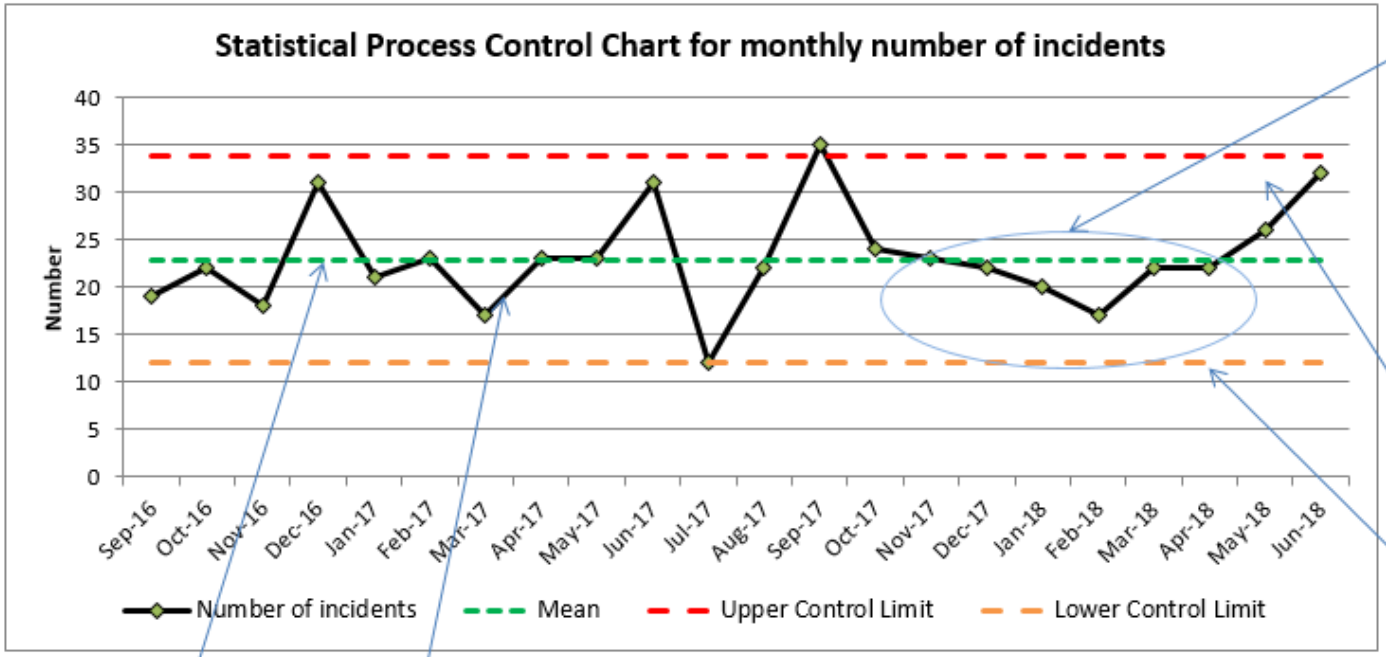
Interpreting Statistical Process Control charts



A run of consecutive data points in the same direction (up or down), or a run of data points all of which are below or above the mean, may be an indicator of a shift in the long term underlying trajectory. The SPC chart allows this to be assessed.

Upper Control Limit - the maximum expected variation above the mean. Set at 2 standard deviations above the mean.

Lower Control Limit - the maximum expected variation below the mean. Set at 2 standard deviations below the mean.

Mean - the arithmetic mean of the source data.

Source data - in this case, the "Number of Incidents". The variation in the data drives where the Upper and Lower control limits are plotted - the greater the variation, the further apart the control limits will be.

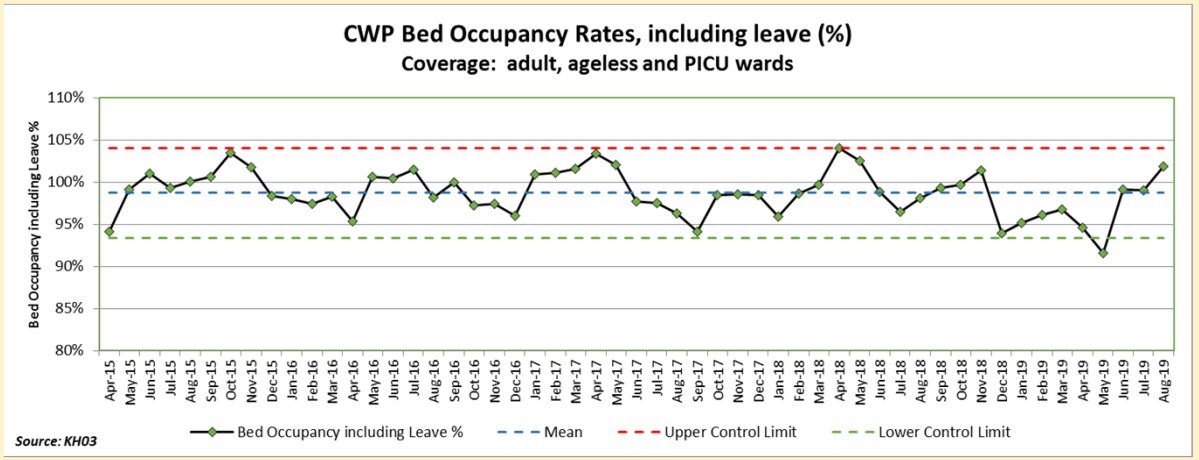
What does the SPC tell us?

The SPC tells us whether a series is "in control". This is a statistical term equivalent to being predictable or stable. That's not to say there won't be variation, but the SPC shows what kind of variation can be expected. In the example above, the latest two months have shown increases, but we know from the rest of the data that this is within the bounds of expectation.

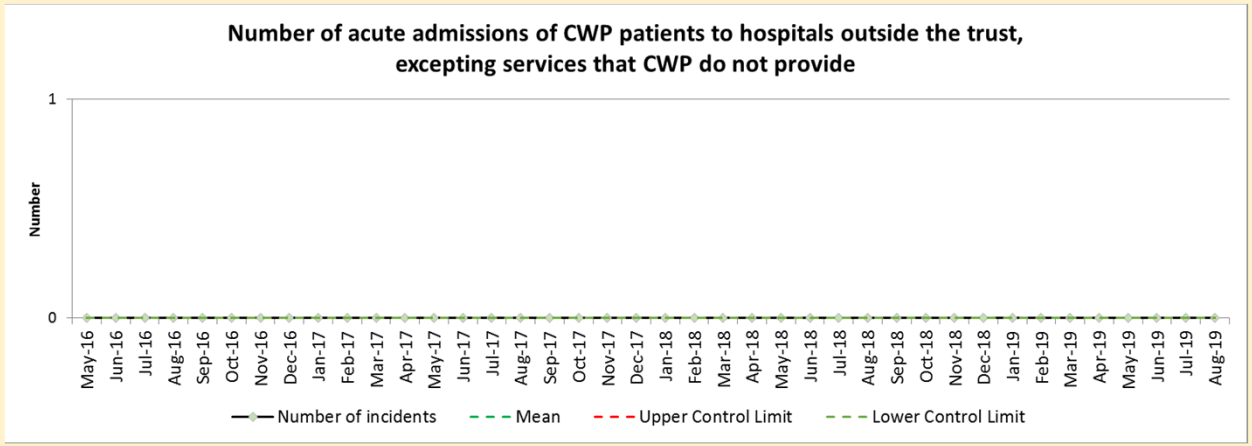
What's the science behind setting the control limits at two standard deviations from the mean?

One of the properties of what is known as "the normal distribution" is that 95% of the data are within 2 standard deviations either side of the mean. The remaining 5% of the data are further away from the mean than that, in either direction. 95% is equivalent to one in 20. So we would expect, when looking at a SPC based on data that are distributed normally, that 19 out of 20 data items will be within the control limits, and one in 20 of the data items will exceed the control limits.

Deliver high quality, integrated and innovative services that improve outcomes

Metric	Data	Further Explanation
Bed Occupancy	 Comment: Bed occupancy including leave for the eight adult, ageless and PICU wards has been within the control limits for all bar one month since April 2015. It dipped below the lower control limit in May of this year at 91%. In this case, a data point below the lower control limit is a positive feature, albeit still above the target occupancy rate of 85% recommended by the Royal College of Psychiatrists.	Data source: KH03 file from the Information Team. Next Planned Deep Dive:

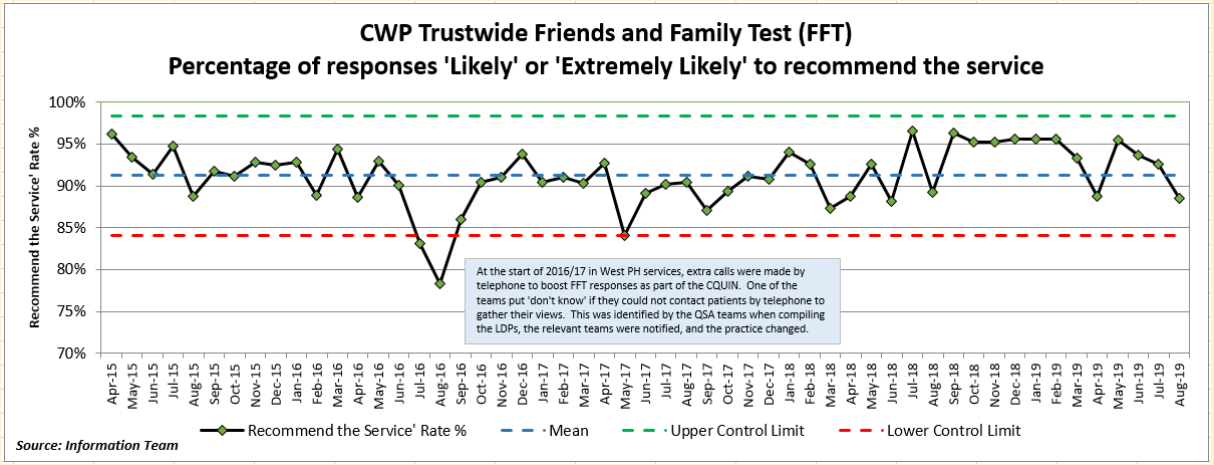
Deliver high quality, integrated and innovative services that improve outcomes

Metric	Data	Further Explanation
Out of Area Acute Admissions	 Note: A CWP patient was admitted to a hospital in Bolton in September 2018. CWP determined that this did not fit the criteria to be counted as an out of area placement, but we are aware that it is being recorded as an 'inappropriate out of area placement' for CWP in NHS Digital datasets.	Next Planned Deep Dive:

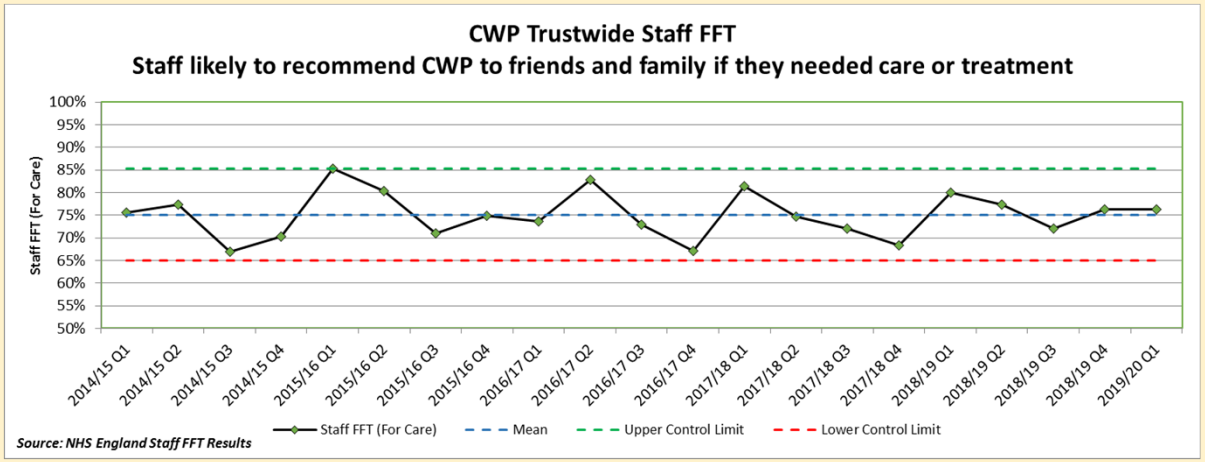
Work to develop further measures for this strategic objective is as follows:

Deliver high quality, integrated and innovative services that improve outcomes	
Metric	**Development Plans**
Admission to hospital for those in the dynamic support register	A Report Manager report is available for people under the LD CAMHS service and this currently shows one hospital admission. Work is underway by the Information Team to a) Verify the existing data stream b) Extend the report to include adults as well as children

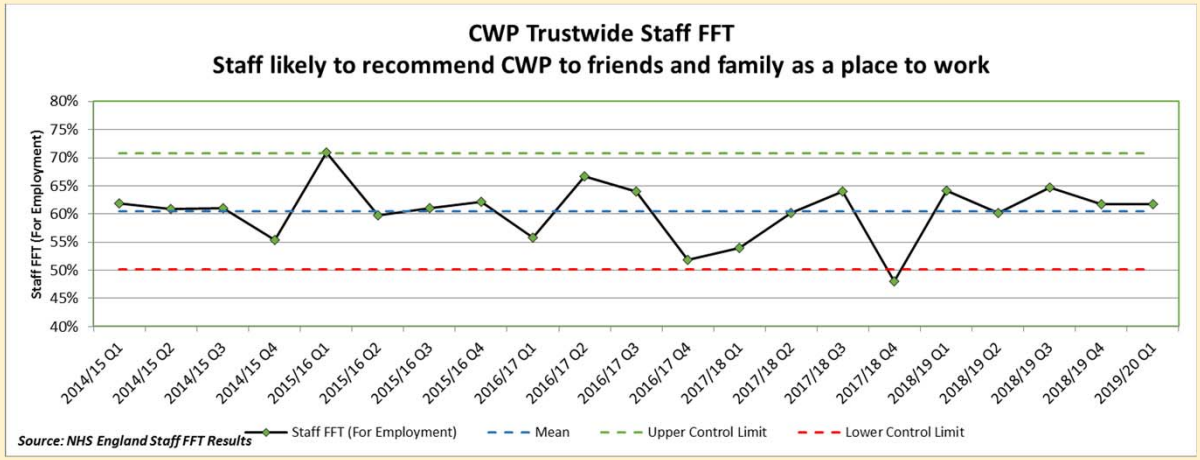
Ensure meaningful involvement of service users, carers, staff and the wider community

Metric	Data	Further Explanation
Friends and Family Test – responses from users of our services	 Comment: The annotation in blue explains why the proportion of 'likely' and 'extremely likely' responses dipped in July, August and September 2016.	Next Planned Deep Dive:

Ensure meaningful involvement of service users, carers, staff and the wider community

Metric	Data	Further Explanation
Friends and Family Test – responses from our staff – about CWP as a care provider	 Comment: 2018/19 Q4 results were better than Q4 in the two previous years. In the earlier periods, the Staff FFT survey took place in only one locality each quarter; the Q4 surveys took place in Central and East locality. The time series therefore includes an element of locality driven variation.	Next Planned Deep Dive:

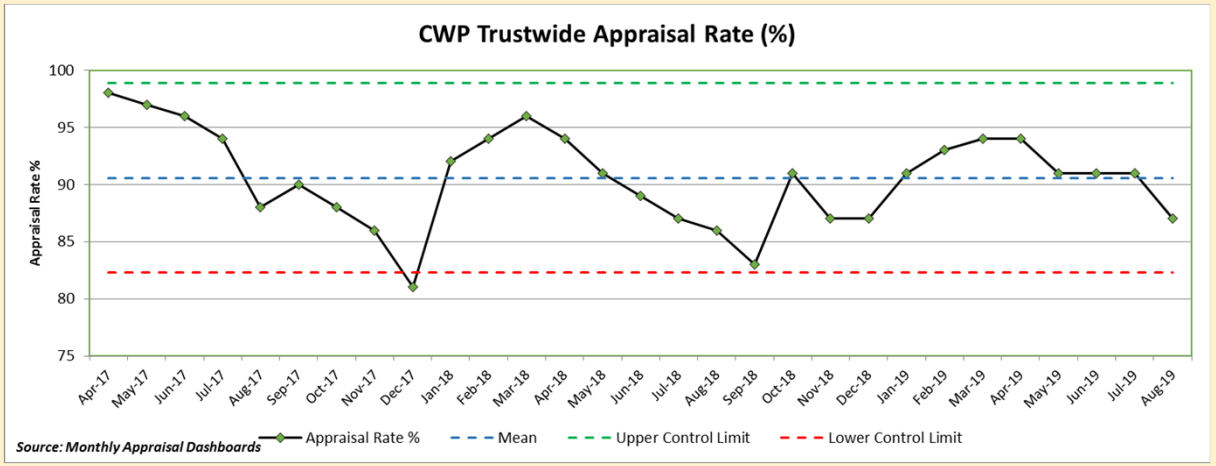
Ensure meaningful involvement of service users, carers, staff and the wider community

Metric	Data	Further Explanation
Friends and Family Test – responses from our staff – about CWP as a place to work	 Comment: Like the previous chart, 2018/19 Q4 results were better than Q4 in the two previous years. For this metric, the 2017/18 Q4 data point dipped below the lower threshold ie it was an atypically low response.	Next Planned Deep Dive:

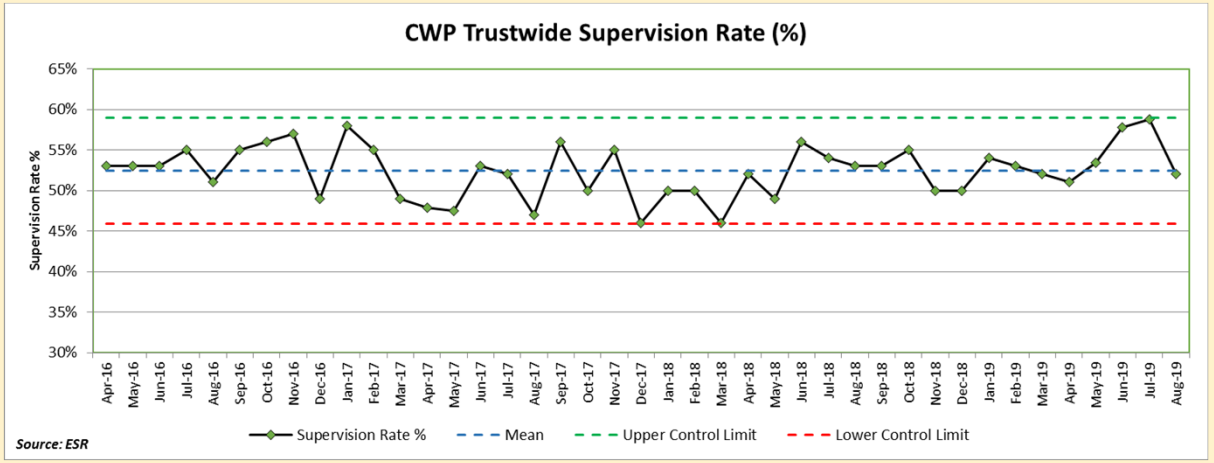
Work to develop further measures for this strategic objective is as follows:

Ensure meaningful involvement of service users, carers, staff and the wider community	
Metric	**Development Plans**
Effectiveness of working with the wider community	Every six months, a report from the Lived Experience, Volunteering and Engagement Network (LEVEN) is taken to Quality Committee. The Associate Director of Patient & Carer Experience has suggested that the Trust should give further thought to how this report provides qualitative information to demonstrate progress against this objective.

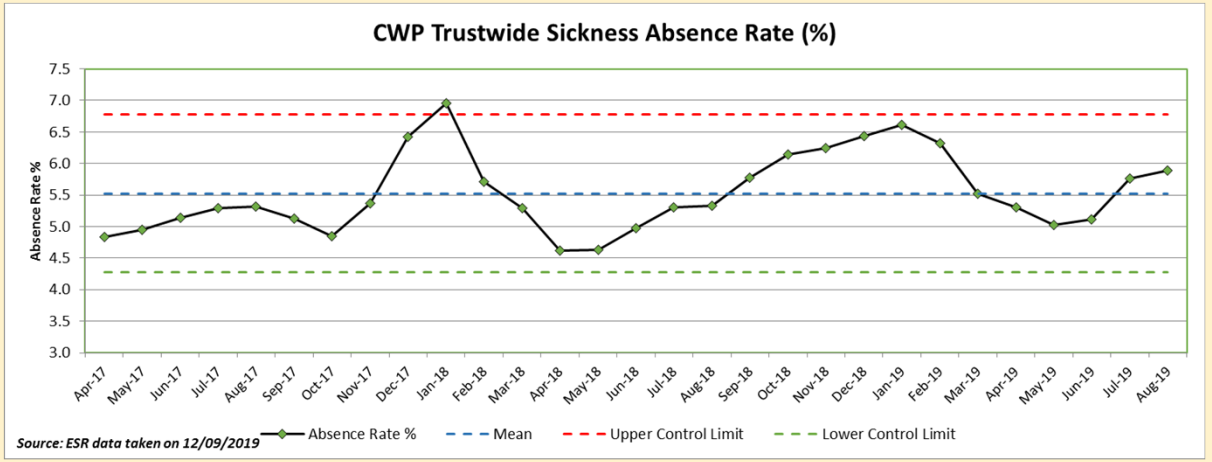
Be a model employer and have a caring, competent and motivated workforce

Metric	Data	Further Explanation
Appraisal	 Comment: Peaks have tended to be at March/April. The dip in December 2017 was part of the legacy of the introduction of the new appraisal process in May 2016. The band specific appraisal phases were shifted forwards by a month in the 2017-18 year compared with the previous year and a large cohort of bands 1-4 were still not compliant by the end of November 2017, leading to Dec 17 being atypically low.	Next Planned Deep Dive:

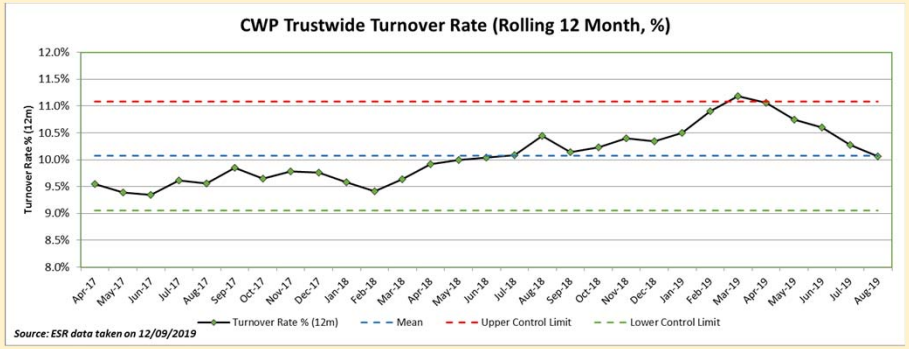
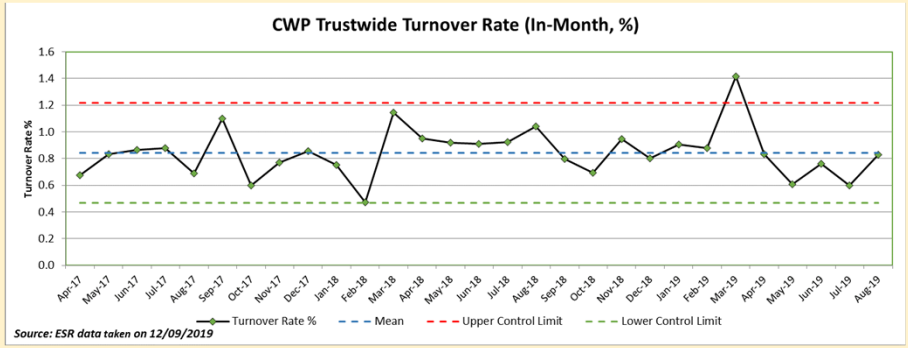
Be a model employer and have a caring, competent and motivated workforce

Metric	Data	Further Explanation
Supervision	 Comment: Supervision compliance has been within the 45%-60% range since April 2016, with two of the three most recent months being among the highest.	Next Planned Deep Dive:

Be a model employer and have a caring, competent and motivated workforce

Metric	Data	Further Explanation
Sickness Absence	 Comment: sickness absence exceeded the upper control limit in January 2018.	Next Planned Deep Dive:

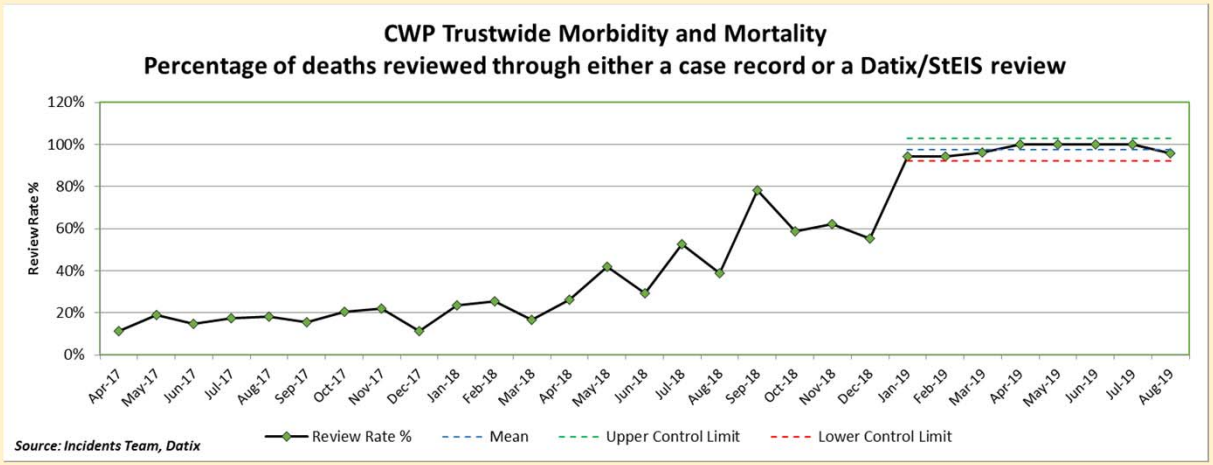
Be a model employer and have a caring, competent and motivated workforce

Metric	Data	Further Explanation
Staff Turnover	 	Comment: The lower chart indicates that March 2019 drove the peak in the rolling 12 month turnover series, taking the series above the upper control limit for that month. People Information suggest that this is due to March being a more common month for fixed term contracts to end.	Next Planned Deep Dive:

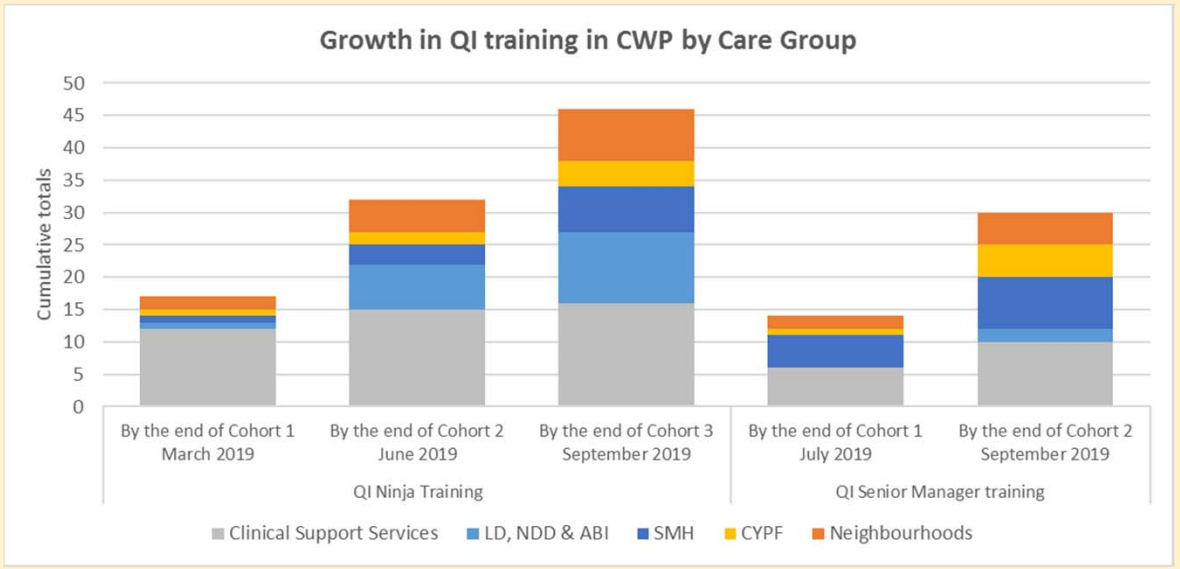
Work to develop further measures for this strategic objective is as follows:

Be a model employer and have a caring, competent and motivated workforce	
Metric	**Development Plans**
There are no more metrics in the pipeline at present for this strategic objective.	

Improve the quality of information to improve service delivery, evaluation and planning

Metric	Data	Further Explanation
Morbidity and Mortality	 Comment: The scope of which deaths are to be reviewed was changed in January 2019, so SPC control limits have only been included from that point.	Next Planned Deep Dive:

Improve the quality of information to improve service delivery, evaluation and planning

Metric	Data	Further Explanation
QI Training	 Comment: The chart shows the focus on training staff from Care Groups (rather than staff in clinical support services) from Cohort 2 onwards.	Next Planned Deep Dive:

Work to develop further measures for this strategic objective is as follows:

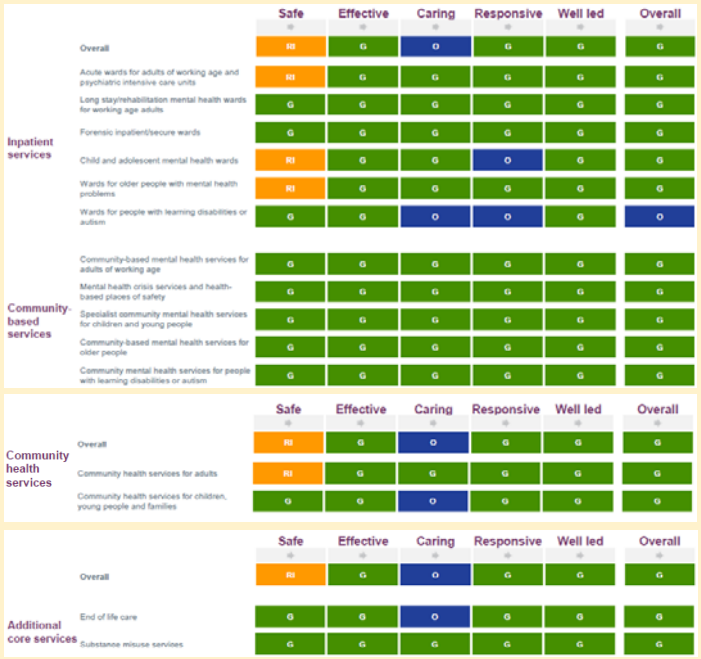
Improve the quality of information to improve service delivery, evaluation and planning	
Metric	**Development Plans**
Dashboard development	There is a proposal to measure the pace of development of new reporting dashboards for Care Groups. This may take the form of progress against milestones from a project plan. This will be led by the Information Team.
Quality Improvement (QI) Projects	One Care Group (LD, NDD and ABI) is currently recording their QI Projects in the Sharepoint register. Once the register is being used by all Care Groups, a metric will be included to summarise this information.

Sustain financial viability and deliver value for money		
Metric	**Data**	**Further Explanation**
Use of Resources Rating	In June 2019, the rating for CWP was '2'.	
		Next Planned Deep Dive:

Work to develop further measures for this strategic objective is as follows:

Sustain financial viability and deliver value for money	
Metric	**Development Plans**
Delivery of Value for Money	Business and Value will add plans into this section as they develop.
Reduction in unwarranted variation	

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

Metric	Data	Further Explanation
CQC Rating		Next Planned Deep Dive:

Comment: Improvement actions are being monitored through Quality Committee.

Work to develop further measures for this strategic objective is as follows:

Be recognised as an open, progressive organisation that is about care, well-being and partnership	
Metric	**Development Plans**
Duty of Candour	Work is underway within Safe Services to improve reporting streams and introduce a new indicator.

Work to develop further measures for this strategic objective is as follows:

Maintain and develop robust partnerships with existing and potential new stakeholders	
Metric	**Development Plans**
No metrics have yet been finalised for this objective	

NHS
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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Board assurance framework and strategic risk register
Agenda ref. number:	19.20.75
Report to (meeting):	Board of Directors (meeting in public)
Action required:	Discussion and Approval
Date of meeting:	25/09/2019
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 NHSI Single Oversight Framework themes this report reflects:	
Quality	Yes
Finance and use of resources	Yes
Operational performance	Yes
Strategic change	Yes
Leadership and improvement capability	Yes

CWP Quality Framework:		
Patient Safety	Safe	Yes
Clinical Effectiveness	Effective	Yes
	Affordable	Yes
	Sustainable	Yes
Patient Experience	Acceptable	Yes
	Accessible	Yes

http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	Yes
All 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 apprise the Board of Directors of the current status of the strategic risk register 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 September 2019, the Trust has 9 strategic risks – 3 are rated red and 6 are rated amber. There is 1 risk currently in-scope – rated amber.

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

The Medical Director (Executive Lead for Quality) and the Quality Committee are the designated officer and committee respectively for risk management. The Board of Directors monitors and reviews the corporate assurance framework and receives assurances on risk via the Quality Committee. Complemented by Audit Committee's oversight of the system of internal control, this framework provides assurance regarding the quality and safety of the services that the Trust provides.

Assessment – *analysis and considerations of the options and risks*

New risks/ risks in-scope (since the last report to the Board of Directors in May 2019):
One risk continues to be in-scope:

Risk of breach of legislation and CQC regulation in respect of adherence to the Mental Health Act, potentially impacting on patient safety, safeguards and experience; likelihood of legal challenges; reputation of the Trust – rated 10 (amber). The June 2019 meeting of the Clinical Practice & Standards Sub Committee approved the terms of reference for a Mental Health Act Standards task and finish group. The group is due to meet for the first time later in September 2019 and will be developing the full risk treatment plan at this time.

Amended risk scores

The residual risk score for strategic risk 10 – *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* – has been increased to a risk score of 16 (red) reflecting the sporadic and more recently, a prolonged period of escalation to Operational Pressures Escalation Level (OPEL) 4. As of 2 September 2019, de-escalation to OPEL 3 has been achieved, as a result of implementing mitigations identified in response. Diverting capacity to achieve de-escalation of this risk has delayed receipt, by the Quality Committee, of the care group response to the previously submitted bed usage review. This will now be submitted in November 2019 and will provide additional assurance to the Quality Committee, in particular the proposed longer term recommendations that will be taken forward to sustainably reduce the Trust's OPEL level to the best it can be. In the meantime, the Operational Committee received a status update regarding this risk at its meeting on 18 September 2019 as part of ongoing monitoring.

Archived risks

The risk in-scope of *Risk that patients' privacy, dignity and safety is compromised as a result of breaches in relation to the Department of Health guidance on mixed sex accommodation* rated 9 (amber) was agreed for archive by Quality Committee at its July 2019 meeting, following discussion with the risk lead and in response to the progress with actions reported to the CQC as part of the 2018 inspection action plan. Residual elements of this risk remain and are being mitigated through the risk treatment plans for strategic risk 2 (sustaining safe and effective services within Central and Eastern Cheshire) and strategic risk 10 (pressures on acute care bed capacity).

An update on the progress with the treatment of strategic risk 1 (compliance with supervision) was reviewed by Audit Committee at its meeting on 17 September 2019. The anticipated date of the completion of the risk treatment plan was by the next meeting of the Quality Committee in November 2019; however expected assurance, via receipt of the conclusions of an internal audit review of the Trust's supervision policy, was noted as deferred at the Audit Committee meeting. This was due to the new policy being in its early stages of implementation. It was agreed to keep this internal audit on the internal audit plan, but to reschedule it for quarter 4 2019/20 and to await the assurance opinion of this audit before considering archive of this strategic risk.

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

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

Who has approved this report for receipt at the above meeting?	David Wood, Associate Director of Safe Services
Contributing authors:	Louise Brereton, Head of Corporate Affairs

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	18/09/2019

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

Appendix No.	Appendix title
1	Board assurance framework and strategic risk register

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Single Oversight Framework
Agenda ref. number:	19.20.76
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	25/09/2019
Presented by:	Tim Welch, Director of Business and Value

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 NHSI Single Oversight Framework themes this report reflects:	
Quality	Yes
Finance and use of resources	Yes
Operational performance	Yes
Strategic change	Yes
Leadership and improvement capability	Yes

CWP Quality Framework:		
Patient Safety	Safe	Yes
Clinical Effectiveness	Effective	Yes
	Affordable	Yes
	Sustainable	Yes
Patient Experience	Acceptable	Yes
	Accessible	Yes

http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No

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

REPORT BRIEFING

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

The Single Oversight Framework has recently been updated and reissued. Now applicable to both foundation trusts and CCGs, it sets out the joint approach NHS Improvement and NHS England will now take together to oversee organisational performance and identify where providers and commissioners may need support.

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

The Single Oversight Framework has been in place for a number of years setting out NHS Improvement's performance and regulatory approach to oversight of Foundation Trusts

Assessment – *analysis and considerations of the options and risks*

The key general changes are:

- As NHSE/I align their operating models to support system working, 2019/20 will be a transitional year, with NHSE/I regional teams coming together to support local systems. The existing statutory roles and responsibilities of NHSE/I in relation to providers and commissioners remain unchanged, however these roles and responsibilities will be carried out by working with and through system leaders where possible.

- In line with the move to greater autonomy for better performing local systems, oversight arrangements will reflect both the performance and relative maturity of integrated care systems (ICSs). In 2019/20 it will be for regional teams to determine the level of oversight that best meets their assurance needs.

- Four metrics have been added to the 2019/20 dataset used to identify issues at providers based on questions in the annual NHS Staff Survey covering bullying and harassment, teamwork and inclusivity.

- From 2019/20, ICSs and emerging ICSs will be increasingly involved in the oversight process and support of organisations in their system. Regional teams will use data from the metrics as well as local information and insight to identify where commissioners and providers may need support, involving system leads in this process.

A separate document has been issued setting out the specific provider approach to the implementation of the Single Oversight Framework. In line with the above, the key changes from the previous approach for providers includes the role of the local systems to support improvement and the introduction of the four staff survey metrics as additional measures of provider performance.

In line with the previous approach, the framework considers providers across the five themes of Quality of Care, Use of Resources, Operational Performance, Strategic Change, Leadership and Improvement, working in a complementary way to the CQC framework. Within the five themed areas are a number of defined metrics which are used to assess providers and help identify where providers may need additional support. Performance around these metrics determines the segmentation of the provider – this is a rating between 1(maximum autonomy) to 4 (special measures) which identifies the support needs of individual providers – CWP currently hold a segment 1 rating.

A new Oversight Framework will be developed for 2020 onwards which will be consulted on later in the year. This will incorporate the commitments from the LTP people plan and will consider the growing balance between organisational and system oversight.

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

Who has approved this report for receipt at the above meeting?	Tim Welch, Director of Business and Value
Contributing authors:	Louise Brereton, Head of Corporate Affairs.

Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued

Appendices provided for reference and to give supporting/ contextual information:	
Appendix No.	Appendix title
1	Single Oversight Framework. - https://improvement.nhs.uk/resources/nhs-oversight-framework-201920/

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Ward Daily Staffing Levels July and August 2019
Agenda ref. number:	19.20.77
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	25/09/2019
Presented by:	Gary Flockhart, 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 NHSI Single Oversight Framework themes this report reflects:		CWP Quality Framework:		
Quality	Yes	Patient Safety	Safe	Yes
Finance and use of resources	Yes	Clinical Effectiveness	Effective	Yes
Operational performance	Yes		Affordable	Yes
Strategic change	No		Sustainable	Yes
Leadership and improvement capability	Yes	Patient Experience	Acceptable	Yes
			Accessible	Yes
		http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No

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

REPORT BRIEFING

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

This report details the ward daily staffing levels during the months of July and August 2019 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 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 the options and risks*

During July 2019 the trust achieved staffing levels of 97.5% for registered nurses and 98.6% for clinical support workers on day shifts and 96.8% and 101.4% respectively on nights. During August 2019 the trust achieved staffing levels of 92.2% for registered nurses and 91.1% for clinical support workers on day shifts and 91.2% and 93.4% respectively on nights.

In the month of August 2019 Greenways experienced pressures in terms of staffing due to staff sickness, maternity leave, patients on increased levels of observations and vacancies.
Numbers of registered nurses were lower due to increased vacancies, the ward were able to implement the following measures to give assurance that the ward staffing remained safe:

- Staffing levels were monitored closely at the twice weekly staffing meetings.
- The staffing levels were escalated to the Head of Clinical Services and the Matron on a daily basis and reviewed at the end of each day to ensure RN cover was in place.
- The ward manager was included in the numbers to support the team on a regular basis.

Note: Only full shifts are covered within the percentage rates, where wards are supported for less than this, this is not captured in the return. For example if the matron spends 2 hours on the ward this is not reflected in the return, nor are the hours the multi disciplinary team who provide care to support the wards.

Appendix 1 and 2 details how all 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 has approved this report for receipt at the above meeting?	Gary Flockhart, Director of Nursing, Therapies and Patient Partnership
Contributing authors:	Charlotte Hughes, Business and Innovation Manager, Educaion CWP

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Gary Flockhart, Director of Nursing, Therapies and Patient Partnership	12.09.19

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

Appendix No.	Appendix title
1	Ward Daily Staffing July 2019
2	Ward Daily Staffing August 2019

		Day				Night				Day		Night		Safe Staffing was maintained by:
		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff						
Service Line	Ward	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 (%)	
SMH - Bed Based West & East	Adelphi	1207	1207	1169.5	1169.5	690	667	1181	1181	100.0%	100.0%	96.7%	100.0%	
	Bollin	1308.5	1285.5	1073	1038.5	614.5	614.5	808.5	808.5	98.2%	96.8%	100.0%	100.0%	
	Croft	890.5	910.2	1449	1529.5	596.6	611.1	977.3	1158	102.2%	105.6%	102.4%	118.5%	
	Beech	1308.5	1285.5	1073	1038.5	614.5	614.5	808.5	808.5	98.2%	96.8%	100.0%	100.0%	
	Cherry	1306.5	1265	1035	1018.5	586.5	540.5	908.5	897	96.8%	98.4%	92.2%	98.7%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Juniper	970	979.83	1430.25	1402.25	701.5	690	724.5	724.5	101.0%	98.0%	98.4%	100.0%	
	Willow PICU	1067.5	1067.5	1027.5	1027.5	715.5	715.5	920	920	100.0%	100.0%	100.0%	100.0%	
SMH - Forensic, Rehab, CRAC	Alderley Unit	890.5	910.2	1449	1529.5	596.6	611.1	977.3	1158	102.2%	105.6%	102.4%	118.5%	
	Maple	840	832.5	1037.5	1037.5	655.5	655.5	678.5	678.5	99.1%	100.0%	100.0%	100.0%	
	Rosewood	890.5	910.2	1449	1529.5	596.6	611.1	977.3	1158	102.2%	105.6%	102.4%	118.5%	
	Saddlebridge	980	932.5	1265	1244	690	690	759	759	95.2%	98.3%	100.0%	100.0%	
Learning Disabilities & NDD	Eastway A&T	1012.5	1012.5	1221	1221	589	589	1294.5	1294.5	100.0%	100.0%	100.0%	100.0%	
	Greenways A&T	980	932.5	1265	1244	690	690	759	759	95.2%	98.3%	100.0%	100.0%	
CYP - Tier 4 CAMHS & Outreach	Coral	1095.75	927.75	1471	1413	701.5	558	1460.5	1387	84.7%	96.1%	79.5%	95.0%	Nursing staff working additional unplanned hours. Cross cover arrangements. Ward Manager and Multi Disciplinary Team actively worked within the staffing establishment.
	Indigo	890.5	910.2	1449	1529.5	596.6	611.1	977.3	1158	102.2%	105.6%	102.4%	118.5%	
SMH - Bed Based Wirral & PICU	Brackendale	1091	1056.5	1233.5	1222	644	644	824.5	814.5	96.8%	99.1%	100.0%	98.8%	
	Brooklands	1067.5	1067.5	1027.5	1027.5	715.5	715.5	920	920	100.0%	100.0%	100.0%	100.0%	
	Lakefield	1067.5	1067.5	1027.5	1027.5	715.5	715.5	920	920	100.0%	100.0%	100.0%	100.0%	
	Meadowbank	1297	1297	2026.95	2026.95	582.5	582.5	1563.5	1563.5	100.0%	100.0%	100.0%	100.0%	
	Oaktrees	1224.25	1224.25	1014	1014	645	645	578.5	578.5	100.0%	100.0%	100.0%	100.0%	
	Trustwide	22278.05	21702.28	25737.5	25318.7	12546.1	12115.6	20382.4	20647.4	97.5%	98.6%	96.8%	101.4%	

		Day				Night				Day		Night		Safe Staffing was maintained by:
		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff						
Service Line	Ward	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 (%)	
SMH - Bed Based West & East	Adelphi	1034	1013.25	1343	1310.5	713	701.5	736	690	98.0%	97.6%	98.4%	93.8%	
	Bollin	1115.25	1115.25	1122	1122	599	599	966	966	100.0%	100.0%	100.0%	100.0%	
	Croft	1223.5	1223.5	1390	1384.5	632	620.5	1430.5	1430.5	100.0%	99.6%	98.2%	100.0%	
	Beech	1185.5	932.5	1480	1330.5	679.5	622	1200	1188.5	78.7%	89.9%	91.5%	99.0%	Nursing staff working additional unplanned hours. Cross cover arrangements. Ward Manager worked within the staffing establishment.
	Cherry	1088.4	881.4	1329	1307	677.9	646.4	1023.5	911.5	81.0%	98.3%	95.4%	89.1%	Nursing staff working additional unplanned hours. Cross cover arrangements. Ward Manager and Multi Disciplinary Team actively worked within the staffing establishment.
	Juniper	1057.25	1057.25	1068.25	1068.25	731	731	920	920	100.0%	100.0%	100.0%	100.0%	
	Willow PICU	754	754.25	1021.5	1021.5	505.9	494.5	1004	1004	100.0%	100.0%	97.7%	100.0%	
SMH - Forensic, Rehab, CRAC	Alderley Unit	1274	1229	1096.5	1096.5	636.5	645	893	893	96.5%	100.0%	101.3%	100.0%	
	Maple	1275.75	1275.75	1828.75	1828.75	657.5	657.5	1436.5	1436.5	100.0%	100.0%	100.0%	100.0%	
	Rosewood	1085	1009	1368.5	1346.5	644	598	942.6	942.6	93.0%	98.4%	92.9%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements. Ward Manager worked within the staffing establishment.
	Saddlebridge	754	754.25	1021.5	1021.5	505.9	494.5	1004	1004	100.0%	100.0%	97.7%	100.0%	
Learning Disabilities & NDD	Eastway A&T	1188.5	1051.5	1934.5	1603	713	621	1564	1555	88.5%	82.9%	87.1%	99.4%	Nursing staff working additional unplanned hours. Cross cover arrangements. Ward Manager worked within the staffing establishment.
	Greenways A&T	782	873.95	1138.3	774.1	666.8	529.8	759	822	111.8%	68.0%	79.5%	108.3%	Nursing staff working additional unplanned hours. Cross cover arrangements. Ward Manager and Multi Disciplinary Team actively worked within the staffing establishment.
CYP - Tier 4 CAMHS & Outreach	Coral	1273	1215.5	1390	1269.5	713	701.5	1426	1376.5	95.5%	91.3%	98.4%	96.5%	
	Indigo	1231.5	1231.5	1076	1024	682.5	556	938.5	777.5	100.0%	95.2%	81.5%	82.8%	Nursing staff working additional unplanned hours. Cross cover arrangements. Ward Manager and Multi Disciplinary Team actively worked within the staffing establishment.
SMH - Bed Based Wirral &	Brackendale	858.25	858.25	1401.5	1401.5	623	623	1400.5	1400.5	100.0%	100.0%	100.0%	100.0%	
	Brooklands	967	977.05	1115.5	1115.5	586.5	586.5	644	644	101.0%	100.0%	100.0%	100.0%	
	Lakefield	1387.5	1387.5	894.25	894.25	682.5	682.5	617.5	617	100.0%	100.0%	100.0%	99.9%	

PICU	Meadowbank	867.5	881.5	1242	1242	506	517.5	1000.5	1000.5	**101.6%**	**100.0%**	**102.3%**	**100.0%**	
	Oaktrees	1224.25	1224.25	1014	1014	645	645	578.5	578.5	**100.0%**	**100.0%**	**100.0%**	**100.0%**	
	Trustwide	20771.9	20080.3	24401.05	23301.35	12190.1	11673.7	19902.6	19576.1	**92.2%**	**91.1%**	**91.2%**	**93.4%**	

Cheshire and Wirral Partnership
NHS Foundation Trust

Report subject:	Learning from Experience report – trimester 1 2019/20 (incorporating an update on the national Learning from Deaths framework)
Agenda ref. no:	19.20.79
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and approval
Date of meeting:	25/09/2019
Presented by:	Gary Flockhart, Director of Nursing, Therapies & Patient Partnership

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

1. Situation

This Learning from Experience report aggregates qualitative and quantitative analysis from key sources of feedback from people who access and deliver the Trust's services, and other relevant sources of learning, covering the period from April 2019 to July 2019, trimester 1 of 2019/20. The report compares current performance across a four trimester time series to mitigate seasonal variations, whilst also facilitating the identification of potential triggers to detect and prevent incidents by comparing current performance with the previous trimester. The in-depth Learning from Experience report received by the Quality Committee uses Statistical Process Control (SPC) charts to help with more effective and visual depiction of learning from experience and identification of recommendations, as well as to alert, as part of an early warning framework, any emerging trends.

2. Background – Key performance indicators

2.1 Performance indicators

Performance indicator			2018/19			2019/20
			T1	T2	T3	T1
Number of safety incidents reported			3370	3331	3551	**3708**
Number of safety incidents by speciality	*Inpatient*		*2317*	2160	*2316*	***2313***
	Community physical health		*572*	577	*666*	***764***
	Community mental health		*424*	556	*534*	***587***
	Other		*57*	38	*35*	***44***
Reports to external agencies	StEIS		38	37	39	**35**
	National Reporting & Learning System		1469	1645	1720	**1910**
	NHSR	Non clinical	2	0	5	**4**
		Clinical	0	0	2	**1**
Number of complaints			74	93	105	**70**
Number of compliments			1041	1046	1019	**1095**

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

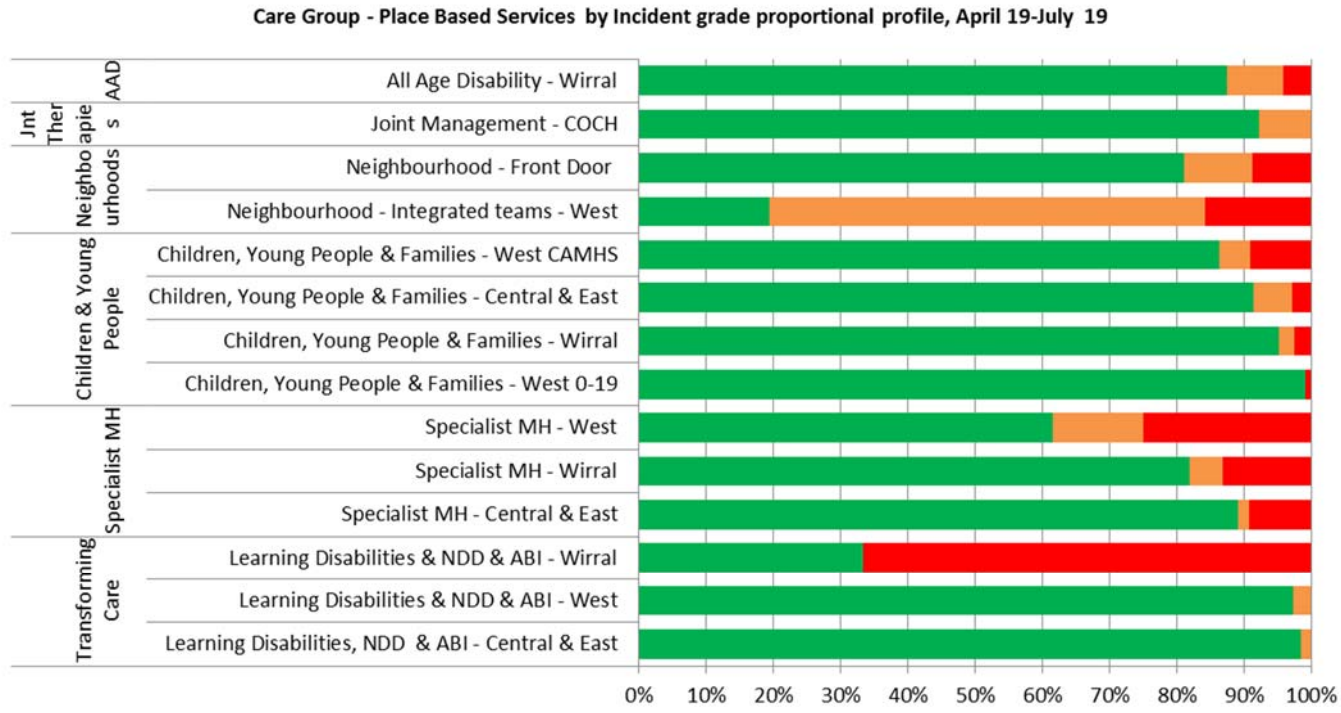
2.2 Proportional reporting performance indicators – Incident reporting

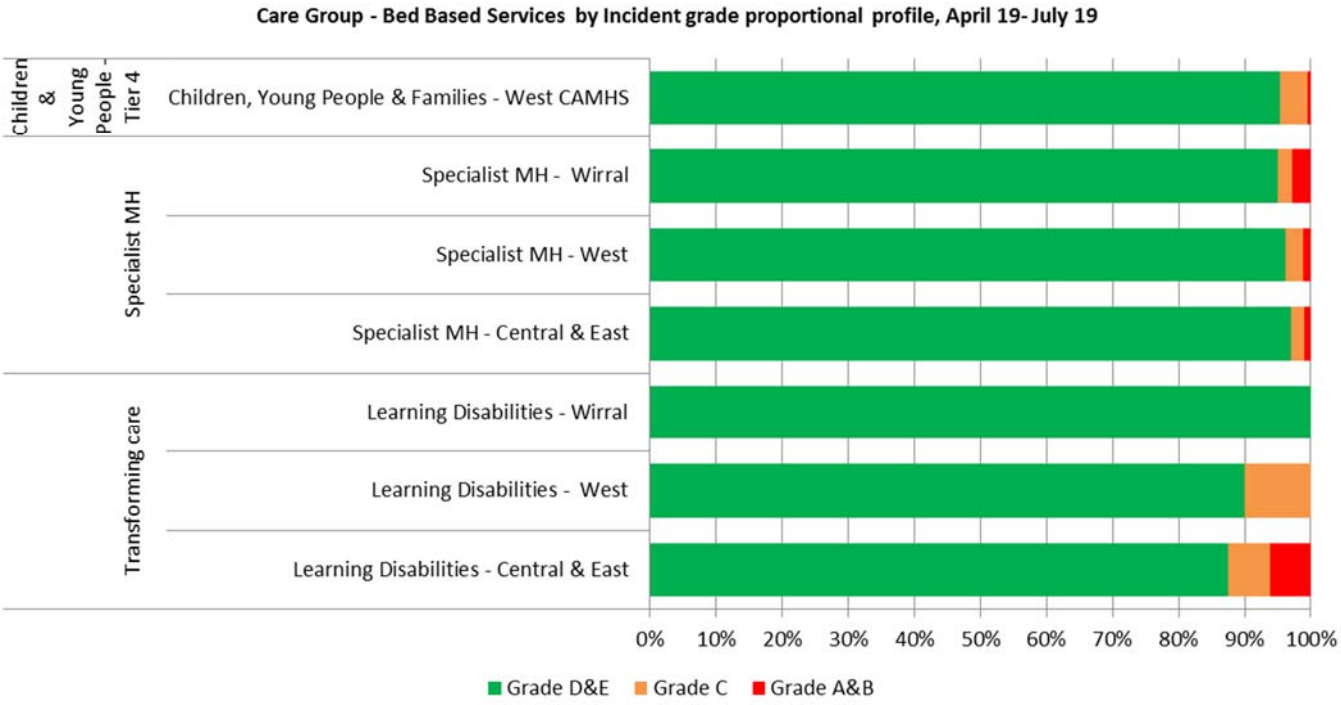
"Proportional reporting" of incidents measures incidents against the care group. This approach was taken following a Quality Account aspiration to develop how CWP measures incident reporting profiles – for example:

- Neighbourhood integrated care teams' reporting profiles (as evident in the chart below) are influenced by pressure ulcer incident reporting because of the way they are reported as (currently) required nationally.
- Learning Disability services (Wirral) reported a low number of incidents in trimester 1, 2019/20 (three). Two of these were reported as unexpected deaths; natural causes suspected, but both incidents are reportable to the LeDeR mortality programme.

By presenting the incident reporting profiles in this way, the charts reveal fundamental differences between the care groups that can be used to identify where focus is needed to reinforce the that reporting no or lower harm incidents promotes learning to be able to potential mitigate future actual or significant harm incidents.

The charts below show a proportional split of incident grade per care group. This illustrates the differences in severity of incident occurrence and can further inform potential opportunities for both Service Improvement and Quality Improvement activity.





3. Analysis

3.1 Incident reporting

Overall, the number of incidents reported this trimester internally via the Trust's incident reporting system is the highest of the past four trimester period, with all specialities bar inpatient services (a minimal reduction of three incidents from last trimester's 2316 incidents) contributing to this increase. CWP continues to promote incident reporting, in line with best evidence, which shows that this is an indicator of patient safety being an organisational priority.

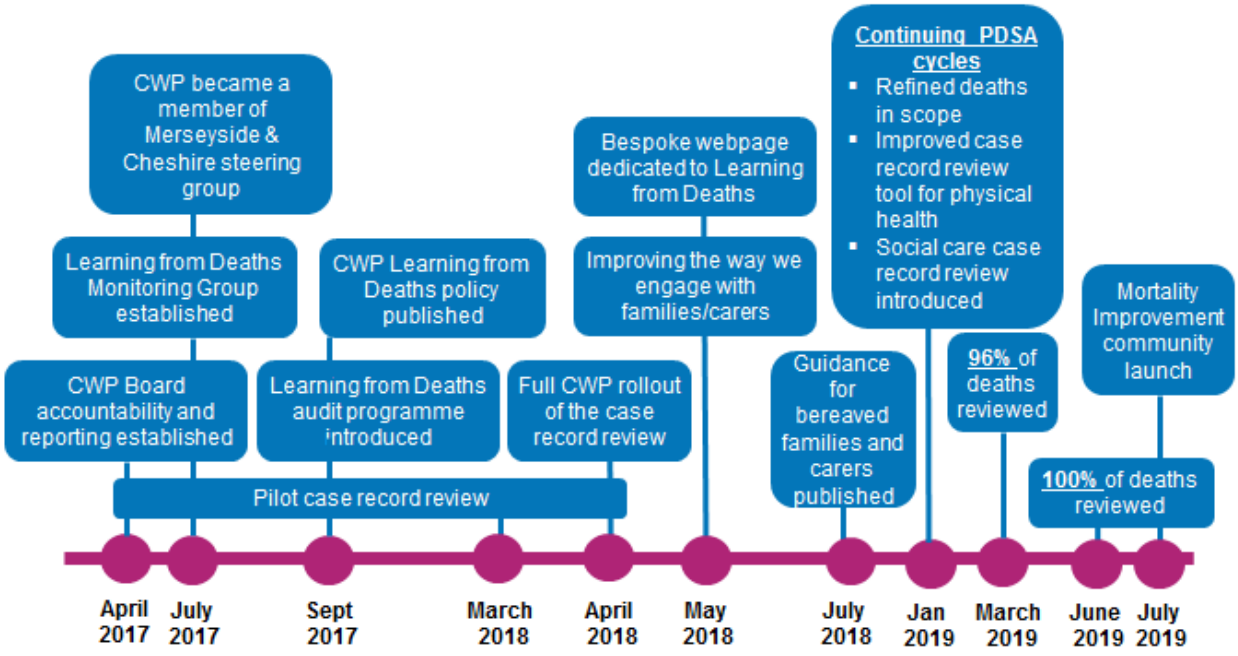
3.2 NHS Patient Safety Strategy

NHS England and NHS Improvement published the NHS Patient Safety Strategy in July 2019. It is recognised that more can be done to share safety **insight** and, through **involvement**, empower people (patients and staff) with the capability to **improve** safety. Addressing these challenges will enable the NHS to achieve its safety vision: *to continuously improve patient safety*. To do this, the NHS will build on two foundations: a **patient safety culture** and a **patient safety system**. Elements of the in-depth Learning from Experience report received by the Quality Committee have been reviewed to align to the strategic

aims of this NHS strategy and this will evolve over time. The Quality Committee will receive a presentation at its November 2019 meeting on the Trust's patient safety strategic delivery plan.

3.3 Learning from deaths monitoring and engaging with bereaved families and carers

CWP milestones since the launch of the Learning from Deaths national guidance 2017:



During trimester 1 2019/20, a multidisciplinary group of NHS staff across the North West attended the first mortality improvement community workshop launched by AQuA in July 2019. Each organisation spent time value stream mapping the current learning from deaths state and compared variations, with a view to bringing about continuous improvement across the region. As detailed in the timeline above and the table below, clinical teams are to be congratulated for having achieved, during trimester 1 2019/20 a **review of 100% of deaths reported to the Trust**.

Mortality monitoring*	2018/19			2019/20
	T1	T2	T3	T1
Inpatient deaths	1/ 100%	1/ 100%	4/ 100%	**1/ 100%**
Deaths reported to the Trust/ subject to a case review record	344/ 37%	334/ 60%	302/ 80%	**205/ 100%**
Deaths reported as a serious incident/ subject to a serious incident investigation	21/ 100%	19/ 100%	22/ 100%	**19/ 100%**

*For serious incidents, investigatory performance is 100%

3.4 Learning from inquests

The Trust received two Regulation 28 reports this trimester. One report was issued in relation to ensuring that those who carry out mental health assessments have regard to how a mental disorder manifests in a patient. A Grand Round for all clinicians will be held in September 2019 to share learning from this report. Another report was issued to a number of organisations concerning discharge planning, the Trust has drafted a response ready for the 56 day timeframe.

3.5 Learning from national external reviews and investigations in other trusts

As well as learning from our own experience, the Trust welcomes the opportunity to learn from reviews and investigations undertaken externally to the Trust. There were two external investigations of services provided by other trust noted this trimester. One report by the Parliamentary Health Service Ombudsman related to significant failings in the care and treatment provided to two vulnerable men at North Essex Partnership University NHS Foundation Trust. The report found insufficient serious incident investigations and learning from incidents that did not appear to have prevented mistakes from reoccurring. One report issued by the Healthcare Safety Investigation Branch (HSIB) connected to another trust identified incidents relating to the incorrect prescribing of warfarin (an anticoagulant) via ongoing monitoring of NHS incident

reporting systems. The summary of recommendations identified in section 4.5 below describes the next steps identified to enable CWP to identify and implement transferable learning.

4. Recommendation

Recommendations from Trimester 1 analysis

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

4.1 The Clinical Governance team to review the incident reporting and management policy in preparation for the publication of the Patient Safety Incident Response Framework and to ensure alignment with the NHS Patient Safety Strategy.

4.2 A task and finish group to be developed, with involvement of people with lived experience, to identify further quality improvement work for this year in relation to learning from deaths and engaging with bereaved families and carers. A self-assessment against the National Quality Board guidance will be undertaken to determine progress to-date and to identify further improvements against the standards set out in this guidance.

4.3 The Clinical Governance team to develop a survey to ascertain how the Learning from Experience report can be developed further to support the sharing and integration of learning from complaints, incidents, inquests and compliments.

4.4 The Clinical Governance team to develop systems to flag index learning from claims to be incorporated into ongoing quality improvement work.

4.5 The themes arising from external reviews and investigations of other trusts identified in the Parliamentary Health Service Ombudsman (PHSO) report should be incorporated into the quality improvement work around medicines management, clinical risk assessment, restrictive practices, admission and discharge processes and sexual safety. Care Groups to discuss the case studies in the PHSO report through the learning from experience meetings and make local recommendations to highlight areas of/ for improvement.

4.6 Engagement of medics and line managers, to address prescribing errors through the promotion of reporting incidents, to be monitored by the Medicines Management Group.

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

Clinical support service teams have been asked to:

- Review the findings and key analysis within the report and identify any changes for improvement required to their enabling work programmes.

Clinical services have been asked to:

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

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

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

Who/ which group has approved this report for receipt at the above meeting?	Gary Flockhart, Director of Nursing, Therapies & Patient Partnership
Contributing authors:	Lisa Parker, Incidents Manager David Wood, Associate Director of Safe Services

Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
2	Board of Directors	17/09/2019

Appendices provided for reference and to give supporting/ contextual information:	
Appendix number	Appendix title
1	Updates and assurances received against trimester 3 2018/19 recommendations

Appendix 1 – Updates and assurances received against trimester 3's recommendations

Safe Services to work with the Learning from Experience meetings to build capability in (i) sharing learning across via the Learning from Experience report and the Patient and Carer Experience Sub Committee; and (ii) reporting, by exception to the Clinical Practice & Standards Sub Committee, on improvement work being taken to address any identified gaps in the definition of clinical standards and/ or their application of them through building clinical practice capability.
The locality Learning from Experience meetings are transitioning into meeting by Care Group. The Head of Clinical Governance is supporting the Care Groups to focus learning from experience meetings around systems and culture to further integrate learning to ensure outputs are escalated through the governance structure. The Associate Director of Patient and Carer Experience has agreed to strengthen the review of the Learning from Experience report through the Patient and Carer Experience Sub Committee. The Quality Surveillance Specialists represent Safe Services at the Learning from Experience meetings and are supporting the Care Groups to ensure consistency.
Head of Clinical Governance to develop a checklist to ensure appropriate standards have been met throughout the investigation and final report. The checklist will be piloted with the governance teams who support the care groups to ensure a consistent approach.
The Head of Clinical Governance and Medical Director are developing a quality assurance process based on the standards outlined by the Royal College of Psychiatrists. Specialist Mental Health (Place Based) have agreed to pilot the new template to ensure the principles within the NHS Patient Safety Strategy are encompassed.
Patient experience and complaints teams to explore corporate systems to best capture all compliments received to ensure externally we don't under-report compliments and continue to be able to learn from what works well, whilst not increasing the burden on staff to report.
The Patient and Carer Experience Sub Committee has supported the Care Groups to create gratitude boards which is being promoted in the Communication & Engagement Team publication 'The Pulse' which shows real-time feedback from people who access services. Data is collected from compliments and for the friends and family tests. During trimester 1 2019/20, the Quality Surveillance team has supported Care Groups by displaying compliment wordles.
The learning from deaths monitoring group to consider CQC findings within the Learning from deaths: A review of the first year of NHS trusts implementing the national guidance report. A self-assessment will be undertaken to enable any gaps identified to continuous improvement plans
Details are provided in section 3.3. In addition to this, a task and finish group of the Patient and Carer Experience Sub Committee is due to meet in September 2019 to develop an improvement plan and to achieve the Trust's Quality Account priority 2019/20 regarding 'Improvement in engagement with bereaved families and carers'.

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Quality Improvement Report, Edition 1 (2019/20)
Agenda ref. number:	19.20.80
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	25/09/2019
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 NHSI Single Oversight Framework themes this report reflects:	
Quality	Yes
Finance and use of resources	No
Operational performance	Yes
Strategic change	Yes
Leadership and improvement capability	Yes

CWP Quality Framework:		
Patient Safety	Safe	Yes
Clinical Effectiveness	Effective	Yes
	Affordable	Yes
	Sustainable	Yes
Patient Experience	Acceptable	Yes
	Accessible	Yes

http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	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 is one of many reviewed by the Trust's Board of Directors that, together, give a detailed view of CWP's overall performance in relation to quality. The report highlights and showcases the innovative quality improvement projects being undertaken by staff throughout the organisation. The report is produced three times a year and this is the first of 2019/20.

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

The Quality Improvement reports are produced three times a year to update people who access and deliver the Trust's services, carers, the public, commissioners, internal groups, and external scrutiny groups on progress in improving quality across our services. The Trust is required to formally report on our quality improvement (QI) priorities in the annual Quality Account. The QI report provides a highlight of what CWP is doing to continuously improve the quality of care and treatment that its services provide.

Assessment – *analysis and considerations of the options and risks*

The report provides the progress against the three Trustwide QI priorities for 2019/20:

- The **patient experience** priority to improve engagement with bereaved families and carers.
- The **clinical effectiveness** priority to improve access to physiological therapies.
- The **patient safety** priority to reduce the severity of the harm sustained by those people accessing CWP services that cause harm to themselves.

Further, this Quality Improvement Report provides a highlight of what CWP is doing to continuously improve the quality of care and treatment that its services provide, including how efforts to build QI capability as part of the Trust's QI strategy are having an impact. Examples of Quality Improvement (QI) projects across all the domains of the CWP 'quality framework', as detailed below.

Delivering **'Safe'** and **'Effective'** care:

- Reduction in AWOL incidents from Beech ward requiring Police involvement
- Implementing Dialectical Behaviour Therapy (DBT) reducing self-harm and suicidality in the community
- Macmillan Community Palliative Care Team providing a hospice based Strength & Balance Class to prevent falls
- Development of Journeygrams – visual pictures of a person's journey through CWP teams and wards

Delivering '**Affordable'** care:

- New Leaf employment advisors, integrated into community mental health teams, work with over 150 people to help them gain competitive employment
- Liaison Psychiatry Wirral service providing training to Arrowe Park Hospital staff to increase mental health awareness
- Implementation of Values Based Recruitment (VBR) across CWP seeing an increase in quality in good quality candidates

Delivering **'Sustainable'** care:

- Education CWP have created the "CWP Virtual Academy" for a faster, higher quality and more user friendly e-learning experience

Delivering **'Acceptable'** and **'Accessible'** care:

- The Poppy Factory supporting veterans with health conditions into work
- 'Doing What Matters' – introduction of an Acceptance and Commitment Therapy group for young people at Ancora House
- New, innovative Nurse-led CWP Community Erectile Dysfunction Service eases pressures on secondary care

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

The Board of Directors is asked to **note** the assurance provided in relation to the delivery of quality improvement and to **approve** this report.

Who has approved this report for receipt at the above meeting?	David Wood – Associate Director of Safe Services
Contributing authors:	Agata Lewis – Patient Safety Improvement Lead

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	18/09/2019

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

Appendix No.	Appendix title
1	Quality Improvement Report, Edition 1 2019/20

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Quality Improvement Report

Edition 1
April 2019 – July 2019

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

New Leaf employment advisors, integrated into community mental health teams, are working with over 150 people to help them gain competitive employment
(see page 10)

Welcome to CWP's first *Quality Improvement* Report of 2019/20

These reports are produced three times a year, this being the first edition of 2019/20, to update people who access and deliver our services, carers, the public, commissioners, internal groups, and external scrutiny groups on progress in improving quality across our services. We are required to formally report on our quality improvement priorities in the annual *Quality Account*.

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

CWP's *Quality Account* and *Quality Improvement Report*s are available via:
http://www.cwp.nhs.uk/resources/reports/?ResourceCategory=2335&Search=&HasSearched=True

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

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

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

This *Quality Improvement Report* provides a highlight of what CWP is doing to continuously improve the quality of care and treatment we provide. It also provides examples of Quality Improvement (QI) projects.

Implementation of our new Quality Improvement strategy commenced in April 2018. Phase 1 of the strategy stretches across three years and describes how our people and teams who deliver and support the delivery of our services will work together to create a culture where QI can flourish.

EXECUTIVE SUMMARY
QUALITY IMPROVEMENT HEADLINES THIS EDITION

Improvements have resulted in a successful reduction in AWOL incidents from Beech ward requiring Police involvement
⇨See page 6

Implementing Dialectical Behaviour Therapy (DBT) has reduced self-harm and suicidality in the community
⇨ See page 7

Macmillian Community Palliative Care Team are providing a hospice based Strength & Balance Class to prevent falls
⇨See page 8

Journeygram – creation of a visual picture of a patient's journey through CWP teams and wards
⇨See page 9

New Leaf employment advisors, integrated into community mental health teams, have worked with over 150 people to help them gain competitive employement
⇨See page 10

Education CWP have created the "CWP Virtual Academy" for a faster, higher quality and more user friendly e-learning experience
⇨See page 11

Liaison Psychiatry Wirral service have provided training to Arrowe Park Hospital staff to increase mental health awareness
⇨See page 13

Implementation of Values Based Recruitment (VBR) across CWP sees improvement in the quality of people recruited
⇨See page 14

The Poppy Factory is providing support to Veterans with health conditions into work
⇨See page 15

Doing what Matters' – introduction of an Acceptance and Commitment Therapy group for Young People at Ancora House
⇨See page 16

New, innovative Nurse-led CWP Community Erectile Dysfunction Service eases pressures on secondary care
⇨See page 17

QUALITY IMPROVEMENT PRIORITIES

We have set three **Trustwide QI priorities** for 2019/20, which reflect our vision of "**working in partnership to improve health and well-being by providing high quality care**". They are linked to our Trust strategic objectives, and reflect an emphasis on **patient safety**, **clinical effectiveness** and **patient experience**. We have made a commitment in our *Quality Account* to monitor and report on these goal driven measures in our *Quality Improvement Report*s.

The **patient safety** QI priority identified for this year is:

To reduce the number of incidents of people accessing CWP services that have caused harm to themselves

We want to:

Reduce, Trustwide, incidents of severe or moderate self-harm – because the negative impact of self-harm on people and their families can be life-changing and is also associated with a higher risk of suicide.

The following describes our achievements in progressing with this priority:

- ✓ Continued to facilitate an expert group to lead this project and to ensure robust oversight.
- ✓ Agreed amendments with our Safe Services team colleagues to improve incident reporting processes.
- ✓ Continued to present at Clinical Networks and QI events to promote this project and gather feedback from staff.
- ✓ Continued the self-harm strategic steering group, collaborating closely with other related initiatives such as suicide prevention.
- ✓ In-depth analysis undertaken of self-harm data to identify themes and specific areas/ opportunities for improvement.
- ✓ Initiated use of Safety Crosses to plot incidents.

Last year, we made significant progress in reducing moderate and severe incidents of self-harm, achieving a commendable **12% reduction**. We have increased the profile of self-harm within the organisation and continuous improvements are being seen as a result, which is why we are going to continue with this priority this year too. Furthermore, we now established a clinical expert panel, with the strategic aim of eliminating the use of unwarranted restrictive interventions. The panel has identified this critical QI project as an interdependent workstream.

For more information, please contact Marjorie Goold, Consultant Nurse CAMHS, on 01244 397623 or Kate Baxter, Patient Safety Improvement Manager, on 01244 397410

The **clinical effectiveness** QI priority identified for this year is:

To improve access to psychological therapies for people accessing acute care services
(this priority will also aim to improve access for people accessing community and primary care services)

We want to:

Reduce the gaps and variation in the current psychological therapeutic offer to people accessing care across each inpatient unit – because by using a range of therapeutic interventions, people accessing our services are more actively able to participate in their treatment and recovery, thus reducing length of stay, improving their experience and achieving better outcomes.

The following describes our achievements in progressing with this priority:

- ✓ Our Specialist Mental Health care group presented a number of options for a psychological therapies model to our Quality Committee.
- ✓ The Quality Committee supported the care group's approach to identifying a preferred clinical model, by considering the benefits realisation of each option.
- ✓ The care group has identified a preferred clinical model for delivery of psychological support to the wards, funding is in the process of being identified to operationalise the clinical model.

For more information, please contact Beccy Cummings, Service Improvement Manager, at rebecca.cummings1@nhs.net

The patient experience QI priority identified for this year is:

To improve engagement with bereaved families and carers

We want to:

Reduce the variation in the current levels of engagement with bereaved families and carers by using the Always Events ® methodology to ensure our commitment to listening to and working with them to ensure that we provide support in the best and right way through their bereavement.

The following describes our achievements in progressing with this priority:

✓ Our Patient and Carer Experience Sub Committee is developing a task and finish group, with involvement of people with liuved experience, to identify further quality improvement work for this year.
✓ We have identified that we will undertake a self assessment against the National Quality Board guidance, to determine progress to-date and to identify further improvements that we can make against the standards set out in this guidance.
✓ We are developing an improvement plan for delivery by the end of March 2020.

This project is a continuing national priority, so we will continue this year with our QI approach, ensuring that true co-production is realised and sustained. The overarching principle is to offer bereaved families and carers with information that is as person-centred and supportive as possible, ensuring they are able to provide feedback on their experiences in order that we can learn and improve.

For more information, please contact Cathy Walsh, Associate Director of Patient and Carer Experience, on 01244 393173

QUALITY IMPROVEMENT PROJECTS

Patient Safety Improvements

Delivering *Safe* care

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

Reduction in AWOL incidents from Beech ward requiring Police involvement

Background:

Beech ward is a 22 bedded ward based within Bowmere Hospital in Chester. It is an open age, acute mental health ward. The initial purpose of the project was to reduce incidents of people being AWOL (Absent Without Leave) and in doing so to reduce the involvement of emergency services in helping return people to the ward.

What did we want to achieve?

Our previous system was a signing out sheet, which was not used properly and did not provide sufficient information should a person not return when expected. We therefore sought to redesign our signing out process that allowed staff to collect the necessary information. We wanted people to have contact with staff prior to leaving the ward. This contact would concurrently ensure that people received a risk assessment, and assure staff that individuals were able to keep themselves safe whilst away from the ward.

What we did:

To begin with, we discussed the aim of the project with people accessing care on Beech ward, we were clear that it was not designed to be restrictive. Firstly, we redesigned the sheet, to enable it to be person-centred. Using the Trust's therapeutic observations policy signing out sheet as a guide, we sought to make the interaction between staff and inpatients more meaningful. The first section of the form is completed by qualified staff who carry out an assessment of the person's mental state, where they are going, for how long and expected time of return including what they are wearing. Staff and inpatients then sign out and sign in on return. The second part of the sheet is a continuation, updating the person's mental state and what they are wearing (whether it has changed or not). The expectation is that people do not leave the ward before they have spoken to staff and signed out.

Results:

We have found that people are happy to speak to staff and sign out before leaving the ward and are usually patient when the ward is busy. Some people have left the ward without signing out, but did speak to staff before leaving the ward. If a person does not return in time, there is a clear marker for when they were last seen and a shorter time delay in carrying out a search of the Hospital grounds and surrounding areas, often negating the need to inform emergency services. Overall there has been a 32% reduction in the number of AWOL incidents reported to the Police in the 6 months since we implemented the project compared to the previous 6 months. The cost saving has been reduced time for staff spent in reporting to the Police. Inpatients have stated that it gives them an extra connection with staff, which is an opportunity to raise questions they may have.

Next steps:

Next steps are to further modify the signing out sheet to include a prompt for staff to ask people if they have brought restricted items back to the ward such as illicit substances, alcohol or ignition sources for themselves or others. This will support a safer ward environement and safeguard people who are at risk of harm from others.

For further information, please contact Aoife Coyne, Ward Manager, Beech Ward, at a.coyne1@nhs.net

Implementing Dialectical Behaviour Therapy (DBT) reduces self-harm and suicidality in the community

Background:

One of the most common identifying features of personality disorder is risk taking behaviour such as intentional self-harm and suicidality, which in some instances, will result in death by suicide. The purpose of the Dialectical Behaviour Therapy (DBT) team in West Cheshire is to provide people accessing primary and secondary care with specialist psychological therapeutic support, as recommended by NICE.

What did we want to achieve?

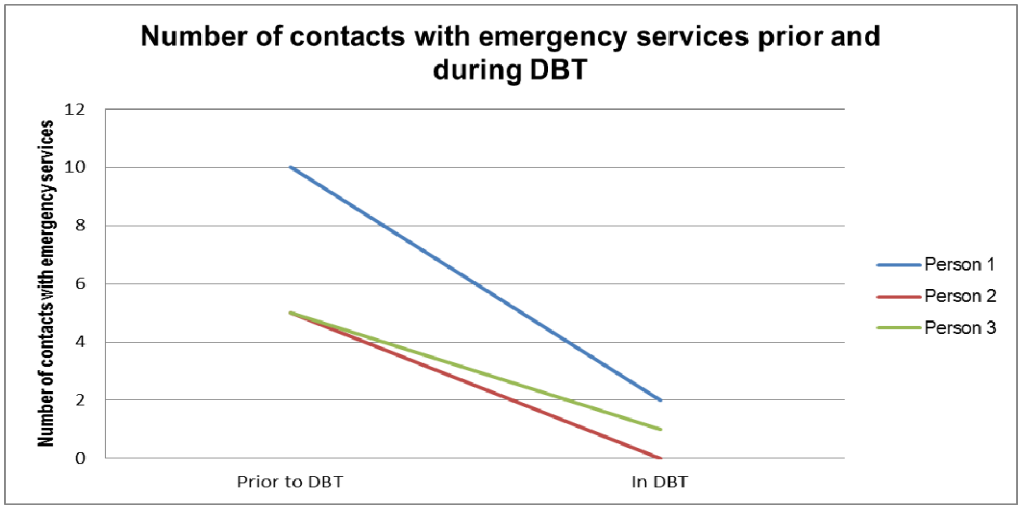
The aim of providing DBT is to reduce the occurrence of risk taking behaviours with the people we work with. We wanted to do this by delivering individual therapy, skills training and telephone coaching. The overall goal is to help people to change behaviour and their emotional thinking, interpersonal patterns associated with problems in living, and reduce life threatening behaviours.

What we did:

In the last year, a number of staff from different teams have offered time aside from their usual clinical work to ensure the delivery of this programme. This has consisted of a combination of weekly individual psychotherapy, skills training groups, therapist consultation and telephone coaching. The small team of staff have worked hard to deliver skills training sessions for people across West Cheshire who wish to engage with treatment in the community. We recruited an Honorary Assistant Psychologist to provide adaptations that can be made for people who meet criteria for Autism Spectrum Disorders as well as Personality Disorder. A person with lived experience representative has helped to support the skills training groups, providing people accessing our services with a perspective from someone who has benefitted from the strategies taught.

Results:

Self-harm and suicide attempts are tracked weekly. The below graph also shows how people presenting with self-harm are engaging with emergency services less as a result of accessing DBT. Current data tracking for the three people, below, indicates costs savings for CWP of at least £54,801.



Firstly, thank you for listening... really listening. For so many years before I met you my existence, for the most part was just painful.

I didn't think I'd verbally do justice to the amount you have helped me and the difference in my life between now and two years ago, I hope this letter portrays at least some of the changes as for the first time in my life I feel as though I'm living rather than surviving.

Next steps:

The intention is to share the outcome data with other interested professionals through the Personality Disorder clinical network day and to present the data at the next annual DBT conference.

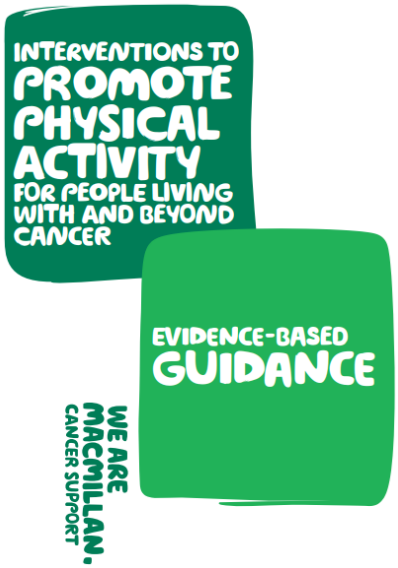
For more information, please contact Dr Katie Thomas, Clinical Psychologist, West Cheshire DBT Team, at katie.thomas14@nhs.net

Macmillian Community Palliative Care Team provide a hospice based Strength & Balance Class to prevent of falls

Background:

Our Macmillan Community Palliative Care Team provides patient advocacy, support and information about cancer treatments and the disease process. The team also gives advice on complex symptom control and provides support in future care planning, including Occupational Therapy and Physiotherapy.

What did we want to achieve?



To provide a regular class for a group of people to access in a community venue.To target a group of people at risk of falls, who have limited access to third sector services due to their complex health needs.
To maintain and/ or improve their strength, balance, mobility and general well-being.

What we did:

The Care Team arranged an appropriate time and day for the class with the Hospice. The programme and class structure was designed around appropriate exercise programmes depending on individual need. An appropriate pilot cohort of people were invited to participate. One of the team's main learning points was recognised the vast variation of patient morbidities, which prompted further re-modelling of the class structure.

Results:

The classes were well received, many giving positive feedback. The team have found that the programme has provided cost saving as it enabled them to see 6 people in an hour, reducing the travel and clinical time of seeing people in the community. Subsequently, the team also found that the programme aided the **prevention of falls** and facilitated **early identification of physical, social, psychological and environmental needs** of people with complex needs. It also encouraged **collaborative working with the hospice for signposting to their services and vice versa**. Consequently, there was a natural evolvement of carers engaging on a social level whilst their people they cared for attended the class.

I do not worry about falling now, due to improved balance

I do not worry about falling now, due to improved balance

Class keeps me motivated and maintains my fitness

I feel very happy coming and seeing other carers when my partner is in the class – I have made new friends

Next steps:

Moving forward, the team aims to continue to evaluate the class due to its popularity and consider offering more specialised classes for different age ranges and conditions. Programme promotion will continue, particularly aiming to target and engage people who are at a level where third sector services are no longer appropriate.

For more information, please contact Gemma Coombes, Physiotherapist on gemmacoombes@nhs.net or Celene Morgan, Therapy Assistant, on celene.morgan@nhs.net

Journeygram – a visual picture of a person's journey through CWP teams and wards

Background:

Our Medical Director (Executive Lead for Quality) shared a news article from the Nuffield Trust about an approach to visualise 'patient journeys'. Whilst there are data access restrictions to NHS activity other than within CWP, Bev Tudor, one of the leads for the Quality Surveillance Team (pictured left), recognised that an adaption of this approach to show all CWP engagement and treatment within services in one view was a new concept. A new charting tool to illustrate a patient journey through CWP teams and wards, showing spells, episodes and community contacts using visualisation techniques and accompanying spot analysis, was developed.

What did we want to achieve?

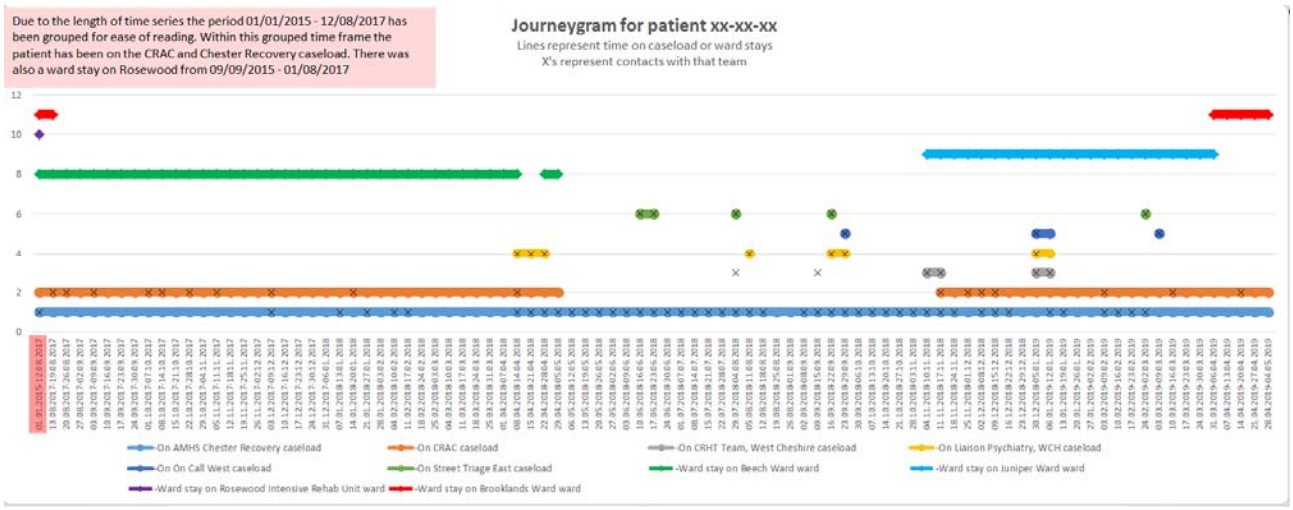
Bev wished to adapt the findings in the Nuffield Trust article to show a person's journey with CWP in a visual way. This way of representing data aims to establish patterns of engagement and other intelligence quickly, subsequently, this could aid future care planning for that particular person. There was a consultation with the Performance & Information team to discuss creation of this report. Unfortunately this was stalled due to current server design. However, Bev and Michael Croman (Quality Surveillance Officer, pictured right) used some lateral thinking and were able to devise an alternative method to deliver an Excel version.

What we did:

The first use of a journeygram supported a 'collective crisis response' meeting. This combined Inpatient, Liaison Psychiatry, Consultant, Psychologist, Community Mental Health Team, Home Treatment Team and social services representatives to pool knowledge and identify how different CWP teams could integrate to meet people's complex needs. Glenda Bryan, Head of Clinical Services feedback was very complimentary, stating that the visualisation technique gave details previously unseen.

Results:

The first journeygram revealed a gap from CAMHS to Adult services, that resulted in an urgent GP referral. An approach was outlined including flexibility built into the crisis management plan for short admissions of up to 72 hours to circumvent some of the known behaviour escalation and subsequent admission/ assessment procedures. Other journeygrams have shown multiple community activity whilst a person was admitted, a person's increasing involvement with crisis teams after discharge from a rehabilitation ward, and a person with a consistent spell under CAMHS and then shorter and frequent spells under Adult services. As the journeygram is an illustration of one patient's journey, the results from each journeygram will be different.



Next Steps:

The 'collective crisis response' meeting requests new monthly journeygrams to support planning for people with complex needs. A recent request was for a person accessing community services who makes excessive telephone calls to multiple CWP teams.

For more information, please contact Bev Tudor, Quality Surveillance Specialist on beverley.tudor@nhs.net or Michael Croman, Quality Surveillance Officer on michael.croman@nhs.net

Clinical Effectiveness Improvements

Delivering a*ffordable* care

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

New Leaf employment advisors, integrated into community mental health teams, work with over 150 people to help them gain competitive employement

Background:

Employment advisors, employed under the Cheshire and Merseyside New Leaf contract, have been integrated into community mental health and early intervention teams in Cheshire since November 2018 on what is a one year project to support people with severe mental health problems into work using the evidence based Individual Placement Support model. This model provides people with intensive, individual support. A placement in paid employment is arranged and time-unlimited support for both employee and employer is provided. New Leaf is a charity organisation aimed to increase economic development in Cheshire. The organisation provides a wide range of support to people, including employment advice, money management and initiatives to improve confidence in the workplace.

new leaf
Motivating Cheshire

What we wanted to achieve?

To increase access to employment support for people using community mental health and early intervention services. To provide another important aspect of care, recognising that gaining employment can be a significant part to recovery.

What we did:

Individual placement support (IPS) was provided by Standguide in Central and East Cheshire and by Cheshire West and Chester Council in West and Vale Royal. IPS aims to get people with mental health problems into competitive employment, this can be via training and education or directly into work. The only criteria used to access the service is that the person wants to

work and the employment specialist takes 'referrals' from any member of the team. Our employment specialists have developed relationships with local employers and provide time unlimited individualised support for the person and their employer once successful in getting a job.

Results:

Cheshire West and Chester IPS have received approximately 200 referrals and are currently working with 84 'customers' who are accessing training courses or actively job searching and 14 who have entered paid employment so far, with others in the pipeline. Central and East IPS have received approximately 150 referrals and have 78 active customers with 14 having gained employment so far, but this figure is forecasted to rise to around 30 before the end of the project. Examples of employment successfully being sustained by customers include data processing, office administration, self employed dog walker and web site designer. The feedback from staff has been excellent, with most commenting about the positive effect on people's mental health after accessing the New Leaf IPS service. One person, who is now self employed as a beautician and has weddings and party bookings until Christmas, said 'New Leaf IPS has changed my life for the better, I am so thankful that my Community Psychiatric Nurse introduced me to the service'.

Next steps:

The current IPS project ends in September 2019, however the Wirral and Cheshire CCGs have recognised the importance of continuing to support people with severe mental health problems into work and are providing funding to ensure that IPS workers remain integral to the multidisciplinary team. Teams have begun to collect together patient stories from people who have benefitted from involvement from an employment advisor into a collection of 'good news' stories which can be shared with other customers embarking on their employment journey and with the staff.

For more information, please contact Linda Friend, Employability Consultant on linda.friend1@nhs.net

Education CWP have created the "CWP Virtual Academy" for a faster, higher quality and more user friendly e-learning experience

Background:

Recent technological innovations have opened up possibilities to greatly enhance the training and education on offer to staff, including mobile learning, Virtual Reality and Artificial Intelligence. Education CWP recognised the need to set up a more user friendly, modern learning system that takes advantage of these technologies.

What did we want to achieve?

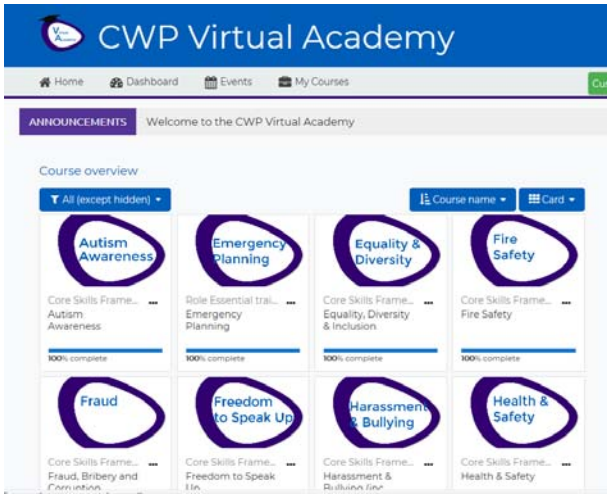
To use technological developments to support our staff to access a more efficient system that improves user experience and learning with opportunities for a more technological blended approach now and for the future.

What we did:

Initially a free platform (Moodle) was sourced to administer the Care Certificate programme. The potential of this site was quickly recognised and soon the team designed, developed, made and set up a number of other courses, for example, Psychopharmacology (created in partnership with the University of Chester) and STOMP – STopping the Over Medication of People with learning disabilities and/ or autism (created with our Pharmacy team). It soon became clear the benefits to our organisation of further developing this to have our own Virtual Academy and the possibilities this would open up for the Trust. Following a presentation at our Operational Committee in December 2018, the team have been piloting e-learning mandatory training for new members of staff using the Virtual Academy and managing our leadership and management, preceptorship (Practice Education team), and CAREnotes revalidation programmes (IT Training team). Education CWP have very recently added Quality Improvement training and Better Support, Better Lives training (in partnership with CANDDID: Centre for Autism, Neuro-Developmental Disorders and Intellectual Disability).

Results:

Education CWP have developed a system that provides a **much improved quality learning experience for our staff** as it is easier to access and navigate, more user friendly and is a free platform. We are reducing time taken to access e-learning, with a more visually appealing system thanks to the design skills of Matt Crouch, e-Learning Developer. We have been working with the Education CWP administration team to manage how we move all staff to this platform for mandatory e-learning whilst continuing to ensure quality of data transfer into the Electronic Staff Record. This is being managed alongside our mandatory training review. We can also analyse data for the courses on offer using a range of modern Learning Analytics techniques, leading to a greater understanding of our learners and their needs. Since we launched the Virtual Academy:



- ✓ 47 staff have used it to complete the Care Certificate
- ✓ 17 people have completed the Psychopharmacology programme allowing them to proceed to study non-medical prescribing
- ✓ 102 GPs across the North of England have had access to our STOMP course
- ✓ 48 staff have completed a programme of management training
- ✓ 311 staff have used the system for essential learning

Next steps:

After a successful pilot, Education CWP will, over the coming months, be moving all CWP staff onto our Virtual Academy to complete their mandatory training (e-learning). The team will continue to add new programmes to the Virtual Academy and they will be working as a team to develop a broader blended approach, for example, discussion boards, web conferencing and live chat. Sandra Johnson, Professional and Personal Development Lead and Matt are currently researching the potential for creating Virtual Reality simulation exercises and making them available via the Virtual Academy to develop this into a collaborative learning environment and experience.

For further information, please contact Sandra Johnson, Professional and Personal Development Lead on sandra.johnson10@nhs.net or Matthew Crouch, e-Learning Developer on matthew.crouch2@nhs.net

Liaison Psychiatry Wirral service provide training to Arrowe Park Hospital staff to increase mental health awareness

Background:

The Liaison Psychiatry team are a mental health service consisting of administrators, mental health practitioners, Psychiatrists and Clinical Psychologists. The Wirral team is based at Arrowe Park Hospital (APH) and helps support people presenting at A&E with mental health difficulties, as well as people admitted to physical health wards who are experiencing mental health difficulties alongside physical illnesses. Between June 2018 – May 2019, the Liaison Psychiatry team were involved in over 4000 referrals, providing assessment, formulation, diagnosis, advice/ signposting, medication reviews, and brief psychological therapy. During the same period every ward at Arrowe Park Hospital, and three of the rehabilitation wards at Clatterbridge Hospital, requested support from the Liaison team.

What did we want to achieve?

We sought to increase capability and awareness with the departments within Arrowe Park hospital. The rationale was, if staff within the hospital had more knowledge and confidence with mental health awareness, this could consequently decrease the amount of requests for support.

What we did:

The Liaison Psychiatry team provided training to medical doctors, nurses and clinical support workers within the hospital wards. This has included provision of training on suicide awareness, understanding of self-harming behaviours, medically unexplained symptoms, psychosis and motivational interviewing. Staff self-care provision has also been provided, with sessions on compassion focussed self-care, mindfulness, reflective practice and case formulation/ discussion delivered.

Results:

Arrowe Park Hosptial staff described being interested in the training offered, and felt it provided new perspectives and enabled understanding of how to apply different techniques and strategies. Staff found provisions very informative and useful, and stated that it solidified knowledge and encompassed a variety of topics and issues. Psychiatrists within the team inputted into ortho-geriatric MDTs, consulted and inputted into Parkinson clinics, and provided assessment and interventions for oncology and perinatal departments. Clinical Psychologists have provided consultation, assessment and brief psychological interventions for the young person's diabetic service, and for people admitted to the acute stroke ward. The diabetes service advised that they found the provision of input from Liaison Clinical Psychology invaluable in supporting the provision of a quality service to young people with diabetes and also incredibly useful in supporting staff within their demanding roles, through the provision of staff support. **The acute stroke ward showed a 42% reduction in their referrals to Liaison Psychiatry** following the provision of a Clinical Psychologist from the Liaison team.

Next steps:

The team plans to replicate the success achieved so far across other hospital departments.

For more information, please contact Graham Jones, Team Manager, on graham.jones15@nhs.net or Dr Claire Blakeley, Clinical Psychologist, on claire.blakeley@nhs.net

Implementation of Values Based Recruitment (VBR) across CWP sees increase in quality in good quality candidates

Background:

Values Based Recruitment (VBR) helps to attract and select employees whose personal values and behaviours align with the Trust to support delivery of outstanding patient care. The questions and responses provide insight into an applicant's values, what they consider to be important, and provides insight into the reasons and motivation for their behaviour in the workplace.

What we wanted to achieve:

Developing VBR is considered a culture change for the organisation and getting the framework correct was key to successful outcomes. The Recruitment and Organisational Development Team therefore needed to establish what the values mean in practice at CWP and information was gathered from engagement across CWP with all stakeholders. The team also used our network across other NHS organisations to work collaboratively to understand best practice. Overall, this new approach will help attract and recruit people with values that match the Trust's values which will support happy and engaged staff, increasing retention and engagement and supporting outstanding care.

What we did:

The information gathered resulted in a behaviour framework based on the 6Cs values, question bank and interview score sheet. The framework and training were co-produced with our Lived Experience Volunteers and Education CWP. A paid role was developed for our volunteers to co-deliver our training to our staff and volunteers.

Results:

The training sessions are being very well received by all of the managers, staff and volunteers who have participated thus far. One service, who have implemented the changes from advert level, reported they have already seen an increase in good quality candidates. Other managers have taken time out to praise the process stating that it is helping them assess candidates in a different way which is bringing positive outcomes. The approach is also supporting a new, rolling recruitment approach. The team's co-trainers have been approached to take part in other training across the Trust. The team have been able to share their outcomes to partner organsiations who have attended the training sessions. Additionally the team have also presented to organisations such as Wirral CCG who are particularly interested in designing and implementing their own VBR.

Next steps:

- Training continues to the end of the year when all of our people who currently take part in interview selection will have been trained. Training will continue and develop on an ongoing basis.
- Continual reviews will take place to ensure our method and toolkit remains up-to-date.
- New starters and leaver feedback and relevant data such as turnover will be reviewed continually to assess impact.

For more information, please contact Joanne Wing on joanne.wing@nhs.net or 01244 393124

Delivering *Acceptable* and *Accessible* care

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

The Poppy Factory supports veterans with health conditions into work

Background:

The Poppy Factory is the country's leading employability charity for veterans with mental and physical health conditions, helping more than 1,200 people into work since 2010. Unemployed veterans who receive health treatment on the Wirral can now get help moving back into employment through a new service launched by The Poppy Factory in partnership with CWP and other NHS providers. Ex-Forces men and women who go for treatment at the Stein Centre at St Catherine's Hospital in Birkenhead can access one to one support with career planning, training opportunities, CV writing and job application advice.

What did we want to achieve?

We wanted to bring together The Poppy Factory's long established expertise supporting ex-Service personnel with health conditions into an NHS healthcare setting for the first time. This is a three-year study and we wanted to provide a package, based on the principles of Individual Placement Support (IPS), that takes each person's physical health and mental health needs into account, with the aim of securing meaningful long-term employment that they are interested in doing outside of the Forces. The project is funded by the Forces in Mind Trust (FiMT), a £35 million funding scheme run by the FiMT using an endowment awarded by The National Lottery Community Fund.

What we did:

We worked closely with health and social care partners in the area, including local GPs, Wirral University Teaching Hospital NHS Foundation Trust and NHS Wirral Clinical Commissioning Group. We embedded and co-located an experienced local Employability Consultant from The Poppy Factory, Lynne Evans, in the NHS multidisciplinary team to deliver high quality comprehensive employment support to ex-Forces men and women who are wounded, sick or injured. Lynne grew up on the Wirral and has an extensive local network of contacts. She draws on her past employment support experience with the Shaw Trust, Gingerbread and Merseyside Youth Association to support veterans with physical and mental health conditions in the area.

Results:

This project is still its infancy and the figures will be evaluated by the Institute of Mental Health at the University of Nottingham; we anticipate that this data will reveal any gaps in knowledge and research.

Next steps:

We hope the project will contribute to the improvement of existing services and forge closer links between health providers and the Armed Forces charity sector. The team will continue to promote the service and aim to increase referral numbers via two pathways: self-referrals directly to Lynne at the Stein Centre and medical practitioners referring people who they feel would benefit from our service.

For more information, please contact Lynne Evans, Employability Consultant – The Poppy Factory, on 07387 415429 or email lynne.evans9@nhs.net

'Doing What Matters' – introducing an Acceptance and Commitment Therapy group for young people at Ancora House

Background:

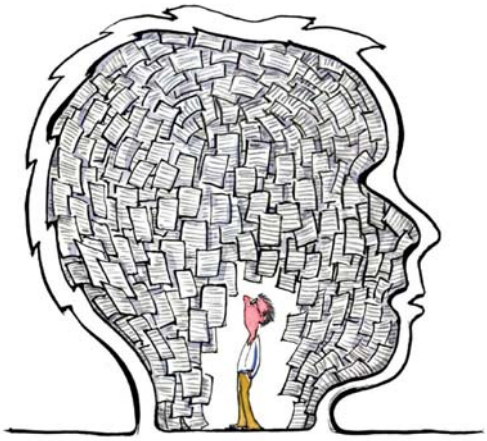
Ancora House is a child and adolescent mental health inpatient unit based in Chester. The centre provides inpatient care for children and young people experiencing severe and/ or complex mental health difficulties. The aim of this project was to redesign the psychology group offering at Ancora House, to introduce a new therapeutic model (Acceptance and Commitment Therapy or ACT). ACT aims to help people build richer, fuller and more meaningful lives by (i) helping them to identify what matters to them and (ii) teaching a range of skills to help them handle the difficult thoughts and feelings that will inevitably show up when they begin to behave more like the person they want to be.

What did we want to achieve?

To provide interventions that are: up to date, in line with the increasing evidence base for mindfulness-based approaches; and applicable to the broad spectrum of difficulties we work with at Ancora House. ACT has been shown to be beneficial and accessible for young people who are experiencing a variety of difficulties.

What we did:

Redesigned the set-up and facilitation of psychology groups at Ancora House, based on ACT principles. The group is currently being held jointly across both wards, to encourage socialisation and feelings of inclusion. The content of the group has been designed from scratch, incorporating fun and engaging ACT metaphors and ideas such as 'dropping the struggle' and 'passengers on the bus'. The slides and accompanying workbook contain practical exercises, tips for practice and helpful internet resources that young people can refer to outside of the group. It is hoped that by learning techniques to accept difficult thoughts and feelings, young people will feel less distressed by, and more able to cope with them as they arise.



Results:

This is currently a pilot project in its very early phases of roll-out. However, the multi-disciplinary team are excited about this venture, and we believe young people will benefit from this new approach.

Next steps:

We will be reviewing the group as we go along, and adding in fun, new, exciting activities as they emerge within the wider ACT community. Over the next few months, we will be gathering feedback from young people both formally and informally and adapting the group as required. We plan for it to become a permanent feature in our timetable in September.

For further information, please contact Karen Ryder, Clinical Psychologist, on karen.ryder3@nhs.net

New, innovative Nurse-led CWP Community Erectile Dysfunction Service eases pressures on secondary care

Background:

Erectile dysfunction affects more than 50% of men at some stage in their lives which can affect relationships and general health and wellbeing Historically in West Cheshire, the provision of Erectile Dysfunction (ED) services is delivered as part of the secondary care urology services at the Countess of Chester Hospital and is consultant-led.

What did we want to achieve?

The purpose of this project was to the highlight the safe and cost effective implementation of a new Community Nurse-led ED service. Moving this service to the community, we hope that this will improve access as people will have a choice of community clinics to attend. Additionally this will also reduce demand on hospital resources.

What we did:

Over an 18 month period, by working with the CCG, Consultant Urologists and GPs, a community based highly specialist Nurse-led ED service was planned by developing integrated care pathways. The service was implemented in January 2019. This was achieved through expansion of the current community based continence/ urology service. The service will accept referrals from GPs, consultants and other health professionals.

Results:

This initiative has resulted in the transfer of activity from the Countess of Chester Hospital Urology service to the Community Continence & Urology Service for people who require treatment for ED. Achievements to-date are:

- A fully operational, established Community Nurse-led ED service.
- The service has stopped people requiring to attend a Hospital appointments and utilising Consultants' time which will ease pressures on secondary care resources greater scope to meet their 18 week targets.
- The new innovation is recognisable as an open, progressive service that is about care, well-being and partnership.

Next steps:

The introduction of a Community Urology Nurse Specialist has developed new services over the last 5 years. There is greater scope in the future to continue to work collaboratively with secondary care to transfer more traditional hospital based services to the community.

For further information, please contact Kenny Henderson, Community Urology Lead Nurse on kenneth.henderson@nhs.net

Between April 2019 and July 2019, CWP formally received 1095 compliments from people accessing our services, and others, about their experience. Below is a selection of the comments and compliments received:

All Age Disability
"Thank you for your ongoing communication and joint working. Your ethics and passion for your role is lovely to see."

Children, Young People & Families
"Thank you does not really seem enough to say for your care and guidance through some extremely taxing times. A listening ear and kind words have been invaluable to myself and (young person) and we will miss you."

Joint Management
"Practical worries and apprehensions disappeared as your team arrived and got started. They have looked after my wife (and helped me) with obvious care, competence and confidence. They gave clear advice and linked well with the district nurses. They have been incredibly helpful and supportive at an extremely difficult time."

Neighbourhoods
"Thank you for helping me rebuild my confidence to face the challenges that life throws at you. It has been a difficult year but I know I have the strength to carry on and most importantly that life is full of many possibilities and to be enjoyed and I have everything to live for. I have learned a lot and when times get hard I will try and remember all the skills you have taught me."

Specialist Mental Health – Bed Based
"Thank you all for your patience and kindness shown towards me without passing judgement at what's been a scary and difficult time, words are not enough to describe how much I have appreciated you all."

Specialist Mental Health – Place Based
"This service has been extremely helpful . I learned lots of skills to cope with my anxiety. The staff listened and made me feel good about myself. Now I can recognise how to deal with anxiety and depression."

Learning Disability, Neuro Developmental Disorders & Acquired Brain Injury
"Mum said she could not have asked for any more. The care was 'beyond expectation' and they were grateful for the physical health care that was also provided."

Share your work

We welcome your best practice examples and Quality Improvement successes; please share your work via the Safe Services Department using the QI Hub page on the intranet or contact the Patient Safety Improvement Team on 01244 397410

Look out for more about Quality Improvement in Edition 2 2019/20 of the Quality Improvement Report

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Equality, Diversity & Inclusion Annual Monitoring Report 2018-19
Agenda ref. number:	19.20.81
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	25/09/2019
Presented by:	Gary Flockhart, 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	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 NHSI Single Oversight Framework themes this report reflects:	
Quality	Yes
Finance and use of resources	Yes
Operational performance	Yes
Strategic change	Yes
Leadership and improvement capability	Yes

CWP Quality Framework:		
Patient Safety	Safe	Yes
Clinical Effectiveness	Effective	Yes
	Affordable	Yes
	Sustainable	Yes
Patient Experience	Acceptable	Yes
	Accessible	Yes

http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No

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

REPORT BRIEFING

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

This SBAR provides a brief summary of the detailed Equality, Diversity & Inclusion Annual Monitoring Report 2018-19 regarding EDI activity within the organisation. Following submission to Trust Board, there will be a requirement that this information is made publically available on the Trust website

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

This report provides information in relation to the activity taken by the organisation in regard of Equality, Diversity & Inclusion in the past year. It also details challenges and priority areas for next year. The report contains a range of information that was previously available via separate reports, and in particular :

- Equality Delivery Standard 2 (EDS2)
- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)
- Staff Monitoring Information
- Interpretation and Translation Report
- Equality, Diversity & Inclusion 4 Year Objective Action Plan
- Gender Pay Gap Report

Assessment – *analysis and considerations of the options and risks*

•The Trust has met its statutory obligations in accordance with the requirements of the Equality Act 2010 and the CCGs Equality, Diversity & Inclusion Quality Requirements.

•Regular updates are provided to the various commissioners as requested within the quality contract.

•CWP has met its statutory obligations to monitor and report on workforce and patient Equality, Diversity & Inclusion issues and provides assurance that action is being taken to address issues of note.

The executive summary at appendix 1 gives details of our key areas of work:

1. Improving Our Intelligence
2. Developing Our Staff
3. Working With Our Communities

Two recently published documents provide guidance in relation to protected characteristics (including ethnicity). The first offers ten high impact evidence based actions, which if acted upon will help boards foster a more diverse and inclusive NHS. The second, 'A Fair Experience for All' document relates specifically to closing the ethnicity gap in rates of disciplinary actions. Both papers compliment, impact upon, and influence each other. Taking on board these actions and developing this work further will support in our Equality, Diversity and Inclusion objectives over the coming year.

The Annual report at appendix 2 is a 60 page documents that provides considerable detail on activities undertaken and outlines the work that took place in 2018-2019 and identifies the challenges and priorities.

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

The Board is asked to:

- Agree submission of the full report to the public website

And to note the following:

- The Trust has met its statutory obligations in accordance with the requirements of the Equality Act 2010 and the CCGs Equality, Diversity & Inclusion Quality Requirements.
- Regular updates are provided to the various commissioners as requested within the quality contract.
- CWP has met its statutory obligations to monitor and report on workforce and patient Equality, Diversity & Inclusion issues and provides assurance that action is being taken to address issues of note.

Who has approved this report for receipt at the above meeting?	Gary Flockhart
Contributing authors:	Philip Makin Equality, Diversity and Inclusion Coordinator Cathy Walsh Associate Director Patient and Carer Experience

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Trust wide EDI Meeting	Sept 2019
1	People and OD Sub-Committee	Sept 2019
1	Trust Board	Sept 2019

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

Appendix No.	Appendix title
1	Equality and Diversity Annual Report 2018/19

NHS
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Equality, Diversity & Inclusion Annual Monitoring Report 2018 -2019

Cheshire and Wirral Partnership
NHS Foundation Trust

Title of Report: Equality, Diversity & Inclusion Annual Monitoring Report 2018-19

Action sought: For Noting

Author: Philip Makin - Equality, Diversity & Inclusion Co-ordinator

Authorised by: Cathy Walsh - Associate Director of Patient and Carer Experience

Strategic Objectives that this report covers:

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

Contents

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1. INTRODUCTION

Purpose of the Report

Welcome to the Cheshire and Wirral Partnership NHS Foundation Trust Equality, Diversity & Inclusion Annual Monitoring Report for 2018/2019. This document provides assurance that we are meeting our equality, diversity and inclusion requirements. It includes information about people accessing our services, people delivering our services as well as our local population. It outlines our commitment to promoting equality in all our services and to valuing the diversity of staff, people accessing our services and the community. Finally, it provides details of our current performance and what we have been working on to achieve this. It identifies challenges and sets key actions for moving forward.

Background

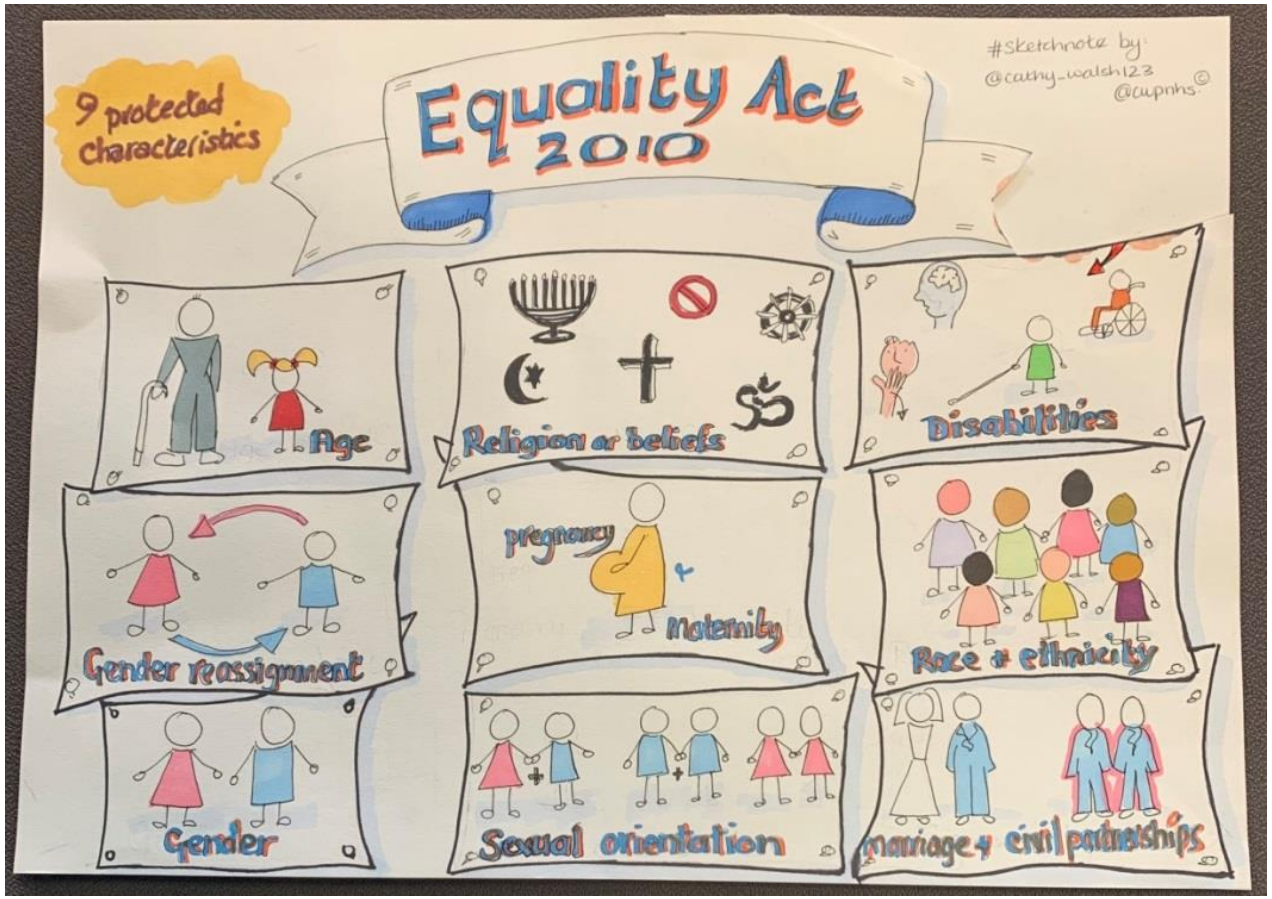
The Equality Act (2010) brought together existing legislation and frameworks that relate to discrimination and inclusion. The spirit of the Act is intended to recognise that people are all different but everyone has characteristics about them that mean that they may be subject to discrimination or exclusion. The Act clarifies characteristics which could lead to discrimination and places a duty on public sector organisations to eliminate unlawful discrimination and promote equality between people who have protected characteristics and those who do not. The characteristics are:

- Age
- Disability
- Ethnicity/Race
- Gender
- Gender Reassignment
- Marriage & Civil Partnership
- Pregnancy & Maternity
- Religion & Belief
- Sexual Orientation

The Equality and Human Rights Commission (EHRC)

The Equality and Human Rights Commission (EHRC) is the body charged to ensure compliance. As future guidance emerges from the EHRC, the Trust will incorporate this into plans and actions around equality.

During 2018-19, we took the decision to incorporate "Inclusion" into our work to make certain a greater focus on ensuring that everyone has the same access and opportunities to services and employment. Whilst Diversity is about recognising that no two people are the same, Inclusion recognises that what one person finds easy to achieve may be more challenging for somebody else.



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Our Equality, Diversity and Inclusion (EDI) Governance Structure

Our approach to Equality, Diversity & Inclusion within CWP demonstrates how important it is within everything we do. It continues to develop and become embedded into all of our governance structures.

Each area has a group of EDI Champions who meet regularly and invites members from the diverse community. The local / champion groups also respond to the EDS2 assessment and focus on driving improvement in the provision of services to people with protected characteristics. The groups also provide assurance to the Trust wide Equality, Diversity & Inclusion Group in relation to the quality of equality, diversity and inclusion within service delivery. The Trust wide Group reports through the People and Organisational Development Sub Committee and the Patient and Carer Experience Sub Committee to Trust Board, also feeding into Operations Board and Quality Committee.

To build on this work, we plan in the coming year to update our EDI Policy to make it more person centred and also incorporate a greater emphasis on inclusion.

Person Centred Framework

CWP's person-centred approach is about connecting with people as unique individuals with their own strengths, abilities, needs and goals. "Inclusion" is one of its eight overarching principles. These principles aim to celebrate and support us and share how we relate to the people who access our services as well as how we relate to each other as colleagues:

1. Respect
2. Support
3. Collaboration
4. Learning
5. Clarity
6. Partnership
7. Choice
8. Inclusion

Focussing on "Inclusion", we aim to work with everyone's strengths, abilities and things we may not be so good at so as to work together to achieve our goals and take time to celebrate the good things we do.

It is important for us to know what matters to each person we meet so we strive to be adaptable in our approach, working in partnership to provide care, which, as far as possible, takes into account each person's preferences.

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Lived Experience Connector®

Last year saw the further development of the Lived Experience Connector®. This innovative new role has been specially designed for people with lived experience of accessing our services to link together with our new Nursing Associates.

Due to the success of this programme, each Board Member now has a Lived Experience Connector ® (LEC). Working with our LECs gives us the opportunity to be supported in our person centred approaches.

2. Equality Delivery System (EDS2)

1. Introduction:
Cheshire and Wirral Partnership NHS Foundation Trust has implemented the Equality Delivery System (now EDS2) which was launched by the Department of Health in 2011. EDS2 is a tool to drive up equality performance and embed equality into mainstream NHS business.
The EDS2 is a public commitment of how NHS Organisations plan to meet the needs and wishes of local people and staff and meet the duties placed on them by the Equality Act 2010. It also sets out how they recognise the differences between people and how they aim to make sure that any gaps and inequalities are identified and addressed.
The EDS2 is split into four measurable areas:

1. Better Health Outcomes

2. Improved patient access and experience

3. A representative and supported workforce

4. Inclusive leadership

Against these four areas there are a set of 18 outcomes. These range from service quality to how staff are managed in the Trust.

2. How does it work?
It works by ensuring that all of the work of the Trust is benefiting protected groups in different ways. It is also about creating a system where our stakeholders are the ones that are assessing our performance rather than the Trust doing a simple self-assessment. This includes CWP providing detailed evidence and locality based presentations to our stakeholders who then get together to discuss how we are doing.

1. Undeveloped	**Evidence provided for 0-2 protected characteristics**
2. Developing	Evidence provided for 3-4 protected characteristics
3. Achieving	Evidence provided for 5-7 protected characteristics
4. Excelling	Evidence provided for 8-9 (all) protected characteristics

3. Grading

Grading is based on a simple criteria for each of the standards as highlighted below.

•4. Public sector equality duty

This has three aims. It requires public bodies to give due regard to the need to:

• eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;

• advance equality of opportunity between people who share a protected characteristic and people who do not share it; and

• foster good relations between people who share a protected characteristic and people who do not share it.

5. What are protected characteristics?

Protected characteristics refer to all the different groups of people that are covered under the Equality Act 2010 – the main piece of legislation that protects people from discrimination in the UK. These are:

•Age
•Disability
•Ethnicity/Race
•Gender
•Gender Reassignment
•Marriage & Civil Partnership
•Pregnancy & Maternity
•Religion & Belief
•Sexual Orientation

6. What are the benefits?

The introduction of the EDS2 helps to recognise, encourage and highlight the existing good practice and evidence that already exists at the Trust. At the same time, it ensures that there is better or consistent engagement with our local communities, that any gaps are identified and addressed and that we become more reflective of the community we serve at all grades and positions.

7. How are we doing?

Over the past year, the Trust has been working hard to implement the NHS Equality Delivery System (EDS2).

At the end of 2018-2019, the Trust undertook its assessment of performance against the EDS2; Goal 3. 'Empowered, engaged and well-supported staff' and Goal - 4 Inclusive Leadership' (incorporating the Trust Equality Objectives) the assessment was completed by CWP staff side and the Trust scored "Achieving" for all of the outcomes in Goals 3 and 4. In June 2019, the EDS2 assessment for Goals 1 – **'**Better health outcomes for all' and Goal 2 – 'Improved patient access and experience' took place with Cheshire East / West Healthwatch at CWP Ancorra House, Chester. The Trust provided Cheshire East / West Healthwatch and its representatives with examples of various case studies highlighting how CWP is providing services to members of the diverse community. Also, discussions and evidence was presented to the Healthwatch panel and people delivering and accessing our services came to share their experiences with the panel. All outcomes within both Goal 1 'Better health outcomes for all' and Goal 2 'Improved patient access and experience' scored "Achieving" which is an improvement on last year's scores where outcome 2.3 was scored as "Developing".

In 2018-19, a number of Equality, Diversity & Inclusion network meetings took place across the Trust and these provided the Trust with an opportunity to provide updates on its activity in relation to the various EDS2 Goals. The meetings consisted of CWP staff / equality champions and representatives from some of the diverse groups. At the group meetings, people were provided information, presentations and training on the various community groups they support.

8. Stakeholders:
Health Watch - Body Positive / Silver Rainbows - Wirral Change - Proud Trust

Equality, Diversity & Inclusion Champions meet with representatives from Proud Trust, Body Positive and Silver Rainbows

Healthwatch Cheshire representatives and volunteers meet with CWP Equality, Diversity & Inclusion Leads

Wirral Change representatives meet with people from CWP

People working within CWP services and people accessing CWP services present evidence to Healthwatch Cheshire representatives

9. The EDS2 partners' assessment graded the Trust as follows:

The assessment score for the Trust wide grade has been calculated by adding the assessment grade for each locality to form the Trust wide assessment. The information below also highlights improvements since the 2017-2018 assessment.

Developing = **Achieving =**

Equality Delivery System 2: Goal 1		
1. 'Better health outcomes for all'	Verified by: Stakeholders	
Individual Outcome grades for Goal 1		
	2017-18	2018-19
EDS2 Outcome 1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities	Achieving	Achieving
EDS2 Outcome 1.2 Individual people's health needs are assessed and met in appropriate and effective ways	Achieving	Achieving
EDS2 Outcome 1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	Achieving	Achieving
EDS2 Outcome 1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	Achieving	Achieving
EDS2 Outcome 1.5 Screening, vaccination and other health promotion services reach and benefit all local communities	Achieving	Achieving

Equality Delivery System 2 Goal 2:		
2. 'Improved patient access and experience'	Verified by: Stakeholders	
Individual Outcome grades for Goal 2:		
	2017-18	2018-19
EDS2 Outcome 2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Developing - Additional evidence being provided for Achieving	Achieving
EDS2 Outcome 2.2 People are informed and supported to be as involved as they wish to be in decisions about their care	Achieving	Achieving
EDS2 Outcome 2.3 People report positive experiences of the NHS	Achieving	Achieving
EDS2 Outcome 2.4 People's complaints about services are handled respectfully and efficiently	Achieving	Achieving

Equality Delivery System 2 Goal 3:	
Goal 3. 'Empowered, engaged and well-supported staff'	**Verified by: Staffside Reps**
	Grade 2017-18 and 2018-19 Received the same assessment score
EDS2 Outcome 3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	**Achieving**
EDS2 Outcome 3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	**Achieving**
EDS2 Outcome 3.3 Training and development opportunities are taken up and positively evaluated by all staff	**Achieving**
EDS2 Outcome 3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source	**Achieving**
EDS2 Outcome 3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	**Achieving**
EDS2 Outcome 3.6 Staff report positive experiences of their membership of the workforce	**Achieving**

Equality Delivery System 2 Goal 4:	
4. 'Inclusive Leadership'	**Verified by: Staffside Reps**
CWP Trustwide	**Grade 2017-18 and 2018-19 Received the same assessment score**
EDS2 Outcome 4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	**Achieving**
EDS2 Outcome 4.2 Papers that come before the Board and other major Committees identify equality related impacts including risks, and say how these risks are to be managed	**Achieving**
EDS2 Outcome 4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	**Achieving**

10. Conclusion:

The EDS2 assessment completed by the Trust and its partners across the Trust footprint highlights its commitment to meeting the needs and wishes of people and meets the duties placed on us by the Equality Act 2010.

3. Our People (Staff)

The following People Information data is collected routinely by the Trust:

- Age
- Disability
- Ethnicity / Race
- Gender
- Marital & Civil Partnerships
- Pregnancy & Maternity
- Religion & Belief
- Sexual Orientation

For the purposes of this report, we have reviewed the data which is available to us in terms of the above protected characteristics. The Trust does not currently hold data on Gender Reassignment for its workforce profile although we are starting to collect this in relation to Recruitment and Selection statistics.

As at 31 March 2019, 3245 people were working for CWP and according to their record on our Electronic Staff Record system:

- **Age** **60%** were aged under 50 and **40%** were aged over 50.
- **Disability** **4.43%** reported that they considered themselves to have a disability, **86.94%** told us they did not consider themselves to have a disability with the remainder either unknown or choosing not to tell us.
- **Ethnicity / Race** Across the areas where we hold contracts (Cheshire West & Chester, Cheshire East, Wirral, Trafford, Sefton and Warrington), there are between **2.57% and 15%** of staff from Black, Asian and Minority and Ethnic backgrounds depending on where staff are located across the Trust with the average Trust wide figure being **4.00%.**
- **Gender** **80%** were recorded as female.
- **Marriage & Civil Partnerships** 50.8% stated they were married, 24.9% stated they were single.
- **Pregnancy & Maternity** **1.8%** of our female colleagues were on Maternity Leave.
- **Religion & Belief** **55.02%** considered themselves to be Christian, **11.53%** as Atheist and the third biggest group at **8.12%** chose to define their religion as Other. **19.40%** chose not to tell us their Religion or Belief.
- **Sexual Orientation** **80.55%** were Heterosexual, **1.60%** as Lesbian, Gay or Bisexual with the remainder unknown or choosing not to tell us.

Age

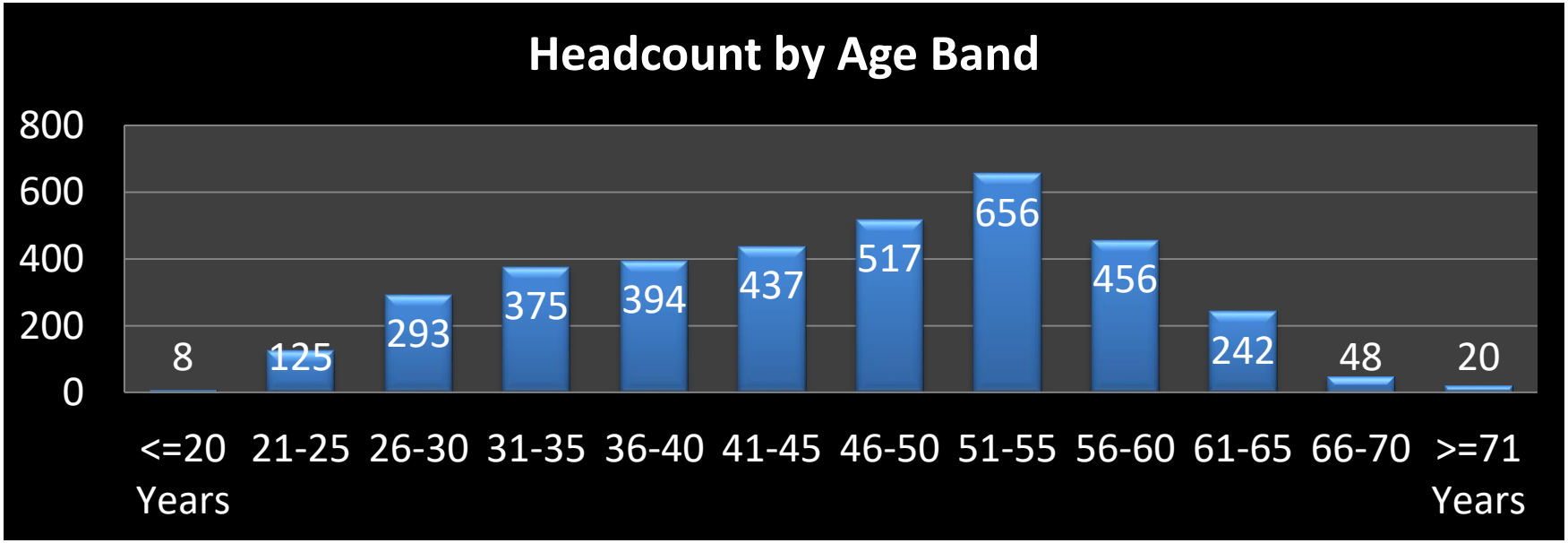
Cheshire and Wirral Partnership NHS Foundation Trust

As at 31 March 2019, staff breakdown was:

60% under 50

40% over 50

Slight year on year increase in the proportion of staff aged 60+ years has led to an ageing workforce.



Disability

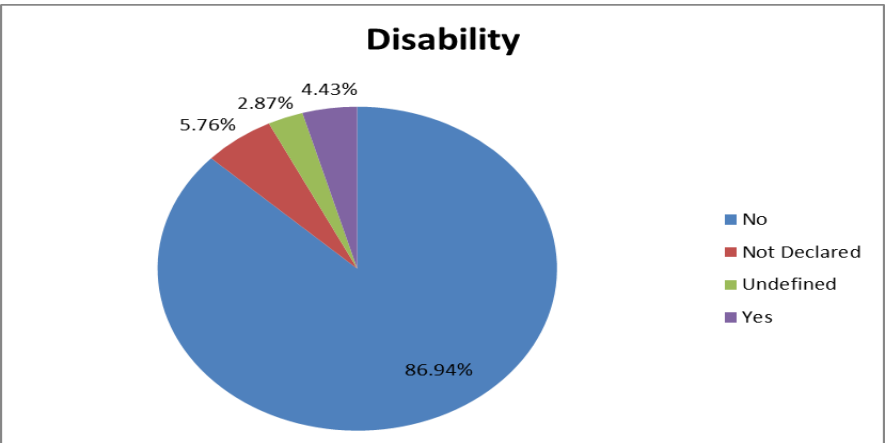
Cheshire and Wirral Partnership NHS Foundation Trust

As at 31 March 2019

4.43% of the Workforce have declared that they are living with a disability.

This is consistent with the 2018 figure.

Within **Recruitment**, 3.5 % of applicants declared that they were living with a disability.



Disability	Trust Staff				
	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19
No	83.02%	85.10%	86.01%	87.13%	86.94%
Not Declared	3.19%	2.96%	2.80%	2.61%	5.76%
Undefined	9.57%	7.87%	7.23%	6.13%	2.87%
Yes	4.22%	4.06%	3.96%	4.13%	4.43%

Ethnicity/Race

As at 31 March 2019:

94.04% White staff (92.67% local population)

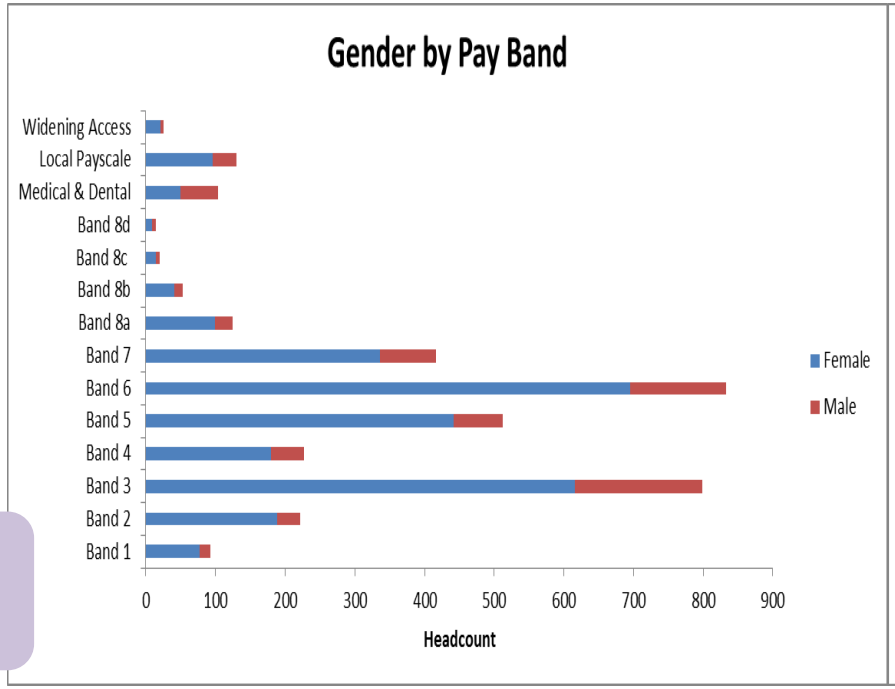
As at 31 March 2019:

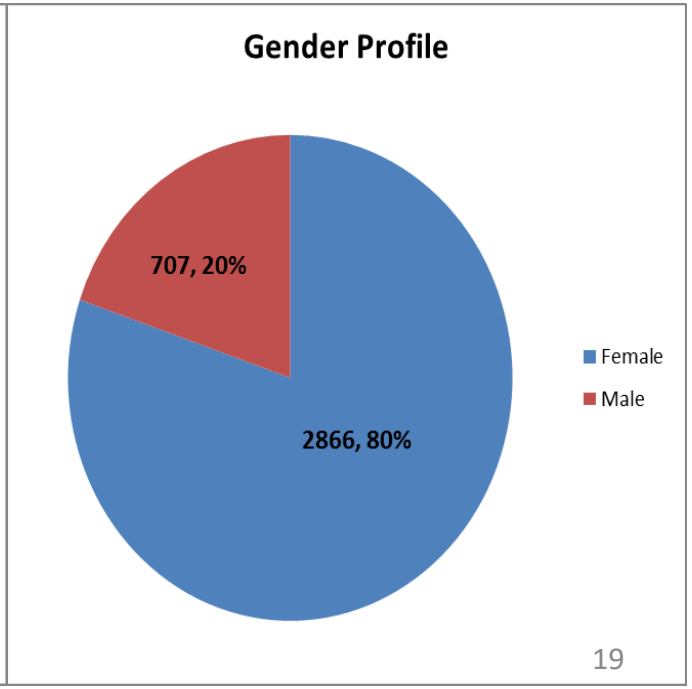
4% of staff from BAME background. (7.08% local population)

Cheshire and Wirral Partnership NHS Foundation Trust

Across the areas where we hold contracts (Cheshire West & Chester, Cheshire East, Wirral, Trafford, Sefton and Warrington), there are between **2.57% and 15%** of staff from Black, Asian and Minority and Ethnic (BAME) backgrounds depending on where staff are located across the Trust with the average Trust wide figure being **4.00%.**

Gender





80% of our colleagues were recorded as female.

Marriage and Civil Partnership

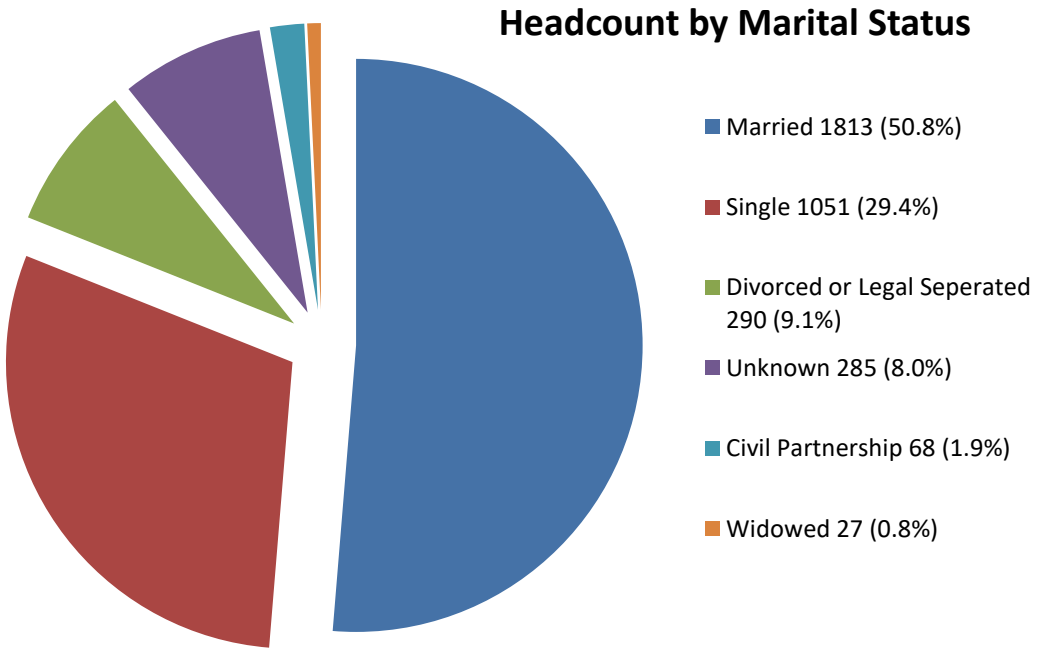
Cheshire and Wirral Partnership NHS Foundation Trust

As at 31 March 2019:

50.8% of staff were **Married**

1.9% were in a **Civil Partnership**

29.4% Single, 9.1% Divorced or Legally Separated, 0.8% Widowed, 8% Unknown.

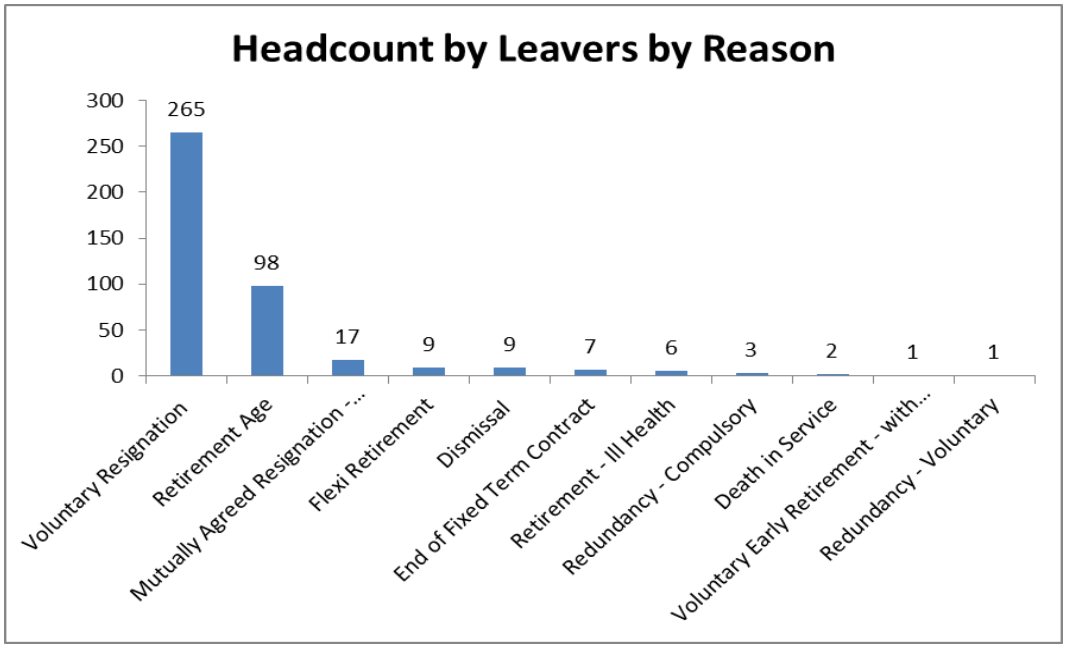


Pregnancy and Maternity

As at 31 March 2019, a snap shot from the Electronic Staff Record indicated that:

1.8% of female staff were on **Maternity Leave**

Leavers by Reason



Religion and Belief

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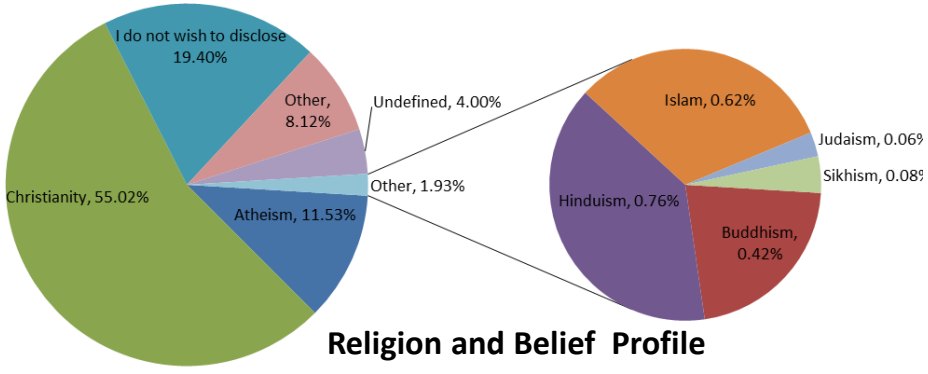
55.02% Christianity **11.53%** Atheism

Remaining staff split across a range of religions and beliefs with the highest number being in the `other` category (8.12%).

A significant proportion of staff have not declared their religion and belief (19.40%).



Religion and Belief Profile

Religion and Belief	Trust Staff				
	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19
Atheism	9.24%	9.62%	10.11%	10.72%	11.53%
Buddhism	0.44%	0.45%	0.47%	0.43%	0.42%
Christianity	56.89%	56.68%	56.48%	55.75%	55.02%
Hinduism	0.59%	0.62%	0.67%	0.72%	0.76%
I do not wish to disclose	16.95%	17.92%	17.63%	18.72%	19.40%
Islam	0.47%	0.40%	0.44%	0.52%	0.62%
Jainism	0.03%	0.00%	0.00%	0.00%	0.00%
Judaism	0.06%	0.06%	0.06%	0.06%	0.06%
Other	7.20%	7.62%	8.02%	7.85%	8.12%
Sikhism	0.06%	0.06%	0.09%	0.11%	0.08%
Undefined	8.06%	6.58%	6.03%	5.13%	4.00%

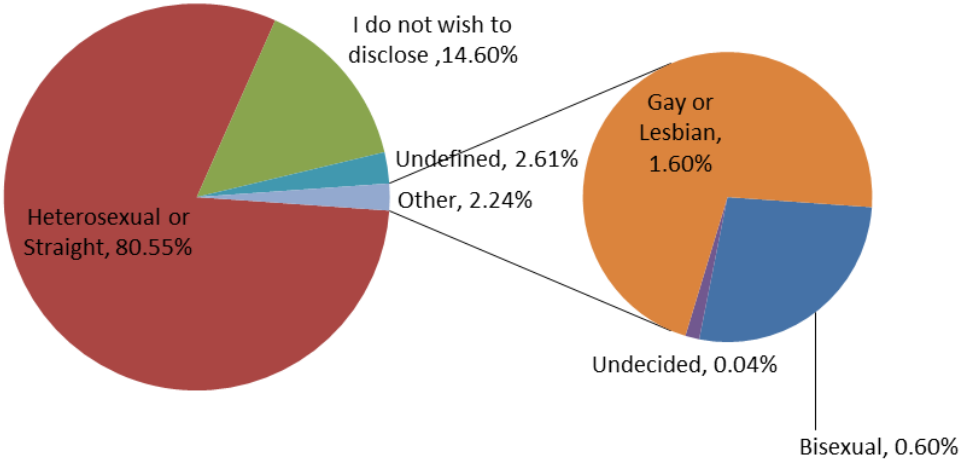
Sexual Orientation and Gender Reassignment

As at 31 March 2019:

80.55% Heterosexual

2.2 % Gay, Lesbian or Bisexual

14.60% did not wish to disclose.



Gender Reassignment information for current staff is not recorded on ESR so we cannot therefore undertake workforce profile monitoring at present.

Within our electronic recruitment system we have recently introduced the facility to record whether people identify or have ever identified as Transgender. We will therefore be looking to analyse this information moving forward.

Sexual Orientation	Trust Staff				
	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19
Bisexual	0.18%	0.20%	0.29%	0.37%	0.60%
Gay or Lesbian	1.24%	1.24%	1.25%	1.26%	1.60%
Heterosexual	76.68%	77.39%	78.37%	78.79%	80.55%
I do not wish to disclose	13.52%	14.31%	13.73%	14.22%	14.60%
Undecided	-	-	-	-	0.04%
Undefined	8.39%	6.86%	6.35%	5.36%	2.61%

Patient and Carer Experience Team

During 2018-2019, there were some changes within the Patient and Carer Experience (PACE) Team including the appointment of Philip Makin (rear left) to the role of Equality, Diversity & Inclusion Co-ordinator in January 2019.

Partnership Working

During 2018-2019, we developed networking and collaboration with partner organisations and other agencies in the local area so as to share best practice. We plan to build on this further during the coming year.

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Disability Confident Employer

CWP holds Level 2 of the Disability Confident Employer standard which is a scheme designed to help recruit and retain disabled people and people with health conditions for their skills and talent.
The standard includes a guaranteed interview scheme for people applying to work with us who are living with a disability and meet the essential criteria within the person specification for the post applied for.

HSJ Best Places To Work

FOR HEALTHCARE LEADERS
HSJ BEST PLACES TO WORK
In association with NHS Employers

We have been recognised by the Health Service Journal as one of the top places to work in the health service for the last two years running.

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NHS Foundation Trust

4. Pride 2018

To celebrate and raise awareness of inclusivity across CWP regarding working, volunteering, and accessing services, during the summer of 2018, CWP sponsored and participated in both Macclesfield Pride and Chester Pride events. We also took the opportunity to publicise the wide range of support offered by our Involvement, Recovery & Wellness Centres.

Research shows that nearly 1 in 4 LGBT+ young people have tried to take their own life. 52% have reported self-harm, compared to 25% of heterosexual young people. This difference is due to many factors, including but not limited to social isolation, bullying, feelings of distress and not being accepted; all of which can cause anxiety, depression and suicidal ideation. With this in mind, members of our Winsford CAMHS team once again took part in the Chester Pride parade with the ultimate aim of helping and supporting the young people we work with to feel safe to discuss their individual thoughts around their own gender and sexuality, to reassure them that it is ok to be different and to celebrate inclusion together.

PRIDE! CHESTER

5. Autism Training

During 2018-19, we held a high profile Autism Training event which was opened by The National Autism Champion and CWP's Medical Director, and delivered by the National Autism Champion and Consultant OT of CANDIDD Autism Service) with a range of guest speakers. We now plan to develop and roll out a programme of Autism Training across all Care Groups and localities within the Trust and to include within these events a session highlighting links to EDI and protected characteristics.

Cheshire and Wirral Partnership NHS Foundation Trust

6. Workforce Race Equality Standard (WRES)

The CWP 2018 NHS Staff Survey was completed by 1683 staff, which is a response rate of 48% and is above average (45%) for a combined mental health / learning disability trust in England. It compares with a response rate in the Trust in 2017of 53%. Equality, Diversity and Inclusion feedback from the NHS Staff Survey indicates that this is one of our strongest themes and that we are amongst the highest when compared with other Mental Health providers.
Indicators from the Staff Survey also contribute to certain criteria within the Workforce Race Equality Standard (WRES) and the new Workforce Disability Equality Standard (WDES). Highlighting any differences between the experiences and treatment of people covered by protected characteristics who are working within CWP.

The NHS Workforce Race Equality Standard Indicators *(please note the wording used is directly from the criteria)*

Workforce Indicators

For each of these four workforce indicators, compare the data for White and BME staff

Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

Note: Organisations should undertake this calculation separately for non-clinical and for clinical staff

Relative likelihood of staff being appointed from shortlisting across all posts

Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

Note: This indicator will be based on data from a two year rolling average of the current year and the previous year

Relative likelihood of staff accessing non-mandatory training and CPD

National NHS Staff Survey indicators

For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.

KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion

Q217. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

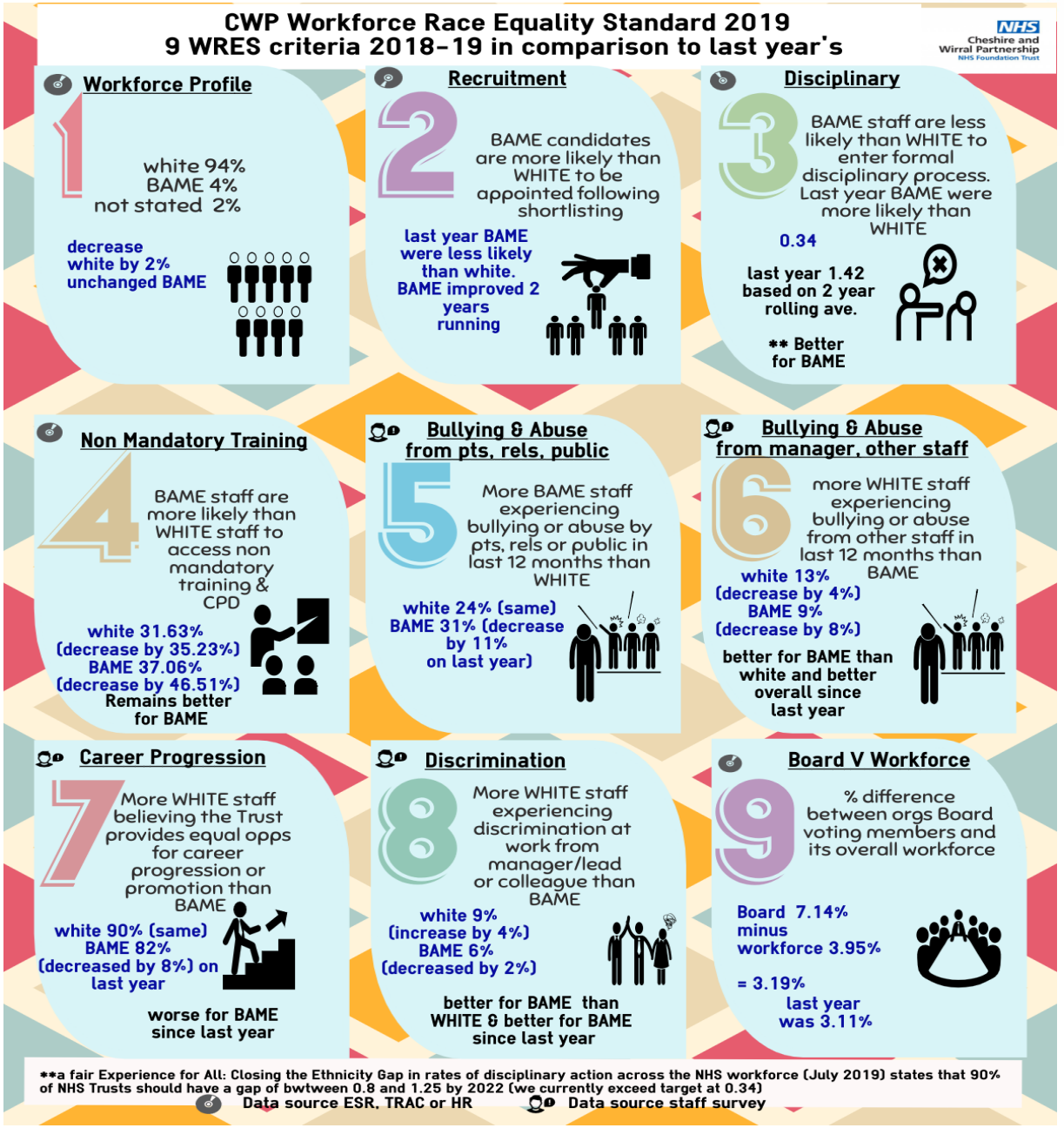
Board representation indicator

For this indicator, compare the difference for White and BME staff

Percentage difference between the organisations' Board voting membership and its overall workforce

Note: Only voting members of the Board should be included when considering this indicator

The infograph image provides an ‘at a glance’ view of the WRES criteria and results for CWP. The detailed data is contained further within this report.



Workforce Race Equality Standard (WRES)

The NHS Equality and Diversity Council agreed in July 2014 that action across the NHS needs to be taken to ensure employees from black and ethnic minority (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

Whilst Equality, Diversity and Inclusion feedback from the NHS Staff Survey indicates that this is one of our strongest themes and that we are amongst the highest when compared with other Mental Health/Learning Disability and community trusts, responses from BAME staff members which inform certain parts of the WRES highlight some areas for improvement which will remain a focus moving forward as we also look to develop our network for staff members from a BAME background.

The WRES consists of nine metrics, four of which are specifically on workforce data and one of which is concerned with the percentage difference between Trusts' Board voting membership and the overall workforce. In terms of workforce data, CWP continues to perform better than a number of other Trusts in respect of BME Board representation.

Following last year's report, we developed a WRES action driver diagram to progress key actions within Criteria 5, Criteria 6 and Criteria 8 which is where improvements were required. Since both of these criteria have shown improvements this year, we will now revisit, refresh and refocus since Criteria 5 still needs further improvement and criteria 7 now needs additional work. We also intend to engage with members of our BAME Network to help us understand how we can look to progress in a positive way.

WRES Action Driver Diagrams

Diagram 1

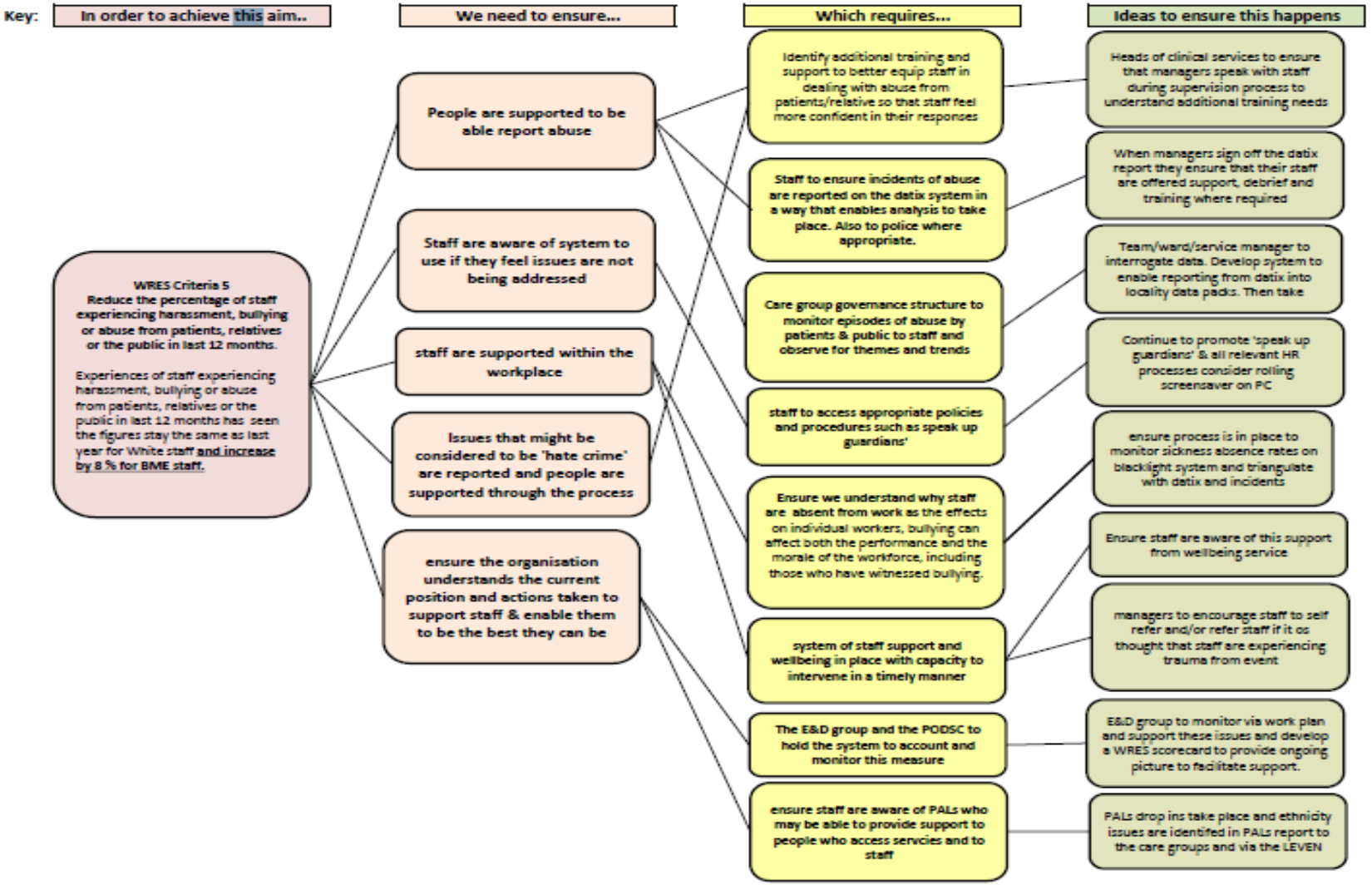


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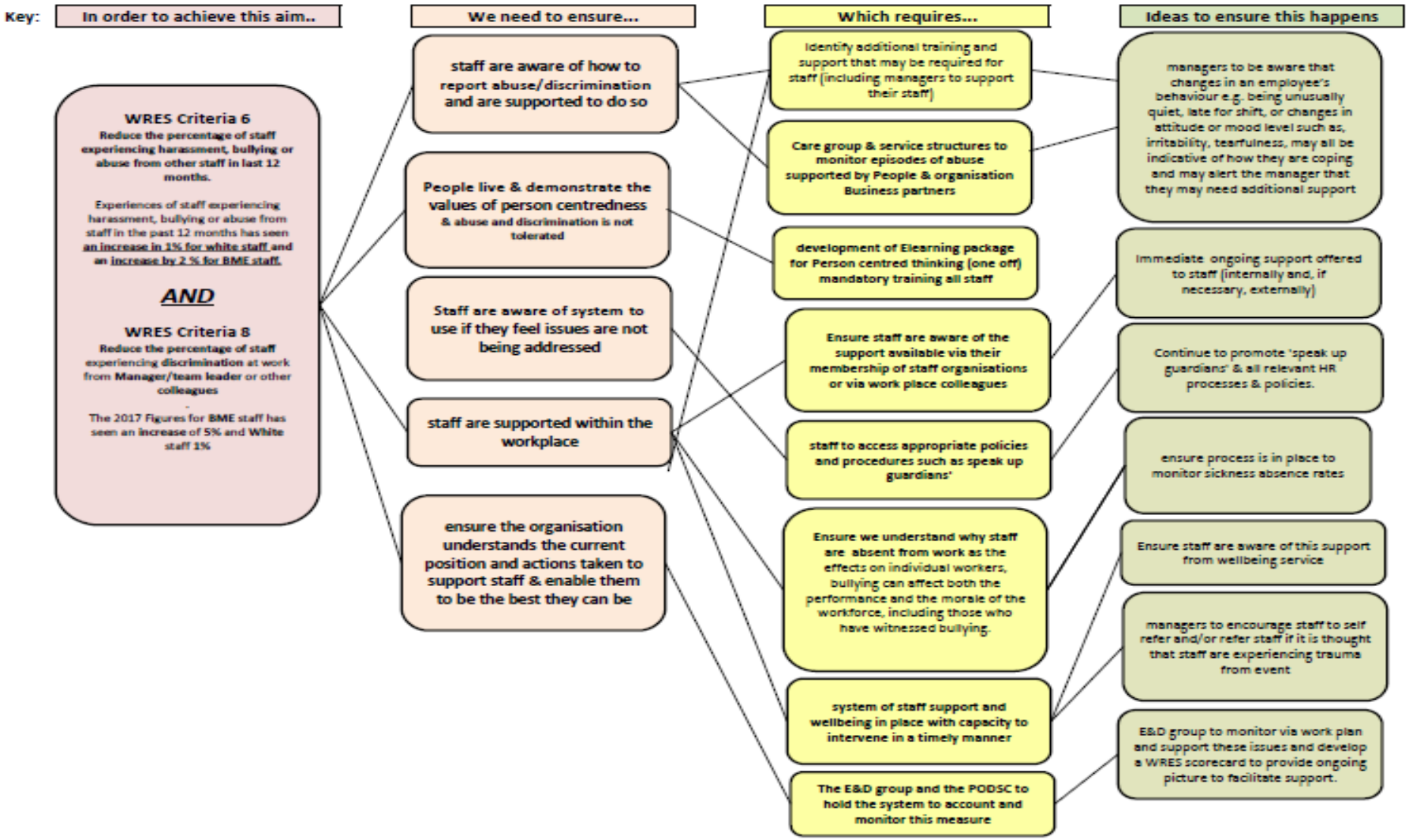
Diagram 2



Workforce Indicators (Workforce Race Equality Standard (WRES)

For each of these four workforce indicators, compare the data for White and BME staff

1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

Note: Organisations should undertake this calculation separately for nonclinical and for clinical staff

2. Relative likelihood of staff being appointed from shortlisting across all posts
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

Note: This indicator will be based on data from a two year rolling average of the current year and the previous year

4. Relative likelihood of staff accessing non-mandatory training and CPD

National NHS Staff Survey Indicators

For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.

5. KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6. KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
7. KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.
8. Q217. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.

Board representation indicator

For this indicator, compare the difference for White and BME staff

9. Percentage difference between the organisations' Board voting membership and its overall workforce

Note: Only voting members of the Board should be included when considering this indicator.

Cheshire and Wirral Partnership
NHS Foundation Trust

Workforce Indicators

Indicator 1 - Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

Clinical or non-clinical		BME	White	Not stated
Clinical	Band 1	0.0%	0.0%	0.0%
	Band 2	0.0%	100.0%	0.0%
	Band 3	3.0%	95.6%	1.4%
	Band 4	3.3%	95.6%	1.1%
	Band 5	2.2%	96.9%	0.9%
	Band 6	2.1%	95.7%	2.2%
	Band 7	4.2%	91.5%	4.2%
	Band 8a	1.0%	97.1%	2.0%
	Band 8b	16.7%	83.3%	0.0%
	Band 8c	0.0%	90.0%	10.0%
	Band 8d	0.0%	100.0%	0.0%
	Other / Local Pay	2.3%	92.4%	5.3%
	VSM	0.0%	100.0%	0.0%
	Medical and Dental	**46.7%**	**52.3%**	**0.9%**
	of which consultants	47.6%	51.2%	1.2%
	of which Senior medical manager	50.0%	50.0%	0.0%
	of which non cons career grades	42.9%	57.1%	0.0%
	of which trainee grades	46.2%	53.8%	0.0%
	of which others	0.0%	100.0%	0.0%
Clinical Total		**4.6%**	**93.2%**	**2.2%**
Non clinical	Band 1	3.2%	94.6%	2.2%
	Band 2	3.3%	96.2%	0.5%
	Band 3	2.3%	97.3%	0.3%
	Band 4	2.9%	94.9%	2.2%
	Band 5	1.7%	96.6%	1.7%
	Band 6	1.4%	95.7%	2.9%
	Band 7	0.0%	97.6%	2.4%
	Band 8a	8.7%	87.0%	4.3%
	Band 8b	0.0%	96.7%	3.3%
	Band 8c	0.0%	100.0%	0.0%
	Band 8d	0.0%	0.0%	0.0%
	Other / Local Pay	0.0%	88.9%	11.1%
	VSM	0.0%	100.0%	0.0%
Non clinical Total		**2.5%**	**96.1%**	**1.4%**
Grand Total		**4.0%**	**94.0%**	**2.0%**

Cheshire and Wirral Partnership
NHS Foundation Trust

Indicator 2 - Relative likelihood of staff being appointed from shortlisting across all posts

Current Year 2018-19

	Shortlisted	Appointed	Relative Likelihood of Shortlisted/Appointed
White	4544	295	6.49%
BME	378	26	6.88%
Not Stated	150	42	28.00%
I do not wish to disclose	40	4	10.00%
Relative Likelihood of White staff being appointed from shortlisting compared to BME			0.94

Previous Year 2017-18

	Shortlisted	Appointed	Relative Likelihood of Shortlisted/Appointed
White	3111	433	13.92%
BME	264	29	10.98%
Not Stated	43	14	32.56%
I do not wish to disclose	8	2	25.00%
Relative Likelihood of White staff being appointed from shortlisting compared to BME			1.27

The relative likelihood for the current year 2018-19 indicates that BME staff are **MORE** likely to be appointed when compared to white staff. This is in contrast to the previous year 2017-18 where BME staff were **LESS** likely to be appointed when compared to white staff.

Indicator 3 - Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

Note: This indicator is based on data from a two year rolling average of the current year and the previous year.

Current year's average April 2017 to March 2019

Average over 2 years	Entering Formal Disc Process	Headcount	Relative Likelihood of staff entering the Disciplinary Process
White	70	3367	2.08%
BME	1	143	0.69%
Not Stated	0	106	0.00%
Relative Likelihood of BME staff entering the formal Disciplinary process compared to White staff.			0.34

Previous year's average April 2016 to March 2018

Average over 2 years	Entering Formal Disc Process	Headcount	Relative Likelihood of staff entering the Disciplinary Process
White	82	3258	2.52%
BME	5	140	3.57%
Not Stated	0	77	0.00%
Relative Likelihood of BME staff entering the formal Disciplinary process compared to White staff.			1.42

The relative likelihood of the current year's average for April 2017 to March 2019 indicates that BME staff are **LESS** likely to enter the formal disciplinary process when compared to white staff. This is in contrast to the previous year's April 2016 to March 2018 where BME staff were **MORE** likely to enter the formal disciplinary process when compared to white staff

Cheshire and Wirral Partnership NHS Foundation Trust

Indicator 4 - Relative likelihood of staff accessing non-mandatory training and CPD

Current Year 2018-19

	Accessing non-mand / CPD training	Headcount	Relative Likelihood of staff accessing non-mand / CPD training
White	1065	3367	31.63%
BME	53	143	37.06%
Not Stated	26	106	24.52%
Relative Likelihood of White staff accessing non-mand / CPD training.			0.85

Previous Year 2017-18

	Accessing non-mand / CPD training	Headcount	Relative Likelihood of staff accessing non-mand / CPD training
White	2146	3258	65.86%
BME	117	140	83.57%
Not Stated	42	77	54.54%
Relative Likelihood of White staff accessing non-mand / CPD training.			0.79

The relative likelihood for the current year 2018-19 indicates that BME staff are **MORE** likely to access non-mandatory training when compared to white staff. This is in keeping to the previous year 2017-18 where BME staff were also **MORE** likely to access non-mandatory training when compared to white staff.

National NHS Staff Survey Indicators

Indicator 5 - KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

	2018 Survey	2017 Survey	2016 Survey
White	24%	24%	27%
BME	31%	42%	40%

The results from the latest staff survey indicates that a larger proportion of BME staff have experienced harassment, bullying or abuse from patients, relatives or the public when compared to white staff. This is also the case for the previous 2 years of staff survey results but the percentage is reducing.

Indicator 6 - KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

	2018 Survey	2017 Survey	2016 Survey
White	13%	17%	16%
BME	9%	17%	15%

The results from the latest staff survey indicates a smaller proportion of BME staff have experienced harassment, bullying or abuse from staff when compared to white staff. This is also the case for the previous 2 years of staff survey results.

Indicator 7 - KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion

	2018 Survey	2017 Survey	2016 Survey
White	90%	90%	91%
BME	82%	90%	97%

The results from the latest staff survey indicate that fewer BME staff believe the trust provides equal opportunities for career progression or promotion when compared to white staff. For the previous staff survey in 2017 the figures for both BME and white were the same and in 2016. The proportion of BME staff that believe the trust provides equal opportunities for career progression has reduced from 97% in 2016 to 82% in 2018.

Indicator 8 - Q217. In the last 12 months, have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

	2018 Survey	2017 Survey	2016 Survey
White	9%	5%	4%
BME	6%	8%	3%

The results from the latest staff survey indicates that fewer BME staff have experienced discrimination from their manager when compared to white staff.

Indicator 9 - Percentage difference between the organisations' Board voting membership and its overall workforce

Current Year 2018-19

	Board Member		Overall Workforce		Percentage difference between the organisation board voting membership and its overall workforce
White	12	85.71%	3367	93.11%	-7.40%
BME	1	7.14%	143	3.95%	3.19%
Not Stated	1	7.14%	106	2.93%	4.21%

As at March 2019, the Trust's Board is made up of 7.14% of BME staff compared with 3.95% of the overall trust. A difference of 3.19%.

Previous Year 2017-18

	Board Member		Overall Workforce		Percentage difference between the organisation board voting membership and its overall workforce
White	12	85.71%	3258	93.76%	-8.04%
BME	1	7.14%	140	4.03%	3.11%
Not Stated	1	7.14%	77	2.22%	4.93%

As at March 2018, the Trust's Board was made up of 7.14% of BME staff compared with 4.03% of the overall trust. A difference of 3.11%.

WRES Indicators

- There has been an improvement since last year in relation to the recruitment of Black, Asian and Minority Ethnic (BAME) people in that they are now more likely than white people to be appointed following shortlisting. Last year BAME people were less likely.
- Disciplinary information also shows improvements for BAME people in that they are now less likely than their white colleagues to enter the disciplinary process. Last year BAME people were more likely.
- BAME staff are still more likely than their white colleagues to access non-mandatory training.
- The percentage of BAME staff who have experienced harassment, bullying or abuse from patients, relatives or the public has decreased for the third year running. However, the percentage still remains higher than for white staff.
- Less BAME staff are experiencing bullying and abuse from managers or staff than their white colleagues. This was also the case for the previous 2 years.
- For the second year running, fewer BAME staff have experienced discrimination from their manager when compared to white staff. The percentage itself has also decreased from last year.
- CWP still has a higher representation of BAME people at Board level than the Workforce as a whole.

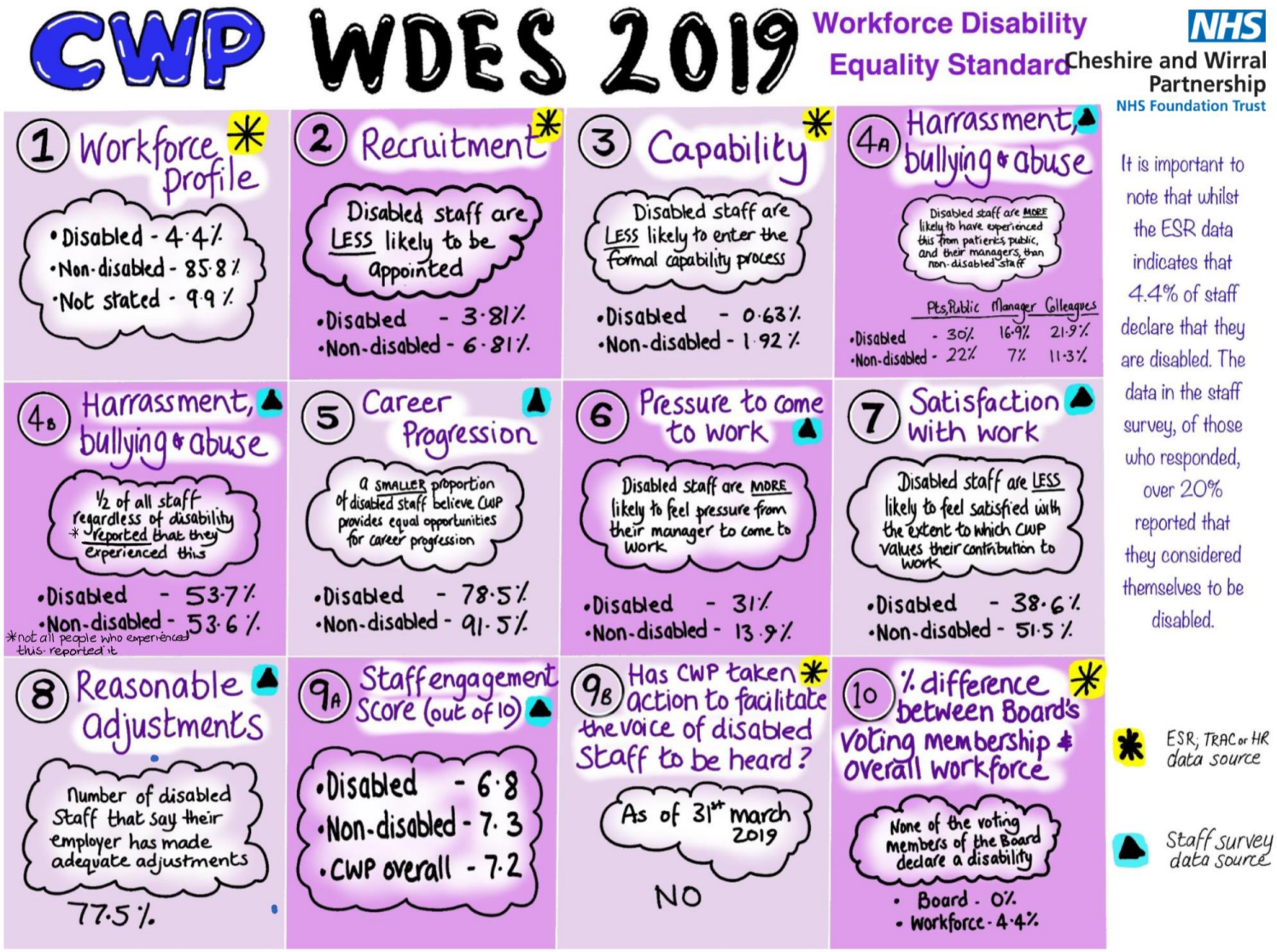
However:

- As stated above, despite the year on year reduction, more BAME staff than white staff are experiencing bullying and abuse from patients, relatives or the public than white staff.
- Less BAME staff than white staff believe that the Trust provides equal opportunities for career progression and this is in contrast to last year when feedback from BAME was the same as feedback from white staff.

It is hoped that the BAME Network will help us to understand what is behind these responses and how to progress in a positive way. In terms of Career Progression for BAME, we will also consider addressing the lack of BAME staff at certain levels within the Trust with a view to considering BAME representation on interview panels when BAME candidates are shortlisted for interview at these levels. Furthermore, two recently published documents provide guidance in relation to protected characteristics (including ethnicity). The first offers ten high impact evidence based actions which, if acted upon, will help Boards foster a more diverse and inclusive NHS. The second, 'A Fair Experience For All' document relates specifically to closing the ethnicity gap in rates of disciplinary actions. Both papers compliment, impact upon and influence each other. Taking on board these actions and developing this work further will support in our Equality, Diversity and Inclusion objectives over the coming year.

7. Workforce Disability Equality Standard (WDES)

Cheshire and Wirral Partnership NHS Foundation Trust



The infograph image provides an 'at a glance' view of the WDES criteria and results for CWP. The detailed data is contained further within this report.

Workforce Disability Equality Standard (WDES)

From 2019, the WDES forms part of the NHS Standard Contract. Our first report covers staff information for the 2018-2019 reporting year. It consists of a set of specific measures to enable us to compare the experiences of disabled and non-disabled staff since research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety. The report will enable us to better understand the experiences of disabled staff and will support positive change for existing employees, enabling a more inclusive environment for disabled people delivering our services.

As can be seen, there are positives from our first report. For noting is that 21% of all staff completing their staff survey in 2018 identified that they have a disability whereas of the current workforce profile on ESR, only 4.43% have a disability recorded against their staff file. We therefore need to raise awareness of the need for people to update their ESR records in the coming year.

Feedback relating to bullying, harassment and abuse from colleagues and pressure to come to work and feeling valued all highlight areas for us to review our employment practises for disabled staff. . We also need to focus on ensuring that we are making all reasonable adjustments for people working in the Trust. The launch of our Disabled Staff Network will help us to understand how we can address these areas. We will work with our People Services colleagues to develop a driver diagram so that we can demonstrate and measure improvement over the coming year.

The NHS Workforce Disability Equality Standard Indicators *(wording is taken from the criteria)*

Workforce Indicators

For each of these four workforce indicators, compare the data for Non-Disabled and Disabled staff

1. Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes

2. Relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff across all posts
3. Relative likelihood of Disabled staff compared to Don-Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Note: This indicator will be based on data from a two year rolling average of the current year and the previous year

Indicators of the National NHS Staff Survey (or equivalent) *(wording taken from the criteria)*

For each of the staff survey indicators, compare the outcomes of the responses for Non-Disabled and Disabled staff.

4.

a)Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months from:

i. Patients/service users, their relatives or other members of the public
ii. Managers
iii. Other colleagues

b) Percentage of Disabled staff compared to Non-Disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

5. Percentage of Disabled staff compared to Non-Disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

6. Percentage of Disabled staff compared to Non-Disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

7. Percentage of Disabled staff compared to Non-Disabled staff saying that they are satisfied with the extent to which their organisation values their work.

8. Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

9.

a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)

If yes, please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. If no, please include what action is planned to address this gap in your WDES annual report. Examples are listed in the WDES technical guidance

Board representation indicator

For this indicator, compare the difference for Non-Disabled and Disabled staff

10. Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

Note: Only voting members of the Board should be included when considering this indicator.

NHS
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NHS Foundation Trust

Indicator 1 - Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

Clinical or non-clinical		Disabled	Non-Disabled	Not stated
Clinical	Band 1	0.0%	0.0%	0.0%
	Band 2	0.0%	91.7%	8.3%
	Band 3	4.8%	82.7%	12.5%
	Band 4	2.2%	90.0%	7.8%
	Band 5	4.1%	90.2%	5.7%
	Band 6	3.5%	87.7%	8.7%
	Band 7	4.5%	89.4%	6.1%
	Band 8a	2.9%	89.2%	7.8%
	Band 8b	0.0%	91.7%	8.3%
	Band 8c	0.0%	70.0%	30.0%
	Band 8d	0.0%	100.0%	0.0%
	Other / Local Pay	4.6%	26.7%	68.7%
	VSM	0.0%	100.0%	0.0%
	Medical and Dental	**3.7%**	**87.9%**	**8.4%**
	of which consultants	3.6%	86.9%	9.5%
	of which Senior medical manager	0.0%	100.0%	0.0%
	of which non cons career grades	6.3%	93.8%	0.0%
	of which trainee grades	0.0%	100.0%	0.0%
	of which others	0.0%	100.0%	0.0%
Clinical Total		3.8%	84.7%	11.5%
Non-clinical	Band 1	9.7%	83.9%	6.5%
	Band 2	6.2%	90.0%	3.8%
	Band 3	4.7%	90.0%	5.4%
	Band 4	5.8%	90.5%	3.6%
	Band 5	6.8%	89.8%	3.4%
	Band 6	2.9%	92.8%	4.3%
	Band 7	2.4%	92.9%	4.8%
	Band 8a	0.0%	87.0%	13.0%
	Band 8b	3.3%	86.7%	10.0%
	Band 8c	12.5%	87.5%	0.0%
	Band 8d	0.0%	0.0%	0.0%
	Other / Local Pay	11.1%	0.0%	88.9%
	VSM	8.7%	91.3%	0.0%
Non clinical Total		5.6%	88.8%	5.6%
Grand Total		4.4%	85.8%	9.9%

Indicator 2 - Relative likelihood of staff being appointed from shortlisting across all posts

Current Year 2018-19

	Shortlisted	Appointed	Relative Likelihood of Shortlisted/Appointed
Disabled	341	13	3.81%
Non-Disabled	4520	308	6.81%
Not Stated	153	43	28.10%
I do not wish to disclose	98	3	3.06%
Relative Likelihood of Non-Disabled staff being appointed from shortlisting compared to Disabled			1.79 Times more likely

The relative likelihood indicates that Disabled staff are **LESS** likely to appointed when compared to Non-Disabled staff

Indicator 3 - Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Note: This indicator is based on data from a two year rolling average of the current year and the previous year

Current Year 2017-18 and 2018-19

Average over 2 years	Entering Formal Capability Process	Trust Headcount	Relative Likelihood of staff entering the capability Process
Non-Disabled	59	3071	1.92%
Disabled	1	158	0.63%
Not Stated	1	16	6.25%
Relative Likelihood of Disabled staff entering the formal Disciplinary process compared to Non-Disabled staff.			0.33

The relative likelihood indicates that Disabled staff are **LESS** likely to enter the formal capability process when compared to Non-Disabled staff.

Indicator 4a - Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from

Category	Question	2018 Survey	2017 Survey	2016 Survey
Non-Disabled	Patients/service users, relatives or public	22.6%	22%	24%
	Managers	7.0%	8.0%	Not available
	Other colleagues	11.3%	9.0%	15%
Disabled	Patients/service users, relatives or public	30.8%	33%	27%
	Managers	16.9%	15%	Not available
	Other colleagues	21.9%	20%	21%

The results from the latest staff survey in 2018 indicate that Disabled staff are **MORE** likely to have experienced harassment, bullying or abuse from Patients/Service users, relatives or other members of the public and from their managers than non-disabled staff.

Indicator 4b - Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

Category	2018 Survey	2017 Survey	2016 Survey
Non-Disabled	53.6%	61%	60%
Disabled	53.7%	58%	56%

The results from the latest staff survey indicates that approximately half of all staff regardless of disability reported an experience of harassment, bullying or abuse at work.

Indicator 5 - Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

Category	2018 Survey	2017 Survey	2016 Survey
Non-Disabled	91.5%	91%	92%
Disabled	78.5%	84%	88%

The results from the latest staff survey indicates that a larger proportion of disabled staff believe the trust provides equal opportunities for career progression than non-disabled staff.

Indicator 6 - Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Category	2018 Survey	2017 Survey	2016 Survey
Non-Disabled	13.9%	16%	49%
Disabled	31.0%	24%	64%

The results from the latest staff survey indicates that disabled staff are **MORE** likely to feel pressure from their manager to come to work than non-disabled staff. This was also the case for 2017 and 2016.

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Cheshire and Wirral Partnership
NHS Foundation Trust

Indicator 7 - Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

Category	2018 Survey	2017 Survey	2016 Survey
Non-Disabled	51.5%	50%	Not available
Disabled	38.6%	39%	Not available

The results from the latest staff survey indicates that disabled staff are **LESS** likely to feel satisfied with the extent to which CWP values their work than non-disabled staff. Results of the 2017 staff also indicate that disabled staff are less likely to feel satisfied with the extent to which CWP values their work than non-disabled staff.

Indicator 8 - Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

Category	2018 Survey	2017 Survey	2016 Survey
Disabled	77.5%	79%	84%

The percentage of disabled staff saying that the trust has made adequate adjustment(s) to enable them to carry out their work has declined year-on-year. Almost a quarter of disabled staff feeling that trust hasn't made adequate adjustments.

Indicator 9a - The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation. (Out of 10)

Category	2018 Survey
Non-Disabled	7.3
Disabled	6.8
Overall Trust	7.2

Indicator 9b - Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)
If yes, please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. If no, please include what action is planned to address this gap in your WDES annual report. Examples are listed in the WDES technical guidance (to note we are taking action since the reporting period)

Indicator 10 - Percentage difference between the organisations' Board voting membership and its overall workforce.

Category	Board Member		Overall Workforce	
Non-Disabled	13	100.00%	3071	85.71%
Disabled	0	0.00%	158	4.41%
Not Stated	0	0.00%	354	9.88%
Percentage difference between the organisation board voting membership and its overall workforce			-4.41%	

The Trust's Board is made up of 0% of Disabled staff compared with 4.4% of the overall Trust.

8. Gender Pay Gap

CWP is passionate about creating a fulfilling, diverse and inclusive place to work, with equality and fairness at the heart of our values, policies and everyday practices. We are committed to be an employer of choice and work hard to ensure that our staff have equality of access to vacancies, promotion and training. This and other supportive policies make CWP a more inclusive place to work.

The Gender Pay Gap is a measure of comparisons between average hourly rates and bonuses. It does not cover equal pay as this would look at comparing the individual earnings of a female and a male doing equal work.

In line with our Gender Pay Gap obligations, we now publish on our website and on a government website, the following:

- mean gender pay gap
- median gender pay gap
- mean bonus gender pay gap
- median bonus gender pay gap
- proportion of males and females receiving a bonus payment
- proportion of males and females in each pay quartile.

For CWP's full Gender Pay Gap report, please see the link below: http://www.cwp.nhs.uk/resources/reports/cwp-gender-pay-gap-report-2018/

Our data highlights that there is a gender pay gap with women across the average, median and bonus gap being paid less than males. There is a significant gap in average bonus payments for the year 1/4/17-31/3/18 due to Clinical Excellence Award payments for medical staff – the average bonus payment to men was 72.03% higher, however the median was 0%.

CWP's hourly gender pay gap continues to be less than the national public sector gender pay gap but there is room for development to reduce the gap further wherever this exists for each band and staff group. In addition the gender gap in bonus payments also needs to be addressed. Key drivers for the gender pay gap are understood to be the outcome of a variety of factors outside the control of individuals such as unpaid carer responsibilities. CWP is committed to workforce equality and have agreed the following actions:

Strengthening of unconscious bias training for recruiting managers including refresher training

- Task and Finish group to review the flexible working policy and access to flexible working opportunities which will lead to raising awareness
- Development of a talent management programme to support all employees with their career development which may be outside of their current role
- Continue to roll out the development programme for people to shadow senior leaders and executive board members
- Further publicise story telling by people working at VSM level within the Trust
- Promotion of development opportunities such as Apprenticeships and regional training
- Continue encouraging applications from female medics for Clinical Excellence Awards.

We have met Gender Pay Gap reporting obligations and the results are published on the CWP internet website.

9. Translation & Interpretation

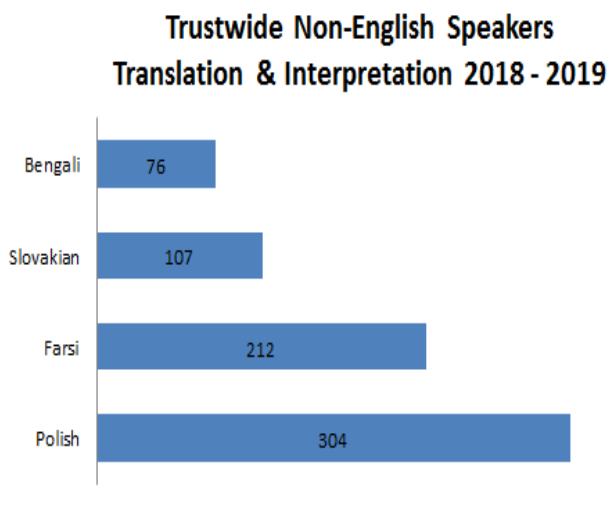
In order to meet the needs of people accessing our services whose first language is not English, the Trust has a varied list of recognised service providers in place to meet interpretation and translation requirements. This includes telephone interpretation, face to face interpretation, written translation, British Sign Language, Easy Read, Audio, Braille and Large Print.

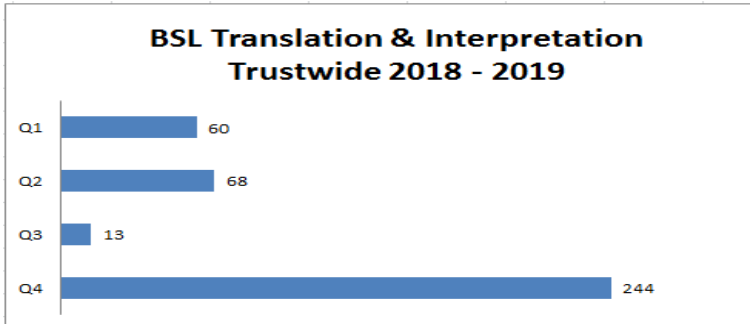
The Trust continues to promote its Interpretation & Translation Best Practice Guidance for booking interpretation and translation services. The CWP website has the Browse Aloud facility, which adds speech, reading and translation support to the Trust website facilitating access and participation for those people with print disabilities, dyslexia, low literacy, mild visual impairments and those with English as a second language.

For the year 2018-2019 the 4 most common languages requested for interpretation across the CWP footprint were Polish followed by Farsi, Slovakian and Bengali.

For our full Translation and Interpretation Report, please see the link below:
http://nww.cwp.nhs.uk/TeamCentre/PatientCarerExperience/Pages/Equality-and-Diversity.aspx

For the year 2018-2019, the 4 most common languages are detailed in the image below.



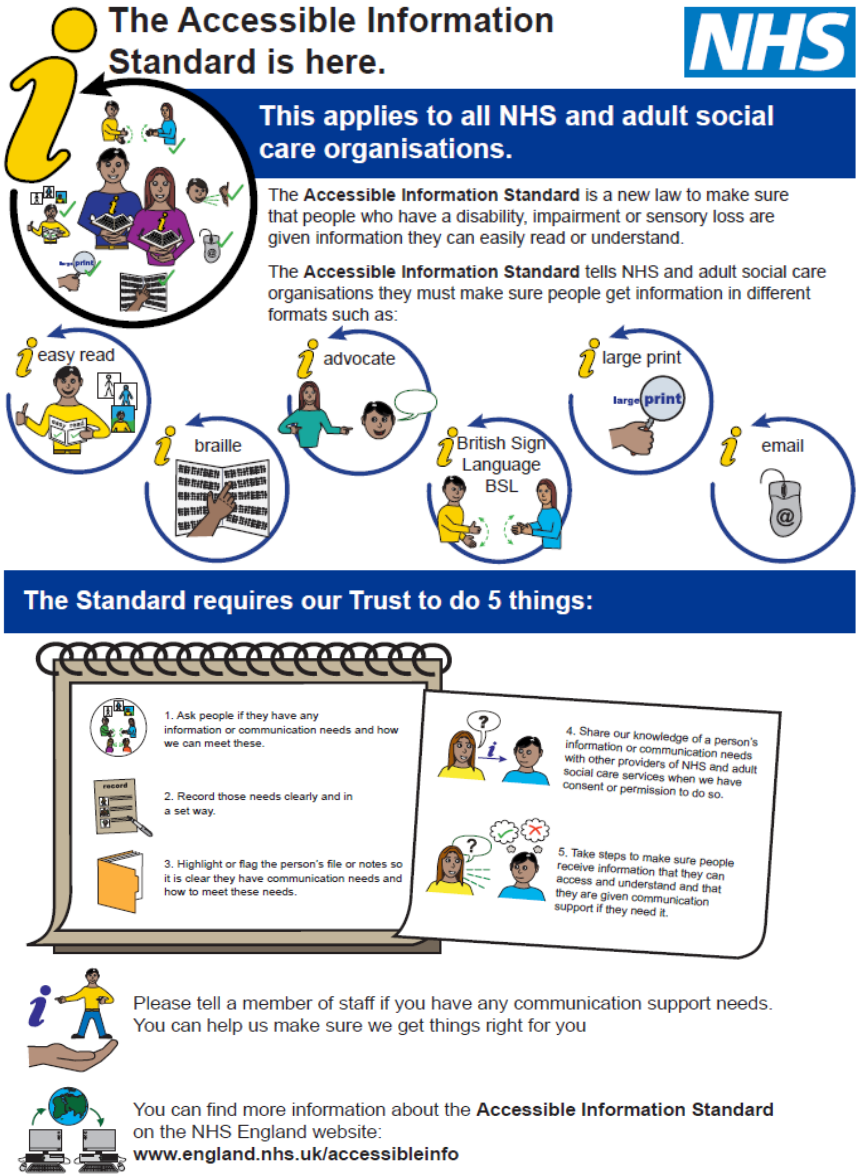


This graph highlights the use of British Sign Language (BSL) interpreters for members of the Deaf Community from April 2018 to March 2019. In total, a BSL interpreter was used on 385 occasions during the year.

10. Accessible Information Standard

This aims to ensure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand with support so they can communicate effectively with services. Examples of possible types of support include large print, braille or a British Sign Language (BSL) interpreter.

The Trust has promoted the Accessible Information Standard and has begun to implement the five requirements of the standard:



1. Ask people if they have any information or communication needs, and find out how to meet their needs.

2. Record those needs clearly and in a set way.

3. Highlight or 'flag' the person's file or notes so it is clear that they have information or communication needs and how those needs should be met.

4. Share information about people's information and communication needs with other providers of NHS and adult social care, when they have consent or permission to do so.

5. Take steps to ensure that people receive information which they can access and understand and receive communication support if they need it.

11. CWP Equality Priorities 2016 -2020

CWP's Commitment to Delivering Personal, Fair and Diverse Healthcare Services Equality Priorities 2016—2020

In 2016, CWP produced its Trust wide 4 year Equality Objective Action Plan 2016-2020, the actions in the plan were agreed after reviewing information and evidence from the various EDS2 assessments, NHS England initiatives and issues raised by staff and the local EDI network groups.

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

CWP' Values: Care Compassion Competence Communication Courage Commitment

Improving our Intelligence

- Develop a Trust-wide approach to collecting equality information
- Review current people accessing CWP services data/ information in order to address gaps in equality and diversity information reporting.
- Develop in partnership with representatives of local community group processes and information sessions for improving CWP staff collection of equality data / information
- Work with lived experience representatives to further consult with people who access CWP services and their carers in relation to Trust E & D objectives and action plan
- Formalise relationship with Local Authority, third sector and other statutory bodies to enable greater sharing of data and intelligence information in relation to equality groups and health inequalities

Developing our Staff

- Provide training and development opportunities for all staff across the Trust and provide a summary of mandatory and non - mandatory training by ethnic groups providing data for the Trustwide Equality & Diversity Committee
- The Trust to develop a diverse workface in the various bandings and attract minority staff across the range of job opportunities and in particular into senior roles.
- Develop a range of successful community and staff engagement events and activities that highlight different communities and demonstrate the Trusts commitment to being a personal, fair and diverse organisation
- Develop a successful staff diversity forum and champions network that plays a meaningful role within the Trust and local community
- Staff to complete all CWP mandatory training

Working with out Communities

- Corporately and locally develop robust partnership working with third sector providers including the sharing of information and intelligence, partnership service delivery and shared training events
- Develop leaflets with partnership organisations to ensure they are reflective and meet the needs of our targeted communities and ensure our website is truly reflective of our personal, fair and diverse services we deliver.
- Develop the various CWP locality network groups that consist of staff and members of the various diverse community groups
- Invite representatives from the various diverse community to present information and training sessions on issue relating to their specific group,
- Support local community events across the CWP footprint example: Chester Pride

Underpinning Requirements

The Equality Act 2010 NHS Equality Delivery System (EDS2) Workforce Race Equality Standard (WRES) Care Quality Commission requirements

Quality Contracts

Contract Guidance recommends that commissioners' service specifications should clearly set out requirements for protected groups where there is a need to do so. Through their contract monitoring, commissioners ensure that providers are working towards better health outcomes for all and improved patient access and experience. The EDS2 provides a tool to flag issues of concern which can then be dealt with through the contract monitoring process.

Trust Diversity Information

This year, the Trust has published a variety of reports and information to meet both its statutory and contractual obligations. These reports can be found on the CWP website:

http://www.cwp.nhs.uk/about-us/our-vision-and-values/equality-and-diversity/

- Equality Delivery Standard 2 (EDS2)
- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)
- Interpretation and Translation Report
- Equality, Diversity & Inclusion 4 Year Objective Action Plan 2016-2020
- Gender Pay Gap Report

12. Equality Impact Assessments

Equality, Diversity & Inclusion influences all CWP policies. We therefore ensure that all new or reviewed policies undergo an Equality Impact Assessment to provide assurance that all aspects of the Equality Act 2010 have been considered. Equality Impact Assessments are completed on all CWP policies, strategies and proposed changes to services.

In the early part of 2019/2020, we plan to link this process to the Quality Impact Assessment framework so as to ensure that Quality and Equality continue to go hand in hand

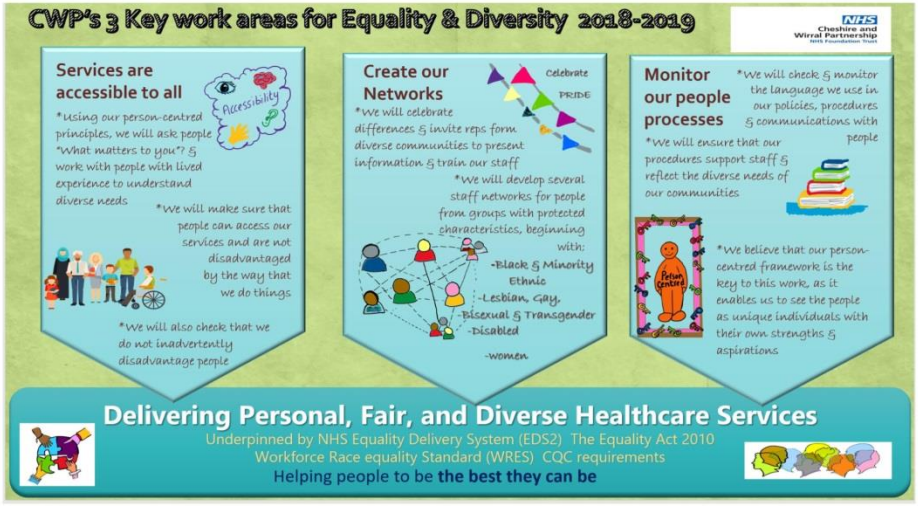
in every aspect of service delivery and employment practice and that we are providing the best possible service and employment provision for everybody including those covered by protected characteristics under the Equality Act 2010.

We will also improve the level of guidance in the template and so increase people's understanding of completing assessments.

13. Key Developments and Challenges

Key Developments

- EDS2 Evidence: worked with Healthwatch and have had guest speakers coming to the Trust to meet the CWP Equality Champions to discuss issues relevant to their specific groups: i.e. Unique: Transgender Organisations, Body Positive LGBT group, Wirral Change Refugees & Asylum Seekers



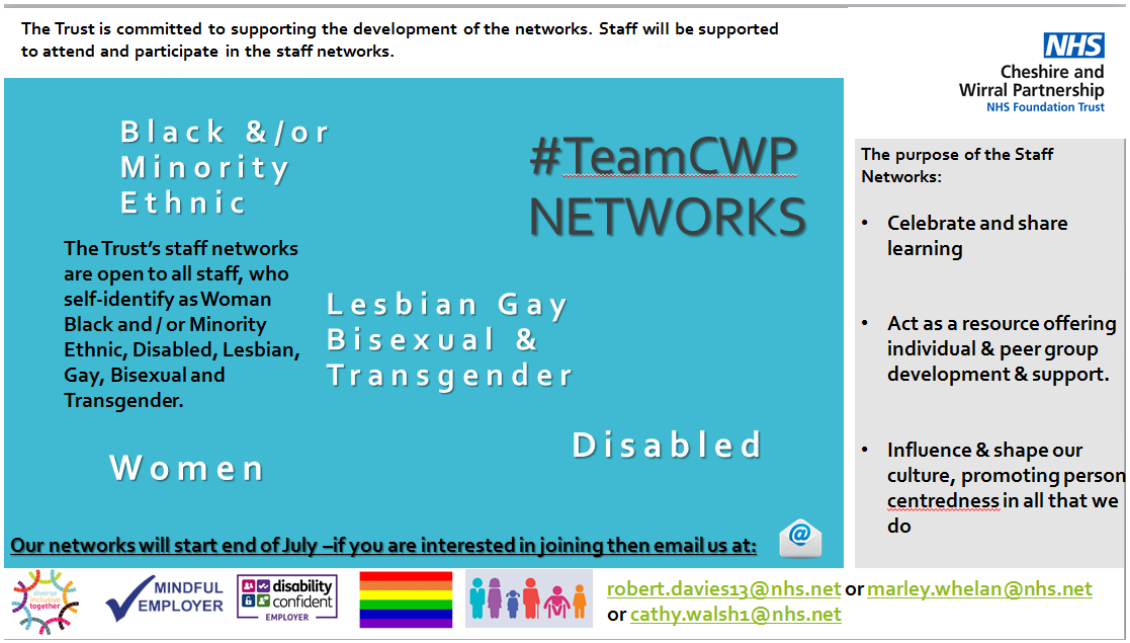
- This year's Workforce Race Equality Standard (WRES) Report has highlighted a number of improvements including the disciplinary rates for BAME staff.

- Staff network groups for BAME, Disability and LGBT were publicised widely across the Trust to gauge the level of interest. We plan to move forward with the setting up of these in 2019-20.

- Issues relating to data collection within the Trust: highlighted certain areas that need to be improved on within CareNotes, the collection of data on sexual orientation, particularly in light of the Sexual Orientation Monitoring Standard.

- The Trust has promoted Stonewall's publication 'What's It Got To Do With You?', a publication which highlights reasons for collecting data. This has been promoted on the CWP intranet and CWP Essential. Copies were also sent to all 3 Locality Equality leads and Champions and raised at the CWP Equality, Diversity & Inclusion Groups.

- During the summer of 2018, CWP supported Pride Events in Macclesfield and Chester. We plan to build on this work during the summer of 2019, involving people in the planning and implementation of our participation so as to make them really inclusive events.



- We began to develop networking and collaboration with partner organisations and other agencies in the local area so as to share best practice.

- We held a large one day Autism Training event which was delivered by the National Autism Champion and Consultant OT, CANDIDD Autism Service and a range of guest speakers.

- The Trustwide Equality, Diversity & Inclusion Group will continue to monitor the actions in response to these challenges.

Improvement priorities for 2018/19

Improving Our Intelligence

- Recognising that our reporting systems need upgrading in order to achieve improvements in the collection of data, review how protected characteristics on current systems are captured, entered and reported on and how this information is fed back to Care Group and Information & Governance Meetings, with a view to making improvements within Data Completeness Reports.
- Ensure that EDI is covered on all Care Groups Business and Governance meeting agendas.
- Accessible Information Standard (AIS) the Trust will continue to raise the profile of the AIS to staff and monitor developments and progress against the standards, working in parallel to the Green Light Toolkit. Review standard of Alerts on Care Notes in line with the AIS.
- Review the effectiveness of EDI data recorded on our DATIX computer system in relation to complaints and feed statistical data into the EDI process.
- Link the Equality Impact Assessment process to the Quality Impact Assessment framework so as to ensure that Quality and Equality are considered together in every aspect of service delivery and employment practice. We will also improve the level of guidance in the template and so increase people's understanding of completing assessments.
- Work with the Data Team to ensure compliance with all aspects of the Sexual Orientation Monitoring Information Standard.

Developing Our Staff

- Strengthen working links between People Services and EDI so as to provide the best possible service to people working within CWP services.
- Review the EDI and Human Rights Policy to reflect up to date language, make it more person centred and include more information regarding the Human Rights Act.
- In relation to the Workforce Race Equality Standard (WRES) Report, a number of positive improvements have taken place. We will continue to monitor these as part of our WRES action plan and will also work with our BAME Network to address the Staff Survey feedback that fewer BAME staff believe the Trust provides equal opportunities for career progression or promotion when compared to white staff.

Developing Our Staff (Continued)

- The introduction of the new Workforce Disability Equality Standard (WDES) highlights the requirements to review employment practises for disabled staff. The implementation of the CWP Disabled Staff Network should assist in looking to address some of the points highlighted within the report. We will work with our People Services colleagues to develop a driver diagram so that we can demonstrate and measure improvement over the coming year.
- We will also look into addressing the low numbers of BAME staff at certain levels within the Trust with a view to considering a pilot of BAME representation on interview panels when BAME candidates are shortlisted for interview at these levels.
- Progress and launch staff networks for BAME, LGBT and Disabled people.
- Review the current content, format and frequency of EDI Training for staff to ensure that this is fit for purpose.
- Devise and deliver EDI Training for members of our Council of Governors.
- Plan and deliver training events across the Trust linked to protected characteristics including the following:
    - Following the success of last year's large scale Autism Training, we will develop and roll out a programme of Autism Training across all Care Groups and localities within the Trust. These events will include a session highlighting links to EDI and protected characteristics.
    - Plan and deliver Transgender Awareness Training for staff, working with Jessica Lynn, world-renowned transgender advocate, educator, and activist and as well as people who have accessed our services.
- Participate in People Services Policy Reviews such as Flexible Working and Management of Attendance.
- Refresh the list of EDI Local Group members, review roles and responsibilities of Champions and agree and implement refreshed Terms of Reference with a view to relaunching the Groups.
- Consider the issue of Rainbow Lanyards to identify EDI Champions and so assure people that CWP is an inclusive place to work, volunteer and access services.
- Establish EDI intranet pages as a reference and signposting resource for people.
- Source and publish Staff Stories to raise awareness of protected characteristics.
- Establish and develop links with the Freedom to Speak Up team.

Working With Our Communities

- Strengthen our networking and collaboration with partner organisations and other agencies in the local area so as to share best practice.
- Devise and publish an online Calendar of Events to raise awareness of protected characteristics and celebrate local and national festivals and events throughout the year.
- Make use of quarterly CWP Life magazine, CWP Staff Facebook Page and CWP Twitter account to further increase the profile of EDI in order to continue to make it part of everything we do.
- Encourage effective use of pronouns.
- Sponsor, promote and attend Crewe Pride In The Park as well as Chester Pride, enlisting executive level involvement so as to influence as many people as possible to become involved. Hold Pride Launch events in Crewe and Chester with Board leadership as a visible demonstration of inclusion to our community.
- Following planning group meetings for Pride events within Crewe and Chester, develop networks for LGBT people.
- Plan and implement networking groups for BAME staff and staff living with a disability.
- Further develop and enhance networking and collaboration with partner organisations and other agencies in the local area so as to continue to share best practice.
- Two recently published documents provide guidance in relation to protected characteristics (including ethnicity). The first offers ten high impact evidence based actions, which if acted upon will help boards foster a more diverse and inclusive NHS. The second, 'A Fair Experience for All' document relates specifically to closing the ethnicity gap in rates of disciplinary actions. Both papers compliment, impact upon, and influence each other. Taking on board these actions and developing this work further will support in our Equality, Diversity and Inclusion objectives over the coming year.

14. Conclusion

- The Trust has met its statutory obligations in accordance with the requirements of the Equality Act 2010 and the CCGs Equality, Diversity & Inclusion Quality Requirements. Regular updates are provided to the various commissioners as requested within the quality contract.

- CWP has met its statutory obligations to monitor and report on workforce and patient Equality, Diversity & Inclusion issues and provides assurance that action is being taken to address issues of note.

- Work around the requirements of the Equality Delivery System 2 (EDS2) is enabling the Trust to develop stronger foundations to support the progression and implementation of Equality, Diversity & Inclusion principles into mainstream processes. This report demonstrates the commitment within the Trust to progress work around equality.

- The progress made in embedding the Equality, Diversity & Inclusion Framework across the Trust is updated at the Trustwide Equality, Diversity & Inclusion Group. Equality Delivery System 2 (EDS2) assessments have been completed by Healthwatch and a process for collecting evidence for the EDS2 assessments for 2019-20 has been agreed. Updates will be presented to Healthwatch at stages throughout the year and the Trust's progress will be reported on at the Trustwide Equality, Diversity & Inclusion Group.

- CWP continues to work towards our Commitment to Delivering Personal, Fair and Diverse Healthcare Services 2016—2020.

- There are governance arrangements in place to monitor progress of the CWP Trustwide 4 Year Equality, Diversity & Inclusion objective action plan. Updates will be provided to the various CWP committees.

- The Trust is compliant with the requirements of the Equality Act 2010 and the CCGs' Equality, Diversity & Inclusion Quality Requirements.
- Regular updates are provided to the various commissioners as requested in the Quality Contact.
- The progress made in embedding the Equality, Diversity & Inclusion Framework across the Trust is updated at the Trustwide Equality, Diversity & Inclusion Group.
- The Equality Delivery System 2 (EDS2) assessments have been completed by Healthwatch and a process for collecting evidence for the EDS2 assessments for 2018-19 has been agreed. Updates will be presented to Healthwatch throughout the year. The Trust's progress with be updated at the Trustwide Equality, Diversity & Inclusion Meeting.
- There are governance arrangements in place to monitor progress of the Trust's Equality, Diversity & Inclusion 4 year objective action plan - Delivering Personal, Fair and Diverse Healthcare Services 2016—2020 and updates will be provided to the various CWP committees.

15. Recommendation

- Trust Board members are invited to receive and approve the Annual Equality, Diversity & Inclusion Monitoring Report 2018-19.

NHS
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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	The Cheshire East and Cheshire West Partnerships' Five Year Plans
Agenda ref. number:	19.20.82a
Report to (meeting):	Board of Directors
Action required:	Endorse approval by other group
Date of meeting:	25/09/2019
Presented by:	Sheena Cumiskey, 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 NHSI Single Oversight Framework themes this report reflects:		CWP Quality Framework:		
Quality	Yes	Patient Safety	Safe	Yes/ No
Finance and use of resources	Yes	Clinical Effectiveness	Effective	Yes/ No
Operational performance	Yes		Affordable	Yes/ No
Strategic change	Yes		Sustainable	Yes/ No
Leadership and improvement capability	Yes	Patient Experience	Acceptable	Yes/ No
			Accessible	Yes/ No
		http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	Yes/ No

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/ No

REPORT BRIEFING

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

The Cheshire East and Cheshire West Place Partnerships' Five Year Plans are high level statements of intent, that set out the vision and aspirations of the Partnerships, to transform the health and care system across their respective local authority areas. They will feed into the Cheshire and Merseyside Health and Care Partnership Five Year Strategy – which will help to determine whether or not they achieve Integrated Care System (ICS) status.

Although there are separate Plans for each borough, they have been developed alongside each other and aligned wherever possible. Cheshire West's Plan will also replace the Health and Wellbeing Strategy for Cheshire West and Chester, which expires in 2020.

The Plans aim to improve the health and wellbeing of local communities, enabling people to live longer and healthier lives. This will be achieved by creating and delivering safe, integrated and sustainable services that meet people's needs making the best use of all the assets and resources we have available to us.

As a key partner with both Partnerships, the Five Year Plans are brought to the CWP Board of Directors for endorsement. The Plans are being taken to the governing bodies of all partner organisations prior to their final submission to the Cheshire and Merseyside Partnership.

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

NHS England requires each Sustainability and Transformation Partnership area (now known as Health and Care Partnerships) to prepare Five Year Strategies, as their response to the NHS England Long Term Plan (published January 2019). The Cheshire and Merseyside Health and Care Partnership (C&MH&CP) has started work on its Strategy and, to inform this, has asked that each of the nine 'Place based' health and care partnerships in Cheshire and Merseyside (aligned to the local authority geographies) develop their own Five Year Plans.

The Sustainability and Transformation Partnerships were formed in 2015/2016 as a result of the NHS England 'Five Year Plan's' aspirations to see closer working across health and care and progress being made towards integrated provision. There was also an imperative to make more effective use of resources across the system. The Cheshire and Merseyside STP was formed in January 2016, a partnership of the twelve clinical commissioning groups, twenty NHS provider organisations (hospitals, community and mental health trusts) and the nine local authorities. The STP was re-branded as the Cheshire & Merseyside Health & Care Partnership in 2017.

The publication of the NHS Long Term Plan in January 2019 has re-emphasised the importance of these Partnerships in the NHS future plans, with the transition to Integrated Care Systems (ICS) being the aspiration for each regional partnership by 2021. Achieving ICS status will bring additional resource and a level of autonomy for the Partnership in its decision making. The Five Year Strategy is a key element of this, demonstrating that the C&MH&CP has the maturity and ambition to deliver what NHS England expects from the ICS. Similarly the Place-based Five Year Plans need to show that there is a common vision for the provision of health and care services within that area, with a good understanding of the local challenges, a commitment from local partners to work together and clarity in relation to what needs to be delivered.

The Cheshire and Merseyside Health and Care Partnership (and its equivalents elsewhere in the country) and local place-based health and care partnerships are seen by NHS England as a pragmatic way to join up planning and service delivery across primary and specialist care, physical and mental health and health and social care.

With regard to the Cheshire East and Cheshire West Partnerships' Five Year Plans, the draft Plans were shared with the public during August and submitted (as drafts) to the C&MH&CP at the end of August. Revised final draft Plans are now to be taken through the governing bodies of the Partners for endorsement. The final endorsed versions will be submitted to the Cheshire and Merseyside Health and Care Partnership by the end of October.

Cheshire East Partnership Five Year Plan

The Cheshire East Partnership Plan sets out the vision of the Partnership (made up of the Local Authority, the Clinical Commissioning Groups, NHS Providers, local GPs – and through the Health and Wellbeing Board, the Police and Fire and Rescue Service, the community and voluntary sector, NHS England and Healthwatch). This is to improve the health and wellbeing of local communities, enabling people to live longer and healthier lives. We will do this by creating and delivering safe, integrated and sustainable services that meet people's needs by the best use of all the assets and resources we have available to us. Wellbeing comes from everyone taking ownership of what they can do for themselves and their community, with support available and focussed when and where it's needed.

The Cheshire East Place Five Year Plan recognises that health and wellbeing go hand in hand with economic growth and prosperity and are significantly impacted upon by the quality of housing, education, employment, infrastructure and services available to local people.

Our focus will be upon tackling inequalities, prevention of ill health and early intervention, having a person focussed approach and planning and decision making in partnership with local people. At the heart of our new approach will be the Care Communities and the Integrated Care Partnership.

The key outcomes that the Partnership through the Plan aspires to achieve are:

a) To create a place that supports health and wellbeing for everyone living in Cheshire East;
b) To improve the mental health and wellbeing of people living and working in Cheshire East;
c) To enable more people to live well for longer in Cheshire East;
d) To ensure that children and young people are happy and experience good physical and mental health and wellbeing.

Cheshire West Place Five Year Plan

Cheshire West is taking an innovative approach, having decided to make the Place Plan the new Health and Wellbeing Strategy, so that there is one Plan for the Place going forward (the current Strategy expires in 2020). Development of the draft Place Plan has been overseen by a working group, which consists of the following organisations:

a) Cheshire West and Chester Council
b) West Cheshire CCG
c) Vale Royal CCG
d) Cheshire West Integrated Care Partnership
e) Central Cheshire Integrated Care Partnership
f) Cheshire and Wirral Partnership NHS Foundation Trust
g) Healthwatch
h) Cheshire West Voluntary Action

Like Cheshire East, the Cheshire West draft Plan focuses on the wider (social) determinants of health, tackling inequalities, preventing ill health and early intervention. The vision is to reduce inequalities, increase years of healthy life and promote mental and physical health and wellbing for everyone in Cheshire West.

The draft Plan has been developed by system leaders in health and social care, including health and care commissioners, providers, the voluntary sector and residents. It promotes a system-wide vision and highlights areas where morecan be done together to benefit the people of Cheshire West. It takes a person centered approach, with planning and decision making in partnership with local people. The nine emerging care communities and the Integrated Care Partnership are integral to this.

Assessment – *analysis and considerations of the options and risks*

Options

There are no other options. The Place Plan is a 'must do' for each of the 9 Places in Cheshire and Merseyside and and it is a statutory requirement to have a Health and Wellbeing Strategy.

Risks

a) There is local reputational risk if the Plan is not progressed through the tight timescales set by the Health and Care Partnership.
b) There is local risk to our residents and to health and care services if integration of the latter does not move at scale and pace.
c) Financial sustainability is a key driver of this agenda. If we do not address the integration agenda, the local health and care system will not achieve financial sustainability

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

The Board of Directors is asked to endorse the Cheshire East and Cheshire West Five Year Plans.

Who has approved this report for receipt at the above meeting?	Anushta Sivananthan
Contributing authors:	Guy Kilminster Cheshire East Council Professor Helen Bromley, Cheshire West and Chester Council

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
Drafts	Cheshire CCGs Joint Commissioning Committee (both Plans)	26th July 2019
	Cheshire East Partnership Board (Cheshire East Plan)	4th September 2019
	Cheshire East Adults, Health and Communities Overview and Scrutiny Committee (Cheshire East Plan)	12th September 2019
	Cheshire East Children and Families Overview and Scrutiny Committee (Cheshire East Plan)	23rd September 2019
	Health and Wellbeing Board	24th September 2019
	Joint CCGS Governing Bodies (both Plans)	26th September 2019
	East Cheshire NHS Trust	3rd October 2019
	Mid Cheshire Hospital NHS Foundation Trust	7th October 2019
	Cabinet	8th October 2019
	Cheshire West draft Place Plan	
	Joint Overview and Scrutiny (People, Places, Health)	23rd September 2019
	ICP Board	26th September
	Shadow Cabinet	3rd October 2019
	Cabinet	9th October 2019
	Health and Wellbeing Board	16th October 2019

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

	Appendix title
1	Cheshire East Partnership Draft Five Year Plan 2019 - 2024

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Cheshire West Integrated Care Partnership – Terms of Reference and Business Plan 2019/20
Agenda ref. number:	19.20.83
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	25/09/2019
Presented by:	Sheena Cumiskey, 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	No
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 NHSI Single Oversight Framework themes this report reflects:		CWP Quality Framework:		
Quality	Yes	Patient Safety	Safe	Yes
Finance and use of resources	Yes	Clinical Effectiveness	Effective	Yes
Operational performance	Yes		Affordable	Yes
Strategic change	Yes		Sustainable	Yes
Leadership and improvement capability	Yes	Patient Experience	Acceptable	Yes
			Accessible	Yes
		http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No

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

REPORT BRIEFING

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

Further to ICP Partner Boards' agreement of the Integration Agreement during March 2019, terms of reference have now been finalised for the Cheshire West Integrated Care Partnership (ICP) Board and also the Directors' Group (formerly referred to as ICP Executive Team).

The ICP Board will operate via a collaborative governance model, with aligned decision making, and this is reflected within its terms of reference, albeit with a stepped approach to governance which will see decisions come back to Partner Boards for the first six months, as agreed at the ICP Governance Workshop on 25th April 2019 with ICP Partners.

Cheshire West ICP has developed and agreed, via the shadow ICP Board, a Business Plan, *Our Plan for Integrated Care 2019/20*.

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

The Integrated Care Partnership is an alliance of providers collaborating to meet needs of a defined population. Integrated care will bring together the different organisations and services that look after people in Cheshire West to better co-ordinate care, to make sure patient and carer experiences are as joined-up as possible and to support more people to stay healthy and well.

During March 2019 the six Partner Boards of the Cheshire West Integrated Care Partnership agreed a non-legally binding Integration Agreement to align the work of the parties with regards to integrating care within West Cheshire via a new collaborative governance model.

Assessment – *analysis and considerations of the options and risks*

See appendix 1 and 2

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

The Board of Directors are recommended to:

- Approve the Cheshire West Integrated Care Partnership Board terms of reference;
- approve the Cheshire West Integrated Care Partnership Directors' Group Terms of Reference;
- Board agrees delegated authority to its named individual member of the ICP Board to agree the contents of the forthcoming ICP Governance Handbook, including any future ICP Stakeholder Group terms of reference, Transformation Group terms of reference and any future updates to the ICP Directors' Group terms of reference
- endorses the Cheshire West ICP Business Plan, Our Plan for Integrated Care 2019/20

Who has approved this report for receipt at the above meeting?	Sheena Cumiskey, Chief Executive
Contributing authors:	

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued

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

Appendix No.	Appendix title
1.	Document overview
2	Terms of Reference and Business plan.

Cheshire West Integrated Care Partnership

Cheshire West and Chester Council and the NHS working together

NHS Cheshire West and Chester

19.20.83 Appendix 1

Cheshire West Integrated Care Partnership

Cheshire West Integrated Care Partnership – Terms of Reference and Business Plan

PURPOSE

1. The purpose of this report is to provide a short narrative to support the recommendations.

BACKGROUND

2. An Integrated Care Partnership is an alliance of providers collaborating to meet needs of a defined population. Integrated care will bring together the different organisations and services that look after people in Cheshire West to better co-ordinate care, to make sure patient and carer experiences are as joined-up as possible and to support more people to stay healthy and well.

3. During March 2019 the six Partner Boards of the Cheshire West Integrated Care Partnership agreed a non-legally binding Integration Agreement to align the work of the parties with regards to integrating care within West Cheshire via a new collaborative governance model.

4. An ICP governance workshop was held on 25th April, 2019, and a stepped approach to governance was agreed between partners which will see any ICP Board decisions come back to Partner Boards for agreement for the first six months whilst the requirements for individual delegated decision making authority for the Partner member of ICP Board is further clarified.

5. Terms of reference have been developed by the ICP Governance Programme.

6. It should be noted that the Stakeholder Group, as referenced in the Integration Agreement, is not yet established and, therefore, terms of reference are not yet available

TERMS OF REFERENCE FOR ICP BOARD

7. The shadow ICP Board agreed its terms of reference on 27th June, 2019, and these are now proposed to Partner Boards for approval, as included in ***Appendix One***.

8. Considerations to develop these terms of reference have included:

- parity of representation for aligned decision making by consensus and that ICP Board is not a Joint Committee;
- establishing a named Deputy Chair;
- agreeing named deputies for individual Partner members;
- non-voting members forming part of the quorum;
- frequency of meetings; and
- arrangements for identifying and managing conflicts of interest.

9. It is recognised that the ICP and its governance arrangements will evolve and the terms of reference will be reviewed regularly to ensure they remain fit for purpose and reflect the way in which the ICP develops and operates. Future updates to the ICP Board terms of reference will be taken to ICP Partner Boards for approval.

TERMS OF REFERENCE FOR ICP DIRECTORS' GROUP

10. The ICP Governance Programme has assisted to develop the Directors' Group terms of reference, which have been agreed by members of the ICP Directors' Group and subsequently agreed by the shadow ICP Board on 27th June, 2019. These terms of reference can be found within ***Appendix Two***.

11. Considerations to develop these terms of reference have included:

- The remit of Directors' Group;
- That membership includes representatives from the different ICP Partner organisations;
- Operational decision making being subject to the Scheme of Delegation to individuals by each of their employing Partner organisations;
- Frequency of meetings;
- Arrangements for identifying and managing Conflicts of interest; and
- That reporting arrangements for Directors' Group will be into ICP Board.

12. It is recognised that the ICP and its governance arrangements will evolve and the terms of reference will be reviewed regularly. It is proposed that any future updates to the ICP Directors' Group terms of reference will be made under delegated authority at ICP Board by individual partner member representatives, via aligned decision making by consensus.

ICP GOVERNANCE HANDBOOK

13. The ICP Governance Handbook has been under development and is due for completion in September 2019. Its contents will include:

- the terms of reference for ICP Board, Directors' Group, ICP Stakeholder Group (once established, unless a current stakeholder forum is utilised as an alternative) and, in future, an ICP Transformation Group;
- a narrative on the current arrangements for aligned decision making by consensus within ICP Board;
- Specific ICP governance principles;
- a narrative that describes that Partners are still responsible for their registered services that they "align" to the ICP;
- a narrative that describes the integrated management model within the ICP; and
- Reference to the Nolan Principles and behaviours expected within the ICP, along with Partner organisation Codes of Conduct applying to their staff within the ICP

14. It is proposed that delegated authority is given to named individual members of the ICP Board by the ICP Partner organisations to agree the contents of the forthcoming ICP Governance Handbook including any future ICP Stakeholder Group terms of reference and any future updates to the ICP Directors' Group terms of reference

ICP BUSINESS PLAN, *OUR PLAN FOR INTEGRATED CARE 2019/20*

15. Cheshire West ICP has developed and agreed, via the shadow ICP Board, a Business Plan, Our Plan for Integrated Care 2019/20. This one year plan sets out how Cheshire West ICP will support local people to improve health and care outcomes on behalf of our Partner organisations. It is a strategic business plan and links to our Partner organisation operational plans. It sets out the Scope of Service and high-level, preliminary healthcare budget for Cheshire West ICP c.£38.3m per year.

16. Cheshire West ICP has two Mission Statements which have been linked to an agreed set out outcomes. An outcomes framework is currently being developed by the Business Intelligence Programme.

17. The Cheshire West ICP one year Business Plan has been developed across the Partnership and has identified 4 Priority Programmes and 6 Enabling Programmes to support service development and its Transformation Plan. Underpinning the Business Plan is a series of strategic and Operational objectives. There is a commitment to develop a 5 year Transformation Plan.

Cheshire West Integrated Care Partnership

Cheshire West and Chester Council and the NHS working together

NHS Cheshire West and Chester

Appendix One

CHESHIRE WEST INTEGRATED CARE PARTNERSHIP

Terms of Reference for the Integrated Care Partnership (ICP) Board

Version 1 (August 2019)

1. Terms of reference

1.1. The role of the ICP Board is to maintain strategic oversight of and accountability for the Partnership and to support the ICP Directors' Group to carry out their functions, including assistance to remove barriers within Partner organisations which the Directors' Group is unable to resolve.

1.2. The specific functions of the Board are set out below:-

Strategy - to formulate and agree **with partners** a long term strategic plan for the ICP Board which is aligned to the ICP objectives;

Accountability - to be accountable for the delivery of the Strategy, to receive reports on progress and to seek assurance that systems of control are in place which are robust and reliable;

Culture – to shape a positive culture within the Board and the wider Partnership;

Financial stewardship - to ensure the effective and efficient use of resources;

Risk management – to identify, review and manage risks; and

Operational planning – to develop, agree and monitor an annual operational plan with clear objectives;

1.3. It is intended to review these terms of reference at least annually as the ICP develops, to be mutually agreed by the Partners.

2. Delegations and Reserved Matters

2.1. Decision making by the Board is subject to the Scheme of Delegated Decision making and Reserved Matters of each Partner organisation set out in **Schedule 1** and their respective statutory obligations.

2.2 A record of the discussion and decision made by each of the six partner representatives should be recorded in the minutes of the ICP Board.

2.3 Care is needed to ensure that discussion still takes place at the ICP Board prior to recommendations being referred to Partner organisations for decision.

3. Board membership

3.1 The Board will consist of the following core Partner organisations;

- Countess of Chester Hospital NHS Foundation Trust
- Cheshire West and Chester Council
- Cheshire and Wirral Partnership NHS Foundation Trust
- South Cheshire and Vale Royal GP Alliance
- Primary Care Cheshire
- Central Cheshire Integrated Care Partnership.

3.2. Each core Partner will be entitled to appoint **one voting representative** (Executive / Officer) to the Board. In additional one non-voting representative/Non-Executives/Members may be appointed with the agreement of the Board, to attend and speak, with the aim of parity of representation.

3.3. It is for each Partner to decide who they wish to nominate to the Board. Representatives may be executive or non-executive. However, each representative should have sufficient individual delegated decision making authority from their Partner organisation to make the decisions outlined in these terms of reference (*N.B. for NHS Foundation Trusts individual delegated decision making cannot be made to a Non-Executive Director*).

3.4. A list of nominated representatives is set out in **Schedule 2** along with those 'in attendance'.

4. Chair

4.1. The ICP Board will be led by the Chair of the ICP who will be a Non-Executive Director of the Countess of Chester Hospital NHS Foundation Trust (the Host).

4.2. The Deputy Chair will be Non-Executive Director, Andrea Campbell, from Cheshire & Wirral Partnership NHS Foundation Trust.

5. Deputies

5.1. For consistency it is expected that the use of deputy representatives will be avoided wherever possible. However, it is recognised that this may be necessary on occasion. Named deputies will be permitted to attend and participate fully in meetings of the Board with the prior agreement of the Chair but can only take part

in aligned decision making if they have individual delegated authority from their Partner organisation.

6. Quorum

6.1. The Board will be quorate where the voting representative or named deputy of each core Partner is in attendance with individual delegated authority to make decisions on behalf of their organisation, along with the Chair (or Deputy Chair) and two non-voting members.

7. Attendance

7.1 Nominated representatives should attend at least 80% of ICP Board meetings and ensure that their named deputy with the appropriate delegated authority attends when they are unable to attend. *See section 8.5 regarding non-attendance in relation to decision making.*

8. Decision Making/Voting

8.1. It is recognised that the Board is working towards delegated aligned decision making; the Board should adopt the principle of reaching a consensus on recommendations on proposals to Partner Boards before they are made. Once **Schedule 1** on delegated and reserved matters is agreed, the Board will seek to achieve a consensus on all decisions via aligned decision making. Where a consensus cannot be reached and a decision requires to be taken, the issue will be referred back to each partner organisation by the member who could not reach a consensus. Alignment means that the organisations within the ICP retain their own decision-making authority, but have agreed to make their decisions taking into account a vision that is common to all of them, along with common aims and principles.

8.2. Before making a decision or proposal back to Partner Boards on an issue, the Board may ask for further work to be undertaken to explore, clarify, mitigate or minimise any concerns.

8.3. Areas of deadlock will be resolved in accordance with the Dispute Resolution Procedure set out in the Governance Framework Integration Agreement.

8.4. An individual acting under delegation from their Partner organisation that abstains or does not cast a vote has decided not to make a decision and, notwithstanding the views of the majority, that decision holds unless the individual chooses to change it or the decision is referred to the partner organisation board for a decision.

8.5. Where a Partner representative with delegated decision making authority or their deputy with delegated authority is unable to attend a meeting of the ICP Board and there is a consensus on a decision from the remaining partners present, there should be an attempt to seek agreement from the absent member in a virtual way, and failing that the final decision will need to be referred to the following meeting when the Partner is present to carry the decision.

9. Frequency of Meetings

9.1. The ICP Board will meet six times per year formally along with three times per year informally as a workshop. The frequency of meetings will be reviewed at least annually.

9.2. The Chair may call an extraordinary meeting on not less than 5 working days' notice.

10. Conflicts of Interest

10.1. Members of the ICP Board should disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with the operation of the ICP Board, immediately upon becoming aware of the conflict of interest or at the latest within 28 days of becoming aware.

10.2. Individual representatives need to be alert to conflicts of interest and be open and transparent. Individual representatives should check Board/meeting agendas in advance and discuss any potential or real conflict with the lead for the Governance Programme or their organisational governance lead and the chair of the meeting prior to ICP Board, to agree a way forward. Members of the ICP Board should not participate in any decision-making in respect of any aspect of the ICP Board that could allow them to be placed in a position of conflict of interest, without the prior consent of the other Partners to participate in that decision-making.

10.3. Members of the ICP Board should make declarations of interest with their employing organisation which should be made available and be copied into a Cheshire West ICP Board register and updated at least annually or promptly as they acquire new interests of (or) relinquish existing interests.

10.4. Members of the ICP Board should adhere to the Nolan Principles (*The Seven Principles of Public Life*), the Code of Conduct as set out in the Governance Handbook along with relevant employing organisation Codes of Conduct.

11. Access to the public

11.1. It is the intention of the Board to work towards formal meetings of the ICP Board which will be open to the public. This will require development of an appropriate framework and implementation date.

12. Role of the Commissioners

12.1. Commissioners are permitted to attend the meetings of the ICP Board. In the event that any matters to be discussed may result in a conflict of interest or the remaining attendees consider that matters are confidential and need to be discussed without the inclusion of the Commissioners, then such matters shall be discussed in private session of the relevant board meeting.

13. Board working arrangements

13.1. The Managing Director will put in place arrangements for the following support to the Board to ensure;

- The correct minutes are taken and once agreed by the Chair distributed to the members;
- Conflicts of interest are recorded along with the arrangements for managing those conflicts;
- A record of matters arising is produced with issues to be carried forward;
- An action tracker is produced following each meeting and any outstanding action is carried forward on the action tracker until complete;
- Appropriate support to the Chair and committee members;
- The agenda is agreed with the Chair prior to sending papers to members

- Agenda and supporting papers to be circulated no later than five working days before the meeting;
    - An annual programme of work is up to date and distributed at each meeting;
    - The minutes of the meeting are distributed within 14 working days of the meeting taking place;
    - The papers of the committee are filed and retained in accordance with any relevant policies and procedures; and
    - There is adequate notice and scheduling of meetings to ensure attendance, with a meeting schedule established for at least six months ahead.

13. **Reporting Groups**

13.1. In accordance with the Cheshire West Integrated Care Partnership Governance Structure, the groups that will report into the ICP Board are:

- the Stakeholder Partnership Forum; and
- the Cheshire West ICP Directors' Group.

The ICP Board will receive the minutes/notes of both of the above.

14. Accountability

14.1. The ICP Board does not have decision making powers in its own right (and is not a joint committee), however, the individual Partner representatives with delegated authority will be accountable for their decisions on the ICP Board to their respective Partner boards.

14.2. The ICP Board will also report to:

- NHS West Cheshire CCG
- NHS Vale Royal CCG
- Health & Wellbeing Board
- All Partner Organisations

15. Responsibilities and behaviours

15.1. Members of the ICP Board have a collective responsibility for its operation. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability and endeavour to reach a collective view.

15.2. The members will behave in a manner which is consistent with Integration Principles, any relevant organisational Codes of Conduct or ICP Code of Conduct and will adhere to the behaviours highlighted in the Nolan principles recognising that the success of the programme will depend upon relationships and an environment of integrity, trust collaboration and innovation.

SCHEDULE 1 – Scheme of Delegated Decision Making and Reserved Matters

The Scheme of individual delegated decision making and reserved matters for each Partner organisation are yet to be agreed as Cheshire West ICP will adopt a stepped Governance approach with decision-making on key issues reserved back to the Partners for an initial period of 6-months from the date of agreement of these terms of reference, and then will review the appetite for delegations.

SCHEDULE 2 – Nominated Representatives

Partner Name	Individual decision making member of ICP Board	Named Deputy
Cheshire West & Chester Council	Delyth Curtis, Deputy Chief Executive - People	Ian Ashworth, Director of Public Health
Cheshire & Wirral Partnership NHS Foundation Trust	Sheena Cumisky, Chief Executive Officer	Tim Welch, Deputy Chief Executive & Director of Finance
Countess of Chester Hospital NHS Foundation Trust	Susan Gilby, Chief Executive Officer	Alison Kelly, Deputy Chief Executive & Director of Nursing & Quality
South Cheshire & Vale Royal GP Alliance Ltd	Tina Cookson, Nurse Director	Catherine Wall, Chair, Primary Care Cheshire
Primary Care Cheshire (CIC)	Catherine Wall, Chair	Tina Cookson, Nurse Director, South Cheshire & Vale Royal GP Alliance
Central Cheshire Integrated Care Partnership	Denise Frodsham, Director of Strategic Partnerships, Mid Cheshire Hospitals	Tina Cookson, Nurse Director, South Cheshire & Vale Royal GP Alliance

Chris Hannah, Chair, Cheshire West ICP (or Deputy Chair as outlined in section 4.2)

Non-Voting Members:

Managing Director, CWICP

Directors' Group members, CWICP

Andrea Campbell, Non-Executive Director, Cheshire & Wirral Partnership NHS Foundation Trust

Chair, CCICP

Elected Member, Cheshire West & Chester Council

Member, Primary Care Cheshire

Member, SC&VR GP Alliance

In Attendance:

Louise Barry, Chief Executive Officer, Healthwatch

Lead for CWICP Governance Programme

Version 1 (August 2019)

Appendix Two

CHESHIRE WEST INTEGRATED CARE PARTNERSHIP

Terms of Reference for the Directors' Group

1. Terms of Reference

1.1 The ICP Directors' Group will advise and be accountable to the ICP Board on the strategic direction and priorities, developing a transformation plan and for the delivery of the operational plan for Cheshire West's health, social care and wellbeing.

1.2 The specific remit of the Directors' Group includes:

- Oversight of the production and delivery of key business plans and cases for investment and to make proposals to ICP Board;
- Delivery of the key milestones and outcomes associated with implementation of strategic plans;
- Monthly oversight of the system performance dashboard and for making exception reports to ICP Board;
- Monthly oversight of the ICP corporate system risk register; and
- Escalation of risks, strategic and high level operational issues to ICP Board.
- Reporting on service delivery for services agreed within the scope of the ICP, including high-level/exception reports, for example, for finance, staffing and key performance indicators.

2. Directors' Group Membership

2.1 The ICP Directors' Group will consist of the following:

- Managing Director
- Medical Director
- Director of Population Health Management
- Director of Service Delivery
- Director of Transformation & Partnerships
- Director of Public Health
- Director of Adult Social Care
- Associate Director of Nursing

High level finance support will be accessed via Cheshire & Wirral Partnership NHS Foundation Trust via their Director of Finance in the first instance. Corporate governance support to the ICP Directors' Group should be accessed via the lead for the ICP Governance Programme.

2.3 The Managing Director will lead the Team of Directors and chair Directors' Group Meetings.

2.4 The meeting will be chaired by the Medical Director in the Managing Director's absence.

3. Deputies

Attendance from named deputies at Directors' Group will be permitted.

4. Quorum & Attendance

Directors' Group members should attend at least 75% of formal meetings and communicate and agree this attendance with their employing organisation.

5. Decision Making

Operational decision making by the Directors' Group is subject to the Scheme of Delegation to individuals by each of their employing Partner organisations. Proposals for ICP investment and transformation, sign-off of ICP business plans, sign-off of the ICP corporate system risk register and sign-off of ICP strategic plans should be proposed to Cheshire West ICP Board by the Directors' Group.

6. Frequency of Meetings

The Directors' Group will meet at least monthly, formally on a bi-monthly basis initially, along with additional informal meetings as required.

7. Conflicts of Interest

Members of Directors' Group should disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with the operation of the Directors' Group and the ICP, immediately upon becoming aware of the conflict of interest or at the latest within 28 days of becoming aware.

Members of the Directors' Group need to be alert to conflicts of interest and be open and transparent and check meeting agendas in advance for potential conflicts, discussing with

the lead for the Governance Programme or their organisation governance lead and the chair of the meeting prior to the Directors' Group meeting, to agree a way forward.

Members of the Directors' Group should not participate in any decision-making in respect of any aspect of ICP business or Directors' Group that could allow themselves to be placed in a position of conflict of interest, without the prior consent of the other members of the Directors' Group to participate in that decision-making and agreement on actions to mitigate and manage the conflict.

Members of the Directors' Group should make declarations of interest with their employing organisation which should be made available and be copied into a Cheshire West ICP Board register and updated at least annually or promptly as they acquire new interests of (or) relinquish existing interests.

Members of the Directors' Group should adhere to the Nolan Principles (The Seven Principles of Public Life), the Code of Conduct as set out in the ICP Governance Handbook along with relevant employing organisation Codes of Conduct.

8. Directors' Group Working Arrangements

The Managing Director will put in place arrangements for the following support to the Directors' Group:

- The correct notes/minutes are taken and, once agreed by the Chair, distributed to the members;
- Conflicts of interest are recorded along with the arrangements for managing those conflicts;
- A record of matters arising or action tracker is produced with issues to be carried forward;
- Appropriate support is in place to produce the agenda and circulate papers, and that the agenda is agreed with the Managing Director prior to circulation;
- Agenda and supporting papers are to be circulated no later than five working days before the meeting;
- The minutes of the meeting are distributed within five working days of the meeting taking place;
- The papers of the meeting are filed and retained in accordance with any relevant policies and procedures; and
- There is adequate notice and scheduling of meetings to ensure attendance, with a meeting schedule established for at least six months ahead.

9. Reporting

The Directors' Group will report into the ICP Board, with minutes of the meeting provided to ICP Board in a timely manner and the escalation of issues and system risks as appropriate and in line with the ICP strategic objectives.

10. Accountability

The Directors' Group is accountable to the ICP Board, with the individual team members reporting into the Managing Director of the ICP.

11. Responsibilities and behaviours

The Directors' Group should ensure:

- Attendance for at least 75% of meetings and endeavour to attend more than 75%;
- That when attending meetings they have read the necessary papers for the meeting;
- That behaviour is appropriate and adheres to the Code of Conduct within the ICP Governance Handbook;
- Contributions are made appropriately to each meeting;
- Conflicts of interest for individuals are considered in advance of the agenda and declared and discussed for advice on how to manage, where relevant; and
- Adherence to principles of the ICP as set out in the Integration Agreement and the Governance Handbook.

Draft Terms of reference considered by Directors Group on 14th June 2019

Date of agreement of terms of reference by ICP Board: 27th June, 2019

Date of final approval of terms of reference by Partner Boards: (insert)

Version One