Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting of the Foundation Trust Board of Directors

Wednesday 28th January 2015 at 1.00pm

Boardroom, Redesmere, Countess of Chester Health Park

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
14/15/86	Apologies for absence	Receive apologies	Verbal	Chair	1 min (1300)
14/15/87	Declarations of interest	Identify and avoid conflicts of interest	Verbal	Chair	1 min (1301)
14/15/88	Minutes of the previous meeting held 26th November 2014	Confirm as an accurate record the minutes of the previous meetings	Written minutes	Chair	3 mins (1302)
14/15/89	Matters arising and action points	Provide an update in respect of ongoing and outstanding items to ensure progress	Written action schedule and verbal update	Chair	5 mins (1305)
14/15/90	Business Cycle 2014/15	Confirm that agenda items provide assurance that the Board is undertaking its duties	Written Report	Chair	2 mins (1310)
14/15/91	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	5 mins (1312)
14/15/92	Chief Executive's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	5 mins (1317)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
Assurance: Quality/ Effectiveness/ Experience/ Safety					
14/15/93	Corporate Assurance Framework and Risk Register	To note current Corporate Assurance Framework and Risk Register	Written Report	Medical Director	15 mins (1322)
14/15/94	Comprehensive review of staffing levels	To approve the comprehensive staffing review report	Written Report	Director of Nursing, Therapies and Patient Partnership	15 mins (1337)
14/15/95	Q3 Infection, Prevention and Control report	To note the Q3 Infection, Prevention and Control report	Written Report	Deputy Director of Nursing	10 mins (1352)
14/15/96	Q3 Quality Report and Best Practice event Quality Report	To note the Quality Reports	Written Report	Medical Director	10 mins (1402)
14/15/97	Saddlebridge Investigation Report - Management Response	To note the management response to the report and recommendations	Written Report	Acting Director of Operations	20 mins (1412)
14/15/98	Learning from Experience Report	To approve the Learning from Experience report for T2	Written Report	Director of Nursing, Therapies and Patient Partnership	15 mins (1432)
10 minute break (1447-1457)					
Performance					
14/15/99	Corporate Performance Report - December 2015	Review Trust performance	Written Report	Director of Finance	10 mins (1457)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
14/15/100	Q3 Quality Governance Assessment	Approve the quality governance assessment	Written Report	Director of Finance	10 mins (1507)
14/15/101	Q3 Monitor quarterly return	Approve Q3 declarations to Monitor	Written Report	Director of Finance	10 mins (1517)
Strategy					
14/15/102	5 Year Forward View • Planning into Action 2015/16	To update on planning process for 2015/16	Written Report	Director of Finance	10 mins (1527)
Assurance: Governance					
14/15/103	Fit and Proper Persons regulations	To approve the Trust approach to ensuring compliance with new regulations	Written Report	Head of Corporate Affairs	10 mins (1537)
14/15/104	CQC Registered Locations	To update the list of CWP registered locations for CQC	Written Report	Medical Director	5 mins (1547)
14/15/105	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	5 mins (1552)
14/15/106	Any other business	Consider any urgent items of other business	Verbal or written	Chair/ All	5 mins (1557)
14/15/107	Review of meeting	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and	Verbal	Chair/All	2 mins (1602)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
		management of time)			
14/15/108	Date, time and place of next meeting: **Wednesday 28th March 2015 1.00pm at Redesmere Boardroom.**	Confirm arrangements for next meeting	Verbal	Chair	2 mins (1604)

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Minutes of the Board of Directors Meeting
Wednesday 26th November 2014,
Boardroom, Redesmere, commencing at 1.00pm

PRESENT	David Eva, Chair Dr Faouzi Alam, Medical Director Sheena Cumiskey, Chief Executive Dr Jim O'Connor, Non-Executive Director Fiona Clark, Non-Executive Director Lucy Crumplin, Non-Executive Director Avril Devaney, Director of Nursing Ron Howarth, Non-Executive Director Mike Maier, Non-Executive Director Rebecca Burke Sharples, Non-Executive Director Dr Anushta Sivananthan - Medical Director Andy Styring, Director of Operations
IN ATTENDANCE	David Harris, Director of Workforce and Organisational Development Louise Hulme, Head of Corporate Affairs (inc.CoSec) Val McGee, Service Director CWP Wirral (for item 14/15/78) Amanda Miskell, Head of Infection, Prevention and Control (for item/ 14/15/73) Derek Bosomwoth, Member of the public Brian Green, West Cheshire CCG Phil Jarrold, Service User/ Carer Governor Murdo Kennedy, Involvement Representative Anna McGrath Public Governor Rob Robertson, Public Governor
APOLOGIES	Tim Welch, Director of Finance

	MINUTES	**ACTION**
14/15/66	**WELCOMES AND APOLOGIES FOR ABSENCE** The Chair welcomed everyone to the meeting. Apologies were noted from Tim Welch, Director of Finance. The meeting was quorate.	
14/15/67	**DECLARATIONS OF INTEREST** There were no interests declared.	
14/15/68	**BOARD MINUTES- MEETING OF 24TH SEPTEMBER 2014** The minutes of the meeting held on the **September 24th 2014** were **approved** as a correct record.	

14/15/69	**MATTERS ARISING AND ACTION POINTS** With regard to action 14/15/58, Sheena Cumiskey advised that there are ongoing discussions with stakeholders regarding the key issues in the manifesto. Action closed.	
14/15/70	**BOARD MEETING BUSINESS CYCLE 2014/15** The business cycle for 2014/15 was noted.	
14/15/71	**CHAIR'S ANNOUNCEMENTS** The Chair announced that: **My Mind** CWP's pioneering website 'MyMind' has received two 'Highly Commended' accolades at recent award ceremonies. Representatives from Child and Adolescent Mental Health Services (CAMHS) attended the awards where they were nominated in the Innovation in Mental Health category at the HSJ Awards and the Innovation in CAMHS category at the national Positive Practice in Mental Health Awards. **Contract for 5-19 Health & Wellbeing Service and Immunisation & Vaccination Service in West Cheshire** CWP are pleased to have been awarded the contract to provide the 5-19 Health & Wellbeing Service and Immunisation & Vaccination Service in West Cheshire from 1st January 2015. **East Cheshire Substance Misuse Service** Back in the summer, East Cheshire Council appointed CWP as the lead provider of a new specialist substance misuse service in Cheshire East. The service will be provided collaboratively with a range of providers. The service is now operational and between now and January 2015, CWP will work together with the other providers on the transition towards the new model which will focus on early intervention, prevention and recovery. **Operation Street Triage** This month CWP has teamed up with Cheshire Police to lead a new approach to policing incidents involving people with mental ill-health. Across East and West Cheshire, Operation 'Street Triage' will see a team of CWP mental health community nurses accompanying dedicated police officers during 999 and 101 call-outs to offer advice and assist in reducing the number of people being arrested under section 136 of the Mental Health Act or being unnecessarily taken to hospital for treatment. **Fit and Proper Persons Test and Duty of Candour** The CQC have published guidance for NHS providers to meet the requirements of both the duty of candour and fit and proper persons test for Director which comes into force this month. The guidance aims to make clear how CQC will decide if NHS organisations are meeting the two new regulations, including during registration and inspection as well as if information is brought to CQC's attention by members of staff or the	

	public. This will be discussed further at the Audit Committee in January 2015.	
13/14/72	**CHIEF EXECUTIVE'S ANNOUNCEMENTS** **NHS 5 year forward view** Sheena Cumiskey that the new NHS 5 year forward view had recently been published. This has a clear focus on the need to deliver sustainable services while enabling people to take greater control of their own personal health and well-being. There is a strong emphasis on progressing personalised budgets and this is reflected locally in the developing mutualisation agenda. There is also a drive to identify the funding gap around the increasing elderly population and the demand this will continue to place on public services. Sheena Cumiskey advised that the key themes from this will feed into the December Board seminar focusing on Trust strategic planning and strategy refresh. **Saddlebridge Incident - 5th July 2014** Sheena Cumiskey advised that the Closed Board meeting had looked at the investigation report. A management response to the recommendations will now be progressed. Refurbishment work has been completed and an open day was held attracting several stakeholders which was received positively. Relatives of patients also attended an open evening and Parish Councillors were also in attendance. The number of patients returning to the unit was queried. It was confirmed that six of the previous occupants will be returning. Sheena Cumiskey advised that the New Alderley unit has been completed and this is in the process of being commissioned. There is a plan for a similar event to formally open this unit. **Formal opening of CWP East education facility** The Board were advised that the CWP education facility in east Cheshire locality is now open and support training and development opportunities for east based CWP staff. **Director of Operations** Sheena Cumiskey advised that Andy Styring, Director of Operations will be taking a planned period of sickness leave. Julie Critchley will be acting Director of Operations during this period.	
14/15/73	**CORPORATE ASSURANCE FRAMEWORK AND RISK REGISTER** Dr Anushta Sivananthan introduced the report and advised the Board that scrutiny and in-depth discussion on the risk register had been undertaken at the Quality Committee and Audit Committee continue to undertake a deep dive on an individual strategic risk at each meeting. Attention was drawn to the Corporate Assurance Framework for note and comment.	

	Highlighting key areas, Dr Anushta Sivananthan informed the Board that a new risk had been added to the register around service delivery, potential fragmentation of care pathways and ensuring that patients receive safe care in changing environments. The risk lead had presented this risk and the risk treatment plan to the November Quality Committee. Dr Anushta Sivananthan informed that the pressure ulcers risk had now archived following completion of the risk treatment plan and achievement of the risk target score. With regard to the falls risk, this has not archived as the final parts of the treatment plan needs to be completed as part of the capital programme work. The Board were informed that the Audit Committee scrutinised the CARSO risk at their last meeting. The risk treatment plan had resulted in a significant improvement in the position and this risk is nearing archive. The Audit Committee will review the mandatory training risk at the January 2015 meeting including consideration of the downgrading of the compliance target. A query was raised regarding the ligature risk and the fact that the works due for completion by October have been completed but the risk score has not been reduced. Dr Anushta Sivananthan advised that this was because some further new issues identified in other areas which need addressed by the Estates, so the risk has not yet been reduced. Assurance was given that there is no risk to safety while the further work is being completed. Ron Howarth advised that the Quality Committee had requested that the wording on the staffing risk be revised to ensure that it is consistent with other areas of reporting such as the daily staffing levels report. The revised risk will be presented to the January 2015 Quality Committee. . The Board **resolved** to **approve** the Risk Register and Corporate Assurance Framework.	
14/15/74	**DAILY WARD STAFFING LEVELS - OCTOBER 2014** Avril Devaney presented the report and advised the Board that the second phase of the comprehensive ward staffing review had commenced which will review staffing levels, skill mix and the wider team including any gaps. The review will also consider the progress made with recruitment as the Trust has not met the establishment agreed following the first review, mainly due to staff turnover. The review will also look at shift patterns, particularly length of time on shifts. The Chief Nursing Officer looking at this nationally so the Trust is awaiting this before changing our internal processes. The second review will report to the January 2015 Board meeting. The Board were informed that there is a need to look at issues around staff working hours and those working shifts and then further bank hours. This can potentially have an impact on quality. The workforce team have a system in place to flag where this maybe happening.	

	A discussion ensued regarding feedback on the role of Resource Managers and the difference they are making to the role of Ward Managers in enabling them to free up their time for clinical leadership. A discussed ensued regarding the recruitment and staffing issues. This is more of a problem in certain areas but changes are needed to the wider recruitment model. This is being led by David Harris. The Board resolved to **note** the report.	
14/15/75	**Q2 INFECTION, PREVENTION AND CONTROL** (Amanda Miskell joined the meeting). The Board were informed that there had been a case of c-diff infection on an inpatient ward in Macclesfield. The individual concerned had received a surgical intervention prior to coming on the ward. This is the first incidence of this infection at CWP and has been reported accordingly. The new contract has started with Vale Royal CCG from 1st November 2014. The Board were assured that the IPC team will continue to undertake surveillance on prevalence of infection across the area. A discussion ensued regarding the new contract roll out and whether the tender brought any resources for new staff given the size of the contract. Amanda Miskell informed that there are ongoing discussions with the commissioners on this and recruitment to new posts is in progress. It was commented that the IPC team are well established in the west Cheshire locality but work is ongoing to establish the team in the Vale Royal area. The Board **resolved** to **note** the Infection, Prevention and Control Quarter 2 report.	
14/15/76	**Q2 QUALITY REPORT** Dr Anushta Sivananthan introduced the report and highlighted some key areas. These included: • The healthy living and preventative work currently ongoing in the Lache integrated early support centre. This is supporting child development to support achievement of good outcomes and potentially reducing impact on health services in the future. This centre also received a royal visit earlier in the year. • Successful Mental Health Act training undertaken with east Cheshire police which had led to a reduction in s136s. • The positive mental health community survey results which have been previously discussed. The Board **resolved** to **note** the report.	

14/15/77	**BOARD DASHBOARD (CORPORATE PERFORMANCE REPORT)** Andy Styring introduced the report and highlighted the Trust is close to target threshold on 7 day follow up. This is being followed up in localities for action. The level of sickness absence in the Trust is high. A task and finish group is in place to look at the accuracy of reporting and what we can do to either prevent sickness or manage it when it happens. This is reporting to the December Operational Board. There is a need to look at whether we are making the best use of the interventions the Trust offers. In terms of context to the sickness figures, the Trust is comparable to other trusts on this issue so is not a particular outlier. A discussion ensued regarding the Blacklight implementation and the aspiration that this will lead to more accurate reporting and as such, the potential for a further increase in the figures. The Board noted that the CIP plan is still off profile and it was queried whether the services are using concepts such as LEAN to try to close the CIP gap. Andy Styring advised that this is the case and that often ideas are developed but do not pass the quality impact assessment process and therefore need reworking. Dr Jim O'Connor queried the message to services regarding any contingency to close the gap. Andy Styring assured that the the message is very clear on the availability of contingency and that all plans need to be in line with the clinical strategies. The Board **resolved** to **note** the report.	
14/15/78	**RESEARCH ANNUAL REPORT 2013/14** Dr Faouzi Alam introduced the report and highlighted a number of areas. These included: • The number of those recruited to studies has exceeded the targets. • The Trust is working collaboratively with University of Chester and has contributed to 63 publications. • The team are working on a Research Strategy which is due in January 2015 and will link into the clinical strategies to use research to drive improved services. • A Research Conference was held recently which was well received with a large number of people in attendance. Dr Jim O'Connor commended the development of the Research Strategy and it was noted that this will be approved by the Board following the approval of the clinical strategies. It was noted that the clinical networks now in place will support the dissemination of outcomes from research. A discussion ensued regarding the potential commercial opportunities	

	arising from research in the future. Dr Chris Link is taking is forward and is making commercial contacts for potential future links. The Board **resolved** to **note** the report.	
14/15/79	**WIRRAL VISION 2018 UPDATE** (Val McGee joined the meeting). Sheena Cumiskey provided an overview of the integration programme across the Wirral area which is the five year view in action from a Wirral perspective. Val McGee introduced the update report from the Vision 2018 Board which had been provided to all partner boards and the Wirral Council Cabinet. Of the three underpinning programmes, CWP are leading on the Long Term Conditions work stream. The update also sets out the governance arrangements to the programme. It has been recognised by the Vision 2018 Board that there is a need to add pace and rigour to programme as this has now been in situ for the last 2 years. Within mental health, the key areas of focus are dementia, alcohol related issues, anxiety and depression. These cut across physical health issues and will be reflected in the primary care tender which is expected shortly. A discussion ensued acknowledging the need to expedite the programme. It was also noted that staff consultation and engagement is key to the success of the programme. It was noted that there is a workforce work-stream in place and this is driving engagement with all groups including communities and their use of big data. The mutualisation project will draw this through further. The Board were informed of the progress around asset based community development which is looking at community connectors that can support the development of resilient communities by highlighting community hubs that people can access before recourse to statutory services. There are around 4000 community connectors in Wirral and further work is needed to understand where these are and how to signpost people to them. The Board **resolved** to **note** the report.	
14/15/80	**CWP SOCIAL VALUES AND 6 CS** Avril Devaney introduced a presentation around the CWP ambitions on social values and gave an overview of the projects that are currently on going. These included the ongoing work to support Kisiizi Hospital via a branch of the Trust charitable funds and the use of monies from Jamie's fund to support the development of a new building at the Kisiizi hospital. The Trust is also undertaking a campaign to provide washpacks to a local homeless shelter to give residents access to their own toiletries for their time in the shelter.	

	The Trust has also linked with a school in Wirral to support the ebola campaign in Sierra Leone. A discussion ensued regarding raising the profile of this work and thinking about engaging some of the big contractors to potentially support the building work in Kisiizi.	
14/15/81	**PROVIDER LICENCE COMPLIANCE ASSESSMENT** Dr Anushta Sivananthan introduced the report and reminded the Board that an assessment of compliance against the licence is undertaken on a six monthly basis. Using a criteria similar to the quality governance assessment, the Trust is complaint with the conditions of the licence. There are two areas rated as amber green. These are due to the Trust having a legacy risk around potential breaches to the licence. There is a further risk is around subcontracting which the Trust is mitigating via a risk treatment plan. It was noted that the Audit Committee will receive quarterly assessments on the provider licence moving forward. The Board **resolved** to note and **approve** the report.	
14/15/82	**REVIEW OF RISK IMPACTS OF ITEMS DISCUSSED** There were no further risk areas identified through the discussions during the meeting.	
14/15/83	**ANY OTHER BUSINESS** The Chair offered members of the public in attendance to ask a questions or comment. Murdo Kennedy queried the Trust's approach to providing feedback from 'near miss' incidents and how may this be affected by the statutory duty of candour' Avril Devaney provided an overview of the Trust's policy on incident reporting and learning from experience processes. Murdo Kennedy asked a question regarding approval process for innovations. Dr Anushta Sivananthan advised on the number of routes available in the Trust to promote innovation which includes innovation panels and the recent approach via an innovation competition which is currently ongoing.	
14/15/84	**REVIEW OF MEETING** All agreed the meeting had been effective.	
14/15/85	**DATE, TIME AND PLACE OF NEXT MEETING** **Wednesday 28th January 2015, 9.30am, Boardroom, Redesmere.**	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Action points from Board of Directors Meetings
28th January 2015

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
28/11/2014	14/15/78	**RESEARCH ANNUAL REPORT 2014/15** Research strategy is in development alongside the Clinical Strategy refresh. To report to the January 2015 Board	Jan 2015	FA	This will come to the March Board for approval in order to align to the locality clinical strategies	In progress

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

No:	Agenda Item	Executive Lead	30/04/2014 Seminar	28/05/2014	25/06/2014 Seminar	30/07/2014	24/09/2014	29/10/2014 Seminar	26/11/2014	18/12/2014 Seminar	28/01/2015	25/02/2015 Seminar	25/03/2015
1	Chair's announcements	Chair		√		√	√		√		√		√
2	Chief Executive announcements	Chief Executive		√		√	√		√		√		√
	Matters for Discussion /Board Action Assurance Quality / Safety												
3	Receive Quarterly Infection Prevention Control Reports	Director of Infection Prevention and Control		Qtr 4 13/14			Qtr 1 14/15		Qtr 2 14/15		Qtr 3 14/15		
4	Director of Infection Prevention and Control Annual Report 2013/14 inc PLACE	Director of Infection Prevention and Control				√							
5	Safeguarding Children Annual Report 2013/14	Director of Nursing, Therapies and Patient Partnership				√							
6	Safeguarding Adults Annual Report 2013/14	Director of Nursing, Therapies and Patient Partnership				√							
7	Accountable Officer Annual Report inc. Medicines Management 2013/14	Medical Director Compliance Quality and Regulation				√							
8	Health and Safety Annual Report and Fire 2013/14 link certification	Director of Nursing, Therapies and Patient Partnership				√							
9	Receive Appraisal Annual Report 2013/2014 and declaration of medical revalidation	Medical Director of Effectiveness and Medical Workforce				√							
10	Implemtation of service redesign programmes	Director of Operations					√						√
11	Implemetaton/ refresh of Trust Clinical Strategy	Director of Operations					√						√
12	Emergency Planning Annual Report 2013/14	Director of Nursing, Therapies and Patient Partnership					√						
13	Avoidable Harm / Zero Harm strategy reporting	Medical Director Compliance Quality											√
14	Monthly Ward Staffing update	Director of Nursing, Therapies and Patient Partnership				√	√		√		√		√
15	Six monthly staffing review	Director of Nursing, Therapies and Patient Partnership		√							√		

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

31	Approve BOD Business Cycle 2015/16	Chair											√
32	Review Risk impacts of items	Chair/All		√		√	√		√		√		√

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/15/93)

Report to:	**Board of Directors**
Date of meeting:	**28 January 2015**
Title of report:	**Strategic risk register/ corporate assurance framework update**
Action sought:	**For DISCUSSION & APPROVAL**
Author:	**David Wood, Associate Director of Safe Services**
Presenting Executive:	**Dr Anushta Sivananthan, Medical Director (Compliance, Quality & Regulation)**

Strategic Objective(s) that this report covers *(delete as appropriate):*

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

Distribution

Version	Name(s)/Group(s)	Date Issued
1	D Wood to L Hulme for Board of Directors	20 January 2015

Executive director sign-off

Executive director (name and title)	Date signed-off
Dr Anushta Sivananthan, Medical Director	21 January 2015

1. Purpose of the report

To apprise the Board of Directors of the current status of the corporate assurance framework and strategic risk register, as per the requirements of the Trust's integrated governance strategy. This report also details planned changes to the corporate assurance framework, in order to meet the recommendations as set out in *Monitor*'s Well-led framework for governance reviews.

2. Summary

The following report indicates controls and assurances and progress against the mitigating actions identified against risks to the Trust's strategic objectives. The Quality Committee is the designated committee for risk management operationally and last reviewed the strategic risk register at its meeting on 15 January 2015. The Audit Committee, at its January 2015 meeting, received assurances on the management of the 'Risk of not being able to deliver safe and effective services due to inadequate attendance on mandatory training' and endorsed the recommended target risk score of 12 for achievement by December 2015.

3. Current status

3.1 Strategic risk register

Description of the risk	Residual risk rating Sep 2014	Residual risk rating Nov 2014	Residual risk rating Jan 2015	Risk score since last review	Summary risk treatment plan
Risk of harm to patients due to lack of staff competency to manage changing physical conditions	20	20	20	↔	▪ The 4 March 2014 meeting of the Audit Committee undertook an in-depth review and initially agreed a target risk score of 15 to be achieved by January 2015. ▪ The 19 June 2014 Patient Safety and Effectiveness Sub Committee received assurances on progress towards the target risk score from the physical healthcare network group and requested that it strengthen the controls and assurances in managing this strategic risk by: o Benchmarking CWP position, in relation to outcomes and performance against NICE guidance, with other mental health trusts in the region. o Developing an assurance framework as a priority. o Ensuring seamless linkage with the national "improving physical healthcare to reduce premature mortality in people with severe mental illness" CQUIN scheme. **Patient Safety & Effectiveness Sub Committee 4 December focussed on the current and forward national**

Description of the risk	Residual risk rating Sep 2014	Residual risk rating Nov 2014	Residual risk rating Jan 2015	Risk score since last review	Summary risk treatment plan
					CQUIN scheme. The target risk score achievement date will be amended in year based on details [yet to be] received on the national CQUIN for 2015/16. All inpatient and community teams are scoping resources, training, support and equipment needs which will then be reported to Board in March 2015.
Lack of robust ligature management programme within the Trust may result in harm to patients with associated reputational and financial impact on the organisation	**20**	**20**	**20**	↔	▪ Board approved capital programme in place, with update provided to December 2014 Operational Board. Capital programme for 2015/16 includes additional finance for Bowmere Hospital. ▪ Works completed [October 2014] regarding en-suite door top alarm systems and clinical risk management of dressing gown cords. ▪ Suicide prevention action group meeting every two months bringing together observation and environment policies. **Risk description under review based on 2015/16 approved capital programme. Currently scoping the operationalisation of the use of HoNOS score 4 for self-harm risk and/ or sudden new or sudden emergence of known risk factors to self. Learning from a peer review of a serious incident has identified immediate organisational learning and this learning has been implemented – provision of training to staff and guidance the technical aspects of the en-suite door top alarm system and testing protocol.**
Risk of harm to patients and staff due to staffing levels across inpatient services in the three localities	**20**	**20**	**20**	↔	▪ Position statement prepared by the Associate Director of Nursing [Mental Health] and DIPC on current staffing levels, including safety and skill mix across all professional types, benchmarked against other trusts presented to Operational Board in October 2013. ▪ A review team was established with

Description of the risk	Residual risk rating Sep 2014	Residual risk rating Nov 2014	Residual risk rating Jan 2015	Risk score since last review	Summary risk treatment plan
					external input and undertake a review to consider staffing levels identified by ward managers and modern matrons, use of bank and financial impact of this and rostering issues. ▪ Review was presented to Operational Board in January 2014 which approved, in principle, the operational recommendations. Review was noted at March 2014 meeting of the Quality Committee for qualitative recommendations. Specific, immediate actions identified were presented and approved by January 2014 Board of Directors – update report subsequently provided at March 2014 meeting. ▪ Programme lead now in place and publication of staffing establishment levels on website from 1 April 2014. ▪ July 2014 Board of Directors agreed recommendation to increase residual risk score to 20 on the basis of recruitment difficulties in CWP East and new agreed inpatient staffing levels not yet fully implemented. **Action required to review risk description. This will be informed by second comprehensive staffing review to be completed and discussed at January 2015 Board of Directors meeting.**
Adults, children and young people are not protected through practitioners not implementing safeguarding practice and principles	**16**	**16**	**16**	↔	▪ The risk is reviewed by Quality Committee following receipt of safeguarding exception reporting every two months. ▪ Discussed at November 2013 Board of Directors, with request that risk is re-modelled to reflect the focus of the risk on training. ▪ Safeguarding training targets in place in West with current consistent over-performance. ▪ Positive outcome of the West Cheshire CQC inspection of safeguarding for looked after children w/c 20 January 2014.

Description of the risk	Residual risk rating Sep 2014	Residual risk rating Nov 2014	Residual risk rating Jan 2015	Risk score since last review	Summary risk treatment plan
					▪ Continuous monitoring of safeguarding practice through the Trust's compliance visits, safety metrics programmes, CQC visits, and practice audits. ▪ The Trust is providing the monthly safeguarding assurance framework to each CCG for both adult and children's services. ▪ Individual safeguarding referrals re Saddlebridge have been reviewed by Cheshire East Council and the criteria for a large scale investigation has not been triggered. Meeting re investigation of Millbrook red complaints scheduled for 21 January 2015 with recommendation a joint review is undertaken. **Risk description under review to capture changing landscape within safeguarding across health and social care and also to scope wider determinants of the safeguarding strategic risk based on emerging national evidence and CWP benchmarked position (e.g. seclusion, segregation, restraint, DoLS). Target risk score of 12 and timescale for achievement agreed as March 2015 as per corporate assurance framework – this may be deferred once the risk description has been reviewed. Associate Director of Safe Services is meeting with Deputy Director of Nursing [Physical Health] to review the safeguarding assurance framework ahead of the next meeting of the Trustwide safeguarding group on 29 January.**
The inability of staff to manage the occurrences of slips, trips and falls of patients, resulting in patient injury	**16**	**16**	**16**	↔	▪ FallSafe care bundle is in place across all wards. ▪ Patient Safety and Effectiveness Sub Committee has approved a risk treatment plan to implement control measures to mitigate this risk to a target risk score. The report was in response to the findings of an external acute falls nurse specialist

Description of the risk	Residual risk rating Sep 2014	Residual risk rating Nov 2014	Residual risk rating Jan 2015	Risk score since last review	Summary risk treatment plan
					who undertook a review of falls prevention and management. The review found that, in general, CWP has a robust system in place for the management of slips, trips and falls however, sometimes locally these systems are not always fully implemented. Additionally, issues such as environmental improvements and training also need to be addressed at local level. ▪ Audit Committee has undertaken two in-depth reviews of the risk during 2014 to agree target risk score of 12. ▪ Action plan is being implemented by a task and finish group and is reviewed routinely by the Patient Safety and Effectiveness Sub Committee. **Residual falls/ clinical specific actions that are outstanding were reported to the September 2014 meeting of the Audit Committee and will continue to report to the Patient Safety & Effectiveness Sub Committee. Other residual elements of this risk are being assessed for their interdependency/ placement with other strategic risks [in relation to environment and physical healthcare/ pathways]. Ongoing monitoring of proportion of harm/ no harm reporting via the Learning from Experience report.**
Risk of harm to patients due to CARSO risk assessment not being completed as per policy	**16**	**16**	**16**	↔	▪ Completion and quality of CARSO risk assessments included in community safety metrics programme. ▪ Recruitment to CPA/ effective lead complete – who will look at developing care plan training and guidance, including risk assessment. This will be based on historic and recent serious incident reporting themes including those in relation to the standalone 'ligature management' risk. ▪ Further assurance needed on quality

Description of the risk	Residual risk rating Sep 2014	Residual risk rating Nov 2014	Residual risk rating Jan 2015	Risk score since last review	Summary risk treatment plan
					of CARSO assessments prior to re-modelling. The main priority is ensuring services reach and sustain over 99% completion rates. Audit on a case by case basis end of 2014/15 where no completed CARSO summary to understand what might be the individual clinician or managerial issues preventing completion. **September 2014 Quality Committee agreed a target risk score of 12 and timescale for achievement. The Audit Committee received an in-depth review of this risk at its November 2014 meeting and noted the risk treatment plan.**
Risk of not being able to deliver safe and effective services due to inadequate attendance on mandatory training. This may result in harm to patients, litigation claims and breach of legislation.	**16**	**16**	**16**	↔	▪ A review of the Trust's training strategy has been undertaken following corporate services review and follows planning priorities and links to response to Francis and Berwick reports and CWP always events framework. ▪ Revised mandatory employee learning programme presented and approved by October 2013 Operational Board. ▪ 2014 dashboard reports have identified improvements in essential learning compliance Trustwide. **Workforce [People] and Organisational Development Sub Committee has adjusted Essentials 1 target to 85% to take into account turnover and other absences – discussed at September 2014 Quality Committee and recommended that a stepped/ stretch targets be agreed over a longitudinal period to encourage a continuous improvement focus on this risk. The Audit Committee received an in-depth review of this risk at its meeting in January 2015 and agreed with a target risk score of 12 for achievement by December 2015.**

Description of the risk	Residual risk rating Sep 2014	Residual risk rating Nov 2014	Residual risk rating Jan 2015	Risk score since last review	Summary risk treatment plan
Data quality may have an adverse impact on external (regulatory, contractual) monitoring and governance ratings and on effective internal decision making regarding service planning and development	16	16	16	↔	▪ Data quality improvement framework approved at November 2014 Operational Board; better use of information is detailed in the five year strategic plan. ▪ An external audit regarding the processes and systems associated with development of the quality dashboard reported to January 2014 Quality Committee – with positive assurance. ▪ Risk was reviewed as part of Q3 2013/14 Monitor quality governance self-assessment – returned to green and remains green to-date. ▪ Quality Account external audit 2013/14 received no qualifications. **Implementation plan now required for the approved data quality improvement framework to assure the Board of Directors, as part of its duties to monitor via the quarterly *Monitor* quality governance framework self-assessment, that the required systems, processes, competencies and gatekeeping arrangements are in place to operationalise the framework.**
Risk of adverse clinical incident or regulatory action due to dual record keeping systems (electronic and paper) and quality of recording	16	16	16	↔	▪ The Records and Clinical Systems Group is correlating clinical systems priorities with the dual record keeping risk – also tying into review of system effectiveness and functionality. ▪ A revised dual record keeping action plan was presented to the December and February 2013/ 2014 Patient Safety & Effectiveness Sub Committee meetings, for completion end March 2014. Confirmed as completed. ▪ Escalated to risk score of 16 following CQC visits to Springview in November 2013 and Bowmere in January 2014 which highlighted minor concern in respect of outcome 21 (records). Subsequently CQC have provided full assurance on

Description of the risk	Residual risk rating Sep 2014	Residual risk rating Nov 2014	Residual risk rating Jan 2015	Risk score since last review	Summary risk treatment plan
					compliance at Springview and Bowmere following re-inspections. **Updated assurance frameworks are presented to the Patient Safety & Effectiveness Sub Committee. Target risk score of 12 deferred with target date to be agreed pending confirmation of processes supporting IT enabled transformation programmes.**
Risk of harm to patients, carers and staff as well as reputational and litigation risks due to a/ unable to show consistent investigation of incidents; b/ unable to show learning from actions of incidents, claims etc is cascaded; c/ unable to be assured investigations are carried out in a timely manner d/ inability to communicate in a timely manner with partners	**16**	**16**	**16**	↔	▪ Learning from experience report and always events performance will be monitored to inform risk treatment plan on an ongoing basis. ▪ Service Directors have been asked to monitor the management of actions arising from root cause analysis investigations – this is routinely monitored at the Compliance, Assurance & Learning Sub Committee. ▪ Ongoing work around improving the process around interface incidents and ensuring actions arising/ learning points are clear. **Full review of incident reporting and management policy is deferred pending a review, as commissioned by the Executive Directors, of new ways of working to bring about better outcomes rather than addressing this risk solely through adding process focussed capacity. Target risk score will then be pending discussions with commissioners regarding agreed future performance management of investigations. This meeting has been scheduled for February 2015.**
Risk of breach of Trust Provider Licence as a result of external scrutiny	**15**	**15**	**12**	↓	▪ The CQC visited Eastway on 27 September 2013 and found the unit fully compliant against all standards. ▪ The Monitor governance rating for the Trust has returned to Green. ▪ The two minor concerns following the CQC unannounced visit to Clatterbridge mental health services registered location have returned to compliant. CQC has also confirmed

Description of the risk	Residual risk rating Sep 2014	Residual risk rating Nov 2014	Residual risk rating Jan 2015	Risk score since last review	Summary risk treatment plan
					compliance for Bowmere. **Audit Committee undertook an in-depth review of this risk at their May 2014 meeting. Target risk score of 10 identified to achieve by December 2014. This has been deferred as will be informed by scheduled internal audit of the provider licence.** **Residual score reduced to 12 on the basis that first CQC intelligence monitoring reports highlight CWP as a low risk organisation.**
Fragmentation of commissioning leading to fragmented patient pathways	N/A	N/A	**12**	N/A	▪ Existing discussion and engagement with commissioners and partner organisations, including across key complex patient pathways and populations and to take account of extensive change in commissioning structures. ▪ Quality assurance, improvement and governance mechanisms in place and routinely assessed to promote delivery of good quality patient care and outcomes. **Full risk treatment plan is in development, informed by overarching clinical strategy that will be presented to Board as part of annual/ forward planning round.**
Capacity and skills of the workforce to respond to emerging and new models of care provision and evidence based interventions	N/A	N/A	**12**	N/A	▪ Programme of education and learning interventions designed to meet clinical and non-clinical skills and knowledge needs. ▪ Trust Workforce Plan produced and submitted to Health Education England. ▪ Process in place for vacancy approval and filling. ▪ Ward staffing review identifying capacity issues and focusing recruitment activity. ▪ Mandatory training features as a Trust key performance indicator and is scrutinised via Trust's governance processes. ▪ Bank and Agency usage reported to Operational Board. ▪ Investors in People assessment

Description of the risk	Residual risk rating Sep 2014	Residual risk rating Nov 2014	Residual risk rating Jan 2015	Risk score since last review	Summary risk treatment plan
					recognised good practice in a range of associated areas. **People and Organisational Development strategy in development. Reconfiguration of People and Organisational Development sub committee to lead on risk treatment plan.**
Risk of not being able to deliver planned financial risk rating due to incomplete CIP plans resulting in potential breach of terms of authorisation and reputational damage	12	12	12	↔	▪ Strengthened financial infrastructure via recruitment of locality accountants and establishment of a performance and redesign function to support tracking of CIP delivery. ▪ Board seminars in October and December 2013 considered financial projection and revised approach to CIP going forward. ▪ January and February 2014 Board received outline financial projects and plans. March 2014 Board approved operational plan including 2014/15 CIP plans. **Improved process now in place, including weekly updates on CIP plans to Executive Team and also at every Operational Board meeting. Risk re-modelled to take account of improvements to process. To be reviewed based on year-end position.**
Loss of current services due to risks associated with the market environment and the potential for commissioners to seek further competitive tendering for clinical services	N/A	N/A	4	N/A	▪ Ability to influence commissioners via close working relationships. ▪ History of good performance. ▪ Robust Standard Operating Procedures developed by Effective Services Department to respond to tender opportunities. ▪ Clinical and financial review and involvement throughout tender process. ▪ Executive Director sponsor assigned to each tender. ▪ "Black Hat" meeting undertaken in advance of tender submission ▪ Executive Director sign-off of tender submission. **It is acknowledged that this risk score is likely to be volatile based on market environment. A service**

Description of the risk	Residual risk rating Sep 2014	Residual risk rating Nov 2014	Residual risk rating Jan 2015	Risk score since last review	Summary risk treatment plan
					improvement and tendering event was held in November 2014 resulting in a draft Service Improvement Framework to guide localities, mitigate governance issues associated with sub contracted services, and to bring about consistency to mitigate the volatility of the risk score. This will be monitored closely for its impact during the 2015/16 financial year.

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

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

4.1 New risks
The three risks identified through the strategic planning process were presented by the risk leads at the November 2014 Quality Committee for approval. These are:

- *Loss of current services due to risks associated with the market environment and the potential for commissioners to seek further competitive tendering for clinical services.*
- *Capacity and skills of the workforce to respond to emerging and new models of care provision and evidence based interventions.*
- *Fragmentation of commissioning leading to fragmented patient pathways.*

These have been added to the strategic risk register following approval at the November 2014 meeting of the Quality Committee. As forward/ five year strategic risks, the risk treatment plans are acknowledged to be iterative. It is encouraging that the Trust scoped similar forward strategic risks as those introduced in the NHS Five Year Forward View ("5YFV") [NHS England], for example new models of care.

4.2 Amended risk scores or re-modelled risks
The 'Risk of breach of Trust Provider Licence as a result of external scrutiny' has been re-scored from 15 to 12 to reflect the first CQC intelligence monitoring reports highlighting CWP as a low risk organisation. The scheduled Trustwide announced visit in June 2015 does not change this low risk status.

The recommendation from the previous meeting of the Quality Committee that the 'Risk of harm to patients and staff due to staffing levels across inpatient services in the three localities' description be re-modelled is deferred pending the second comprehensive staffing review, which is being discussed by the Board of Directors today subsequent to receipt of this report.

4.3 Archived risks
No risks have been archived in this reporting period.

4.4 Audit Committee review of the strategic risk register
The Audit Committee undertook an in-depth review of the 'mandatory training' risk at its January 2015 meeting and agreed with the risk treatment plan to decrease the risk score to its target of 12 by December 2015. At its next meeting it will review the 'investigation and learning from experience' risk.

4.5 Development of the corporate assurance framework
The next corporate assurance framework to the Board of Directors will be a planned, refined presentation with more focused and contemporaneous content in response to *Monitor*'s (2014) Well-led framework for governance reviews. It sets out a number of recommendations that foundation trusts should include in a dynamic corporate assurance framework.

5. Recommendations
The Board of Directors is asked to:

- **Review, discuss** and **approve** the amendments that have been made to the strategic risk register and corporate assurance framework as recommended by the Quality Committee, as presented in this report.
- **Recommend** to the March 2015 meeting of the Quality Committee that it reviews the current risk descriptions of the following two risks, to ensure that they are inclusive of all the contemporary and emerging issues associated with them as described in the current risk treatment plans:
  - 'Lack of robust ligature management programme within the Trust may result in harm to patients with associated reputational and financial impact on the organisation.'
  - 'Adults, children and young people are not protected through practitioners not implementing safeguarding practice and principles.'
- **Recommend**, based on the subsequent report that the Board of Directors is receiving today [the comprehensive staffing review report] a description of the current/ future strategic 'staffing' risk, which has to-date been the 'risk of harm to patients and staff due to staffing levels across inpatient services in the three localities'.
- **Note** that the next corporate assurance framework will be a reviewed version to reflect the recommended inclusions as per *Monitor*'s Well-led framework for governance reviews.

Appendix 1
Corporate assurance framework
T:\01. BoD Committees\Board of Directors\Meetings\2015\150128\Open

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/15/94)

Report to:	**Board of Directors**
Date of Meeting:	**28 January 2015**
Title of Report:	**First 6 monthly review of ward nursing staffing establishments in line with the NQB requirements November 2014 and December 2013 submission to NQB**
Action sought:	**For Discussion and approval**
Author:	**Maria Nelligan, Associate Director of Nursing & Therapies (MH) & DIPC** **Julie Anne Murray, Practice Education Lead** **Natalie Larvin, Consultant Nurse (Acute Care)** **Anne Casey, Programme Manager [Inpatient Bed/Ward Review]**
Presented by:	**Avril Devaney, Director of Nursing, Therapies and Patient Partnership**

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

Distribution

Version	Name(s)/Group(s)	Date Issued
1	Ward Staffing Project Group	16/01/15
2	Avril Devaney	16/01/15

Executive director sign-off

Executive director (name and title)	Date signed-off
Avril Devaney	19/01/15

First 6 Monthly Review of

Ward Nursing Staffing Establishment

November 2014

Authors:

Maria Nelligan

Associate Director of Nursing & Therapies (MH) &

Director of Infection, Prevention and Control

Julie Anne Murray

Practice Education Lead

Natalie Larvin

Consultant Nurse (Acute Care)

Anne Casey

Programme Manager [Inpatient Bed/Ward Review]

Table of Contents

1. Introduction

This report sets out the key recommendations from the First 6 Monthly Review of Ward Nursing Staffing Establishment completed in November 2014 in line with NHS England and the National Quality Band (NQB) requirements. Moving forward this review will be carried out at 6 monthly intervals and be reported to the board of directors. A summary of the ward staffing levels monthly reports, previously submitted to the Board of Directors, is included.

1.1 Background to the ward nurse staffing review

- In January 2014 the Operational Board received a paper setting out the Trusts current position in relation to ward staffing, vacancies and skill mix and areas for improvement. Maria Nelligan, Associate Director of Nursing & Therapies (MH) led a review of ward staffing levels on behalf of the Board. The board approved the recommendations of the review and a programme board was established to take forward these recommendations including staffing levels and a programme of continuous improvement. The Director of Operations is the lead executive for the programme board and Avril Devaney, Director of Nursing (DoN), chairs the Ward Staffing Project group. The DoN has oversight of ward staffing levels and reports directly to the Board of Directors in line with the NQB requirements.

- From May 2014 the trust has displayed daily staffing levels on in-patient wards. A six monthly review was undertaken in June 2014 and monthly reports have been provided to the board of directors since from June 2014 onwards. In order to comply with NHS England and NQB requirements these reports and the trusts performance are also published on the trust and NHS Choices websites.

- An in-depth 6 monthly review of ward nursing staffing was undertaken during November and December 2014. The areas covered within the review include both qualitative and quantitative data and the review methodology follows the Telford Model which uses a consultative approach based on professional judgement. To prevent bias quantitative data has also been used to aid triangulation. The review followed the same format of the comprehensive review undertaken in 2013.

- The composition of the review team included the Associate Director of Nursing & Therapies (MH), Practice Education Lead, Programme Manager [Inpatient Bed/Ward Review], Consultant Nurse (Acute Care). The review team met with each ward's representatives, including the Ward Manager, Modern Matron, Consultant Psychiatrist and Allied Health Professionals in order to discuss issues currently impacting on ward staffing on a shift by shift basis, and progress made since the original review in 2013. The areas discussed covered the range of factors impacting on nursing and the ability to deliver high quality care.

- The review team challenged the ward representatives on areas of practice and assumptions in order to support the resulting conclusions and recommendations. The review team undertook analysis the information available and have made recommendations to the Board within this report.

- The data examined for each ward included:

- current ward MDT establishments;
- rosters;
- skill mix ratios;
- bank usage;
- sickness;
- incidents;
- uptake of education; and
- Supervision/appraisal compliance.

The range of data was considered alongside the National Benchmarking Report 2014, the National Bed Enquiry (2000) and Boardman (2007), NICE guidelines, CQC essential standards and contractual service specifications.

1.2 National context to safe staffing levels

- Considerable discussion has taken place regarding the impact nursing staffing levels have on the quality of patient care. Francis (2013), Berwick (2013) and Keogh (2013) highlight the negative impact on patient outcomes where staffing levels are not sufficient. An example being the high profile case of Mid Staffordshire Hospital.

- Research demonstrates that there are better outcomes for patients in terms of safety and quality where there is a high Registered Nurse ratio. Little research exists for mental health; however the principles are transferable across the nursing disciplines.

- It is recognised that staff shortages have an impact on patients and staff and compromise care directly and indirectly. Recurrent shortages of staff impact on the wellbeing of staff leading to higher sickness and greater dependency on bank, reducing continuity of care and impacting on substantive workload. This has an impact on the quality of care delivered to patients and ability to provide care within the current resources.

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

- It is recommended by the NQB (2013) that the Board monitors staffing capacity and capability via regular and frequent reports on the actual staff on duty on a shift by shift basis versus planned staffing levels; that they examine trends and review in the context of key quality and outcome measures. It is the expectation that the boards give the Director of Nursing the authority to oversee this at board level.

- Boards will ensure that the organisation is open and honest if they identify potential unsafe staffing levels and take steps to maintain patient safety.

- The NQB (2013) also recommends that staff working within structured teams are able to practice effectively through the supporting infrastructure of the organisation such as the use of IT, deployment of ward clerks, housekeepers and supportive line management. These are key standards for moving our inpatient wards forward.

- It is recommended that staffing establishments take into account the need to allow nurses and care staff to have time to undertake continuous professional development and fulfil mentorship and supervisory roles.

- Commissioners will actively seek assurances from Boards with regards to the staffing establishment and the competency and skills of the workforce; some have started to ask for this information already in contract monitoring meetings.

- The NQB (2013) state that papers to the Board on establishment reviews should aim to be relevant to all the wards and cover the following points:

    - Difference between current establishment and recommendations following the use of evidence based tools
    - What allowances have been made in establishment for planned and un-planned leave
    - Demonstrate the use of evidence based tools where appropriate
    - Details of any element of supervisory allowances that is included in the establishment for the lead Ward Manager
    - Evidence of triangulation between the use of tools and professional judgement and scrutiny
    - The skill mix ratio before the review and the recommendations for after the review
    - Details of any plans to finance any additional staffing required
    - The difference between the current staff in post and current establishment and details how the gap has been covered and resourced
    - Details of workforce metrics, for example data on vacancies; sickness; absence; turnover and use of temporary staffing
    - Information against key quality and outcome measures for example data on safety thermometer; serious incidents; complaints and patient satisfaction

- The Review papers should make clear recommendations to the Board which should be considered and discussed at public Board meetings monthly and reviewed 6 monthly. This data will be part of the CQCs Intelligent Monitoring of NHS Providers.

2. Safe Staffing Levels - National Quality Board Reporting

2.1 Overview of the trust response

In response to the national requirements (NQB), the Trust implemented a system for capturing and reporting daily nursing staffing levels from May 2014. Each month the trust has submitted these figures to UNIFY in the required template (December 2014 submission can be found in Appendix 1).

To further improve this system an automated process for data collection is being developed and the Trust is reviewing how information can be used to monitor and escalate acuity. Having reviewed what is available in the market place and learning from other Trusts the

trust has had and initial meeting with Hedron, (an external supplier) to explore options in taking this work forward.

To date no national thresholds have been set in relation mental health and learning disabilities ward nurse staffing level compliance however trusts are expected to demonstrate month by month improvement in relation to planned and actual staffing levels.

In order to maintain safe staffing levels WMs plan for adequate staffing levels on a shift by shift basis supported by Modern Matrons and Clinical Services Managers. If, however, the required levels are not achieved staff follow an escalation procedure to source additional staffing. Should this be unsuccessful staff then review and evaluate the work of the team and put in place actions to mitigate harm to patients. These measures will include reviewing the workload for the day, prioritising patient interventions, review of non-direct care and cancelling non-essential patient care activities.

The Trusts performance from May – December 2014, with respect to national reporting of safe staffing levels is included in the table below:

Month	Day				Night				Fill Rate			
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Day		Night	
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ Midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)
May-14	20939	19320.75	24768.5	23801.25	13412	12619	18068	18097	92.3%	96.1%	94.1%	100.2%
Jun-14	20124.2	19083	24960.2	22753.5	13612.5	12544.5	16698.4	16806.5	94.8%	91.2%	92.2%	100.6%
Jul-14	20209.9	18955	24322.1	22555.25	13095.5	12451	16989.9	16799	93.8%	92.7%	95.1%	98.9%
Aug-14	19023.75	18248.3	24346	23228.5	12875.5	12314	17344.6	17125.1	95.9%	95.4%	95.6%	98.7%
Sep-14	19329.6	17431.9	24299.5	23672	12912	12144.5	16422.5	16330	90.2%	97.4%	94.1%	99.4%
Oct-14	21376.25	18945.13	24599	24560.5	13453.5	12157	16615.5	17281.65	88.6%	99.8%	90.4%	104.0%
Nov-14	20412	18547.15	24797.9	24873.73	12858.15	11656.3	16750	17643	90.9%	100.3%	90.7%	105.3%
Dec 14	21160.5	19161	26528	25168	13849	12728	17534	18042	90.5%	94.9%	91.9%	102.9%

The figures above demonstrate that the trust has achieved a Registered Nurse (RN) staffing level of above 90% trustwide, across days and nights, on all but one month (Oct 2014). In Oct 2014 the wards reported a high number of RN vacancies contributing to the lower fill rate, although these vacancies were within the recruitment process, staff were not yet in post. Non-registered nurse fill rates were above 90% throughout this time and over 100% on occasions. Where non-registered nurse fill rates exceed 100% this is due to non-registered staff back-filling unfilled RN shifts. It should be noted that these are trust averages and ward by ward monthly averages vary significantly and are highlighted and reported monthly; for example Juniper and Beech wards have consistently fallen significantly below a 90% RN fill rate. To address this and maintain patient safety, additional CSWs were rostered on duty and the MDT worked on the ward with the nursing staff. This situation is mainly due to

recruitment timescales and staff turnover which is detailed below in section 2.3. The locality management team is conscious of this situation and is proactively managing it, additionally they are supported by the Staffing Review Project Group. For the next 6 monthly report to the Board of Directors an analysis of trends over the period will be included in the report.

2.2 Themes from monthly staffing reports to Board of Directors

The monthly staffing reports to the Board of Directors has highlighted recurring themes relating to the challenges faced by ward teams to ensure that safe staffing levels are maintained. Each month these issues are highlighted by the Clinical Service Managers (CSMs) and submitted for the monthly board report .The occurrence and intensity of these themes varies from ward to ward and fluctuates in response to recruitment of substantive staff and bank fill rates. The ward staffing project group will be looking at how this information is reported in a quantifiable format from February 2015. However in general the feedback from the ward teams was positive during the review in 2014 and this was evident in this 6 month review interviews with ward managers and MDTs as detailed in section 2.3.This indicates that the work undertaken since the first review is having a positive impact but there is still more work to be done.

- **Nursing staff working additional unplanned hours** –This includes nursing staff not having an unpaid meal break during the shift or working unplanned extended hours at the end of a shift. This is concerning as it has been found that insufficient rest breaks is one of the contributing factors to an increased risk of errors and is a recognised contributing factor in patient safety incidents (RCN, 2012). With regards to nursing staff working beyond their planned shift time, given that the current shift pattern is predominantly long days, this raises concern as the Health and Safety Executive advises that after working 12 hours the risk of error, accident or injury doubles (HSE, 2012). In addition this time needs to be paid back to staff at a later date. The occurrence of this issue is reducing as we increase the ward establishments and the dependence on bank staff reduces.

- **Ward managers and the multi-disciplinary team supporting the maintenance of safe staffing levels –**Ward managers, who are intended to be supernumerary, and the multi-disciplinary team are frequently supporting shift staffing numbers. This impacts not only on the workload of these staff but also on the direct and indirect care activities that may have to be rescheduled. The introduction of Resource Managers has enabled Ward managers to spend time on direct and indirect patient care and Ward Managers and teams report this is having a positive impact on patient care and the team.

- **Impact on patient activities–** Wards report the shortening, rescheduling or cancelling of patient activities each month, examples of this happening were also raised during the review meetings. This has an impact on patient and staff experience and on the quality of care delivered. Alterations in changes to planned activities are reducing and ward teams work hard to ensure activities are rescheduled and not cancelled. Ward managers with Occupational Therapists are developing and implementing initiatives which increase activities on the ward including enhancing CSW skills in delivering meaningful activities; this work is being co-ordinated by the Ward Managers Task and Finish Group.

- **Impact on training and development –** The cancellation of essential learning, supervision and appraisals may impact on quality standards being met and on staff experience. Undertaking these activities help ensure staff feel valued and supported

and are important in promoting the delivery of quality care. Additionally there is a need to meet thresholds in order to advance through incremental pay-points. CWP safe services team, through unannounced visits, have highlighted compliance with essential learning, supervision and appraisal as a recurring issue within wards. Ward Managers have indicated that the introduction of Resource Managers is supporting them carry our appraisals and supervisions on the wards more effectively and implement a rolling programme on the roster for staff to complete Mandatory training. In addition Education CWP with clinical staff have reviewed the mandatory training programme to meet the needs of staff which includes more on the ward skills based training .

- **Diluted skill mix –** NQB staffing level submissions show that skill mix is being diluted due to current RN staffing levels. This occurs when the backfill for vacant shifts is unable to be met by the correct grade of staff. This frequently means that non-registered staff backfill for registered staff and to a lesser extent vice versa. Backfill is required when staffing levels are not met within the substantive staffing establishment due to reasons such as vacancies, sickness and maternity leave. Research demonstrates that there are better outcomes for patients in terms of safety and quality where there is a high registered nurse ratio therefore this dilution of skill mix is a concern. Additionally the Safe Staffing Alliance (2013), recommend that RN-to-patient levels should never fall below 1:8 during the day. The ward staffing levels agreed by the Board of Directors following the 2013 review ensure that CWP wards have the minimum daytime RN to bed ratio of 1:8 however when shifts have to be backfilled by different grades of staff the maintenance of this ratio cannot be assured. It should be noted that this ratio was developed in acute care where the majority of patients are in bed and not ambulant. The Ward Staffing Project Group and Programme Manager is overseeing the implementation of the establishments agreed by the Board and carrying out monthly monitoring and reporting to Services Directors, Executives Directors and Ward Managers. Where there are specific issues identified Ward Managers are supported by CSM and corporate managers.

2.3 Progress of nurse recruitment in response to the 2013 ward nurse staffing review

The implementation of the staffing review is being overseen by the programme board who agreed to look at the recruitment of the staffing levels in 2 phases. Phase one, in 2014, to focus on the recruitment of RNs, CSWs and partial recruitment to Resource Manager posts, with phase two being implemented once this has been completed. There is no current overarching electronic system to manage recruitment; there are multiple people involved in the process, there are dual manual and electronic elements and therefore it is difficult to categorically quantify the length of recruitment. However the ward monitoring tool, developed by the performance and redesign team, shows that the length of time to recruit to posts ranges from 11 weeks to 23 weeks for CSWs and 20 weeks to 25 weeks for RNs. This, combined with turnover rates has impacted on the wards ability to sustain the achieved recommended staffing levels approved by the board. Locally teams are looking at how they can increase recruitment for example recruiting local nursing students and developing staff through the apprentice scheme.

Staff turnover has a significant impact on the wards achieving and retaining the appropriate nursing staffing levels. Since January 2014 the trust has recruited 67.92 WTE RNs and 48.83 WTE CSWs to in-patient positions. Significant work in recruiting and supporting the recruitment of staff has taken place both locally and corporately over the

past 12 months. However, due to recruitment processes and leavers (turnover), the current staffing position is 19.74 WTE RNs below the target approved by the board in January 2014. The locality with the biggest challenge in recruiting nursing staff vacancies currently is CWP West where the staffing gap for RN is 18.42 WTE.

It is recommended that a proactive monthly recruitment drive is implemented in each locality to maintain adequate nurse staffing levels. To support this human resources (HR) are responding to this issue through an improvement project in place which will include:

- reviewing end to end processes, roles, structure and required skills
- developing a proposal for a new recruitment system
- setting up a 'People planning group' to raise the profile and management of vacancy filling

In the interim the ward staffing project group should look at supporting this manually until the electronic system is in place.

The table below shows the trustwide recruitment position statement as of November 2014. The detail of the locality recruitment is in appendix 2. It should be noted that the board approved additional staffing requirements detailed in column 3 do not align to the board approved uplift. This is due to a number of anomalies arising from headroom calculations; this is being addressed with finance and will be resolved imminently.

Trust	Vacancies as at Jan 2014	Board approved additional staffing requirements	Total to recruit Jan 2014	Leavers during 2014	Recruited during 2014	Vacancies currently in recruitment process	Overall target	Current WTE	Staffing gap
Phase one									
RN	29.37	17.71	47.08	59.5	67.92	23.77	256.89	237.15	19.74
CSW	2.39	31.46	33.85	21.31	48.83	17.22	275.18	277.33	-2.15
Total	31.76	49.17	80.93	80.81	116.75	40.99	532.07	514.48	17.59
Phase Two									
RM	1	18	19	1	9.8	0	18	9.3	8.7
AP	0	6	6	0	0.5	0	6	0	6
Total	1	24	25	1	10.3	0	24	9.3	14.7

2.4 Analysis of bank usage Jan – Dec 2014 compared to 2013 ward review data

In the 12 months prior to the 2013 ward staffing review 118 WTE bank staff were used to maintain safe staffing levels on in-patient units. For the same period the vacancies rate ran at an average total of 60 WTE. The 2013 review recommended an up lift of 58 WTE (RN and CSW) therefore the recommended uplift aligned to the corresponding bank usage and vacancies. However as noted in the 2013 review, this did not include sickness backfill and fluctuations in patient acuity.

This year 88 WTE bank staff were used on in-patient wards. This is a reduction of 18% on the previous year. The challenge of recruiting the 58 WTE staff recommended by the 2013 review coupled with the additional recruitment due to 81 WTE leavers continues to have a significant impact on the bank demand. However finance advice that the bank spend during 2014 does not bring the ward nurse staffing spend above the cost of the establishments agreed in the 2013 review despite bank usage remains high.

Bank usage of greater than 5 WTE is deemed as high as this equates, on average, to more than one member of bank staff on each shift throughout the course of a week. Bank staff provide valuable support to wards to mitigate staffing shortfalls however it is acknowledged that high use of bank can have an impact on continuity of care and delivery of quality outcomes. There were 8 wards with high bank usage during the past 12 months including Adelphi, Croft, Greenways, Maple, Meadowbank, Oaktrees, Pine Lodge and Willow. In 2013 there were 9 wards with high bank usage however it should be noted that Saddlebridge was closed for 6 months of the year.

3. Six monthly ward nurse staffing review findings

3.1 Findings from service user focus groups

As part of the staffing review service users focus groups carried out to ensure that the views of our current patients were included within this review. These were carried out by the Consultant Nurse (Acute Care) in December 2014 in the three main inpatient localities (Chester, Wirral, Macclesfield). To align with the 2013 review the same questions were asked as follows:

1) How has your stay been on the ward?

2) What interventions/treatments have you received on the ward?

3) Can you suggest any improvements in terms of staffing on the wards?

The common themes were as follows (Where comments are in brackets these comments were in the localities specified only):

<table>
<tr><td colspan="2">What patients said about nurses:</td></tr>
<tr><td>2013
Positive:
1:1 time with nursing staff is provided.
Nursing staff are good but very busy.
Areas for improvement:
There is little 1 to 1 time with nurses
Staff are often in the office most of the time
Staff are busy with administrative tasks.</td><td>2014
Positive:
They have done lots to promote my independence, increase my confidence and support my recovery
They have helped me work on what I want to especially improving my physical health and mental wellbeing
More 1:1 with nurses
Areas for improvement:
There is inconsistency some days there are enough staff others there are not enough
When they are short this means that plans are cancelled
They try to help but they are always rushing round
The domestics have more time to speak to you than the nurses do</td></tr>
<tr><td colspan="2">What patients said about care and therapy:</td></tr>
<tr><td>Positive:
OT is offered as an intervention.
OT is viewed as good.
Peer worker really helped us as he understand us (CARS)
Areas for improvement:
No talking therapy offered.
When the ward is disruptive it feels scary.
Medication is main intervention.
More staff are needed to drive (Lime walk house, CARS)
If you smoke you get more time outside than if you are a non- smoker</td><td>Positive:
Medication and review of medication.
OT
Recovery star
Education re Drugs and Alcohol
Confidence building course
Making mosaic
One to ones
Best place I have been and I’ve been to a lot
Areas for improvement:
There is no OT at weekends
There is not enough going on at weekends</td></tr>
</table>

What the patients said about the environment:	
Positive: • The food is good (West) • I like having my own room (West) • I like having a mixed ward (CARS/West) Areas for improvement: • There is a lack of quiet areas on the wards • The wards can be noisy • I don't like having a mixed ward (West/East)	Positive: • Good, peaceful, being here has helped improve my mental health. • Easy going and relaxed atmosphere. (East rehab wards)

There was positive feedback relating to each of the three areas discussed. Within the care and therapy section patients demonstrated engagement with a wider range of options than in 2013. Feedback relating to nurse staffing levels and workload of nurses demonstrated that there is an impact on patient care and experience when wards are short-staffed and that patients felt the difference when this occurred. This theme has already been identified in the review of the monthly board reports.

The issues, in regards to improving practice and workforce, are being taken forward by the WM T&F group who meet on a monthly basis and report to the ward staffing project group.

3.2 Findings from interviews with WMs and the multi-disciplinary team (MDT)

It was evident to the review team that the clinical teams continue to be committed to delivering quality care to patients. In light of the significant challenges in maintaining safe staffing levels morale in the clinical teams was positive. There is acknowledgement of the impact of the potential benefits of additional resources committed to the wards and additional support that has been given to WMs. In the reviews the 6c's were evident throughout the discussion and examples given by the clinical teams. The clinical team were also realistic in their expectations regarding resources in the current economic climate. To review recommended establishments the requirements for patients and staff were examined on a shift by shift basis by the review team and the ward representatives.

3.2.1 Positive feedback from WMs and MDT evident since the 2013 review:

1) Improved staffing levels on some wards, albeit not fully achieved, have improved the following:

    - Time spent with patients
    - Protected therapeutic time
    - Increased meaningful and therapeutic activity
    - Quality of assessments and care-planning

- Reduced reliance on bank and overtime
- Increased staff morale
- Increased ability to develop outreach work and impact on admission avoidance (LD)

2) The introduction of resource managers has made a significant difference to WM administrative workload allowing them to increase clinical leadership and role model/teach junior staff. For example since the resource managers have been in post WMs report being able to attend MDT ward reviews and handovers; engaging with patients and allowing a greater understanding of who is on their ward.

3) Introduction of IT solutions such as Ipads has had a positive impact where there is adequate infrastructure to support their use. For example where wifi has been available throughout the ward nurses have been able to work on care plans with patients using the devices reducing duplication in work-load.

4) Reduction in the number of ward reviews with consultant psychiatrists has had a positive impact on MDT working and patient experience.

3.2.2 Areas continuing to impact on the ability to provide high quality care include:

1) Enhancing meaningful activity in the following areas:
    - Increased activity at weekends (acute wards)
    - Increased access to gyms
    - Increased physical activity in general
2) Length of time to recruit new starters
3) Reducing incidents of cross cover between wards
4) Improved IT infrastructure, such as adequate wifi coverage and multi-user access to devices, is needed to support IT solutions
5) Patients who have undiagnosed dementia on admission on to open age wards require additional support
6) Access to PICU (East)
7) Access to appropriate care homes when ready for discharge (East and West)

These issues are being addressed in a number of Trust work streams, working together. The Ward Staffing Project Group is leading on recruitment issues and on addressing meaningful activities including looking at increasing physical activities for patients. The IT Enabled Group is addressing IT infrastructure issues and mobile devices. Both are working with the Ward Managers Task and Finish Group which is focusing on enhancing clinical practice and working at implement solutions to improve the ward environment. It is evident from the findings of the 6 month review that the programme of change, to address nurse staffing levels and ward practices, is beginning to have a positive impact. This significant piece of work is being undertaken through a systematic approach by the programme board, ward staffing project group and the ward manager's task and finish group. Whilst progress has

been made in our inpatient wards the continuous improvement this will not be fully achieved until staffing levels can be consistently met by the substantive establishment with bank usage as ad-hoc backfill as intended. The 2013 ward staffing review noted that whilst the Trust has continued to maintain safe staffing levels through the use of bank to continue in this way is not sustainable. Many of the bank staff are existing substantive staff working extra hours, this may be good for patient continuity but is not so good for the health and wellbeing of staff.

Alternatively a consistent staff team is needed to successfully develop therapeutic engagement with patients and to establish a cohesive team within a therapeutic environment. Reliance on bank has continued in the past 12 months and proactive monthly recruitment is needed to minimise this. These issues are continuing to be addressed through the ward staffing project group and the Ward managers Task and Finish Group.

4. Recommended staffing levels

4.1 Headroom

When setting nurse establishments it is important to include headroom (NQB, 2013). Headroom is the collective term for planned and unplanned staff absence from the 'numbers' on the ward for example annual leave, sickness, mandatory training etc. Currently headroom within the rostered areas of the Trust is set at 17% - this is made up of 14% annual leave (agenda for change average) and 3% essential learning (EL). Sickness headroom has not been included in the rosters, it was recommended in the last review that this was set aside as a bank budget. It should be noted that headroom needs to be calculated as a margin rather than a mark-up in order to ensure that roster templates and subsequent reporting is accurate.

4.2 Recommended staffing levels following the 6 monthly review

Following the 2014 review the recommended ward nursing establishment have been calculated by identifying the clinical hours needed shift by shift and incorporating headroom (appendix 3). In this six month staffing review the following adjustments are recommended:

- Adelphi – an uplift of 0.4 WTE RN and 3 WTE CSW brings Adelphi's staffing levels in line with the other 2 open-age acute wards; reflecting the higher number of beds and the ward environment.

- Bollin – an uplift of 1 WTE CSW to enhance the meaningful activity on the ward by allowing the assistant practitioner protected time to deliver a daily programme for patients.

- Juniper – an uplift of 0.3 WTE RN is needed to support the on-going pressure of out-patient ECT. This is not reflected in the occupancy figures however pre and post ECT care is delivered to out-patients on the ward.

- Saddlebridge – an uplift of 2.6 WTE CSW to further support enhanced meaningful activities on and off the ward

- Maple and Pine Lodge require uplift in order to maintain staffing levels recommended in 2013. This is due to the move from 11.25 hour long shifts to 11.5 hour long shifts in order to align to other wards.

- Juniper, Lakefield and Lime Walk require an additional RN on duty at weekends and nights to support the carer advice line, this equates to an additional 3.3 WTE band 5 RN on each of the 3 wards. This carer advice line has a significant impact on these wards and wards report that they routinely receive calls within hours. The 2013 review recommended that an alternative to these lines be introduced however they remain in place at this time. This is currently under review by the Acting Director of Operations and a solution has been identified.

In relation to the staffing establishments recommended in the 2013 review, adjustment to skill mix is recommended in the following areas:

- Brackendale, Juniper and Adelphi – increase band 6's by 1 WTE to reflect the complex patient mix, band 5's would be reduced by 1 WTE.

- Brooklands – trainee assistant practitioner post, to focus on physical well-being, to be developed from existing band 3 CSW post through uplift.

- Pine Lodge – **temporary** increase band 6's by 3.2 WTE to allow for one band 6 on each shift until the unit is relocated from the current stand-alone site. The band 5's would be reduced by 3.2WTE.

- Maple and Pine Lodge to consider recruiting a band 6 learning disability nurse to work across both wards within the current establishment.

- The 2013 staffing review recommended that an increase in the number of band 6 RNs, with skills and competencies in complex assessment and care planning, was needed on dementia and eating disorders wards. This recommendation from the 2013 review has not been fully been implemented but there are plans being developed to address this.

The recommended adjustments from this review are summarised in the table below:

Recommended WTE adjustments				
	B6	B5	B4	B3
West	4.2	-3.4	0	0.4
Wirral	1	-1	1	-1
East	1	-0.6	-0.7	7.3
Total WTE	**6.2**	**-5**	**0.3**	**6.7**

NB West B6 include temporary increase of 3.2 WTE and temporary decrease of 3.2 WTE B5

4.3 Next steps

The Chief Nursing Officer published a paper in November 2014 setting out best practice when review nursing staffing levels .The focus on this latest report has been in response to suggestions that nurses are not visible and often busy with administrative tasks thus unable to deliver direct patient care. NICE recommends monitoring patients receiving the nursing care and contact time they need with the emphases on safe patient care not the number of staff available. Nursing time will be distributed between direct patient care, indirect patient care and non-patient care activities. CWP has already undertaken an audit of this nature in 2012 and the results prompted the design and introduction of the resource manager role. The aim of this role is to reduce the non-clinical management activity of clinical staff to free them then to provide more direct clinical care. Commencing from spring 2015 a further programme of activity audits will be carried out to identify how direct patient care can be increased and non-essential activity can be eliminated. This will be introduced in a phased approach and the productive ward releasing time to care instruments will again be used and the findings will be reported in the next staffing review report to board.

NICE have also published a consultation document to look at developing a staffing tool for acute mental health wards and this will be incorporated in the next 6 monthly review.

The staffing review 2013 recommended a review of staffing levels for OT on our wards. This review has commenced and the recommendations will be reported to the Board of Directors in February 2015.

5. Summary

This report sets out the key recommendations from the 6 monthly Ward Staffing Review completed in November 2014. The report also contains a review of the trusts compliance and performance in relation to delivering the NQB standards on safer staffing levels within CWP. Areas for improvement have been discussed within the paper and the actions that are underway to address these.

The Board is asked to consider the contents of this report and

1. To consider the reviews recommendations set out in section 6.2 in relation to the staffing levels and skill mix on the wards and to ask the Operational Board to make recommendations on how these can be taken forward.

2. To support the implementation of a proactive monthly recruitment drive is implemented in each locality to maintain adequate nurse staffing levels.

3. To note the progress in meeting the NQB requirements.

6. Bibliography

Rethink (2007) report for nursing and midwifery council on nursing skills for working with people with a mental health diagnosis: London

Hurst K (2010) Evaluating the strengths and weaknesses of NHS Workforce Planning methods – Nursing Times 2 October Vol 106 No. 40

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

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

Hurst K (2003) Selecting and Applying Methods for estimating the size and mix of nursing teams, A systematic review of the literature commissioned by the Department of Health

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

NHS Scotland (2004) Response to the Nursing and Midwifery Workload and Workforce Planning Project; Edinburgh

RCN (2003) Setting safe staffing levels. An exploration of the issues. RCN London

RCN (2013) “Frontline First” running the red light protecting services improving care. RCN London

NHS (2013) Meeting needs and reducing distress. Guidance in the prevention and management of clinically related challenging behaviour in NHS settings, London

Nursing Hours per Patient day (NHPPD) Government of Western Australia Department of Health

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

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

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

DH (2012) Compassion in practice, Nursing midwifery and care staff our vision and strategy. London

DH (2014) Safer Staffing : a guide to care contact time. London

Appendix 1:

	Ward	Day				Night				Fill Rate			
		Registered midmives/nurses		Care Staff		Registered midmives/nurs		Care Staff		Day		Night	
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
East	Adelphi	1041	986	1492	1446	701.5	621	1173	1115	94.7%	96.9%	88.5%	95.1%
	Alderley Unit	727	717	1518	1514	713	667	816.5	805	98.6%	99.7%	93.5%	98.6%
	Bollin	1146.5	1014	1516	1452	724.5	724.5	1093	1001	88.5%	95.8%	100.0%	91.6%
	CARS	893	795.5	990.5	973.5	736	690	690	697.5	89.1%	98.3%	93.8%	101.1%
	Croft	1311	1116	1955	1635	830.5	830.5	1661	1500	85.1%	83.6%	100.0%	90.3%
	Greenways A&T	1133.5	1016	1784	1645	713	632.5	460	517.5	89.6%	92.2%	88.7%	112.5%
	LimeWalk Rehab	1001	992.5	1068	1004	667.5	635	773.5	786	99.2%	94.1%	95.1%	101.6%
	Saddlebridge	391	402.5	517.5	529	391	345	391	448.5	102.9%	102.2%	88.2%	114.7%
Wirral	Brackendale	931.5	789	1122	1202	713	552	713	782	84.7%	107.2%	77.4%	109.7%
	Lakefield	828	797.5	1151	1078	701.5	690	816.5	837.5	96.3%	93.7%	98.4%	102.6%
	Meadowbank	1302	1110	1783	1969	713	563.5	1426	1438	85.2%	110.4%	79.0%	100.8%
	Oaktrees	946	912	1482	1448	678.5	667	368	368	96.4%	97.7%	98.3%	100.0%
	Brooklands	846.5	827	1139	1128	713	510	713	989	97.7%	99.0%	71.5%	138.7%
West	Beech	1426	1047	1070	1070	713	644	713	701.5	73.4%	100.0%	90.3%	98.4%
	Cherry	1081	1011	995	891	621	598	805	908.5	93.5%	89.5%	96.3%	112.9%
	Eastway A&T	1118.5	1055	1231	1137	758.9	690	920.5	933.4	94.3%	92.4%	90.9%	101.4%
	Juniper	1069.5	963.5	1070	885.5	713	517.5	713	828	90.1%	82.8%	72.6%	116.1%
	Maple Ward	977.5	943	1104	1058	540.5	598	885.5	920	96.5%	95.8%	110.6%	103.9%
	Pine Lodge (YPC)	1012	851	977.5	874	529	506	828	793.5	84.1%	89.4%	95.7%	95.8%
	Rosewood	1219	1036	1656	1272	471.5	506	747.5	784	84.9%	76.8%	107.3%	104.9%
	Willow PICU	759	782	912	960	505.9	540.5	828	889.5	103.0%	105.3%	106.8%	107.4%
	Trust wide	21160.5	19161	26528	25168	13849	12728	17534	18042	90.5%	94.9%	91.9%	102.9%

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document Reference (2014/2015/95)

Report to	**Board of Directors**
Date of Meeting	**28th January 2015**
Title of Report	**Director of Infection Prevention and Control (DIPC) Board Report, Quarter Three (October – December 2014)**
Action sought	**For Noting**
Author	**Amanda Miskell, Acting Head of IPC**
Presented by	**Maria Nelligan, Director of Infection Prevention & Control**

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

Distribution

Version	Name(s)/Group(s)	Date Issued
V1	Board of Directors	28th January 2015
V1	Infection Prevention & Control Sub Committee	8th January 2015

Executive director sign-off

Executive director (name and title)	Date signed-off
Sheena Cumiskey, Chief Executive	January 2015

1. The purpose of the report

Welcome to the Quarter Three (Q3), Director of Infection Prevention and Control (DIPC) report, 2014/2015. This report will give the board an update on IPC priorities.

This report will include the following:

- IPC Contract for Cheshire West and Chester
- Healthcare Associated Infections (HCAI)
- IPC Audit Programme
- Flu Vaccination Programme

The influenza vaccination programme has been underway for the majority of this quarter and a summary will be provided to update the board in the annual report, June 2015.

There has also been significant work addressing and concluding the CWP IPC audit agenda which is ahead of plan.

2. IPC – New contract (commenced on 1st October 2014) for CWaC

Following a tendering process, CWP IPCT was successful in securing the IPC contract for services for the health and social care services including TB, for Western Cheshire CCG & Vale Royal CCG. The contract held by Cheshire West & Chester Council (CWaC), commenced on 1st October 2014 and includes the following contractual obligations.

- Audit of all Care Homes and GP practices
- Training accessibility for all staff in care homes and GP practices
- Support Dentists with all IPC self-assessments
- Respond to all advice and support requirements for schools, nurseries, hospices and optometrists
- Manage all outbreaks across the footprint
- Report on a regular basis to CWaC and Public Health England

The work plan and KPI's are now agreed. CWP IPCT and CWaC hold regular contract review meetings to review performance.

This quarter has seen three care homes closed due to outbreaks of gastrointestinal illness. Norovirus was confirmed by samples submitted to the laboratory from one home; no causative organism was identified for the remaining outbreaks.

3. Healthcare Associated Infections (HCAI)

The team reports on a monthly basis to the CWP performance team, and to the PHE, for all those infections, attributable to Western Cheshire locality. The ambition set for WCCCG for clostridium difficile toxin (CDT) infections within the community population for 2014/15 is 31. This has been breached to end of Q3. The IPCT have co-ordinated the response and significant work has been carried out to identify trends and causation including:

- Full root cause analysis
- Geographical mapping, inclusive of Welsh cases
- Genotyping requests
- Meetings
- Sampling and collection reviews, including 28 day period exclusions
- Contributory factor scrutiny for all cases
- Trend analysis including age, sex, and gender

Review from key stakeholders has concluded there are no links in these cases and the IPCT has been acknowledged for their contribution to the evaluation of these cases.

4. IPC Audit Programme

The audit programme has concluded ahead of schedule. The reporting of the audits and risks are discussed and actioned at the IPC sub-committee, and reported to performance on a monthly timetable. The team are focussing on supporting the clinical teams in implementing action plans. The 2015/16 programme will be prioritised and included in the Q4 DIPC report due to board in May 2015.

5. Flu Vaccination Programme

Uptake for the Influenza Vaccination programme has been challenging this year for quarter three. However, it is to be noted that the uptake from registered nurses is the highest we have seen to date. The vaccine is still available for all staff. The vaccine this year contains two Influenza A and an Influenza B. Further information regarding this situation will be discussed in Quarter Four. The teams are linking into Occupational Health and clinical staff to review update.

6. Recommendations

The Board of Directors is asked to note the DIPC Quarter Three report for 2014/15.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document Reference (2014/15/96)

Report to:	**Board of Directors – meeting in public**
Date of Meeting:	**28 January 2015**
Title of Report:	**Quality report – Quarter 3 2013/14** **Quality report – Special edition: Best practice showcase**
Action sought:	**For DISCUSSION and ENDORSEMENT of approval**
Author:	**David Wood, Associate Director of Safe Services** **Hayley Mannin, Quality Support Manager**
Presenting Executive:	**Dr Anushta Sivananthan, Medical Director (Compliance, Quality & Regulation)**

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

Distribution

Version	Name(s)/Group(s)	Date Issued
1	D Wood to L Hulme for Board of Directors	20.01.2015

Executive director sign-off

Executive director (name and title)	Date signed-off
Dr Anushta Sivananthan, Medical Director	20.01.2015

1. Purpose of the report

To provide an update on progress in improving quality across CWP's services, which CWP is required to formally report on in its annual Quality Account.

2. Discussion

Regular, transparent reporting on the quality of CWP's services strengthens the Trust's approach to listening and involving staff, people who use the Trust's services, carers, the public, commissioners, internal groups, and external scrutiny groups in improving quality across CWP's services.

These Quality Reports provides a highlight of what CWP is doing to continuously improve the quality of care and treatment that its services provide. The quarter 3 report describes progress in delivering against CWP's Trustwide quality priorities for 2014/15, as well as work to improve outcomes by supporting recovery, and also a number of quality success stories. The special edition is an executive summary of the Trust's annual Best Practice Showcase that featured as part of the 2014 Annual Members Meeting, including an in-depth review of a selection of quality initiatives, their impacts in improving quality, and next steps to facilitate sustainability in quality and continuous quality improvement.

3. Recommendation

The Board of Directors is asked to **endorse** the Quality Committee's approval of the quarter 3 Quality Report and Best Practice Showcase special edition.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Quality Report

Quarter 3
October – December 2014

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

Children's Commissioner's Take Over Day 2014 was a huge success for CAMHS. The day gives children and young people the chance to work with adults for the day and be involved in decision-making.
Children benefit from the opportunity to experience the world of work and make their voices heard, while adults and organisations gain a fresh perspective on what they do.

Young people from Cheshire East, Cheshire West, Wirral and Tier 4 pictured with members of staff, including chief executive Sheena Cumiskey – see page 11

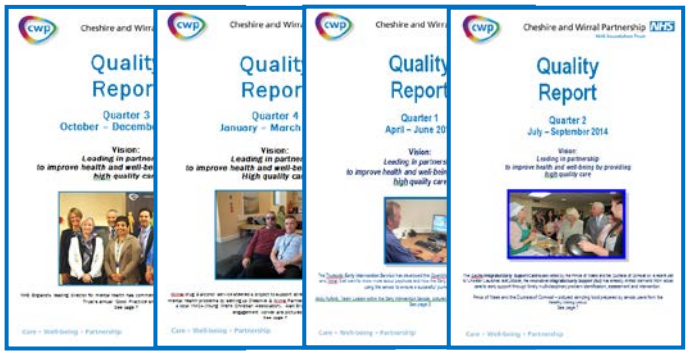
Care • Well-being • Partnership

CONTENTS

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

Welcome to CWP's third *Quality Report* of 2014/15

These reports are produced every quarter to update staff, people who use the Trust's services, carers, the public, commissioners, internal groups, and external scrutiny groups on progress in improving quality across CWP's services, which CWP is required to formally report on in its annual *Quality Account*.



CWP's *Quality Account* 2013/14 and the previous *Quality Reports* of 2013/14 and 2014/15 are available on the Trust's internet site:

http://www.cwp.nhs.uk/our-publications/reports/categories/431

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

Quality in the NHS is split into three parts. It can mean different things to different people, for example:

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

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

- the three times a year *Learning from Experience* report –
  reviews learning from incidents, complaints, concerns, claims and compliments, including Patient Advice and Liaison Service [PALS] contacts;
- the quarterly Infection Prevention and Control report –
  reviews the management and clinical governance systems in place to ensure that people experience care in a clean environment, and are protected from acquiring infections;
- the monthly Performance dashboard –
  reviews the Trust's quality and safety performance by reporting on compliance in achieving key local and national priorities;
- the Medicines Management Group newsletter –
  contains clinical information for practitioners, articles of interest and general pharmacy information for ward staff and teams.

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

EXECUTIVE SUMMARY – QUALITY HEADLINES THIS QUARTER

CWP has made good progress in delivering against its trustwide **quality priorities** for 2014/15 in quarter 3

➲ see page 5

CYP IAPT is a **service transformation** programme provided in partnership Catch 22 by CAMHS staff. They have introduced the full use of **outcome measures** in clinical practice which **supports clinicians and service users** to **enhance treatment**.

➲ see page 6

Wirral CAMHS in **Adcote House** have been awarded a judgement of **'Outstanding'** by **Ofsted** for the work they do with **Wirral Hospitals School and Home Education Service**

➲ see page 7

CWP CAMHS MyMind were **'Highly Commended'** in the **Innovation in Mental Health** category at the **HSJ Awards 2014**

➲ see page 8

Wirral locality published the results of their pilot project, the **Wirral Complex Needs Service** which received **positive results**

➲ see page 9

CWP jointly hosted a national **Smoke Free Conference** with **SLaM (South London and Maudsley NHS Foundation Trust)** and **Public Health England**

➲ see page 10

Children's Commissioner's Take Over Day 2014 was a huge success for **CAMHS**

➲ see page 11

CWP has received 575 **formal compliments** about the quality of its services during the third quarter of 2014/15

➲ see page 13

QUALITY PRIORITIES 2014/15

CWP has set three **trustwide quality priorities** for 2014/15, which reflect the Trust's vision of "**leading in partnership to improve health and well-being by providing high quality care**". They are linked to the Trust's strategic objectives, and reflect an emphasis on **patient safety**, **clinical effectiveness** and **patient experience**.

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

Patient Safety priority for 2014/15 – Achieve a continuous reduction in unnecessary avoidable harm and make measurable progress to embed a culture of patient safety in CWP, including through improved reporting of incidents

CWP has worked towards achieving this quality priority, as detailed below:

- 119 staff have now attended Human Factors awareness since April 2014 and they have made a total of 226 pledges, as "culture carriers", to implement **safe, clinical Human Factors practices** in their area of work.
- The Trust's Medical Director, Safe Services and Effective Services Department managers and locality Clinical Directors have completed a 5-day "**Advanced Team Training Programme for Safety**" [ATTP4S] to support the delivery of the Trust's Zero Harm strategy.

Clinical Effectiveness priority for 2014/15 – Achieve a continuous improvement in health outcomes for people using the Trust's services by engaging staff to improve and innovate

CWP has worked towards achieving this quality priority, as detailed below:

- Effective Service Managers are working with locality Service Directors to refresh and build a **continuous improvement framework** into the locality clinical strategies.
- The **innovation competition** poster published in November resulted in 11 innovation ideas being submitted; the ideas will now be assessed and shared with the Business Development and Innovation Sub Committee in January – an update will be provided in the next *Quality Report*.

Patient Experience priority for 2014/15 – Achieve a continuous improvement in people's experience of healthcare by promoting the highest standards of caring through implementation of the Trust's values

CWP has worked towards achieving this quality priority, as detailed below:

- Trust values are now incorporated into each CWP job advert to help with **values based recruitment** centred around **care and compassion**.
- An Organisational Development practitioner has been appointed to ensure that **values** are central to the delivery of a new People and Organisational Development strategy.
- An online solution for the friends and family test has been agreed and will be developed early in 2015.

STOP THINK LISTEN
#CWPZeroHarm

IMPROVING OUTCOMES BY SUPPORTING RECOVERY

CWP is committed to **improving outcomes** for the people who use its services, so that the care and treatment that the Trust provides improves their **quality of life**, **social functioning** and **social inclusion**, self-reported **health status** and supports them in reaching their best level of **recovery**. Recovery is CWP's approach to **helping people to be the best they can and want to be**. In each Quality Report, CWP reports on how its services are improving outcomes for people who use its services by supporting recovery.

The **Children and Young People's Improving Access to Psychological Therapies** programme (CYP IAPT) is a **service transformation** programme that aims to improve existing Child and Adolescent Mental Health Services (CAMHS) working in the community. The programme works to transform services provided by the NHS and partners from Local Authority and Third Sector that together form local area CAMHS Partnerships. The programme began nationally in 2011 and has a target to work with services that cover **60% of the 0-19 population** by March 2015.

What they did

CWP CAMHS were successful in a **joint bid** in partnership with **Catch22** (3rd sector) provider, to join the **CYP IAPT** project, which started in January 2014. By joining **CYP IAPT** the services became part of a **Learning Collaborative**. Each **Learning Collaborative** includes a Higher Educational Institution (HEI) which provides **training** to existing CAMHS staff set out in the CYP IAPT **National Curriculum**. The **psychological therapies** selected for the curriculum are **NICE** approved. As part of the programme CWP will be given access to resources to improve participation by children, young people and their families in service delivery and design, and to carry out session by session **routine outcome monitoring** (ROM).

Impact

CAMHS used their **Services User Groups** to help **review practice** and introduce the full use of **outcome measures** in clinical practice. By using outcome measures in sessions it **supports clinicians and service users** to understand what is happening throughout their treatment and to have meaningful discussions with each other. Research shows that this can **enhance treatment** and may help spot 'off track' cases early.

By linking with the IT department CAMHS have **developed their session by session feedback** by using and developing the use of **IPads** in sessions. Young people and their families respond to questionnaires which are then uploaded directly to the Trust's patient information system (CAREnotes) without the need for duplication and young people, their families and clinicians can then see the **progression in their care**. The development of the CAREnotes system to incorporate the outcome measures from sessions was acknowledged by CYP IAPT and CAMHS were asked to deliver a workshop to the **national CYP IAPT conference** in London in October 2014.

Conclusion & Next Steps

CAMHS have successfully identified staff for training opportunities at postgraduate degree level for CBT, Parenting and next year for **Systemic Family Practice**. CWP joined the North West collaboration, which has 14 members; this gave the Trust access to training being delivered by **Salford Higher Education Institute**. There are 8 trainee places: 6 for CWP CAMHS and 2 for Catch22, 4 of these places are for **Cognitive Behavioural Therapy** and 4 places for delivering **Parenting training** to families. At the end of the programme the trainees will have a post graduate diploma in the relative specialism so enhancing the evidence based practice delivery. In addition to the above there are also two Supervisors being trained. The joint partnership have successfully secured further training for 2015/16 by obtaining a further 9 places for trainees who will come from CWP CAMHS.

QUALITY SUCCESS STORIES

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

Patient Safety News

Dr Anushta Sivananthan, consultant psychiatrist and medical director, recently had an article published in the HSJ (Health Service Journal). The article was in response to new patient safety challenges to mental health services following the Francis, Keogh and Berwick reports into patient safety and demonstrated how the Trust is responding to these challenges.

The article detailed the plans in relation to the Trust's #CWPZeroHarm 'stop, think, listen' campaign which aims to **deliver improvements in safer care** and to **provide better outcomes in mental health**.

Ofsted recently visited **Wirral Hospitals School** and **Home Education Service** community base. The Trust provides outreach education and teaching to small groups of students attending the **Wirral CAMHS/ Education Assessment Unit** in **Adcote House**. **Adcote House** is a short-term pupil assessment unit for both primary and secondary students. It has a Primary Group and two Secondary Groups; each group has no more than six pupils at any one time. Placements are part time and short term, lasting 6-8 weeks unless there is a clear plan showing how longer placement may better meet the student's needs at the time.

What they did

Adcote placements can be used for a number of reasons:

- It provides the opportunity to observe a child or young person in an independent yet familiar setting with access to Child and Adolescent Mental Health Specialists to **gain a better understanding** of their presentation. This often includes **neuropsychological psychometric testing** looking at IQ, **attention, impulsivity, memory, planning ability, mental flexibility, processing skills and social skills**.
- Staff can **observe** how a child or young person's behaviour changes in the **small, nurturing environment**.
- To provide a small, nurturing environment for young people with acute mental health needs who may not currently be able to get into school or even out of their own home. This can provide a first step and offer a **supportive daily structure** in order to help the student **reintegrate socially and educationally** without leaving the roll of their current school.
- To provide a place where children and young people with acute mental health difficulties can be monitored in relation to their wellbeing, mood or response to changes in medication. In some cases this **can help to avoid an inpatient placement**.

As part of the Ofsted inspection:

- **Inspectors visited all classes** to look at teaching and learning and its impact on students' progress over time. A learning walk and three lessons were jointly observed with senior leaders.
- **Meetings** were held with the head teacher, senior and middle leaders, governors, a school consultant and a group of students.
- Inspectors took account of the 20 responses to the **Parent View questionnaire** (the online questionnaire for parents), of an email sent to school by a parent and of the 28 questionnaires returned by staff.

Impact

- Students have stated: *'The school provides a safe welcoming place to gain confidence, self-esteem and the necessary academic qualifications to support them in the next stage of their education.'*
- Outstanding teaching over time had had a very strong impact on students' learning.
- Students' achievement was outstanding. Their wide range of abilities was well supported, enabling everyone to make exceptional progress form their starting points.

- Every staff member was dedicated and fully committed to providing a nurturing environment where students were supported and cared for exceptionally well.

Conclusion & Next Steps

Ofsted awarded the school a judgement of **'Outstanding'** for the first time in its 20 year history meaning that the school is deemed to be **highly effective in delivering outcomes exceptionally well for all its pupils' needs**, ensuring pupils are very well equipped for the next stage of their education, training or employment.

The next step for the **Wirral Hospitals School** and **Home Education Service** community base and **Wirral CAMHS** is to further improve the existing high quality of teaching to support students' achievement by ensuring all marking clearly identifies the next steps in their learning.

Clinical Effectiveness News

The **HSJ Awards** recognise initiatives that **deliver excellence and innovation**. By shining a spotlight on cutting-edge innovations and best practice, the awards give impetus to improving the quality of healthcare in the UK.

CAMHS MyMind was **Highly Commended** at this year's HSJ awards in the **Innovation in Mental Health** category. This means the Trust were second place nationally in a category that included all areas of Mental Health, not just CAMHS.

Proud to represent the Trust and to be acknowledged for the Trust's innovative working with service users were *Dr Faouzi Alam, consultant psychiatrist and medical director, Fiona Pender, consultant clinical psychologist, CWP Wirral CAMHS, Jasmine, an ex-service user* who has helped develop the site and deliver the pitch to the judges and *Lesley Dougan, children and young people's practitioner* who leads on the twitter feed and chairs the MyMind steering group.

Pictured right, the BBC's Nick Robinson who was hosting the event and Dr Faouzi Alam, consultant psychiatrist and medical director.

All-Party Parliamentary Group on Global Health
All-Party Parliamentary Group on Mental Health

A new report, *"Mental Health for Sustainable Development"* has recently been published by the **Global Health and Mental Health All-Party Parliamentary groups**.

Special thanks have been given to *Maureen Wilkinson, Medical Lead*, for contributing ideas and evidence for inclusion within the report.

The simple message of the report is that **progress in development will not be made without improvements in mental health**. The reasons are equally straightforward. Mental illnesses cause more disability than any other health condition; bring enormous pain and suffering to individuals and their families and communities; and can lead to early death, human rights abuses and damage to the economy. **Improving mental health is therefore a vital part of a successful development programme**.

The report was officially launched on 26 November at the **Houses of Parliament**. The event was hosted by *Lord Nigel Crisp and Meg Hillier, MP, co-chairs of the APPG group on Global Health*, and *James Morris, MP, chair of the APPG on Mental Health*. Present were invited guests working within UK and global mental health research, policy and practice. The Trust's contribution will influence national policy and strengthen the health system.

The Wirral Complex Needs Service was a pilot project established from 1 October 2013 to September 2014. The overall remit of the project was to attempt to engender better mental health outcomes with clients with high levels of service utilisation presenting with combinations of severe personality disorder, ADHD, other commodities such as drug and alcohol misuse and significant levels of risk to self and others.

What they did

Within the period of the pilot, it was agreed that the team would take on 102 new referrals comprising 50 new community referrals, 35 ADHD referrals, 5 CAMHS referrals and 12 existing clients from the personality disorder case load. The overall focus of intervention involved the assertive engagement of client who had not engaged with conventional treatment but who, nonetheless, currently accessed services in an unplanned, crisis driven way. Working within this framework, the objectives were to increase the clients' stability, reduce levels of service utilisation, broadly improve mental health outcomes, and increase the likelihood of the clients' engagement in formal, planned mental health treatments. An ancillary aim was to provide educational workshops about the assessment and management of complex clients to Primary Care staff.

The team was comprised of a number of largely part time professionals from a number of different disciplines. This included: a part time psychiatrist, a clinical lead, a psychotherapist, a clinical psychologist, a team manager and 3 drug and alcohol practitioners. In addition to this the team has also included a full time mental health nurse, and 2 recovery mentors and full time admin support.

At the inception of the team, a number of outcome measures were established using CAREnotes Assist technology. This provided a means by which outcome data could be entered on a regular and consistent basis by clinicians and also provided a basis for easily accessed information of aggregated data relating to team performance.

The following measures were used:

1. Mental Health Recovery Star. This is a measure rated by both practitioners and clients. The Recovery Star comprises 10 dimensions of mental health which are rated on a 10 point scale.
2. An adapted version of the Personality Disorder Severity Scale. This is a widely used observer rating scale which requires practitioners to rate levels of severity of personality disturbance within a number of different domains. The adaptation to the scale involved incorporating ADHD as a factor in the evaluation of the severity and complexity of diagnostic formulation.
3. Information related to service utilisation. From the outset practitioners were required to capture information related to clients' usage of different forms of primary and secondary care service. Information captured involved areas such as GP attendance, A & E attendance, out-patient attendance etc.

All of the measures were repeated at 3 monthly intervals, thus providing some indication of client progress throughout the period of the pilot project.

Impact

Over the duration of the pilot period the service received the following referrals:

Personality Disorder referrals:	19
Community referrals:	73
ADHD referrals:	37
CAMHS referrals:	5
Total referrals:	**134**

From the total number of referrals received, 18 clients (13%) did not engage and did not attend any appointments. Of those who did engage, approximately 52 (49%) were retained in some form of ongoing treatment whilst 64 (51%) engaged in assessment and consultation alone. The did not attend rate as a percentage of total appointments offered over the period of the pilot was 14% and the average waiting time for a first appointment was approximately 4 weeks.

Conclusion & Next Steps

When looking at the **mental health Recovery Star** data, 51 complex needs patients had completed at least one or more Recovery Star. The data indicated modest improvements in total Recovery Star scores with an **overall improvement of** 18%.

The ADHD/ PD Severity Scale was completed on 52 complex need patients. The overall rating of this scale suggested an 18% **improvement** indicating a movement towards more planned, managed interactions with services.

Service Utilisation Data – The table below reports completion of information on 52 complex needs clients.

Review of Service Utilisation (52 patients)	First	Follow Up	Difference (- represents a reduction)
Visits to GP Surgery	245	75	-170
Visits to Out Of Hours team	12	1	-11
Visits to A&E	97	12	-85

Of note there are very **dramatic reductions in GP attendances**. These reduced from an aggregated total of 245 attendances over the 3 month, pre-treatment period of baseline assessment, to only 75 at follow-up, post intervention period. Equally impressive is the **reduction in A & E attendances**, which reduced from an average of 97 over the 3 month pre-treatment period to 12 at the post assessment review.

The results of the pilot project, discussions within the complex need team and related professionals, along with preliminary discussions with commissioners suggest the following areas might be considered as a way forward for the team:

- **Retain focus on clients** with complex presentations of PD, ADHD and other co-morbid conditions
- **Consider expanding** the number of referrals per annum beyond the figure of 102 agreed for the period of the pilot project
- **Retain a hybrid model** of case management, psycho-social interventions, psychological/psychiatric treatment and assessment
- **Consider adjusting the service criteria** to accommodate service users who currently fall between existing step 4 and 5 referral criteria
- **Expand focus of outcome research**, possibly looking at the impact of intervention for clients who attend for assessment alone
- **Continue to roll out and develop** primary care workshops on complex clients
- **Develop** more formal links with the Frequent Attender panel at Arrowe Park Hospital
- **Consider expanding** the range of group therapy options (e.g. peer support type groups)
- **Develop** self-help literature and self-help workshops (e.g. psycho-educational workshops on 'living with a personality disorder')
- **Expand and adapt** the Trust's Personality Disorder website that is being developed by the West Cheshire Personality Disorder team

In October, the Trust jointly hosted a national **Smoke Free Conference** with **SLaM (South London and Maudsley NHS Foundation Trust)** and **Public Health England** to help support the implementation of the NICE guidelines on smoking cessation in mental health and learning disability services.

Smoking amongst people with mental illness has remained largely unchanged for the past 20 years compared to the trend in the general population despite research showing that 60% of people with a mental illness want to stop smoking.

The Trust **cares about providing a safe, smoke free environment for all service users, staff and visitors**. At the event learning was shared from the launch of the Trust's Nicotine Management Policy earlier this year and together with SLaM and Public Health England, CWP will encourage other organisations to make the same positive changes in their services.

Patient Experience News and patient feedback

The Children's Commissioner's Take Over Day 2014 was a huge success for CAMHS. Young people from Cheshire East, Cheshire West, Wirral and Tier 4 spent the morning completing various different activities. In the afternoon, young people from across the Trust met with CWP Trust Board (including chief executive Sheena Cumiskey) to raise issues important to them.

Wirral CAMHS ran 'The CAMHS Apprentice', a fun, interactive workshop that aimed to allow young people to make decisions about their CAMHS service. These activities allowed the young people to design their perfect CAMHS worker, to design a child's journey through CAMHS and to discuss their ideas about where they feel money from a CAMHS budget is spent.

The first activity, led by *Matt Howie, mental health support worker*, involved the young people designing their perfect CAMHS worker. They designed a worker that had characteristics of warmth, smart and patient, but also that professionally they were able to understand and connect with the young person, able to create a friendly and informal environment and to promote equality and value between clinician and client.

The second activity, led by *Rachel Pulham (assistant psychologist)*, involved designing a child's journey through CAMHS. The young people created a girl called 'Megan', who was having trouble with her mood. The main theme the young people prioritised was that of choice. They decided that it would be good to have an Ice Breaker session before 'Megan' received any therapy. The session would take 10-15 minutes and this would be for the clinician and 'Megan' to get to know each other – equality. After this 'Megan' would meet with her clinician 2-3 times and then would access an appropriate group with other children and young people with similar problems. The young people pointed out that 'Megan' should have a choice about venue, times and dates, but also a choice about clinician, whether to attend group work or continue 1-1, and their discharge.

The third activity, led by *Rebecca Moon (assistant psychologist)*, involved the children running the 'Bank of CAMHS'; they were given a budget and asked to place money on CAMHS resources, such as staff, activities, and groups. The children placed monetary importance on more support workers, more activities and resources, and less emphasis on buildings. Also, the young people placed importance on more involvement workers, specifically with regards to children and young people involved in the service being involved in the training of staff.

All the ideas raised were to be raised by the young people at the CWP Trust Board, chaired by CWP Chief Executive, Sheena Cumiskey.

Pictured below, young people from across the Trust with members of the Trust Board, including chief executive Sheena Cumiskey.

The findings of the annual CWP Carer's Survey, launched on 9 June to celebrate National Carer's Week, have now been published this quarter. The survey was conducted for one calendar month to ensure staff had time to distribute the survey to known carers. The purpose of the survey was to:

- Obtain an understanding of carer needs around information, support and guidance from the Trust and jointly commissioned carer support services by the Local Authorities and respective Clinical Commissioning Groups.
- Identify positive experiences and what worked well for carers.
- Identify any gaps in the system at a locality level.

What they did

2,100 hard copies of the questionnaire were distributed via the Communications and Engagement Team and a new electronic version of the questionnaire was also introduced to offer carers a choice of feedback. Questionnaires were dispatched directly to the locality Business Support Managers and 200 hard copies were delivered to key partner organisations that provide carer support.

Of the 2,100 questionnaires that were distributed there were 228 returns. Despite best efforts to engage with carers the overall response rate to the 2014 Carer Survey was disappointing. However, the Carer and Patient Experience Leads have seen the results as an opportunity to work with colleagues in other Trusts as part of a project entitled 'Next Steps in Patient Engagement'. Several Trusts have worked together to explore Best Practice and the findings confirmed that they have also struggled to obtain good response rates to their Annual Carer Surveys.

Impact

The Trust aspires to achieve 2 gold stars from the Triangle of Care which was launched in July 2010 as a joint piece of work between the Carers Trust and the National Mental Health Development Unit. Triangle of Care emphasises the need for better local strategic involvement of carers and families in the care planning and treatment of people with mental ill-health. From the results of the survey the Trust are now formulating action plans to introduce Carer Related Outcome Measures (CROMs) to ensure that outcomes for carers are added to the performance dashboard and will ensure that carer engagement is routinely recorded on the system with regular performance reporting.

A project is currently underway to implement Real Time Patient Feedback and it is hoped that this will be extended to include Real Time Carer Feedback. The Trust is keen to work in partnership with carers and understand their experience; therefore it is important to offer a range of tools to gather carer feedback.

As the Trust has adopted locality based structures, and aspires to achieve fully integrated teams, it would be more efficient to streamline the Annual Carer's Survey by undertaking a joint process with each Local Authority; this also is in line with the Triangle of Care which recommends better partnership working between service users, their carers and organisations. Most importantly it would help reduce the expectation on carers who are likely to be stretched in managing the demands on their time and in some cases struggling to sustain their caring roles.

Conclusion & Next Steps

- Discussions with the respective Clinical Commissioning Groups are to commence to look to move to an integrated locality response led by the Local Authority to replace a solely standalone CWP Annual Carers Survey in 2015.
- Modify and review the Triangle of Care Carers Questionnaire to ensure episodic carer feedback is routinely sought ensuring the tool is applicable to all service lines and settings.
- Extend the Real Time monitoring to include carers to offer a variety of methods to obtain carer experience.
- Invest in Carer Awareness training for all staff to meet the requirements of the Triangle of Care and ensure Carers are actively engaged and listened to when offering service users support.

In quarter 3, CWP formally received 575 *compliments* from people using the Trust's services, and others, about their experience of the Trust's services. Below is a selection of the comments and compliments received for the services across the Trust:

Adult mental health services – CWP West

"Every single one of the team have been helpful, pleasant and willing and a delight to have in our home. Never once have we felt they are intrusive and nothing is too much trouble. We are very grateful for all of the support. Thank you!"

Physical health services

"You really were a lifeline and (service user) was so glad of your care, and had confidence in each and every one of you."

Adult mental health services – CWP Wirral

"You are all doing a splendid job and I do not know how we would have coped without you all."

Drug and alcohol services

"Thank you for all your patience, help and advice."

Adult mental health services – CWP East

"I am greatly impressed by the standard of care and the coordination/connectivity between the various teams involved."

Share your stories

We welcome feedback about any of the Trust's services; please share your stories via email at hayley.mannin@cwp.nhs.uk

Look out for more quality stories in the quarter 4 *Quality Report*

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Quality Report
Best Practice Showcase

Special Edition
November 2014

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

The annual *Best Practice Showcase 2014/15* was held at Crewe Alexandra Stadium and was an opportunity for all CWP colleagues to showcase the excellent work that they do

Care • Well-being • Partnership

Welcome to a special edition of CWP's *Quality Report* for the annual *Best Practice Showcase*

The ***Best Practice Showcase*** was held at the Crewe Alexandra Stadium on 30 September 2014. It was the second ***Best Practice Showcase*** to be held by the Trust and it continued to prove to be a wonderful opportunity for colleagues to share the excellent work taking place across the Trust, with 220 patients, carers, staff and partners in attendance. There were over 40 stalls from all localities exhibiting good clinical practice, highlighting their ideas and innovation to support the Trust's drive for excellence in care.

Local MP for Congleton, Fiona Bruce (*pictured below*), formally opened the event and commented:

"I was delighted to formally open the Best Practice event. It was great to see a celebration of the innovative work CWP staff are doing every day to support local people.
What particularly interests me is how we can improve the care of people with mental health, learning disability and drug and alcohol conditions so that they can - where possible - remain in their own homes and local communities and continue to lead fulfilling lives.
I was therefore very pleased to hear about the excellent performance of CWP in the recent CQC Community Mental Health Survey. I would like to congratulate CWP on coming top of the table for mental health trusts nationally. It's important to take the time to celebrate great outcomes and share good ideas."

The event was also used to launch the second ***Big Book of Best Practice 2014/15***. There was a significant increase in the number of submissions for this year's book; the ***Big Book of Best Practice 2013/14*** had 25 Best Practice stories from across the services but 2014/15 saw submissions soar to **86**, with **40** of the best stories being selected for publication. The book features case studies from around the Trust which aim to demonstrate **examples of leading clinical practice** and facilitate the **sharing of innovative ideas**.

Dr Anushta Sivananthan, consultant psychiatrist and medical director *(pictured to the right)*, said:

"When putting the book together we were inundated with case studies, ideas and innovative ways of working – more than we could publish in the book you can read today. I'd like to thank all contributors from across the Trust for sharing their case studies for service improvements and patient centred care. Continuous improvement and innovation will help us meet the challenges that the Trust and our partners are facing, whilst providing the best care possible to our patients and carers."

To view this year's ***Big Book of Best Practice 2014/15*** please use the link below:

http://www.cwp.nhs.uk/news_items/2507-big-book-of-best-practice-2014-15

The event also supported the Trust's **'*Zero Harm*'** initiative. One of the actions the ***Zero Harm*** initiative focuses on is to *achieve a continuous improvement in health outcomes for people using the Trust's services by engaging staff to improve and innovate*. The event was an opportunity for staff to:

STOP: To look at ways to improve safety and be innovative

THINK: About the risks, benefits and options

LISTEN: To the views of their colleagues, people who use our services and carers that were present at the event

With over 40 stalls highlighting Best Practice, this special report will highlight a stall from each locality and also a Trustwide stall in order to provide you with an insight into the type of information that was shared at the event.

Trustwide – Medicines Management

The ***Pharmacy Team*** highlighted many aspects of how they share Best Practice across the Trust, an example of which was the work they have done in partnership with their ***Recovery College*** colleagues to set up a workshop called **"Understanding My Medicines"**.

The ***Recovery College*** is an excellent opportunity to engage with people about their medicines in the community setting. The Pharmacy Team based in the inpatient setting do not always get to meet the people who are outpatients or carers.

What they did

- They facilitated a number of workshops for the ***Recovery College*** in the East & West localities.
- Although a teaching plan was prepared in advance, the team were keen to respond to the needs of those present. Therefore at the start of the sessions, they listed all the topics that people wanted to cover.
- Attendees were asked to vote about whether statements about medicines were truth or myth with some interesting results!
- An interactive discussion then took place.

Impact

The sessions have been very well received, being described as:

- Interesting
- Helpful
- Fun

People were keen to have similar workshops in the future.

Conclusion & Next Steps

As the sessions were deemed a success by those attending, the team now plans to:

- Continue to engage patients about their medicines, via the ***Recovery Colleges*** in East & West.
- Extend the scope to include the ***Recovery College*** in the Wirral.
- Offer further workshops entitled 'Physical Health and My Medication' and 'Medicines for Psychosis'.

Pictured left, ***Abiola Allinson, Lead Clinical Pharmacist***, discussing Best Practice with ***Helen Davies, Infection Prevention and Control Nurse.***

CWP East – Community & Inpatient Learning Disability Services

Our colleagues in CWP East highlighted good practice and team working in both their Community and Inpatient settings, an example of which can be seen below.

A key function of the new roles within the ***community team*** was to develop an **'outreach'** approach to support clients in the locality whose behaviours had become a risk to themselves and/ or others and who historically would have been admitted to the local ***Assessment & Treatment Unit (A&T)*** – ***Greenways***, usually detained under a section of the Mental Health Act.

What they did

The ***Clinical Nurse Specialist*** facilitated an Away Day which was attended by members of the ***Local Clinical Commissioning Groups, Local Authority, local providers, and carers*** in order to agree a shared vision that promoted personalisation, quality care and helped people with a Learning Disability and Challenging Behaviour to live locally.

Impact

During that day, the 'outreach approach' was discussed and an agreement was reached that it was an excellent method to **prevent both family and placement breakdowns, whilst safely supporting an individual to remain within their own community**.

Conclusion & Next Steps

The team now plans to:

- Formalise the **'patient journey'** utilising the above approach.
- Scope a means of increasing the staffing complement and availability to provide the 'outreach' model in order to continue to respond prior to crisis.

Pictured above, ***Avril Devaney, Director of Nursing, Therapies & Patient Partnership***, discussing Best Practice with colleagues from the ***Community & Inpatient Learning Disability Services.***

CWP West – Early Supported Discharge Team for Stroke

Our colleagues in CWP West highlighted partnership working with other healthcare providers, an example of which can be seen below.

The ***Early Supported Discharge Team*** has been set up in partnership between the ***Countess of Chester Hospital*** and ***CWP*** and is based at the Countess of Chester Hospital and Ellesmere Port Hospital. The team provides support in the discharge of stroke patients by early rehabilitation and therapy.

The team is led by ***Team Coordinator, Kellyann Lea*** – a ***Stroke Specialist Speech and Language Therapist***. The team also provides **Occupational Therapy, Physiotherapy, Stroke Specialist Nursing** as well as support work to assist patients in reaching their rehabilitation goals and care needs.

What they did

The early rehabilitation of stroke patients at home following their care in hospital is a national priority. The goals of the team centre around an increase in functional independence within a stroke patient's home environment, which can lead to a **reduction in longer term dependency on social care**, following a period of intensive rehabilitation.

Impact

The Early Supported Discharge Team facilitated the discharge of people who had experienced a stroke from hospital to receive therapeutic intervention in their own home. The team received 50% of all those admitted to the Countess of Chester Hospital following stroke and were able to demonstrate that they **saved 2962 bed days in the last year**.

Conclusion & Next Steps

They have involved patients and carers in seeking feedback and have been able to showcase the excellent feedback they have received regarding the quality of service they provide. In partnership with the **Countess of Chester Hospital** on 29 October the service promoted the **World Stroke Campaign** which aims to disseminate essential life-saving information and **share knowledge** about actions and lifestyle behaviours that could avert stroke. The campaign also aims to identify opportunities to improve and educate the lay public on the fundamental need for appropriate and quality long term care and **support** for stroke survivors, including the empowerment of stroke care providers. Also the team will continue to strive to save more bed days next year.

Pictured above, Kellyann Lea, Team Coordinator for the Early Supported Discharge Team, speaking to Jim O'Connor, Non Executive Director about Best Practice.

CWP Wirral – Kidstime

Our colleagues in CWP Wirral highlighted the work they have done in collaboration with the Local Council and both Adult and Children's mental health services, an example of which can be seen below.

Run in collaboration with ***Youth Support Wirral Borough Council***, ***CAMHS*** (Child and Adolescent Mental Health Service) and ***AMHS*** (Adult Mental Health Service) work together to run a varied menu of activities, offering something for everyone. ***Kidstime Wirral*** also works in conjunction with the national mental health charity, the ***Kidstime Foundation***.

What they did

Kidstime is a monthly workshop for local children and their families where a parent or carer has a mental health difficulty. They are fun and informal meetings which help children, young people and their parents and carers to connect and share their experiences of how the mental health issue is affecting them personally; with an emphasis on helping children and young people access up to date information and support. The core objectives of Kidstime are:

- To support and develop methods to help children and young people who have parents with a mental illness/ disorder.
- To educate professional staff of different disciplines, as well as the general public, about the needs of the children of parents with a mental illness/ disorder.
- To develop educational tools and interventions to raise awareness of the needs of the children of parents with a mental illness/ disorder, and to counteract stigma.

Impact

If left unchecked, it can be easy for a child or young person to have the wrong idea about an adult's mental health difficulty. This can range from the child feeling responsible, wrongly blaming themselves for causing the condition, to a young person worrying about 'catching' a mental health illness. By helping to open up conversations, sharing factual information and working through resources and activities, the ***Kidstime*** programme **supports children, young people and their families to find ways of talking about mental health difficulties** that can be acceptable to all of them. This can help to reduce anxiety and avoid uncertainty and half-truths, allowing fears and concerns to be named and addressed.

Conclusion & Next Steps

The final stage of the workshop brings the whole group back together and gives parents and carers chance to see the children and young people's creative interpretation of the workshop's topic and how it had affected them. Parents and carers are invited to give feedback as well as discuss the issues raised from within their own group activity. Using an 'open mic' metaphor, everyone is welcome to contribute should they want to and all contributions are given the same level of importance, acknowledging their effort and involvement.

Kidstime also celebrated 'World Mental Health Day' 2014 at the Williamson Art Gallery and Museum in Birkenhead. The event was an opportunity for staff and service users to talk to visitors from other agencies, charities, the council and the public about how CAMHS uses art to enhance young people's wellbeing and as a means of involving young people in our health care service. Service users will be displaying some of their artwork at the event.

Feedback

Following the **Best Practice Showcase** an electronic survey was sent out to all staff asking for their feedback, here are some of their comments along with more pictures from the event.

"I was encouraged to see diverse use of OT and therapies, such as gardening and cooking, reminiscing. I was encouraged to hear that the 'Smoke free' policy is having good results, and this will inspire me to keep making patients aware of this and support the policy."

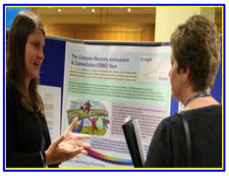
"I loved the video footage!"

"I learnt other rehab activities to try out."

"Really good networking opportunity."

"I now have a greater awareness of what is available over the Trust, different ideas from different localities."

"The event enhanced my own knowledge in dementia and learning disabilities."



Share your stories

We welcome feedback about any of the Trust's services; please share your stories via email at hayley.mannin@cwp.nhs.uk

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document Reference (2014/15/97)

Report to:	**Board of Directors**
Date of Meeting:	**28 January 2015**
Title of Report:	**Update in relation to the internal investigation recommendations made following the major incident at Saddlebridge Recovery Centre on 5th July 2014**
Action sought:	**To discuss and approve**
Author:	**Dave Jones, Clinical Service Manager Julia Cottier, Service Director**
Presented by:	**Julie Critchley, Acting Director of Operations**

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

Distribution

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

Executive director sign-off

Executive director (name and title)	Date signed-off
Julie Critchley, Director of Operations	28 January 2015

1. Purpose of the report

Following the major incident which occurred at Saddlebridge Recovery Centre on 5th July 2014 an internal investigation was commissioned, the findings of which were approved by the CWP Board of Directors on 26th November 2014. This report is to provide an update on the progress made in meeting the recommendations made in the internal investigation report and also to highlight any ongoing actions which may be required.

2. Summary

There were a total of 26 recommendations for action detailed in the internal investigation report, the majority of which have been addressed in the time that has elapsed since the incident. In the section below each of these recommendations have been detailed with an update on progress provided.

3. Content

1. *It is essential that strong and positive relationships are developed within the service to enable all members of the care team at Saddlebridge to support each other, better meet the needs of patients and provide effective relational security. The 'two team approach' must be addressed using team building approaches.*

   Since the incident occurred there have been significant changes within the multi-disciplinary team specifically affecting the medical, psychology and occupational therapy input within the unit. A peer supervision process has been introduced involving all professional groups, key decisions in relation to a service users care and treatment are made within the ward review at which each professional can put their views forward and a team building session has been facilitated by Education CWP during a recent training programme.

2. *A plan of activities involving all members of the team should be agreed and implemented in order to increase joint working and achieve a sense of shared decision making in relation to admission, care planning, managed risk taking and readiness for discharge. It is essential that practical arrangements for these activities enable nurses to be fully engaged on an equal footing with other non-nurse members of the care team.*

   Staff attended a 2 week training programme following the review prior to Saddlebridge reopening in December. Since re-opening the development of the activity programme is led by the Occupational Therapy Team with input from all other professional groups e.g. nurses, psychologists etc. This is then discussed with the service users during the 'my service, my say' meetings where it can also be amended if required.

3. *Nurses should be actively involved in the gatekeeping process and attend the weekly panel meetings. Pre-admission assessment information and opportunities to work with patients in advance of their admission should be fully utilised to understand the expectations of patients, develop relationships and develop plans for treatment, care and risk taking. Nurses should be given the opportunity to take an active role in the assessment process*

   It has been agreed that members of the registered nursing team will attend the Gatekeeping Meeting which occurs on a weekly basis when a service users case is being presented following the assessment taking place. Once the decision to admit has been made then a named nurse is allocated by the Ward Manager and then carries out joint

visits with the Outreach Practitioner as a means of introducing the service and preparing the care plans/ risk assessments prior to admission.

4. *The overarching care plan should reflect the care and treatment provided by all disciplines and be jointly owned by the patient and the care team. This should assist in achieving a shared understanding of, and a consistent approach to, treatment, care and interventions to support the patient achieve progression and recovery. The treatment and care being developed by all members of the care team should be articulated within this single document. Staff training in My Shared Pathway should be arranged as some staff do not appear to be aware of it even though evidence clearly shows it is in use.*

   A carenotes Assist system has been developed and rolled out within secure services. The 'My Shared Pathway' process has been clarified within the clinical pathway.

5. *Patients' initial expectations and desired outcomes need to be identified prior to admission so that the preliminary care and treatment plan can be formulated and in place on admission.*

   Once the decision to admit has been made then a named nurse is allocated by the Ward Manager and then carries out joint visits with the Outreach Practitioner as a means of introducing the service and preparing the care plans/ risk assessments prior to admission. The peer supervision process will further support this process.

6. *As part of the preadmission assessment process, compatibility issues with existing patients' needs to be considered and the admission should not go ahead if it is considered that the risk is too great by so doing.*

   The compatibility issues can now be better identified in the Gatekeeping Meeting now that the registered nurses from the ward are present at the case presentations.

7. *Plans to address risks identified from the pre-admission assessment will form part of the initial care plan on admission.*

   It has been agreed that members of the registered nursing team will attend the Gatekeeping Meeting which occurs on a weekly basis when a service users case is being presented following the assessment taking place. Once the decision to admit has been made then a named nurse is allocated by the Ward Manager and then carries out joint visits with the Outreach Practitioner as a means of introducing the service and preparing the care plans/ risk assessments prior to admission.

8. *The risk assessment process is dynamic and are therefore subject to regular review and updates. Protocols need to be in place of how changing risk is communicated to all staff especially those who cannot access the information electronically due to them not being issued with a password.*

There are several risk assessments completed within secure services in reflection of the complex risk history relating to this service user group. The clinical pathway details the timeframes for completion of these documents along with the frequency of review. Any changes to an individual's presenting risks are to be reflected in a risk event within the carenotes system at the time and then added to the appropriate risk assessment document.

9. *Full utilisation of 'See Think Act' within the processes of the unit is essential. All staff should be aware and understand the of See Think and Act booklet. Their understanding could be assessed during supervision.*

   The 'See, Think, Act' process relates to relational security which was covered within the 2 week training programme delivered to the staff within Saddlebridge Recovery Centre.

10. *A clear shared philosophy needs to be in place which guarantees that respect and compassion are at the core of how patients are treated at Saddlebridge. Use of the 6 C's to check that this is happening may be helpful :*

    1. ***Caring** defines us and our work. People receiving care expect it to be right for them consistently throughout every stage of their life.*
    2. ***Compassion** is how care is given through relationships based on empathy, respect and dignity. It can also be described as intelligent kindness and is central to how people perceive their care.*
    3. ***Competence** means all those in caring roles must have the ability to understand an individual's health and social needs.*
       It is also about having the expertise, clinical and technical knowledge to deliver effective care and treatments based on research and evidence.
    4. ***Communication** is central to successful caring relationships and to effective team working. Listening is as important as what we say and do. It is essential for "no decision about me without me". Communication is the key to a good workplace with benefits for those in our care and staff alike.*
    5. ***Courage** enables us to do the right thing for the people we care for, to speak up when we have concerns. It means we have the personal strength and vision to innovate and to embrace new ways of working.*
    6. ***Commitment**. A commitment to our patients and populations is a cornerstone of what we do. We need to build on our commitment to improve the care and experience of our patients.*

    A team philosophy was developed by the ward staff as part of the team building session delivered by Education CWP.

11. *Nursing staff need to have access to on-going training in supporting patients with Personality Disorder and other presentations which require a more behavioural type approach. It may be helpful if this is provided via action learning sets or similar in order to enable the team to work together to build skills, knowledge and capacity across the whole team. Care should be taken to ensure that nurses have sufficient protected time to engage fully in any training initiatives.*

    A module relating to Personality Disorder was included in the training programme undertaken prior to the re-opening of the ward. A secure specific training package is being explored which would be undertaken on an annual basis.

12. *Nurses need to be present at all MDT meetings*

    Nurses are now involved in all ward reviews and CPA meetings as are other professionals within the MDT but more importantly due to the changes made to these systems each professional has an equal opportunity to put their views forward. The peer supervision sessions have also been re-arranged to ensure that members of the ward nursing team are also able to attend.

13. *Staffing levels available to work directly with patients', needs to be reviewed through Part Two of the Comprehensive Nursing Review. Outstanding actions from the initial review need to be addressed.*

    A further review of ward staffing is currently being undertaken Trustwide. The recommendations being made will also take into account the need for the security role to be separate from the clinical numbers. These revised recommendations are currently being implemented across both Saddlebridge and Alderley Units. There are plans being developed to ensure full implementation of the staffing review recommendations by the middle of 2015/ 16.

14. *A clear protocol needs to be developed on the granting, taking away and the facilitation of patient leave; the protocol then needs to be applied consistently and communicated to all patients and staff*

    A section 17 leave standard operating procedure has been developed and has been in operation since the unit re-opened. This document will form part of the secure specific Operational Procedure currently under development.

15. *Peer supervision sessions need to always included members of the nursing staff*

    The day and times of the peer supervision sessions have been re-arranged to ensure that members of the ward nursing team are also able to attend. This system will also be used to ensure that all plans are developed prior to a service user's admission using an MDT approach.

16. *All staff need computer passwords as a matter of urgency, not only so they can view relevant patient information such as current patient risk, but also to enable them to input other things that they are required to do such as booking leave and placing off duty requests*

    All staff currently in work now have the relevant log in details.

17. *All blanket rules need to be reviewed. Rules and restrictions that are introduced in response to specific risk events should be reviewed by the team as soon after the event as possible to ensure these are necessary and proportionate. All rules should be regularly reviewed and should only be in place if it can be demonstrated they have a positive effect on the running of the unit and the wellbeing of patients'*

Any rules in place prior to the incident have been reviewed with the ward team and adapted where necessary There is a daily routine in place to ensure that staff are working in a consistent way.

18. *Daily community meetings need to move away from how someone feels (this can be done on a 1:1 basis) to ensuring activities for the day are planned and patients' concerns listened to and noted. These meetings need to be minuted by staff. Each meeting must go through the previous days agreed activities and concerns to check if the activities went ahead as planned and if not why, and that patient concerns have been dealt with appropriately. The issues raised in these meetings need to be fed into the My Service My Say meetings.*

    The community meeting since the unit has re-opened has changed its focus to be purely around the planning of the day's activities. The provision of 25 hours of meaningful activity is monitored by the commissioners on a quarterly basis during the contract monitoring meetings and can be evidenced by the service.

19. *There needs to be a clear timetable of more relevant activities which include weekends and after 5pm. Staff should be qualified to supervise cooking on the unit and the activities in general should be one which the patients enjoy and benefit from.*

    An activity timetable is produced by the Occupational Therapy team for both units with individual copies being provided to all service users. The new timetable is available to all staff and service users and does include some weekend and after 5 provision

20. *The lack of fresh air breaks needs to be addressed and it is recommended that consideration be given to only requiring one member of staff needing be present in the court yard*

    There is now open access to secure outside space within the unit

21. *The policy of locking off rooms, especially when no activities are available, needs to be revisited*

    The restriction in relation to service user room access has been reviewed resulting in service users now having open access to their bedrooms at all times. An engagement document has been produced which aids in this process.

22. *Senior staff directly connected to the unit, need to consider how they can work alongside staff in ways which staff feel is more supportive.*

    Senior staff such as the Clinical Service Manager, Modern Matron, Consultant Psychologist, Lead Occupational Therapist, Social Worker and Ward Manager have all been involved in delivering and recieving the 2 week training package which in itself has assisted in enhancing relationships within the team.

23. *All staff need to be MVA compliant. Even though there is no evidence to suggest this was a factor when the incident occurred, it does provide staff we a greater degree of confidence if most of the staff on the shift are able to use restraint techniques. This will also has an*

impact on the decision of how many staff need to remain on the unit when agreeing which staff can facilitate leave.

The senior management team are working with Education CWP to ensure that all staff are MVA trained and compliant.

24. *Most patients spend at least twelve months on the unit and for some the length of stay is much longer. Given that this is the case the need for a comfortable environment with some homely touches should be balanced against physically security requirements. Small comfortable areas, which could also for de-escalation, would also be beneficial. Repairs to the internal environment need to be completed rapidly.*

    A significant programme of improvements to the ward environment have been made since the incident occurred which not only addressed the damage caused. A full programme of redecoration including the introduction of artwork has changed the clinical feel of the environment. New furniture has been purchased for the day spaces which makes them more comfortable for service users. The small lounges linked to each of the bedroom corridors are accessible throughout the day which provide the opportunity for service users to seek some quiet time if they wish.

25. *There is a 'Quality Network Action Plan'. Some of these seem particularly relevant in light of the incident on 05.07.2014 – in particular action 51 which relates to governance and says "ensure that there are local protocols in place in relation to all contingency plans which have been agreed with police and other emergency services including loss of control and – serious operational failures" . This needs to be addressed as it showing as Red*

    As a result of the incident an Emergency Bed Contingency Plan has been agreed both locally and across the North West and there has been a review of the Business Continuity plan which covers both Saddlebridge Recovery centre and the Alderley Unit.

26. *As gathering benchmarking information is considered by many services to be commercially sensitive it is recommended that we approach NHS England to explore possibilities.*

    Benchmarking the service against other secure services is achieved currently by the services membership of the Quality Network developed by the Royal College of Psychiatrists. This provides the service with the opportunity to be peer reviewed against a set of national standards for low secure services and establish how the service performs in comparison to others. The initial peer review was undertaken in January 2014 with the next review taking place in April 2015.

4. Conclusion

It is concluded that since the release of the internal investigation report a significant amount of progress has been made in relation to meeting the 26 recommendations made. There are 5 recommendations which have not currently been completed, however action plans are in place for completion of these recommendations and all recommendation will be completed by April 2015. It should be noted that the majority of the recommendations have been achieved with plans in place to achieve those where work is still required.

5. Recommendations to the Board of Directors

The Board are recommendation to discuss and approve the report.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/15/98)

Report to:	**Board of Directors**
Date of meeting:	**28 January 2015**
Title of report:	**Learning from Experience report – Trimester 2 2014/15**
Action sought:	**For DISCUSSION and ENDORSEMENT of approval**
Authors:	**Audrey Jones, Head of Clinical Governance** **David Wood, Associate Director of Safe Services**
Presented by:	**Avril Devaney, Director of Nursing, Therapies & Patient Partnership**

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

Distribution

Version	Names/ Groups	Date issued
1	A Jones to D Wood	19.01.2015
2	D Wood to L Hulme for Board of Directors	20.01.2015

Executive director sign-off

Executive director (name and title)	Date signed-off
Dr Anushta Sivananthan, Medical Director	20.01.2015

1. Purpose of the report

This Learning from Experience report aggregates qualitative and quantitative analysis from key sources of feedback from people who use the Trust's services, staff, and other relevant sources of learning, covering the period from August 2014 – November 2014, trimester 2 of 2014/15.

2. Key performance indicators

Performance indicator			2013/14		2014/15	
			T2	T3	T1	T2
Number of patient safety incidents reported			2418	2514	2673	2368
Severity (Increase in level of harm ⇧)	**Category A**		17	11	26	33
	Category B		30	33	18	37
	Category C		270	409	313	306
	Category D		915	786	847	734
	Category E		1137	1220	1469	1258
Reports to external agencies	StEIS		43	79	31	47
	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations		5	10	9	1
	NHS Litigation Authority – NHSLA	Non clinical claims	9	2	9	11
		Clinical claims	2	0	1	1
Number of complaints			59	85	70	69
Acknowledgement of complaints within 3 days			93%	95%	99%	100%
Number of compliments			671	864	927	825

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

3. Analysis – key highlights

Follow up from the actions identified in trimester 1 of 2014/15 are outlined in *Appendix A*.

3.1 Incident reporting

All relevant incidents involving patient safety are reported to the *National Reporting and Learning System* [*NRLS*]. CWP's Safe Services Department has met with the Patient Safety Reporting Lead, *NHS England*, to improve the data quality uploaded onto *NRLS*. Recommendations were subsequently made, CWP completed an improvement plan, and this has resulted an increase in the number of incidents uploaded onto *NRLS*. However, the number of all incidents reported this trimester is 5% less than the overall average number of all incidents reported in the last four trimesters. Increases in incident reporting are encouraged, in line with best practice. Category A and B incident reports have increased, the main contributor being an expected increase within *Drug and Alcohol Services* as a result of clarification on the reporting of unexpected deaths within Drug and Alcohol teams provided part way through trimester 1. Further analysis of Category A and B incident data is currently being undertaken by locality Quality Surveillance Support Managers to understand variation and significance, taking into account the rate of incidents (based on occupied bed days/ community contacts/ attended appointments), considering acuity, and changes over time associated with emerging and new models of care provision and evidence based interventions.

3.2 Falls incidents

There has been a continuous reduction in reported falls incidents over the four trimester time series, this trimester to 145 compared with 162 previously. This is in part as a consequence of the risk treatment plan in place as part of management of this risk through the corporate assurance framework process. The most frequently reported severity of falls has been category E [near miss/ prevented] patient safety incidents. There were three Category C incidents compared to seven last trimester; there were no Category A or B incidents. Outstanding residual falls/ clinical specific actions were reported to the Audit Committee in September 2014, which will continue to report to

the Patient Safety & Effectiveness Sub Committee. Further statistical analysis and exploration of falls data is currently underway to understand the impact that variables such as education, admission rates and change in documentation and policy has on trends.

3.3 Medicines incidents

The total number of medicines incidents this trimester is 134; this is a 14% decrease from trimester 1 and a 24% reduction from trimester 3. *Adult MH Wirral*, *Adult MH East* and *Clinical/ corporate support services* reported more incidents, however this represents a lower number of reports than the four trimester time series. Other services continue to report fewer medicines incidents compared with the previous trimester/s. A number of recommendations have been identified to mitigate the top three medicines incident themes, which remain consistent, as detailed below.

3.4 Complaints, PALS, compliments

69 complaints were received under the NHS complaints procedure during the trimester. Of these, they were received per locality as follows: *CWP East* 17 complaints, *CWP West* 30 complaints, *CWP Wirral* 21 complaints, *CWP Corporate Support* 1 complaint. This trimester there has been an increase in PALS contacts to 172 contacts handled compared with 135 in trimester 1. The PALS officer continues to work with services to ensure that concerns are dealt with quickly to try and resolve issues locally, which has contributed in part to the reduced number of complaints.

3.5 Management of challenging behaviour

In the twelve months since the launch of the new mandatory restraint training modules, incidents of physical holding has reduced by 55%. Of the reported physical intervention incidents, 43% involved the use of the new restrictive interventions. This is an increase of 3% from the previous trimester. There is a decreasing trend in the number of prone restraint incidents reported over the past four trimester time series, however when benchmarked nationally, further and faster reductions are indicated. A review of the Datix risk management system reporting fields has resulted in planned changes which make reporting more transparent and compliant with national standards, additionally a quality improvement project has been identified – see the recommendations detailed below.

4. Summary of recommendations

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

	Recommendation	Action	By Whom	When
1	Explore new and improved ways of working in relation to the investigation of incidents to focus on learning and bring about better outcomes	To meet with all CCG quality leads in February 2015 to agree consensus way forward and reflect this in CWP policy and contract monitoring processes	Director of Nursing, Therapies & Patient Partnership/ Medical Director (Compliance, Quality & Regulation)/ Associate Director of Safe Services	30.03.2015
2	Address further contributory factors for the failure to administer medicines	Each locality to review relevant incidents and formulate a robust improvement plan which should be submitted to the Medicines Management Group	Pharmacy Team/ Locality senior management team	01.03.2015
3	Ensure that the temperatures of	Explore systems to	Pharmacy Team/	01.03.2015

	Recommendation	Action	By Whom	When
	medicines fridges and pharmacy rooms on the wards where medications are stored are recorded and any variance from the recommended range is recorded promptly	facilitate wards in routinely recording and reporting temperature variance of medicines fridges and pharmacy rooms	Ward management/ Matrons	
4	Bolster protected time for administration of medications on the ward	Identify mechanisms to free capacity to implement protected time for the administration of medicines	Ward management/ Matrons	01.03.2015
5	Improve availability of peer support for new Investigation Managers	Implementation of a formal programme of peer support	Head of Clinical Governance	01.04.2015
6	Ensure that those people who use/ have used the Trust's services who have had complaints upheld consistently have support offered to them	Complaints policy to be updated to include a process for facilitating support to those people whose complaints have been upheld	Head of Clinical Governance	25.03.2015
7	Develop reporting codes for the recording of restraint incidents within Datix [the Trust's incident reporting system]	Develop the reporting system for restraint incidents within Datix to ensure more transparency and compliance with national standards	Complaints & Incidents Manager/ Safety & Security Lead	01.03.2015
8	Review prone restraint incident reporting using meta analysis and develop recommendations for practice in relation to managing challenging behaviour, including application of safe clinical human factors practices	Plan and implement a quality improvement project to accelerate prone restraint reduction	Medical Director [Compliance, Quality & Regulation]/ Safe Services Department/ Education CWP	30.04.2015

5. Recommendation

The Board of Directors is asked to:

- **Discuss** the findings and key analysis within the report.
- **Endorse** the recommendations identified that have been approved by the Quality Committee; these recommendations will be monitored by the Quality Committee.

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

As part of the review of the Trust's incident reporting and management policy, the Root Cause Analysis [RCA] documentation and peer review documentation should be updated. The updates should include questions which include questions regarding human factors practices and should be piloted for a period of 2 months.
The RCA documentation and peer review documentation are currently being updated and will be submitted to the policy discussion board for comment. The peer review document will be updated to incorporate an SBAR [communication] approach; this will also include prompts for care planning, risk assessment and human factors. This documentation will feature in the revised overarching policy, which is currently deferred pending receipt of national policy from *NHS England*, publication expected January 2015.
The Datix incident reporting system should be developed from being an incident management framework to an integrated platform to manage incidents, claims, complaints and organisational risks. This will assist the team in moving towards a case management approach for claims, coronial inquests, incidents and complaints – interfacing with Human Resources and safeguarding investigations as appropriate.
This work is currently ongoing. The incidents, complaints and inquests team are incrementally moving towards a more locality based approach from April 2015 onwards. Further, work is currently being undertaken with Datix to improve the system.
The Pharmacy Team should request that each locality formulate a robust action plan to address the reasons for failure to administer medicines. This should promote that staff employ approaches that ensure frequency of 'failure to administer' is minimised. This action plan should come to the Medicines Management Group every 2 months to assess improvements through a reduction in reported incidents in this sub-category.
This action has not been completed and has therefore been repeated in this report.
The Pharmacy Team should alert and remind prescribers to prescribe antibiotics in line with the antibiotic formulary and if clinically appropriate.
Prescribers are made aware of the antibiotic formulary in their medicines management induction training and receive updates including feedback from antibiotic audit results in their ongoing training. All prescriptions for antibiotics are clinically checked by the pharmacy team and non-formulary prescribing discussed with the prescriber.
The Pharmacy should communicate the following recommendations: • All teams should review their current systems to minimise the risk of prescriptions being lost. • Memory Clinic West should review and update strategies to prevent prescriptions being lost and/ or mislaid. • GP Out of Hours service should adhere to the prescription paperwork reconciliation process that has recently been introduced.
The memory clinic has strategies in place to reduce the need to post prescriptions. A review was offered but it was felt that as most patients were moving over to shared care and having prescribing done by their GP the current systems would be sufficient. Lost prescriptions will continue to be monitored. Staff in all three GP out of hours bases have received training in the prescription reconciliation process. Adherence to the process is monitored by the out of hours service operational manager and the pharmacy team.
The Head of Clinical Governance should write a report for the values group which will theme gaps in communication and attitude from all investigations across the Trust; this can then be incorporated into the plans for this group for the implementation of the 6Cs.
This report is in progress and will be completed by 31 January 2015 ready for the next meeting.
The complaints policy should be updated to reflect feedback from the recent audit of people who have made complaints. A common theme from the feedback has been in relation to not specifically enough addressing the complaint made. More work is required to support teams at the beginning of the process rather than at the end when impending deadlines affect the completeness and quality of responses and communication.
The complaints policy has been updated and has been submitted to the policy discussion board week commencing 6 January. It was also circulated to Quality Committee members for consultation/ comment.

Restraint awareness training should be introduced through Education CWP courses and also through the scheduled clinical trainers inpatient drop in sessions.
Factored into appropriate courses and drop in sessions and is ongoing.
The Incidents and Complaints Manager should work together with the Safety, Security and Clinical Education Lead to develop the Datix incident reporting system to better record the details of incidents and restraint. The focus will be to ensure the reporting codes are clear and that staff are able to record why they have used the technique that has been used. This will specifically focus on prone restraint.
This is ongoing and further refinement is indicated, therefore this recommendation has been repeated in this report.

Document Reference (2014/15)	Jan-15

Date of Meeting: 28th January 2015

Title of Report: CWP Performance Dashboard

Open Board Version

Action sought: **DISCUSSION & APPROVAL**

Author: Neil Griffiths, Acting Head of Performance and Information
Mandy Skelding-Jones, Associate Director of Performance and Redesign

Presented by: Mandy Skelding-Jones, Associate Director of Performance and Redesign

The Board are asked to:

Note:

1. The Continuity of Services Risk Rating for December 2014 remains at 4.

2. Trustwide CIP performance has worsened in December to £257k behind year-to-date target. Remedial actions continue.

3. Performance for all Monitor indicators is above target.

4. Sections of this new-format dashboard remain in development and work is ongoing to provide all data. Items remaining in development (estimated dates of availability in parenthesis):

- Customer Satisfaction *(Q4 2014-15)*
- Friends and Family Test *(Q4 2014-15)*
- Staff Experience *(Q4 2014-15)*
- Timely reporting for ESR data *(January 2015 - see item 6)*

5. A new Clinical Strategies section is now provided in the dashboard, detailing locality performance against various proxy measures intended to assess progress in the implementation of each locality's clinical strategies. This remains in development and will evolve over time as feedback is received.

6. Live data from ESR is now available to the Trust, and development is underway to obtain the various Workforce and Essentials 1 indicators using real time, which will ensure that data can be provided for the most recent month, rather than a month behind as at present - this month (January's) report contains November ESR data, and not December's. Real time reporting is expected to commence by late January 2015.

7. Waiting time reporting is currently being provided for the services CWP provide which are subject to 18-week RTT reporting (Allied Health Professional-led services in CWP West Physical Health Services only). Over the next months, this will be developed to provide waiting time data for all services following the addressing of data quality issues. Following the recent governmental announcement of new waiting times indicators for Mental Health, work has commenced on providing the current Trust position on these indicators, and work will commence to ensure full implementation with clinical services.

8. Overall compliance with new Essential 1 training has further decreased, to 84.1% for November (from 84.6% in October), and remains below the 85% compliance target. The graphs in the workforce section have been split between no renewal, annual renewal, and three-yearly renewal courses. Low compliance with annually-renewed training is the cause of the below-target overall performance for all three localities.

Discuss:

9. The Trustwide performance for sickness has decreased, and is now at 6.39% for November, which is a slight improvement on October's position of 6.47%. The Trust tolerable threshold is 4.5%, however, and all three localities are markedly over target. CWP East remains the worst-performing area, at 7.14%. CWP West is at 6.59%, and CWP Wirral at 6.91%. CWP Wirral is in the process of introducing the BlackLight attendance management system which is anticipated to help the locality improve its performance.

Strategic Objective(s) that this report covers:

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

Version	Name(s) / Groups(s)
1	Andy Harland, Deputy Director of Finance
2	Operational Board

Executive Director

Tim Welch, Director of Finance/Deputy Chief Executive

CWP Board Dashboard

Reporting Month: December 2014

Exception Reports

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

	Previous month	Current month	Trend
Monitor Targets - 7			
Finance			
Income & Expenditure			
CoSRR (Monitor Target)			
Cashflow			
Cost Improvement			14/15 value - £5.3m Plan to date - £3,385k Delivered - £3,128k Gap - £257k behind
Contracting			

	Target	Previous month	Current month	Trend
Workforce				
Essentials 1	85%			
Appraisals (including medical staff)	85%			
Safeguarding	80%			
Supervisions	85%			
Sickness	< 4.5%			
Disciplinary	TBC			
Patient Experience				
Complaints per 1000 episodes	< 2.17			
Staff Concerns	TBC			
Customer Satisfaction	80%	Process for data collection in development. Expected to be in place Q4 2014/15		
Family & Friends Test	Process for data collection in development. Expected to be in place Q4 2014/15			

	Bed occupancy rate	Number of closed wards	Ward staffing levels	
Previous Month	88.80%	2	Planned Shifts 6,506 Actual 6,324	**97.20%**
Current Month	91.54%	2	Planned Shifts 6,774 Actual 6,402	**94.51%**
Trend				

Number of people waiting	Average Wait	Maximum wait (no. of people)
648	5.7 weeks	16 weeks (8 people)
508	6.4 weeks	18 weeks (2 people)
Average wait		Max wait

CWP Board Dashboard

Reporting Month: December 2014

Exception Reports

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Risks	Number of risks						Number of new risks added to register	Number of risks archived from register
	Red		Amber		Green			
	Current	Trend	Current	Trend	Current	Trend		
Strategic	10		5		0		4	0
Clinical Services	14		38		2		2	0
Corporate Support	In development - being piloted by Performance and Redesign							

Quality	Previous month	Current month	Trend
Patient Safety Composite Score			
Staff Experience	Process for data collection in development. Expected to be in place Q4 2014/15		

Incidents	Category A&B (SUIs)		Category C&D (Mild / Moderate harm)		Category E (No harm)		Trend
	Previous month	Current month	Previous month	Current month	Previous month	Current month	
Clinical Services							A&B C&D E
Clinical Support Services							A&B C&D E
Total							A&B C&D E

Infection Prevention and Control	Previous audit compliance	Current audit compliance	Trend
Infection Control	4/6 passed 95% average compliance	6/6 passed 98% average compliance	

Clinical Strategies	CWP West	Previous month	Current month	CWP Wirral	Previous month	Current month	CWP East	Previous month	Current month
KPI 1		Worsening	Worsening		Static	Static		Worsening	Worsening
KPI 2		Static	Static		Static	Static		Static	Static
KPI 3		Static	Static		Static	Static		Improving	Improving
	Risk Rating			Risk Rating			Risk Rating		

Board Dashboard - Glossary

Back to top

Theme	Link to Strategic Objectives	Definition	Threshold	RAG Status	Trigger for exception report to Board	Reviewing Group/ Person	Submission Frequency
Monitor Targets	5 and 6	Composite view of performance against the 7 reportable monitor targets	100% of targets meeting required standard	Green = 7 targets above threshold Amber = 1 or more target(s) failed by 0.1% - 5% Red = 1 or more target(s) failed by =>5.1%	Exception reports will be provided for any indicators that are classified as Amber or Red.		Quarterly
Income & Expenditure	6	Income and Expenditure Accounts (I/E) are used by non- profit making organisations. They are prepared on an accrual basis and include only transactions incurred within, and relevant to, period covered. Resulting in an overall bottom line surplus/ deficit position.	Forecast surplus < £250k	Green = On plan I&E rating =>3 Amber = I&E rating =3 and forecast surplus =>£250k < plan Red = = I&E rating <3 and forecast surplus =<£225k	Exception reports will be provided when the position is reported as either Amber or Red.		Quarterly
CoSRR (monitor target)	6	Continuity of Service Risk rating identifies the level of risk to the ongoing availability of key services	Continued downward trend in performance, over 2 quarters	Green = on plan and/or risk rating of above 3 Amber = risk rating of 3, with downward trend over 2 quarters Red = risk rating of 2 or below	Continued downward trend in performance, over 2 quarters		Monthly
Cash	6	Level of in bank	=> £2 million	Green = on or above plan Amber = behind plan with agreed remedial actions in place to rectify position Red = behind plan by => £2 million with no agreed actions in place to recover position or position not recoverable	Exception reports will be provided when the position is reported as either Amber or Red.		Quarterly

Theme	Link to Strategic Objectives	Definition	Threshold	RAG Status	Trigger for exception report to Board	Reviewing Group/ Person	Submission Frequency
Cost Improvement Programme	6	CIP is the term widely used in NHS to describe schemes to make efficiency savings and improvements in productivity	=> £x	Green = on or above plan Amber = behind plan with agreed remedial actions in place to rectify position Red = behind plan by => £ x with no agreed actions in place to recover position or position not recoverable	Exception reports will be provided when the position is reported as either Amber or Red.	Ops Board and Execs	Monthly
Contracts Held	4	Number of contracts held by the trust with commissioners	Loss of any contract or new contracts gained	Green= status quo or increase in contracts held Amber = intention to tender given on contract Red = loss of contract	The board would receive exception reports for any change in contract status	CAL	Monthly
Essentials 1	1 and 3	Percentage of staff being fully compliant with essentials 1 requirements	85%	Green => 85% Amber => 80% and < 85% Red < 80%	Exception reports will be provided when the position is reported as either Amber or Red.	CAL	Monthly
Appraisal	1 and 3	Competition of annual PDR for non-medical staff and annual appraisal for medics. Excludes Students, Locums & Bank Staff	85%	Green => 85% Amber => 80% and < 85% Red < 80%	Exception reports will be provided when the position is reported as either Amber or Red.	CAL	Monthly
Safeguarding	3 and 7	Level of compliance with safeguard training for all eligible staff	80%	Green => 80% Amber => 75% and < 80% Red < 75%	Exception reports will be provided when the position is reported as either Amber or Red.	CAL	Monthly
Complaints	7	Number of complaints received represented as a rate per 1,000 episodes (including mental health, LD, Drug and Alcohol, IAPT services and community physical health)	= < the rate for previous year	Green = rate =/less than the rate for the previous year Red = rate higher than previous year	Exception reports will be provided when the position is reported Red.	CAL	Monthly
Customer Satisfaction	2 and 7	Currently being developed as a measure				TBC	Monthly

Theme	Link to Strategic Objectives	Definition	Threshold	RAG Status	Trigger for exception report to Board	Reviewing Group/ Person	Submission Frequency
Staff Experience	3 and 7	Overall rating for staff survey	= > the rate for previous year and organisational ranking in national survey	Green = rate =/higher than the rate for the previous year Amber = ranking in national survey reduced Red = rate lower than previous year	Exception reports will be provided when the position is reported as Amber or Red.	TBC	Annual
Staff Concerns	3 and 7	Number of staff concerns captured through raising concerns process				TBC	Monthly
Sickness	3	Rolling staff sickness levels	=< national benchmark rate	Green = rate that is => national rate Amber = rate that is x.x% above or below the national rate Red = rate that is x.x% above or below the national rate	Exception report and action plans will be provided when the position is reported as Amber or Red.	ODE/WOD	Monthly
Disciplinary	3	Current number of staff subject to disciplinary process	TBC			TBC	Monthly
Bed Occupancy rate	1 and 5	Average bed occupancy rate for the month	TBC		All incidents where occupancy is significantly below or above plan will be reported to board	In Patient Ward Review Programme	Monthly
Number of closed wards	1 , 5 and 7	Number of wards closed within the month	>0		All reported ward closures will require an exception report and action plan	In Patient Ward Review Programme/ Execs	Monthly
Ward Staffing levels:	1 , 5 and 7	Actual v Planned staffing levels	Actual staffing level is below plan		All incidents where staffing is significantly below or above plan will be reported to board	In Patient Ward Review Programme/ Execs/ Board	Monthly
Waiting times	1 , 5 and 7	Number of community physical health patients waiting for their first appointment with an Allied Health Professional	95% within 18 weeks	Red = Less than 90% compliance Amber = 90-95% compliance Green = 95% compliance	Reported as Amber or Red		Monthly
Risks	1 and 7	Provides overview of the current risks managed by the trust and movements in risk status	New red rated risk identified	Not applicable	Any new red risks should be reported to board by exception	Quality	Monthly

Theme	Link to Strategic Objectives	Definition	Threshold	RAG Status	Trigger for exception report to Board	Reviewing Group/ Person	Submission Frequency
Incidents	1 and 7	Provides overview of incidents occurring within the month. Categorised into three groups, serious harm, mild/moderate harm and no harm.	Current month performance should be equal to or less than the average of the previous 13 months for serious harm and mild/moderate harm. No harm incidents should be greater than average of the previous 13 months.	Cat A&B - Red if increase, Amber if decrease, Green if zero Cat C&D - Always Amber Cat E - Green if increase, Amber if static, Red if decrease	All serious incidents would be reported to board by exception. Growth over 3 month period in 'serious and mild/moderate' incidents an exception report and action plan would be required Should the number of 'no harm' incidents continually reduce over 3 month period, an exception report and action plan would be required	Quality	Monthly
Clinical Strategies	1, 2, 6 and 7	Proxy measures for the implementation of locality clinical strategies	Improvement on previous financial year	For individual measures: Green - improvement Amber - no significant change (+/- 5%) Red - worsening of position For overall KPI: Green - majority improving Amber - equal amount improving / worsening Red - majority worsening	Any indicator being red		Monthly
Infection Prevention and Control	1, 3 and 7		All areas audited in the month >93%	Green: All areas >= 93% Amber: Average >= 93% Red: Average < 93%	Any area having a compliance score of less than 93%	IPCSC	Monthly

Theme	Link to Strategic Objectives	Definition	Threshold	RAG Status	Trigger for exception report to Board	Reviewing Group/ Person	Submission Frequency

CWP Objectives

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/15/100)

Report to:	**Board of Directors**
Date of Meeting:	**28 January 2015**
Title of Report:	***Monitor* Quality Governance Framework – self assessment for quarter 3**
Action sought:	**For DISCUSSION and APPROVAL**
Author:	**David Wood, Associate Director of Safe Services**
Presenting Executive:	**Tim Welch, Director of Finance**

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

Distribution

Version	Name(s)/Group(s)	Date Issued
1	D Wood to L Hulme for Board of Directors	19.01.2015

Executive director sign-off

Executive director (name and title)	Date signed-off
Tim Welch, Director of Finance	20 January 2015

1. Purpose of the report

To provide an update on the Trust's current quarter 3 position with respect to the *Monitor* Quality Governance Framework. Scrutiny against this framework provides the Board of Directors with assurance that the organisation is working effectively to improve patient care.

2. Discussion

The Quality Governance Framework helps Boards to understand what is required of its internal assurance mechanisms for assuring the organisation wide processes for governing quality, with a view to improve decision making and to support Boards in discharging their responsibilities to improve care for patients. It helps Boards to consider and assess the assurance on the following quality governance systems and processes:

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

The *Monitor* Quality Governance Framework is intended as an iterative document. CWP has a sound history of rigorous challenge of this framework, by undertaking a quarterly self-assessment to provide assurance that governance arrangements are contemporary and fit for purpose. The quarter 2 self-assessment was contained in the *Monitor* quarterly compliance report to the Board of Directors. To further strengthen this rigour, and in support of the rigorous review of specific aspects of governance as described in *Monitor*'s Well-led framework for governance reviews: guidance for NHS foundation trusts, commencing this quarterly period, indicative scoring is being applied to the self-assessment against each quality area/ well-led domain. Whilst *Monitor* guidance around this scoring is primarily in relation to aspirant foundation trusts, applying this scoring methodology increases transparency of the current Trust position and acts as an early warning framework in relation to emerging risks/ gaps. This will also mitigate risks that have been identified nationally from 'well-led governance reviews' to-date in relation to minimal interrogation of 'green' key performance indicators and data quality.

Appendix 1 details that all quality areas are assessed as being 'green' this quarter, which equates to the Trust's current summative score of 0.0 [a score greater than 3.5 would indicate concerns regarding a Trust's quality governance arrangements]. All the quarterly returns assist the Board in undertaking a full annual assessment at the end of the financial year.

3. Recommendations to the Board of Directors

The Board of Directors is invited to comment on the self-assessment attached as *Appendix 1* and, subject to any recommended changes, **approve** and adopt it as the Trust position.

Appendix 1: *Monitor* Quality Governance Framework – self-assessment quarter 3 2014/15
Following a review of *Monitor*'s Quality Governance Framework, the following self assessment has been completed. Below is a summary of each area, with a self-assessment RAG rating. A comprehensive assessment is outlined in *Appendix 1.1*, detailing information used to formulate this assessment and areas that may required further development, with suggested actions.

QUALITY AREA/ WELL-LED DOMAIN		Q3 2014/15 self-assessment [RAG] rating
Strategy		
1a	Does quality drive the trust's strategy?	GREEN
1b	Is the Board sufficiently aware of potential risks to quality?	GREEN
Capabilities and culture		
2a	Does the Board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?	GREEN
2b	Does the Board promote a quality-focused culture throughout the Trust?	GREEN
Processes and structure		
3a	Are there clear roles and accountabilities in relation to quality governance?	GREEN
3b	Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	GREEN
3c	Does the Board actively engage patients, staff and other key stakeholders on quality?	GREEN
Measurement		
4a	Is appropriate quality information being analysed and challenged?	GREEN
4b	Is the Board assured of the robustness of the quality information?	GREEN
4c	Is quality information being used effectively?	GREEN
SCORE		**0.0**

The rating scale is explained below:

RAG	Indicative score [based on *Monitor*'s rating scale]	Definition
GREEN	0.0	Meets or exceeds expectations. Many elements of good practice. No major omissions.
AMBER/ GREEN	0.5	Partially meets expectations but confident in management's capacity to deliver green performance within reasonable timeframe.
AMBER/ RED	1.0	Partially meets expectations but some concerns on capacity to deliver within a reasonable timeframe.
RED	4.0	Does not meet expectations.

Appendix 1.1 – Self-assessment as at Quarter 3 2014/15

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1/ Q2 with update	Further actions for completion by end Q4 2014/15
1. Strategy				
1a: Does quality drive the Trust's strategy?	• Quality is embedded in the Trust's overall strategy. ▪ Overall vision '*Leading in partnership to improve health and well-being by providing high quality care'.* ▪ The Trust's vision and strategy comprises a number of Trust-wide quality goals covering safety, clinical effectiveness/ outcomes and patient experience which drive year on year improvement. ▪ Quality goals reflect local as well as national priorities, reflecting what is relevant to patient and staff – forward planning events and working with commissioners and other local scrutineers on development of quality priorities help identify priorities. ▪ Overall Trustwide quality goals link directly to goals in localities/ services [which will be tailored to the specific service] – as part of annual and strategic plans and clinical strategies. • Quality goals are communicated as part of quality accounts, regular quality reporting, via Clinical Directors at Quality Committee [via	**GREEN**	None.	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1/ Q2 with update	Further actions for completion by end Q4 2014/15
	a quality dashboard], and as part of clinical performance reviews. • CWP performance dashboard has quality section.			
1b: Is the Board sufficiently aware of potential risks to quality	• The Board regularly assesses and understands current and future risks to quality and is taking steps to address them. Risks are aligned to annual and strategic plans. • The Board regularly reviews quality risks in an up-to-date risk register and assurance framework, which has been mapped to the strategic objectives for the Trust. • The strategic risk register is supported and fed by quality issues captured in locality/ service risk registers – there is a process of escalation in place for 'red' rated risks on the clinical service risk registers to be considered for inclusion on the strategic risk register. • The risk register covers potential future external risks to quality [e.g. new techniques/ technologies, competitive landscape, demographics, policy change, funding, regulatory landscape] as well as internal risks – risks are aligned to the annual planning process, which looks at external risks. • There is clear evidence of action to mitigate risks to quality – actions	**GREEN**	Potential strategic risks have been identified as part of the development of the strategic plan 2014/19. These are currently being modelled and will be added to the strategic risk register for discussion at the September 2014 Board of Directors. *September 2014 Quality Committee agreed that each risk lead would present at the November 2014 meeting of the Quality Committee a description of these potential risks, current controls and assurances, gaps/ mitigating actions required with timeframes.* **Associate Director of Safe Services and Head of Corporate Affairs in partnership with the respective risk leads** **COMPLETED**	Development of a standardised report communication to explicitly correlate information within corporate and locality reports with potential risks to quality. **Associate Director of Safe Services**

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1/ Q2 with update	Further actions for completion by end Q4 2014/15
	on the risk register are monitored by the Safe Services Department. • Proposed initiatives are rated according to their potential impact on quality [e.g. clinical staff cuts would likely receive a high risk assessment] – there is an impact assessment in place for new service developments, which incorporates risk. • There is an appropriate mechanism in place for capturing frontline staff concerns. • Quality measures monitored before and after implementation through quality impact assessments.			
2. Capabilities and culture				
2a: Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	• The Board is assured that quality governance is subject to rigorous challenge, including full NED engagement and review – NEDs chair Quality Committee and Audit Committee. • Board development programme in place. • Board seminars in place which allow time to debate issues on quality and assurance. • Board members have attended training sessions covering the core elements of quality governance and continuous improvement.	**GREEN**	None.	Board seminar to be scoped and delivered [February 2015] as a follow up to the new clinical and professional leadership structure implemented 2013/14 to ensure capacity and effectiveness in relation to ensuring well-led services. **Medical Director [Effectiveness & Medical Workforce]/ Director of Nursing, Therapies & Patient Partnership/ Head of Corporate Affairs**

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1/ Q2 with update	Further actions for completion by end Q4 2014/15
2b: Does the Board promote a quality focused culture throughout the Trust?	• Quality Committee chaired by NED, attendance by Executive team and other NEDs. • The Board takes a proactive approach to improving quality [e.g. it actively seeks to apply lessons learnt in other Trusts and external organisations]. • The Board regularly commits resources [time and money] to delivering quality initiatives –e.g. QIPP agenda discussions, zero harm continuous improvement cultural programme. • The Board is actively engaged in the delivery of quality improvement initiatives [e.g. some initiatives led personally by Board members]. CQUIN monies reinvested into QIPP and continuous quality improvement programmes. • NED involvement in compliance visit schedule. • Staff are encouraged to participate in quality/ continuous improvement training and development – the Trust has reviewed its mandatory training underpinned by patient safety following Berwick review and also the zero harm implementation plan is underpinned by a learning and development programme. • Staff feel comfortable reporting harm and errors [these are seen as the basis for learning, rather than	**GREEN**	Patient safety cultural assessments to be rolled out during quarters 2 and 3 at ward and team levels to inform baseline in order to demonstrate shift of culture during way points of the zero harm continuous improvement cultural programme. *Organisational baselines have been scoped using the current and previous NHS staff surveys and incident reporting associated questions. Appropriate cultural assessments will be scoped and implemented as per ongoing Zero Harm implementation plan.* **Safe Services Department supported by zero harm 'culture carriers' in partnership with ward and team managers** **IN PROGRESS**	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1/ Q2 with update	Further actions for completion by end Q4 2014/15
	punishment] –positive feedback from staff survey, which is reviewed at Operational Board level and National Reporting and Learning System data stating that CWP reports incidents in line with other Trusts in its benchmarked cluster. • Staff are entrusted with delivering the quality improvement initiatives they have identified [and held to account for delivery – link to annual and strategic plans]. • Internal communications [e.g. monthly newsletter, intranet, notice boards] regularly feature articles on quality – quarterly quality report, three times per year learning from experience report.			
3. Structures and processes				
3a: Are there clear roles and accountabilities in relation to quality governance?	• Each and every Board member understands their ultimate accountability for quality – discussed at Board seminars and as part of the self assessment process and signed off by Board as part of the Annual Governance Statement. • The governance structure is in place within the Trust with committees/ sub committees with clear terms of reference, outlining roles and responsibilities in relation to quality. • Quality is a core part of main Board	**GREEN**	Action identified following governance workshop for localities to draw up a forward plan to include what help and support is needed to help the new clinical and professional structure deliver on their roles and accountabilities in relation to quality governance. This will inform the development of a "good governance" framework as a resource tool for localities. *See action identified for quality area 2a.*	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1/ Q2 with update	Further actions for completion by end Q4 2014/15
	meetings, both as a standard agenda item and as an integrated element of all major discussions and decisions. • Quality performance is discussed in more detail each month by a quality focused Board sub committee. Quality Committee meets every two months but any issues requiring discussion in relation to quality are brought to Operational Board which meets monthly.		**Clinical Directors – locality and specialty, Service Directors, General Managers supported by Safe Services Department senior managers** **IN PROGRESS**	
3b: Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	• Boards are clear about the processes for escalating quality performance issues to the Board – performance dashboard in place. • Process for escalation of risks to the Board is outlined in Integrated Governance Strategy. • Process for escalation of incidents to Board is outlined in Incident reporting and management policy – level 3 incidents reported to Board and actions followed up by Quality Committee. • Robust action plans are put in place to address quality performance issues [e.g. including issues arising from serious untoward incidents and complaints] – monitored by Compliance, Assurance and Learning Sub Committee. • Lessons from quality performance	**GREEN**	Performance management systems to be further reviewed and plans identified to strengthen. *Corporate reporting format has been reviewed and is now via a CWP performance dashboard, including locality key performance indicators. Terms of reference have been developed for the performance reviews to integrate the process into the formal governance structures of the Trust.* **Associate Director of Performance and Redesign** **COMPLETED**	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1/ Q2 with update	Further actions for completion by end Q4 2014/15
	issues are well-documented and shared across the Trust on a regular, timely basis - communicated via lessons learned publication and learning from experience report. • There is a proactive clinical audit programme in place aligned to national audit priorities, contractual requirements and quality priorities identified by the Trust. • There is also scope for undertaken reactive audits/ re-audits linked to risks. • There is an internal audit programme in place, which links to quality. • An error reporting process is defined and communicated to staff.			
3c: Does the Board actively engage patients, staff and other key stakeholders on quality?	• Quality outcomes are made public [and accessible] regularly, and include objective coverage of both good and poor performance – quality report and learning from experience report presented to public Board. Inpatient safety metrics results presented on all inpatient wards for staff/ patients/ visitors to see. • The Board actively engages patients on quality, e.g. - Patient feedback is actively solicited, made easy to give and based on validated tools, e.g. surveys, patient stories,	**GREEN**	The Trust has signed up to the Care Connect pilot which is a platform for patients' active engagement in relation to sharing of experiences, asking questions and reporting problems. An implementation plan needs to be developed for this pilot. *The national project has passed from the NHS Information Centre to NHS England. The Care Connect helpdesk is not yet in a position to add new Trusts to the system because they are still*	Appointment of an Associate Director of Patient & Carer Experience to strengthen engagement of patients and other stakeholders, including carers, on quality. **Director of Nursing, Therapies & Patient Partnership**

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1/ Q2 with update	Further actions for completion by end Q4 2014/15
	video diaries, PALS, real time patient experience. - Patient views are proactively sought during the design of new pathways and processes - via surveys/ focus groups, attendance at annual planning events. - All patient feedback is reviewed on an ongoing basis, with summary reports reviewed regularly by the Board –learning from experience report looks at patient feedback via PALS/ complaints. - The Board regularly reviews and interrogates complaints and serious untoward incident data –via the learning from experience report quarterly and standing agenda items reviewing SUIs/ complaints. - The Board uses a range of approaches to 'bring patients into the Board room', e.g. patient stories. • Staff are encouraged to provide feedback on an ongoing basis, as well as through specific mechanisms – staff blog, annual staff survey, training feedback. • The Board actively engages all other key stakeholders on quality, e.g.		*reviewing the programme as part of a wider review of programmes that has been instigated by the new Chief Executive. Action therefore suspended and will be re-instated through monitoring via the Zero Harm implementation plan.* **Associate Director of Safe Services, Associate Director of Effective Services, Head of Clinical Governance, Head of Communications and Involvement** **COMPLETED**	

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1/ Q2 with update	Further actions for completion by end Q4 2014/15
	- Quality performance is clearly communicated to commissioners to enable them to make educated decisions via contract meetings, reports. - Feedback from PALS and local Healthwatch organisations is considered - Healthwatch commentary on quality accounts, feedback from annual planning events, consultations on new service developments etc., PALS talkback. - For care pathways involving GP and community care, discussions are held with all providers to identify potential issues and ensure overall quality along the pathway - Trust working with clinical commissioning groups and via clinical networks. - The Board is clear about Governors' involvement in quality governance – with meetings structure in place. • Public consultation sought on service changes identified as part of annual and strategic planning priorities.			
4. Measurement				
4a: Is appropriate quality information being analysed and	• The Board reviews a monthly 'dashboard' of metrics outlined within the performance dashboard.	**GREEN**	None.	Development of locality data packs as a maturation of the Trust's approach to

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1/ Q2 with update	Further actions for completion by end Q4 2014/15
challenged?	• The Quality Committee reviews quality and safety metrics displayed in a quality dashboard. • Quality information can be analysed and challenged at the individual team level – as part of CAREnotes reporting and data quality/ control. • External assessment/ data delves take place as part of Quality Account auditing and external and internal audit programmes.			continuous quality improvement and quality reporting. These will amalgamate the qualitative information from the current quality dashboard with a number of other qualitative data items such as CQC mental health intelligence information, the mental health minimum data set and service specific indicators. This will strengthen the reporting of trends in relation to quality improvement and quality assurance and strengthen challenge by the Quality Committee. **Safe Services Department/ Performance & Redesign Team**
4b: Is the Board assured of the robustness of the quality information?	• There are clearly documented, robust controls to assure ongoing information accuracy, validity and comprehensiveness: - Roles and responsibilities in relation to data quality are outlined within the Trust's Data Quality Policy. - Assurance on data quality given to Board via Information Governance Toolkit scores and	**GREEN**	Review of assurance processes within the performance and information function to scope the extent of any residual organisational risks in relation to the robustness of quality information associated with data sources – due to manual checks of data sourced for the NHS Benchmarking Network's voluntary participation in the 2013/14 Mental Health	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1/ Q2 with update	Further actions for completion by end Q4 2014/15
	independent review of Quality Account. - Clinical audit programme driven by national audits, with processes for initiating additional audits as a result of identification of local risks [e.g. incidents]. - Electronic systems are used where possible, generating reliable reports with minimal ongoing effort. - Information can be traced to source and is signed off by owners – gate keeping process in place within the Trust. • There is clear evidence of action to resolve audit concerns: - Action plans are completed from audit [and subject to regular follow-up reviews] – Trustwide action plans monitored by Compliance, Assurance and Learning Sub Committee. - Re-audits are undertaken to assess performance improvement.		Benchmarking exercise [adult and community mental health services]. Outcome will inform self-assessment RAG rating for quarter 2. *A data quality improvement framework [for better quality data and business intelligence] has been approved by the Operational Board, October 2014. The current corporate assurance framework identifies further assurance being sought of the robustness of quality information. An implementation plan is being requested to assure the Board of Directors [as part of its duties to monitor via the quarterly Monitor quality governance framework self-assessment] that the required systems, processes, competencies and gatekeeping arrangements are in place to operationalise the framework.* **Associate Director of Performance & Redesign, Acting Head of Performance & Information and Acting Senior Information Analyst supported by Medical Director for Quality, Associate Director of Safe Services and Head of**	

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1/ Q2 with update	Further actions for completion by end Q4 2014/15
			Compliance. **IN PROGRESS**	
4c: Is quality information being used effectively?	• Information in quality reports is displayed clearly and consistently – ongoing development of performance dashboard and quality dashboards. • Information is compared with target levels of performance [in conjunction with a R/A/G rating], historic own performance and external benchmarks [where available and helpful]. • Information being reviewed is the most recent available, and recent enough to be relevant. • 'On demand' data is available/ sought for the highest priority metrics. • The Trust is able to demonstrate how reviewing information has resulted in actions which have successfully improved quality performance, e.g. inpatient safety metrics and care bundles continue to demonstrate sustained improvements.	**GREEN**	Development of a "document of understanding" defining the roles, responsibilities and expectations across teams in relation to data provision to support the subsequent effective use of quality information. This will be achieved by the development of a data set owned and used at ward and team level to enhance the management of their day to day business. September 2014 meeting of the Quality Committee will consider. *Quality Committee agreed the above at its January 2015 meeting. The operational roll out of locality data packs is scheduled for February 2015, see action identified for quality area 2a.* **Quality Surveillance Support Managers in partnership with service and clinical leads** **IN PROGRESS**	No further actions.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/15/101)

Report to:	**Board of Directors**
Date of Meeting:	**28 January 2015**
Report:	**Monitor Quarter 3 Submission**
Action sought:	**FOR DISCUSSION & APPROVAL**
Author:	**Neil Griffiths, Acting Head of Performance and Information** **David Wood, Associate Director of Safe Services** **Andy Harland, Deputy Director of Finance** **Louise Brereton, Head of Corporate Affairs** **Jo Watts, Head of Compliance**
Presented by:	**Tim Welch, Director of Finance**

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

Distribution

Version	Name(s)/Group(s)	Date Issued
1	Neil Griffiths to David Wood, Jo Watts, Louise Brereton, Andy Harland	2 January 2015
2	Neil Griffiths to Mandy Skelding-Jones	16 January 2015

Executive director sign-off

Executive director (name and title)	Date signed-off
Tim Welch, Director of Finance/Deputy Chief Executive	21 January 2015

1. Purpose of the report

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

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

2. Summary

Monitor's *Risk Assessment Framework (updated April 2014)* (URL appended as appendix 1) sets out the approach Monitor will take to assess the compliance of NHS foundation trusts and to intervene where necessary. Monitor uses NHS foundation trusts' annual plans, in-year submissions and relevant third party reports to assign risk ratings for finance and governance.

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

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

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

- **For finance, that:** The Board anticipates that the Trust will continue to maintain a Continuity of Services Risk Rating of at least 3 over the next 12 months. **(One declaration required.)**

- **For governance, that:** The Board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards. **(Two declarations required.)**

- **Otherwise:** The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per Risk Assessment Framework page 21, Diagram 6) which have not already been reported. **(One declaration required.)**

3. Discussion

In relation to the Quality Governance Framework statement, in order to support the declaration made, the Board is asked to note the proposed quality standards rating – the evidence used to support this self assessment and also the areas for further development are detailed in the paper to Board entitled "*Monitor* Quality Governance Framework – self assessment".

The Board is also asked to note that the Trust has met all Monitor performance targets and that there have been no CQC visits during Quarter 3. There are no outstanding compliance actions for the Trust.

3.1 Finance

The Trust will be reporting an overall Continuity of Service Risk Rating of 4 and intends to sign the Governance Declaration which states 'The Board anticipates that the Trust will continue to maintain a Continuity of Service Risk Rating of at least 3 over the next 12 months'.

3.2 Governance

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

Quality Governance Framework statement

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

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

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

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

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

Strategy		**Q3 2014/15 self-assessment (RAG) rating**
1a	Does quality drive the trust's strategy?	**GREEN**
1b	Is the Board sufficiently aware of potential risks to quality?	**GREEN**
Capabilities and culture		
2a	Does the Board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?	**GREEN**
2b	Does the Board promote a quality-focused culture throughout the Trust?	**GREEN**
Processes and structure		
3a	Are there clear roles and accountabilities in relation to quality governance?	**GREEN**
3b	Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	**GREEN**
3c	Does the Board actively engage patients, staff and other key stakeholders on quality?	**GREEN**
Measurement		
4a	Is appropriate quality information being analysed and	**GREEN**

	challenged?	
4b	Is the Board assured of the robustness of the quality information?	GREEN
4c	Is quality information being used effectively?	GREEN

The RAG rating is explained below:

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

Performance against targets declaration

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

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

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

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

Target	Threshold	Quarter 3 Performance	[Quarter 2]
Care Programme Approach (CPA) follow up within 7 days of discharge	>95%	99.12%	[97.51%]
Care Programme Approach (CPA) formal review within 12 months	>95%	96.0%	[95.6%]
Minimising delayed transfers of care	<=7.5%	1.07%	[0.47%]
Admissions had access to crisis resolution home treatment teams	>95%	98.45%	[98.06%]
Meeting commitment to serve new psychosis cases by early intervention teams	>95%	115.45%	[119.51%]
Data completeness: identifiers	>97%	99.56%	[99.56%]
Data completeness: outcomes	>50%	81.04%	[82.96%]
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	Achieved	[Achieved]
Community care - referral to treatment information	50%	100%	[100%]
Community care - referral information	50%	95.92%	[96.33%]
Community care - activity information	50%	91.59%	[88.51%]
Risk of, or actual, failure to deliver mandatory services	Yes/No	No	[No]
CQC compliance action outstanding (as at 30 June 2014)	Yes/No	No	[No]
CQC enforcement action within last 12 months (up to 30 June 2014)	Yes/No	No	[No]
CQC enforcement notice currently in effect (as at 30 June 2014)	Yes/No	No	[No]

Target	Threshold	Quarter 3 Performance	[Quarter 2]
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at 30 June 2014)	Yes/No	No	[No]
Major CQC concerns or impacts regarding the safety of healthcare provision (as at 30 June 2014)	Yes/No	No	[No]
Trust unable to declare ongoing compliance with minimum standards of CQC registration	Yes/No	No	[No]
Unable to maintain, or certify, a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements	Yes/No	No	[No]

Care Quality Commission

There are no outstanding compliance actions for the Trust.

Results of any elections

Further to the summer election held during Quarter 2, a by-election commenced in Quarter 3 (November 2014) for the remaining 6 seats.

- Public – Out of Area – 1 vacancy
- Service User & Carer – 3 vacancies
- Staff – Nursing – 1 vacancy
- Staff – Medical – 1 vacancy

The election process will conclude in January 2015 and the results will be reported in the Quarter 4 report.

Reports of changes to the Board of Directors or Council of Governors

There have been no changes to the Board of Directors or the Council of Governors during Quarter 3.

4 Recommendations to the Board of Directors

The Board is asked to **consider** and **confirm** its final intention in relation to the Quarter 3 submission to Monitor. If the Board is unable to verify its decision at the Board meeting, the Board should seek further clarification to inform their decision before the actual submission date of 31 January 2015.

5. Appendices

Appendix 1: Monitor's Risk Assessment Framework (published August 2013, updated April 2014)

https://www.gov.uk/government/publications/risk-assessment-framework-raf

Appendix 2: Monitor quarterly submission template

To follow

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/15/102)

Report to:	**Board of Directors**
Date of Meeting:	**28 January 2015**
Title of Report:	**The Forward View into Action and guidance on the 2015/16 annual planning round for NHS foundation trusts**
Action sought:	**To approve**
Author:	**Louise Brereton, Head of Corporate Affairs**
Presented by:	**Tim Welch, Director of Finance**

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

Distribution

Version	Name(s)/Group(s)	Date Issued
1	Operational Board	21 January 2015
2		

Executive director sign-off

Executive director (name and title)	Date signed-off
Tim Welch, Director of Finance	21 January 2015

1. Purpose of the report

To brief the Board of Directors on the documents recently issued by Monitor - 'The forward view into action: planning for 2015/16' and the guidance on the 2015/16 annual planning round.

2. Summary

Monitor issued a new document, 'The forward view into action: planning for 2015/16' in December 2014 outlining the approach for local and national organisations to begin to move towards fulfilling the 5 year Forward View which was issued in October 2014. The 5 Year Forward View highlighted that major system changes are required to protect high quality sustainable care for patients now and into the future. In this context Monitor has two main expectations of foundation trusts:

- To address any performance issues engaging appropriately with health system partners. This means meeting operational and financial requirements and having the flexibility and capacity to overcome unexpected short term difficulties along the way. This is referred to as 'resilience.'

- To put together, deliver and evolve a credible strategy for achieving the required performance levels into the long terms. This is referred to as 'sustainability.'

A further document, 'guidance on the 2015/16 annual planning round for NHS foundation trusts' was issued in late December to provide specific direction on planning expectations.

Monitor is also currently consulting on changes to the risk assessment framework (RAF). This sets out how Monitor assesses risk to the continuity of services and the risk of poor governance.

3. 'The forward view into action: planning for 2015/16'

'The forward view into action: planning for 2015/16' describes the national approach to implementing the 'Forward View' and provides detail on how key areas will be taken forward.

A differentiated national approach and achieving core standards

A differentiated national approach will involve a small number of selected areas and organisations that have already made good progress and are able to respond quickly to introducing new models of care. The goal is to make rapid progress in developing new models of promoting health and wellbeing and providing care that can then be replicated much more easily in future years. There will be further emphasis on achieving core standards as set out in the NHS constitution and an expectation to maximise opportunities through localised planning.

Prevention and engaging patients and communities

The document sets out an approach to creating new relationships with patients and communities. This will involve a renewed approach to prevention via six different approaches to improving health and well-being. Empowering patients through providing more direct control and the first steps towards integrated personalised commissioning is a further area for action. Communities will be engaged via focusing on actions to improve the ways that the NHS engages with communities and citizens and there will be clearer roles for the third and voluntary sector.

New care models

Co-creating new care models are central to the success of the 5 year forward view. Four multi-speciality care models will be developed - multi-speciality community providers (MCPs), integrated primary and acute care systems (PACS), additional approaches to creating viable smaller hospitals and models of enhanced health in care homes. Supporting each model will be a structured programme of support to accelerate change, assess progress and demonstrate proof of concept. An initial cohort of sites will be selected to take these prototypes forward. Expressions of interest from local organisations or areas wishing to become first cohort sites are asked by 2nd February 2015.

To enable these transformational changes to take place, the guidance sets out the need for local, system wide planning encouraging all local areas to develop a shared vision of health and care for

their populations. A new regime will also be implemented to tackle the problems in areas with particular quality and financial challenges. The document also describes a renewed focus on primary care with a new plan for this due in January 2015. Priority is also placed on new care models focussing on urgent and emergency care, maternity, cancer and specialised services.

Key priorities for delivery 2015/16 and enablers

The five year view - planning into action sets out a number of key priorities for delivery in 2015/16 and enablers to make these happen. These are:

- Improving quality and outcomes
- Improving patient safety
- Meeting NHS constitution standards
- Achieving parity for mental health
- Transforming the care for people with learning disabilities

There are a number of enablers to support success of the framework. These include improving information access and transparency, supporting the further development of workforce and harnessing innovation in treatment and diagnostics. There is further emphasis on developing a more productive and efficient NHS by achieving efficiency targets, and identifying areas for further efficiency potential, deploying the recently announced additional government funding and improved joint working between commissioners and providers

4. Risk Assessment Framework (RAF)

The risk assessment framework sets out Monitor's approach to assessing risks to the continuity of services and poor governance. The previous framework uses a number of indicators as possible proxies of governance. In line with government announcements and the direction of travel set out in the 5 Year Forward View to introduce new mental health access standards, it is propose that two further indicators will be included in framework as triggers to governance concerns at mental health trusts. These are:

- Two-week wait for receiving treatment from the early intervention in psychosis (EIP) programme. Providers will be required to treat 50% of patients within two weeks by April 2016.

- Referral-to-treatment target for Improving Access to Psychological Therapies (IAPT). Providers will be required to see 75% of patients within 6 weeks and 95% of patients within 18 weeks from April 2015.

The consultation also proposes potential changes to how continuity of services assessments are made and the potential for identifying a further trigger for identifying financial concern at a trust. This would involve the introduction of an override mechanism to initiate an investigation where a trust's liquidity or capital service capacity represents a significant financial risk, even if the overall continuity of services risk rating is maintained at a 3.

5. Submission of annual plans 2015/16

The five year view: planning into action has been followed up by the publication of the guidance on the 2015/16 annual planning round for NHS foundation trusts.

Requirements for 2015/16 are for the submission of a one year operational plan only, setting out the Trust's vision for delivering resilience and sustainability. This plan should be within the context of the current strategic plan 2014/19.

A draft of the one year operational plan is required by **27th February 2015.**

The draft plan will set out high level financial projections with relevant underlying assumptions. This will be supported by a short narrative setting out the assumptions, the degree of confidence in these, the key drivers to financial performance and resulting performance. The draft plan should also set out the extent of alignment to the plans of main commissioners and any reasons for material variances.

The final plan is due for submission on **10th April 2015.**

The final submission will also be accompanied by two Board declarations - a refreshed declaration of sustainability following on from the strategic plan submission in 2014/15 and a declaration of resilience linked to the provider licence condition 7 around availability of resources. The guidance sets out a clear direction for the need to reflect local priorities for populations and as such, clear alignment with the plans of other organisations in the local health economy must be demonstrated. In order to test this, there will be greater emphasis on triangulation of plans following submission.

The grid below sets out the detail required for the operational plan and the key leads for these areas.

Section	Leads
Strategic context: reviewed strategic context informed by a review of the financial, operational and quality performance of the FT and consideration of the external environment. Pending this analysis, this section should set out whether the Trust is likely to recommit, refresh or recreate the strategy.	Sheena Cumiskey Tim Welch Julie Critchley Claire James David Wood Andy Harland
Progress against strategy delivery: To include: • summary of joint planning by the Trust and LHE partners, • translation of initiatives into goals, outcomes, KIPs and actions to address poor performance. • The Trust's CIP programme, • the capital programme aligned to the strategic agenda and resources and • re-allocations reflecting strategic priorities.	Tim Welch Mandy Skelding-Jones Andy Harland John Loughlin
Plan for short term resilience: Quality priorities: including the Trust's quality goals, any existing quality concerns or future risks to quality.	David Wood
Plan for short term resilience: Operational requirements: an assessment of operational requirements including assessment of physical capacity, workforce, IT and beds, based on expected activity levels • An analysis of the key risks and how the trust will be able to adjust its inputs to match different levels of demand.	Julie Critchley Avril Devaney David Harris John Loughlin Maria Nelligan David Wood
Financial Forecast and narrative to include the impact of : • Financial pressure • Activity • Other key movements • Strategic initiatives	Tim Welch Andy Harland

Further communication will be sent out to key leads regarding the development of the plan. It is anticipated that the key leads identified above will be asked to review their relevant sections of the Operational Plan 2014/16 and review in accordance with the requirements above. The draft final plan will be provided to the Operational Board at the March meeting for comment ahead of submission in April 2015.

4. Recommendations to the Board of Directors

The Board of Directors are asked to approve the approach to 15/16 planning as set out in the report.

5. Appendices

5.1. 5 Year Forward View - http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

5.2. The forward view into action- planning for 2015/16
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/389958/forward-view-plning.pdf

5.3. Guidance on the 2015/16 annual planning review for NHS foundation trusts -
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/390070/APR_guidance_Dec14.pdf

5.4 Consultation on the Risk Assessment Framework -
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/386147/RAF_consultation_Dec_14.pd

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/15/103)

Report to:	**Board of Directors**
Date of Meeting:	**28th January 2015**
Title of Report:	**Fit and Proper Person requirements**
Action sought:	**For note**
Author:	**Louise Brereton, Head of Corporate Affairs**
Presented by:	**Louise Brereton, Head of Corporate Affairs**

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

Distribution

Version	Name(s)/Group(s)	Date Issued
1		
2		

Executive director sign-off

Executive director (name and title)	Date signed-off
Sheena Cumiskey, Chief Executive	20 January 2015

1. Purpose of the report

To inform the Board of Directors of the new Fit and Proper Persons regulations that came into force specifically for NHS bodies from 27th November 2014. The regulations will come into force for all care providers on 1 April 2015.

2. Information

2.1 Fit and proper person requirement for directors

Currently, providers have a general obligation to ensure that they only employ individuals who are fit for their role.

The new fit and proper person requirement for directors will have a wider impact, in both the scope of its application and the nature of the test. It makes it clear that individuals who have authority in organisations that deliver care are responsible for the overall quality and safety of that care and, as such, can be held accountable if standards of care do not meet legal requirements.

It will apply to all directors and "equivalents". This will include executive and non-executive directors of NHS foundation trusts. It will be the responsibility of the chair, to ensure that all directors meet the fitness test and do not meet any of the 'unfit' criteria.

In addition to the usual requirements of good character, health, qualifications, skills and experience, the regulation goes further by barring individuals who are prevented from holding the office (for example, under a directors' disqualification order) and significantly, excluding from office people who: "have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider".

This is a significant restriction. It will enable CQC to decide that a person is not fit to be a director on the basis of any previous misconduct or incompetence in a previous role for a service provider. This would be the case even if the individual was working in a more junior capacity at that time, or working outside England.

Regulation 5 sets out the criteria that a director must meet. They must:

- Be of good character
- Have the qualifications, skills and experience necessary for the relevant position
- Be capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010
- Not have been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider
- Not be prohibited from holding the relevant position under any other law. e.g. under the Companies Act or the Charities Act.

Schedule 4, will introduce the good character and unfit persons test. Under Schedule 4 Part 1, a director will be deemed unfit if they:

- Have been sentenced to imprisonment for three months or more within the last five years, although CQC could remove this bar on application

- Are an undischarged bankrupt
- Are the subject of a bankruptcy order or an interim bankruptcy order
- Have an undischarged arrangement with creditors
- Are included on any barring list preventing them from working with children or vulnerable adults.

Under Schedule 4 Part 2, a director will fail the 'good character' test, if they:

- Have been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence
- Have been erased, removed or struck-off a register of professionals maintained by a regulator of health or social care.

2.2 CQC approach to the fit and proper person requirement for directors

CQC will require the chair of the provider's board of directors to:

- Confirm that the fitness of all new directors has been assessed in line with the regulations.
- Declare in writing that they are satisfied that they are fit and proper individuals for that role.

The CQC may also ask the provider to check the fitness of existing directors and provide the same assurance.

The CQC will cross-check notifications about new directors and will have regard to any other information about directors in line with current legislation on when convictions, bankruptcies or similar matters are to be considered 'spent'. Where a director is associated with serious misconduct or responsibility for failure in a previous role, the CQC will have regard to the seriousness of the failure, how it was managed, and the individual's role within that, there is no time limit for considering such misconduct or responsibility.

If necessary the CQC may use enforcement powers to ensure that all directors are fit and proper for that role, this will normally be done by imposing conditions on the provider's registration to ensure that the provider takes the appropriate action to remove the director.

The changes are included in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which have now been published.

2.3 Proposed approach to the fit and proper persons test

Paragraph 24 and Annex 7 of the Trust's constitution broadly sets out the requirements for Directors of the Trust.

Appendix 1 sets out an overview of the specific requirements of the regulations and how the Trust is currently meeting these and details on any further assurance needed. In addition, all existing Directors will shortly be asked to declare their compliance with the regulations. This declaration will be repeated on an annual basis thereafter. The template for this is included as appendix 2.

3. Recommendations to the Board of Directors

That the Board of Directors approve the approach to meeting the Fit and Proper Persons regulations.

CWP Fit and Proper Persons criteria assessment and assurance - DRAFT January 2015

Ref	Guidance Standard	Current Assurance	Evidence	Further Action/ Assurance	Lead
1.1	Providers should make every effort to ensure that all available information is sought to confirm that the individual is of good character as defined in Schedule 4, Part 2 of the regulations. *Sch.4, Part 2: Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence. Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.)*	Employment checks are undertaken as below: • Two references, one of which must be most recent employer qualification and professional registration checks • Right to work checks • Identity checks • Occupational health clearance • DBS checks	References Other pre-employment checks DBS checks where appropriate	Declarations of fitness by candidates To begin annual search of insolvency and bankruptcy register prior to appointment and annually To begin annual search of disqualified directors register prior to appointment	LH for NEDs HR for EDs
1.2	If a provider discovers information that suggests an individual is not of good character after they have been appointed to a role, the provider must take appropriate and timely action to investigate and rectify the matter.	Disciplinary policy and procedure provides for such investigations. Revised contracts allow for termination in the event of non-compliance with regulations and other	Contracts of employment (for EDs and director-equivalents) Terms and conditions of service agreements (for		

		requirements.	NEDs) Disciplinary policy and procedure		
1.3	Where a provider deems the individual suitable despite not meeting the characteristics outlined in Schedule 4, Part 2 of these regulations, the reasons should be recorded and information about the decision should be made available to those that need to be aware.	This would be the subject of debate at the Nominations Committee of the Board and at the Council of Governors (for NEDs). The minutes would record such decisions. The Chair would take advice from internal and external advisors as appropriate.	Minutes of meetings		
1.4	Where specific qualifications are deemed by the provider as necessary for a role, the provider must make this clear and should only employ those individuals that meet the required specification, including any requirements to be registered with a professional regulator.	This would be set out in the post job description/ person specification HR Pre-employment checks.	Post job description/ Person specification Recruitment policy and procedure	Future recruitment packs to explain about the fit and proper persons test and the consequences of false, inaccurate or incomplete information	
1.5	The provider should have appropriate processes for assessing and checking that the individual holds the required qualifications and has the competence, skills and experience required, (which may include appropriate communication and leaderships skills and a caring and compassionate nature), to undertake the role; these should be followed in all cases and relevant	Pre-employment checks include a candidate's qualifications and employment references. The recruitment process also assesses relevant skills, behaviours and values.	Recruitment policy and procedure and values based recruitment exercises (i.e. observed discussions)		CS

	records kept.				
1.6	The provider may consider that an individual can be appointed to a role based on their qualifications, skills and experience with the expectation that they will develop specific competence to undertake the role within a specified timeframe.	This would be decided by the Nominations Committee of the Board for an Executive Director and the Council of Governors for Non-Executive Directress and this would be recorded in the minutes. Actions would be subject to follow-up as part of ongoing review and appraisal.	NED appraisals ED appraisals		
1.7	When appointing relevant individuals the provider has processes for considering a person's physical and mental health in line with the requirements of the role.	All post-holders are subject to clearance by occupational health as part of the pre-employment process.	Occupational health clearance		
1.8	Wherever possible, reasonable adjustments are made in order that an individual can carry out the role.	This is already included in the Trust's disability policy.	Disability policy		
1.9	The provider has processes in place to assure itself that the individual has not been at any time responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases.	This has been incorporated as a specific declaration as part of the pre-employment process. It is also incorporated into a revised reference request template for all director and director-equivalent posts.	NED Recruitment Information pack Pre-employment declaration Reference Request for ED/NED	Annual declaration for all existing Board members to commence Jan 2015	LH

	"Responsible for, contributed to or facilitated" means that there is evidence that a person has intentionally or through neglect behaved in a manner which would be considered to be or would have led to serious misconduct or mismanagement. "Privy to" means that there is evidence that a person was aware of serious misconduct or mismanagement but did not take the appropriate action to ensure it was addressed. "Serious misconduct or mismanagement" means behaviour that would constitute a breach of any legislation/enactment CQC deems relevant to meeting these regulations or their component parts.")				
1.10	The provider must not appoint any individual who has been responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement (whether lawful or not) in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases.	This has been incorporated as a specific declaration as part of the pre-employment process.	NED Recruitment Information pack Reference Request for ED/NED	To include in reference requests for all director and director-equivalent posts	LH for NEDs HR for EDs
1.11	Only individuals who will be acting in a role that falls within the definition of a "regulated activity" as defined by the Safeguarding Vulnerable Groups Act 2006 will be eligible for a check by the Disclosure and Barring Service (DBS).	DBS checks are undertaken for all Executive Director posts	DBS checks undertaken for EDs and NEDs and are repeated on a 3 year cycle		

	CQC recognises that it may not always be possible for providers to access a DBS check as an individual may not be eligible.)				
1.12	As part of the recruitment/appointment process, providers should establish whether the individual is on a relevant barring list.	DBS checks will be undertaken for every recruitment/ appointment process	DBS policy		
1.13	The fitness of directors is regularly reviewed by the provider to ensure that they remain fit for the role they are in; the provider should determine how often fitness must be reviewed based on the assessed risk to business delivery and/or the service users posed by the individual and/or role.	Post-holders undertake annual declarations of fitness to continue in post.	Annual declaration NED appraisal process ED appraisal process	Annual checks of insolvency and bankruptcy register and register of disqualified directors to be undertaken each year	
1.14	The provider has arrangements in place to respond to concerns about a person's fitness after they are appointed to a role, identified by itself or others, and these are adhered to.	The disciplinary policy provides these arrangements. EDs and director-equivalents) and agreements (for NEDs) incorporate maintenance of fitness as a contractual requirement.	Disciplinary policy and procedures ED contracts of employment NED terms and conditions of appointment agreement	Need to consider the potential need for an appeals policy	CS
1.15	The provider investigates, in a timely manner, any concerns about a person's fitness or ability to carry out their duties, and where concerns are substantiated, proportionate, timely action is taken; the provider must demonstrate due diligence in all actions.	This will be undertaken if concerns are identified Contracts provide for termination if individuals fail to meet necessary standards.	ED contracts of employment NED terms and conditions of appointment agreement		
1.16	Where a person's fitness to carry out their role is being investigated, appropriate interim measures	This would be reviewed when concerns are identified.	Disciplinary policy and procedures		

	may be required to minimise any risk to service users.				
1.17	The provider informs others as appropriate about concerns/findings relating to a person's fitness; for example, professional regulators, CQC and other relevant bodies, and supports any related enquiries/investigations carried out by others.	Action would be taken if any concerns were identified.	Referrals made to other agencies		

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Fit and Proper Person Declaration

In line with the requirement for Directors of an NHS Foundation Trust to be a fit and proper person, I hereby declare;

Declaration	**Confirmed (yes/no**
I am of good character by virtue of the following:	
• I have not been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence	
• I have not been erased, removed or struck-off a register of professionals maintained by a regulator of health or social care.	
• I have not been sentenced to imprisonment for three months or more within the last five years	
• I am not an undischarged bankrupt	
• I am not the subject of a bankruptcy order or an interim bankruptcy order	
• I do not have an undischarged arrangement with creditors	
• I am not included on any barring list preventing them from working with children or vulnerable adults	
I have the qualifications, skills and experience necessary for the position I hold on the Board	
I am capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010	
I have not been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider	
I am not prohibited from holding the relevant position under any other law. e.g. under the Companies Act or the Charities Act.	

Signed	
Name	
Position	
Date	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document Reference (2014/15/104)

Report to:	**Board Of Directors**
Date of Meeting:	**28th January 2015**
Title of Report:	**CQC Registered locations & updated Statement of Purpose**
Action sought:	**FOR APPROVAL**
Author:	**Jo Watts, Head of Compliance**
Presented by:	**Anushta Sivananthan, Medical Director**

Strategic Objective(s) that this report covers *(delete as appropriate):*
SO1 - Deliver high quality, integrated and innovative services that improve outcomes
SO4 - Maintain and develop robust partnerships with existing and potential new stakeholders

Distribution

Version	Name(s)/Group(s)	Date Issued
1	J Watts to A Sivananthan	13.01.2015
2	J Watts to L Brereton	19.01.2015

Executive director sign-off

Executive director (name and title)	Date signed-off
A Sivananthan, Medical Director	15.01.2015

1. Purpose of the report

This purpose of this report is to seek approval from the Board of Directors to update the Trust's Care Quality Commission (CQC) registration document including the Trust's Statement of Purpose.

2. Background

The CQC require the Trust to accurately register services provided and to ensure that when any changes occur the CQC are informed. Upon review of the Trust's certificate of registration and in anticipation of our Trustwide inspection in June 2015, the Statement of Purpose has been updated to reflect changes since our last Trust Certificate was provided in October 2013.

3. Subject matter/content

A number of changes have taken place within the Trust since the last update to the CQC in October 2013, including changes to the Trust Head Quarters address, the removal of Kent House inpatient unit, the implementation of the 6c's values and some management changes. As such the Statement of Purpose has been updated to reflect such amendments.

4. Discussion/conclusion

Following feedback and approval from the Board, the relevant applications will be made to the CQC to amend, remove and add locations as appropriate. An updated Certificate will be issued to the Trust and the CQC website updated accordingly.

5. Recommendations to the Board of Directors

To approve the attached Statement of Purpose and agree for amendments to be made with the CQC registration.

6. References

CQC – Statement of Purpose - 20120618: 100456: v 2.00 1

7. Appendices (preferably URLs)

CWP statement of purpose revised Janu