NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Meeting of the Trust Board of Directors held in Public
1.00pm on Wednesday 30 January 2019
Boardroom, Redesmere

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/111	Apologies for absence	Receive apologies	Verbal	Chair	1.00pm (2 mins)
18/19/112	Declarations of Interest	Identify and avoid conflicts of interest	Verbal	Chair	1.02pm (2 mins)
18/19/113	Meeting Guidelines	To note	Paper	Chair	1.04pm (1 mins)
18/19/114	Minutes of the previous meeting held on 28 November 2018	Confirm as an accurate record the minutes of the previous meetings	Paper	Chair	1.05pm (3 mins)
18/19/115	Matters arising and action points	Provide an update in respect of ongoing and outstanding items to ensure progress	Paper	Chair	1.08pm (5 mins)
18/19/116	Board Meeting Business Cycle 2018/19	To note	Paper	Chair	1.13pm (2 mins)
18/19/117	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1.15 (10 mins)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/118	Chief Executive's announcements *(including overview of items discussed in closed meeting)*	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	**1.25pm (20 mins)**
Strategic Change					
18/19/119	Adult & Older People's Specialist Mental Health Redesign: East/South Cheshire/Vale Royal	To note the report	Paper	Director of Operations	**1.45pm (10 mins)**
Quality of Care/ Quality Improvement					
18/19/120	Suicide Prevention Strategy	To approve strategy	Presentation	Director of Nursing, Therapies and Patient Partnership	**1.55pm (25 mins)**
18/19/121	Six monthly ward staffing report	To approve report	Paper	Director of Nursing, Therapies and Patient Partnership	**2.20pm (15 mins)**
18/19/122	Monthly Ward Staffing Up-date November and December 2018	To note	Paper	Director of Nursing, Therapies and Patient Partnership	**2.35pm (5 mins)**
18/19/123	Developing Workforce Safeguards: CWP position statement	To approve response to recommendations	Paper	Director of Nursing, Therapies and Patient Partnership	**2.40pm (10 mins)**
18/19/124	PLACE 2018/19 report	To note report	Paper	Director of Operations	**2.50pm (10 mins)**

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
Operational Performance, Finance and Use of Resources					
18/19/125	Operational Plan / Board Performance Dashboard	To note performance	Paper	Director of Finance	**3.00pm (10 mins)**
Well-led (leadership and quality improvement capability)					
18/19/126	Strategic Risk Register and Board Assurance Framework	To note assurance framework	Paper	Medical Director	**3.10pm (10 mins)**
18/19/127	Learning from Experience Executive Summary (Trimester 2, 2018/19)	To note report	Paper	Director of Nursing, Therapies and Patient Partnership	**3.20pm (10 mins)**
18/19/128	Quality Improvement Report (Ed 2 208/19)	To note report	Paper	Medical Director	**3.30pm (10 mins)**
18/19/129	CQC statement of purpose	To undertake annual review and approve	Paper	Medical Director	**3.40pm (5 mins)**
Governance and Regulation (Assurance and escalation reports from Board Sub-committees (discussion by exception only))					
18/19/130	Chair's Report of the Quality Committee held on 9 January 2019	Review Chair's Report and any matters for note/ escalation	Paper	Chair of Quality Committee	**3.45pm (5 mins)**

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/131	Chair's Report of the Audit Committee held on 15 January 2019	Review Chair's Report and any matters for note/ escalation	Paper	Chair of Audit Committee	**3.50pm (5 mins)**
Closing Business					
18/19/132	Any other business	Consider any urgent items of other business	Verbal	Chair	**3.55pm (3 mins)**
18/19/133	Questions from observers or members of the public. *(relating to specific items on the agenda)*	To encourage openness and transparency	Verbal	Chair	**3.58pm (5 mins)**
18/19/134	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair/ All	**4.03pm (2 mins)**
18/19/135	Key messages for communication	Agree items of particular importance to communicate to staff, governors or other key stakeholders	Verbal	Chair	**4.05pm (2 mins)**
18/19/136	Review of meeting performance	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair/All	**4.07pm (2 mins)**
18/19/137	Date, time and place of next meeting: **Wednesday 27 February 2019 Sycamore House**	Confirm arrangements for next meeting	Verbal	Chair	**4.09pm (1 min)**

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting Attendees' Guidance, January 2016

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

Before the meeting

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

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

At the meeting

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

Attendance

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

After the meeting

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

Standards

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

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

Cheshire and Wirral Partnership NHS Foundation Trust

DRAFT Minutes of the Open Board of Directors Meeting
Wednesday 28th November 2018
Boardroom Redesmere - commencing at 1.30p.m.

PRESENT	Mike Maier	Chair
	Sheena Cumiskey	Chief Executive
	Dr Faouzi Alam	Medical Director, Effectiveness, Medical Education and Medical Workforce & Caldicott Guardian
	Avril Devaney	Director of Nursing, Therapies and Patient Partnership
	David Harris	Director of People Services and Organisational Development
	Dr Anushta Sivananthan	Medical Director, Quality, Compliance and Assurance
	Andy Styring	Director of Operations
	Tim Welch	Director of Finance
	Rebecca Burke-Sharples	Non-Executive Director
	Andrea Campbell	Non-Executive Director
	Lucy Crumplin	Non-Executive Director
	Edward Jenner	Non-Executive Director
	Dr James O'Connor	Non-Executive Director
	Ann Pennell	Non-Executive Director – *left 3pm*
IN ATTENDANCE	Suzanne Christopher	Corporate Affairs Manager (mins)
	Suzanne Edwards (item 18/19/92)	Associate Director of Neighbourhood and Specialist Mental Health
	Justin Pidcock (item 18/19/92)	Associate Director Estates and Facilities
	Cathy Walsh (items 18/19/93 & 18/19/94)	Associate Director of Patient and Carer Experience
	Dr Ian Davidson (item 18/19/96)	Consultant Psychiatrist, Quality Lead for CWP and NHSE/I Clinical Advisor
	Clare Haydon (item 18/19/96)	Consultant Occupational Therapist for CWP and NHSE/I Clinical Advisor
	Fiona Couper (item 18/19/97)	Chief Pharmacist
APOLOGIES	Gemma Caprio	Interim Head of Corporate Affairs

	MINUTES	**ACTION**
18/19/84	**APOLOGIES AND ABSENCE** The Chair welcomed all to the meeting. The meeting was quorate. Apologies were noted as above. The Chair welcomed Caroline Williams, Bridgewater NHS and Peter Ashley-Mudie, CWP Service User / Carer Governor to the meeting.	
18/19/85	**DECLARATIONS OF INTEREST** None were declared.	

18/19/86	**MEETING GUIDELINES** The meeting guidelines were noted.	
18/19/87	**MINUTES OF PREVIOUS MEETINGS** Agenda item 18/19/64 – comment related more to cross cover arrangements within the team. The minutes of the Open board meeting held on the **28 September 2018** were **approved** as a correct record.	
18/19/88	**MATTERS ARISING AND ACTION POINTS** The action schedule was reviewed as follows:- Actions 18/19/69 & 18/19/72 – the CQC feedback, social work landscape and further equality and diversity training have been added to the Board Development Plan. Agreed actions could be closed.	
18/19/89	**BOARD MEETING BUSINESS CYCLE 2018/19** The Board of Directors **noted** the report.	
18/19/90	**CHAIR'S ANNOUNCEMENTS** The Chair gave the following announcements: **Big Book of Best Practice Event** Early in October the Trust held its Big Book of Best Practice Event in Ellesmere Port. The event was a great success. Ellesmere Port MP, Justin Madders and Arlo King, a CWP Governor also presented at the event. Arlo gave a fascinating personal reflection. **CWP Life** CWP Life is now published and includes a section on the QI strategy and the Big Book of Best Practice Event, as well as a patient story. This is available on the Trust website. **World Mental Health Day 2018** This was held on the 10 October. A number of events were held leading up to and during the event. Winsford CAMHS staff and service users performed a special rendition of "This is Me" from The Greatest Showman which is available to view via the CWP website. **Avril Devaney goes to Number 10** Avril attended an event at Number 10 Downing Street, also related to World Mental Health Day. This event formed part of the government's programme surrounding the inaugural Global Summit of Mental Health. Avril commented that the day was very enjoyable and that Teresa May restated her ongoing commitment to mental health.	
18/19/91	**CHIEF EXECUTIVE ANNOUNCEMENTS** The Chief Executive provided the following summary of the discussions held during closed board:-	

	Board Members: • Considered the operational pressures in services and the response to understand the causes, how to best mitigate the pressure and support front-line staff. Board thanked staff for all their efforts. • Received an update on integration of care and the future way forward, taking a population based approach, person-centred approach. • Considered how to improve care for people with dual diagnosis of mental health and substance misuse. • Considered unwanted variation and ways to improve productivity • Received an update on place based work in Cheshire East • Received an update on the implementation of the CWP forward view • Considered payroll provision • Received assurance that CWP remain on track to deliver the financial plan despite the impact on this from current operational pressures.	
18/19/92	**ADULT & OLDER PEOPLE'S SPECIALIST MENTAL HEALTH REDESIGN: EAST/SOUTH CHESHIRE/ VALE ROYAL** Suzanne Edwards (Associate Director of Neighbourhood and Specialist Mental Health) and Justin Pidcock (Associate Director Estates and Facilities) joined the meeting and introduced the item. A presentation was provided to outline the process to-date, key milestones of the consultation process, and the next steps. From March this year a number of consultation events were held. From August to October a decision-making business case was drafted by the CCG's that considered all the feedback from the consultation. The proposals have been scrutinised on a number of levels, including a review of the proposed clinical model. The decision making business case was published on 15th November 2018. A number of options had been considered by the CCG's: Option 1 – do nothing or minimum Option 3 – looking at older peoples services moving to Chester and adult services remaining in Macclesfield. Option 2 – the preferred option in the consultation - improved community services, 22 beds for older adults in lime walk house. 25 acute beds within Bowmere and 3 beds at Springview to increase capacity for adult acute care. Crisis provision would include 6 crisis beds. The CCG having considered the feedback from the consultation process, undertook conscientious consideration as to how option 2 could be improved particularly responding to the concerns about additional travel for acute adult and inpatient services. Therefore, Option 2 plus was formulated to respond to direct feedback of the consultation and also to some of the suggestions and questions raised by the general public. Option 2 plus as well as investing in enhanced community and crisis services across Central and Eastern Cheshire re-provides the majority of adult and older people's beds in purpose designed accommodation in Macclesfield.	

	The presentation provided an overview of option 2 plus, the geography involved and where service provision would move from and to. The Board were appraised with regards to the further consultation process that will take place over the next four weeks with regards to the proposed complex rehabilitation services. It was confirmed that teams are fully engaged with the process and wish to see the plans move forward and reach a conclusion. The team were thanked for all their efforts in taking this work forward. *Suzanne Edwards and Justin Pidcock left the meeting.*	
18/19/93	**LIVED EXPEREINCE CONNECTOR TRAINING REFRESHER** Cathy Walsh (Associate Director of Patient and Carer Experience) joined the meeting and introduced the item. It was confirmed that each Board Member is now linked with a Lived Experience Connector and have held at least one meeting to date. The presentation provided an overview of the role and the purpose of the meetings with Board Members. The presentation also clearly outlined the boundaries that need to be set for such meetings and what is not intended for these sessions. Board Members were encouraged to provide feedback to Cathy Walsh which could be used anonymously to help plan for the future and help CWP to continue to support Lived Experience Connectors. The Lived Experience Connectors have fed back that they found Board Members showed a genuine interest, they felt listened to, valued and it was a good use of their time. M Maier advised that the NEDs would be holding a meeting to consider the process to date and their feedback. Cathy Walsh was invited to join the NEDs. Support was requested from Cathy Walsh's team in regards to the logistics of arranging meeting rooms etc. Feedback was provided by the Executives and the NED's that the process had been positive. It challenged the way Board Members thought, provided clear learning for the Trust, delivered a real insight to that person's experience of living with a condition, as well as their perception about the care they receive. Illness should not define a person; it is a small part of who they are. The Board of Directors **noted** the presentation.	
18/19/94	**CQC COMMUNITY MENATLH HEALTH SURVEY** Cathy Walsh (Associate Director of Patient and Carer Experience) introduced the item providing a presentation in regard to the Community Mental Health Survey – CQC Report.	

	The results of the survey were published on 22nd November 2018. CQC uses ratings called 'the expected range'. The highest rating awarded was 'better than expected', which went to four trusts, one of which was CWP. The results of the survey highlight three key areas for CWP to focus on going forward – reviewing care, changes in who people see and crisis care. Board Members considered and discussed the results. Largely these were very positive and consistent with areas we are aware we would like to improve. S Cumiskey advised that the Trust had received a letter of thanks from Paul Lelliott which acknowledges the favourable performance of CWP and he will advise NHSI of the positive results. **ACTION** – Communication team to publicise the results. It was commented that today's presentations had clearly demonstrated how well CWP was performing in challenging times with limited resources. The Board of Directors **noted** the presentation.	**Katherine Wright**
18/19/95	**MONTHLY STAFFING WARD UPDATE – SEPTEMBER AND OCTOBER 2018** A Devaney introduced the item. Data was provided for the period September to October 2018. In both months 90% cover was achieved. Where a 100% fill rate was not achieved, wards were kept safe with other mitigating actions such as relocation of staff. S Cumiskey noted the change regarding Greenways Staffing. It was confirmed that this related to a particular challenge faced by Greenways. Specific actions had been put in place to address the issues. There is now an improved picture. The Board of Directors **noted** the report.	
18/19/96	**BED HUB PRESENTATION – *Focus on whole system flow to eliminate mental health acute out of area – the national programme.*** Dr Ian Davidson (Consultant Psychiatrist, Quality Lead for CWP and NHSE/I Clinical Advisor) and Clair Haydon (Consultant Occupational Therapist for CWP and NHSE/I Clinical Advisor) joined the meeting. Both Dr Davidson and Clair Haydon were asked to work on the national team to share the experiences about the development of the Acute Care pathway in CWP, to work towards the elimination of acute out of area placements, to act as a critical friend to other STPs nationally and to share learning and best practice from around the country in relation to the elimination of acute out of area placements. The presentation described the work undertaken and the common themes that emerged including workforce issues, financial pressures, service / management restructures, integrated working with all stakeholders and	

	infrastructure issues. It was also apparent that there was a much larger systems issue. CWP's Principles of Bed Flow has been adapted by NHSE. Data was presented that compared CWP performance to other Trusts nationally. Much of this data showed that CWP had performed exceptionally well: for example, CWP were one of the 3 Trusts out of 57 to have no out of area placements between September 2017 and August 2018. This is especially significant given the geography that CWP work in. The interdependency on good quality community services was also discussed to avoid hospital admissions and the use of red2green processes to optimise patient flow. A number of reflective comments were made by Board Members and the achievements of CWP were again noted despite operating in challenging times with limited resources. Board Members commented that the QI agenda is all about continual improvements. It was suggested that consideration should be given to presenting this to our local commissioners to demonstrate the care CWP is providing and how well we provide it. The Board of Directors **noted** the presentation. *Dr Ian Davidson and Clair Haydon left the meeting.*	
18/19/97	**HEALTHCARE WORKER FLU VACCINATION BEST PRACTICE MANAGEMENT CHECKLIST** Fiona Couper (Chief Pharmacist) joined the meeting and introduced the item. F Couper advised Board Members that she had been appointed as chair of the flu planning group this year. NHSE have this year requested that all Chief Executives complete a self-assessment of all flu vaccinations as well as a checklist to demonstrate progress. The self-assessment and checklist have been provided to Board Members for review and approval. F Couper provided some background to Board Members in respect of this year's campaign. Two vaccines have been made available this year, one of which is specifically for the over 65's. Initially, there were issues regarding the availability of this vaccine, however, this has now been overcome and CWP has supplies of both vaccines. Uptake for staff is currently at 50.6% and more staff are being encouraged to take up the offer. Some of the patient areas are showing as red. A detailed discussion took place at Operational Committee and the Flu Group to consider the campaign to date and the actions going forward. Overall, the campaign has been good and there has been an attempt to make this as positive for staff as possible and dispel myths and concerns. Suggestions were made by Board Members as to what further actions may be considered to assist in increasing the compliance rate. Assurance was given that a large variety of options have been made available to staff to encourage and assist them in being able to take up the offer.	

	D Harris offered his thanks to Fiona and the flu group who have done an impressive job this year to proactively advertise and encourage staff to have their vaccines. F Couper advised that this year the Trust has also collected feedback from staff who have declined the offer to help inform next years' campaign. A number have reported a fear of needles, whilst others feel that the vaccine is not wholly effective. S Cumiskey agreed that it is important to seek to understand staff's views. This will also help with some of the national messaging for the future. The Board of Directors **noted** the report.	
18/19/98	**OPERATIONAL PAN / BOARD PERFORMANCE DASHBOARD** T Welch introduced the item. T Welch reflected that there has been a clear shift and Care Groups are now leading the discussions at Operational Committee in respect of their own performance and there is a significant improvement in areas such as gatekeeping with clear ownership. The ADHD programme is listed as red. However, progress is now being made and actions are progressing well. Some challenges remain in regards to absence management processes and acute care bed pressures (also discussed earlier). Efficiencies also need to be improved. D Harris advised the following:- Appraisal compliance – this is an improving picture and Care Groups have a clear focus on moving these forward. Vacancies – comparatively, CWP have a very low turnover rate. It was suggested that the target for this may need to be reviewed, as it appears to be giving a false impression of the situation. Sickness absence – there are a number of operational pressures against a very low resource. Therefore, it is likely to have an impact on sickness levels. Care Groups are also proactively requesting support from clinical support services to assist with deep dives into sickness absence and how this can best be managed. The Board of Directors **noted** the report.	
18/19/99	**GUARDIAN OF SAFE WORKING QUARTERLY** Dr F Alam introduced the item. The report was taken as read which outlined the following:- • 52 doctors in training. • 21 are subject to the new contract. • 2 exception reports were submitted and resolved.	

	• 9 vacancies – which is an improved position. It is anticipated that the figures will see a further improvement in the next report. Real time electronic monitoring is currently being used and is assisting the team to identify breaches of the working time directive. The challenge remains in predicting these. D Harris advised that consideration is being given to the roll out of e-rostering for all teams, but costs would be attached. Dr J O'Connor queried the difficulties in covering shifts (19 shifts not covered) enquiring how safety was maintained. Dr F Alam advised that the Trust has implemented an acting down policy. Last month no acting down was utilised. Work is also on-going to implement a Consultant on-call rota to eliminate on-call vacancies. NEDs requested that acronyms be stated in full within future reports. The Board of Directors **noted** the report.	
18/19/100	**ANNUAL RESEARCH REPORT 2017/18** Dr F Alam introduced the item advising that the way in which the report is presented has changed. The report attempts to address each of the priority work areas. Board Members agreed that the report was much improved. The report provided an overview of the research activity undertaken within the Trust during 2017-18 and provides an update on progress against each of the priorities outlined in the CWP Research Strategy for 2015-18. During this period, the research team relocated from the Wirral to the Countess of Chester Health Park with a dedicated clinical room. This has strengthened the Trust's ability to participate in new trials as a result of being able to undertake physical examinations. The research priorities have been progressed including the development of an innovative programme of research in the area of clinical decision-making. Dr F Alam commented that the Trust is proud of its achievements. CWP's current strategy expires soon and so the team are now working to update and revise this. R Burke-Sharples commented that the report was extremely useful and it was pleasing to see non-academic research also included. The document is readable and reflects the immense amount of work undertaken, which should be commended. E Jenner suggested that as part of the CWP branding the research opportunities within the Trust should be highlighted. The Board of Directors **noted** the report.	

18/19/101	**PROVIDER LICENCE COMPLIANCE** T Welch introduced the item. The report was taken as read and the Board were provided with a copy of the self-assessment. The paper was for noting only, as a submission had not been required for the last few years. However, CWP have continued to undertake the review by way of good practice. The paper had previously been reviewed by the Audit Committee. The Board of Directors **noted** the report.	
18/19/102	**CHAIR'S REPORT OF OPERATIONAL COMMITTEE HELD ON 21 NOVEMBER 2018** S Cumiskey introduced the item. A number of the items discussed at Operational Committee had then been escalated to Board for noting or approval. The report is included in the agenda pack and exceptions are reported to the Board. The last Operational Committee received a very interesting presentation in respect of the CAMHS benchmarking data that demonstrated the effectiveness of our services and good value. The Committee considered the internal audit report regarding spot checks and held a challenging discussion in relation to the WRES (Workforce Race Equality Standard) data. The Committee tried to understand why people from protected characteristics have worse experience of bullying from the general public and from staff. CWP will ensure that there is focus on equality of opportunity in our work around leadership development. The Committee also received an update in respect of the Central and East redesign. The Board of Directors **noted** the report.	
18/19/103	**CHAIR'S REPORT OF QUALITY COMMITTEE HELD ON 7 NOVEMBER 2018** Dr J O'Connor introduced the item. The report was taken as read. Dr J O'Connor highlighted an example that the integrated governance framework was working well. The safeguarding sub-committee had raised some concerns that were quickly escalated to the strategic risk register. These were considered at Quality Committee and also by the Audit Committee. The Committee heard about the great work taking place within the staring well service and the positive outcomes from the patient safety reviews. The Board of Directors **noted** the report.	
18/19/104	**CHAIRS REPORT OF AUDIT COMMITTEE – 13 NOVEMBER 2018** E Jenner introduced the item summarising the following areas of focus for	

	the recent Audit Committee:- Quality Assurance Dashboard – a new style dashboard was presented which the Committee were extremely impressed with and would recommend this to the Board as a future way of reporting. Quality Spot Check Report – the report was received which highlighted three areas for concern. Further discussion will take place at the January 2019 meeting. Cyber Essential Certification – a great deal of work has taken place and assurance was provided to the Committee on the progress made to date. An options report is now expected. Oversight and Assurance of coherent workforce planning – the Audit Committee felt they wish to further understand how the Trust plans and administers workforce planning matters. It was agreed that E Jenner and D Harris would explore this point further outside of the meeting. Risk Register – the Committee noted a number of high level risks. Safeguarding Assurance – the Audit Committee noted the recent report to the Quality Committee and considered an audit of processes, reporting mechanisms and accountabilities should take place as an additional piece of work within the audit calendar. The Committee had reviewed their Terms of Reference and presented these to the Board for approval. The Board of Directors **noted** the report and **approved** the Terms of Reference.	
18/19/105	**ANY OTHER BUSINESS** None noted.	
18/19/106	**QUESTIONS FROM OBSERVERS OR MEMBERS OF THE PUBLIC** Peter Ashley-Mudie commented that he had worked for 20 years in social work and had seen a number of out of city and out of area placements for children. It was pleasing to hear that the Trust is not using out of area beds and perhaps there is learning for social service here. Catherine Williams thanked the Board for allowing her to attend and observe.	
18/19/107	**REVIEW OF RISK IMPACTS OF ITEMS DISCUSSED** None were noted	
18/19/108	**KEY MESSAGES FOR COMMUNICATION** M Maier summarised some of the main discussions points: • Central and East redesign update • Bed hub presentation with examples at CWP of national best practice. • The Trust is performing well despite significant challenges • Some excellent results from the CQC Community Mental Health	

	Survey	
18/19/109	**REVIEW MEETING PERFORMANCE** The meeting was confirmed as effective.	
18/19/110	**DATE, TIME AND PLACE OF NEXT MEETING**: Wednesday 30th January 2019 – 1:30pm – Redesmere.	

Signed

Mike Maier, Chair

Date:

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Action points from Board of Directors Meetings November 2018

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
28/09/18	18/19/61	**CHIEF EXECUTIVE ANNOUNCEMENTS** Suicide Prevention – recent report and learning to be brought back to January 2019 Board meeting.	January 2019	Dr A Sivananthan	On agenda.	Closed
28/09/18	18/19/72	**EQUALITY AND DIVERSITY ANNUAL REPORT** It was agreed that a message should be sent out Trust wide from Board members with the help of the Communications Team. Communications team to devise suggested wording to be communicated on behalf of the Board members.	Nov 2018	Katherine Wright		Open
28/11/18	18/19/94	**CQC COMMUNITY MENTAL HEALTH SURVEY** Communication team to publicise the results.	Dec 2018	Katherine Wright	Results publicised via a number of ways including social media, media release with coverage in two local newspapers, via the Trust website , CWP Life staff and membership magazine and via internal comms	Closed

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

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

11	**Medical Appraisal Annual Report and annual declaration of medical revalidation**	Medical Director Effectiveness, Medical Education and Medical Workforce	Operational Committee				✓							
Finance and Use of Resouces/ Operational Performance														
12	**Operational Plan/ Board performance dashboard (incorporating Operational and Quality dashboard)**	Director of Finance	Operational Committee/ Quality Committee		✓		✓	✓		✓		✓		✓
13	**Chair's Report of the Operational Committee**	Chief Executive	Operational Committee		✓		✓	✓		✓		✓		✓
14	**Annual Report, Accounts and Quality Account**	Director of Finance	Audit Committee (Quality Committee for QA)		✓									
15	**Health and Safety Annual Report and Fire and link certification**	Director of Nursing, Therapies and Patient Partnership	Operational Committee				✓							
Well-led (leadership and improvement capability)														
16	**Board Assurance Framework**	Medical Director Compliance, Quality and	Quality Committee		✓			✓				✓		✓
17	**Learning from Experience Report, inc Learning from Deaths (executive**	Director of Nursing, Therapies and Patient	Quality Committee		✓			✓				✓		
18	**Quality Improvement Report**	Medical Director Compliance, Quality and	Quality Committee				✓			✓				✓
19	**Integrated Governance Framework**	Medical Director Compliance, Quality and	Quality Committee									✓		
20	**CQC Community Patient Survey Report (themes and improvement plan)**	Director of Nursing, Therapies and Patient	Quality Committee							✓				
21	**NHS Staff survey (themes and improvement plan)**	Director of People and OD	Operational Committee											✓
22	**Equality Act Compliance inc. WRES**	Director of Nursing, Therapies and Patient	Operational Committee					✓						
23	**Guardian of Safe Working quarterly report**	Medical Director Effectiveness, Medical Education	Operational Committee		✓		✓			✓		✓		
Governance														
24	**Provider Licence Compliance**	Director of Finance	Audit Committee		✓					✓				

25	**CQC Statement of Purpose**	Medical Director Compliance, Quality and	Quality Committee							✓				
26	**Information Governance Toolkit**	Medical Director Effectiveness, Medical Education and Medical Workforce	Operational Committee											✓
27	**Register of Sealings**	Director of Finance	Audit Committee					✓						
28	**CEO/ Chair Division of Responsibilities**	Chair	N/A		✓									
29	**Corporate Governance Manual**	Director of Finance	Operational Committee									✓		
30	**Chair's Report of the Audit Committee**	Non Executive Director	Audit Committee		✓		✓	✓		✓		✓		✓
31	**BOD Business Cycle**	Chair	N/A											✓
32	**Terms of reference of Quality Committee and Operational Committee**	Non Executive Director/ CEO	Quality Committee/ Operational Committee		✓									
32	**Review risk impacts of items**	Chair/ All	N/A		✓		✓	✓		✓		✓		✓
33	**AOB (including matters that are NOT commecial-in-confidence)**	Chair/ All	N/A		✓		✓	✓		✓		✓		✓

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STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Redesign of Adult and Older People's Specialist Mental Health Services – Update
Agenda ref. no:	18-19-89
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	30/01/2019
Presented by:	Andy Styring, Director of Operations

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	No
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	Yes
37T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
37T	

REPORT BRIEFING

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

The purpose of this report is to update the Board of Directors on the redesign of adult and older people's specialist mental health services in East and South Cheshire and Vale Royal; this includes the conclusion of the additional consultation on specific elements of Option 2 Plus and the decision from the Clinical Commissioning Groups (CCGs) to progress with the implementation.

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

A decision-making business case was presented at the CCGs' joint Committees in Common meeting on 22 November 2018. On the same day the Cheshire East Council's Health and Adult Social Care and Communities Overview and Scrutiny Committee (CE Scrutiny Committee) met to determine the level of engagement required with regards to the preferred option (Option 2 Plus).

The CE Scrutiny Committee requested a further consultation took place until 21 December 2018 on the additional elements of Option 2 Plus that were not covered as part of the original 12-week consultation process. The CCGs agreed to implement Option 2 Plus, subject to the outcome of this further engagement.

Further engagement with service users, carers, mental health forums and staff subsequently took place and a consultation summary report was considered by a CCG panel at a meeting on 28th December 2018. The summary report can be viewed at: https://www.easterncheshireccg.nhs.uk/Your-Views/redesign-of-specialist-mental-health-services-final-consultation.htm

The panel included a CCG accountable officer, other representatives of the executive team, lay members and clinical leads from the Governing Bodies. This panel reviewed the findings of the additional consultation and concluded that there had not been any material or substantial feedback received that would require reconsideration of the decision made on the 22nd November 2018 by the three Governing Bodies. Therefore the decision by the Governing Bodies was to progress implementing Option 2 Plus.

The report was also presented to the CE Scrutiny Committee on 17th January 2019. The Scrutiny committee confirmed due process had been followed throughout this consultation and the previous three month consultation – and welcomed the new model of care.

Assessment – *analysis and considerations of options and risks*

CWP has now commenced the staff consultation with briefing sessions and 1:1 opportunities taking place throughout January 2019.

A focused discharge planning meeting for current Lime Walk House service users took place on 7th January 2019 to ensure that there are no delays and all arrangements for discharge (where discharge is an option) are in place prior to transfer to Bowmere.

A programme structure for the implementation and mobilisation of the service transformation has been developed; leads have been identified and the resources necessary to support this programme of work are being identified. Formal reporting will be via the CWP Programme Management Office.

A service user and carer engagement event to develop the service specification for the Crisis Beds has been planned for 23rd January 2019 which will be followed by a market engagement event on 30th January 2019. This will be led by the CCG.

Implementation of the plans are scheduled to be concluded by September 2019, although recognising that the organisational development and cultural shift will be longer term.

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

The Board of Directors are invited to **note** the following:

- The agreement from the CCGs to approve Option 2 Plus and proceed with implementation;
- The additional engagement and consultation completed regarding the amendments to the provision of Rehabilitation Services at Lime Walk House;
- The positive support from Cheshire East Scrutiny Committee at meetings of 22nd November 18 and 17th January 19
- The positive support of Mental Health forums in Vale Royal, South Cheshire and East Cheshire.
- The next steps and timeframes for implementation.

Who/ which group has approved this report for receipt at the above meeting?		.
Contributing authors:		
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
N/A	N/A	N/A

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
.n/a	

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STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Safer Staffing Six Monthly Review
Agenda ref. no:	18-19-121
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	30/01/2019
Presented by:	Avril Devaney, Director of Nursing Therapies and Patient Partnership

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

REPORT BRIEFING

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

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

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

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

Assessment – *analysis and considerations of options and risks*

The inpatient review findings highlighted that there is effective workforce planning employed to maintain ward establishments to achieve the delivery of safe care. Additionally there are established mechanisms in place to deploy staff effectively. Clear processes are in place for staff to escalate staffing concerns and for remedial action to be taken to unplanned workforce challenges. The organisation has continued to invest in advancing its staffing matrix through role redesign, enhancing clinical roles to improve skill mix and, moreover, broaden clinical capability through MDT working and developing physical health in mental health.

In addition to the six monthly inpatient safer staffing review (Appendix 1) this report details approaches underway in relation to safer staffing in the following areas:

Appendix 2 Learning Disability
Appendix 3 Community Nursing
Appendix 4 Improving Access to Psychological Therapies (IAPT)
Appendix 5 Place Based Care Mental Health

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

The Operational Board are asked to note the report and approve the recommendations.

Who/ which group has approved this report for receipt at the above meeting?	Avril Devaney
Contributing authors:	Marjorie Goold – Consultant Nurse Gary Flockhart – Associate Director of Nursing and Therapies

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Operational Committee	16.01.2019

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

Appendix no.	Appendix title
1-5	As detailed above

18.19.121 Appendix 1

Six Monthly Safer Staffing Report

Period of Review May 2018 – November 2018

Introduction

This report to Cheshire & Wirral Partnership (CWP) NHS Foundation Trust (CWP) Trust Board covers the period May 2018 to October 2018 (inclusive) and aims to confirm the status of the organisation's capacity and capability to provide high quality care'[1] through safer staffing. The Board are requested to note the contents of the report and agree the recommendations.

The guidance for Safer Staffing is set out by the National Quality Board (NQB) who seek assurance that organisational practices, skills development and evidence based tools are in place. Primarily this is to assure the delivery of quality clinical care to patients across the various locations and specialisms in the Trust, including community, in-patient and specialist services. Specifics that are requested to be considered include

- how evidence-based tools are used to inform nursing and care staff requirements
- how a culture of professionalism and responsiveness is fostered where staff feel able to raise concerns
- in what way a multi-professional approach is taken when setting nursing, midwifery and care staff staffing establishments
- how nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct care duties
- NHS providers clearly displaying information about the nurses and care staff present on each ward
- how NHS providers take an active role in securing staff in line with their workforce requirements.

It is noted that the Board receives monthly communication around staffing capacity and capability, therefore, this report facilitates an overarching review across the 6 month period to include workforce planning, deployment of staff, skill mix and workforce challenges.

Process

The CWP contract details that information is presented bi-annually to ensure that there is "sufficient appropriately registered, qualified and experienced staff to enable the Services to be provided in all respects". The achievement of this is continuous across the year through various work streams, task and finish groups, data accumulation and analysis.

The information received and the contributions towards this six month period has included;

In-patient safer staffing meetings

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

These meetings commenced in October 2018 and were held through to December 2018. All in-patient areas were visited with the exception of one whose review was carried out via telephone due to timing and clinical demands. The purpose of these meetings are the facilitated discussions around establishments, recruitment, retention and the clinical management of a specific clinical area to support professional judgement in relation to staffing levels. The narrative received can thereby be appraised and combined with ward data around establishments, supervision/training compliance and fill rates to better understand approaches to maintaining safer staffing. As an example, the majority of in-patient areas work on two or more Registered Nurses per shift, where a Registered Nurse deficit occurred and could not be filled with comparable staff, the preference was to have an experienced Clinical Support Worker (CSW) that knew the ward to enable continuity of care; fill rate data on its own would not reflect this context.

Existing Projects
In addition to the six monthly inpatient safer staffing review (Appendix 1) this report details approaches underway in relation to safer staffing in the following areas:

Appendix 2 Learning Disability
Appendix 3 Community Nursing
Appendix 4 Improving Access to Psychological Therapies (IAPT)
Appendix 5 Place Based Care Mental Health

Effective, Safe, Compassionate and Sustainable Staffing (ESCaSS) for Mental Health Care
As part of workforce planning it is proposed that within Community CAMHS that a pilot takes place using the evidence presented by the National Collaborating Centre for Mental Health in their *guidance Effective, Safe, Compassionate and Sustainable Staffing (ESCaSS) for Mental Health* (NCCMH 2018) . This proposal is in the early stages of planning but is indicative of CWP's intention to use evidence based approaches in setting skill requirements and appraising new opportunities and roles to develop the mental health workforce.

Evidence Based Tools
The previous safer staffing report to Trust Board made reference to the commencement of Care Hours per Patient Day (CHPPD) data. This data has now been submitted for the past six months and an update is reported later in the paper. Additionally, implementation of the Hurst Tool has continued which also provides an evidence based approach which has contributed to our safer staffing enquiry.

Temporary Staffing
A summary position statement relating to Temporary Staffing was obtained and considered, as part of the overall safer staffing evaluation.

The information accumulated has been expansive and evidences the depth of CWP's investment in its approach to safer staffing. To assist the discursive aspects of the report the key headings of **Effective Workforce Planning, Deploying Staff Effectively, Redesigning roles & Skill Mix and Responding to Unplanned Workforce Challenges** were adopted. These are the headings detailed by

NHS Improvement in their *Developing Workforce Safeguards, Supporting providers to deliver high quality care through safe and effective staffing* (NQB, 2018) [2] report.

Appendix 1 Six Monthly Inpatient Review

The following areas have been considered within the six monthly review:

- Effective Workforce Planning
- New Models of Care
- Training and Supervision
- Resource Managers
- Deploying Staff Effectively
- Redesigning Roles and Skill Mix
- Responding to unplanned Workforce Challenges
- Evidence Based Tools
- Temporary Staffing and Recruitment
- Safer Staffing Fill Rates per Ward

The key findings are summarised within the conclusion of the report under the following themes

- Right Staff
- Right Skills
- Right Place and Time
- Recommendations

Effective Workforce Planning

In-patient services roster staff via Healthroster and this enables proactive and planned allocation of nursing staff per shift to be achieved. It also facilitates an evidence base for staff allocation and distribution per shift, week or monthly as required. Indeed, the planned rostering within Healthroster also allows nursing skill mix to be taken into account. This supports clinical care pathways through having the right staff on duty, for example staff trained in the management of violence and aggression or gender mix. The employment of Healthroster also facilitates the early identification of staffing deficits whereupon contingency planning can occur, such as in the realigning of existing staff or seeking nursing cover through planned temporary staff use.

Long term sickness can be managed through making arrangements for planned cover, however challenges occur in the short term when unexpected sickness results in unplanned deficits and consequently results in staff moves from one clinical area to another, where this happens however the staff cross cover cannot be captured within the safer staffing returns as only whole shifts can be captured. This is evidenced through the planned and actual return submissions (example below).

[2] NHS Improvement (January 2018) Developing Workforce Safeguards Supporting providers to deliver high quality care through safe and effective staffing
https://improvement.nhs.uk/documents/3320/Developing_workforce_safeguards.pdf

Ward		Registered		Care Staff		Registered		Care Staff		Safe Staffing was maintained by:
		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	
		1325.00	1227.50	1278.00	1128.00	690.00	690.00	1207.50	1167.50	Nursing staff working additional unplanned hours. Cross cover arrangements. Multi Disciplinary Team actively worked within the staffing establishment.
		1035.50	995.00	1525.50	1470.00	713.00	667.00	793.50	830.00	Nursing staff working additional unplanned hours. Cross cover arrangements. Multi Disciplinary Team actively worked within the staffing establishment.

As highlighted it is the unexpected deficits at short notice that makes safer staffing requirements challenging or additionally a sudden increase in clinical demands requiring increased staff above establishment. CWP's effective workforce planning at such times has relied upon the broader clinical staff team that includes members of the Multi-Disciplinary Team (MDT).

Ward establishments take into account annual leave, uplift for training and also supervision. The obstacles to these in the past six months have included not only unexpected absences such as sickness but also staff being unable to undertake clinical duties; this may be because of a management processes or planned / unplanned leave (for example maternity and carers leave).

The safer staffing meetings highlighted the increasing co-morbidities between physical health and mental health. This included increased physical health presentations and interventions such as wound management, diabetes and complexities arising within eating disorders. Consequently, some clinical areas had elected to reconfigure their posts to employ a Registered Nurse in Adult Nursing to expand ward skill mix and multi-disciplinary team skill set. The areas that elected to reconfigure their posts (for example Oaktrees and Meadowbank) reported positive benefits to their staff group knowledge base and the depth of clinical care extended to patients. In terms of broader physical health there has been ongoing work through the Physical Health in Mental Health committee. This committee is considering skills and staffing requirements along the lines of Allied Health Professionals (physiotherapy and podiatry) within adult and older adult acute care. The longer term aims are to ensure parity of access to provision and that there will be sufficient staff with the necessary skills to meet individual care needs.

New Models of Care

The Specialist Mental Health Care Group (Bed Based) has progressed with a work stream in relation to scoping the optimum staffing configuration for wards (New Models of Care). The New Models of Care for adult in-patient/bed based services has continued to be appraised and to consider the most effective way to reconfigure services to meet the clinical needs of patients. As part of the appraisal there are separate work streams that will contribute to the wider Adult/Older Adult Workforce Planning. The established work streams are

- Overarching work stream including nursing
- Psychological therapies
- Allied health Professionals
- Personality Disorder Hub

These groups and the overarching Adult and Older Adult workforce planning group will continue to give careful consideration to service delivery including the associated staff and skill mix that will be required to meet proposed clinical scenarios.

Training and Supervision
Workforce planning includes providing time and resource for training and supervision. Both are contract compliance areas and staff are given time to attend supervision and training so as to maintain practice proficiencies. Training and supervision compliance can be referenced through the monthly Locality Data Packs (LDPs). From the safer staffing meetings held there were some challenges in achieving levels of compliance particularly where unplanned staffing deficits occurred. To assist compliance, wards employed a cross covers approach wherever possible. This was to ensure safe staffing levels and to enable colleagues to attend scheduled training and supervision, including team meetings.

In some clinical areas challenges in achieving training compliance was not necessarily about attending the specified training but the associated travel time to get to and from training. East Cheshire, for example, has on-site training resulting in staff only needing to be released for the period that the training runs, whereas in Wirral the impact is that there is additional travel time as training is off site. The impact on workforce planning is that in Wirral there needs to be account for staffing deficit for a longer period of time and account of this is taken into staff cover arrangements.

Resource Managers
There remains disparity in the Resource Manager provision and also allocated time to in-patient areas. Some wards and clinical areas take overall responsibility and oversight of their workforce requirements whereas in some areas it is shared between the ward manager and resource managers. The Ward Managers that have resource managers rostering and deploying staff report they find this role effective as it increases capacity for ward managers to clinically and managerially focus on their clinical area. Those Ward Managers that have resource managers that are not ward based report spending more time seeking staff to ensure their services are safe and responsive. In general, ward managers report that having an administrative infrastructure to assist their operational management is welcomed. Areas where there is an absence of resource manager (such as Learning Disabilities community respite) reported decreased time that the ward manager could dedicate to ensuring clinical prioritisation. It was noted that during the discussions with ward managers all appreciated having an administrative infrastructure, however, there was consensus that any post reconfiguration would not occur at the expense of direct clinical posts.

Deploying Staff Effectively
CWP has a number of clinical specialisms including acute mental health, psychiatric intensive care, ageless services, LD, older adult mental health and CAMHS, therefore it is understandable that the staffing configuration for each area including the MDT varies. However, core proficiencies are attained as part of mandatory training for clinical staff groups and this strengthens the capacity to deploy staff to other clinical areas as their shared baseline knowledge and skills. This is the case for both substantive and temporary staff. By achieving baseline competencies there is the ability to cross cover across clinical areas especially where care demands are dynamic, such as changes in staff requirements due to increased risk and levels of therapeutic observations.

The rostering of staff per shift in a clinical area is the overall responsibility of the Ward Manager. Some areas have allocated Resource Managers that contribute to staff rostering and deployment of nursing staff. The deployment of staff also includes the wider MDT such as Occupational Therapy, which is generally managed centrally and allocated to wards as required. There are some exceptions such as in-patient CAMHS, Eating Disorder and LD wards where OTs are included in the ward establishment but this is not the case in the adult and older adult wards. Despite the two different

modalities of OT provision the service overall was valued in clinical areas and were seen as integral to team composition and were deployed as necessary to maintain safe and effective care.

Redesigning Roles & Skill Mix

Over the past six months there has been role reconfiguration within some of the clinical areas primarily to strengthen the skill mix available. As previously stated the incorporation of Registered Nurses in Adult Nursing has occurred. Moreover, the introduction of a Pharmacy Technician was successfully piloted within one of CWP's older adult in-patient wards (Croft); the clinical feedback is that this role enabled consistent oversight in pharmacological dispensing, ordering and also enabling registered nurses more time to deliver nursing care. The positive benefits of the pharmacy technician role have led to other clinical areas considering whether this was an option for their ward establishment through post reconfiguration.

Other areas of redesign that wards have considered to meet the needs of their patient cohort are the reconfiguration of existing posts for example having psychologists within teams or recruiting a housekeeper. The safer staffing review process demonstrated that clinical teams are receptive to thinking about what might meet their clinical requirements with a freedom to discuss and consider options as part of meeting care demands.

CWP Education continues to work on advancing the skills and development of the workforce, including future planning through the investment and training of staff who can assist advancements of care delivery through evidenced based care, educating others and adaptive working. The last six months has seen the recruitment of eight CWP staff to complete the two year training to attain Advanced Nurse Practitioner status. Successful attainment will promote clinical leadership and advance care through increasing the number of non-medical prescribers contributes to a more responsive service. In addition the three Accelerated Masters students are now in their final year, due to qualify in 2019, once qualified will clinically strengthen the matrix of NURSING staff with diverse skills and knowledge.

The advancement of the Trainee Nursing Associates programme has continued and the first cohort are due to complete their training in January 2019. A summary of the programme completion and their inclusion into the CWP workforce will be appraised at the next bi-annual submission.

One additional post developed in the past six months has been the introduction of the Consultant Practitioner in Training post. This post is within the Adult ASD service and again the impact on staff skills and development will be evaluated at a later date.

Responding to unplanned Workforce Challenges

All inpatient areas reported challenges in their ability to fully achieve their daily staffing establishment. This was not because of inappropriate baseline establishments but as a result of staffing pressures arising from sickness, unplanned leave, vacancies and staff being unable to undertake clinical duties, for various reasons (for example maternity leave). Individually wards attempted to fill deficits and there were no reports of clinical areas not being permitted to have the necessary staff they required. All areas highlighted that they were able to voice any concerns relating to staffing pressures. The main challenge was where a sum of areas all had unplanned staffing pressures and despite management agreement to fill deficits attaining the staff was onerous and sometimes unsuccessful; despite using the ward's own staff, seeking temporary staffing and offering overtime. This led to occasions where agency staff were required but this was always a last resort.

Where there were high levels of acute need and unplanned staffing pressures the adoption of daily staffing meetings took place to appraise need, prioritise safe care and consider the distribution of staff accordingly. Additionally, wards called upon their extended multi-disciplinary teams to support safe care by working in the establishment. This lead to some expressed views that the broader care needs could not be achieved (such as provision of MDT reports). Nevertheless, the consensus overall was that in the event of unplanned staffing deficits the responsibility for the whole care team was the safe care and treatment of the client cohort in the short term.

The locality bleep holders continued to play an integral role to the deployment of staff and maintain cover across the unit. The Supernumerary Bleep Holder role commenced in August 2018 and there have been challenges to maintain this although staff endeavours to achieve this continue.

Ward Managers continue to report that they are regularly working in the numbers but this is not easily evidenced as there is no uniform record keeping mechanism. However, it is right that the Ward Manager supports safer staffing within their ward but it is also important that the infrastructure of managing staff (such as in completing appraisals and management of sickness and absence) is completed in a timely manner. Ward managers as with other MDT members concurred that the delivery of safe clinical care was always their priority.

Evidence Based Tools

a) Safer Staffing Audit Tool by Dr Keith Hurst

The implementation of the Hurst tool has continued over the past 6 months and the objectives set for this reporting period was that a quality audit would be completed on Bollin Ward and Eastway LD Unit. The Bollin quality audit was completed on 19th October 2018 and the presenting scores were excellent indicating an efficient ward, good leadership, which is person centred. The scores were as follows

	A	B	C
	Ward Code /Source	1. All 149 Admission Ward	Bollin
1	*Questions*	231804	743
2	*Overall*	82.2%	94.0%
3	*Assessment*	78.5%	96.0%
4	*Planning*	76.2%	88.0%
5	*Implement.*	88.1%	95.0%
6	*Evaluation*	81.0%	95.0%
7	*Ward Score*	90.6%	89.0%

Dr Hurst's findings on the quality scores highlighted that they were "above the 70% watermark (Table, Col. C) and all but one category exceeds the 149-ward average. Consequently, staff deserve recognition and praise for their service quality scores".

The Eastway quality audit was booked for November 2018, as this was after the unit temporarily relocated and rearranged for a further date. Additionally, the full Hurst Audit Tool detailing staff activity and dependency analysis commenced in November. The audit commenced on one ward (Brackendale) but it has been planned for 3 wards (Juniper, Brackendale and Cherry) in total. Each ward audit will take three days, inclusive of one day at the weekend. The findings will assist

workforce development through understanding the tasks that staff complete, the skill mix required on the ward and the activities that occupy most staff time. The findings of these audits will be presented at the next bi-annual submission.

b) Care Hours Per Patient Day (CHPPD)

Following the AHP CHPPD pilot in June 2018 the AHP hours were due to be added to the monthly ward staffing return from September 2018, however national technical difficulties developing the submission template at NHS Digital delayed it for two months. The first AHP collection will be for November's data which will be submitted in December.

In October details of the collection were sent out to those involved in the ward staffing return together with a template created based on the pilot collection as the official template was not published until December 1st. Temporary templates have been issued for the wards to use for November and December and a weekly template was issued to all wards in December in time to be used from January.

Guidance has been issued for clarification of what is an AHP role for this return, such as activity co-ordinators, pharmacists social workers and peer support workers. The AHP hours to be included are for those on the roster for a single ward. AHP's who work across wards are not included. Unlike the pilot collection where the type of AHP was required, AHP's in the ward staffing return will only be reported as Registered and Non-Registered.

Temporary staffing and Recruitment

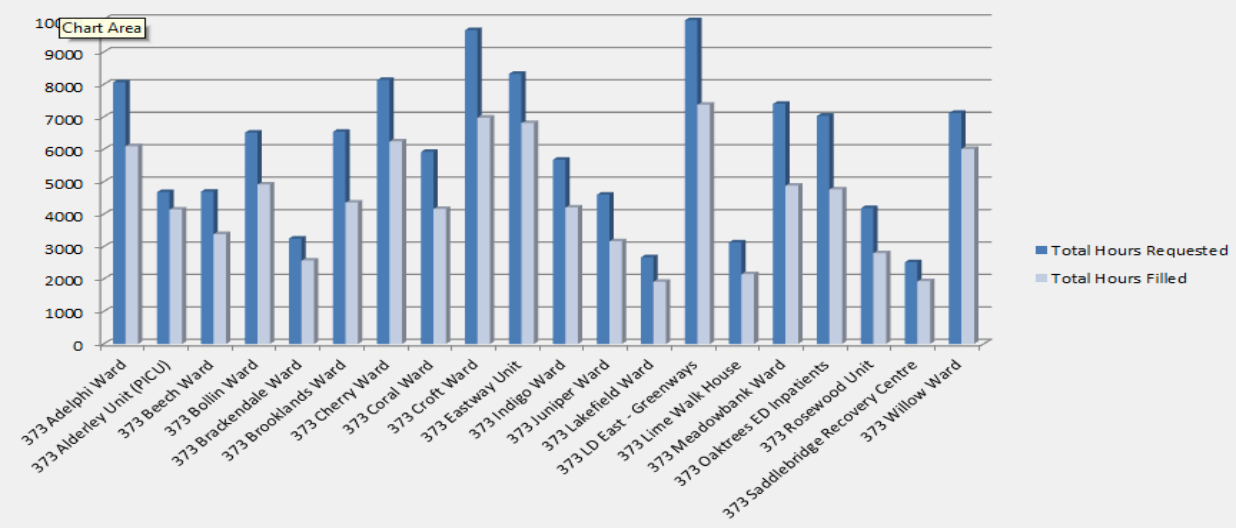
The table below indicates the establishments, vacancies and numbers in recruitment as at October 2018. Over the reporting period there were on average 17.43 WTE (6%) registered nursing inpatient vacancies and 9.84 WTE (3.4%) clinical support worker inpatient vacancies. The time to hire from vacancy advertised to contract letter as at Oct 18 was 49.4 working days and the average time to hire during this reporting period for the same criteria was 52.9 working days. Resourcing are currently working with Finance colleagues to establish rolling recruitment in advance of need and Resourcing will also be rolling out values based recruitment from early 2019 to support rolling recruitment events.

Working closely with clinical services to identify vacant and potentially vacant posts from March 2019, the Trust held an open recruitment day primarily aimed at student nurses in their third year due to qualify in March 2019. This event was well attended (by students in all years of study) and led to 26 employment offers.

Trust Wards	**WTE [budgeted establishment] as at Oct 18**	**WTE [Staff in post] as at Oct 18**	**Staffing differential**	**WTE in recruitment as at Oct 18 (from out to advert to start date booked)**
Registered Nurses	290.78	268.54	-22.24	30.27
Clinical Support Workers	288.94	289.83	+0.89	15.04

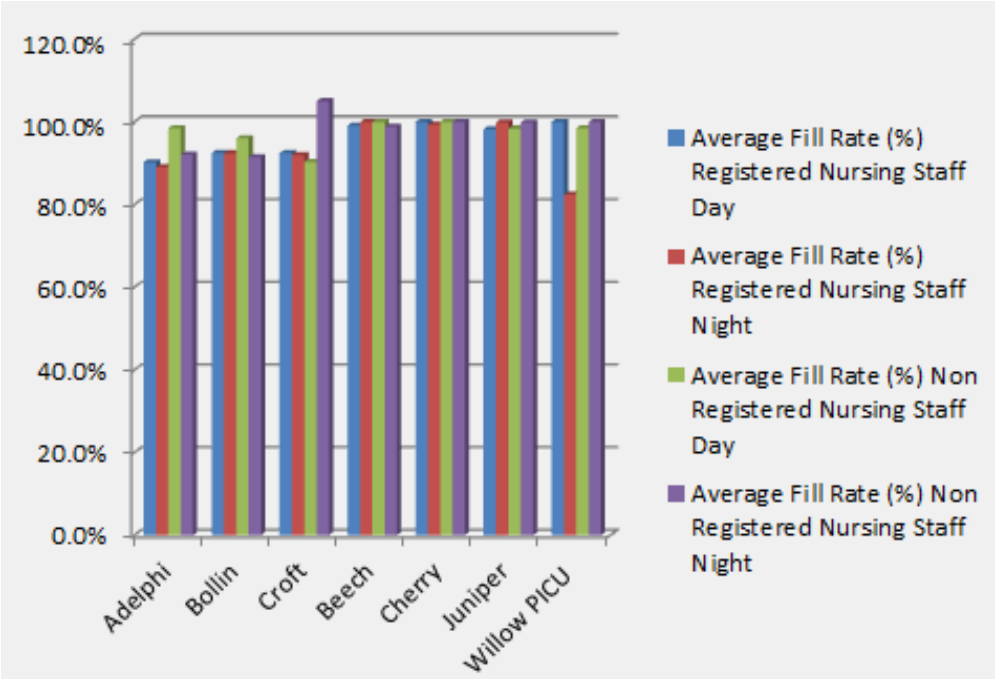
Demand for temporary staffing has risen together with agency use – the total WTE filled has risen from 91.1 WTE Nov 17-April 18 to 120.7 WTE May – Oct 18. The figures include a rise in agency clinical support worker bookings from 3.6 WTE to 6.8 WTE. Due to this increase in demand, bank recruitment for registered and non-registered nursing roles has been prioritised for all areas and there is currently continuous recruitment activity. The Trust has a neutral vendor agreement for agency staffing which has supported increased supply of clinical support workers at a standardised price under the NHSI cap. This agreement is due to end March 19 and Temporary Staffing are currently involved with Cheshire and Merseyside Health and Social Care Partnership to work collaboratively towards standard rates across the region and a high quality of compliance for supply.

Temporary Staffing Fill Rates per ward

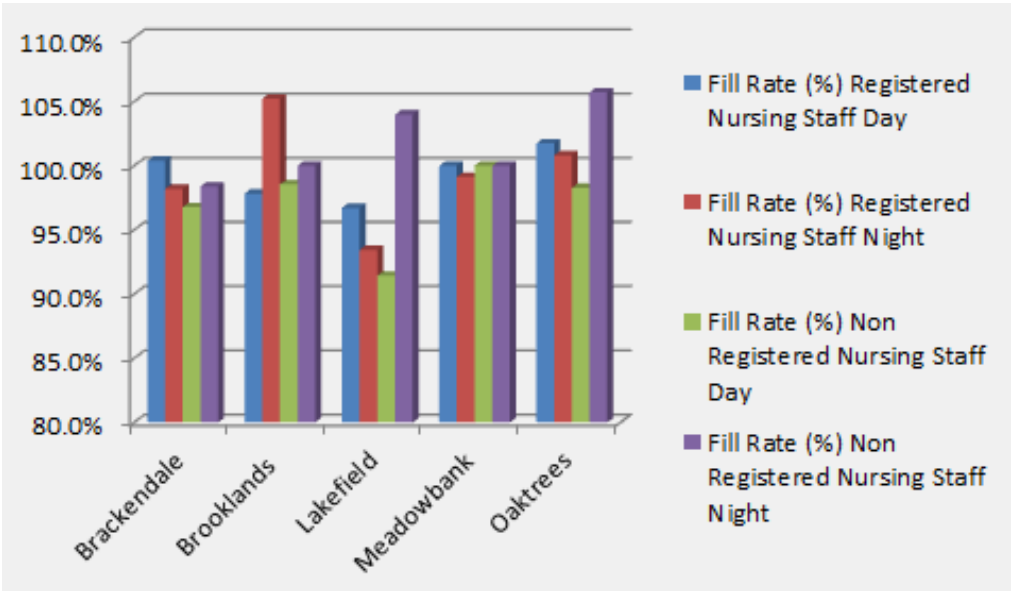


Ward Safer Staffing Average Fill Rates May – October 2018

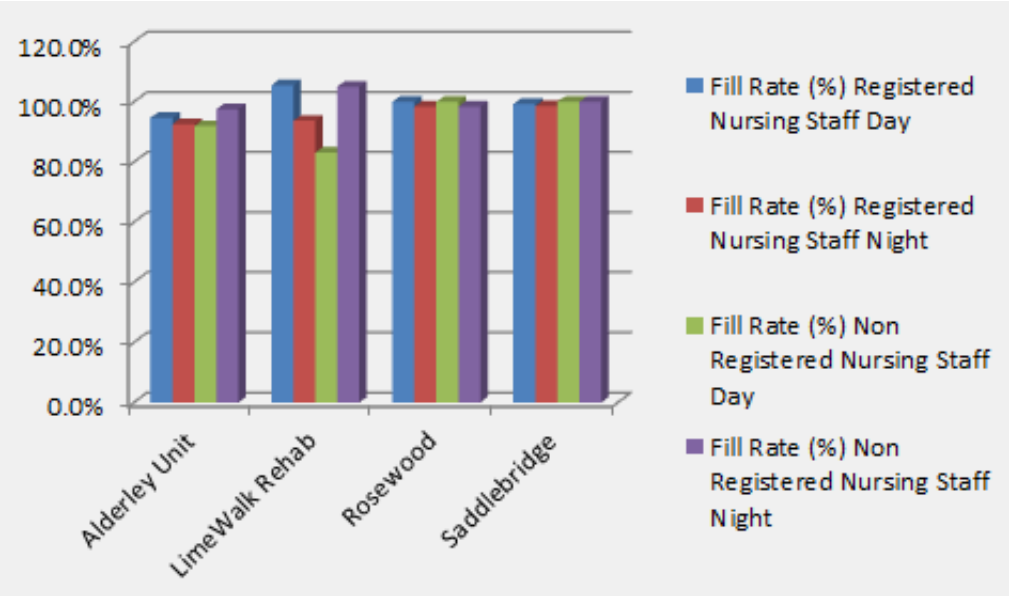
Bed Based West & East including PICU



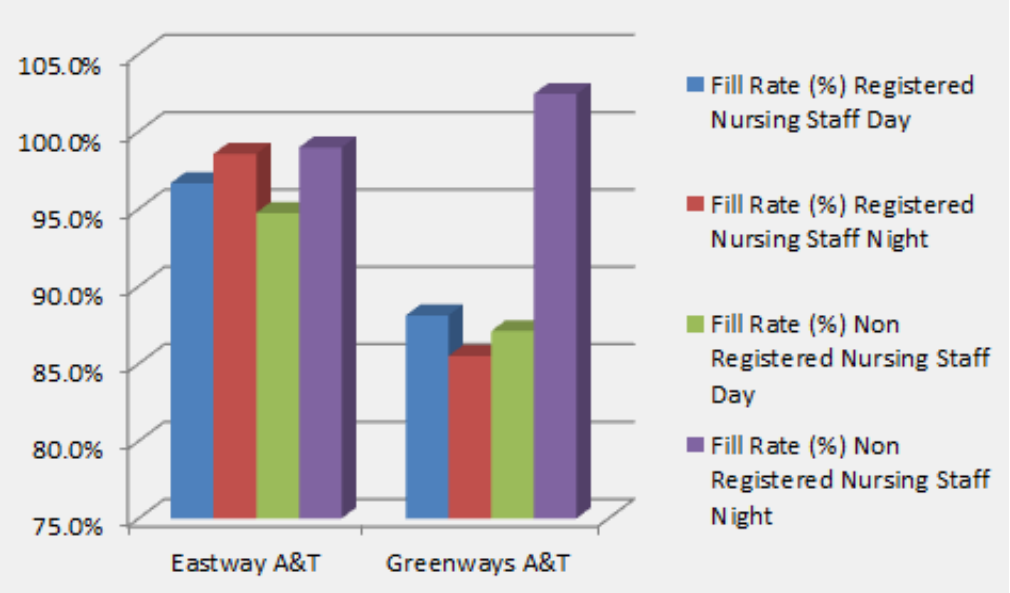
Bed Based Wirral including PICU



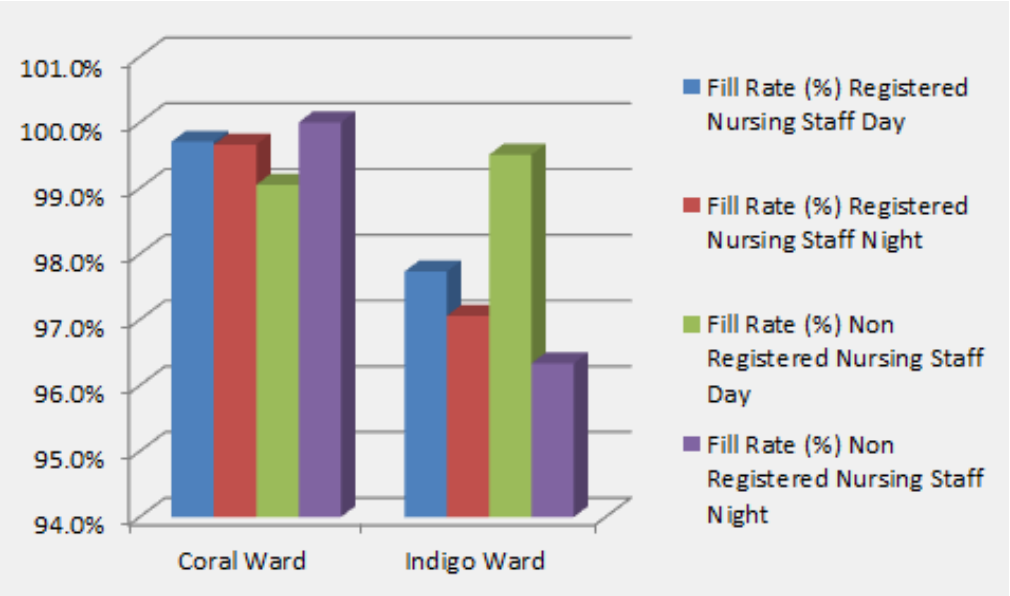
Forensic Rehab and CRAC



Learning Disability



Tier 4 CAMHS



Conclusion and Recommendations

Right Staff

The past 6 months have brought challenges within in-patient areas due to requirements to staff wards particularly as a consequence of unplanned absences and increased clinical demand. There was a proactive management approach to address deficits through taking a MDT approach in staffing a ward, engaging temporary staff, paying overtime and as a last resort the use of agency staff. The were no concerns relating to seeking additional staff to provide safe care but the challenges were accessing staff. There was cross locality management of staffing to safeguard safe staffing levels. There has been ongoing recruitment into vacancies particularly nursing and this remains a challenge and is not unique to CWP as this forms part of national nursing pressures. There remains commitment to attain the right staff and the recent recruitment of student nurses proved a successful iniative. Additionally the development of new roles and the incorporation of a broader skill mix is evolving and includes the incorporation of pharmacy technicians and Registered Nurses from other branches. What is evident from a safer staffing perspective is that the delivery of effective care is not only about the numbers of staff, but also the skill mix of the ward teams and the value of an MDT, in the context of changing clinical demands and priorities. Having the right staff has been a continuous process and requires ongoing monitoring.

Right Skills

CWP has continued to develop its workforce through the development and expansion of new roles and remains committed to doing so. Key developments have included introducing further Trainee Nursing Associates, Advanced Practitioner in Training (including AHP) and Consultant in Training post. As part of the Trust professional networks 'Your Career at CWP' pathways have been

developed and will be promoted. Additionally during review there has been evidence of multi-disciplinary working to enhance the quality of care to meet the care needs of the population served. Supervision and training remain ongoing staffing requirements to embed skills to enhance care; supervision will form a Quality Improvement Initiative (QI) during 2019.

Right Place & Time

Although clinical areas roster for their own clinical area there is a philosophy of cross unit working to meet the care needs of patients and ensure safe staffing. During the review period there were occasions where staff had to be relocated due to clinical pressures and demand across the organisation, whilst staff fully understood the rationale and requirement to do this at times they also expressed frustration at not being able to always provide continuity within their role.

Recommendations

The report outlines an extensive programme of work in relation to our approach to safer staffing and workforce initiatives to meet the current and future needs of the populations we care for. The Board are asked to note the developments within the report and approve the continued approach to safer staffing.

Appendix 2 Learning Disability

A key driver within the transforming care agenda is to be cared for within the community with a care package that meets an individual's care needs. It is well evidenced that those with a Learning Disability who have been admitted to hospital led to significantly protracted lengths of stay and institutionalisation. Redressing this through the transforming care programme includes work in relation to repatriation of inpatients back into the community from out of area hospitals and community placements and also identifying those at risk of admission to consider if admission is in their best interest.

Right staff

The co-morbidities for those with a Learning Disability are significant and evidence from the Learning Disability Mortality Review[3] will require proactive and pre-emptive planning by health and partner agencies to address this. From a CWP perspective future planning around the capabilities of individual staff and also the combination of skill mix, including nursing, medical and allied health professionals (Physiotherapy, Speech and Language and Occupational Therapy) has commenced. This is not just exclusive to health but also considering aligned roles such as transformation workers to identify individual care needs and social workers to ensure arrangement around health and social care needs. Developments have started in this area through having an Autism coordinator in Trafford and also Transition practitioners. This will require further evaluation over the next six months to consider how the successes in these roles may help deliver transforming care objectives.

Right skill

Established mechanisms are in place through staff knowledge and training to identify those at risk of admission through the Care and Treatment Review process; within CWP there is the active use of the Dynamic Support Database (DSD) to identify at risk patients and for intervention (intensive support) to negate this where possible. Thus having a community staff team that can dynamically assess risk and intervention via the DSD process means that those patients who can remain in the community are getting timely intervention. It is only those with specific care needs that cannot be met within a community setting and require admission who need to be accessing Learning Disability Assessment and Treatment Services.

Community staff skills and knowledge will enable consideration of what is required for discharge, and support intervention to address this in a timely manner. Transformation objectives to meet bespoke care needs requires a skilled staff group that includes the core proficiencies in understanding Learning Disability and managing the complex challenges around behaviours and the management of risk. An enhanced knowledge base around physical health and mental health is required given the increased co-morbidities within those with a Learning Disability aimed at reducing health inequalities and increase life expectancy. The Trust has recently recruited three Advanced Practitioners in Training within Learning Disability services: a Nurse, Speech and Language Therapist and Physiotherapist.

Right time & place

New specialist practitioner roles to support and develop staff practice in each specialist discipline are being put in place. A Consultant Occupational Therapist (in training) has recently been introduced specialising in Autism Spectrum Disorder (ASD), these new clinical leadership roles will assist in

[3] University of Bristol (2018) Learning Disabilities Mortality Review http://www.bristol.ac.uk/sps/leder/

gathering evidence and deliver training as part of staff development to increase skills and capability to meet clinical needs in a timely manner.

In summary to develop CWP's safer staffing priorities for Learning Disability services the aim over the next 6 months is to map our current provision with the future needs of our LD cohort using An Improvement Resource for Learning Disabilities Services guidance. [4]

[4] NQB (January 2018) An Improvement Resource for LD Services https://improvement.nhs.uk/resources/safe-staffing-improvement-resources-learning-disability-services/

Appendix 3 Community Nursing

Introduction

The National Quality Board (NQB) (2018) highlights the critical directions in which to start advancing; retaining the focus on safe, sustainable and productive staffing with three key expectations: Right Staff, Right Skills, Right Place and Time.

The principles of setting "safe caseloads" (NQB 2018) within community nursing (physical health) apply where services are reconfigured, such as the development of new health and care models with organisations working together to implement the principles.

This first report is inclusive of all community nurses based within the Community Care Teams (CCT's), Neighbourhood Based Care Group. Future consideration may include allied health professionals and specialist nurses (for example specialist palliative care nurses) to truly reflect the delivery of care through our integrated CCTs.

Staffing

Right staff

Workforce planning:

The current nursing establishment is historically based upon the population size of people aged 65 years and above within identified GP clusters. The integration of services within CCTs ensures that patient needs are managed on a multi-professional requirement.

Although the nursing establishment is based on practice population data; professional judgement is also used to ensure establishments reflect the population need. An example of this is the identification that Ellesmere Port CCT required additional staffing due to them consistently requiring support. The nursing establishment has been reviewed and the team received additional resource resulting in a significant reduction in reliance upon other teams to support their patient demand.

On a daily basis teams submit a capacity tool indicating their capacity predictions for the following day and what they actually achieved the previous day. This tool includes the monitoring of the number of visits that have needed to be 'deferred' on a given day due to clinical priorities. Alongside this, teams prioritise their visits ensuring that those with immediate / urgent need are given highest priority; priority 1. This shared oversight of working amongst teams enables effective communication and enhances the team's ability to collectively respond to patient requirements.

The service is working on the development and introduction of a risk stratification tool as part of the Integrated Care Partnership (ICP). This will assist to identify areas that need to be targeted alongside partnership working within the Care Communities to ensure that staff skill and preventative requirements inform future workforce profiles. This information will inform the nursing workforce is developed in order to meet the current and future healthcare needs of our population.

Right Skills

In November 2017 an Adult Community Nurse Induction Skills Programme was implemented. The two day Skills Programme is accessible each quarter to all new community nursing staff as part of their induction to the service (including non-registered staff) and is in addition to a preceptorship programme for newly qualified nurses. Existing staff that require skills updates are invited to join the programme.

A Clinical Skills Matrix has been developed that identifies the role essential skills and competencies for each community nursing role. This enables each team to ensure that they have the full range of skills and competencies to meet the needs of the population; from a service perspective it enables specialist nursing skills to be identified and share across the service. The clinical skills matrix is used to inform the training needs analysis.

The service reviews the staff skill mix regularly to enable the needs of the population to be met. Administration of insulin by non-registered nursing staff has been a success and demonstrates appropriate development of skills. Likewise, the service has enabled the role of the nursing associate to be introduced and is currently supporting the development of Advanced Practitioners. It is recognised that the current roles, namely community matron and clinical caseload manager, need to be aligned to the wider Trust standards of Advanced Practice and need to be clearly defined to enable effectiveness of these positions to be known.

Recruitment and retention:
Recruitment requirements are centralised through a shared monitoring system which informs recruitment needs and identifies level of vacancies to be appointed to through the rolling recruitment programme for band 5 community nurses. Local soft intelligence is used within CCT's who are best able to interpret such to assist in anticipating the recruitment and retention requirements of community nursing workforce. The Trust wide student nurse recruitment event held in September 2018 supported advance workforce planning, recruiting into current vacancies and horizon scanning for the future.

Turnover rates for vacancies are monitored through determined reporting systems as part of the governance process. Any risk of staff shortages are mitigated locally initially by team leaders having access to a regular pool of bank staff and close liaise with fellow teams and colleagues. Assurance is evidenced by CCTs not requiring support from Locum Agencies in the last 12 months.

Right Place and Time
Information contained within Locality Data Packs assists to inform the reasons for referral of patients to the CCTs. Use of this type of information requires development to inform how patients' needs are met promptly and according to clinical priority.

Community Care Teams currently report activity of patient reallocation and associated risk of not being able to meet patients' needs according to their clinical priority via the Daily Capacity Reporting Tool. This provides assurance that patient's with a priority 1 need, those patients' with a clinical need requiring a community nursing visit that day, have been met. This has been achieved by responding to the determined risks identified by use of the tool, inclusive of the ability to redeploy staff; to care for patients with the greatest clinical need when and as needed; with the most appropriate skill to meet the needs of the patients at a particular point in time. Presently, this tool provides anticipatory data but does not provide information in real-time. To address this, a Daily Situation Report is being developed across Community Care Teams using a quality improvement approach.

Recommendations:

- To review the daily capacity tool and the use of using 'deferred' patients as the method of informing capacity and demand.
- Develop the use of locality data packs and determine how the information can be used to inform practice.
- Review the role of community matrons.

Appendix 4 Improving Access to Psychological Therapies (IAPT)

Core Improving Access to Psychological Therapies Safer Staffing Report

The Improving Access to Psychological Therapies (IAPT) programme supports the NHS in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people with depression and anxiety disorders.
NHS England recommend services employ IAPT trained staff or train their existing staff in the recognised therapy modalities to expand capacity and where services are employing non-IAPT trained staff those staff should be accredited, by the recognised body (British Association for Behavioural and Cognitive Psychotherapies (BABCP) for Cognitive Behavioural Therapists) for the modality of therapy they are offering.

Right Staff:

	Trainee PWPs	Qualified PWPs	Senior PWP	Trainee HITs	Qualified HITs	Qualified Counsellors	Assistant PWPs/HCAs	Total Staffing
South Cheshire and Vale Royal	3	5.74	1	2	9.5	5.3	1	27.54
West Cheshire	1	9.4	1	0	10.9	7.6	0	29.9
South Sefton, Southport & Formby	2	15.49	2	4	11	5.52	0	38.01

Currently the services in West Cheshire and Vale Royal & South Cheshire are lower that the NHSE recommendations for step 2. The current national IAPT model assumes a 60% low intensity work force and a 40% high intensity workforce. To bring South Cheshire & Vale Royal in line with this model we would require an extra 5 whole time equivalent (WTE) qualified Psychological Wellbeing Practitioners (PWPs) and West Cheshire would require an additional 2 WTE PWPs. Currently we are utilising a higher percentage of high intensity therapy to meet the demand.

Supervision:
There are sufficient numbers of supervisors for core PWPs, counsellors, and high intensity therapists (HITs) to meet the NHSE recommendations for IAPT. Within all localities it is identified that there are insufficient supervisors to provide supervision related to Eye Movement Desensitization and Reprocessing Therapy (EMDR). To address this EMDR consultant sessions across the IAPT sites will be purchased to provide the required supervision by February 2019. Sufficient number of supervisors to include supervision for counselling for depression will be available by December 2019; this will be as a result of the current trainees qualifying and accessing the Health Education England (HEE) commissioned supervisor course.

The impact of this is limited as we are providing core IAPT supervision to across the sites and this would be and additional offer.

Right Skills

Locality	% of PWP Trainee on IAPT approved training	% of IAPT Qualified PWP	% of HIT Trainee on IAPT approved trainee	% of IAPT Qualified HIT	% of Qualified Counsellors with IAPT approved training or commencing training
South Cheshire & Vale Royal	100%	100%	100%	100%	91%
West Cheshire	100%	100%	100%	100%	79%
South Sefton, Southport & Formby	100%	100%	100%	100%	100%

We are assured by reaching 100% compliance for training in accordance with expected standards for all staff groups. It is not mandated that qualified counsellors have IAPT approved training but it is recognised good practice. This is an area of improvement and we plan to enable our qualified counsellors to access this additional training by the end of 2019.

Right Time / Place:
The discussions of individual clinical cases during supervision are prioritised according to clients' needs and a pre-determined schedule. All cases are regularly reviewed within a reasonable period of time (2-4 weeks) with some services delivering weekly supervision.

High intensity activity is currently higher than the national model for step 3 across the IAPT services. All services are offering a compliant stepped care model with all patients being offered an initial step 2 intervention. This enables staff to meet patient need effectively by identifying those with a greater need to continue onto a high intensity programme. To ensure we are offering the correct intervention at the right time therapist continually monitor patients improvement through psychometric measure and patients are stepped up to a higher intensity therapy if the patient is not recovering as expected. The services have the capacity to deliver this offer through the stepped care model.

All IAPT services deliver treatment through a range of alternative delivery systems such as telephone, group therapy or 1-1 therapy which is delivered according to the IAPT guidance. All areas apart from South Sefton Southport and Formby offer web based support which is a better use of staff resource to meet patient need. This is an identified area of improvement and we will be working with our delivery partner to ensure that this is offered for 2019.

Recommendations:

1. To work with our delivery partner in South Sefton and Formby for web based support to be available to patients as a step 2 intervention.
2. To enable qualified counsellors without IAPT approval training to access such in 2019.
3. To progress with the provision of internal supervision for EMDR and Counselling for Depression.

Appendix 5 Place Based Care Mental Health

Overview

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

Background

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

It should be noted that there are considerable interdependencies with the wider redesign of specialist mental health services, including the programme of work being done across Central and Eastern Cheshire to ensure that services are safe and sustainable; clinically effective and accessible whilst providing a good service user experience within the current financial envelope. This potentially results in changes to staffs' roles resulting in some early planning with CWP Education and Organisational Development as part of the programme of work to ensure a skilled and motivated workforce.

The CMHT workforce is starting to routinely develop and utilise advanced skills and roles within clinical practice. Particular examples include the development of Non-Medical Prescribers, Advanced Practitioner roles, [although to date these positions are generally held by nurses], and the new Nursing Associate role. Historically, there has not been a strategic plan across the organisation with regard to the development of these roles – particularly the Advanced Practitioner, and how the advanced skills are utilised to their optimum, Recent training positions have sought to address this and have been developed in a considered manner with the vision for services and the desire to address '*the right staff, the right skill, the right place*' agenda in mind.

Right Skills

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

The programme of work has focused upon identifying the skills required to meet the needs of service users in terms of being able to deliver the evidence-based interventions recommended within NICE clinical guidance. This approach has been taken at every level of the workforce – from support worker to consultant level. This approach has then supported the identification of the roles required to deliver the necessary skills.

An audit completed across place based, specialist mental health services revealed a limited number of people who held advanced skills and a number of those lack current experience in their use – particularly the use of psychological interventions. Thus, a comprehensive training strategy together with a full programme of organisational development and culture change is required to support the full transformation programme.

Right Staff

The identification of skills required to be delivered has enabled an innovative approach to the development of a multi-disciplinary enabling a much broader range of professional backgrounds to be involved, including pharmacy. This approach has also provided an increased resilience with regard to some of the roles that are becoming increasingly difficult to recruit to.

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

Right Time

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

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

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Ward Daily Staffing Levels November and December Data 2018
Agenda ref. no:	18/19/122
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	30/01/2019
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

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

REPORT BRIEFING

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

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

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

The monthly reporting of daily staffing levels is a requirement of NHS England and the National Quality Board in order to appraise the Board and the public of staffing levels within in-patient units.
The recommendations made within the latest six monthly report are being followed through and will be monitored via the Inpatient Service Improvement Forum and the People Planning group which oversees the strategic approach to safe staffing.

The Trust is engaged in the national Optimum Staffing Project a programme of work commissioned by Health Education England to develop a generic tool (multi-disciplinary) for Safe Staffing that can be used in any service setting for inpatient mental health services.

Assessment – *analysis and considerations of options and risks*

During November 2018 the trust achieved staffing levels of 96.1% for registered nurses and 96% for clinical support workers on day shifts and 96.7% and 97.5% respectively on nights. During December 2018 the trust achieved staffing levels of 98.9% for registered nurses and 96.3% for clinical support workers on day shifts and 96.3% and 98.9% respectively on nights.

In the months of November and December 2018 the wards continued to experience pressures in terms of staffing in particular on the wards in Central and East locality due to staff sickness, maternity leave, patients on increased levels of observations and vacancies.

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

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

The Board of Directors are recommended to note the report.

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Gary Flockhart, Associate Director of Nursing [MH and LD] Avril Devaney, Avril Devaney, Director of Nursing, Therapies and Patient Partnership	22.01.19

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

Appendix no.	Appendix title
1 2	Ward Daily Staffing November 2018 Ward Daily Staffing December 2018

		Day				Night				Day		Night		
		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff						
Service Line	Ward	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Safe Staffing was maintained by:
SMH - Bed Based West & East	Adelphi	1281	1212	1206.5	1123.5	713	713	1081	1046.5	94.6%	93.1%	100.0%	96.8%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.Multi Disciplinary Team actively worked within the staffing establishment .
	Bollin	1359.5	1146	1469	1324	701.5	690	1426	1296.5	84.3%	90.1%	98.4%	90.9%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.Multi Disciplinary Team actively worked within the staffing establishment .
	Croft	1286.25	1327.25	1562.5	1337	690	672.5	1538.5	1458	103.2%	85.6%	97.5%	94.8%	Nursing staff working additional unplanned hours. Cross cover arrangements. Multi Disciplinary Team actively worked within the staffing establishment .
	Beech	1320	1251	881.5	847	609.5	598	747.5	724.5	94.8%	96.1%	98.1%	96.9%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Cherry	1165	1165	1058	1058	632.5	632.5	1000.5	1000.5	100.0%	100.0%	100.0%	100.0%	
	Juniper	1258	1212	848	825.5	598	598	770.5	770.5	96.3%	97.3%	100.0%	100.0%	
	Willow PICU	920.5	904.5	1160.5	1166	667	609.5	862.5	851.023	98.3%	100.5%	91.4%	98.7%	Nursing staff working additional unplanned hours. Cross cover arrangements.
SMH - Forensic, Rehab, CRAC	Alderley Unit	987	954.5	1375.5	1293.5	655.5	609.5	690	724.5	96.7%	94.0%	93.0%	105.0%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.
	LimeWalk Rehab	1127.2	1114.5	1023.5	877.05	690	657.8	690	608.85	98.9%	85.7%	95.3%	88.2%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Rosewood	964.5	953	1299.5	1265	632.5	632.5	575	563.5	98.8%	97.3%	100.0%	98.0%	
	Saddlebridge	759	703.5	1445	1435	655.5	598	839.5	851	92.7%	99.3%	91.2%	101.4%	Nursing staff working additional unplanned hours. Cross cover arrangements.
Learning Disabilities & NDD	Eastway A&T	1188	1130.5	1541	1518	552	552	1552.5	1529.5	95.2%	98.5%	100.0%	98.5%	
	Greenways A&T	1198.5	1042.75	2018.5	1783	701.5	655.5	1368.5	1368.5	87.0%	88.3%	93.4%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.Multi Disciplinary Team actively worked within the staffing establishment .
CYP - Tier 4 CAMHS & Outreach	Coral Ward	1133.5	1133.5	1187	1187	506	506	1000.5	1000.5	100.0%	100.0%	100.0%	100.0%	
	Indigo Ward	869	834.5	951	928	575	564.5	737.5	714.5	96.0%	97.6%	98.2%	96.9%	
SMH - Bed Based Wirral & PICU	Brackendale	990	975	1033.5	1009	667	644	690	690	98.5%	97.6%	96.6%	100.0%	
	Brooklands	913.5	869.5	1192	1192	586.5	563.5	943	919.5	95.2%	100.0%	96.1%	97.5%	
	Lakefield	1139	1124	880	868.5	667	667	885.5	874	98.7%	98.7%	100.0%	98.7%	
	Meadowbank	1166.5	1143	1573	1584.5	694.5	660	1058	1056.5	98.0%	100.7%	95.0%	99.9%	
	Oaktrees	1221.15	1171	759	758.5	667	598	443.5	385.5	95.9%	99.9%	89.7%	86.9%	Nursing staff working additional unplanned hours.
	Trustwide	22247.1	21367	24464.5	23380.05	12861.5	12421.8	18900	18433.873	96.1%	96.0%	96.7%	97.5%	

		Day				Night				Day		Night		
		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff						
Service Line	Ward	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Safe Staffing was maintained by:
SMH - Bed Based West & East	Adelphi	1246.50	1191.00	1241.00	1094.40	724.50	701.50	1081.00	1023.50	95.5%	88.2%	96.8%	94.7%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Bollin	1305.50	1271.00	755.50	747.00	632.50	621.00	793.50	793.50	97.4%	98.9%	98.2%	100.0%	
	Croft	864.50	841.50	1403.00	1403.00	678.50	644.00	989.00	989.00	97.3%	100.0%	94.9%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Beech	1305.50	1271.00	755.50	747.00	632.50	621.00	793.50	793.50	97.4%	98.9%	98.2%	100.0%	
	Cherry	1197.50	1197.50	943.00	943.00	759.00	759.00	1046.50	1046.50	100.0%	100.0%	100.0%	100.0%	
	Juniper	985.00	985.00	921.00	909.50	602.50	602.50	736.00	736.00	100.0%	98.8%	100.0%	100.0%	
	Willow PICU	762.50	762.50	993.50	993.50	540.50	563.50	655.50	655.50	100.0%	100.0%	104.3%	100.0%	
SMH - Forensic, Rehab, CRAC	Alderley Unit	864.50	841.50	1403.00	1403.00	678.50	644.00	989.00	989.00	97.3%	100.0%	94.9%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	LimeWalk Rehab	1115.50	1184.00	1092.50	944.50	713.00	640.00	713.00	664.50	106.1%	86.5%	89.8%	93.2%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Rosewood	864.50	841.50	1403.00	1403.00	678.50	644.00	989.00	989.00	97.3%	100.0%	94.9%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.
	Saddlebridge	759.00	741.50	1575.50	1564.00	552.00	552.00	770.50	770.50	97.7%	99.3%	100.0%	100.0%	
Learning Disabilities & NDD	Eastway A&T	1143.00	1101.00	1594.00	1584.00	374.60	363.00	1805.50	1722.50	96.3%	99.4%	96.9%	95.4%	
	Greenways A&T	1216.00	1186.00	2070.00	1672.50	747.50	586.50	1380.00	1495.00	97.5%	80.8%	78.5%	108.3%	Nursing staff working additional unplanned hours. Cross cover arrangements.
CYP - Tier 4 CAMHS & Outreach	Coral Ward	864.50	841.50	1403.00	1403.00	678.50	644.00	989.00	989.00	97.3%	100.0%	94.9%	100.0%	Nursing staff working additional unplanned
	Indigo Ward	882.10	836.10	937.00	902.50	607.00	595.50	663.00	651.50	94.8%	96.3%	98.1%	98.3%	Nursing staff working additional unplanned hours.
SMH - Bed Based Wirral & PICU	Brackendale	1115.50	1184.00	1092.50	944.50	713.00	640.00	713.00	664.50	106.1%	86.5%	89.8%	93.2%	Nursing staff working additional unplanned hours.
	Brooklands	1105.00	1105.00	1564.00	1564.00	729.00	729.00	1138.50	1138.50	100.0%	100.0%	100.0%	100.0%	
	Lakefield	1032.00	1032.00	943.00	943.00	690.00	690.00	839.50	828.00	100.0%	100.0%	100.0%	98.6%	
	Meadowbank	1105.00	1105.00	1564.00	1564.00	729.00	729.00	1138.50	1138.50	100.0%	100.0%	100.0%	100.0%	
	Oaktrees	1162.50	1162.00	1058.00	989.00	713.00	678.50	356.50	345.00	100.0%	93.5%	95.2%	96.8%	Nursing staff working additional unplanned hours.
	Trustwide	20896.1	20680.6	24712	23718.4	13173.6	12648	18580	18423	98.9%	96.3%	96.3%	98.9%	

Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Developing Workforce Safeguards
Agenda ref. no:	18.19.123
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	30/01/2019
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

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

REPORT BRIEFING

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

This paper provides a position statement and recommendations in relation to the NHS Improvement published Developing Workforce Safeguards; Supporting providers to deliver high quality care through safe and effective staffing (October 2018).

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

In October 2018 NHS Improvement published 'Developing Workforce Safeguards; Supporting providers to deliver high quality care through safe and effective staffing' to support trusts to manage common workforce challenges. The document builds on the National Quality Board's (NQB) guidance and informs that trusts compliance will be assessed against such.

Implementing Developing Workforce Safeguards recommendations alongside the Trusts strong effective governance will provide assurance that workforce decisions promote patient safety and in doing so comply with the Care Quality Commission's (CQC) fundamental standards.

NQB's guidance states that providers:

- Must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively.
- Should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times.
- Must use an approach that reflects current legislation and guidance where it is available.

Assessment – *analysis and considerations of options and risks*

Developing Workforce Safeguards (Oct 2018) requires that trusts take required action to ensure that the given principles are in place in line with stated recommendations. Cheshire and Wirral Partnership NHS Foundation Trust's position against the Developing Workforce Safeguards (Oct 2018) recommendations:
Recommendation 1 and 2:

- Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.
- Trusts must ensure evidence based tools (where they exist), professional judgement, and outcomes are used in their safe staffing processes.

Safer staffing is reported to the Trust Board via the Trust Operational Board on a six monthly basis. Workforce planning and the strategic approach for safer staffing (in line with NQB guidance) is included within the terms of reference for the People Planning group.
Recommendation 3 to 6:

- Trusts will be required to confirm their staffing governance processes are safe and sustainable. Assessment will be based on the annual governance statement.
- The annual governance statement will be reviewed by NHS Improvement through the usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures.
- NHS Improvement will seek assurance through the Single Assessment Framework.
- The director of nursing and medical director must confirm as part of the safer staffing review in a statement to the board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.

The annual governance statement regarding safer staffing will be included within the annual governance statement from 2019.
The Director of Nursing will present the six monthly safer staffing reviews and will state, alongside the Medical Director, their level of satisfaction of the outcomes of assessments that staffing is safe, effective and sustainable.
Recommendation 7:

- Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The workforce plan should be discussed in a public meeting. (Recommendation 7)

The workforce plan will be included within the board's public meeting business cycle from April 2019.
Recommendation 8 to 10:

- Trust must have agreed local quality dashboard that cross checks comparative data on staffing and skill mix with other efficiency and quality metrics; and report on this to the board each month.
- An assessment or re-setting of the nursing establishment and skill mix must be reported to the board by ward or service area twice a year in accordance with NQB guidance.
- There must be no local manipulation of the identified nursing resource from the evidence based figures in the evidence based tool used.

Safer staffing report has been presented to the Trust Board every six months since January 2014. The safer staffing report for January 2019 has been expanded to include community nursing, learning disabilities, IAPT, and place based care mental health. This report highlights our approach to ensuring right staff, right skills, right time and place in accordance with NQB guidance.

Performance dashboard is reported to Trust Operational Board each month inclusive of the staffing levels; skill mix and workforce are considered within a number of areas at Care Group level and Trust wide within the People Planning Group.

It is recognised by NHS Improvement that developing a consistent approach to safer staffing levels across all clinical workforce groups is a requirement that needs further attention. The Trust continues to use evidence based tools that are available without manipulation; as detailed within the six monthly safer staffing reports.

Recommendation 11 and 12:

- All service changes, including skill mix changes, must have a full quality impact assessment review.
- Redesign and introduction of new roles are considered a service change and must have a full quality impact assessment.

Requirements for completing quality impact assessments are recognised and led by the People Planning Group. The introduction of the nursing associates from January 2019 onwards is a significant change to the workforce that has been subject to a quality impact assessment and will be approved through the Trust's governance structures.

Recommendation 13 and 14:

- Dynamic staffing risk assessments including formal escalation processes in response to day to day operational challenges.
- Risks associated with staffing that increase or mitigation is insufficient must be escalated to the board to maintain safety and care quality.

Processes are in place to enable frontline staff to escalate concerns in relation to staffing levels and wards / service areas have appropriate articulated risks regarding staffing

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

The Board of Directors is recommended to:

- Receive the findings of this position statement.
- Accept the statement from Director of Nursing and Medical Director, in conjunction with the six monthly safer staffing reviews, that they are satisfied with the outcomes of the assessments that staffing is safe, effective and sustainable.
- Note that the forthcoming annual governance statement will include a section detailing the staffing governance processes and the extent of compliance to with the NQB guidance.
- Confirm that the business cycle for the public meeting includes the workforce plan for approval from April 2019.
- Acknowledge and seek assurance through Trust Operational Committee that all service changes, inclusive of redesign and introduction of new roles are subject to a quality impact assessment.

Who/ which group has approved this report for receipt at the above meeting?	Avril Devaney, Director of Nursing, Therapies and Patient Partnership
Contributing authors:	Victoria Peach, Associate Director of Nursing and Therapies Gary Flockhart, Associate Director of Nursing and Therapies

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
n/a	n/a	n/a

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

Appendix no.	Appendix title
n/a	

Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	PLACE report 2018-19
Agenda ref. no:	18.19.124
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	30/01/2019
Presented by:	Andy Styring, Director of Operations

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

REPORT BRIEFING

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

CWP are required to undertake and report on environmental standards through the Patient-Led Assessments of the Care Environment (PLACE) which are a annual self-assessment of non-clinical services which contribute to healthcare delivered in both the NHS and independent/ private healthcare sector in England.

PLACE is reported directly to NHS Improvement and results are calculated nationally and broken down into organisations, and formulate part of the Model Hospital matrix as outlined in Lord Carters report to central government.

PLACE encourages the involvement of patients, the public and other healthcare bodies, both national and local (e.g. Local Healthwatch) in assessing healthcare providers, this is done in equal partnership. The full detailed report is enclosed as appendix 1.

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

The aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care. The non-clinical activities of concern are:-Cleanliness, Food and Hydration, Privacy, Dignity and Wellbeing, Condition, Appearance and Maintenance of healthcare premises, Dementia, Disability.

A wide variety of patient assessors were used to perform the inspections these included, registered PPI representatives, volunteers, past and current Service users and representatives from Healthwatch in each locality. CWP also had external verification provided by a trained individual on two visits within the 2018 assessments.

Assessment – *analysis and considerations of options and risks*

Overall Cheshire & Wirral Partnership has improved on most elements assessed, the Facilities and Estates teams are proud to be the top organisation within the North commissioning region in all areas of the inspection within the local Mental Health and Learning Disability Trusts, while also achieving above national average in all elements of inspections.

While the inspections were extremely positive, action plans were developed to address any issues noted during the inspections and distributed to the appropriate managers for rectification. All cleaning issues and minor maintenance issues were addressed immediately. These actions also align with the service improvements developed in response to MIAA quality spot check audits. All patient assessors were very complimentary of the Trust and expressed they had learnt a great deal by participating in the PLACE inspections.

Overall the 2018 PLACE inspection programme has been very successful, the assessments completed help to provide assurance to Cheshire & Wirral Partnership Board of Directors.

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

The Board of Directors is recommended to **note** the report

Who/ which group has approved this report for receipt at the above meeting?		Andy Styring
Contributing authors:		David Pearson
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Operational Committee	16 January 2019

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1	2018-19 PLACE report

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Document Reference (2018/PLACE)

Report to: CWP Public Board Meeting

Date Report Due: November 2018

Title of Report: PLACE (Patient Led Assessment of the Care Environment) results 2018

Author: David Pearson MBIFM Head of Facilities & Infrastructure Services Management

Objectives that this report covers:

O1 – Introduction

O2 – Principles of PLACE

O3 – Process

O4 – Results

O5 – Conclusion

Distribution

Version	Name(s)/Group(s)	Date Issued
FINAL	Justin Pidcock MRICS – Associate Director Operations - Infrastructure & CYP Andy Styring – Director of Operations	08/11/18

Introduction

Patient-Led Assessments of the Care Environment (PLACE) are a self-assessment of non-clinical services which contribute to healthcare delivered in both the NHS and independent / private healthcare sector in England. PLACE is reported directly to the Department of Health and results are calculated nationally and broken down into organisations, and formulate part of the Model Hospital matrix as outlined in Lord Carter's report to central government.

Through focussing on the areas which matter directly to patients, families and/or carers, the PLACE programme aims to promote a range of principles established by the NHS Constitution, including:-

- Putting patients first;
- Actively encouraging feedback from the public, patients and staff to help improve services;
- Striving to get the basics of quality of care right;
- A commitment to ensure that services are provided in a clean and safe environment that is fit for purpose.

PLACE encourages the involvement of patients, the public and other healthcare bodies, both national and local (e.g. Local Healthwatch) in assessing healthcare providers. This is done in equal partnership with NHS staff to both identify how they are currently performing and to identify which services can be improved for the future.

There have been further developments of the dementia assessment section within 2018; the criteria within this section assess how well healthcare providers' premises are equipped to meet the needs of caring for patients with dementia. It should however be noted that this does not represent a comprehensive assessment relating to dementia, rather it focused on a limited range of aspects with strong environmental, and buildings-associated components. Organisations are encouraged to separately undertake a comprehensive dementia-related assessment using a recognised environmental assessment toolkit. (CWP adopts the principles of the University of Stirling Audit toolkit)

The Principles

The aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care. The non-clinical activities of concern are:-

- Cleanliness
- Food and hydration
- Privacy, dignity and wellbeing (the extent to which the environment supports the delivery of care with regards to the patient's privacy dignity and wellbeing)
- Condition, appearance and maintenance of healthcare premises
- Dementia (whether the premises are equipped to meet the needs of dementia patients against a specified range of criteria)
- Disability

The criteria included in PLACE are not standards, but they do represent aspects of care which patients and the public have identified as important. It also represents good practice as identified by professional organisations whose members are responsible for the delivery of these services. These include, but are not limited to, the healthcare estates facilities managers association (HEFMA), the association of healthcare cleaning professionals (ACHP), the hospital caterers association (HCA) and the British institute of facilities managers (BIFM). In the case of dementia they draw heavily on the work of The Kings fund and Stirling University.

The assessments cover:

Cleanliness

- The assessment of Cleanliness covers all items commonly found in healthcare premises including patient equipment, baths, toilets and showers, furniture, floors and other fixtures and fittings.

Food & Hydration

- The assessment of food and hydration includes a range of organisational questions relating to the catering service for example, the choice of food, 24-hour availability, meal times and access to menus. An assessment of food services at ward level is conducted assessing three elements:
    - Taste
    - Texture
    - Temperature

Privacy, Dignity and Wellbeing

- The assessment of privacy, dignity and wellbeing includes infrastructure and organisational aspects such as the provision of outdoor recreation areas, changing and waiting facilities, access to technology. The assessment includes the practicality of male and female services such as sleeping and bathroom facilities, and ensuring patients are appropriately dressed to protect their dignity.

Condition, appearance and maintenance

- The assessment of condition, appearance and maintenance includes various aspects of the general environment including:
    - Décor
    - Condition of fixtures and fittings
    - Signage
    - Lighting (including access to natural light)
    - Linen
    - Car parking
    - Waste management
    - External appearance of buildings
    - Maintenance of grounds

Dementia and Disability Assessment

- The Dementia and disability assessment does not constitute the full range of issues requiring assessment, which are too numerous to include in these assessments. However they do include a number of key issues. Organisations are encouraged to undertake more comprehensive assessments using one of the recognised environmental assessment tools available.

Process

In 2018 Cheshire and Wirral Partnership participated in the Patient-Led Assessment of the Care Environment (PLACE) inspections. These assessments were led by the facilities management team; all assessments were concluded by the end of May 2018, all NHS organisations are given a window in which to carry out an assessment of all sites, these dates were provided by NHS Improvement and were unannounced to the wards until day of inspection.

A wide variety of patient assessors were used to perform the inspections, as per the guidance from NHS improvement. The Facilities team prioritised involvement from external agencies such as local Healthwatch. CWP also had external verification of visits conducted by a trained individual from another NHS organisation, this was to ensure that process was fair, reasonable and consistent as set out within Department of Health guidelines.

All assessments were undertaken using a standard assessment format issued by NHS Improvement; all CWP's inpatient units, over 10 beds, were inspected.

The premises assessed were as follows:

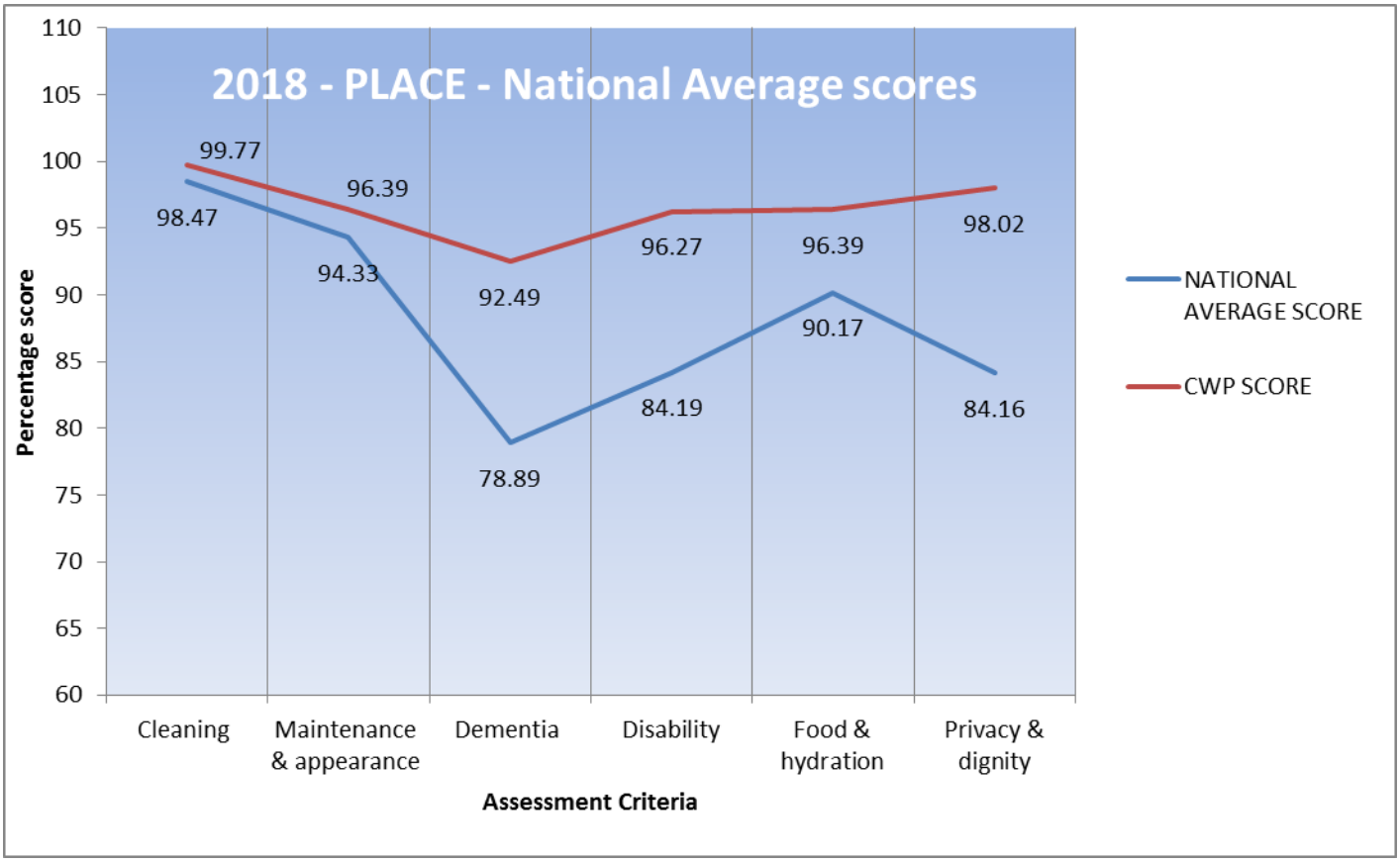
- Bowmere
- Springview
- Millbrook
- Lime Walk

- Greenways
- Alderley Unit
- Saddlebridge Unit
- Eastway
- Ancora House

Within 2018 the process used to facilitate the PLACE visits ensured a consistent member of the Facilities team was present at each inspection. We ensured that the number of inspectors was appropriate based on the size of the unit/ward being inspected, so not to cause too much disruption the ward environment.

Results

Below is a visual representation of all scores, for Cheshire & Wirral Partnership, benchmarked against overall national average, clearly showing CWP is above national average on all assessment criteria:



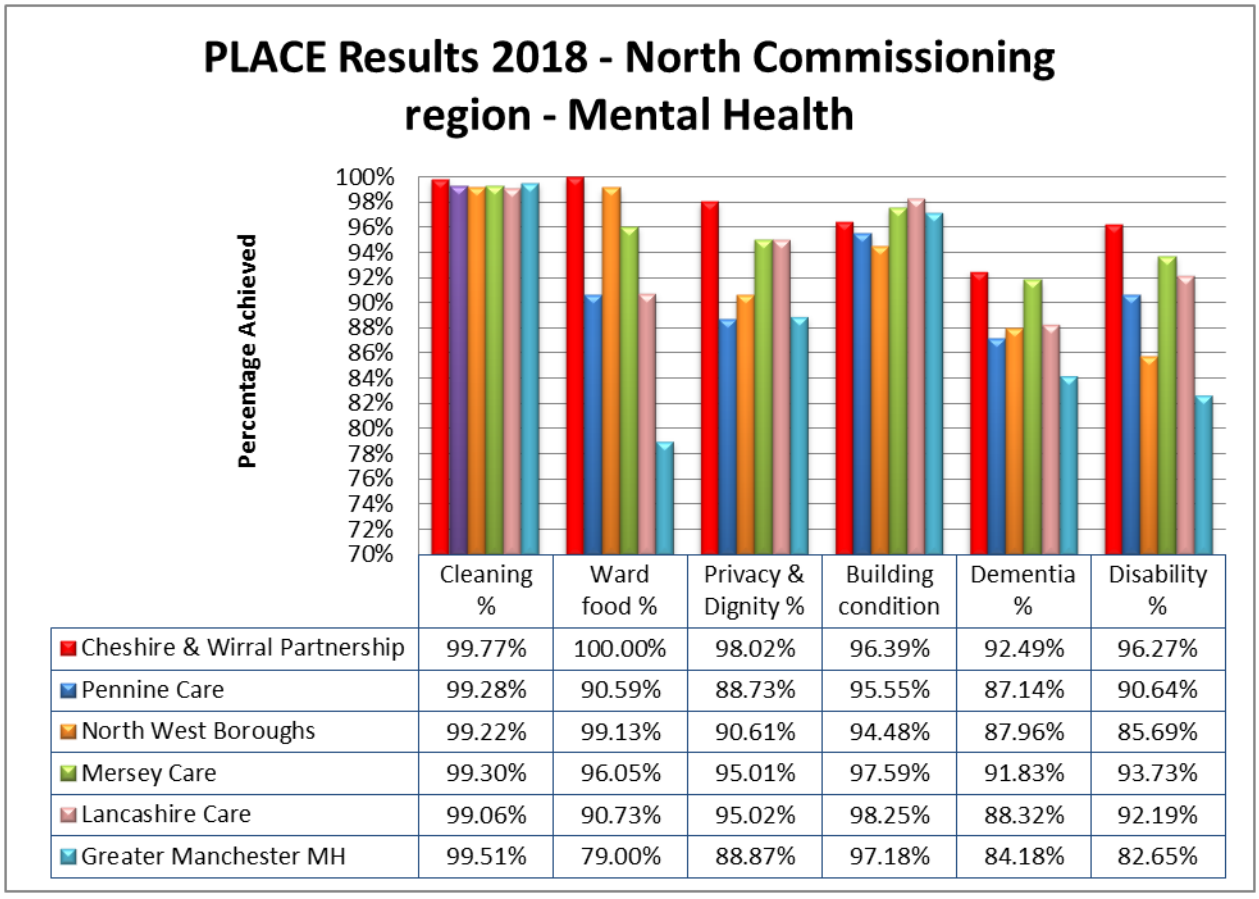
There has been an improvement in the majority of areas of inspection within Cheshire & Wirral Partnership. There has been a slight reduction in scoring under the condition

maintenance and appearance compared with 2017, this is due to issues identified within the East Cheshire locality, to which CWP are currently working with commissioners to resolve (highlighted in red below).

Overall CWP is performing above national average in all areas of the assessment criteria. This is down to the hard work input by the Facilities and Estates teams across the organisation. The scoring also demonstrates the good working relationship the support services team have with clinical services. PLACE is a useful tool to help gauge how the investment the Trust has put into wards is perceived by patient representatives, as well as external organisations with an interest in healthcare (healthwatch).

Site Name	Cleaning Score %	Food Score %	Org Food Score %	Ward Food Score %	Privacy Dignity Score %	Building condition Score %	Dementia Score %	Disability Score %
Bowmere Hospital	99.93%	97.29%	94.71%	100.00%	98.24%	99.63%	97.74%	96.25%
Lime Walk House	99.57%	96.96%	93.86%	100.00%	98.08%	95.29%	N/A	93.03%
Greenways	100.00%	95.91%	93.86%	100.00%	94.70%	100.00%	N/A	100.00%
Springview Unit	100.00%	96.23%	93.86%	100.00%	100.00%	97.63%	85.82%	92.54%
Millbrook	99.13%	95.72%	93.86%	100.00%	93.09%	85.42%	94.89%	98.63%
Soss Moss Site	99.66%	96.23%	93.86%	100.00%	100.00%	100.00%	N/A	100.00%
Eastway	100.00%	94.33%	92.61%	100.00%	100.00%	98.12%	N/A	94.88%
Ancora House	100.00%	96.23%	93.86%	100.00%	100.00%	100.00%	N/A	100.00%

Finally below is a visual representation of how CWP compares with surrounding mental health NHS organisations in regards to the PLACE inspections:



	Cleaning %	Ward food %	Privacy & Dignity %	Building condition	Dementia %	Disability %
Cheshire & Wirral Partnership	99.77%	100.00%	98.02%	96.39%	92.49%	96.27%
Pennine Care	99.28%	90.59%	88.73%	95.55%	87.14%	90.64%
North West Boroughs	99.22%	99.13%	90.61%	94.48%	87.96%	85.69%
Mersey Care	99.30%	96.05%	95.01%	97.59%	91.83%	93.73%
Lancashire Care	99.06%	90.73%	95.02%	98.25%	88.32%	92.19%
Greater Manchester MH	99.51%	79.00%	88.87%	97.18%	84.18%	82.65%

Conclusion

Overall Cheshire & Wirral Partnership has improved on most elements assessed above, the Facilities and Estates teams are proud to be the top organisation within the North commissioning region in all areas of the inspection within the local Mental Health and Learning Disability Trusts, while also achieving above national average in all elements of inspections.

While the inspections were extremely positive, action plans were developed to address any issues noted during the inspections and distributed to the appropriate managers for rectification. All cleaning issues and minor maintenance issues were addressed immediately. These actions also align with the service improvements developed in response to MIAA quality spot check audits.

All patient assessors were very complimentary of the Trust and expressed they had learnt a great deal by participating in the PLACE inspections.

Overall the 2018 PLACE inspection programme has been very successful, the assessments completed help to provide assurance to Cheshire & Wirral Partnership Board of directors,

commissioners and general public that the standards of the environment and Facilities services provided are meeting the needs of service users. These assessments also demonstrates the hard work that the Facilities and Estates team, in conjunction with clinical services, provide in improving the environment for service users to ensure it is safe and effective.

David Pearson **MBIFM**

Head of Facilities

Infrastructure

NHS
Cheshire and Wirral Partnership
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STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Operational Plan 2018/19- delivery indicators dashboard [December data]
Agenda ref. no:	18.19.125
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	30/01/2019
Presented by:	Tim Welch, Director of Finance

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

REPORT BRIEFING

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

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

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

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

The operational plan delivery indicators dashboard in appendix 1 reflects the review of the metrics that has been undertaken with lead officers to ensure that the focus of monitoring the delivery of the Operational Plan and the Trust's strategic objectives is in line with the revision of the Operational Plan 2017/19 and highlights areas for improvement.

Following the Board seminar in December work is continues to align reporting formats/ styles/ definitions across the Trusts committee structures, phase one of this work is focusing on the Quality Committee and Trust Board dashboard reporting, and the redevelopment of the dashboard will be delivered for the new year.

Assessment – *analysis and considerations of options and risks*

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

The dashboard reflects month 9 (December) performance and there are 14 indicators off track.
SO1: 1.3 Clinical Effectiveness
SO1:1.6 Patient Safety Indicators
SO3: 2.1 Capacity: % of staff vacancies (Contracted)
SO3: 2.2 Competence: % of staff receiving annual appraisal
SO3: 2.3 % staff absence due to sickness
SO3: 3.2 100% of contract targets met & CQUIN performance quarterly review
SO3: 3.3/6/7a&b /9/10/13 Priority Projects

Following review of the operational performance dashboard, at Operational Committee on 16 January 2019 it was agreed to escalate the following issues to Trust Board for oversight and discussion,:

- CHEDs 4 week wait for routine referrals NHSI target has been challenging and performance this month is much improved
- Improved management of bed resources over the Christmas period

Challenges:

- Sickness absence in particular in bed based services
- Efficiency savings (please refer to finance report)

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

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

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

Who/ which group has approved this report for receipt at the above meeting?	Tim Welch
Contributing authors:	Mandy Skelding-Jones, Associate Director Performance & Redesign, Viv Williamson, Hayley Curran, Lisa Parker
Distribution to other people/ groups/ meetings:	

Version	Name/ group/ meeting	Date issued
36T	Tim Welch	17.01.19

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1 2	December 2018 Board Operational Plan Dashboard. Operational Plan 2017/18 – Delivery Indicators/ Board KPIs

Appendix 1: Trust Dashboard

	Indicator	Outturn 2017/18	Target or Thresholds for escalation	Target	Q1	Q2	Oct-18	Nov-18	Dec-18	Q3	Q4	Year End	General Comment
Strategic Objective 1 – Quality													
SO1: 1.8	Patient Safety: Reduction in the severity of harm (by 20%) sustained by those people accessing CWP services that cause harm to themselves	121 (10 per month)	97 (8 per month)	8 per month	29	23	7	11	6	24			Long term trajectory is continuous improvement against 2017/18 outturn, however progress needs to be made in the remainder of quarter 4. A driver diagram has been developed and QI work is being implemented. Note: As incident reporting numbers represent a snapshot as at the time of reporting they are subject to change over time, for example: re-categorisation of incidents following receipt of further information. A planned data quality review was been undertaken in Q3 and retrospective adjustments made in this reporting period.
SO1: 1.2	Patient experience: Demonstrable increase in the uptake of the Friends and Family Test (FFT) each quarter	Average 201 (per month)	330 per month	330	841	711	333	312	300 *	945			* Decmeber figures are inclusive of paper and elctronic surveys completed.
SO1: 1.3	Clinical Effectiveness: Demonstrable improvement in the Trustwide average bed occupancy rate, excluding leave, for working age adult wards	93.30%	Improvement to 85% by KH03's month 12 (December 2017)		93.58%	91.16%	92.97%	93.77%	87.96%	91.57%			The trust has experienced improvement in the bed occupancy rates this year. However this improvement continues to be at a level that is higher than the Royal Psychiatrist nationally reccomended bed occupanct rate of 85%.
SO1: 1.4	Patient Safety: Total % inpatient deaths subject to a case record review	100%	100%	100%	100%	**N/A**	N/A	N/A	N/A	**N/A**			N/A
SO1: 1.5	Patient Safety: Total number of inpatient deaths subject to a case record review identifying that there may have been a problem in the care provided	3	2 in 2018/19 (1 in any month)	2	1	**N/A**	N/A	N/A	N/A	**N/A**			N/A
SO1: 1.6	Patient Safety: Total % deaths reported by and to the Trust (including inpatient deaths) subject to a case record review	18%	15%	15%	* 34%	*54%	*61%	*65%	*58%	*63%			* Includes only CAREnotes and PCMIS data in the denominator - Amber rating reflects this position. The learning from deaths monitoring group met in January 2019 to discuss changes to the inclusions the denominator due to the differences to the deaths in scope for different populations and agreed to develop revised reporting criteria for the future to ensure a practicable and sustainable approach longer term. Learning points identified in sample audit (relating to Q1 2018/19): May-18: Improvements required to documentation (care plans, clinical records) but no impact in terms of care or service delivery problems.
SO1: 1.7	Patient Safety: Total number of deaths (including inpatient deaths) subject to a case record review identifying that there may have been a problem in the care provided	4	3 in 2018/19 (1 in any month)	3	**0**	**0**	0	0	0	0			N/A

Strategic Objective 2: People and OD/ Approach to workforce													
SO3: 2.1	Capacity: % of staff vacancies (Contracted)	5.00%	equal to or below baseline 5.31%		5.98%	5.57%	5.72%	5.36%	6.3%	6.3%			The vacancy figure from the Finance ledger of 6.29% equates to 208.46 WTE (which is an increase from 175.86 WTE in November). In comparison, as at 10/1/19 there were 239.52 WTE at various stages of recruitment including 110.05 WTE at offer stage). Time to hire, from advert to date of unconditional offer was 49.6 working days for Quarter 3 – a decrease of 3.7 working days compared to Quarter 2. The time to hire has been reducing from a peak of 61 working days in April 18 after staffing issues in the team were resolved.
SO3: 2.2	Competence: % of staff receiving annual appraisal (via new proposed framework)	97.6%	100.0%		89.14%	82.91%	91.08%	87.04%	86.60%	86.60%			A 0.8% reduction in compliance since December. Plans to address include Business Partners working with care groups to undertake targeted work. OD team targeting individuals directly. Letters of concerns will be issued to managers that haven't completed their appraisal via their respective Executive Director. The quality of appraisal discussions was discussed at Scrutiny Committee and Staff Governors Meeting and a short paper has been produced to update on the latest position. A project to review current appraisal and supervision (both clinical and management) will be commencing with the aim of further improving quality and aligning all processes together.
SO3: 2.3	% staff absence due to sickness	5.89%	Above annual plan projection for 3 months		5.24%	6.04%	6.18%	6.30%	6.66%	6.38%			This is the third month that this indicator has been higher than target threshold. The issue has been discussed with Care Group leads at Operational Committee and PODSC and POD Business Partners are supporting Care Groups to ensure that absences are being addressed as effectively as possible through a more detailed analysis of the situation.
SO3: 2.4	Staff, in month, Turnover rate (as a percentage)	0.91%	3 consecutive months where the turnover rate is 25% above the planned rate		0.78%	0.67%	0.64%	0.91%	0.73%	0.73%			

Operational Performance / Priority areas													
SO3: 3.1	100% of the 13 NHSI operational performance targets achieved (including waiting times)	100%	100%	100%	100.00%	93.0%	93.0%	93.0%	100.00%	95.0%			The Trust achieved complaince across all indicators in December. Over the quarter the trust missed two separate KPIs - Gate Keeping - CYP Eating Dosorders 4 week routine wait
SO3: 3.2	100% Contractual targets met	324 (98.1%)	100%	100%	95.5%	95.6%	96.0%	95.2%					This indicator reports a month behind 21 targets not met out of 376 , 5 targets off track due to over performance.
	CQUIN performance quarterly review		100%										Q2 CQUIN all have been approved, with the exception of CYP CQUIN, a resubmission has been made and we expect to receive a partial payment for the CYPCQUIN for Q2 milestones.
Trust Priority Projects													
Care Group: Neighbourhood Care													
SO3: 3.3	Single Model for Integrated Care	N/A	Delivery of Key Milestones										Revised timescales for project plan to be agreed in line with system planning expectations. This will now be inclusive of PCMH and IAPT integration improvements to ensure that this is a whole system approach, inclusive of mental Health.
Care Group: Specialist mental Health													
SO3: 3.7a	Redesign Adult OP MH services - Responsive Care in Communities	N/A	Delivery of Key Milestones										The project is currently under review, and a new PID is to be submitted to Operational Committee February 2019.
SO3: 3.7b	Redesign Adult & Older peoples MH services - Bed based	N/A	Delivery of Key Milestones										Following the Outcome of consultation in support of option 2 plus a new project review and new PID is to be submitted to Operational Committee February 2019.
SO3: 3.10	Wirral All Age Disability	N/A	Delivery of Key Milestones										Extension required to the project. To enable the co-location of staff at the Millennium Centre. There is no risk to the project
Care Group: Children Young People & Families													
SO3: 3.5	Children and Young Families Prevention/ Early interventions:	N/A	Delivery of Key Milestones										Project Closure report submitted to Operational Committee Jan 2019.
SO3: 3.4	0-19 Starting Well Service Implementation	N/A	Delivery of Key Milestones										Project Closure report submitted to Operational Committee Jan 2019.
Care Group: Learning Disabilities & Nuero Developmental (LD&ND)													
SO3: 3.6	Transforming Care - LD	N/A	Delivery of Key Milestones										Commissioners have delayed re-provision of short breaks and lead commissioner has indicated that only schemes that are mandatory and cost saving will be approved by Wirral Health and Care Commissioning . The reduction in inpatient delayed until April 2019. the 4 uncommissioned beds are being used as Income Generating Beds.
SO3: 3.9	ADHD	N/A	Delivery of Key Milestones										QIA completed and reviewed. Outcome of the review was that service can not be continued as is, however should commissioners sign up to the new service offer , risks would reduce .
Enablers													
SO3: 3.11	People& OD Strategy	N/A	Delivery of Key Milestones										
SO3: 3.12	Health Informatics	N/A	Delivery of Key Milestones										
SO3: 3.13	Quality Improvement Strategy	N/A	Delivery of Key Milestones										Revised delivery plan being developed and agreed
SO3: 3.14	Communications & engagement	N/A	Delivery of Key Milestones										
Strategic Objective 6: Financial Planning													
SO6: 1	Use of resources	1	Use of Resources [UoR]		**1**	**1**	1	1	1	1			Further detail is available in Finance Report

Appendix 2: Trust Dashboard Reporting Framework

Op Plan ref	Indicator	Target or Thresholds for escalation	Base line	Reporting and Frequency	Reporting Months	Reporting Committee	Reporting Format	Director	Project Lead	Risk Register/ CAF ref
Strategic Objective 1 – Quality										
SO1: 1.1	Patient safety: The target for improvement is a 10% increase in the number of D&E incidents reported, based on numbers reported at the start of Trimester 1 of this year. The indicator is shown as a rate per 1,000 episodes of care.	10% improvement in reporting of low and no harm incidents **Escalation Thresholds** Red: Below 2016/17 outturn Amber: better than 2016/17 outturn (58.6) Green: above 2016/17 target (64.5)	Red: Below 2016/17 outturn Amber: better than 2016/17 outturn Green: above 2016/17 target(64.6)	Learning from Experience report Every 4 months	May August January April	Quality Committee	Trend line	Anushta Sivananthan/ Avril Devaney/ Jim O'Connor	David Wood	Risk 6 – learning from incidents (amber 6)
SO1: 1.8	reduction in the severity of harm sustained by those people accessing CWP services that cause harm to themselves	97 (per year) **Escalation Thresholds** Red: higher than outrurn Amber: = to outturn position but higher than target Green: = to or below target	121 (10 per month)	Learning from Experience report Every 4 months	May August January April	Quality Committee	Achievement trend line	Avril Devaney/ Anushta Sivananthan	David Wood	
SO1: 1.2	Patient experience: Demonstrable increase in the uptake of the Friends and Family Test (FFT) each quarter	10% improvement in Trustwide uptake of FFT based on 15/16 outurn	Average 201 per month (16/17)	Quality Improvement Report Every 4 months	May August January April	Patient and Carer Experience Sub Committee	? Trajectory for improvement	Avril Devaney/ Jim O'Connor	Cathy Walsh	Risk 5 – feedback from learning (amber 9)
SO1: 1.3	Clinical Effectiveness: Demonstrable improvement in the Trustwide average bed occupancy rate, including leave, for working age adult wards	Improvement to 85% by KH03's month 12 (December 2017)	93.30%	Continuous Improvement Report Monthly	May-March	Quality Committee	Tabular	Faouzi Alam/Anushta Sivananthan/ Jim O'Connor/	Sarah Quinn	
SO1: 1.4	Patient Safety: Total % inpatient deaths subject to a case record review	100%	100%	Learning from Experience report Every 4 months	May August January April	Quality Committee	Tabular	Avril Devaney/ Jim O'Connor	Lisa Parker	
SO1: 1.5	Patient Safety: Total number of inpatient deaths subject to a case record review identifying that there may have been a problem in the care provided	2 (improvement by year end)	3	Learning from Experience report Every 4 months	May August January April	Quality Committee	Tabular	Avril Devaney/ Jim O'Connor	Lisa Parker	

SO1: 1.6	Patient Safety: Total % deaths reported by and to the Trust (including inpatient deaths) subject to a case record review	KPI escalation via Learning from Experience report	18%	Learning from Experience report Every 4 months	May August January April	Quality Committee	Tabular	Avril Devaney/ Jim O'Connor	Lisa Parker	
SO1: 1.7	Patient Safety: Total number of deaths (including inpatient deaths) subject to a case record review identifying that there may have been a problem in the care provided	3 (improvement by year end)	4	Learning from Experience report Every 4 months	May August January April	Quality Committee	Tabular	Avril Devaney/ Jim O'Connor	Lisa Parker	
SO3: 2.1	Capacity: % of staff vacancies	5.00%	5% or below is green 5.1-5.99 is amber 6% and above being red	Any 3 consecutive months where we are amber or red rated	By exception	People and OD subcommittee	Chairs escalation	Dave Harris	Viv Williamson	Risk 11 – staffing (rated amber 6)
SO3: 2.2	Competence: % of staff receiving annual appraisal (via new proposed framework)	100% of available eligible cohort	97.6%	Any quarter in which each of the three months the appraisal rate is below the baseline position	Quarterly	People and OD subcommittee	Performance against plan chart or variance from plan	Dave Harris	Hayley Rigby	Risk 11 – staffing (rated amber 6)
SO3: 2.3	% staff absence due to sickness	5.30%	5.89%	Any 3 consecutive months where we are above the monthly baseline set out in the annual plan.	By exception	People and OD sub committee	Variance from target trend line	Dave Harris	Chris Sheldon	Risk 11 – staffing (rated amber 6)
SO3: 2.4	Staff , in month, Turnover rate		0.91%	3 consecutive months where the turnover rate is 25% above the planned rate	By exception	People and OD sub committee	variance from plan	Dave Harris	Gill Kelly	

Operational Performance / Priority areas										
SO3: 3.1	100% of the 13 NHSI operational performance targets achieved (including waiting times)	100%	100%	Any occasion where the compliance with any monitor target is missed for 3 consecutive months	By exception	Operational Board	Achievement trend line	Andy Styring/ Tim Welch	Service Directors	Risk in scope re. IAPT delivery
SO3:3.2	100% Contractual targets met	100%	Avg 98.1%	Any occasion where the same target for any contractual KPI is missed	By exception	Operational Board	Achievement trend line	Andy Styring/ Tim Welch	Service Directors	Risk in scope re. IAPT delivery
	CQUIN Achievement of milestones	(100% of CQUIN Milestones achieved)		Report quarterly on CCG confirmed achievement against milestones	By exception	Operational Board	written report	Andy Styring/ Tim Welch	Service Directors	Risk 14 Financial performance/ CIP delivery (rated green and risk archived)
Op Plan ref	**Indicator**	**Target or Thresholds for escalation**	**Base line**	**Reporting and Frequency**	**Reporting Months**	**01/04/2017**	**01/05/2017**	**Executive Sponsor**	**Project Lead**	**Risk Register/ CAF ref**
SO3: 3.3	Priority project 1: Children and Young Families Prevention/ Early interventions:	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	April - March	Operational Board	Delivery of Key Milestones	Avril Devaney and Dave Harris	Val Sturgess	Risk 13 – tendering of services (rated green and risk archived)
Care Group: Neighbourhoods										
SO3: 3.3	Single Model for Integrated Care (Improved Place Based Care)	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Dave Harris	Karen Moore	
Care Group: Specialist Mental Health Services										
SO3: 3.7a	Redesign Adult & Older peoples MH services- responsive care in the community	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Nush Sivananthan & Faouzi Alam and Dave Harris	Sally Sanderson	
SO3: 3.7b	Redesign Adult & Older peoples MH services- Bed Based	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Nush Sivananthan & Faouzi Alam and Dave Harris	Suzanne Edwards	
SO3: 3.8	EI Review & delivery			Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Faouzi Alam	Trish McCormack	
SO3: 3.10	Wirral All Age Disabilities	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Andy Styring	Trish McCormack	

Care Group Children & Young People										
SO3: 3.5	Children and Young Families Prevention/ Early interventions:	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Avril Devaney	Fiona Pender	
SO3: 3.4	0-19 Starting Well Service Implementation	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Avril Devaney	Val Sturgess	
Care Group: Learning Disabilities & Nuero Developmental										
SO3: 3.6	Transforming Care - LD Care Model	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone	Monthly	Operational Board	Delivery of Key	Andy Styring	Mahesh Odiyoor	
SO3: 3.9	ADHD	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Andy Styring	Mahesh Odiyoor	
ENABLERS										
SO3: 3.11	People & OD Strategy	N/A	Delivery of Key Milestones		Monthly	Operational Board	Delivery of Key Milestones	Dave Harris/ Faouzi Alam	Jane Woods	
SO3: 3.12	Health Informatics	N/A	Delivery of Key Milestones		Monthly	Operational Board	Delivery of Key Milestones	Tim Welch	Jane Thomas/ Mandy Skelding-Jones	
SO3: 3.13	Quality Improvement Strategy				Monthly	Operational Board	Delivery of Key Milestones	Anushta Sivananthan	Hayley Cavanagh	
SO3: 3.14	Communication & Engagement	N/A	Delivery of Key Milestones		Monthly	Operational Board	Delivery of Key Milestones	Avril Devaney	Kathrine Wright	
Strategic Objective 6: Financial Planning										
SO6: 1	Use of resources	Use of Resources [UoR] score of 3 or 4	Plan	Monthly	April - March	Trust Board		Tim Welch/ Edward Jenner	Andy Harland	

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STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Corporate assurance framework and strategic risk register – update report
Agenda ref. no:	18.19.126
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	30/01/2019
Presented by:	Dr Anushta Sivananthan, Medical Director (Executive Lead for Quality)

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

REPORT BRIEFING

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

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

As at January 2019, the Trust has 12 strategic risks – 3 red and 9 amber rated. There are 3 risks currently in-scope (all amber).

The significance level of the risks (as per the corporate assurance framework heat map) has reduced in this period of reporting and is indicative that the Trust's capacity to handle risk currently remains sound.

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

The Quality Committee is the designated committee for risk management operationally and ensures the quality agenda is implemented across the Trust, including the review and oversight of the strategic risk register. It works closely with the Audit Committee in identifying in-depth reviews of strategic risks as part of ongoing reviews of the effectiveness of integrated governance and internal control systems.

The Board of Directors monitors and reviews the corporate assurance framework and receives assurances on risk via the Quality Committee. This is a key component of the Trust's integrated governance strategy which provides assurance regarding the quality and safety of the services that the Trust provides.

Assessment – *analysis and considerations of options and risks*

Risks in-scope

Risk A: *Potential ligature points risk due to curtain rails that may fail to collapse for patients with low body weight*. The risk was escalated to the Suicide Prevention Strategy Group, having been raised through the Mental Health Forum following an incident at a mental health trust, caused by a failure of a collapsible curtain rail by a person weighing 42kg. Staff have been made aware of the potential risks, remedial action is being taken by the Estates team using a risk based approach.

Risk B: *Risk that patients' privacy, dignity and safety is compromised as a result of breaches in relation to the Department of Health guidance on mixed sex accommodation.* This risk has been added in response to the recent CQC inspection of CWP core services that identified residual issues relating to EMSA compliance. The reconfiguration of services (including inpatient services for older people) will ultimately address these residual concerns (therefore there is an interdependency with strategic risk 2) whilst the Trust continues to utilise the centralised bed management hub to support our clinical teams in implementing current national guidance, complemented by appropriate use of enhanced therapeutic observations if necessary.

Risk C: *Risk of inconsistent recording of patient level data.* This risk was escalated via the integrated governance framework by the Operational Committee and is currently in-scope; interdependency with strategic risks 4 and 12 will be considered. A risk treatment plan will be developed by a task and finish group chaired by the Director of Finance, for approval at the 06/03/2019 meeting of the Quality Committee.

New risks

The following risks were previously in-scope and have now been escalated to the strategic risk register and treatment plans developed within the corporate assurance framework.

Risk 1 – *Supervision compliance rates are below Trust target of 85% and show varying levels of compliance across clinical and non-clinical staff groups. This includes a risk that some staff may not be accessing supervision (clinical or management).* Short term remedial and improvement actions are in progress and a new framework (underpinned by a new policy and guidance) is being developed and consulted on.

Risk 9 – *Risk of harm due to deficits in familiarity with and staff capability in applying safety critical policies and frameworks.* As agreed at the last Quality Committee, some work has progressed to identify specific safety critical risks arising from the recent CQC inspection, e.g. supervision, mandatory training and EMSA compliance. Following CQC workshops held with clinical support services in December 2018 and January 2019, action has been agreed to develop gap analyses/ improvement plans in relation to other safety critical areas.

Amended risk scores

Risk 5 – *Risk of not achieving safeguarding contractual obligations and subsequent reputational impact, due to increased inspectoratory burden and acute increase in the volume of multiagency case reviews*. Risk score increased to 12 as agreed at the November 2018 meeting of the Quality Committee. The impact of increasing the capability of the safeguarding service will be monitored and the risk score reviewed in March 2019.

Exceptions

Further information on 11 incomplete risk treatment actions is included in the exception report tab of the corporate assurance framework. The Quality Committee is overseeing progress with the remedial actions that have been identified to return progress with risk treatment plans back to on track. In response to the increase in the number of active strategic risks and with further risks being in-scope, to ensure that the Trust's capacity to handle risk continues to be sound, the Quality Committee has agreed that it will monitor strategic risk treatment as part of the quality assurance dashboard, with escalation criteria identified that will trigger in-depth periodic reviews based on risk appetite (further detail is outlined in the Quality Committee Chair's Report).

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

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

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	23/01/2019

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

Appendix no.	Appendix title
1	Corporate Assurance Framework

Cheshire and Wirral Partnership
NHS Foundation Trust

Report subject:	Learning from Experience report – trimester 2 2018/19 (incorporating an update on the national Learning from Deaths framework)
Agenda ref. no:	18.19.127
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and approval
Date of meeting:	30/01/2019
Presented by:	Avril Devaney, Director of Nursing, Therapies & Patient Partnership

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

1. Situation

This Learning from Experience report aggregates qualitative and quantitative analysis from key sources of feedback from people who access and deliver the Trust's services, and other relevant sources of learning, covering the period from August 2018 to November 2018, trimester 2 of 2018/19. The report compares current performance across a four trimester time series to mitigate seasonal variations, whilst also facilitating the identification of potential triggers to detect and prevent incidents by comparing current performance with the previous trimester. The in-depth Learning from Experience report received by the Quality Committee uses Statistical Process Control (SPC) charts to help with more effective and visual depiction of learning from experience and identification of recommendations, as well as to alert, as part of an early warning framework, any emerging trends. The use of SPC will be reflected more in future reports to the Board of Directors.

2. Background – Key performance indicators

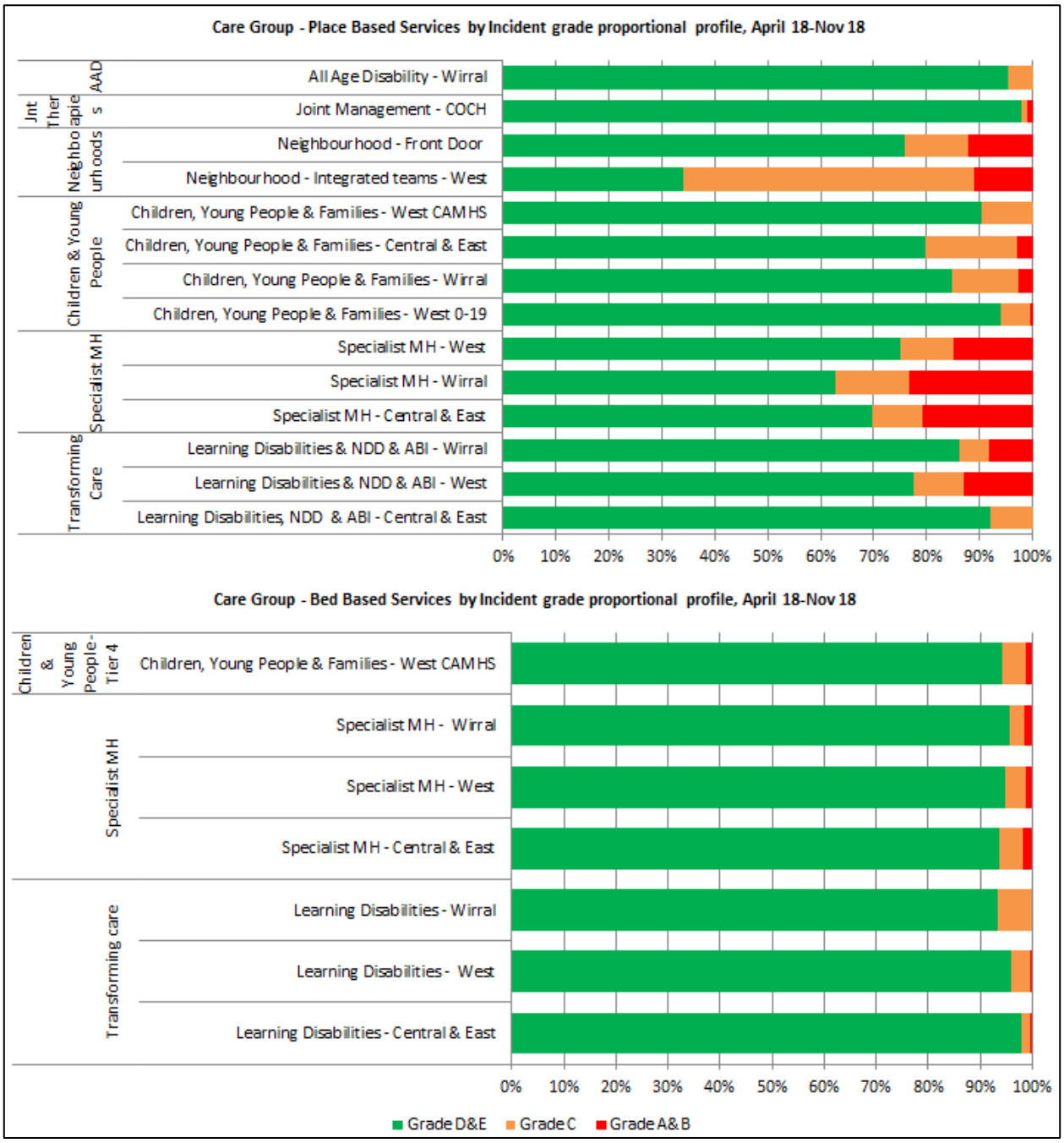
2.1 Performance indicators

Performance indicator			2017/18		2018/19	
			T2	T3	T1	T2
Number of safety incidents reported			3348	3007	3370	**3331**
Number of safety incidents by speciality	*Inpatient*		*2372*	*2030*	*2317*	**2160**
	Community physical health		*536*	*517*	*572*	**577**
	Community mental health		*399*	*411*	*424*	**556**
	Other		*41*	*49*	*57*	**38**
Reports to external agencies	**StEIS**		54	53	39	**36**
	National Reporting & Learning System		1758	1428	1469	**1645**
	NHSR	Non clinical	4	4	2	**0**
		Clinical	2	1	0	**0**
	NHS Protect					
	Staff assaults		303	290	454	**446**
	Missing patient		123	81	98	**76**
	Suspected theft		9	4	3	**4**
	Damage to property		8	13	19	**32**
	Lost or missing items		18	15	20	**16**
Number of complaints			52	70	74	**93**
Number of compliments			1202	1032	1041	**956**

All incident and compliment numbers above and as detailed in the main body of this report 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.

2.2 Proportional reporting performance indicators – Incident reporting

The charts below show a proportional split of incident grade per Care Group and service peer group[1]. By presenting the incident reporting profiles in this way, the charts reveal fundamental differences between the service types that can be used to identify where focus is needed to reinforce the Zero Harm message that reporting no or lower harm incidents promotes learning to be able to potential mitigate future actual or significant harm incidents. The charts can further inform potential opportunities for continuous improvement activity.



3. Analysis

3.1.1 Incident reporting

CAMHS tier 4, bed based and non-patient facing services contributed to the overall decrease in incident reporting this trimester. Analysis of the last four trimesters of incident reports shows an increase in reporting of incidents in the community based services, both mental health and physical health, which takes into account the new All Age Disability services that commenced in August 2018. There is little change in the number of externally reportable serious incident this trimester [*T1, 2018/19 n.37* and *T2, 2018/19 n.38*].

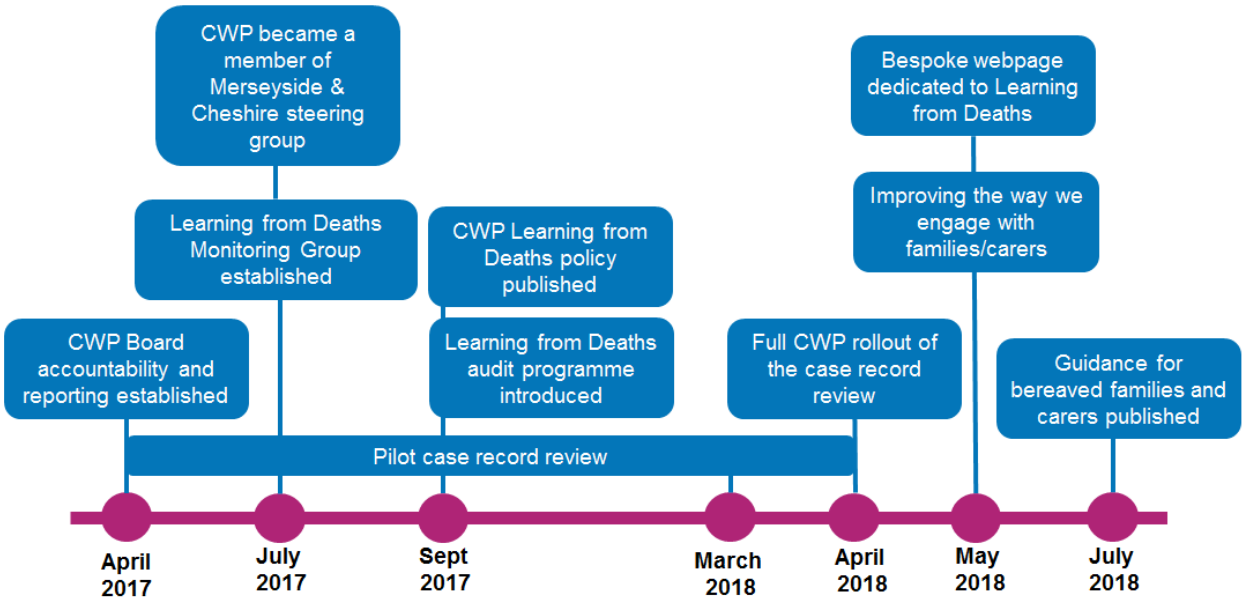
The top five ranked incident categories are violence (1); self-harm (2); pressure ulcers (3); estates and facilities (4); falls (5). This represents no change, with the exception of falls which returned to fifth position.

Organisation Patient Safety Incident Reports for the providers of the NHS in England was published by *NHS Improvement* in September 2018. CWP have reported 1,965 patient safety incidents to the *National Reporting & Learning System* (*NRLS*) that occurred between October

2017 and March 2018 (this is the most recently published data – the next data set is due to be published in March 2019). The report showed that CWP continues to rank 34th for reporting of incidents per 1000 bed days when benchmarked against 54 other mental health trusts across the NHS in England. The report indicated that CWP reports 9% more self-harm related incidents compared to the average percentage reported by other mental health trusts, which is a priority area for Quality Improvement that has been identified as part of the Quality Account for this year. The last benchmarked report from *NHS Improvement* showed this to be 20%, indicating the improvement already being seen as a result of the progress of the self-harm strategic steering group's quality improvement work in this area. *NRLS* reporting will continue to be monitored through the quality assurance dashboard presented to Quality Committee.

New dates for the training programme to support staff who report and approve incidents, to improve the efficiency and effectiveness of incident reporting, are now available to book on ESR. A new and improved Dif1 incident reporting form and Dif2 incident approving form are now available on Datix. This is in direct response to common themes emerging from the outputs of the Trust's safety management system, specifically the patient safety improvement reviews undertaken with individual teams. The communication and feedback section is a new feature that enables reviewers to provide the outcome of the review and to share the lessons learnt.

3.1.2 Learning from deaths monitoring and engaging with bereaved families and carers
In November 2018, the Council of Governors received a presentation summarising the milestones that CWP has achieved since the national 'learning from deaths' guidance was launched in 2017.



During the collaborative workshop, suggestions were made regarding how can we better support families and carers and improve the way we share learning to prevent recurrence. Further work is taking to place to improve the way we work with partners to enable a whole system approach, including discussion at the national Directors of Nursing meeting in April 2019.

To identify all deaths and therefore to increase the number of case record reviews that CWP can complete to identify learning, the Trust has devised a mortality comparison report from the national list of deceased persons held by NHS Digital. The report compares the list to the information held on the CWP clinical care record to identify people who have died while accessing our care, including people discharged from our care within six months of their death. The report is updated in retrospect of a person's death, thus increasing the scope and number of deaths to review further.

The most recent next learning from deaths monitoring group, chaired by the Director of Nursing, Therapies & Patient Partnership, with Care Group and corporate representation, took place in January 2019. The group plans to meet a minimum of three times a year. Risks, learning and

good practice will be shared with the relevant committees. The group is reviewing inclusion criteria for which deaths are subject to a case record review, such as older people, community physical health and specialist services, to ensure a continuous improvement approach to learning from deaths, including assurance that the review process is adding value.

During this trimester, *n.151* case record reviews have been undertaken, none of which has led to further investigation, though the clinical audit programme in place (acting as a 5% quality control process for case record reviews that judged as there having been no problems in care) did identify scope for improvement when formulating care plans and the quality of documentation. As such, the group have increased the sample size of the clinical audit to 10% from trimester 3 2018/19 to provide further assurance that reflective practice being undertaken by multi-disciplinary teams is effective and identifying as many potential opportunities for learning and improvement as possible.

Completion of case record reviews has improved this trimester to 61% from the previous high point of 35%, which is a substantial improvement supported by promotional communications for clinical teams launched by the incidents team in August 2018.

Learning from deaths monitoring	2018/19	
	T1	T2
Inpatient deaths (including deaths 30 days after discharge)/ subject to a case record	1/ 100%*	**1/ 100%***
Deaths reported to the Trust/ subject to a case review record	352/ 35%*	**348/ 61%***
Deaths reported as a serious incident/ subject to a serious incident investigation	19/ 100%**	**18/ 100%****

*The % reflects the case record reviews undertaken by teams subject to the learning from deaths review process, the target is 100%.
**For deaths meeting NHS England criteria as a serious incident, investigatory performance is 100%.

The data relating to learning from deaths from April 2017 is available on the Board dashboard as a quality objective; it is published every two months with the agenda for the meeting of the Board in public. The webpage has now been fully implemented and provides bereaved families and carers with information on how to access bereavement support services. It provides information as to what people can expect to happen when a person who access CWP services dies. The accessibility of the learning from deaths monitoring data published each month has been improved – the webpage has been designed to display the data for people to view and understand easily.

3.1.3 Reporting deaths for people with a learning disability (Learning Disabilities Mortality Review – LeDeR)

CWP has reported 47 deaths since the launch, in October 2016, of the process to report the death of a person with a learning disability. There are 20 investigations allocated for a LeDeR review. NHS England's North Regional LeDeR training is now available online.

3.2 Falls incidents

There has been a Trustwide increase in the reported number of falls this trimester from 210 to 234, which returns this category of incident to the fifth rank. The main increase has been in the number of low and no harm incidents, there have been no serious falls incidents reported.

3.3 Incidents associated with the management of behaviour that challenges

The Quality Improvement project reported on previously, to: improve reporting and data quality of restraint episodes; capture the experience of people who have been restrained; and develop more effective clinical education and training, is in progress but is now a workstream of the expert clinical panel which is focusing on the elimination of the use of unwarranted restrictive practices to manage behaviour that challenges, led by the Medical Director (Executive Lead for Quality). The

Quality Committee is the oversight committee for this work and will monitor the outcomes of this quality improvement work.

3.4 Feedback from people who access the Trust's services

During this trimester, the Trust received 93 complaints under the NHS complaints procedure. Of these, they were received per Care Group as follows: SMH (community-based) *n.30* complaints, SMH (bed-based) *n.18* complaints*,* Neighbourhoods *n.9* complaints, CYP & Families *n.7* complaints, LD, NDD & ABI *n.5* complaints, All Age Disability Services introduced in August 2018 *n.14* complaints. Corporate Support Services had *n.6* complaints reported. The 'communication/ information' category associated as a theme continues to be the highest ranked theme over the past four trimesters. This trimester, there has been an decrease in the number of compliments recorded, from 1041 to 956. The complaints team have been working with services to gather feedback in order to make improvements to the way we capture compliments.

3.5 Learning from external reviews and investigations

As well as learning from our own experience, the Trust welcomes the opportunity to learn from reviews and investigations undertaken externally to the Trust. There were two such reports discussed within the in-depth Learning from Experience report received by the Quality Committee. Recommendations have been identified to review these for the purpose of implementing lessons learned as they apply to CWP, and to support ward to Board assurance. This includes learning from NHS Resolution and the Healthcare Safety Investigation Branch. The summary of recomemndations identified in section 4 (4.5 and 4.6) below describes the next steps identified to enable CWP to identify and implement transferable learning.

4. Recommendation

Recommendations from trimester 2 analysis

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

4.1 All inpatient staff to implement the learning outlined in share learning bulletin number 93 and confirm this to their Matron for providing assurance to the clinical pharmacy team. The policy will be re-audited in trimester 3 to ensure all the required monitoring is carried out following administration of rapid tranquillisation.

4.2 The incidents team to develop a governance framework for the reporting of corporate/ clinical support team incidents and complaints, including making it easier to report these on Datix, to promote parity with Care Group reporting.

4.3 The complaints and incidents team to review the support that teams require to enable the accurate reporting of all compliments received.

4.4 Complaints and incidents team to undertake further analysis into the longitudinal database of claims to identify opportunities for transferable learning.

4.5 The complaints and incidents team to self-assess CWP's position relating to recommendations outlined in the Learning from suicide-related claims: a thematic review of NHS Resolution data report in order to identify any areas for improvement.

4.6 CWP representatives at the Emergency Department Delivery Boards to ensure discussion regarding the Healthcare Safety Investigation Branch Investigation report into the Provision of Mental Health Care to Patients Presenting at the Emergency Department.

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

Clinical support service teams have been asked to:

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

Clinical services have been asked to:

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

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

Recommendation to the Board of Directors

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

Who/ which group has approved this report for receipt at the above meeting?	Avril Devaney, Director of Nursing, Therapies & Patient Partnership
Contributing authors:	Audrey Jones, Head of Clinical Governance Lisa Parker, Incidents Manager David Wood, Associate Director of Safe Services

Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Board of Directors	23/01/2019

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

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

All appraisers should add to their oversight that all relevant staff have completed the mandatory and role specific e-learning related to insulin.
E-learning is monitored by appraisers to ensure that mandatory training and role specific e-learning has been completed.
The Safe Services Department should facilitate the establishment of a task and finish group to theme learning identified within currently relevant externally produced investigation reports from NHS Resolution, the Care Quality Commission, NHS England and the Betsi Cadwaladr University and undertake a gap analysis of current CWP service provision. Where transferable learning is identified, this should be taken forward as quality improvement work with the relevant locality and/ or experience meetings – with an exception report provided in subsequent and ongoing (for future external investigation reports) Trustwide Learning from Experience reports for ward to Board assurance to Quality Committee and the Board of Directors.
Prior to a task and finish group being established, a summary of the main findings from these reports has been established. A gap analysis has been undertaken by the Head of Clinical Governance. The output is to be shared with Care Groups, with the aim of a discussion and consensus building on the transferable learning and priority areas agreed for work to be taken forward as quality improvement work. An exception report will be presented through the Learning from Experience report for trimester 3.
The Head of Clinical Governance and Head of Quality Assurance & Improvement to work with Strategic Clinical Directors, as part of the review of the Green Light Toolkit 'Better Audit' to identify any recommendations for CWP to feed into the Care Group governance and effectiveness meetings. This will inform quality improvement work in relation to: 1. Clinical and pathway variation. 2. Effectiveness of transition arrangements including planning. 3. Risk assessment and care planning (including CPA). 4. Person-centredness (this was lacking in this reference case).
Improvement plans resulting from the Green Light Toolkit audits and the NHSI LD Improvement Standards implementation plan are being managed together, with oversight from the Strategic Change and Transformation meeting of the LD, NDD & ABI Care Group. A working group has been established with key corporate and Care Group leads to oversee the associated improvement plans, as each Care Group has a duty to support the improvements and monitor standards. A repeat self-assessment has been undertaken in November 2018 by the working group and another final self-assessment will be undertaken in January 2019, to ensure that improvement actions are completed and have been effective. Assurance of progress against the nine basic audit standards will be brought to the March 2019 meeting of Quality Committee, accompanied by a forward plan for the 'Better Audit' implementation during 2019/20.

Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Quality Improvement report: Second Edition, 2018/19
Agenda ref. no:	18/19/128
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	30/01/2019
Presented by:	Dr Anushta Sivananthan

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

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*
This report highlights and showcases the innovative quality improvement projects being undertaken by staff throughout the organisation. The report is produced each trimester and this is the second edition of 2018/19.

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

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

Assessment – *analysis and considerations of options and risks*

The report includes progress against the three Trust wide QI priorities for 2018/19:

Patient Safety - Reduce the severity of the harm sustained by those people accessing CWP services that cause harm to themselves.

Clinical Effectiveness - Improve inpatient access to psychological therapies.

Patient Experience - Improve engagement with bereaved families and carers.

The report also showcases the brilliant work that staff are delivering in order to improve the quality of care provided to the people the Trust are here to serve, these include:

Safe care:	Safety Huddles; Understanding benefits and risks around social media through discussion and education.
Affordable care:	Mental Health Law bespoke training; Community care team's transformation of referral system; Red2Green.
Sustainable care:	QI Hub; Cognitive Stimulation Therapy programme.
Patient experience:	Improving well-being and recovery through Mindfulness and Tai-Chi; Mini posters: Building relationships between patients and staff; Learning Disability Coffee Morning drop-ins; Multi-family Therapy Workshop for Anorexia Nervosa; Neston and Willaston Community Care Team collaboration with the Third Sector Greater collaboration between Macmillan specialist palliative care team Hospice of The Good Shepherd.

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

The Board of Directors are asked to **note** the contents of this report.

Who/ which group has approved this report for receipt at the above meeting?	Hayley Cavanagh, Head of Quality Assurance and Improvement
Contributing authors:	Kate Baxter, Healthcare Quality Improvement Manager

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Quality Committee	09/01/2019

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

Appendix no.	Appendix title
1	Quality Improvement Report: Second edition, 2018/19

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Quality Improvement Report

Edition 2
August – November 2018

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

CWP's Quality Improvement (QI) Hub
Making QI accessible to all
(see page 12)

Helping people to be **the best they can be**

Welcome to CWP's second *Quality Improvement* Report of 2018/19

These reports are produced three times a year, this being the second edition of 2018/19, to update people who access and deliver the Trust's services, carers, the public, commissioners, internal groups, and external scrutiny groups on progress in improving quality across our services. We are required to formally report on our quality improvement priorities in the annual *Quality Account*.

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

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

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

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

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

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

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

EXECUTIVE SUMMARY
QUALITY IMPROVEMENT HEADLINES THIS EDITION

Safety huddles reduce therapeutic observation levels through a multi-disciplinary approach
⇨see page 7

Understanding the benefits and risks around social media through discussion and education
⇨ see page 8

Community care team transform referral system, improving access to care
⇨See page 10

CWP's Quality Improvement (QI) Hub is an ongoing success
⇨See page 12

Learning Disability Coffee Morning drop-in builds people's confidence and facilitates friendships and opportunities
⇨See page 16

Multi-Family Therapy Workshop for Anorexia Nervosa wins national award!
⇨See page 18

Neston and Willaston Community Care Team collaborate with the Third Sector to improve quality of life
⇨See page 20

QUALITY IMPROVEMENT PRIORITIES

We have set three **Trustwide QI priorities** for 2018/19, which reflect our current vision of "**working 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**. We have made a commitment in our *Quality Account* to monitor and report on these goal driven measures in our *Quality Improvement Report*s.

Goal driven measure for **patient safety**

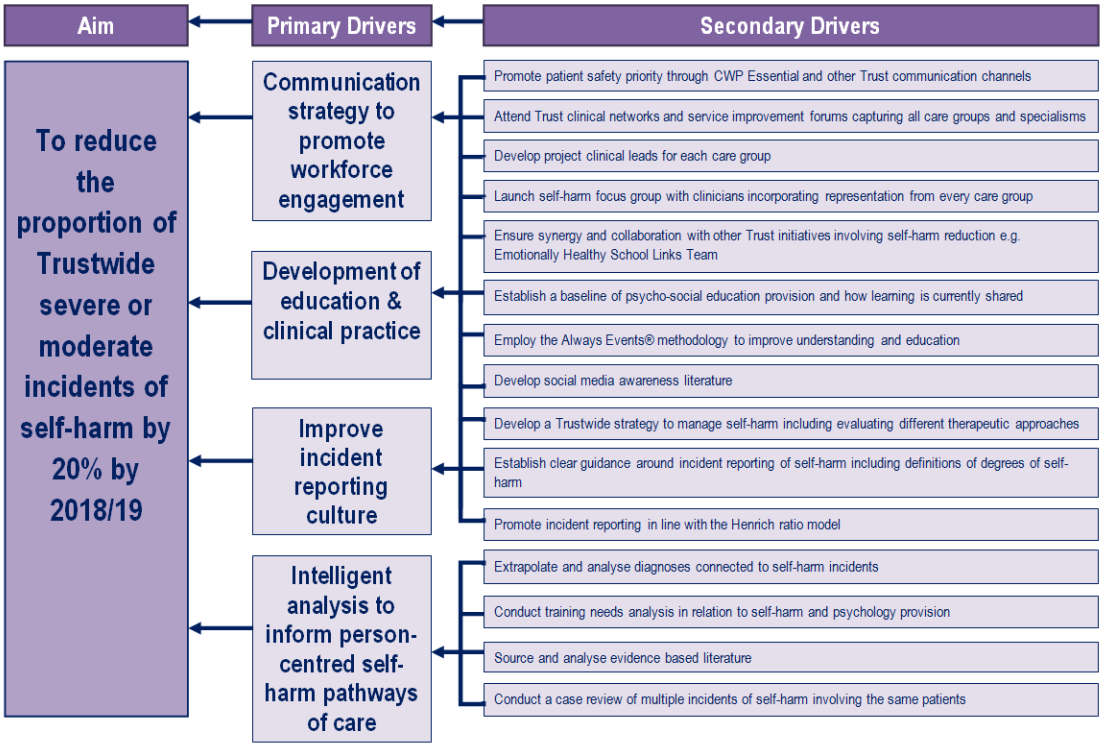
Reduce the severity of the harm sustained by those people accessing CWP services that cause harm to themselves

Nationally, there is wide variation between services in the frequency of self-harm.

We want to:

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

We have developed this driver diagram to help us describe our aim:



Steps we have taken so far to work towards achieving our aim:

✓ Presented at Clinical Networks and QI events to promote this project and gather feedback from staff.
✓ Developed a self-harm strategic steering group, collaborating closely with other related initiatives such as suicide prevention.
✓ In-depth analysis of self-harm data to identify themes and specific areas/ opportunities for improvement.

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

Goal driven measure for **clinical effectiveness**

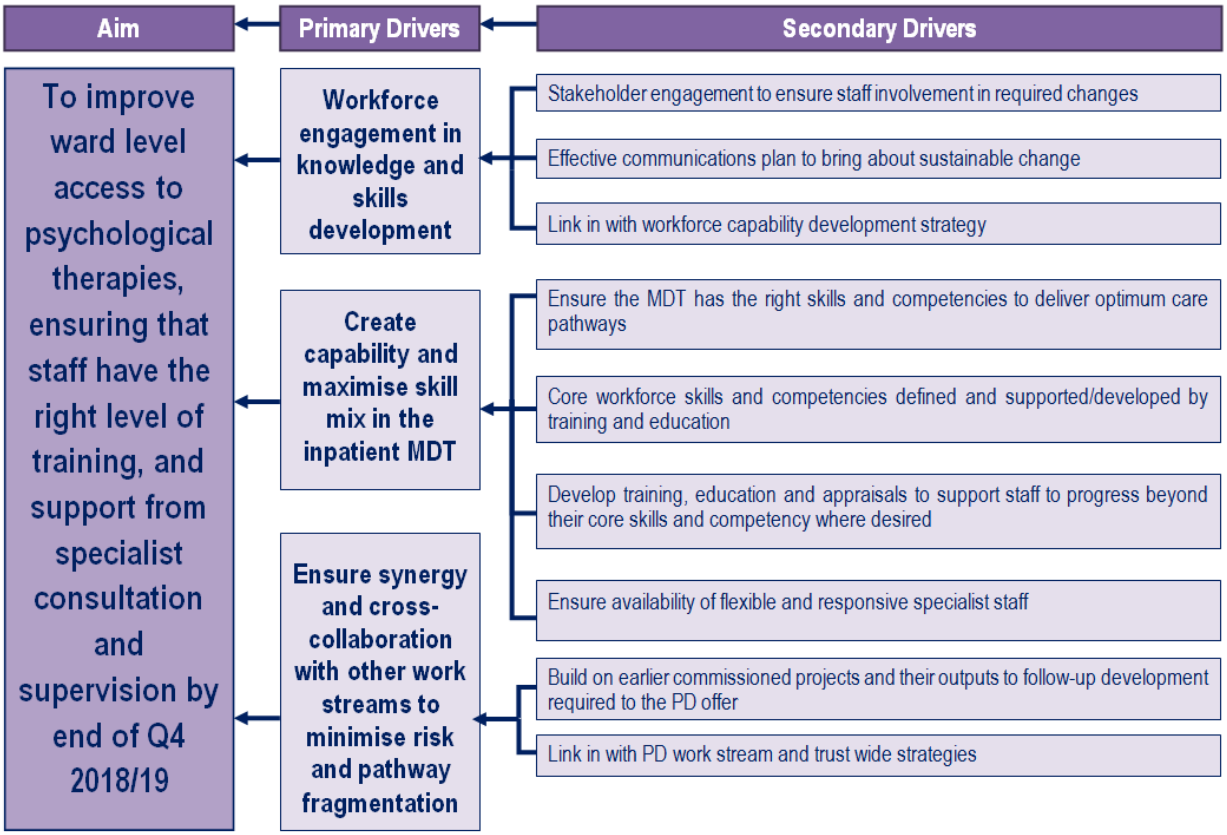
Improve inpatient access to psychological therapies

Health care organisations should be assured that they are providing effective care that includes psychological interventions.

We want to:

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

We have developed this driver diagram to help us describe our aim:



Steps we have taken so far to work towards achieving our aim:

✓ Multi-disciplinary psychology work stream has been convened focussing on the application of psychology skills on wards.
✓ Developed the work stream, ensuring that it brings together people across the Trust already exploring ward psychology provision.
✓ Linked closely with the Personality Disorder work stream, developing Trustwide guidelines to support staff in this area.

For more information, please contact Beccy Cummings, Service Improvement Manager, at rebecca.cummings1@nhs.net or Kate Baxter, Healthcare Quality Improvement Manager, at kate.baxter@nhs.net

Goal driven measure for patient experience

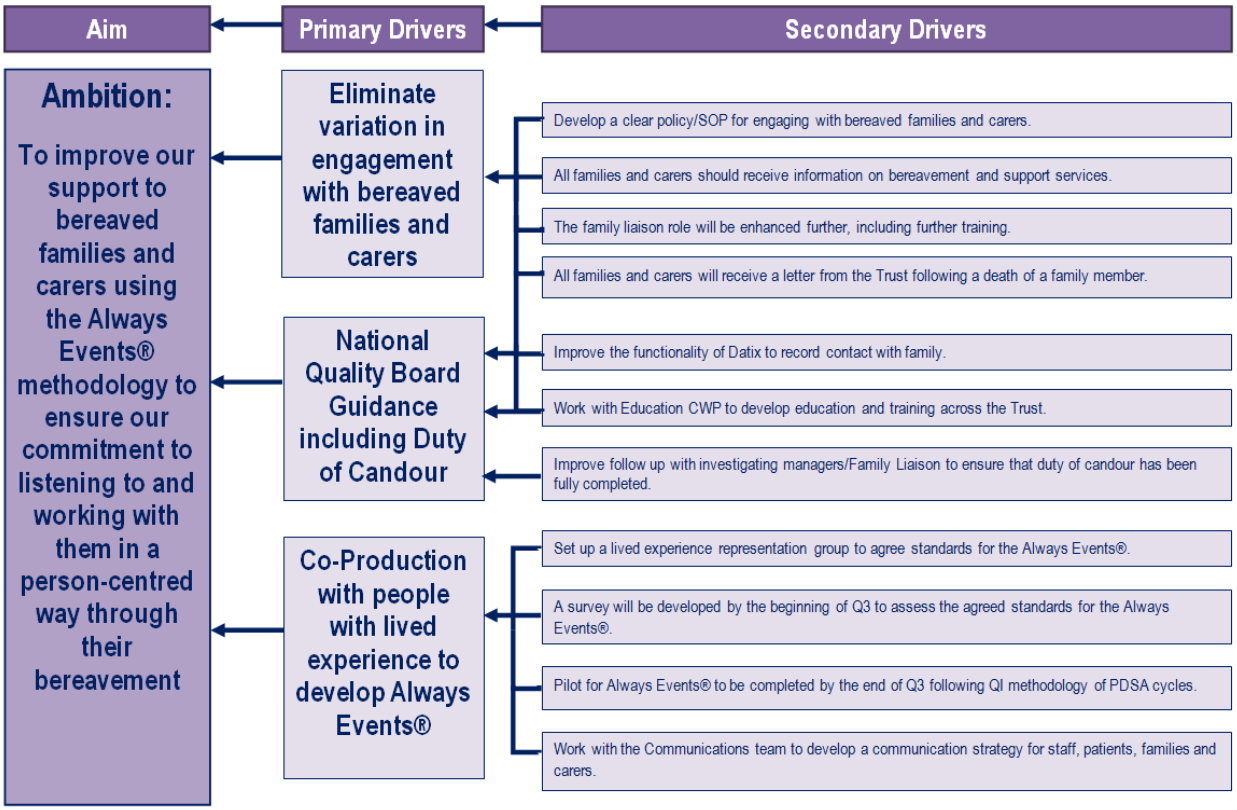
Improve engagement with bereaved families and carers

Health care organisations should prioritise working more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.

We want to:

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

We have developed this driver diagram to help us describe our aim:



Steps we have taken so far to work towards achieving our aim:

✓ Information for families following bereavement has been adapted, involving people with lived experience.
✓ The bereavement survey has been further developed and reviewed, including addition of with supporting information.
✓ A project plan has been developed, with a pilot to be rolled out by the end of January 2019.

For more information, please contact Audrey Jones, Head of Clinical Governance, on 01244 397387 or Cathy Walsh, Associate Director of Patient & Carer Experience, on 01244 393173

QUALITY IMPROVEMENT PROJECTS

Patient Safety Improvements

Delivering *Safe* care

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

Safety huddles reduce therapeutic observation levels through a multi-disciplinary approach

Background:

Safety huddles are brief and routine meetings for sharing information about potential or existing safety problems. They increase safety awareness among staff, allow for teams to develop action plans to address identified safety issues, and foster a culture of safety.

What did we want to achieve?

The aim of using safety huddles on acute mental health wards was to review any people who were on increased levels of therapeutic observations and use a team based approach to plan care for a safe reduction of observations.

What we did:

We looked at the wards in Bowmere (in Chester) and where the highest numbers of increased therapeutic observations were. It was then decided that we would pilot safety huddles on Cherry ward and Juniper ward as these were the wards with the highest number of therapeutic observations and for the longest durations. Initial discussions took place with the team consultants and ward managers and then with ward staff. A template was devised and a start date for the pilot was agreed.

Results:

Since the introduction of the safety huddle, there has been a significant reduction in level 3 and level 4 observations, with only one person requiring this (before accessing ECT). Level 2 observations have been reviewed daily and there has also been a noticeable reduction in the number of people requiring 5 or 10 minute observations. Staff have engaged well with the safety huddle and have noticed the benefit of this being an multi-disciplinary team (MDT) approach and staff report that they feel supported in making decisions relation to therapeutic observations.

Next steps:

Moving forward, the intention is to measure effectiveness using quantitative indicators, continuing to gain feedback from MDT members and monitor patient feedback in relation to care planning and level of observations. Ultimately, the plan is to embed the safety huddle concept on all acute wards within Bowmere.

For further information, please contact
Louise Gill, Modern Matron, on 07810156448

Understanding the benefits and risks around social media through discussion and education

Background:

As a specialist eating disorder unit, Oaktrees ward has seen an expansion of access to and the use of social media and the effect it has on people accessing the service. Not only has the negative influence towards eating disorders grown online in the form of 'pro-anna' sites and 'thinspo' sites, but also the amount of positive recovery focused blogs and vlogs has expanded.

What did we want to achieve?

Going the extra mile for their patients is central to the ward's ethos and having identified that social media was very important to them, the ward decided to create a social media initiative; the aim was to find out more about what sites people were using and how this impacted on their mental health, helping them identify how the negative social media was empowering their eating disorder and to provide them with a space to discuss this with a lead nurse. As part of the initiative, another aim was to identify more helpful and recovery focused information and sites for people to look into and make more informed choices.

What we did:

A lead nurse was identified with a special interest in social media and the effects it can have on an eating disorder. This lead nurse would then discuss with each person what social media they used, to what end and how it made them feel. They would also discuss how ready the person felt to stop using the negative forms of social media. This information was then formulated into a social media domain within the care plan and fed back to named nurse. The ward also installed a 'social media information board' which provides information about different recovery focused sites and blogs, also identifies relevant pages and people to follow on popular social media platforms. The ward has set up a self-help shelf in the communal area and provided self-help books for people who struggle to use social media sites. The lead nurse also uploads regular tweets to the CWP eating disorder service twitter account, this may include links to interesting articles or motivational quotes. As it became apparent what a big topic this was for the people accessing the service, the staff added it to the agenda for their weekly community meeting; this enables them to bring forward any social media they have found particularly helpful/ unhelpful to share with others.

Results:

People have reported they find talking about their social media use to someone quite eye opening as it is usually something they have kept quite private. Also they have found some of the blogs and pages identified on the social media board helpful, people are also informing staff of sites they have found helpful to put on the board.

Next steps:

The wards plans are to continue to develop their library dedicated to self-help books with the intention to include more staff within the team who have an interest in social media. Furthermore, the ward hope to the share the best practice that they have employed to colleagues focussing on the Patient Safety Quality Account priority in relation to self-harm (see page 4). The techniques and skills could be of significant benefit to people who self-harm.

For more information, contact Cath Moore, Clinical Lead Nurse, at cath.moore1@nhs.net

Delivering *affordable* care

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

Responsive Mental Health Law team provide bespoke training for staff

Background:

Mental Health Act (MHA) monitoring visits by the Care Quality Commission (CQC) and MHA audits have highlighted areas for improvement regarding compliance with the Mental Health Act Code of Practice. The CQC have previously identified certain areas for quality improvement including documentation of capacity assessments in relation to admission and treatment, explanation of rights at appropriate times and inclusion and completion of reports and leave forms.

What we wanted to achieve:

A mandatory e-learning package is available for all staff regarding the Mental Health Act 1983, but this is supported by comprehensive face-to-face training at centralised locations across the Trust. Attendance at these training sessions had reduced since their inception and the Mental Health Law (MHL) team wanted to look at ways to improve and maximise the delivery of training to clinical staff.

What we did:

The MHL team manager discussed with Matrons how MHA training could be delivered differently for ward staff to maximise attendance and impact. As a result, the existing centralised training programme was overhauled to take the training to staff instead. Face-to-face sessions were set up at the Bowmere, Springview and Millbrook inpatient units to encourage staff attendance by reducing their time off the ward. PowerPoint presentations were replaced with scenario-based sessions. These include a close look at documentation on CAREnotes, learning from CQC MHA visits, discussions on how improvements can be made and sustained, and examples of identified good practice.

Results:

Although key areas are covered, each session is different and driven by discussions based on 'live' scenarios. This has proved to be a successful approach with feedback being extremely positive. The word cloud below is composed of attendees' comments from what they found most useful about the training, in addition to other positive feedback.

"All relevant and interesting."

"Session was really helpful."

"Useful discussing different scenarios in practice."

"More engaging than previous sessions."

"Really useful update which can be transferred into practice."

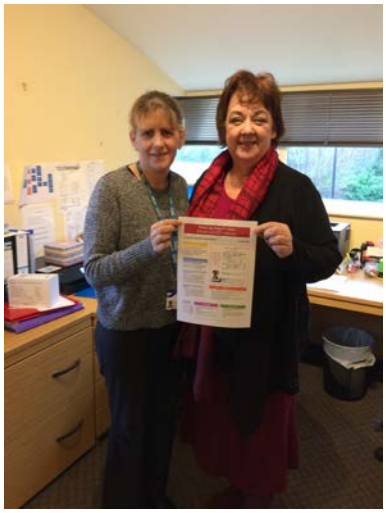
Next steps:

The MHL Team intend to continue to review the content of the sessions using a PDSA approach, building in feedback from future CQC MHA visits and learning from incidents and audits. Sessions are currently scheduled up until March 2019, however the training programme is to be extended Trustwide for a further twelve months.

For more information, please contact Jan Devine, Mental Health Law Manager, on 01244 393167

Community care team transform referral system, improving access to care

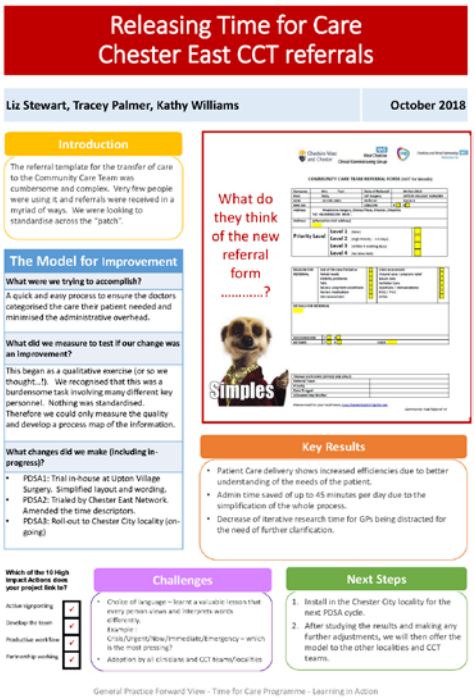
Background:



There are nine community care teams (CCTs) across the Trust, three of which are in Chester and includes East CCT. A CCT is very multi-disciplinary in nature and includes district nurses, community staff nurses, assistant practitioners, health care assistants, physiotherapists, occupational therapists, therapy assistants, clinical case managers, social workers, care co-ordinators and administration support. Referrals to the team are received through many different methods including from a hospital or GP practice through a referral form. The team identified that there was insufficient information being received at the point of referral which was impacting on time, resource and person-centredness, as a referral can be made for a huge variety of reasons reflected by the multi-disciplinary nature of the team.

What did we want to achieve?

The team recognised that the referral form was cumbersome and complex and required improvement. Furthermore, referrals were being made to the Community Care Team in many different ways from the GP practices in the cluster, of which there are four, and to address this the team also wanted to standardise the overall referral system.



What we did:

The team developed a new referral form, ensuring that a triage system or priority assessment was included to ensure **timely access to the service**. The team were very keen to ensure that the form was piloted and undertook a PDSA cycle, collaborating with one of the GP cluster practices', gathering feedback on any areas on which to improve before spreading the initiative to the rest of the cluster.

Results:

The results have been very encouraging; everybody in the cluster feels the form is **more efficient, streamlined and effective** and has **impacted positively on the delivery of patient care**. There is a **greater awareness and understanding of the person's needs on referral** which precipitates an **improved timeliness to a person's access to the appropriate service**. Furthermore, through the PDSA cycle, the team have identified that the administration time within the GP practices and CCT has, on average, **saved 45 minutes a day**.

Next steps:

The new referral form has been shared with the team's CCT colleagues within the Trust and their GP network colleagues with the intention of rolling it out to all teams.

For more information, please contact Liz Stewart, Chester East Community Care Team Manager, on 01244 385579

Red2Green continues to makes strides in improving quality and reducing length of stay

Background:

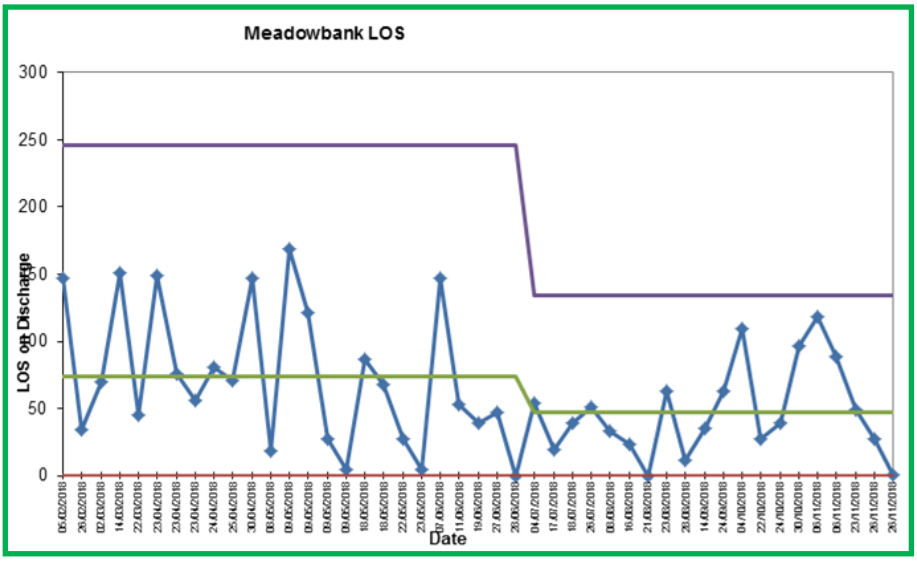
The Red2Green project has been running for over a year and the next stage is now focussed on the **sustainability of the project and embedding it within the culture of the wards** in CWP. Red2Green aims to optimise patient flow through the identification of wasted time in a person's journey, and reduce internal and external delays. The emphasis is on people receiving **active and timely care in the most appropriate setting and for no longer than required**, so that people do not lose one more day of community living than is absolutely necessary. For inpatient settings, this is vital in improving quality of care and freeing up capacity within the system by reducing length of stay.

What we did:

A steering group for the future of the Red2Green project has been planned to support the continuous improvement of flow through inpatient services and ensure consistency in the approach across the Trust. Administration support has been identified as being vital and is being allocated to support the board rounds on the wards. The criteria was redeveloped to be applicable to an organic ward.

Results:

Red2Green has successfully spread to nine wards within CWP including Acute and Organic wards and is being trialled within community intensive support services in Wirral. The engagement and motivation from staff in the project has maintained and been the driver for the continued success of the project. It has been particularly successful on Meadowbank, an organic ward, where the average length of stay (LOS) has reduced from 73.6 to 47.3 days – a 35% reduction after a shift on the 04/07/18 after beginning the project on 21/06/18.



Next steps:

The plan is for the Red2Green data on all participating wards to be included in the Trust's Locality Data Packs (LDPs) on an ongoing basis. The escalation processes are to be refined, in addition to reviewing the process on each ward to identify issues and further areas for improvement. The Trust's rehabilitation wards are to adapt and trial the use of Red2Green initiative. Furthermore, the impact on the Intensive Support Service is to be reviewed as we would be hoping to reduce the amount of time someone is identified as in crisis on the Dynamic Support Register. From an electronic point of view, the functionality of the Trust's clinical notes system, CAREnotes, is being reviewed with the intention of Red2Green data and actions being captured through CAREnotes in order to reduce duplication.

For further information, please contact Kyle Blackwood, Service Improvement Project Officer, on 01244 397391

Delivering *Sustainable* care

Quality services and systems include sustainability as a fundamental principle. The following projects show how CWP teams are delivering care that can be supported within the limits of financial, social and environmental resources.

CWP's Quality Improvement (QI) Hub

A centralised intranet site for all things QI

Background:

Quality Improvement (QI) is about **continuously improving to provide safer care, better outcomes and experiences for people who access our services**. CWP formalised this approach by introducing a QI strategy in 2018, which has been agreed and approved by the Board. The Trust's QI Strategy describes how, over an initial 3 year period, we will create the right environment and foster a culture that supports and continues to build our QI capability.

What did we want to achieve?

From the outset, when the Quality Improvement Faculty held their first meetings in the early part of 2018 with the Trust's Associate Directors in attendance, it was clear that there was no predominant location for staff to find information about QI. There were multiple stand-alone intranet pages located across a wide range of teams, with snippets of information about QI, but this caused confusion when trying to find resources or look for signposting. QI is everybody's business and we wanted to make the information and resources about QI to be as engaging and easily accessible from a central intranet based hub. We wanted the QI hub to be a jargon free environment that enticed staff to read the content rather than frighten them away.

What we did:

The Quality Support Manager from the Safe Services team knew that the team's administrator had experience with web design, was skilled on the computer and would love a challenge. She took her idea of a centralised QI intranet hub to him and explained the vision. Engagement with other colleagues helped to develop a creative image that would become the identity of any CWP QI work and become the QI theme for the Trust. Everybody involved enjoyed being creative with coloured pens and post-it notes, and with some great contributions #cwpQI was born. A Twitter account was also created and this image became the 'handle' that any staff member can use when tweeting about their QI projects and achievements. They worked collaboratively with other teams across the support services network to engage participation and encourage contribution of resources with which to populate the Intranet pages. Using mobile phones, clinical staff were filmed talking about how they had started their QI projects and what steps they had put in place to sustain the project; this part of the intranet site will continue to expand.

Results:

The project gained momentum and buy-in from senior Trust management when the leads delivered a series of presentations to the Safe Services team, the Quality Committee and the Non-Executive Directors' business meeting. On each occasion, the enthusiasm and praise was inspiring and motivating for the team to keep progressing the project. Feedback included congratulations for being a QI champion and for taking on a project using initiative, rather than waiting to be asked. By tweeting regularly about QI related work that is happening in the Trust, the number of twitter followers has rapidly increased from 2 on launch day to now more than 150.

Next steps:

The current QI Hub can be accessed by more than 3500+ CWP staff and whilst the Twitter account is available for public access, the Hub is not. CWP is keen to share with other NHS trusts and members of the public the excellent work they are doing around QI, a project plan is being developed to assist with the launch of a public accessible internet QI hub.

For further information, please contact Alison Reavy, Quality Support Manager, on 01244 393137

Cognitive Stimulation Therapy programme reaps rewards for patients

Background:

The National Institute for Health Clinical Excellence (NICE) and Memory Service National Accreditation Programme (MSNAP) have identified the value of psychosocial interventions such as Cognitive Stimulation Therapy (CST) for people with dementia. The Older People's Mental Health Service in Chester have been providing CST for several years and over that time have developed the intervention in accordance with best practice.

What did we want to achieve?

The team wanted to build on the foundation of current CST sessions to spread the programme further, making it accessible to more people and gaining feedback from carers in order to evaluate the impact of the therapy.

What we did:

Initially people attended seven weekly sessions; as the team's skills and confidence developed, they were extended to ten weekly sessions. The team are now in the position to deliver a programme of fourteen hourly sessions, held twice weekly for up to eight people at a time. It is run by two staff members, usually an occupational therapist and support worker. Again the confidence and experience of staff involved has increased to enable sessions to be led by different staff members within the team. Sessions are structured and always include discussion on current affairs and activity relating to a specific topic, for example childhood memories, creative activity, sounds or word games. The principles of reality orientation and reminiscence therapy are incorporated into the sessions in a helpful and sensitive way though the emphasis is on enabling people to give their opinions rather than having to give factual information which they may find difficult to recall. For the final session of the programme, carers were invited to help them understand the principles of CST and provide a pack of activity ideas to enable them to continue to support people at home once the programme has ended.

Image courtesy of MR Lightman at FreeDigitalPhotos.net

Results:

Research has shown that CST **improves communication** for those attending the groups. The qualitative research gathered has shown a general **improvement in mood, confidence, concentration and alertness** for those attending. Feedback from people and their carers has been positive.

> *"It's given me more thinking capacity. It gives you confidence."*

> *"I take more notice of the news and read the paper, it's helped my memory"*

Carer's perspective:

"she can't wait to tell me what has happened and speaks about the group with eagerness"

Next steps:

The team's intentions are to further extend the range of disciplines within the team to act as co-therapist in the sessions with a view to having a wider range of staff available to lead subsequent programmes; furthermore, to investigate the possibility of other agencies taking on the role of maintenance CST as well.

For further information, please contact Rebecca Stancombe, Specialist Occupational Therapist, on 01244 397427

Patient Experience Improvements and Patient Feedback

Delivering *Acceptable* and *Accessible* care

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

Improving well-being and recovery through Mindfulness and Tai-Chi

Background:

The Trust's Millbrook Unit, based in Macclesfield, wanted to develop a well-being group facilitated by various staff, adopting a collaborative, multi-disciplinary approach to aid recovery for people within their acute adult mental health and dementia wards.

What did we want to achieve?

The staff wanted to encourage patients to improve their skills in managing distress, enhance well-being and self-awareness and improve physical health using a variety of mindfulness techniques and adapted Tai Chi. It was important that the sessions were accessible to everyone, including those with no previous knowledge, in a friendly informal environment. It was also important that it was available to all patients, across every ward, to enable efficient use of therapy staff time and collaborative working.

What we did:

The Well-being sessions were developed as a joint effort between members of the Therapy team, once identified that Mindfulness and Tai Chi could have positive benefits. The Mindfulness section of the session is facilitated by an Art Therapist and the Tai Chi exercises are facilitated by a Physiotherapist. The Occupational Therapy staff also support the session by helping to identify and encourage people who may benefit from attendance, and by helping to co-facilitate the session. The team recognised that it is crucial to identify whether the sessions are valuable and helpful to people, so they have developed evaluation forms which are offered for completion after the session.

A bit of background to these therapies:

Mindfulness

Mindfulness is the skill of being able to bring our attention to what we want to focus on, being immersed in, and appreciating the present moment; it involves noticing our thoughts, feelings and senses and choosing when to act on these and when just to observe them. The well-being group sessions often focus on sensations such as experiencing different pleasant scents or passing round

musical instruments to try. They also explore ways that we can be compassionate to ourselves such as giving ourselves a kind message: 'May you be happy. May you find peace. May you be well.'

Tai Chi

Tai chi sessions involve slow graceful movements and stretches to music in a sitting position.
The goals are as follows:

- To improve joint range of motion and muscle strength.
- To improve balance and coordination.
- To improve awareness, attention span and concentration.
- To improve health and well-being.
- To improve hand eye coordination.
- To improve functional reach.

Results:

The sessions are now an established part of the Therapeutic activity timetable and take place weekly. The therapeutic activity timetable has a better balance of activities and opportunities, encompassing daily living skills sessions, social groups, well-being sessions and gym. As the well-being session is available to people across three wards, it enables them to mix with different people and is an efficient use of workforce. Staff have also improved skills and awareness of Tai Chi and Mindfulness interventions.

People's feedback:

During the period of eleven weeks, 91 people attended in total, averaging eight people per session. The staff were really pleased to find that on the whole people found the sessions really helpful. With regards to Tai Chi, 80% of people found it helpful or very helpful, whilst for Mindfulness, it was 83%. Feedback received from participants included:

"Closing your eyes, having positive thoughts was relaxing and I found it helped. We discussed our thoughts when you're down or depressed, and talked about things to make it more positive."

"Helps focus the mind."

"Reawakened the senses."

"Very enjoyable and relaxing..."

"The session was calming and restful."

"A Change of rhythm, calming."

Next steps:

The positive feedback indicates that the sessions should continue and are a valued part of the therapeutic activity program. The staff plan to explore the benefits of other therapy staff widening their skills in order for individual or further sessions to be facilitated.

For further information contact Syed Zaheer, Specialist Physiotherapist or Sally Turner, Art Therapist on 01625 508 582

Mini posters: Building relationships between patients and staff

Background:

Through gathering feedback from young people at Ancora House, the Trust's CAMHS inpatient service learned that, on admission, they would like to see pictures of who their mini team is in order to allay anxieties. Although Ancora already had a staff team board on the ward, young people wanted to know who their individual team members were, including their consultant, named nurse, associate nurse, clinical support worker, psychologist and occupational therapist.

What did we want to achieve?

Staff were keen to ensure that a simple way of providing this information was used that could be easily tailored to each young person and quickly completed on admission. What was very important was that it was young person friendly and easy to read.

What we did:

Coproduction was identified as being crucial to the success of this initiative and as a result, young people collaborated with staff to designing a poster to achieve the aim. They used rainbow coloured boxes and simple wording to explain who the team members are, designing the layout and creating the colour scheme.

Results:

The qualitative feedback from young people has highlighted how helpful they have found the posters:

"I love the colourful chart which brightens up my notice board"

"I can't remember names so is great to see the pictures of staff and know who I am seeing"

"This is really useful and helps relieve anxieties of who I am seeing"

Next steps:

As this initiative has been really successful, the ward want to continue to work with young people to design and create helpful information and update and refresh existing literature, including the Smoking cessation leaflet, CHEDS welcome leaflet and information about keeping safe on the ward.

For further information, please contact Clair Josting Moulder, Participation Lead on 01244 397667

Learning Disability Coffee Morning drop-in facilitates friendships and opportunities

Background:

For individuals with a learning disability, it can be difficult to have access to social inclusion opportunities outside of the typically commissioned service times; this can lead to loneliness and can have a detrimental impact on the health and wellbeing of those with learning disability.

What we want to achieve?

The community learning disabilities team in Trafford wanted to combat this loneliness for people who have limited opportunities for social engagement within their local community. One of the ways in which to do this was to try to re-establish longstanding friendships, thus improving their overall health and wellbeing.

What we did:

The team identified that there were people who had known each other since their youth and following a change in day service provision lost contact and did not have the means to re-establish this. Research was completed and it was identified that there were limited services within the Trafford locality for people with LD at the weekends. The idea of a drop-in was discussed with people with Learning Disabilities who the team felt would benefit from weekend social engagement opportunities. An accessible venue was sought and negotiations were carried out with the venue staff around cost and timings. Flyers were produced and distributed within the local community.

Results:

The drop-in has been running since January 2018, and the number of attendees has increased each month with friendships having been re-established. Since attending the drop-in, people's confidence has increased and some have also made their own social arrangements with one another, without CLDT involvement. Families and carers have volunteered their skills, for example one parent has volunteered to attend do some sewing and quilting with members. Positive feedback has further demonstrated that this initiative really is benefiting people.

> "As a parent, it was a pleasure to meet other parents and form new friendships. We chatted about the ups and the downs of caring for our special loved ones"

> "I like to go to coffee morning with my friend... I have a good morning"

> "Helping out at the coffee morning felt like I was giving something back and rewarding in itself and it gave me the opportunity to interact with our service users outside of the assessment and care planning processes"

Next steps:

The future plans for this successful initiative are to establish additional drop-in groups, including an evening group with the introduction of a rota of volunteers, including social care colleagues, to ensure the longevity of the group/s. The team want to continue gaining regular feedback from clients and carers to further improve the service maintaining a person-centred focus. Furthermore, the team would also like speakers to attend the drop-in coffee mornings to discuss topics such as cancer screening programmes.

For further information, please contact Louise Stott, Clinical Support Worker, on 0161 912 2809

Multi-Family Therapy Workshop for Anorexia Nervosa wins national award!

Background:

Cheshire Eating Disorder Service run a bi-annual 4-day intensive workshop for families called "Multi-Family Therapy", with the aim of facilitating conversations with other families, sharing experiences and developing a greater understanding.

What did we want to achieve?

The team wanted to find out what the families participating in the workshop liked and disliked, valued and didn't value to better understand the experiences of the families invited to take part. It was also important to find out if families had any preconceptions that were then changed by taking part, and whether there is anything that needed to be altered with regards to the workshop to make it more accessible to families, as attending the workshop for 4 consecutive days is a big commitment.

What we did:

The team liaised with the CWP research department who supported in the writing up of a proposal, and completion of an ethics application. Afterwards, the team created a questionnaire for the participating families that would cover 4 time points (pre-workshop, post-workshop, 6-week follow up and 12-week follow up) in order to follow the views and opinions of the families over time and understand any changes; from preconceptions to ending-reflections. Questions covered a range of topics, and included rating scales and open-answer questions to allow for both qualitative and quantitative data collection. The families were happy to be involved in giving feedback, particularly to help us improve the workshop for the future. Once all the data was gathered, the results were analysed and grouped by their themes.

Results:

A range of themes were identified including “Feeling Less Alone”, the “Importance of Other Families” and “Recovery Focussed Drivers” (e.g. hope, less fear for the future, determination, optimism). It also highlighted themes of “Negative Emotions” (e.g. apprehension, emotionally draining, intense therapy) and made the team more aware of the impact the 4-day workshop has on family life (e.g. taking time out of work). Despite the high commitment and emotional toll of such an intensive therapy, the qualitative results demonstrated that recovery focussed language, e.g. hope and optimism, increased exponentially by the final follow up day 12 weeks after the workshop, in addition to “Familial Changes” such as more open communication, closeness and greater “Understanding of the Experiences of Young People & Anorexia”. The project itself was greatly appreciated by the families who felt listened to and involved in their care by taking part in the project. It also allowed staff to understand more about their experiences and how their views of the workshop and of anorexia alter over time.

“We are not alone…We can beat this”

“A painful, emotional, powerful week”

“Be prepared for ups and downs for a long time. Keep hope alive!”

“Things can get better if I want them to”

“I really didn't want to come at the start of the week but I'm leaving feeling quite positive, so thank you”

“I have seen that I'm not alone in my feelings!"

Not only did the workshop receive considerable positive feedback from families, a poster was submitted National CYP Community ED Conference in London earlier this year in in relation to the initiative and it won first place in the 'Interventions' category. The team were very proud to be able to showcase the work of CHEDS' Multi-family therapy workshop at a national level, but also to demonstrate how their commitment to getting feedback from people and families can help to maximise understanding of their experiences and ultimately improve services further.

Next steps:

The intention is to repeat the service evaluation again in order to compare and contrast the feedback and experiences between different groups of families, and highlight what has been improved upon, but also, to highlight any other areas that may need attention.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Participant experiences of a Multi-Family Therapy Workshop for Anorexia Nervosa and the perceived helpfulness of the workshop over time

Author: Elenya Harston, Cheshire and Merseyside Adolescent Eating Disorder Service (CHEDS)

Aims and Objectives:

- Understanding the experience of families taking part in a Multi Family Therapy Workshop (MFTW) over time
- Determining what participants found most and least helpful to better inform our delivery of MFTW

Sampling

Multi Family Therapy workshops (MFTW) are run twice yearly at CHEDS for up to 6 families of young people (YP; aged 13-18) with anorexia nervosa. The diagram (below) outlines time points at which data was collected, in addition to the number of participants giving feedback from the total number in attendance.

- Introduction Evening: T1 (N=14 of 18)
- Final day of MFTW: T2 (N=13 of 15)
- 6 Week Follow-up Day: T3 (N=6 of 6)
- 12 Week Follow-up Day: T4 (N=7 of 7)

Measures

Questionnaires consisted of 5-point Likert scales (see examples below), in addition to a number of qualitative answer questions, covering themes of helpfulness, changes made, what families found most and least important and what they will take away from the MFTW at each time point.

1	2	3	4	5
Very Unhelpful	Quite Unhelpful	Neither	Quite Helpful	Very Helpful

Lots of Negative Changes	Some Negative Changes	No Changes	Some Positive Change	Lots of Positive Changes

Data Analysis

Descriptive statistics were used to analyse quantitative data from Likert scales. Thematic analysis of qualitative data resulted in themes being identified and grouped into larger categories displayed in Figure 1.

Results

As shown in Table 1, average helpfulness ratings increased from T1 to T3, then decreased at T4. In Table 2, average change ratings were less positive from T1 to T4.

Table 1: Average Helpfulness Ratings of the MFTW on 5-Point Likert Scales

	T1 (n=11)	T2 (n=12)	T3 (n=6)	T4 (n=7)
Mean (SD)	3.82(0.87)	3.92(1.16)	4.5(0.55)	4.14(0.90)

Table 2: Average Response to "Do you feel you/your family will make/have made any changes as a result of the MFTW?" Rated on 5-Point Likert Scales

	T1 (n=10)	T2 (n=11)	T3 (n=5)	T4 (n=7)
Mean(SD)	4.20(0.42)	4.18(0.60)	3.80(0.84)	3.71(0.76)

What was most important to you from the Multi Family Therapy Workshop? Consistently "Feeling Less Alone" , "Importance of Other Families", "Recovery Focused Drivers" and "Support & Supportive Environment".

What was least important to you from the Multi Family Therapy Workshop? At T2, frustration over structured activities being unhelpful (e.g. mindfulness) and the difficulty of meal times. At T3, this question received no responses. T4 highlighted repetitive themes and activities but the majority of the sample gave no response (71.4%).

What will you take away with you from the Multi Family Therapy Workshop? Consistently "Recovery Focused Drivers", "Sharing of information and New Skills", the "Importance of Other Families", "Support," and "Understanding". At T1, "Staff Support" was highlighted, but did not arise at later time points.

Do you feel you and/or your family will make any changes as a result of the Multi Family Therapy Workshop? At T1, "Negative Emotions" (e.g. Apprehension, Anxiety, Uncertainty), "New Skills," "Support" and "Familial Changes". At subsequent time points, participants consistently highlighted "Familial Changes" (dominant at T2), "Understanding" (dominant at T3) and "Recovery Focused Drivers" (discussed increasingly until T4 when it was the dominant theme across the sample).

Figure 1: Themes identified through Thematic Analysis of qualitative feedback

'Final Thoughts'-Space for participants to discuss any other thoughts they had about the workshop At T1, themes of "Negative Emotions" (e.g. apprehension) and "Recovery Drivers" (e.g. hope) were equally prominent. At T2, discussion focused on apprehension becoming optimism as a result of the MFTW and the impact "Timing & Organisation" has on normal family life. At T3, "Recovery Focused Drivers" and "Support" discussion increased until T4 when "Recovery Focused Drivers" became the dominant theme, highlighting hope for the future and the value of seeing recovery examples (e.g. BEAT Youth Ambassador).

Conclusions

To better understand the experience of families in our intensive 4-day MFTW, we invited participants to give feedback at 4 time points.

Perceived helpfulness of the MFTW generally increased over time, which may reflect the initial trepidation of families embarking on the MFTW slowly becoming optimism. Changes made were gradually rated as less positive perhaps reflecting how families had high expectations of the workshop initially, and these views subsequently became more realistic, or perhaps participants had already been able to make positive changes earlier in the process.

The "Importance of Other Families" was a dominant theme throughout this service evaluation, which highlighted how providing more opportunities for families within our service to meet in supportive environments (e.g. parent support groups) could be very beneficial.

What also became apparent was the disruption MFTW has on families, and practitioners should consider methods of reducing this impact, for example by considering using evening or weekend hours for future MFTWs.

Despite the high commitment and emotional toll of such an intense therapy, statements reflecting "Recovery Focused Drivers" (e.g. hope for the future, less fear, optimism, strength) had increased exponentially by T4, in addition to "Familial Changes" such as more open communication, closeness and greater "Understanding of the Experiences of Young People & Anorexia".

These rudimentary findings have shed some light on the complex experiences of families embarking on MFTW at CHEDS, which will help inform practitioners conducting future MFTWs in our service, in addition to the next evaluation scheduled for April 2018.

Acknowledgements The author would like to thank all the families for their honest and detailed feedback throughout this process.

"We are not alone. We can beat this…"
"…A painful, emotional, powerful week…"
"Things can get better if I want them to…"
"I have seen that I'm not alone in my feelings!"
"I really didn't want to come at the start of the week but I'm leaving feeling quite positive, so thank you ☺"
"Be prepared for ups and downs for a long time. Keep hope alive!"

For further information, please contact Elenya Harston, Clinical Psychology Assistant on 01244 393220

Neston and Willaston Community Care Team collaborate with the Third Sector to improve quality of life

Background:

There is a high incidence of over 65 year old females living alone in the Neston area, and as part of compassionate communities, Neston and Willaston Community Care team wanted to try to build collaborations with the third sector to improve wellbeing, especially for this demographic.

What did we want to achieve?

The team's aim was to try to improve quality of life and educate, also being inclusive with other demographics such as male residents over the age of 65, with the hope of decreasing the chance of possible hospital admission in the future. In order to do this, it was identified that collaborative working with other services to enhance patient care and improve understanding of support available would be of real benefit.

What we did:

The team engaged with Healthbox who are just starting up initiatives in the Neston area such as introducing foodbanks and combatting social isolation. The team also engaged with Live at Home which is an initiative, arranging events for local people who may be socially isolated and aims to offer lunches, outings and guest speakers. The team met with representatives from both initiatives and arranged for their therapy assistant to attend a session and deliver a talk on falls prevention. In addition, one of the community nurses is to soon deliver a talk on the importance of looking after your skin, especially in pressure areas.

Results:

The results so far are demonstrating cohesive and collaborative working with the third sector to improve the patient experience within the local areas, with lots of positive feedback from many different stakeholders.

"excellent opportunity for working together to improve quality of life for Neston residents"

Healthbox

"Lovely meeting your team and felt the session was excellent"

Live at Home

"really looking forward to helping reduce inequalities in the Neston area and offering health education to our residents"

Welcome Network

Members of the public attending afternoon coffee and cake session:

"enjoyed the talk today and found the information very useful"

"It was nice to listen to the nurses and I found the session comforting to know that the nurses are there"

"Such a nice afternoon and very interesting"

Next steps:

The team are planning to deliver sessions on care provision by the integrated community team and engagement in compassionate communities. The end result will hopefully identify people who are potentially at rising risk of hospital admission and, as a result, the team can intervene earlier and offer support to prevent admission and further complications.

For further information, please contact Fran Johnston, Neston and Willaston Community Care Team Manager and Clinical Case Manager, on 0151 488 8440

Greater collaboration between CWP's Macmillan specialist palliative care team and their hospice colleagues

Background:

The community Macmillan specialist palliative care team is made up of a number of healthcare professionals including clinical nurse specialists, an occupational therapist, physiotherapist, therapy assistant and assistant practitioner who provide advice and support to patients in the community diagnosed with cancer or another life limiting condition; their focus is very much around improving the quality of life. They also provide a link between care agencies and the home, e.g. hospital, hospice or community services. Last year, the team moved bases to be located within the Hospice of the Good Shepherd.

What did we want to achieve?

The principle aim of the relocation was to ensure that the link or 'joined up' care was maximised for the people they serve, many of whom are also hospice patients.

What we did:

With the help of CWP Estates and ICT, the team systematically moved base to the hospice. The team consider themselves very fortunate that the hospice were able to offer a large office space which was vacant following the building of a new day hospice, now known as the Living Well Centre. The team are now fully settled and are on site and able to attend multi-disciplinary team meetings more frequently and liaise more closely with their hospice colleagues.

Results:

The team have greatly improved their working relationships with their hospice colleagues who both strive to provide a seamless service for patients. As a result of the move, closer working has been easily facilitated and the ability to work more collaboratively due to their colocation with hospice staff has meant that more timely admissions and discharges are achieved. The team are also able to seek face to face expert advice and, reciprocally, hospice staff are able to discuss patient issues with them. Although the team have always provided Occupational Therapy and Physiotherapy to the hospice, being based on site has furthermore improved access to more timely interventions.

Next steps:

The team are working with their colleagues within the hospice and the Countess of Chester Hospital to look at the possibility of pooling referrals via a single point of access. This will avoid duplication and further enable the patient to be seen by the most relevant team and clinician in as timely a manner as possible.

For further information, please contact Adrian Bunnell, Clinical Specialist Occupational Therapist and Team Leader, Macmillan Specialist Community Palliative Care Team, on 01244 397356

Between August and November 2018, CWP formally received 956 compliments from people accessing the Trust's services, and others, about their experience. Below is a selection of the comments and compliments received:

Learning Disability, Neuro Developmental Disorders & Acquired Brain Injury:

- "My daughter seemed happy on return from Respite Care. Staff kept me informed about my daughter's health and well-being. Staff are always friendly and helpful when I call the centre."
- The care co-ordinator from another Trust has been very impressed with the multi-disciplinary approach towards the patient's care that he has observed at Greenways. He acknowledges that this has been very beneficial for the patient and acknowledges that the patient's father has been well supported in the process. He wanted to pass his compliments on to the team.

Specialist Mental Health – Bed based:

- A bench has recently been sited by the entrance door to the unit; this was utilised by a service user and his mother to facilitate a visit in the fresh air within eye sight of staff. The service user's mother commented on how nice it was to be able to sit outside with her son and enjoy the sunflowers.
- "Every aspect of my stay was aimed at making me feel secure and confident whilst recovering."
- His sister thanked the staff for all of the help and contact during his admission. She stated that the discharge/ transfer home to Poland was arranged beautifully and could not thank the staff involved enough.
- "Thank you for all your help, love and support through a difficult time."
- Patient's parents wanted to thank the team for all their help and support at their difficult time.

Specialist Mental Health – Place based:

- "I can't tell enough what a help the Recovery College has been in my recovery, particularly the Reader Workshop. I can't wait for the next one to start."
- She had complimented her experience of the service and felt it had been a very positive one – that we had taken time to hear her current difficulties and she didn't feel dismissed.
- "I found the discussions and leaflets the most useful part of the course. I found the tutor very friendly and helpful."

Children, Young People & Families:

- "Things were explained to me, I was asked if I understood and if I was okay with everything. I now feel things are going in the right direction."
- "The service is absolutely amazing, very carefully put across, very comfortable to work with and talk to."
- "The communication between all departments was seamless, the care and compassion we were given was really appreciated and their expertise was second to none."
- "The nurse was lovely and took time to listen to both my son's and my concerns."
- "CAMHS helps with a lot of worries and concerns I have for my daughter's behaviour."

Neighbourhood Based Services:

- Patient's daughter said she felt very reassured during the care by the nurses and that her mum was safe and said she really cared for the nurses a lot.
- "I found it really helped my thought process and how to look at situations differently."
- "Everyone he has met has been pleasant, helpful and extremely caring and he has enjoyed his many attendances in our clinics. He is very happy with the service he has received."

Share your stories

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

Look out for more about Quality Improvement in Edition 3 2018/19 of the Quality Improvement Report

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STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Care Quality Commission registration & Statement of Purpose – Update
Agenda ref. no:	18.19.129
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	30/01/2019
Presented by:	Dr Anushta Sivananthan – Medical Director/ Executive Lead for Quality

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

REPORT BRIEFING

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

To provide an update to the Statement of Purpose and CQC registration as specified by the business cycle for the Board of Directors.

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

The Statement of Purpose was last approved at Board in January 2018, in line with the business cycle for the Board of Directors. The Trust is required to update the statement of purpose in accordance with the registration guidance outlined by the CQC at the point of any changes to service provision.

Assessment – *analysis and considerations of options and risks*

The Statement of Purpose (**Appendix 1**) has been updated in conjunction with business support managers and Head of Clinical Service within each Care group. All locations and addresses have been reviewed to ensure that they are up-to-date and, where necessary, amendments have been made to ensure accuracy. The key amendments are:

- The registration of Westminster Surgery for "surgical procedures" – *pending final approval from CQC – submitted 03/09/2018.*
- Update of the Statement of Purpose to reflect the acquisition of the Wirral All Age Disability in Service in quarter 3 of 2018 including;
    - Registration of the Millennium Centre, Leasowe as a registered location – *pending final approval from CQC – submitted 26/09/2018.*
    - Registration of "personal care" as a regulated activity for the Trust – *pending final approval from CQC – submitted 26/09/2018.*
- Removal of references to substance misuse services since the transfer of services in October 2018.

Each community location is noted as either a hub or a satellite to assist the CQC in understanding the main locations from which care is provided.

The description of services provided by the Trust has also been updated in line with the services currently provided by CWP.

Appendix 2 is the current Certificate of Registration for CWP which was issued in October 2018. We are awaiting an updated certificate to fully reflect the above changes.

The Board of Directors will receive a further comprehensive update to the Statement of Purpose in January 2020, or sooner if there are significant changes required prior to this due to service development or re-configuration.

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

The Board of Directors is asked to **note** the information held within the Statement of Purpose and **approve** the submission to the CQC registration team.

Who/ which group has approved this report for receipt at the above meeting?	David Wood, Associate Director of Safe Services
Contributing authors:	Elspeth Fergusson, Compliance Manager

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	D Wood and L Brereton for BoD agenda	23/01/2019

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

Appendix no.	Appendix title
1	CWP Statement of Purpose – Revised January 2019
2	CQC Certificate of Registration – October 2018

Cheshire and Wirral Partnership
NHS Foundation Trust

CHAIR'S REPORT – QUALITY COMMITTEE 9 JANUARY 2019

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

1. Reducing restrictive practices – expert clinical panel

This panel has been established to identify standards, guidance and principles for delivering care in ways which support positive behaviour to mitigate the need for unwarranted restrictive practices. The panel has agreed to focus on nine inter-dependent topics, which are being looked at in more granular level detail at individual task and finish groups. The aim is that each task and finish group defines what good care looks like through agreeing a number of core/ key standards, guidance and positive principles/ statements. The panel will then consider these outputs in light of the different issues and care pathways across learning disability, forensic, children/ young people and adults/ older people services, in implementing PDSA cycles and reduction plans to work towards eliminating the use of unwarranted restrictive practices to manage behaviour that challenges.

The Quality Committee has agreed to be the oversight committee for this quality improvement work.

2. Strategic risk register – including risks associated with pressures on acute care bed capacity

The Quality Committee received assurance on progress against the mitigating actions identified against the Trust's strategic risks and the controls and assurances in place that act as mitigations against each current strategic risk. Specific risk treatments have been identified with the benefit of considering feedback from the CQC (as part of the Trustwide annual inspection) on the subjects of mandatory training, the elimination of mixed sex accommodation and supervision. The Quality Committee also agreed to strengthen even further how it is assured of progress against mitigating actions. In-depth periodic reviews of strategic risks will be added to the Quality Committee business cycle and the quality assurance dashboard thus (i) strategic risks with a red risk appetite score of 2 to be reviewed if still under treatment after 12 months (ii) strategic risks with an amber or green risk appetite score of 3-5 to be reviewed if still under treatment after 18 months.

The Quality Committee received a specific update on strategic risk 10 regarding pressures on acute care bed capacity. These are currently being well managed, with CWP's stretch target of people requiring admission not waiting longer than 4 hours for a bed to be allocated performing well, in addition to CWP not requiring the use of out of area placements. By way of continuous and anticipatory risk treatment, a quantitative and qualitative review of bed usage is underway to give important analysis about who from where uses which bed days, which may suggest possible targeting of interventions and/ or flag up testable hypotheses and potentially usable solutions. This will be critical data for any future resource decisions and/ or any team redesigns. An interim report will be provided to the next meeting.

The Quality Committee approved the amendments made to the strategic risk register for update of the corporate assurance framework to the Board.

3. CQC inspection August – September 2018: areas for improvement

The CQC's inspection report detailed actions CWP is required to take, by 31 January 2019, to improve services. Progress with the actions CWP must take by 31 January 2019 was presented to the Quality Committee. The named executive leads will sign off these actions before submission to the CQC.

The Board is asked to note progress with the CQC inspection 2018 improvement plan.

4. Willaston Surgery

The aforementioned CQC inspection activity included an inspection of Willaston Surgery, which was rated 'Good' in all domains despite a number of challenges, including the practice environment and population needs. CWP has provided services from this practice since December 2017; how it has made improvements and achieved a positive CQC rating, through a "personal approach", was presented to the Quality Committee, as was areas that the practice is continuing to work on. The Quality Committee congratulated the practice team for its focus on people accessing and delivering primary medical services to the population of the Willaston and Thornton ward.

The Board is asked to endorse the Quality Committee's congratulations to the practice team.

Lucy Crumplin
Non Executive Director/ Vice Chair of Quality Committee

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CHAIR'S REPORT – AUDIT COMMITTEE 15 JANUARY 2019

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

- Patient Safety Improvement Review programme
  The Committee received a presentation on the Patient Safety Improvement Review programme based on the framework for measuring and monitoring safety in a health care setting. The new approach takes a more dynamic and holistic approach ensuring regulatory expectations are met but using an intuitive and qualitative approach to build a rounded picture of the issues.

- Quality Spot Check Report follow up
  The Audit Committee received an update on actions taken following the quality spot checks – ward cleanliness report which provided moderate assurance and three 'medium' level recommendations reviewed at the last meeting. The Committee was briefed on a 12-month development programme being led by the Deputy Director of Nursing and Therapies, working with ward managers around standards, ward cultures and person centredness,

- Internal Audit
  MIAA provided an update on the 2018/19 audit programme. A change to the programme has been agreed, removing an audit on flexible working/ retirement policies, replacing this with an audit on processes around consultant pay increments which will report to the next Audit Committee. The programme is expected to be fully delivered by the end of March 2019.

- External Audit
  KPMG presented the 2018/19 external audit plan to the Committee. The key financial statement risks were reviewed and management responses considered. Pre-audit work is due to commence in February. The Committee was informed of the work being taken forward with Trust Governors to select the local indicator for audit. The Scrutiny subcommittee will be asked to consider this at its February meeting with final approval to be sought at the April 2019 Council of Governors meeting.

- Anti-fraud
  The Committee was provided with an update on anti-fraud activity undertaken since the last meeting. All aspects of the programme were on track. The Committee was also provided with an overview on investigations and ongoing cases.

- Workforce planning
  The Committee reiterated its expectation that strategic workforce planning has a greater profile in the 2019/20 Board of Directors business cycle. This will be taken forward and actioned by the Head of Corporate Affairs, working with the Director of People and OD.

Edward Jenner
Non-Executive Director/ Chair of Audit Committee