Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting of the Foundation Trust Board of Directors

Wednesday 30th July 2014 at 1.00pm

All Hallows College, Romero Centre, Macclesfield

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
14/15/19	Apologies for absence	Receive apologies	Verbal	Chair	1 min (1300)
14/15/20	Declarations of interest	Identify and avoid conflicts of interest	Verbal	Chair	1 min (1301)
14/15/21	Minutes of the previous meeting held 28th May 2014	Confirm as an accurate record the minutes of the previous meetings	Written minutes	Chair	3 mins (1302)
14/15/22	Matters arising and action points	Provide an update in respect of ongoing and outstanding items to ensure progress	Written action schedule and verbal update	Chair	5 mins (1305)
14/15/23	Business Cycle 2014/15	Confirm that agenda items provide assurance that the Board is undertaking its duties	Written Report	Chair	2 mins (1310)
14/15/24	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	5 mins (1312)
14/15/25	Chief Executive's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	5 mins (1317)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
Assurance: Quality/ Effectiveness/ Experience/ Safety					
14/15/26	Community Services Improvement Programme - locality evaluations	To update on the locality evaluations	Written Report	Director of Operations	15 mins (1322)
14/15/27	Board Assurance Framework and Risk Register	To note current Board Assurance Framework and Risk Register	Written Report	Medical Director	10mins (1337)
14/15/28	Health and Safety Annual Report 2013/14	To receive the 2013/14 Annual Report	Written Report	Director of Nursing, Therapies and Patient Partnership	10 mins (1347)
14/15/29	Safeguarding Children and Adults Annual Report 2013/14	To receive the 2013/14 Annual Report	Written Report	Director of Nursing, Therapies and Patient Partnership	10 mins (1357)
14/15/30	Accountable Officer and Medicines Management Annual Report 2013/14	To receive the 2013/14 Annual Report	Written Report	Medical Director	10 mins (1407)
14/15/31	Medical Appraisal Annual Report 2013/14	To receive and approve the 2013/14 Annual Report	Written Report	Medical Director	10 mins (1417)
14/15/32	Nicotine Management Policy	To update on the implementation of the Nicotine Management Policy	Written Report	Director of Nursing, Therapies	15 mins (1427)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
				and Patient Partnership	
14/15/33	Infection Prevention and Control Annual Report 2013/14	To receive the 2013/14 Annual Report	Written Report	Deputy Director of Nursing/ Infection, Prevention and Control	10mins (1442)
14/15/34	Daily Ward Staffing Levels	To note the daily ward staffing levels for June 2014	Written Report	Deputy Director of Nursing	10 mins (1452)
Performance					
14/15/35	Corporate Performance Report - June 2014	Review Trust performance	Written Report	Director of Finance	10 mins (1502)
Assurance: Governance					
14/15/36	Monitor Quarterly Compliance - Q1 14/15 and Q1 14/15/ Quality Governance Assessment	To note the Q1 Quality Governance Assessment and to approve the Q1 submission to Monitor	Written Report(s)	Director of Finance	10 mins (1512)
14/15/37	Monitor Well-led Governance Reviews	To update on the recent Monitor guidance on governance reviews	Written Report	Head of Corporate Affairs	10 mins (1522)
14/15/38	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	5 mins (1532)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
14/15/39	Any other business	Consider any urgent items of other business	Verbal or written	Chair/ All	5 mins (1537)
14/15/40	Review of meeting	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair/All	2 mins (1542)
14/15/41	Date, time and place of next meeting: **Wednesday 24th September 2014, 1.00pm at Redesmere Boardroom.**	Confirm arrangements for next meeting	Verbal	Chair	2 mins (1544)

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Minutes of the Board of Directors Meeting
Wednesday 28th May, Boardroom, Redesmere, Countess of Chester Health Park
commencing at 1.00pm

PRESENT	David Eva, Chair Fiona Clark, Non-Executive Director Lucy Crumplin, Non-Executive Director Sheena Cumiskey, Chief Executive Avril Devaney, Director of Nursing, Therapies & Patient Partnership Ron Howarth, Non-Executive Director Mike Maier, Deputy Chair and Non-Executive Director Dr Jim O'Connor - Non Executive Director Dr Anushta Sivananthan, Medical Director Compliance, Quality & Assurance Tim Welch, Director of Finance & Deputy Chief Executive	
IN ATTENDANCE	Louise Hulme, Head of Corporate Affairs (inc. CoSec) Helen Pilley, Infection, Prevention and Control Nurse(for item 14/15/09) Rob Robertson, Public Governor Phil Jarrold, Service User/ Carer Governor Stanley Mayne, Public Governor Ann McGrath, Service User/ Carer Governor	
APOLOGIES	Andy Styring, Director of Operations Dr Faouzi Alam, Medical Director, Effectiveness & Medical Workforce	
	MINUTES	**ACTION**
14/15/01	**WELCOMES AND APOLOGIES FOR ABSENCE** The Chair welcomed everyone to the meeting. Apologies were noted. The meeting was quorate.	
14/15/02	**DECLARATIONS OF INTEREST** There were no interests declared.	
14/15/03	**BOARD MINUTES- MEETING OF 26th March 2014** An amendment was required for page 3 and the reference to the safeguarding inspection. Subject to this amendment, the minutes of the meeting held on 26th March 2014 were **approved** as a correct record.	
14/15/04	**MATTERS ARISING AND ACTION POINTS** There were no actions for this meeting. Avril Devaney updated that in relation to the NQG requirements around safe staffing; the Trust's position has position slightly changed. A report	

	will be provided to the June Board of Directors but due to the NQB submission needed on the on 10th June, the information is needed ahead of the meeting. Board members will be provided with the data for the submission on the 6th June 2014 so they will have sight of this prior to submission on the 10th June 2014. The data will also be published on the CWP website.	
14/15/05	**BOARD MEETING BUSINESS CYCLE 2013-14 AND 14/15** The Business cycles for 2014/15 were noted.	
14/15/06	**CHAIR'S ANNOUNCEMENTS** David Eva announced that: **Non-Executive Directors** Non-Executive Director Stephen McAndrew has resigned from the Board with immediate effect due to him taking up a new post with the Priory group who offering mental health services. David Eva extended his thanks to Stephen McAndrew for long service to the Trust during which he acted as both Deputy Chair and Senior Independent Director for some time. Council of Governors are to be informed and the Nomination Committee will be convened to look at the process for recruiting to the post. A collection will be started to contribute to two causes which LH will collect. Dr Jim O'Connor, Non-Executive Director was also welcomed to the Board at his first Board meeting. **IAPT services** The Trust's IAPT Service in West Cheshire has been recognised as providing one of the top performing primary mental health services (IAPT) in England. The service offers assessment and assistance to people with a wide range of mental health needs including feeling stressed, anxious, low in mood or depressed. Therapies include face-to-face and telephone consultations, computer assisted treatments and courses/workshops. To celebrate Jane Palombella, CWP clinical services manager and Janet Foster, CWP IAPT clinical lead were invited to the Department of Health in London to attend an audience with Norman Lamb, minister of state for care and support. **Zero Harm** Over 30 members of clinical staff from CWP have taken part in a leading patient safety training course, as part of the Trust's 'Zero Harm' campaign. 'Zero Harm' is CWP's response to national reports such as the Francis, Keogh and Berwick reviews – working to drive up safety standards across the Trust and ensure that plans for excellence are implemented at every opportunity. The two day Human Factors training course focussed on enhancing patient safety performance through an understanding of the effects of teamwork, tasks, culture and organisation on human behaviour and abilities as well as the application of that knowledge in a clinical setting. The Zero Harm campaign will continue to be rolled out Trustwide	

	over the next 3 years. **Recovery Colleges** New Recovery College prospectuses for Crewe, Macclesfield and West Cheshire are now available to be downloaded from CWP's website. The wide range of courses are aimed at supporting people, through self-management, to deal with the mental health challenges they experience and to achieve the things they want to in life. All courses are friendly, welcoming and available to patients who are 18 or over who use services delivered by the Community Mental Health teams (CMHT), families and friends of those who use services delivered by CMHT and CWP staff who work within secondary care services. **International visitors coming to CWP** During week commencing 9th June the Trust will be hosting England's Recovery Theme as part of the annual International Leadership Exchange organised by the Initiative for Mental Health Leadership (IIMHL). Visitors have expressed an interest to come to CWP to find out more about our services, including the early intervention service in Wirral, the service provided at Rosewood intensive rehabilitation unit at Bowmere Hospital, Chester and Ellesmere Port South integrated community care team. Eight visitors have signed up including four from Australia, two from New Zealand and one from Ireland.	
13/14/07	**CHIEF EXECUTIVE'S ANNOUNCEMENTS** Sheena Cumiskey announced that: **Integration Work** Collaborative work has been on going with other northwest Mental Health trusts commissioned to look at a number of areas and bench-marking information to look at comparisons and continuous improvement with a particular focus on early intervention services. Regarding Connecting Care in mid Cheshire, the two CCGs there wanted different approach on how take the integration agenda forward and gave the three providers in the patch the challenge of how to work together to solve the health and social care problems in the area. There was agreement to help mid Cheshire with downsizing and looking at the methodology for this at present. The focus is on reinvesting in community services and this has now been expanded to social care and primary care and will now involve third sector organisation further down the line going forward. A 4 patient per day reduction at the acute hospital is the target and understanding what is involved in making this happen. **CPR** Tim Welch reported that work to improve the CPR is ongoing. There is no CPR on the agenda today as this work is being concluded. The closed board meeting looked at the new dashboard and whether it is fit for purpose. This was approved and it was agreed that this will now go into the open meeting with the removal of any identifiable data.	

	A key line of enquiry from the CPR is 12 month CPA follow up - targets have been achieved but are on a downward trend, so the Trust looking at whether this is a seasonal issue. With regard to financial performance, the Trust is achieving the CoS RR but is undershooting on month 1 largely due to the non-achievement of CIP plans. This is being addressed with the Locality Service Directors and work is being undertaken to ensure these do not have an impact on quality.	
14/15/08	**BOARD ASSURANCE FRAMEWORK AND RISK REGISTER** Dr Anushta Sivananthan introduced the report and reported on the changes to the risk register since the last update to the Board. The CIP risk has been remodelled in light of the due to development of a more robust process to maintain oversight of CIP progress and achievement. This has resulted in a reduction of the risk score. The slips, trips and falls risk has also reduced due to the programmes put in place taking effect. Mike Maier commented on the progress made with the risk register and the reduction of red rated risks indicating the improving dynamism of the register. Dr Jim O'Connor queried the risk around physical conditions and staff competencies in dealing with these. Dr Anushta Sivananthan advised that this risk has come about due to mental health staff requiring knowledge on managing both physical health care and mental health care needs. The target risk score for this risk is 15 and this is due to be achieved by January 2015. Work is ongoing to enable the Trust to progress towards achieving this. Avril Devaney commented on the dual qualification and need for as many staff to achieve this as possible. There is a cost implication to this but there is potential to work with other Trust's which may enable some cost sharing. Fiona Clark queried the safeguarding training and practice risk and queried how gaps in safeguarding training and practice are followed up in practice. Dr Anushta Sivananthan advised that this is monitored on the wards. Fiona Clark queried the gaps potentially impacting on quality of care. Dr Anushta Sivananthan advised that the Trust monitors this from learning from incidents and RCAs. David Eva queried the reduction in the risk scoring of the CIP risk, given that the month 1 reporting is indicating that CIP achievement is already off target. Fiona Clark queried whether the CIP plans were deliverable. Andy Styring advised that there is a need to ensure that the quality impact assessment process is robust and is addressing any concerns. Tim Welch commented on the need for managers to ensure they adequately manage their CIP plans and do not rely on contingency funding if they do not achieve as has been the case historically. Fiona Clark queried whether the overall CIP targets are achievable. Tim Welch advised that in the cases where there are plans underpinning the targets, these are achievable; however this cannot categorically be said for those targets without plans at this time.	

	It was agreed that should the CIP position worse in the immediate future, then this risk would be escalated for remodelling. The Board **resolved** to **approve** the report	
14/15/09	**Q4 INFECTION, PREVENTION AND CONTROL (IPC) REPORT** The Chair welcomed Helen Pilley, Infection, Prevention and Control Nurse to the Board meeting. Helen Pilley introduced the report and informed the Board of a D&V outbreak on Juniper Ward. This incident had been well managed by the staff and the facilities teams but had affected 9 patients. No staff were affected by the outbreak. Helen Pilley also highlighted work that her team had undertaken with the local Recovery colleges on health and well-being issues. Helen Pilley also advised that with regard to the IPC role outside CWP services that there has recently been an outbreak of scarlet fever and the team have been working closely with local authorities to monitor the situation. The team are also working with the local authorities to monitor illegal tattooing in the west Cheshire area. Fiona Clark commended the IPC team on the wider range of work and projects that they are undertaking, much of this in collaboration with other organisations and partners. Ron Howarth queried any potential commercial opportunities to expand this further. Helen Pilley informed that a tender has been submitted for work in west Cheshire with a wider remit. CWP is the incumbent provider for some elements of the tender, but this has now been widened to include several aspects in the Vale Royal area. The Board **resolved** to **approve** the report.	
14/15/10	**Q4 QUALITY REPORT** Dr Anushta Sivananthan introduced the report and drew attention to some outcomes based work currently underway in Drug and Alcohol services in Wirral working with the YMCA. This is an excellent example of innovation, reducing harm and mainstreaming patients which has arisen from staff working with patients and third sector. Dr Anushta Sivananthan informed that the Mental Health Act administrators have recently undertaken work with Cheshire Police on their S136 responsibilities. This has helped to increase police officer knowledge on the Mental Health Act and has also improved the links between CWP and the Police around specific cases. Dr Anushta Sivananthan highlighted that the Trust had received 656 compliments in Q4. Mike Maier queried whether there were any commercial opportunities which could be developed around Mental Health Act training. Dr Anushta Sivananthan confirmed that this is currently being explored. The S12	

	approval process has also changed so there is also potential to respond to this through offering training opportunities. Dr Jim O'Connor commended the report and queried how the Trust is promoting services to other CCGs. Dr Anushta Sivananthan confirmed that the Quality Reports are circulated to all CCGs. There is also a good practice website under development in which CWP will be able to promote 'our offer' more effectively. The Board **resolved** to **note** the report.	
14/15/11	**LEARNING FROM EXPEREINCE REPORT Q4** Avril Devaney introduced the report and reminded Board members that the full analysis and scrutiny of the LFE report is undertaken at the Quality Committee. Avril Devaney highlighted that there has been a 4% increase in incident reporting, however the number of incidents resulting in harm has plateaued and this is the intended direction of travel that the Trust is moving towards. Avril Devaney drew attention to the recommendations at the end of the report and informed that the progress achieved for the previous recommendations are also included. Dr Jim O'Connor queried how the Trust is going to ensure that practice changes are sustained. Avril Devaney commented that is an ongoing challenge to all Board members and needs continued attention going forward. The Board **resolved** to **note** the report.	
14/15/12	**UPDATE ON THE DEVELOPMENT OF THE 5 YEAR STRATEGIC PLAN** Tim Welch updated the Board on the development of the 5 year Strategic Plan. The Trust's Operational Plan for 2014/16 was submitted to Monitor on the 4th April 2014 and the initial feedback received from Monitor has been positive. Tim Welch reminded Board members of the seminar held to explore the key elements of the plan. From this, the Trust is now developing the plan focusing on the changing external context during the period of the plan, the financial constraints and the need to continue to ensure quality and how we work with partners moving forward. The plan has several sections looking at both internal and external transformation and how we can work further with partners. The plan will also set out development options within specific services and what this may look like. The plan must also assess sustainability in terms of both service and organisational sustainability. The Board will be required to sign off a specific declaration regarding sustainability as part of the submission. This will be presented to the June 2014 Board meeting. Tim Welch advised that he will be also presenting the key elements of the Strategic Plan to the Operational Board. The Council of Governors have	

	also been involved throughout the planning cycle and a third governor seminar will be held on 9th June 2014 to further explore the key elements of the Strategic Plan. The Board **resolved** to **note** the report.	
14/15/13	**MONITOR QUALITY GOVERNANCE AND PROVIDER LICENCE SELF ASSESSMENT** Tim Welch introduced the report and informed Board members of the need to annually assess the Trust's compliance with the provider licence and the quality governance framework. The paper has combined the two issues; however quality governance is also monitored through the quarterly monitoring process. It was noted that there were no specific areas of risk in terms of compliance. The Board **resolved** to **note** the report.	
14/15/14	**INTEGRATED GOVERNANCE FRAMEWORK** Dr Anushta Sivananthan introduced the report setting out the revised integrated governance strategy incorporating the corporate governance structure. This has recently been approved by the Quality Committee and the Audit Committee. The strategy has been refreshed to reflect the locality governance structures and the amendments to the corporate governance structure. Dr Anushta Sivananthan also updated on a new training programme for Clinical Directors which is currently being implemented. This is including specific workshops on finance, performance, governance and effectiveness to support Clinical Directors in their wider accountability role. It was noted that the structure diagram needed to include the Clinical Directors network and the Professional Advisers networks. **Action:** LH to request amendments to the structure diagram. The Board **resolved** to **approve** the report.	**LH**
14/15/15	**REVIEW OF RISK IMPACTS OF ITEMS DISCUSSED** There were no further risk areas identified.	
14/15/16	**ANY OTHER BUSINESS** There were no further items of business raised.	
14/15/17	**REVIEW OF MEETING** It was agreed that this Board meeting had been of a good pace and had been well focused. The Chair asked the Governors in the public gallery for any comments.	

14/15/18	**DATE, TIME AND PLACE OF NEXT MEETING** Wednesday 30th July 2014, Romero Centre, Macclesfield. 1.00pm	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Action points from Board of Directors Meetings
30th July 2014

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
29.01.2014	13/14/95	**Community Services Improvement Programme- 6 month evaluation** Board to receive further CSIP evaluation report at March 2014 Board meeting to detail output from further evaluation events	~~March 2014~~ July 2014	ASt	Locality evaluations underway - Board to receive evaluation report at July Board meeting. Scheduled for July Board meeting	Completed
26th March 2014 - No Actions Arising						
28.5.2014	14/15/08	**Board Assurance Framework and Risk Register** To continue to closely monitor CIP risk and escalate risk should the position worsen	July/ September 2014	AS/TW	Monitoring via Operational Board on a monthly basis.	Completed
25.6.14	14/15/14	**Integrated Governance Framework** It was noted that the structure diagram needed to include the Clinical Directors network and the Professional Advisers networks. **Action:** LH to request amendments to the structure diagram.	July 2014	LH	Completions added. Structure to be added to Corporate Governance Manual.	Completed

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

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

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/15/26)

Report to:	**Board of Directors**
Date of meeting:	**30th July 2014**
Title of report:	**Community Service Improvement Programme – Further review of quality impact following implementation [May 2013 to April 2014]**
Action sought:	**To Note**
Author:	**David Wood, Associate Director of Safe Services** **Neil Griffiths, Acting Head of Performance and Information** **Andy Styring, Director of Operations**
Presented by:	**Andy Styring, Director of Operations**

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

Distribution

Version	Name(s)/Group(s)	Date Issued
1	N Griffiths to M Skelding-Jones	11.06.2014
2	M Skelding-Jones to N Griffiths	23.06.2014
3	N Griffiths to M Skelding-Jones	24.06.2014
4	M Skelding-Jones to N Griffiths	24.06.2014
5	N Griffiths to D Wood	25.06.2014
6	N Griffiths to D Wood and A Sivananthan	04.07.2014
7	A Sivananthan to N Griffiths	07.07.2014

Executive director sign-off

Executive director (name and title)	Date signed-off
Andy Styring, Director of Operations	22nd July 2014

1. Purpose of the report

To provide the Board of Directors with the quality impact evaluation findings of the Community Service Improvement Programme [CSIP], using the twelve months of information available following implementation.

2. Background

A paper was provided in September 2013 to Trust Board reviewing the impact to date of CSIP on service provision across the three localities using the Quality Dashboards to measure this impact, 3 months post-implementation (provided in appendices). An action identified in this paper was to repeat the review at 12 months post-implementation, which is provided here.

3. Discussion

3.1 Process

A risk assessment of quality was undertaken prior to implementation of the CSIP, with a number of key quality indicators identified, against three quality domains (Safety, Effectiveness, and Experience), to ensure that quality care was maintained, and where applicable mitigating actions could be implemented. *Appendix 1* details this specification.

The quality indicators form the basis of the Trust's **quality dashboard**. The quality dashboard was initially developed in 2013/14 to enable the Trust to effectively monitor the provision of safe services, specifically to ensure that CSIP is not adversely impacting patient care. It interprets quality through the comparison of different data sources across different areas. By monitoring trends, any potential of compromises to the delivery of quality care are identified, on an early warning basis, thus ensuring remedial actions are initiated in a timely manner. The outputs from the quality dashboard are used to:

- Monitor the quality of care provided during the Trust's performance reviews of clinical services.
- Target areas for review, as part of the Trust's unannounced visit schedule to CMHTs.
- Inform reviews of the Trust's strategic risk register and local risk registers, to closely monitor and move forward continuous improvements to the quality of patient care.

Scores for each CMHT are determined by assigning a score to each of the qualitative measures identified, where there is the potential to compromise the delivery of care. Therefore, **a higher score indicates a higher potential of compromise**. These 'composite scores' are presented by graphs; these are presented in sections 4.1 - 4.3 of this report.

4. Evaluation

The CSIP implementation date was 1 May 2013. Using twelve months of validated information available after implementation of the CSIP [May 2013 to April 2014 inclusive], the following trends have been identified, per locality. The current team names are used to indicate the composite scores.

As sufficient data is now available, statistical process control [SPC] has been undertaken, to highlight significant variance from the norm. This can be viewed on the trend graphs.

Key terms used are listed below:

Care Programme Approach – CPA
The process mental health service providers use to co-ordinate care for mental health patients.

Category A incident
Incidents that result in death or cause such serious harm that they place a patient's or staff member's life in jeopardy

Community safety metrics
An audit, undertaken every two months by a peer team manager from another team, of the quality of care plans, risk assessment, and crisis/ contingency plans of a sample of 10 patient records.

CPA review within 12 months
A yearly care review meeting, for people receiving care under CPA, to discuss their care.

Interface incident
An incident reported by CWP in relation to care provided by another organisation.

Quality Account
An annual report to the public, from providers of NHS services, about the quality of services they provide.

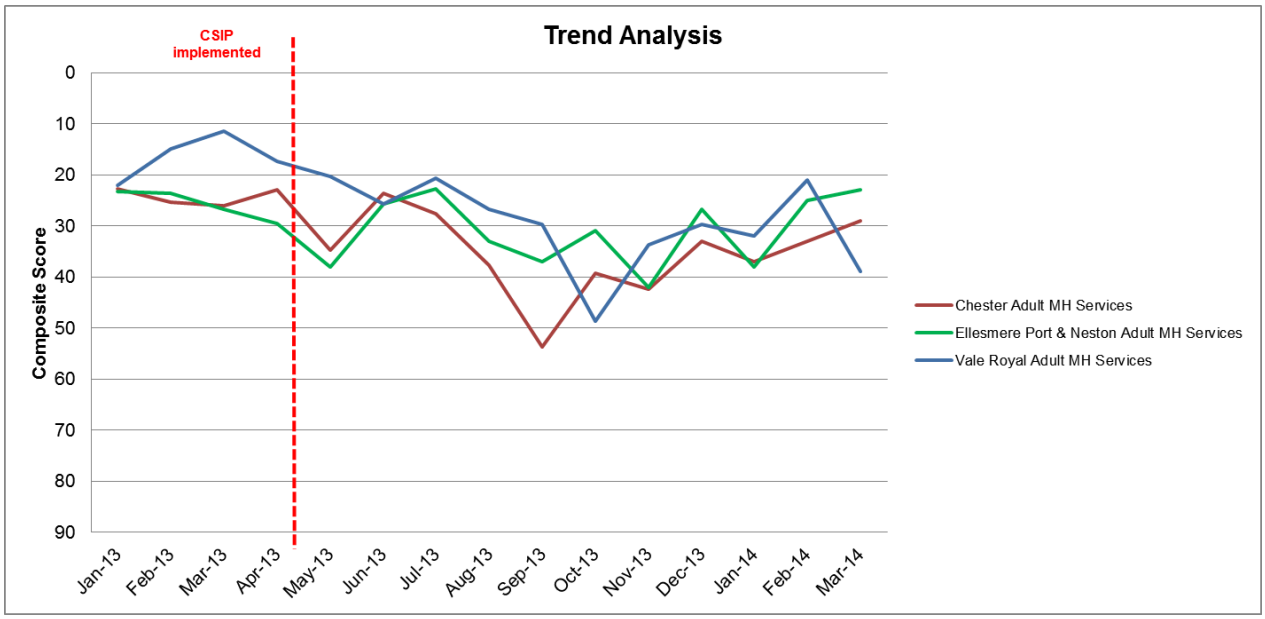
Readmission
Readmission rates help to monitor success in preventing or reducing unplanned readmissions to hospital following discharge.

Recovery
CWP's approach to helping people to be the best they can and want to be.

7-day follow up
Follow up within 7 days for service users discharged from hospital is important because the early days after discharge are when service users and their carers can feel especially vulnerable.

Standard care
A person receives care under 'standard care' if they do not have complex needs.

4.1 CWP West



The trend for the Chester Team was on an upwards trajectory for five months following implementation, which is a negative indicator, showing more risk of compromises to the delivery of quality care. The composite score has a number of factors, which are partly linked to pressures in the team at the point of implementation.

- There was a reduction in the number of care co-ordinators in the team, which was offset by transitional staffing arrangements.

- In September 2013, a number of staff were off sick and a set of urgent measures were agreed with the Director of Operations and HR which included recruitment (both internal and external), additional hours, temporary staff, support from other teams in CWP West and use of bank staff.

- Potentially as a result of the trend then changed to a downward trend for the remainder of the financial year indicating that the risk of compromising the quality of care has begun to decrease, and is on a trajectory to return to the level at the time of implementation.

The trend for the Ellesmere Port and Neston Team has been gradually upward, this is an indication that the quality of care could be compromised. However the scores are within statistical controls, with one occurance outside normal variance in October 2013, attributable to a category A Incident (giving a high composite score). The variance in March 2014 is attributable to a Category B incident, relating to a Physical assault by a patient, and a Category C Interface incident as a result of a patient being admitted to an acute setting.

The composite score for the Vale Royal Team remained stable, as pre CSIP for the first five months, since then the trend has been downward (which illustrates that the risk of compromising the quality care is decreasing). In March 2014 it fell below the level of risk immediately before implementation. The peaks in scores are attributable to:

- October 2013 - 3 re-admissions within the month that occurred within 7 days of the original date of discharge. The CSM has reviewed the 3 re-admissions with the clinical lead – the three cases are unrelated. One case relates to a service user with a long term history of re-admissions; the team are working with the service user to address this pattern as part of contingency planning. The second case relates to social factors and the team resolved this. The third case related to an individual who self-discharged before treatment was complete, subsequently re-engaged, and was appropriately re-admitted.

- December 2013 - 1 category A incident occurring within that month.

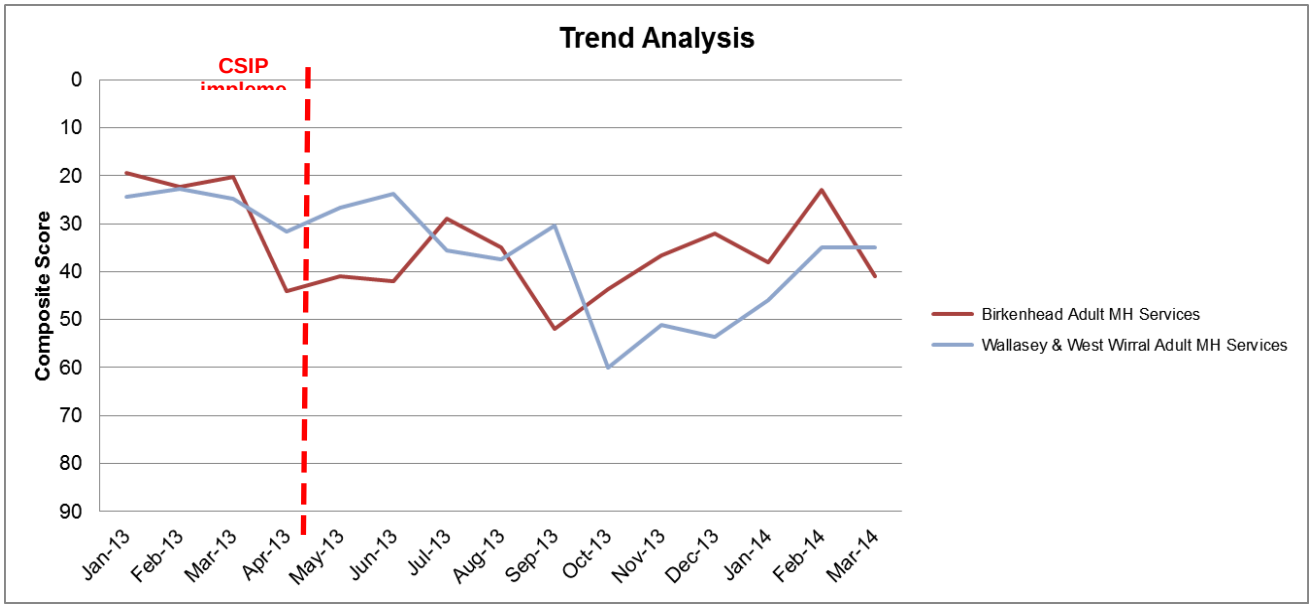
Within CWP West community services, there have been some additional pressures in terms of care co-ordinators with an increase in caseload. As part of the development of services, increased resources were allocated to SPA which in West is located in primary care mental health, this included additional medical sessions and CPN sessions. In the short term by making referral process easier via SPA, this initially increased referrals through SPA although the teams anticipate that the education and advice offered via SPA will ultimately increase capacity in primary care and reduce demand on specialist services.

Staff skill mix within West has not benefitted from an established adult advanced practitioner, which has significantly delayed the setting up of practitioner-led clinics, meaning that staff continue to undertake home visits where interventions could take place in clinic settings. CWP West have now established an advanced practitioner post and recruitment is in progress (the locality management are due to discuss this with the consultants in West shortly as it is essential they support this approach).

The Chester Adult mental health team have also considered the recovery journey and the new `Moving Forward` pathway to facilitate and support discharge from secondary services starts in September and is being led by the Chester Team clinical psychologist and OT practitioner (relative numbers of discharges in Chester team has been identified as an issue which requires more analysis). This will include group and individual work and will be run from the Chester Healthy Living Centre as part of the Recovery College.

As part of the monitoring of the implementation of CSIP changes, a number of evaluation events have taken place, most recently an event involving community services, staff, service users and carers held at Sycamore House resulted in the development of an action plan to progress further actions to help improve the quality of services and act on feedback received from staff. Issues include training, revision to management arrangements and role of clinical support workers, further development on the operational policy including care notes assist and the use of other technologies.

4.2 CWP Wirral



Trends for both the Birkenhead Adult MH Services and Wallasey and West Wirral MH Services have shown several fluctuations over the period January 2013 to March 2014. Composite scores range from 20 to 60 over this time period. However there are only two occasions where they have fallen outside the statistical control parameters both occurring within the Wallasey and West Wirral team.

During the CISP change, the composite scores for both teams have increased, which demonstrates that the redesign of services may have had some impact on service performance. However in November the trend reversed and composite scores started to reduce, not yet returning to pre-CSIP implementation levels. The caseload sizes for both teams remain fairly consistent since the CSIP implementation.

At the time of the implementation of the Stepped Approach to Recovery (StAR), the Local Authority decided that they would not realign their resources to reflect the changes in the care pathway as detailed in the Stepped Approach to Recovery. This may have influenced the performance around some key indicators, due to the competing priorities within the Local Authority. Work is in progress to address this via a formal Section 75 agreement.

The Local Authority has recently finished a “employee voluntary redundancy” programme which has reduced the number of staff working in some parts of the service. There is currently a further invite from the Local Authority with regards to voluntary redundancy.

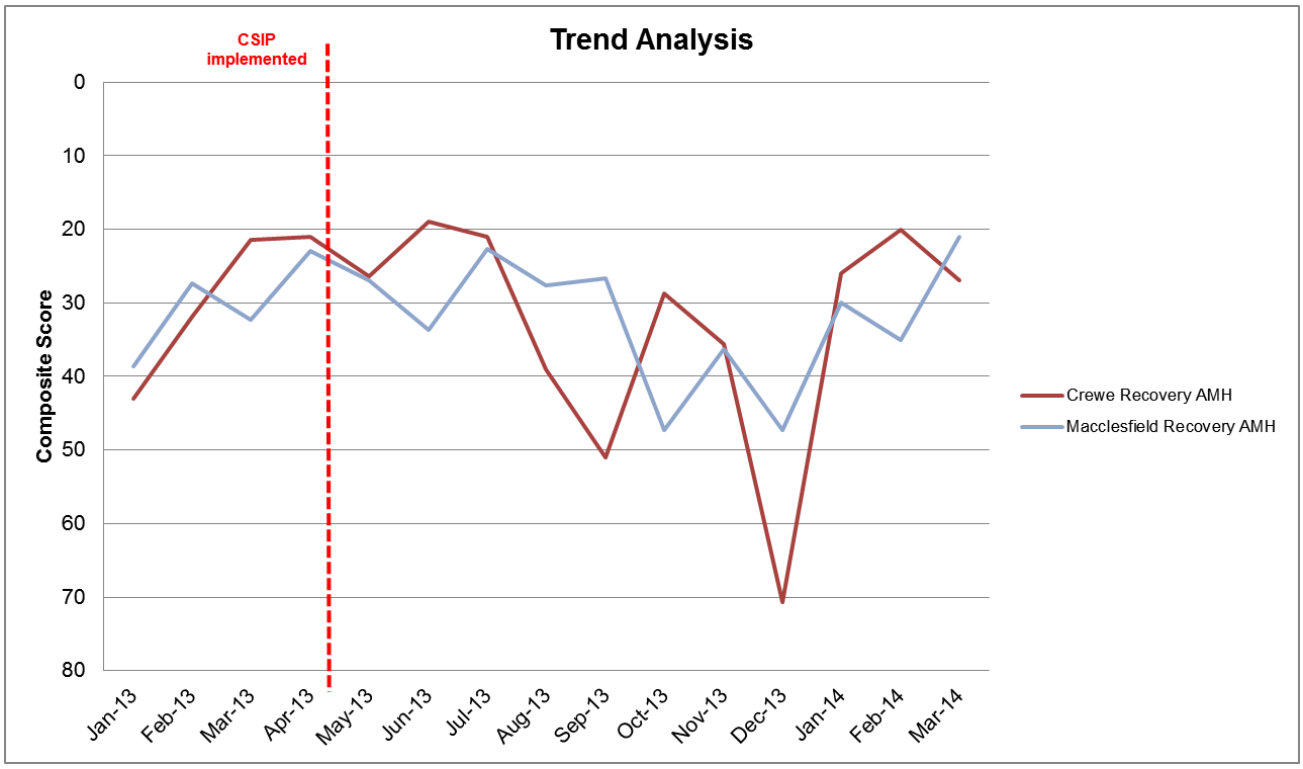
There has been with high sickness within the teams both Local Authority and CWP staff.

For the Birkenhead team, the increase in composite scores in:

- September 13 was attributable to an increase in incidents which included one death and one interface incident.
- March 14 was due to one category A incidents and a category B incidents interface

Overall the composite score pre-CSIP until the present outturn has remained relatively constant.

4.3 CWP East



Although there have been occasional variations form the norm, the trend for each team is stable, which would indicate that the impact of CSIP has not adversely impacted on patient care and is a positive indicator of no risk of compromises to the delivery of high quality care.

Both teams continue to maintain a high level of compliance with 7-day follow up for patients discharged from services. This area is proactively managed and regularly monitored by the Business Support Team.

There has been an improvement in the quality of care provided, as measured by the Community Safety Metrics peer reviews, with the exception of a downward trend for Managing DNA and Transfer of Care.The CMHT managers have action plans in place to address areas requiring improvement. The positive impacts of these action plans will be continuously monitored by these peer reviews, which are undertaken every two months.

The peak for the Macclesfield Recovery AMH team during December 2013 is primarily attributable to an increase in the number of reported incidents, including 3 Category B Incidents. This appears to be an isolated increase which has not been repeated since December. All Serious Incidents are investigated using root cause analysis methodologies to identify learning for these teams and any Trustwide learning.

5. Developments

5.1 CWP commissioned an external review of the quality dashboard in July 2013, undertaken by auditors PricewaterhouseCoopers LLP. It included a review of the methodology applied to devise the composite scoring, and the data sources used to produce the dashboards. This work was completed by the end of September 2013 and informed further development of the quality dashboard so that it could be as robust as possible.

The review document is provided in Appendix 3.

5.2 The quality dashboard has developed over time, to ensure that it uses indicators to best assess improvements to safety and variation, and this is ongoing. Berwick (2013) in a report to the Government: *A promise to learn – a commitment to act, improving the safety of patients in England*, defines a suite of indicators that should be used. CWP does currently use the majority of these indicators in the quality dashboard, and as part of ongoing development will discuss including the other suggested measures.

5.3 Common trends across all teams will continue to be identified and monitored through a process of longitudinal analysis [analysis over time]. As more data and information is gathered, this has facilitated better statistical analysis, and early warning to detect emerging themes and trends, within the services, this enabling the quicker escalation of issues and corrective action to be taken.

6. Conclusion

Overall, trend analysis of the qualitative measures identified to monitor the impact of the CSIP implementation suggests that there has been little impact on the quality of care patients have received in CWP East and CWP West, and a small adverse impact in CWP Wirral, although this is within reasonable statistical variation. Discussions with the service feel that this has in part been linked to reorganisation of local authority services, Wirral having integrated health and local authority community mental health teams.

The key trend analyses have identified isolated qualitative measures where performance has dipped, and assurance has been provided that demonstrates that the issues have been identified and addressed at a locality level. The quality dashboard will continue to monitor the impact of the CSIP. This monitoring involves the clinical directors and service directors, responsible for each of the teams, analysing the impact, and where there are issues, presenting mitigating actions to the Trust's Quality Committee.

In addition to being able to detect and monitor isolated dips in performance, longitudinal analysis, over time, will continue. This is required to ensure that wider service issues and themes – including common themes across all teams – are identified, monitored and responded to.

The above represent hard data and evidence. Softer data indicates that the service redesign has led to improvement of the service to patents and their families. There has been one GREEN concern raised in respect of next of kin not having been notified of change of address of team base (June 2013), none since.

Furthermore there has been positive feedback on services in the national community mental health survey. The results are positive for CWP.

National Community Mental Health Survey
The initial results for the CQC community mental health survey are very favourable for CWP compared to the national average. CWP is a consistent performer across the whole survey, scoring 5% above average in many areas and in some 10% above average. Areas where the Trust has performed particularly well include those which have been boosted by the Stepped Approach to Recovery (StAR) model. The overall rating of experience has changed to an 'out of 10' scoring system - with the initial results indicating 23% of respondents rating CWP 10/10 (average was 18%) - and the majority of respondents rating the Trust 7 or above.

In the following areas CWP is 10% above the average:

- Have you been seen in the last month
- Have you been told who is in charge of organising your care

- Have you agreed with someone what care you will receive (definitely)
- Do you know who to contact out of office hours if you have a crisis
- When you tried to contact them, did you get the help you needed
- Have you been receiving medicines for mh for 12 months or longer
- In the last 12 months did you get any help or advice with physical health needs (definitely)
- Has someone supported you in taking part in an activity locally

These results are published by the CQC in September, so are currently under embargo. Quality Health conduct the survey on behalf of 51 out of 60 of the Trusts that take part. CWP will receive a management report from Quality Health at the end of July that will also include qualitative feedback, which will be a very useful addition to the feedback collected at the recent locality events.

In addition to the impact on patients and families using the services we have reflected upon the staff of the process of implementation of the redesign.

Whilst putting significant effort into consultation prior to and during the early stages of implementation we have recognised that as a Trust we could have done even more to support staff ongoing throughout the change in service model. We have recently been reviewed by Investors in People and will take learning from this assessment to assist any teams / individuals who are having difficulty in managing the change and will also take the learning and experience forward for all future changes.

7. Recommendations to the Board of Directors

The Board of Directors is asked to **note the** findings of the evaluation of the CSIP and content of the report.

Appendix 1 – Quality dashboard specification

Ref no.	Data item	Potential impact	The following items are scored
1	Incidents	Increased risk of harm to patients	Category A, B and C incidents [death, severe, moderate harm]
2	Compliance with 7 day follow up	Capacity of staff to undertake follow up of those patients discharged from inpatient stays	Follow up outside of 7 days without a valid reason
3	Compliance with 12 months CPA review	Capacity of staff to undertake CPA review of patients or risk of patients lost to follow up as part of transition	Review outside of 12 months without a valid reason
4	Numbers of section 136 known to services	Increased need for service users to be moved to place of safety	Numbers of sections 136
5	Readmissions	Increased need for patients to go into psychiatric units due to a reduction in capacity in the community	Length of time to readmission
6	Known service users seen by liaison psychiatry and home treatment and whether these patients have been discharged from services or are on community mental health caseload	Increased need for patients to go into acute trusts or to home treatment due to crisis	% CMHT caseload going into liaison psychiatry or home treatment
7	Interface issues reported from other healthcare organisation or regulatory body	Increased burden on primary and secondary care and issues regarding inappropriate discharge	Any category of incident reported
8	Numbers re-referred to teams following discharge from team	Increased burden on primary and secondary care and issues regarding inappropriate discharge	Numbers re-referred to teams after discharge
9	Community safety metrics: ▪ Quality of risk assessment ▪ Quality of care planning ▪ Quality of contingency planning	Quality of risk assessment and care planning is reduced	Downward trends in compliance
10	Assertive outreach	Patients who are receiving assertive outreach function as part of CMHT [from previous service redesign] will be disadvantaged	Assertive outreach caseload as a percentage of the CMHT caseload
11	NICE guidelines	Non adherence to NICE guidelines	In development as part of Quality Account priority 2013/14
12	Monitoring contractual caseload	Non adherence to contractual caseload	Under/ over performance
13	Caseload size	Quality of risk assessment and care planning is reduced	Average number on caseload by worker
14	Clinical outcomes	Ensuring that clinical outcomes for patients are not adversely affected	In development as part of Quality Account priority 2013/14
15	Care pathway variance	New pathway not finalised at the time of the impact assessment	In development as part of Quality Account priority 2013/14
16	Social outcomes ▪ Employment	Ensuring that social outcomes are not adversely affected	Downward trends

Ref no.	Data item	Potential impact	The following items are scored
	▪ Accommodation ▪ Education and training		
17	Complaints	Patients may have a reduced patient experience which could impact on their wellbeing, therapeutic relationship and the reputation of the Trust. Carers may perceive that there is an increased burden on them which could impact on their wellbeing, therapeutic relationship and the reputation of the Trust.	Red, amber and green complaints

Appendix 2 – Evaluation 3 months Post Implementation (September 2013)

T:\01. BoD Committees\Board of Directors\Meetings\2014\140730\Open

Appendix 3 – PwC Quality Dashboard review – Final Report (December 2013)

T:\01. BoD Committees\Board of Directors\Meetings\2014\140730\Open

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/15/27)

Report to:	**Board of Directors – meeting in public**
Date of meeting:	**30 July 2014**
Title of report:	**Strategic risk register/ corporate assurance framework update**
Action sought:	**For DISCUSSION & APPROVAL**
Author:	**David Wood, Associate Director of Safe Services** **Louise Hulme, Head of Corporate Affairs**
Presenting Executive:	**Dr Anushta Sivananthan, Medical Director (Quality, Assurance & Compliance)**

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

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

Distribution

Version	Name(s)/Group(s)	Date Issued
1	L Hume to D Wood	21.07.2014
2	D Wood to L Hulme	22.07.2014

1. Purpose of the report

To apprise the Board of Directors of the current status of the corporate assurance framework and strategic risk register, as per the requirements of the Trust's integrated governance strategy.

2. Summary

The following report indicates progress against the mitigating actions identified against the Trust's strategic risks, new risks that have been identified, and the controls, assurances in place that act as mitigations against each strategic risk. The Quality Committee is the designated committee for risk management operationally and last reviewed the strategic risk register at its meeting on 2 July 2014. The Audit Committee, at its July 2014 meeting, received assurances on the management of the 'pressure ulcer' risk.

3. Current status

3.1 Strategic risk register

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

Description of the risk	Residual risk rating March 2014	Residual risk rating May 2014	Residual risk rating July 2014	Risk score since last review	Summary risk treatment plan
Lack of robust ligature management programme within the Trust may result in harm to patients with associated reputational and financial impact on the organisation	**20**	**20**	**20**	↔	▪ Board approved the capital programme in May 2013. ▪ Updates provided to September 2013 Quality Committee and November 2013/ January 2014 Operational Boards. ▪ Further action agreed regarding the en suite door top alarm systems and clinical risk management of dressing gown cords. ▪ January 2014 Operational Board agreed to expedite the timeframes for completion of these installation works in response to regulation 28 report [August, September and October 2014 for the high, medium and low priority areas respectively]. It agreed to increase the likelihood score to 4 due to the known residual environmental risk, increasing the current residual risk score to 20. This has also been agreed with the Care Quality Commission. ▪ May 2014 Quality Committee and July 2014 Operational Board received assurances that all actions on track for completion by August 2014 as agreed. **Risk score will be re-visited in August upon completion of high priority works.**
Adults, children and young people are not protected through practitioners not implementing safeguarding practice and principles	**20**	**16**	**16**	↔	▪ The risk is reviewed by Quality Committee following receipt of safeguarding exception report every two months. ▪ Discussed at November 2013 Board of Directors, with request that risk is re-modelled to reflect the focus of the risk on training. ▪ Safeguarding training targets in place in West with potential financial adjustment (across both contracts): £100,000 at year end for non-achievement against 80% thresholds) – however currently over-performing against this target. ▪ Positive outcome of the West Cheshire CQC inspection of safeguarding for looked after children w/c 20 January

Description of the risk	Residual risk rating March 2014	Residual risk rating May 2014	Residual risk rating July 2014	Risk score since last review	Summary risk treatment plan
					2014. ▪ Continuous monitoring of safeguarding practice through the Trust's unannounced compliance visits, safety metrics programmes, Care Quality Commission visits, and practice audits. ▪ The Trust is providing the monthly safeguarding assurance framework to each clinical commissioning group for both adult and children's services. **Target risk score of 12 and timescale for achievement will be suggested to the next Trustwide safeguarding meeting.**
Risk of harm to patients as a result of increased rate of Grade 3/4 pressure ulcers being reported and evidence of recurring themes in RCA reports relating to pressure care (resulting in concerns raised by commissioners)	**20**	**16**	**16**	↔	▪ Risk treatment plan provided to the February 2014 meeting of the Patient Safety & Effectiveness Sub Committee and March 2014 meeting of the Quality Committee. ▪ A pressure ulcer action group has been established, with clinical commissioning group representation, to take forward actions to reduce the risk to an acceptable target risk. ▪ Audit results are demonstrating that the care being delivered is evidence based and standards have improved. ▪ The Board of Directors received the assurance report via the Quality Committee at the March 2014 meeting. This detailed the risk score has been re-modelled to 16 to reflect improvements. ▪ Assurances provided to July 2014 Audit Committee that the risk treatment plan is having impact in reducing the risk score and is on track to meet the identified target risk score. **An aspirant target risk score of 12 for achievement by November 2014.**

Description of the risk	Residual risk rating March 2014	Residual risk rating May 2014	Residual risk rating July 2014	Risk score since last review	Summary risk treatment plan
The inability of staff to manage the occurrences of slips, trips and falls of patients, resulting in patient injury	**20**	**16**	**16**	↔	▪ FallSafe care bundle is in place across all wards. ▪ Patient Safety and Effectiveness Sub Committee has approved a risk treatment plan to implement control measures to mitigate this risk to a target risk score. The report was in response to the findings of an external acute falls nurse specialist who undertook a review of falls prevention and management. The review found that, in general, CWP has a robust system in place for the management of slips, trips and falls however, sometimes locally these systems are not always fully implemented. Additionally, issues such as environmental improvements and training also need to be addressed at local level. ▪ Audit Committee undertook in-depth review of the risk at the January 2014 meeting. Initial risk score target of 15 agreed, however this has been remodelled by the risk lead and 12 is achievable. ▪ Action plan is being implemented by a task and finish group and is reviewed routinely by the Patient Safety and Effectiveness Sub Committee. Risk subsequently re-modelled to 16 to reflect progress. **All actions due for completion by September 2014 to ensure policy reflects outcomes from the national falls conference in July 2014. Further update scheduled at September 2014 Audit Committee regarding impact of actions and controls.**

Description of the risk	Residual risk rating March 2014	Residual risk rating May 2014	Residual risk rating July 2014	Risk score since last review	Summary risk treatment plan
Risk of harm to patients due to CARSO risk assessment not being completed as per policy	**16**	**16**	**16**	↔	▪ Completion and quality of CARSO risk assessments included in community safety metrics programme. ▪ Recruitment to CPA/ effective lead underway who will look at developing care plan training and guidance, including risk assessment. ▪ Recent data quality report indicates a 90% CARSO completion rate. Further assurance needed on quality of CARSO assessments prior to re-modelling. The main priority is ensuring services reach and sustain over 99% completion rates. Audit on a case by case basis in September 2014 where no completed CARSO summary to understand what might be the individual clinician or managerial issues preventing completion. **Update provided to July 2014 Quality Committee as part of zero harm implementation plan. A target risk score and timescale for achievement will be proposed in the next corporate assurance framework update to Board.**
Risk of harm to patients and staff due to staffing levels across inpatient services in the three localities	**16**	**16**	**16**	↔	▪ Position statement prepared by the Associate Director of Nursing [Mental Health] and DIPC on current staffing levels, including safety and skill mix across all professional types, benchmarked against other trusts presented to Operational Board in October 2013. ▪ A review team was established with external input and undertake a review to consider staffing levels identified by ward managers and modern matrons, use of bank and financial impact of this and rostering issues. ▪ Review was presented to Operational Board in January 2014 which approved, in principle, the operational recommendations. Review was noted at March 2014 meeting of the Quality Committee for qualitative recommendations. Specific, immediate

Description of the risk	Residual risk rating March 2014	Residual risk rating May 2014	Residual risk rating July 2014	Risk score since last review	Summary risk treatment plan
					actions identified were presented and approved by January 2014 Board of Directors – update report subsequently provided at March 2014 meeting. **Programme lead now in place.** **Publication of staffing establishment levels on website from 1 April 2014.** **Target risk score and timescale for achievement to be identified by the risk lead at the request of the July 2014 Quality Committee – this will be detailed in the next corporate assurance framework update to Board.**
Risk of not being able to deliver safe and effective services due to inadequate attendance on mandatory training. This may result in harm to patients, litigation claims and breach of legislation.	**16**	**16**	**16**	↔	▪ A review of the Trust training strategy has been undertaken following corporate services review and follows planning priorities and links to response to Francis and Berwick reports and CWP always events framework. ▪ Revised mandatory employee learning programme presented and approved by October 2013 Operational Board. ▪ 2014 corporate performance reports have identified improvements in MEL compliance trustwide. **Workforce and Organisational Development Sub Committee/ Education CWP Sub Group to recommend a target risk score and achievement date.** **Currently Essentials 1 target of 95% is under review to take into account turnover and other absences.**
Data quality may have an adverse impact on external (regulatory, contractual) monitoring and governance ratings and on effective internal decision making regarding service planning and development	**16**	**16**	**16**	↔	▪ Strategy for the better use of information is detailed in the five year strategic plan. ▪ An external audit regarding the processes and systems associated with development of the quality dashboard reported to January 2014 Quality Committee – with positive assurance. ▪ Action plan further to the contract query received from NHS Wirral clinical commissioning group was completed December 2013. ▪ Risk was reviewed as part of quarter 3 Monitor quality governance self-

Description of the risk	Residual risk rating March 2014	Residual risk rating May 2014	Residual risk rating July 2014	Risk score since last review	Summary risk treatment plan
					assessment – returned to green. ▪ Quality Account external audit 2013/14 received no qualifications. **As part of data gathering for the NHS Benchmarking Network's Mental Health Benchmarking 2014, manual checking of information was required to ensure accuracy of data submissions. Assurance is therefore required regarding data sources, validation, accuracy, gatekeeping and information flows. Information Team and Safe Services Department to meet to identify mitigations to close gaps in assurance. Update will be provided in the next strategic register report.**
Risk of adverse clinical incident or regulatory action due to dual record keeping systems (electronic and paper) and quality of recording	**16**	**16**	**16**	↔	▪ The Records and Clinical Systems Group is correlating clinical systems priorities with the dual record keeping risk – also tying into review of system effectiveness and functionality. ▪ A revised dual record keeping action plan was presented to the December and February 2013/ 2014 Patient Safety & Effectiveness Sub Committee meetings, for completion end March 2014. Confirmed as completed. ▪ Escalated to risk score of 16 following Care Quality Commission visits to Springview in November 2013 and Bowmere in January 2014 which highlighted minor concern in respect of outcome 21 (records). Subsequently Care Quality Commission has re-inspected Springview returning this to compliant. Re-inspection of Bowmere awaited. **An updated assurance framework was presented to the June 2014 Patient Safety & Effectiveness Sub Committee. Target risk score is proposed to be 12. Timescales for achievement of this to be confirmed following confirmation of processes supporting IT enabled transformation programmes. To update at September 2014 Quality Committee.**

Description of the risk	Residual risk rating March 2014	Residual risk rating May 2014	Residual risk rating July 2014	Risk score since last review	Summary risk treatment plan
Risk of harm to patients, carers and staff as well as reputational and litigation risks due to a/ unable to show consistent investigation of incidents; b/ unable to show learning from actions of incidents, claims etc is cascaded; c/ unable to be assured investigations are carried out in a timely manner d/ inability to communicate in a timely manner with partners	**16**	**16**	**16**	↔	▪ Learning from experience report and always events performance will be monitored to inform risk treatment plan on an ongoing basis. ▪ Service Directors have been asked to monitor the management of actions arising from root cause analysis investigations – this is routinely monitored at the Compliance, Assurance & Learning Sub Committee. ▪ Ongoing work around improving the process around interface incidents and ensuring actions arising/ learning points are clear. **Incident reporting and management policy currently under review. This is due for completion in September 2014 – it will incorporate the outcomes of a review of investigatory management processes, as commissioned by the Executive Directors, for their decision end July 2014. A target risk score will then be identified.**
Risk of breach of Trust Provider Licence as a result of external scrutiny	**15**	**15**	**15**	↔	▪ The Care Quality Commission visited Eastway on 27 September 2013 and found the unit fully compliant against all standards. ▪ The Monitor governance rating for the Trust returned to Green and remains at Green. ▪ The two minor concerns following the Care Quality Commission unannounced inspection visit to Clatterbridge mental health services registered location have returned to compliant. Bowmere awaiting re-inspection but action plan identified has been completed. The current residual score therefore reflects these assurances. **Assessment of compliance against provider licence reviewed for 2013/14, reported to May 2014 Board of Directors. Audit Committee undertook an in-depth review of this risk at their May 2014 meeting. Target risk score of**

Description of the risk	Residual risk rating March 2014	Residual risk rating May 2014	Residual risk rating July 2014	Risk score since last review	Summary risk treatment plan
					10 identified to be achieved by December 2014.
Risk of not being able to deliver planned financial risk rating due to incomplete CIP plans resulting in potential breach of terms of authorisation and reputational damage	**16**	**12**	**12**	↔	▪ Strengthened financial infrastructure via recruitment of locality accountants and establishment of a performance and redesign function to support tracking of CIP delivery. ▪ Board seminars in October and December 2013 considered financial projection and revised approach to CIP going forward. ▪ January and February 2014 Board received outline financial projects and plans. March 2014 Board approved operational plan including 2014/15 CIP plans. **Improved process now in place, including weekly updates on CIP plans to Executive Team and also at every Operational Board meeting. Additionally, Quality Committee now routinely receives quality impact assessments/ ongoing outcomes of CIP implementation. Risk re-modelled to take account of improvements to process. To identify target risk score by end July 2014.**
Reduction in quality of service provided as a result of service redesign, which may result in patient harm, increased burden on carers, increased complaints and litigations, and a negative impact on Trust reputation to patients, public and commissioners	**10**	**10**	**10**	↔	▪ Quality dashboards presented by Service Directors at each Quality Committee meeting. ▪ The Board approved a paper detailing the quality impact of CSIP programme three months post implementation demonstrating, overall, no impacts on quality. A monthly verbal update is also provided to Operational Board regarding implementation of the CSIP programme and the LD service re-design. ▪ In November 2013, CQC requested assurance regarding impact of CSIP. Response provided, no further information requested. ▪ The CQC also reviewed this risk as part of the monitoring visit re mental health: assessment and application for

Description of the risk	Residual risk rating March 2014	Residual risk rating May 2014	Residual risk rating July 2014	Risk score since last review	Summary risk treatment plan
					detention and admission visit [to Wirral]. No formal action identified over and above ongoing Trust identified actions. The CQC indicated a follow up visit in one year. **Full locality evaluations to reflect impacts of the CSIP are being presented to the July 2014 Board of Directors – will include 12 month quality impact assessment. To consider a risk target score and timescale as part of this evaluation.**

3.2 Corporate assurance framework

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

4. Discussion

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

4.1 New and potential risks

There are three new risks that the Quality Committee was asked to consider adding to the strategic risk register. These have been identified through the strategic planning process, as follows:

- *Fragmentation of commissioning leading to fragmented patient pathways.*

The Trust intends to identify controls and assurances, including through discussion and engagement with its commissioners and partner organisations, to minimise the impacts of this challenge on quality across key, complex patient pathways across populations, for example drug and alcohol services, and the associated risks to financial sustainability, in order that it continues to deliver good quality patient care and outcomes.
Risk owner: Chief Executive.

- *Capacity and skills of the workforce to respond to emerging and new models of care provision and evidence based interventions.*

The Trust intends to identify controls and assurances, including through discussion and engagement with its commissioners and partner organisations including educational institutions and training providers, to minimise the impacts of this challenge of delivering high quality and clinically effective care and treatment in accordance with emerging and new models of care and rapidly changing evidence bases. For example, collaborative care models that require patients and healthcare professionals jointly identify problems and agreeing goals for interventions, and the long term co-ordination of care for long term conditions.
Risk owner: Director of Nursing, Therapies & Patient Partnership.

- *Ability to deliver high quality services due to income risks associated with the current market environment and the potential for commissioners to seek further competitive tendering for clinical services.*

The financial strategy of the Trust will ensure that it remains a viable and sustainable foundation Trust as a going concern, so that new opportunities to enhance sustainability are identified and capacity/ scope to deliver high quality, effective, efficient and innovative services continues to be a priority.
Risk owner: Director of Finance.

The Quality Committee identified the risk owners for these risks, as identified above. The risk leads are currently being identified who will identify the current controls and assurances as well as mitigations/ risk treatment plans and inherent/ residual/ target risk scores. The summary risk treatment plans will be detailed in the next report to the Board of Directors.

Additionally, potential risks posed by the governance of integrated and sub contracted services were discussed at the extended executive directors meeting held on 1 July 2014. Since this potential risk and the above three new risks are currently being modelled, in the interests of good governance, an additional tab has been added to the corporate assurance framework to log such risks to ensure that there is a demonstrable audit trail for the treatment and follow up of such risks that are being scoped should a "consequence" occur during the scoping period.

4.2 Amended risk scores

No risks have been re-scored or re-modelled as at the Quality Committee review of the risk register. However, subsequently the risk owner of the risk *"'Risk of harm to patients and staff due to staffing levels across inpatient services in the three localities"* has requested that the Board of Directors discuss that the risk score be adjusted to 20 on the basis of:

- recruitment difficulties in CWP East;
- new agreed inpatient staffing levels not yet fully implemented.

It is suggested that the risk impact score be adjusted to 5 in accordance with the criteria set out in the Trust's integrated governance strategy. The description of the risk also requires re-modelling to ensure that the current risk reflects the current nature of the risk. The risk lead will be asked to undertake this and report this to the next meeting of the Quality Committee.

4.3 Archived risks

One risk has been archived. This is:

Risk of breach of Equality and Diversity legislation resulting in risk of reputational, financial loss and potential harm to staff and patients

Assurances have been received via the Trustwide Equality & Diversity Group meeting with respect to receipt of locality updates, a Trustwide structure to support the equality and diversity agenda, and an implementation plan being in place to capture the compliance requirements of the quality schedule for 2014 which will be monitored on a six monthly basis and reporting will be on an exception basis. This will indicate the need to re-escalate this strategic risk as appropriate.

4.4 Audit Committee review of the risk register

At its July 2014 meeting, the Audit Committee received assurances in place to manage the 'pressure ulcers' risk. This was further to the initial presentation made to the Audit Committee on this risk in October 2013. The assurances provided indicated that the identified risk treatment plan is progressing the risk towards the target risk score.

At the September 2014 meeting, the Audit Committee will be receiving assurances from the previously reviewed risk in relation to 'falls'.

5. Recommendations

The Board of Directors is asked to:

- **Review, discuss** and **approve** the amendments that have been made to the strategic risk register and corporate assurance framework as recommended by the Quality Committee.
- **Discuss** the proposed adjustment to the score of the risk "*Risk of harm to patients and staff due to staffing levels across inpatient services in the three localities"* with immediate effect and **agree** that the description of the risk be re-modelled by the risk lead to reflect the current nature of the risk, to be agreed at the September 2014 meeting of the Quality Committee.

Appendix 1
Corporate assurance framework

T:\01. BoD Committees\Board of Directors\Meetings\2014\140730\Open

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference: 2014/15/28)

Report to:	Board of Directors
Date of Meeting:	30th July 2014
Title of Report:	Health, Safety and Fire Annual Report
Action Sought:	For Note
Author:	Lyn Ellis, Senior Health and Safety Advisor
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

Strategic Objectives that this report covers

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

Distribution

Version	Names/Groups	Date Issued
1	Justin Pidcock- Head of Estates	30.06.14
2	Avril Devaney-Director of Nursing, Therapies and Patient Partnership	30.06.14
3	Health, Safety and Wellbeing Sub Committee	02.07.14
3	Board of Directors	30.7.14

Executive director sign-off

Executive director	Date signed-off
Avril Devaney-Director of Nursing, Therapies and Patient Partnership	10.7.2014

Contents Page

1. Purpose of the report

Effective management of health and safety risks helps to maximise the wellbeing and safety of Patients, staff and visitors. This report will summarise the effectiveness of our systems for controlling risks by reviewing the activities and performance relating to health, safety and welfare within Cheshire and Wirral Partnership NHS Foundation Trust. The Health and Safety function now sits within Infrastructure Services, specifically within Estates Department.

2. Governance of Health & Safety

CWP is fully committed to developing, promoting and monitoring the highest standards of health and safety practice. CWP also acknowledges its obligations to comply with statutory responsibilities laid down in the Health and Safety at Work etc Act 1974 and subsequent Regulations relevant to the activities of our Trust and our employees. The Health and Safety function provides reports for the Business Cycles for the Health, Safety and Wellbeing Sub Committee (HSWSC), the Patient Safety Effectiveness Sub Committee (PSESC), the Compliance and Learning Sub Committee (CALSC) and the Corporate Performance Report and has responsibility as the Chair of the Medical Devices Group.

The Health, Safety and Wellbeing Sub Committee (HSWSC) are attended by Managers and Staff side representatives which feeds into the Operational Board. It is chaired by the Director of Nursing who has executive responsibility for Health, Safety and Wellbeing. The Sub Committee meets bi – monthly. The terms of reference for this subcommittee are reviewed annually.
There are 4 local Health and Safety Groups, 3 locality groups, West, Wirral and East and the Estates department have their own Health and Safety Group as well as the internal Fire Precautions Group. All local groups' minutes and action points feed into the Trust Health, Safety and Wellbeing Sub Committee and issues may be escalated to the Trust wide Sub Committee if the local chairs request this.

Estates Department also have a Statutory Standards and Compliance Group which incorporates issues relating to Legionella, Asbestos, Work equipment compliance, Medical Gas management, lifting equipment, pressure systems and electrical services. The Estates Department also has responsibility for the contracts for lifting equipment, bed maintenance and servicing and maintenance of medical devices. (See 2.5)

Any local health and safety risks are logged on local risk registers and owned and monitored by the services. Strategic risks aligned to the Sub Committee are discussed and highlighted as part of the business cycle for the Sub Committee. This is monitored by the Board of Directors and the Quality Committee.

The Health and Safety function has specific responsibility to review the following areas of risk;

- Health, Safety and Security Assessments
- Reporting to the Health and Safety Executive (HSE) incidents which fall within the definitions of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations)
- Reporting relevant incidents to the Medicines and Healthcare Products Regulatory Agency(MHRA)
- Management of and reporting on the Central Alerting System and dissemination of relevant alerts (CAS)
- Chair of the Medical Devices Group and joint management of the Medical Devices and Equipment contract

2.1 Health, Safety and Security Assessments

CWP Health and Safety Advisors have been monitoring the effectiveness of the precautions in place to prevent harm to staff by carrying out health, safety and security assessments in different areas.

A total of 69 Health, Safety and Security assessments were carried out during the financial year, all in-patient areas were assessed, some community buildings and resource centres and buildings which are now part of CWP following the completion of TCS (Transforming Community Services)

The main gaps identified related to

- completion and review of workstation assessments in accordance with the Display Screen Equipment Regulations- (1992 as amended 2002)
- lack of presence of signage for toasters not to be left unattended whilst in use - this was rectified immediately by health and safety and estates department
- production and completion of business continuity plans- this is being monitored as part of emergency planning requirements
- Work at Height assessments not being in place in some areas- a generic assessment is available for staff to customise for their areas.

Assessments of workstations are a requirement in law. The training programme for display screen equipment will shortly be available as an E-Learning package. The policy for display screen equipment is under review by the Head of Occupational Health which will clarify requirements for staff to complete workstation assessments. Staff are provided with a self assessment form as part of the Health and Safety report completed after assessments.

100 Health and Safety Law posters were obtained in 2012 and have been issued to Departments that did not have the new version of the poster displayed. The posters needed to be replaced by May 2014. The poster allows for details of specialist contacts within the Trust and Staff Side Representative Contact names to be displayed.

Health, Safety and Security assessment schedules are under review for 2014/2015 and assessment exceptions will be reported to the Health, Safety and Wellbeing Sub Committee. Following completion of the Health Safety and Security Assessments for all areas, the proposal will be to programme assessments for the next year on a risk assessed basis. The future proposal is to assess in-patient units annually and other areas every 2 years with reactive visits taking place as required.

Location and number of Health Safety and Security Assessments carried out April 2013-March 2014

East	West	Wirral	CAMHS	CCWC	Corporate	Learning Disability	Drug and Alcohol
15	12	5	7	5	8	11	6

The Health and Safety Function moved from the Clinical Governance Department into Estates in 2013 and the Local Security Management Specialist role moved into Education CWP, the security element of the assessments may separate and become stand alone assessments in line with the requirements of NHS Protect and this is to be discussed further by HSWSC.

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

As a result of the report by Lord Young 'Common Sense, Common Safety' in October 2010, improvements to 84% of Health and Safety Legislation was recommended, RIDDOR being one of them- The law now requires for injuries requiring more than 7 days incapacitation to be reported to the HSE as opposed to injuries resulting in 3 days absence previously.
Reporting and recording is a legal requirement. The report made to the HSE informs the enforcing authorities about deaths, injuries, occupational diseases and dangerous occurrences so they can identify where and how risks arise and whether they need to be investigated. This allows HSE and Local Authorities to target their work and provide advice about how to avoid work related deaths, injuries, ill health and accidental loss.

For the period April 2013- March 2014 there was a decrease of 5 RIDDOR reports from the previous year that needed to be reported to the HSE. 21 incidents were reported to the HSE for this period.
In 2012-2013, there were 26 incidents that required reporting to the Health and Safety Executive. In 2011-2012, there were 20 incidents reported. This was the lowest reportable number of RIDDOR incidents for the 9 years that the Senior Health and Safety Advisor has reported RIDDOR incidents to the HSE. The average number of RIDDOR reports made each year since 2005 by CWP is 28.7 per year.

There had been a marked reduction in incidents relating to manual handling injuries over several years from 7 requiring reporting to HSE in 2008 to 1 incident requiring reporting during 2012-2013; However, for the period 2013-2014, this had risen to 6 incidents. One of these incidents was due to a violent incident, but was classed as a handling injury due to reporting mechanism of RIDDOR. Following 3 incidents, staff received refresher training in moving and handling procedures. The risk could have been reduced in 1 incident had the correct posture been adopted.
The number of lifting and handling incidents reported on the DATIX system within the Trust had more than halved from 43 in 2011-2012 to 21 in 2012-2013. The improvements in these figures reflected the review and updating of Manual Handling training.

The figures reported for manual handling incidents on the DATIX system has increased slightly to 25 incidents reported during 2013-2014 although 4 of the handling incidents occurred during management of violence and aggression episodes.
The number of Violence/Physical assault incidents to be reported to HSE has decreased from 20 incidents during 2012-2013 to 9 incidents during 2013-2014.

CWP were required to pay a Fee For Intervention to the Health and Safety Executive due to an incident classed as a dangerous occurrence under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (2012).
During some internal alterations works, there was a minor release of asbestos fibres. CWP's emergency action plan was adopted immediately and the area in question made safe. As a reportable incident of this nature, the HSE Inspector visited the Trust and interviewed the Senior Health and Safety Advisor and the Head of Capital and property management.
The Inspector concluded that the incident was unforeseeable. This did present the opportunity for CWP Estates to review the Asbestos Management Policy in line with HSE advice and recommendations and these procedures have now been adopted.

The detail of slips, trips and falls and manual handling related incidents will now form a report that is included in the Business Cycle for the Health, Safety and Wellbeing Sub Committee.
The main causes of work related injury and ill health in the Health and Social Care sector are violence and aggression/physical assault, slips and trips and manual handling/ lifting and handling.(HSE)

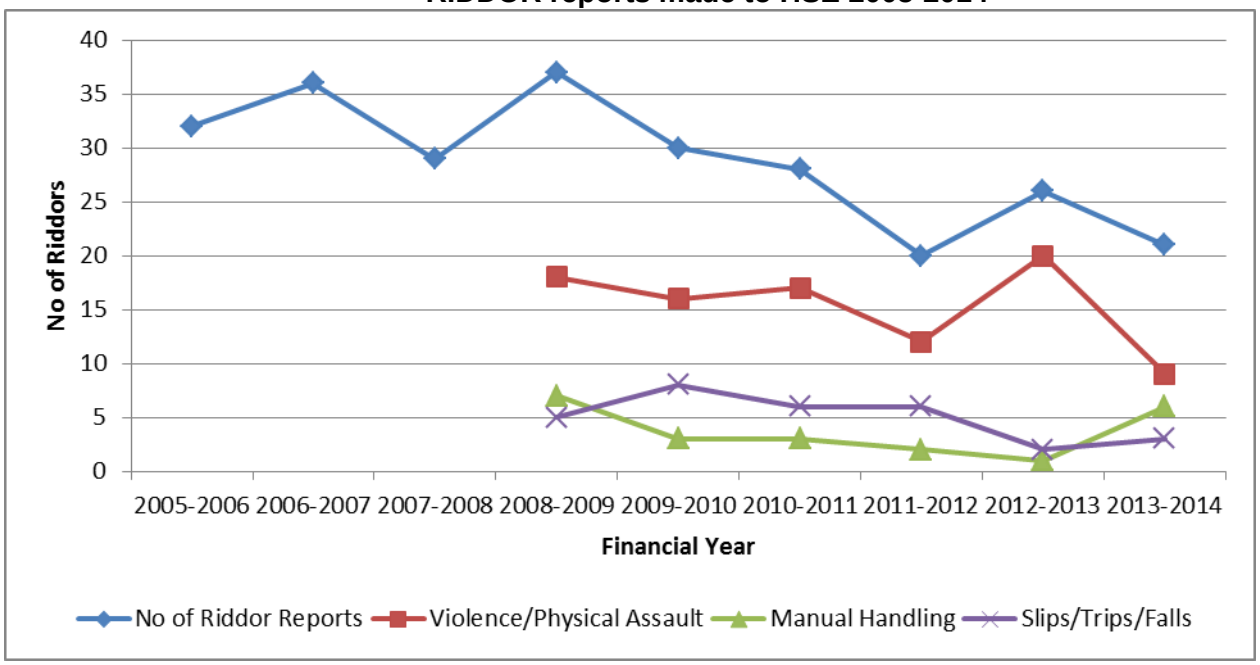
RIDDOR Reported incidents for CWP- annually 2005-2013

2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014
32	36	29	37	30	28	20	26	21

Classification of RIDDOR Reports to the Health and Safety Executive since 2005

Classification of Incident	Number reportable to HSE 2008-2009	Number reportable to HSE 2009-2010	Number reportable to HSE 2010-2011	Number reportable to HSE 2011-2012	Number Reportable to HSE 2012-2013	Number Reportable to HSE 2013-2014
Violence/Physical Assault	18	16	17	12	20	9
Manual Handling	7	3	3	2	1	6
Slips, trips and falls	5	8	6	6	2	3
Struck by an object	4		1		1	
Exposure		2	1			1
Cuts	2	1			1	1
Fall from a height (investigated by the HSE)	1					
Twisting injury (knee)					1	
Collision						1
Total	**37**	**30**	**28**	**20**	**26**	**21**

RIDDOR reports made to HSE 2005-2014



RIDDOR Incidents per quarter 2013-2014

Classification of Incident	Qu 1	Qu 2	Qu 3	Qu 4	Total for year
Violence/Physical Assault	2	2		5	9
Manual Handling	2	1		3	6
Slips, trips and falls	1	1		1	3
Other type of injury- Cut/ Struck/Collision	1	1			2
Exposure (HSE Fee for Intervention Visit)			1		1

2.3 Medicines and Healthcare Products Regulatory Agency (MHRA)

There were no incidents recorded relating to medical devices that needed reporting to the MHRA by CWP and this has now been the case for 3 years.

2.4 Central Alerting System (CAS)

The Central Alerting System replaced the Safety Alert Broadcast System; this enables alerts and urgent patient safety specific guidance to be accessed at any time.

Medical Device Alerts, Safety alerts, emergency alerts, drug alerts, public health alerts and Estates and Facilities alerts are available on the website. They are issued on behalf of the Medicines and Healthcare products Regulatory Agency, the Department of Health and the Chief Medical Officer

All alerts are sent to one nominated person in each Trust, known as the CAS Officer (CWP Senior Health and Safety Advisor) for them to action and disseminate appropriately throughout the organisation. The system of dissemination has been established within CWP for the alerts and this is reviewed annually.

The National Patient Safety Alerting System (NPSAS) has been launched by NHS England to strengthen the rapid dissemination of urgent patient safety alerts to healthcare providers via the Central Alerting System (CAS).

NHS England produced their first Patient Safety Alerts during December 2013 and by March 2014 had produced 7 NHS England Patient Safety Alerts. 3 of the alerts that were published did not require any actions from CWP. Information in 2 alerts published will form part of policy review for Medical Devices Management and review of medication error incident reporting.

Alerts with actions required are monitored by the Patient Safety Effectiveness Sub Committee, which is chaired by the Trust's Medical Director, and reports form part of the Business Cycle for the Health, Safety and Wellbeing Sub Committee which is chaired by The Director of Nursing, Therapies and Patient Partnership. A report is also produced for the bi-monthly Compliance and Assurance Learning Sub Committee. CAS reports are also an agenda item on the Medical Devices Group and the Estates Health and Safety meeting. The status of CAS alerts is also reported monthly to the Board as part of the corporate performance report.

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

Monthly CAS Data is now available on NHS England website and shows all responses to alerts due for completion on or before 31st March 2014 issued by NHSE and outstanding NPSA Alerts.

Summary of alerts received by CWP - April 2013- March 2014

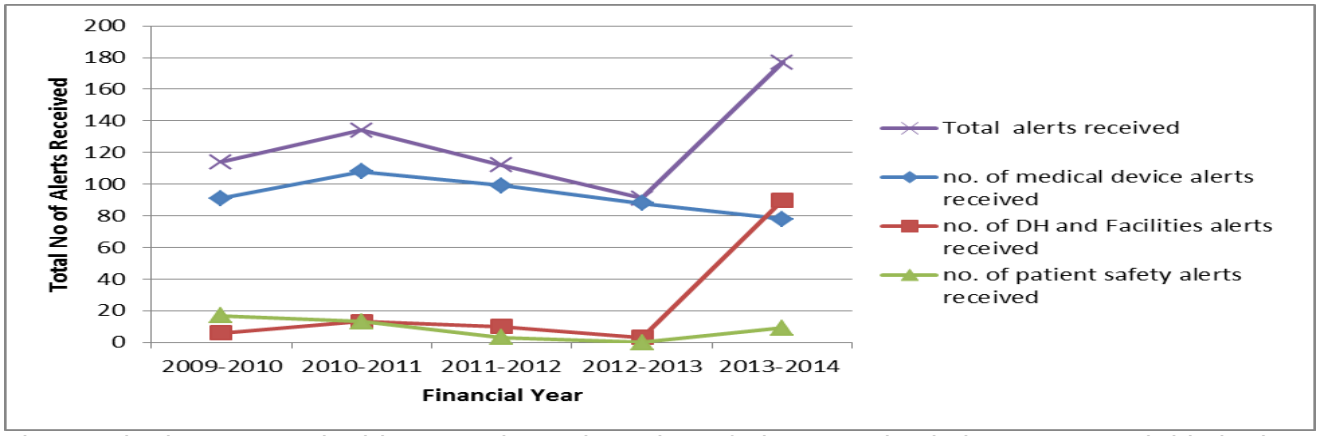
All alerts received by CAS Officer	177
Medical Device Alerts	78
DH Estates and Facilities Alerts (and updates)	90
NHS England	9
Alerts with 'No action required'	77
Alerts with 'Action required- Ongoing'	3
Alerts with 'Action complete'	97
Total	177

At the end of the reporting period (**31.03.14),** CWP had 3 alerts with actions required or their relevance to the Trust being assessed and still within the timeframe for completion.

2 of the alerts have already been referenced above and relate to medical devices incident reporting and medication error incident reporting

A total of 100 alerts required actions throughout the year compared to 34 the previous year.

CAS alerts received per year since 2009



The graph shows a marked increase in total number of alerts received since 2012 and this is due to the publication of Estates and Facilities Alerts and notifications relating to electrical equipment.

2.5 Medical Devices and Equipment

Following the completion of TCS (Transferring Community Services) there had been an ongoing internal review of the existing processes and contracts involved in the management of all medical devices and equipment. Following the review, an action plan, which has been monitored by the Patient Safety and Effectiveness Sub Committee [PSESC], was developed. This identified the need to develop one policy outlining procedures and guidelines to ensure the safe and effective management of CWP medical devices and equipment; from procurement to condemnation, identifying risk issues and removing or reducing them as far as possible. The policy was ratified in November 2012 at the Document Quality Group. The policy complies with the NHSLA standards for user and patient safety (NHSLA Standard 5.4 Maintenance of Medical Devices and Equipment & 5.5 Medical Devices Training).

To achieve the recommendations of a review carried out by Mersey Internal Audit Agency, CWP agreed a contract with an external provider for the management of all devices and equipment. This provider was already supplying a service to the CCWC Service Line which was reducing risks associated within this area successfully. This contract is now the responsibility of the Head of Estates and is managed by the CWP West Business Support Manager and the Senior Health and Safety Advisor. Training needs identified in the Medical Devices policy are being addressed locally and through the Medical Devices Group. A physical health trainer commenced in June 2014.

2.6 Manual Handling

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

2.61 Servicing of Equipment

The contract for the servicing, testing and checking of all hoists, slings and adjustable baths has changed to a new provider who also check bedrails. The contract applies to inpatient areas and is managed and monitored by CWP Estates department.

2.62 Reporting

Manual handling and slips, trips and falls information has been reported twice throughout the year to the Health, Safety and Wellbeing Sub Committee as part of the business cycle.

2.63 Training

Manual handling training is accessible to all staff via Education CWP as part of the Essentials Framework. This training includes the safe methods of moving and handling, safe use of bed rails and also covers slips, trips and falls.

2.64 Bari Suit ©

A new item of training equipment has been introduced for people movement training to raise staff awareness and to practice techniques for the movement of the Bariatric patient. This consists of a Bari Suit which staff wear; this simulates the experience of mobility restrictions that the service user would feel and the colleagues on the training session experience how to move a service user of this build. Feedback from staff for the suit has been extremely positive.

2.65. Mangar Elk

New equipment introduced in 2012 was the Mangar Elk emergency lifting cushion. This equipment is used in the event of a patient fall where the service user requires assistance from staff, thereby reducing the need for staff to manually lift the service user. The training for the use of this new equipment was incorporated into the mandatory employee learning module 3 people movement from January 2012.

2.7 Estates Department

There are requirements under Health and Safety Law to control the risks from exposure to asbestos, control of risks associated with Legionella, for Safe Work at height for employees and delivery of other safety specific training.

All measures required for the control of exposure to asbestos and control of Legionella are managed by the estates department. Risk assessments for work at height are available for staff and staff receive training in safe systems of work.

The estates department have a regular training group meeting that ensures all relevant maintenance staff receive training required according to their area of work, for example, Asbestos Awareness training, Safe Work at height and electrical safety training.

Safety related Training Figures in Estates Department

Training	No of staff requiring training	No of staff completed training	Percentage compliance
Legionella	9	7	78%
Asbestos	19	17	89%
Work at Height	32	31	97%
Electrical Safety	11	8	88%
COSHH (Control of Substances Hazardous to Health)	27	22	81%
Manual Handling	51	51	100%
Pesticides (grounds and Gardens)	10	9	90%

There are also 8 staff within the Estates Department who have completed First Aid at Work Training**.** The Estates Statutory Standards group are responsible for ensuring that all CWP premises are designed and maintained in accordance with all relevant legislative requirements, specific items include asbestos management, legionella management and fire safety management

The asbestos database is held and managed in accordance with the Control of Asbestos Regulations 2012. The database is held within the estates department and updated regularly when in situ asbestos is routinely inspected or where known asbestos is removed. The database covers all premises either owned or occupied by the Trust including former CCWC premises.

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

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

All the above management is in full compliance with the regulations

2.8 Fire Safety

All CWP premises have a Fire Risk Assessment as required by The Regulatory Reform (Fire Safety) Order 2005 (RRO) and all have been inspected during the year starting 1st April 2013 – 31st March 2014. Those premises which required work or change have been issued with an amendment to the Fire Risk Assessment ensuring all premises have a "legal up to date" assessment. A Schedule of Actions has been passed to the Estates Department for action. There is a monitoring system in place to ensure any such work in this schedule is complete.

Generally, fire safety provisions, both active and passive are of a very good standard throughout the Trust

2.81 Fire Strategies for Sleeping Risks

The Fire Safety Advisors recognise that the highest risk buildings in the Trust are the inpatient areas. They have been working towards completing site specific strategies for these risks and strategies for all the 11 In-Patient units are located on the Intranet. (Alderley, Bowmere, Crook Lane, Eastway, Greenways, Lime Walk House, Millbrook, Pine Lodge, Saddlebridge, Springview and Thornheyes Bungalow.
These site specific strategies give all staff access to the actions, roles and responsibilities required during a fire in their premises.
The strategies are located on the intranet in the Estates section under 'Fire

2.82 Fire Evacuation Exercises

CWP now have in place a programme for carrying out fire drills in all inpatient units. The Modern Matrons have been issued with a timetable with <u>two</u> dates per year. The Fire Advisors attend the drills and both oversee and direct the evacuation drills.

This method has produced very positive results with both management and staff benefitting from the procedures.

Following the exercise, staff complete a written document relating to the drill as evidence for both the enforcing authority (Fire Brigade) and the CQC that drills take place. The law only requires one drill per year to be carried out.

The Competent Persons (Fire) who have responsibility for carrying out fire evacuations in premises other than inpatient units are not achieving 100%. The Fire Advisors are continually encouraging the completion of these drills as well as writing to all Competent Person (Fire) annually to remind them of their duties.

2.83 Fire Alarms

To reduce stress levels in service users and staff during alarm testing or during a fire CWP Fire Advisors have embarked on a programme of providing voice over alarms instead of bells and sounders.

This system was trialled in Crook Lane in 2012. CWP Fire Safety Advisors have received excellent feedback from staff.

Saddlebridge 2 the new build is having a voice over system fitted during the build.

As new technology has become available, CWP will be able, in most cases to retrofit most systems or replace when present systems become obsolete.

The system we are presently fitting in Eastway has allowed a voice over to be provided without any disturbance or alteration to the wiring system.

2.84 Fires

A total of 12 fires were reported on the Datix system for the period 1st April 2013 – 31st March 2014.

8 were caused by service users, started with matches or lighters.
6 were confined to a bedroom
1 was outside in a bin
1 was in a ward corridor damaging a carpet

4 fires caused as a result of lack of care whilst cooking.

All fires were considered to be of a minor nature and were contained in the room of origin or the area of origin.

2.85 Unwanted Fire Signals (UwFS)

A total of 39 unwanted fire signals were reported on the Datix system for the period 1st April 2013 – 31st March 2014.

There were no common causes or any particular building involved.

Listed below are the type of unwanted signals the Trust has generated which caused a fire alarm to operate

- Smoking inside building
- Misuse of aerosols

- Malicious operation of manual alarm point by service user
- Accidental operation of manual alarm point by member of staff
- Faults on system
- Toaster left unattended
- Steam from shower
- Contractor created dust
- Unknown

2.86 Fire Drawings

The "Regulatory Reform (Fire Safety) Order 2005" and "Firecode" require the Trust to provide fire drawings for all premises which should be readily available for use by the Fire Brigade.
The plans are to be used by the Fire Service in the event of fire.
Initial drawings of all Trust premises have been completed; once they are proved they will be rolled out across the Trust and retained in the fire documents box adjacent to the fire panel.

3. Updates

3.1 Common Sense, Common Safety and the Löfstedt Review

Lord Young published his report Common Sense, Common Safety in October 2010 following a review of the operation of health and safety laws and the growth of the compensation culture.
In March 2011, as part of the Government's plans to reform Britain's health and safety system, Professor Ragnar Löfstedt, the Director of the Kings Centre for Risk Management was commissioned to chair an independent review of health and safety legislation. The review was published in November 2011 and made recommendations aimed at reducing the burden of unnecessary regulation on businesses while maintaining Britain's health and safety performance. The Government accepted the recommendations which included simplifying and streamlining the stock of regulations, focusing enforcement on higher risk businesses and clarifying requirements. The result was a significant amount of Health and Safety Legislation under review. An official report entitled' Reclaiming health and safety for all; a review of progress one year on, also written by Professor Löfstedt was published in February 2013 confirming that many of the recommendations that were made in the 2011 report have been delivered or are on track.

The main changes affecting the Trust are the changes to requirements for RIDDOR Reports and the requirement removed for organisations to have their First Aid training approved by the HSE.

The requirements for RIDDOR reporting changed from April 1 2012, Organisations, whilst still having to record instances of staff absence following an accident/ injury at work, only have to report more than 7 day 'incapacitation' to the HSE (Health and Safety Executive).

Other Health and Safety legislation remains under review and is subject to consultation and if relevant to CWP will be reported in next year's annual report.

3.2 Fee for Intervention

HSE introduced a scheme called 'Fee for Intervention'. If an organisation makes a material breach and the HSE Inspector judges this is serious enough for the organisation to be informed in writing e.g. Notice of Contravention, an Improvement or a Prohibition notice, then the Inspector will record the time they have spent identifying the material breach, investigating and taking any action including site visits and report writing and the Organisation will be charged accordingly. Examples of material breaches include: not providing guards or effective safety devices to prevent access to dangerous parts of machinery; or materials containing asbestos in a poor or damaged condition resulting in the potential to release fibres.

4.0 Priorities for 2014-2015

1. Following the move of the Health and Safety function to Infrastructure Services (Estates), the Advisors have direct access to the DATIX reporting system and are developing evidence based recording system to ensure governance of incident management in relation to health and safety incidents.

2. Coordination between the Operational Business Support Manager (CWP West) and Health and Safety will continue in maintaining and monitoring the contract for servicing and maintenance of medical devices.

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

4. The Health and Safety Advisors will ensure that by May 2014, all relevant areas are displaying the new style Health and Safety Law Poster.

5. All in- patient areas and community clinics will be assessed using the Health Safety and Security template every year.

6. Resource centres, office buildings and other areas where staff are based will be assessed every 2 years but reactive visits will take place as required.

7. A template for managers to complete to make basic safety checks of their areas will be produced for managers to complete and returns will be monitored by Health and Safety Advisor.

5.0 Recommendations

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

The Board of Directors is asked to approve the proposal for in patient areas and clinics to be assessed annually and a programme of assessments for resource centres, office areas and other buildings to be assessed bi-annually due to the low risk nature of these areas.
Safe systems will be monitored by the implementation of a safety checklist for managers to complete locally which will be reviewed and actioned as necessary by the senior health and safety advisor

6.0 References

HASAW- Health and Safety at Work etc Act 1974
The Management of Health and Safety at Work Regulations 1992 (as amended)
RIDDOR- Reporting of Injuries, Diseases & Dangerous Occurrences Regulations 1995 (as amended 2012)
Governance and Risk Policies- Cheshire and Wirral Partnership NHS Foundation Trust
Clinical Practice Policies - Cheshire and Wirral Partnership NHS Foundation Trust
Work with Display Screen Equipment (as amended 2002)
LOLER- Lifting Operations and Lifting Equipment Regulations 1998.
Health Technical Memorandum – Firecode
The Regulatory Reform (Fire Safety) Order 2005
Control of Substances Hazardous to Health 2009
Control of Asbestos at Work Regulations (as amended) 2012
Health and Safety Commission Approved Code of Practice L8 Legionnaires' disease –The control of Legionellae bacteria in water systems
Health Technical Memorandum 0401 Part A and Part B
Work at Height Regulations 2005 (as amended)

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/15/29)

Report to:	**Board of Directors**
Date of Meeting:	**30th July 2014**
Title of Report:	**Trustwide Annual Safeguarding Report**
Action sought:	**For Approval**
Author:	**Andrea Hughes, Associate Director of Nursing & Therapies** **Satwinder Lotay, Acting Head of Safeguarding**
Presented by:	**Avril Devaney, Director of Nursing, Therapies and Patient Partnership**

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

Distribution

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

Executive director sign-off

Executive director (name and title)	Date signed-off
Avril Devaney, Director of Nursing, Therapies and Patient Partnership	24th July 2014

1. **Purpose of the report**

2. **Summary**

3. **Content**

4. **Conclusion**

5. **Recommendations to the Board of Directors**

1. Purpose of the Report

The purpose of this report is to provide the Trust Board with an annual review of the work undertaken in 2013-2014 and assurance in relation to safeguarding children, young people (including Looked After Children –also referred to as Children in Care) and adults.

The report will focus on how the responsibilities of the Trust have been met, an overview of the work undertaken and identifying the key objectives for 2014-2015. In particular it provides assurance on how the organisation has fulfilled its duty to ensure its functions are discharged with regard to the need to safeguard and promote the well-being of children and young people in line with Section 11 of the Children Act 2004 and Working Together to Safeguard Children (HM Government, 2013). In relation to Children in Care, the report focuses on how the Trust has met its duties and responsibilities as outlined in the Statutory Guidance on Promoting the Health of Looked After Children (DCSF, 2009). For Safeguarding Adults, the report will focus on how it meets the standards set by Care Quality Commission for Safeguarding.

2. Summary

The Trust delivers services to the communities most vulnerable and/ or high risk across the age spectrum. CWP are involved in seven Safeguarding Boards (three children and four adult) and their respective subgroups.

Over the past few years, the safeguarding agenda has proliferated. Health organizations are now involved actively in child sexual exploitation agenda, the radicalization agenda including PREVENT Female Genital Mutilation, Forced Marriage and 'Honour' Based Violence. This is due to increased understanding of the health professionals involvement with all members of the public and the safeguards they can help to provide The public awareness in relation to domestic abuse and changes in legislation has resulted in a vast increase in MARAC cases (high risk cases) and Domestic Homicide Reviews being undertaken. The impact of the roll out of Clare's Law is to be experienced during 2014-15. The Mental Capacity Act (MCA) and the Deprivation of Liberty (DOLS) agenda have also come under the spotlight especially following the recent Court judgment. Health organizations will have to demonstrate their compliance for example, in ensuring staff are trained in MCA.

The political landscape for safeguarding is also changing. Following Winterbourne, Baby P, Daniel Pelka, The Francis Report to name a few, organizations have increasingly become under the spotlight in how well their staff are trained and respond to safeguarding concerns as well as the leadership. The effect has been that the Clinical Commissioning Groups (CCGs) Safeguarding Boards and regulators are scrutinizing and challenging organizations more in their safeguarding responsibilities.

The safeguarding agendas are no longer clearly divided into Children and Adults with many cross cutting both agendas that therefore require the Safeguarding teams to work in an integrated way. Safeguarding continues to be addressed under one combined agenda following a 'Think Family' approach, underpinned by the principles of the 6 C's, with both adults and children's safeguarding retaining specific specialist teams with individual areas of responsibility.

This reporting period has seen many challenges, in conjunction with continuing financial challenges and change across other partner agencies. Safeguarding activity continues to highlight a year on year increase. For example, in the complexity of referrals to social care for both adults and children; a greater number of children subject to a Child Protection Plan or Care Proceedings than before.

Maintaining the consistency and quality of all aspects of safeguarding practice across the Trust has been essential during this challenging period. Over the past year the safeguarding arrangements within all areas of the Trust have continued to be strengthened, with a particular focus on ensuring our staff receive an appropriate level of safeguarding training and are competent to undertake their safeguarding roles.

The report will cover how the Trust has responded to safeguarding agenda at a Trust Wide level and then focus on the how the Trust has implemented its statutory functions focussing on the work undertaken within the three localities.

3.0 Content Trust Wide Response

3.1 Safeguarding Leadership & Accountability

The Board has an identified Executive Director who leads on Safeguarding for CWP. This is the Director of Nursing, Therapies and Patient Partnership who champions safeguarding throughout the organisation and represents the organisation on various LSCB Boards. They are supported by the Associate Director of Nursing and Therapies (Physical Health), who line manages the safeguarding department and represents CWP on various LSAB Boards.

The Trust has a safeguarding department which has Nurse Specialists for Safeguarding Children, Children in Care (Looked After Children), Child Death Overview Panel/Paediatric Liaison as well as Nurse Specialists for Safeguarding Adults and a Safeguarding Nurse (domestic abuse). It is managed by the Named Nurse / Acting Head for Safeguarding and supported by a safeguarding administrative team. The Trust also has 3 Named Doctors for Safeguarding, one in each locality of the Trust, all of whom are consultants working in CAMHS.

The nurse specialists provide advice and support, safeguarding supervision to clinical staff as well as designing and delivering safeguarding training and ensuring policies and procedures are followed. The Named Nurse is responsible for ensuring policies and training are in place and up to date and provides support to the nurse specialists, managers and Directors on safeguarding issues. The Named Nurse sits on a number of LSCB and LSAB sub groups (supported by the nurse specialists). The Named Doctors provide safeguarding children advice, support and supervision to medical staff.

3.2 Safeguarding Governance Arrangements & Assurance

The Trustwide Safeguarding Sub Committee is is chaired by the Director of Nursing, Therapies and Patient Partnership, it reports to the Trust Quality Committee and is responsible for overseeing the Trust's responsibilities to the adult and children safeguarding agenda (includes Looked After Children and Domestic Abuse), monitoring and reviewing action plans, safeguarding training, safeguarding policies and audits. It also reviews the work of its constituent Local Safeguarding Children Boards and Local Safeguarding Adult Boards.

Each locality of CWP, has a Safeguarding Operational Group established and is chaired by a General Manager. The Safeguarding Operational Groups report into the Trustwide Safeguarding Sub-Committee.

The Trust's MARAC Steering Group and the PREVENT Steering Group also report into the Trustwide Safeguarding Sub-Committee. The PREVENT Steering Group was established in March 2014.

The CWP Safeguarding Team completed the Safeguarding Assurance Framework for various Clinical Commissioning Groups on a monthly basis and coordinated the completion of the Self-

Assessment Standards for Safeguarding Children and Adults at Risk for all the CCG's that commission services of CWP.

3.3 Safeguarding Activity

During April 2013-March 2014, The Safeguarding team have seen an overall general increase in activity and complexity. Table 1.below details the activities and compares this with the activity of 2012-13.

Activity	April 2013-March 2014	April 2012-March13	% increase/ decrease
Number of enquires (adults)	904	612	47% increase
Number of referrals to Local Authority (adults) as reported to the Safeguarding team	121	Not captured	-
Number of MARAC sessions CWP attended	68	50	9% increase
Number of Social Care referrals (children) as reported to the by safeguarding team	108	192	43.7% decrease
Number of Practitioners attending / reporting into Child Protection Conferences (reported to the safeguarding team)	387	335	16% increase

Table 1: Overview and comparison of safeguarding activity

Table 1 illustrates that Adult safeguarding enquiries to the Safeguarding Adult Team has increased significantly over the year as well as the number of MARAC sessions that the Trust is now attending. The number of children social care referrals has come down significantly. This may be explained by way of practitioners are making appropriate detailed referrals and by the increasing use of the Common assessment Framework/Team around the Family process. The data collection for the CAF/TAF needs to be strengthened across the Trust as currently most services are self-reporting on this activity. There was an increase in the numbers of practitioners attending and/or reporting into Child Protection conferences, this enables decisions to be taken which have access to a wide range of information.

During this period the Safeguarding Children Team has become actively involved with the Child Sexual Exploitation agenda across all the localities which have had a major impact on the workload of the team. The Nurse Specialists gather information on cases and attend multiagency meetings on the cases. They also attend the CSE operational groups in each locality. Staff in the localities have also been briefed on the referral and process regarding CSE. It is already evident that as the awareness of CSE is increasing, that this area of safeguarding children and young people work is expanding.

3.5 Safeguarding Training

At the end of March 2014, The Trust overall compliance rate to Safeguarding training was 89%. Table 2 illustrates the compliance rates achieved in the various levels of safeguarding training delivered. The Trustwide Safeguarding Sub- Committee continues to monitor and review the

attendance and compliance for safeguarding training. The level 4 safeguarding training relates to the training of Named Professionals working within the Trust and these courses are accessed externally. HealthWrap training (in response to the PREVENT agenda) has begun to be rolled out across the Trust. The attendance and compliance for this training will be monitored at Trustwide Safeguarding Sub Committee. Mental Capacity Act and Deprivation of Liberty's Training compliance will also begin to be monitored at Trustwide Safeguarding Sub Committee.

Safeguarding Training	Number of Sessions Delivered	Wirral	West	East	CSS	Trustwide Compliance Rate as at End of March 2014
Level 1	E-learning (and face to face sessions for volunteers)	93%	92%	91%	84%	90%
Level 2	34 sessions	91%	88%	89%	77%	89%
Level 3	4 sessions	78%	91%	76%		85%
'Honour Based Violence' & FGM conference (Level 3 for Safeguarding)	1 session					
Level 4	Not delivered by CWP – External courses				90%	90%

Table 2 Safeguarding Training Compliance Rates for CWP

Box1 gives examples of how practitioners stated they would be putting the training they had received into their clinical practice

Box 1: Examples of Putting Safeguarding Training into Practice.

From Level 2:

" Sharing information"
"will be able to apply the Escalation process"
"Know that I can share my concerns with Safeguarding nurses to help me"
"highlighted that I need to develop further knowledge to support my team but I know safeguarding team are there"
"Aware of RIC tool**"
"I understand importance of RIC..I will now carry this tool with me everywhere"
"Even though I have adults as patient ...I will ensure I assess the bigger picture where there are children"
" Listen to children"

From Level 3:

"Clearly understanding re FGM* and importance of seeing young person on their own"
"Help me to challenge more and feel more confident"
"Understanding re HBV* – understand not to discuss with family"
"able to respond more appropriately"
"Help me to safeguard/support young people at risk appropriately"

*FGM Female Genital Mutilation HBV Honour Based violence
** RIC Risk Indicator Checklist tool – Tool to assist in risk level to domestic abuse.

3.6 Safeguarding Supervision

This is available for all staff across the whole Trust from the Named Nurse/ Doctor and Nurse Specialists. The Safeguarding Children and Children in Care supervision for Children services and Drug and Alcohol Services is structured and planned. Supervision for Safeguarding Adults is provided on request.

CAMHS service has trained team members who provide safeguarding supervision. The Family Nurse Partnership has a FNP Supervisor who provides supervision for that team and there is a named safeguarding nurse specialist who provides advice, support and supervision to the FNP supervisor and the service. Supervision for Safeguarding Adults is provided on an ad-hoc basis.

All the nurse specialists within the safeguarding department have completed an accredited safeguarding supervision course.

During the past two years a model of case supervision has been utilised more frequently whereby a number of practitioners working within the same family/household come together to review, assess and critically analyse what is happening for the individual child/ young person/ vulnerable adult concerned. It has also given practitioners insight into each other's roles and expertise.

The Named Nurse for Safeguarding provides supervision to all the Nurse Specialists and peer supervision is provided for all the Named Professionals. The Named Nurse and Named Doctors also access safeguarding supervision from Designated Professionals.

A recent Care Quality Commission Review in West Cheshire reported on the safeguarding supervision and the comments from the report are included in box 2

Box 2 Quotes from CQC report on safeguarding supervision (Feb 2014)

> Frontline staff receives feedback and support to address areas for further improvement in their practice. Supervision records seen in these cases are of a good standard with clear direction provided by safeguarding leads. (para 3.4 p16)
>
> School Health Advisors and Health visitors value the opportunities they have for consultation and joins supervision with CAMHS workers...felt would benefit further from closer working with adult mental health staff to embed the "Think Family" approaches (para 5.3.3 p 27)

The CQC report highlighted that the safeguarding supervision for children needed to be strengthened for Adult Mental Health services and an action plan is in place to address this.

3.7 Serious Case Reviews/Domestic Homicide Reviews/ Learning Reviews for Children and Adults

There has been no Serious Case Review (SCR) or Domestic Homicide Review commissioned for CWP during this reported period. However, the SCR for Child G was published in March 2013, the action plan was implemented during this period. There have been a number of multiagency reviews in which CWP have been involved with and Table 3 details these. The resulting Action Plans are reviewed at the most appropriate Safeguarding Operational Groups and are overseen and monitored by the Trustwide Safeguarding Sub- Committee.

Table 3:Summary of Reviews that CWP Involved with April 2013-March 2014

Type of Review	Local Authority and Board Responsible	Services Involved from CWP
Serious Case Review (Child	Wirral LSCB	Adult Mental Health &

G)		CAMHS
Critical Case Review Child 2	Wirral LSCB	CAMHS
Critical Case Review (Adult B)	Wirral LASB	Adult Mental Health
Individual Management Review (Adult DB)	Cheshire West and Chester LSAB	Community Nursing Service and Specialist Physiotherapy Service
Practice Learning Reviews	Cheshire West and Chester LSCB	A number of services
Multi thematic review	East Cheshire LSCB	CAMHS

3.8 Inspections / Reviews

There has been one Care Quality Commission (CQC) Review of Looked After Children and Safeguarding Children in Cheshire West and Chester whereby CWP where significantly involved. A report detailing the review outcomes has been previously brought to the Board. There is an Action plan in place which is being overseen by Trust wide Safeguarding Sub-committee.

Preparation is under way for CQC inspections in both Wirral and East Cheshire working with the respective CCG's with a member of the Safeguarding Team attending the preparation groups.

There has been no OFSTED inspection in which the Trust has been involved with. However, theTrust is actively involved in delivering on East Cheshire's Improvement Plan, with the Director.of Nursing,Therapies and Patient Partnership being part of the Improvement Board.

3.9 Assurance Process and Audits

The 2013/14 Safeguarding Audit Programme was implemented. The Adult Safeguarding audit demonstrated areas of good practice including standards relating to record keeping and awareness of the outcome of referrals. However, there were areas identified for improvement, for example, escalating cases in an appropriate way when not receiving timely feedback from the local authority. An action plan has been developed following this audit; the audit will be repeated in 2014-15.

Safeguarding children referrals were shown to be appropriate and key staff were accessing safeguarding supervision (focus was on West locality only). The outcome of the CAMHs audit is currently being finalised. The quality assurance audits being undertaken by the Children in Care service demonstrate improvements in quality and evidence of engagement with the child/ young person involved.

The Care Matrices completed by all in-patient wards have safeguarding indicators which are completed on a monthly basis. Over the year, wards are demonstrating an increase in compliance to policy and procedure.

Unannounced compliance visits are conducted by a Board member and members of the governance team this includes an assessment of the safeguarding standard of the unit/service.

The CWP Safeguarding Team completed the Safeguarding Assurance Framework for NHS West Cheshire, NHS Vale Royal, NHS East Cheshire and NHS South Cheshire Clinical Commissioning Groups on a monthly basis. The Named Nurse for Safeguarding coordinated the completion of the Self-Assessment Standards for Safeguarding Children and Adults at Risk for all the CCG's that commission services of CWP. The Trust reported compliance with all the standards of the audit.

There is an ongoing process whereby there is oversight of the DATIX submission from the Director of Nursing, Therapies and Patient Partnership. Where further clarity or assurance has been required this is followed up by the safeguarding team

All safeguarding incidents are reviewed by the safeguarding team on at least a weekly basis to ensure appropriate safeguarding procedures have been followed. All complaints which may a safeguarding issue raised within it are also reviewed by the Safeguarding Team. Presently there are two complaints rated as red from CWP East Locality, that had been referred by the Trust to the Local Authority under Safeguarding procedures, which continue to be investigated and to date have not concluded.

All the objectives set for 2013-14 have been achieved, except for one which was undertaking a staff/agencies feedback of the safeguarding service of CWP and this will be carried forward to 2014-15 and undertaken as a priority.

3.10 Localtiy Response

The three localities have taken forward work during the year to improve partnership working, the quality of referrals and the outcomes of safeguarding interventions for the people who use our services.The locality section will highlight the good practice and illustrates the growing complexities and inter dependant relationships between the services we provide to individuals and families.

Each locality has to consider the bespoke needs of their practitioners and the people we deliver services to, within their specific health and social care ecconomies and frameworks.

The CWP Safeguarding Team works in partnership with the localities to ensure consistency of practice and ensure compliance with legistlation. The team is also the conduit of information between LSCBs and LSABs and works with the localities to drive continuouis improvement. The localities have identified specific actions for 2014/15

Each Locality will detail the work undertaken during the year and identify key developments and recommendations

3.11 CWP EAST LOCALITY

3.11.1 Partnership

East locality of CWP covers Cheshire East Local Authority Footprint. In supporting partnership working the Trust participates in the various multiagency forums within the locality see Table 4. An example of what can be achieved within these forums is illustrated in box 3. CWP have also co-delivered training on behalf of the LSCB-“Toxic Trio”.

Table 4 CWP Representation at Boards and subgroups

.

East Cheshire LSCB Board	Director of Nursing Therapies & Patient Partnership
East Cheshire LSAB Board	Associate Director of Nursing & Therapies (Physical Health)
Training and Development (joint)sub group	Named Nurse for Safeguarding
Training Pool	Nurse Specialist for safeguarding and Drug and Alcohol Worker
Serious Case Review (joint) sub group	Named Nurse for Safeguarding
Health and Protect	Named Nurse for safeguarding
Missing From Home/ Child Sexual	Nurse Specialist for safeguarding

Exploitation	
MCA/ DOLs Steering group	Mental Health Act Officer
MARAC Steering Group	Nurse Specialist for safeguarding
Pan Cheshire CDOP	Nurse specialist for CDOP
Improvement Board	Director of Nursing Therapies & Patient Partnership
Improvement Board Executive	Director of Nursing Therapies & Patient Partnership

Box 3: An Example of CWP Participation in sub group

Concerns were raised by a Drug worker of CWP to the Named Nurse for Safeguarding Children that a referral for an unborn baby was not being accepted by social care despite a numerous child protection concerns. The case was escalated.

The case was taken to the Health and Protect Sub-Group. It was identified that there was no robust multi agency guidance regarding pre-birth assessments. CWP took the lead in coordinating the development of the multiagency pre-birth assessment. This is now in place for East Cheshire LSCB

Various practitioners from CWP have also been involved in the LSCB multi agency reflective reviews and also in the LSAB reflective reviews. Lessons learnt from these reviews have been shared with practitioners in the locality.

A multi agency review has recently been commissioned by East Cheshire LSCB, which the CAMHS service has been involved with. The Independent Author is due to share their report in July/August 2014.

3.11.2 East Audit (Safeguarding)

CWP Safeguarding Practice Audit (adults) demonstrated evidence of good practice relating to knowledge and recording of referrals. Areas requiring further improvement were identified and this is being addressed via an action plan.

A CAMHs audit was undertaken on children discharged from the service where safeguarding issues had been identified to ensure CAMHS are compliant to the policy on safe discharge. Outcome of the audit is due to be reported in July 2014.

3.11.3 Referrals received to the Drug and Alcohol Service of CWP

Between April 2013 and March 2014, there have been 109 referrals to the service for children and young people under 18years of age, an average of 9 referrals per month. The highest numbers of referrals were received in July (17 referrals) and the lowest number in August (3referrals). The majority of these referrals come from A&E, self-referrals and school.

3.11.4 Care Concerns /Referrals to Social Care

CWP Safeguarding team monitors and reviews all child protection referrals that have been made into Social Care. Table 5 highlights the number of referrals made by various services. A direct comparison cannot be made with last year's data as the data was collated by service line and not local authority. All the referrals have been reviewed by the safeguarding nurses and were appropriate. The number of care concerns/ enquires raised for safeguarding adults in East Cheshire is detailed in Table 6. In 2012-13 the number of care concerns/ enquires was 316. Therefore there has been an increase in activity by 10%.

Table 5: Number of Child Protection Referrals made to Social Care by CWP services

Service	Number of Referrals
East CAMHS	12
Drug and Alcohol Service	3
Recovery	1
IAPT	5
Psychology	1
Liaison Psychiatry	8
Adult Mental Health	3
Total	**33**

Table 6:The number of Care concerns/enquiries made for safeguarding Adults

Service	Number of Care Concerns/ Enquires
Adult Mental Health	214
Learning Disabilities	120
CAMHS	8
Drug & Alcohol	9
IAPT	2
TOTAL	**353**

3.11.5 Service User Feedback (relating to safeguarding)

Service Users from East Cheshire CAMHS have given feedback to East Cheshire LSCB (see Box 4)

Box 4: Example of Service User Feedback

In November 4 Service Users from East Cheshire CAMHs presented to the LSCB to raise the following issues:

1. Lack of Out of hour crisis support for young people experiencing mental health difficulties

2. Their experiences of support received in A&E departments.

As a result of their presentation, the service users met with the Equality & Patient Experience Manager, Macclesfield General Hospital to give their experience of the service received from A&E. The outcome of this meeting is that the young people will meet with A&E staff

The Learning Disabilities service captures Service Users Stories of their experiences of using the services of CWP. This has informed service delivery and service plans.

3.11.6 Participation Child Protection Conferences

CWP safeguarding department receives copies of all initial case conference invitations. Of the 177 initial child protection case conferences, only 13 cases were open to CWP services (7%). In all 13 cases, reports were available to the conference.

3.11.7 Participation in Common Assessment Framework (CAF).

The data collection for professionals involved in CAF and leading CAF has been identified as needing to be strengthened as it is currently relying on services self reporting and manual data collection. The Drug and Alcohol Services were self reporting their participation in CAF cases on a monthly basis for the East Cheshire LSCB and NHS Eastern Cheshire CCG Safeguarding Assurance Framework. This is an area which has been identified as need to be strengthened.

3.11.8 Adult Protection Conferences/ Strategy meetings/Professional meetings

There are no known Adult protection case conferences in which CWP have been involved with. CWP staff continue to attend Strategy and Professional meetings in relation to Safeguarding Adults

3.11.9 Domestic Abuse

CWP have actively participated in the MARAC held in East Cheshire having attended 24 MARACS (324 cases) held in East Cheshire. This is an increase from 2012/13 when 18 MARACS were attended (an increase of 25%). CWP continue to participate in the CEDAP MARAC Steering Group

3.11.10 Key Innovations and Developments

East Cheshire CAMHS have embedded the active involvement of their service users, their parents/carers in all areas of their service design, development and delivery. Examples are detailed in Box 5. Learning Disabilities have a participation worker who actively seeks out the views of service users and facilitates service user meetings.

Box 5 Examples of Embedding Service User Feedback

Example 1: Recruitment Process
A young person and /or parent/carer are involved in the recruitment of new staff by participating in the interview panel. Since August 2013, young people and their parents/carers have taken part in 23 CAMHS interviews.

Example 2: Sharing young people's experiences at national level
Service users have shared their experiences and been involved in the Department of Health Children and Young People IAPT Programme.

Example 3: Informing learning from Case Reviews
As part of a thematic review being undertaken by CWP, Service users have been approached and their experiences and their messages for agencies will inform the report.

3.11.11 Future Actions and Recommendations

CWP East Cheshire CAMHS will be establishing a group of Young Advisors. It will be the first NHS Trust to work the national Young Advisors Charity. 12-16 young people from CWP East Cheshire CAMHS will be attending 3 day accredited training from the Young Advisors Charity to help them input into service improvements and regeneration projects. Once trained, these Young Advisors will be employed by CWP to ensure their skills are utilised. Agencies will be able to commission the services of the Young Advisors.

Following the successful implementation of East CAMHS involving young people and their parents/carers, East Cheshire Locality Directorate are developing a 2 year strategy to ensure all services embed the active involvement of their service users and their families in all areas of service design, development and delivery. For example, the young person Substance Misuse

Service has developed an “Experience of Service Questionnaire” to gain an understanding of the how young experience their service.

Data collection for CAF participation will also be area that needs further development. It is planned that within the case audits undertaken by CWP will include a number of CAF managed cases which involve CWP staff.

CWP will continue to be actively involved with the LSAB and LSCB and the respective subgroups Feedback from Young people and their families on CWP input into safeguarding needs o be developed.

3.12 CWP West Locality

3.12.1 Partnerships

The West locality covers the footprint of the local authority. Within this locality, sits the Children in Care (Looked After Children) Service and the Paediatric Liaison/ Child Death Nurse Specialist service of CWP. Therefore the respective reports for both of these specialists’ services will be included within this section.

In supporting partnership working the Trust participates in the various multiagency forums and these are detailed in Table 7

Table7 : CWP Representation at Multi Agency Boards and Groups

CWAC LSCB Board	Director of Nursing, Therapies and Patient Partnerships
CWAC LSAB Board	Associate Director of Nursing and Therapies (Physical Health)
Learning and Development (joint)Sub group	Named Nurse for Safeguarding
Training Pool	Nurse Specialist for Safeguarding children / adults
Performance Management and Quality LSCB Sub group	Named Nurse for Safeguarding
Performance and Audit LSAB sub group	Nurse Specialist for Safeguarding Adults
Serious Case Review LSAB sub group	Named Nurse for Safeguarding
Pan Cheshire CDOP (LSCB)	Nurse Specialist for CDOP/ Paediatric Liaison
Children in Care and Care Leavers LSCB sub group	Nurse Specialist for Children in Care
Safer Recruitment LSCB Sub group	HR Representative
Sexual Exploitation and Missing From Home operational group	Nurse Specialist for Safeguarding
Safeguarding Operational Managers Group	Children manager, CAMHS manager, Drug & Alcohol Manager and Nurse Specialist for safeguarding children
NW Regional Healthy Care Partnership Meeting	Nurse Specialist for Children in Care
Cheshire West and Chester multi Agency Healthy Care Partnership Meetings	Nurse Specialist for Children in Care
Children in Care meetings	Nurse Specialist for Children in Care

3.2.2 Paediatric Liaison and Child Death Overview Report

The Nurse specialist for liaison plays an important essential role in the sharing of appropriate information between the Acute Trust and the community services by communicating directly with Health Visitors, School Health advisors and other community health practitioners. The service has dealt with reports from:

- Countess of Chester Hospital Accident and Emergency department where in the year 31/3/2013 to 1/4/ 2014 there were 12,043 visits to the department by children up to the age of 16 years. Of these visits:
- 7,896 children visited once
- 1,758 children visited more than once
- 9,654 different children.
  (Data provided by Countess of Chester NHS Foundation Trust on behalf of CWP)

1. Chester Urgent Care Unit where in the year 31/3/2013 to 1/4/2014 there were 2,896 visits to the department by children up to the age of 18 years
2. Neonatal unit
3. Transitional care unit
4. Paediatric wards
5. Other hospitals and departments out of this area
6. Liaison has also been completed from other services within the locality that have identified children with vulnerability factors e.g. Out of Hours, Countess of Chester Hospital safeguarding team.

Table 8 details the number of liaision reports that have happened per month.

Table 8:Child Death Overview Panel / Liaison - Monthly Figures 2013-2014

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	TOTALS
Child Deaths	1	1	0	0	1	0	0	1	0	0	1	0	5
Neo-natal Deaths	1	1	0	0	0	0	0	0	2	0	2	1	7
Complex Liaison from COCH - Chester E/Port Area	32	36	36	27	31	29	30	30	30	31	49	26	387
Complex Liaison from COCH - Flintshire	14	11	13	8	10	8	6	7	6	5	11	8	107
Complex Liaison from COCH - Out of Area	3	4	5	2	3	4	10	3	1	6	4	3	48
Liaison - Neonatal Unit	34	41	35	50	33	35	38	33	35	45	42	35	456
Liaison - Paediatric Wards includes Transitional Care	58	41	66	44	30	48	42	62	25	56	46	50	568
Liaison Urgent Care (WIC)	1	0	1	2	0	0	0	0	1	1	0	0	6
Liaison - Out of Hours	2	1	1	3	0	4	2	2	3	10	2	5	35
										TOTAL OF ALL LIAISON			1619

The nurse specialist is a core member of the Pan Cheshire Child death overview panel (CDOP) which has been established for almost a year. There have been 4 meetings in this forum thus far and the panel will report on its findings separately with reference to the review of the child deaths across Cheshire, identification of trends and statistics and identification of public health issues. Monthly figures for child deaths is illustrated in Table 8.

The nurse specialist ensures that child death information is communicated effectively and securely between multi agency professionals and that child death reporting is delivered to the Pan Cheshire CDOP in a timely and appropriate way in order for the panel to adequately review deaths. This includes completion of the appropriate department of health child death forms and significant liaison between any involved professionals and where necessary provision of support to the involved professional.

The nurse specialist is able to communicate trends and public health issues to community practitioners to enable consideration for service improvement and training.

3.12.3 Children In Care (Looked After Children)

During the 2013/2014 year, the Nurse Specialists for Children in Care Nurses have undertaken the accredited "Safeguarding Supervision for Supervisors" training course. The Children in Care Nurses have provided clinical supervision for Health Visitors and School Nurses in respect of children on their caseload with Looked after Children status

The annual Children in Care training for 2013/2014 took place over two days, 25th &30th September 2013 This year the focus was "The Voice of the Child and Life Story Work".

The Nurse Specialists provide training is provided at least every quarter for all Health Visitors, School Nurses and Family Nurses recruited to CWP (and staff returning from extended leave).

The audit for review health assessments for Children in Care was reported on to the Trust Wide Safeguarding Sub-committee in August 2013. Quality assurance of review health assessments continues to be undertaken by the Nurse Specialists. Monthly reporting of activity relating to children in care continues to be reported using the Safeguarding Assurance Framework.

The numbers of Children in Care show an overall increase, including the number of children aged 16+ years where the Nurse Specialist is the identified health professional. Table 9 indicates the current numbers of children in care within the CWP footprint. Last year's figures 2012/2013 are also shown for a direct comparison.

The CQC review of health services for Children Looked After and Safeguarding in Cheshire West and Chester (February 2014) acknowledged an improvement in services for children looked after. The review noted good practice in capturing the views of children and in recording their presentation

Table 9 Comparison of the Numbers of Children In Care residing within CWAC

	2013/2014	**2012/2013**
Cheshire West and Chester Local Authority Looked After Children	286	260
Children Looked After by other Local Authorities living in West	108	100
Total Number of Cheshire West and Chester Local Authority Looked After Children Placed Out of Area	135	138
Total Number of Children in Care Living within Cheshire West and Chester local Authority Boundary	**261**	**222**

The report acknowledged the role of the Nurse Specialists in raising the quality of statutory health assessments. This was echoed in the Independent Reviewing Officer's (IRO)) annual report in August 2013 which

"Recognises and values their expertise, accessibility and enthusiasm, and has enabled tighter tracking of health concerns raised through statutory reviews".

The Nurse Specialists work in an integrated way as part of the children in care & care leaver's teams within their localities and work in close collaboration with other agencies.

They regularly participate in the Foster Carer's Induction Training and facilitated a Health Awareness Training Day focusing on the health needs of children who are in care, ensuring foster carer's have a greater awareness of the health needs of children in care and how to access health services locally. They participate in the multi-agency training facilitated by the Cheshire West and Chester IRO's which takes place four times per year across West Cheshire and Vale Royal.

The Nurse Specialists have met with representatives of Cheshire West and Chester children and young people who have LAC status via the Children in Care Council to ensure the service that is provided reflects the views and opinions of both the younger and older service users.

The challenge for the service is the increase in numbers of Children in care and specifically the numbers aged 16 plus. There is currently no provision for Care Leavers and this was highlighted as a commissioning issue in the CQC report.

3.12.4 Safeguarding Training

In addition to the safeguarding training (section of the report) all the staff in Eastway had access to the Anthony Bainbridge safeguarding Adults Training as well as the CWP training.

3.12.5 Reviews and Audits

There has been one adult Individual Management Review commissioned by the CWAC LSAB. The final report is due in July 2014

CWP continues to participate within the Practice Learning Reviews and Audits and have participated in the LSCB Case audit programme. An example of how audit can influence practice is given in box 6

Box 6 Example of audit outcomes influencing development of practice.

Three safeguarding cases within FNP have undergone a multi-agency deep dive audit within the last 12 months. The audits identified that the cases had been managed proactively and identified good and outstanding practice

.In one case and the findings were presented to the LSCB Audit and Incident Review group. This provided an opportunity to discuss the programmes methods and ethos particularly around the use of strength based approach to support engagement and behaviour change. It is evident that a strength based model is supported by the LSCB and this can be seen within policy. The team continue to advocate for this approach within the multi-agency setting and training arena. The audit highlighted the importance of motivational interviewing and "rolling with resistance" as a fundamental element of maintaining engagement with families with complex needs. The audit recommended motivational training for all disciplines alongside the use of evidenced based assessment tools to identify strengths and deficits within families.

Health Visiting Service has audited itself against the NICE guidance (NICE 45 Perinatal Mental Health). The audit demonstrated quality of service in identifying and supporting women in regards to best practice in mental health.

A quality assurance process is in place to audit the TAF assessments undertaken by Starting Well services. This audit has been strengthened following the CQC inspection to focus on capturing the voice of the child and wishes and feelings of the child.

3.12.6 Care concerns /Safeguarding Referrals

CWP Safeguarding team monitors and reviews all child protection referrals that have been made into Social Care. Table 10 highlights the number of referrals made by various services. All the referrals have been reviewed by the safeguarding nurses and were appropriate. The number of Care concerns/ Enquires raised for safeguarding adults in CWAC is detailed in Table 11. In 2012-13, there were 231 care concerns/enquiries raised, therefore there has been an increase by 39%. This may be due to a number of factors for examples:

- staff recognising and responding to care concerns following increasing awareness
- Staff reporting more to safeguarding team
- Safeguarding Team capturing the data effectively

Table 10: Number of Child Protection Referrals made to Social Care by CWP services

Service	Number of referrals
Starting well	19
Ageing well	1
CAMHS (includes In-pts)	12
Drug and Alcohol Service	3
EIT	2
Psychology	1
Liaison Psychiatry	3
Adult Mental Health	1
Total	**42**

Table 11: The number of Care concerns/enquiries made for safeguarding Adults

Service	Number of Care Concerns/ Enquires
Adult Mental Health	247
CAMHS	1
Drug and Alcohol Services	8
Learning Disabilities	52
Home intensive Team	6
Aging Well (Disrict nursing)	7
Total	**321**

3.12.7 Participation Child Protection Case Conferences

CWP Safeguarding children team receives copies of all invitations to child protection case. In total CWP have been invited to 82 initial child protection conference and 170 review child protection conferences. All Clinical staff are expected to submit written conference reports to child protection

conferences Table 12 illustrates the number of conferences reports provided by service as known by the safeguarding team.

Table 12: Number of conferences attended.

Service	Number of Conference Reports Provided April 2013-March 14	Number of Conference Reports Provided April 12-March13
Starting Well (HV, SHA, FNP)	367	378
CAMHS	2	5
Drug and Alcohol	6	21
Adult Mental Health	4	6

Box 7: Example of "exemplary standard of practice " (quote from CQC inspection report 2014 p13

The example is the work of a specialist learning disability CAMHS worker whose expertise has been highly effective in reducing the risk of harm to a young child. This is a family where care proceedings had been previously considered. Child Protection concerns are no longer an issue.

"A is a 4 year old boy with learning disabilities and health needs. His mother also has learning disabilities which were impacting on her capacity to effectively meet her children's needs. An easy read child protection plan was developed to build her understanding of what was expected of her

Through developing a range of visual cues tailored to supporting parents in developing safe routines, their capacity to meet their children's development needs has been considerably enhanced. Parents have engaged well and have been able to implement the suggested strategies for meeting their children's emotional and behavioural needs. 'House rules' were designed that reflected what the parents wanted their children to learn and understand. Their young son is now making good progress at school." (Quote from CQC report p13-14)

3.12.8 Early Support and Team Around the Family (TAF)

Over the year further work has been undertaken to strengthen the TAF process. Starting Well has TAF champions who link in with Local Authority colleagues regarding the TAF process. A quality assurance process is in place to audit the TAF assessments undertaken by Starting Well services. This audit has been strengthened following the CQC inspection to focus on capturing the voice of the child and wishes and feelings of the child.

3.12.9 Adult Case Conference

There are no known Adult Case conferences held. However staff continue to attend Strategy and Professional meetings.

3.12.10 Domestic Abuse

CWP continue to attend the MARAC meetings within the Local authority in 2013/14 attended 18 meetings

3.12.11 Safeguarding Supervision

In order to strengthen the clinical supervision within the Starting Well services for cases at level 3 on the continuum of need model, 20 staff have been trained in providing clinical supervision and in tools to assess risk. The training was based on learning from Family Nurse Partnership to ensure a transfer of skills across services. The supervisors will commence case supervision from July 2014. This supervision will be for cases that would not normally be taken to Safeguarding Supervision with the Safeguarding Team.

3.12.12 Service User Feedback

Patient user survey on the Health Visiting Service and School Nursing Service showed the accessibility of the service which supports good practice in safeguarding.

Service User involvement is an essential part of Camhs, services have service user groups, these groups have interviewed Camhs Managers re the service, they have contributed in interviews process, they are meeting with safe school partnership staff to discuss e safety. Camhs crew have presented nationally regarding camhs experience & CYIAPT. The Camhs process in choice and partnership work involves patient set goals. In Camhs CYIAPT this is facilitated by session by session feedback which influences clinical practice. Information is recorded about patient views about the therapy and therapist. This relationship is key in developing safety regarding discussing safeguarding.

TheFamily Nurse Partnership continually seek out service user feedback at key parts of their programme.

The Learning Disabilities team actively seek out service user stories to give feedback about the services which gives good insight of the experiences the service users have of the service

Service user feedback needs to be developed further to ensure that the safeguarding work undertaken by staff with children, young people, adults and their families and/carers is captured.

3.12.13 Service Developments

One of the main developments within CWP West Physical Health Services has been the development and implementation of the electronic record system EMIS. All services have now moved to using an electronic record system. The Health Visiting, Family Nurse Partnership, School Nursing and Speech and Language Therapy services within CWP Starting Well are now using EMIS as their single patient record. The system has been developed to ensure children who are either on a Child Protection Plan, Child in Need, Looked after Child or on Team around the Family are easily identified. This record is also used by CWP Safeguarding Team.

EMIS has been a key development that will improve outcomes for children and families in relation to safeguarding as it will improve timely communication between services, improved sharing of information, ability to have a full picture of care to inform decision making, collaboration and involvement with children and parents when sharing the record, efficiency of administrative processes, improved supervision of staff to support families.

CWP West have been committed to the development of the CWAC Early Support Model. This has included a secondment to the Early Support Access Team during its development and implementation. This has ensured a strong link between CWP services and the Local Authority model focused on multi-agency working. The new model has required commitment from CWP both at a project board level, implementation of weekly case management meetings, and responses to information requests from the Early Support Access Team and shaping and developing the model as it progresses. The model is focused on providing support to co-ordinate care at level 3 on the continuum of need model to prevent cases escalating to level 4 social care and also to provide a robust step down model for cases no longer requiring level 4 intervention

During 2013/ 2014 the Trust Community Services Improvement Programme (CSIP) was implemented in West services including the Chester, Ellesmere Port and the Vale Royal locality. The focus of the review was to support recovery direction in services and to further develop the single point of access and the Recovery College in West. There is now a team structure of multi-disciplinary adult teams in Chester, Ellesmere Port and Winsford and older adult teams in Chester and Vale Royal. Each of the teams is supported locally by an experienced Clinical Lead. There was service user involvement in the consultation around the review and although a number of clients did require a change of care co-ordinator the approach to staffing of services was to avoid

changes in care co-ordinators where possible. This has helped to ensure continuity of service and local practitioner awareness of any safeguarding issues.

The Learning Disability CAMHS and Youth Offending Service are now co-located with social care.. The CAMHS service have seen this as greater opportunity to share thinking around cases and offered greater communication. The Adult Single point of access has affected the 16-19 teams. It has allowed referrals to be screened, allowing opportunity for Safeguarding issues to be picked up.

3.12.14 Key Innovations and Achievements

A good example of collaboration has been the work surrounding Elective Home Education between the School Nursing Service and the Local Authority. The work has been to identify vulnerable children not in school and ensuring they get the School Nursing offer including immunisations and that they have contact with a health service. Pathways have been developed across the Local Authority to ensure the School Nursing service have an effective communication and notification of these children

Safeguarding champions have been identified in the adult mental health community teams. The role is to support their colleagues, provide information and ensuring CWP safeguarding team are aware of all safeguarding referrals/ care concerns raised. Safeguarding Champions are now being identified across all adult services.

3.13. CWP WIRRAL LOCALITY

3.13.1 Partnership

Wirral locality of CWP covers Wirral Local Authority Footprint and supports the Learning Disability Service who work within Trafford. Therefore this section will also include Trafford local authority.

In supporting partnership working the Trust participates in the various multiagency forums within the locality see Table 13.

Table 13: CWP Representation on Boards and Multiagency sub groups.

Wirral LSCB	Director of Nursing, Therapies and Patient Partnership
Wirral LSAB	Associate Director of Nursing and Therapies (Physical Health)
Learning and Development (joint) sub group	Nurse specialists for safeguarding children/adults
Serious Case Review Panel LSCB	Named Nurse for Safeguarding
Child Sexual Exploitation Operational Group	Nurse Specialist for Safeguarding Children
Staying Safe LSCB Sub Group	Named Doctor for Safeguarding Children
Audit LSAB sub group	Nurse Specialist for Adults
Policy and Procedure LSAB sub group	Named Nurse for Safeguarding
Serious Case Review Panel LSAB	Named Nurse for Safeguarding
Domestic Homicide Panel	Named Nurse for Safeguarding
Mental Capacity Act group	Mental Health Act Officer and Nurse Specialist for Safeguarding Adults

Trafford LSAB	Associate Director of Nursing and Therapies (Physical Health)

CWP is also represented at the Multi Agency Action Group. This is a group chaired by the police and includes Education, Housing Services, Social Services, Health Care Providers and Department of Work and Pensions representatives. The aim of the group is early intervention to break the cycle of offending behaviour that people find themselves caught up in.

A Consultant psychiatrist also attends the Wirral CYPD Risk Management Group which is a multi-agency group which discusses the highest risk cases known to services.

3.13.2 Safeguarding Training

In addition to the corporate safeguarding training program, workshops have been carried out for Drug and Alcohol clinical workers looking at case study examples for child protection, child in need and team around the child. It included what support is available for clients regarding safeguarding adults and children and what support is available for staff if they had any concerns regarding safeguarding children or adults as well as where to document and templates available on Carenotes.

3.13.3 Care Concerns/ Safeguarding Referrals

CWP Safeguarding team monitors and reviews all child protection referrals that have been made into Social Care. Table 14 highlights the number of referrals made by various services. All the referrals have been reviewed by the safeguarding nurses were appropriate. No child protection referrals were made by CWP service in Trafford

The number of Care concerns/ Enquires raised for safeguarding adults in Wirral is detailed in Table 15. During 2013-13 there were 190 care concerns/ enquiries received by CWP safeguarding Adult team, therefore there have been an increase of 4.8%. The practitioners in the Wirral continue to express difficulties in ensuring they are completing the safeguarding adult processes correctly due to having to enter not only on CWP system but on to the local authority system as well. Service leads are currently working together to develop a flow chart to ensure that safeguarding incidents are reported correctly and logged on appropriately on the organisational systems (DATIX/Carenotes/SWIFT).

There have been 3 enquiries received from the Service based in Trafford.

Table 14: Number of Child Protection Referrals made to Social Care by CWP services

Service	**No of referrals**
CAMHS	9
Drug and Alcohol Service	7
Liaison Psychiatry	8
Adult Mental Health	1
Total	**25**

Table 15 The number of Care concerns/enquiries made for safeguarding Adults Wirral

Service	**Number of Care Concerns/ Enquires**

Adult Mental Health	176
CAMHS	4
Drug and Alcohol	6
LD /CAMHS	13
Total	**199**

3.13.4 Participation Child Protection Case Conferences
CWP Safeguarding Team have not routinely notified of initial child protection conferences (historical). The Named Nurse for Safeguarding is discussing this with the Service manager of the Child protection unit in regards to this. The data is therefore not reliable as it is reliant on staff self reporting and is an area that has been identified as needing strengthening. However no issues have been raised by Wirral regarding non attendance at child protection conferences with the Named Nurse for Safeguarding

3.13.5 Team Around the Family
CWP staff have attended training regarding the Team Around the Family and participate in the meetings. The data collection surrounding CWP participation in TAF is being developed so assurance can be given regarding participation of CWP staff.

3.13.6 Adult Protection Case Conferences
CWP Safeguarding have not been notified of any adult safeguarding case conferences being held. CWP staff continue to attend Strategy and Professional meetings.

3.13.7 Domestic Abuse
CWP continue to attend the MARAC meetings on the Wirral. There has been 26 meetings (an increase of 6 meetings from 2012/13) covering 597 cases. Wirral saw an increase of 50% in the last quarter of MARAC cases.

3.13.8 Audit
Safeguarding audit carried out on all staff at Wirral Drug and alcohol service resulted in workshops being arranged for practitioners regarding Safeguarding practice. The workshops took place May – June 2013.

A CAMHS audit regarding the safe discharge from service was undertaken during this reporting period following a recommendation from the Serious Case Review Child G. The report is being finalised at present.

CWP practitioners participated in multiagency case audits of the LSCB and LSAB.

3.13.9 Service Developments
Wirral Drug and Alcohol service have created a family assessment template which will be used by all Wirral Drug and Alcohol key workers when assessing or reviewing clients, with a view to this template being rolled out across Drug and Alcohol trust wide. The template uses questions and prompts for key workers to ask clients re the impact of their drug and or alcohol use on family, domestic abuse and who is in the family home. The template prompts key worker to state risk and protective factors. The key worker is also prompted to document clinical reflection, decision making and actions taken.

Within Adult Mental Health, links to Targeted Preventative Services have been established with an agreement that staff working within this service can directly contact the Access Team if they have any concerns about parental mental health or need general advice and guidance on “what to do”.

Key workers in Drug and alcohol Services are flexible with where reviews are carried out to meet any child care issues, e.g. carry out home visits, meet in children’s centre. Wirral Drug and Alcohol service have a family room which has soft furnishing and toys available to make a less formal setting this is used when clients bring children into service so that the child can be occupied playing with toys. It also used when a victim of domestic abuse attends as the room is comfortable so the client can feel more at ease if staying at the service for a long time (when accessing medical treatment or refuge support). The room is also used for psychology appointments and mental health assessments where appropriate. There has been service user feedback from clients stating what they find helps them. For example,. there has been positive feed back regarding the women’s clinic as serice users state they can see key worker midwife/health visitor and sure start worker all in one clinic to avoid multiple appointments.

CAMHS has developed robust internal risk management and safeguarding procedures to improve practice, raise issues and map on to locality and Trust structures. There is a Risk Management Group which meets 6 weekly, comprising senior clinicians to oversee the implementation of risk and safeguarding policies. It reviews internal issues and reports back through Clinical Governance procedures. All Safeguarding and risk cases are risk managed and discussed at team meetings. High risk cases are discussed at a level 3 meeting held monthly with all teams to review and update plans. This needs to be developed further to ensure the Safeguarding team of CWP are routinely informed.

3.13.10 Service User Feedback (related to safeguarding)

The locality now has a link Patient Partnership Involvement representative who has an interest in safeguarding and will link into the governance structure. The locality will be recruiting to a 0.5wte involvement worker by August 2014.

Within the CAMHS service they utilise the Youth Advisory Partnership Group. The purpose of the Youth Advisory Partnership Group (YAP) is to enable Wirral CAMHS Partnership team to implement its core value of youth participation. Youth Advisor members provide a young person perspective on CAMHS Wirral policy and programme of work, they ensure young people are involved in CAMHS internal governance, they enthuse and engage Wirral‘s children and young people.

Youth Advisors will come up with their own ideas and areas of interest which will help with engagement and improve the quality of our services. As group members they will advise on the design and implementation of a range of events, campaigns and services, help to produce youth-friendly documents and resources, and provide a youth perspective for Wirral CAMHS and to debates in support of child rights and Mental Health.

Further developments of systems need to occur to gather feedback on CWP safeguarding activity with children, young people, adults and their families/ carers

3.13.11 Future Recommendations

To respond to the practitioners concerns regarding the complexity of navigating multiple systems when reporting safeguarding adult concerns. Work is underway and this needs to conclude in a timely manner.

It has been identified that a number of areas for future reporting needs to be strengthened and this will be in conjunction with the Wirral General Manager, Named Nurse for Safeguarding and local

authority (as appropriate). CWP will proactively share reviews and audits with the respective LSAB and LSCBs.

3.14 Key Objectives for 2014-15

.

- To continue to work closely with all Safeguarding Boards and align the objectives of the respective boards with those of the Trusts Safeguarding objectives

- To proactively share findings of audits and reviews with the respective safeguarding boards.

- To strengthen the Safeguarding Audit Program to include qualitative case audits covering Safeguarding Children, Safeguarding Adults and Domestic Abuse.

- To ensure the compliance rates for Safeguarding Training is continually exceeding the minimum requirement and deliver bespoke training tailored to specific staff groups/ services.

- Monitor the compliance rate of the HealthWrap Training (PREVENT) and Mental Capacity Act and take appropriate action if identified.

- Named Nurse/ Head of Safeguarding to work closely with the Mental Capacity Act Lead

- Following the publication of the updated intercollegiate document *"Safeguarding children and young people: roles and competences of health staff"* (March 2014) and "*Domestic Violence and Abuse: How health services, social care and the organisations they work with can respond effectively*" (NICE 2014), the Head of Safeguarding will review the training, job descriptions, safeguarding children and safeguarding adult policy and highlight any recommendations for the Trust.

- Undertake Staff / Agency feedback on the Safeguarding team of CWP.

- To undertake a review of the Safeguarding Department

- Future safeguarding reports to Board to be made available in Easy to read format

- To explore sytems and process for gaining feedback from children, adults and their families/carers on CWP safeguarding input into their care.

- To respond to the recommendations/actions identified in each of the localities

4.0 Conclusion

CWP has worked in partnership with each local LSAB and LSCB and other partners to improve the safeguarding element of the services it provides, and to ensure compliance with the statutory responsibilities of the Trust. Each locality has provided evidence of how this has been undertaken during 2013/14

This report has detailed how the Trust has fulfilled its duty to ensure its functions are discharged with regard to the need to safeguard and promote the well-being of children and young people in line with Section 11 of the Children Act 2004 and Working Together to Safeguard Children (HM Government, 2013). In relation to Children in Care, the report has focused on how the Trust has met its duties and responsibilities as outlined in the Statutory Guidance on Promoting the Health of Looked After Children (DCSF, 2009). For Safeguarding Adults, the report focused on how the Trust mets the standards set by Care Quality Commission for Safeguarding during 2013/14.

5.0 Reccommendations

The Board are asked to approve the Report on Safeguarding Adults and Children (including Children in Care)and to note the work of the Safeguarding team and the three localities.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference: 2014/15/30)

Report to:	**Board of Directors**
Date of Meeting:	**30th July 2014**
Title of Report:	**Medicines Management Annual Report for 2013/14**
Action sought:	**FOR NOTING & APPROVAL**
Author:	**Mrs Fiona Couper, Chief Pharmacist & Associate Director for Medicines Management.**
Presented by:	**Dr A. Sivananthan, Medical Director**

Strategic Objective(s) that this report covers

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

Distribution

Version	Name(s)/Group(s)	Date Issued
1	MMG	12th June 2014
1	Patient Safety & effectiveness Sub-Committee Dr A. Sivananthan	19th June 2014
3	Louise Hulme for Board of Directors	30th July 2014

Executive director sign-off

Executive director (name and title)	Date signed-off
Dr. A. Sivananthan, Medical Director	17th July 2014

1. PURPOSE OF THE REPORT

It is a statutory obligation to give an annual report to the Trust on the activities of the Medicines Management Group (MMG). This report meets the core standards set by the Care Quality Commission (CQC) for the management of medicines which are monitored under outcome 9 of the Trust's quality and risk profile.

This report covers the year April 2013 – March 2014 inclusive.

The Board of Directors are asked to approve the annual report.

2. SUMMARY

This report details the activity and progress that have been made by the Medicines Management Group (MMG) against the group's annual business cycle. In particular it focuses on the following areas of responsibility of the group:

a. Formulary adherence and new medicines
b. NICE Technology appraisals and guidance
c. Response to NPSA alerts and other external standards
d. Medication incident reporting
e. Policies/guidelines approved in medicines management
f. Duties of the Accountable Officer for controlled drugs
g. Non-medical prescribing
h. Education and training in medicines management
i. Clinical audit and research
j. Medicines management strategy
k. Pharmacy service
l. Infection, prevention and control
m. Emergency planning

3. SUBJECT MATTER

The Medicines Management Group (MMG) is multidisciplinary with members from across the organisation including service user representation and representatives from each of the Clinical Commissioning Groups that commission our services as well commissioning support unit medicines management team representatives.

As per the integrated governance structure, the Medicines Management Group report to the Patient Safety and Effectiveness Sub-Committee (PSESC). Any significant areas of risk with regard to medicines management are elevated to the PSESC and if necessary to the Quality Committee. By the Group reporting on a regular basis through the integrated governance structures we are assuring the Board that we are implementing the medicines management strategy, working to the care quality commission standards for medicines management and to the agreed business cycle in ensuring the use of evidence based medicines for our service users.

4. DISCUSSION – Developments and progress against the business cycle

The Group has met eleven times over the 12 months of 2013 -14. Meetings have been held in the Trust Board offices and Sycamore House. The new MMG meeting format appears to have been successful since its implementation in June 2012. In that the internal meetings are more productive in discussing pertinent issues around why incidents with medicines are happening and exploring solutions to address such. Sharing good practice across the localities has also been a strong feature of the new format. The interface meetings have not been as well attended by CWP representatives which has resulted in some meetings not being quorate. In light of this a further review of membership has taken place latterly which will be implemented in quarter 1 of 2014-15. Dr Faouzi Alam stood down as chair of the meetings in December due to him taking up the post of medical director and was succeed by Dr Sarah Proctor in January 2014.

The key developments over the last 12 months are detailed in the following sub-sections.

4.1 Formularies

The CWP Mental Health medicines formulary was launched in March 2013. In line with the recommendation from NICE the formulary is accessible from the Trust public facing website: http://www.cwp.nhs.uk/

The formulary is a reference guide that highlights the formulary decisions approved by the CWP Medicines Management Group in conjunction with Primary Care. Medicine selection is based on evidence of efficacy and adverse effect profile, and prudent considerations around acquisition cost. The formulary is intended to promote rational prescribing of cost effective medicines in recognition of limited resources. The clinical evidence reviewed in reaching these decisions is based on research studies published in reputable journals, national clinical guidelines and technology appraisals from NICE (National Institute for Health and Care Excellence) and SMC (Scottish Medicines Consortium), and professional body guidelines. The review of the mental health formulary is a dynamic process and the contents are updated in line with any new drug review decisions undertaken within CWP and any technology appraisals from NICE. The policy for new drug applications has been revised and approved by the MMG and is contained within Medicines policy (MP6) - Introduction of New psychotropic medicines and non-formulary named-patient requests.

Physical health medicines are prescribed within the Trust in line with our local Acute Trusts and Clinical Commissioning Group formularies – East and Central Cheshire, Western Cheshire and Wirral commissioning groups.

CWP in-patient antimicrobial prescribing is in line with our adopted formulary from Wirral Clinical Commissioning Group. The current antibiotic formulary published in 2012 is not going to be updated as the Wirral Clinical Commissioning Group are in discussions on adopting an alternative formulary. The CWP pharmacy department and Infection Prevention and Control (IPC) team are actively reviewing and proactively discussing options for a change of formulary in this eventuality.

Prescribing of antimicrobial medicines within community care physical health services Western Cheshire is directed by the antimicrobial formulary approved between Western Cheshire Clinical Commissioning Group and CWP.

4.2 Formulary adherence and new medicines

As the NHS in England goes through a reorganisation and financial constraints, medicines optimisation is paramount. With this in mind, all new medicines with a higher acquisition cost, and possibly limited additional benefits compared to existing therapies have to be considered very carefully by the Medicines Management Group to ensure the local health economy is getting value for money from the medicines chosen.

The Horizon scanning paper of new medicines was presented to the MMG in November 2013 for the years 2014-16. This paper highlighted new medicines coming on the market, those that have a change or extension of indications, medications with patents that have expired or are due to expire within the year.

The Horizon scanning paper highlights the possible impact of new mental health medicines, some of these medicines are proactively reviewed by the pharmacy medicines management mini-team and presented to the MMG. The MMG also reviews all applications for new medicines/new formulations/indications as they come through from clinicians. The latter process has been updated and can be reviewed in the medicines policy (MP6).

New medicines usually have a high cost of acquisition; therefore the Horizon scanning paper takes into consideration the potential impact of these on the Trust and the local health economy as well as looking at medicines which will become available generically and therefore could potentially reduce the cost of prescribing.

The table below illustrates decisions that have been made regarding applications for medicines:

Table 1

Medicine	Indication	Decision of MMG
Paliperidone palmitate	Antipsychotic depot injection indicated for maintenance in schizophrenia in patients responsive to risperidone.	Non-formulary within CWP. (If risperidone Long Acting Injection is requested from the MMG and the request is approved then the MMG recommendation would be for paliperidone palmitate to be initiated).
Lisdexamfetamine dimesylate	CNS stimulant indicated for refractory attention deficit hyperactivity disorder (ADHD) in children aged 6 years of age refractory to methylphenidate (under specialist supervision)	Lisdexamfetamine was approved for use across CWP only (**Red drug**). Treatment pathway to be updated regarding positioning of lisdexamfetamine. When more experience is gained, shared care will be discussed with the respective CCG's.

CWP antipsychotic policy (MP22) was launched in January 2012 and is currently being updated. It sets out first line choices of antipsychotics in psychosis. (Note: The policy does not cover bipolar affective disorder). High cost antipsychotic therapy with no superior evidence for use in psychosis have been restricted to non-formulary status and this has had a positive and sustained impact with regards to budget pressures without impacting adversely on patient care, particularly in relation to risperidone long-acting injection.

Quetiapine modified release is non-formulary for both psychosis and bipolar affective disorder. Immediate release quetiapine is an appropriate formulary choice in bipolar affective disorder.

CWP antipsychotics policy (MP24) for antipsychotic choices in bipolar affective disorder was ratified in February 2014 by the MMG. High cost antipsychotic therapy with no superior evidence for use in bipolar affective disorder has been restricted to non-formulary status.

Formulary adherence in the in-patient setting is continually being monitored with our preferred pharmacy supplier using the agreed list of non-formulary medicines and the CWP clinical pharmacy team. CWP has set up an algorithm to identify non-formulary medicines that are requested on prescriptions for dispensing. All non-formulary medicines are not dispensed until they have been checked by the ward pharmacist for a rationale for the prescription. This has importantly stopped a number of non-formulary medicines from being supplied.

In addition to monitoring inpatient adherence to the formulary, the pharmacy team review reports on outpatient prescribing from FP10 (outpatient) prescriptions. The information gleaned from these reports is shared with General Managers and Clinical Directors to monitor adherence with the Trust formulary. This information is also used to inform the locality service performance reviews.

4.3 Named patient/non-formulary requests

There have been several requests during the year for non-formulary medicines. All requests are summarised in the graphs below. These are divided into general non-formulary requests and antipsychotic non-formulary requests. Overall there have been 15 general requests of which 10 were approved. The majority of the requests were for Elvanse (Lesdexamfetamine) which was a new medicine that was licensed in the UK last year for Attention Deficit Hyperactivity Disorder. This is discussed in section 4.2

Due to the advent of the Antipsychotic Policy (MP22) the Pharmacy team monitor requests for the non-formulary antipsychotics and those being requested for off-label indications as a separate database. During the year we have had 60 requests for the non-formulary antipsychotics: aripiprazole, risperidone long-acting injection (LAI), olanzapine pamoate LAI, palperidone LAI and quetiapine of which 43 of them have been approved. Overall there has been a reduction in the use of these three agents since the policy was implemented for psychosis and by the year end we had also maintained reduction of the legacy prescribing of risperidone LAI. There were 4 other requests for antipsychotics for off label indications of which 2 were approved.

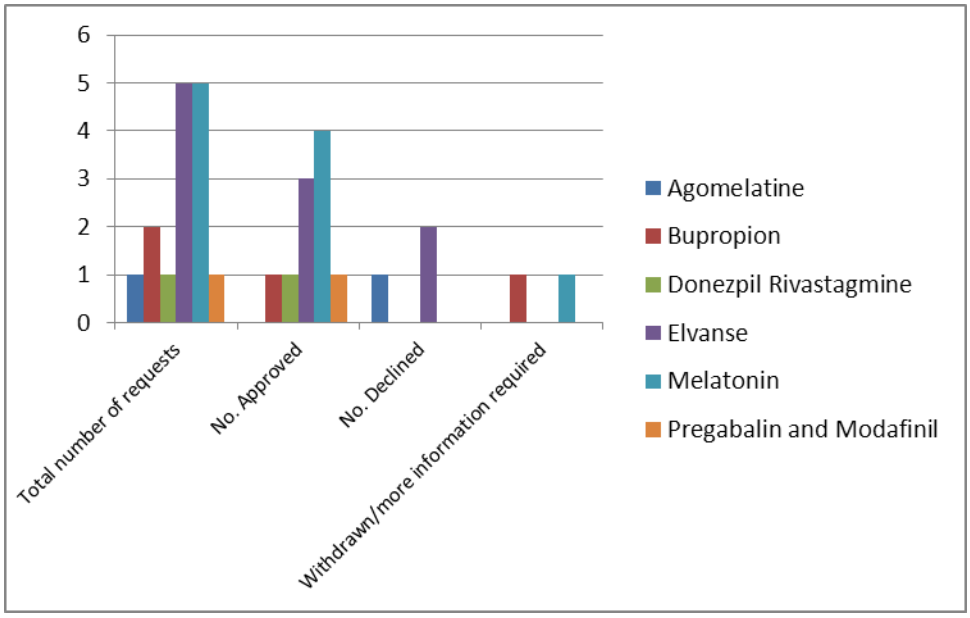
In all approved cases the MMG request feedback from the consultant prescriber on progress with the treatment every three months so that MMG can be reassured that the treatment continues to be beneficial to patient care. The named patient spreadsheet is updated regularly so that the MMG can track progress with these treatments.

General Named Patient Requests - Table 2

General Named Patient Requests 2013/4

	Total number of requests	No. Approved	No. Declined	Withdrawn/more information required
Agomelatine	1	0	1	0
Buproprion	2	1	0	1
Donepezil and Rivastigmine	1	1	0	0
Lisdexamfetamine	5	3	2	0
Melatonin	5	4	0	1
Pregabalin and Modafinil	1	1	0	0
Total	**15**	**10**	**3**	**2**

General Named Patient Requests - Graph 1

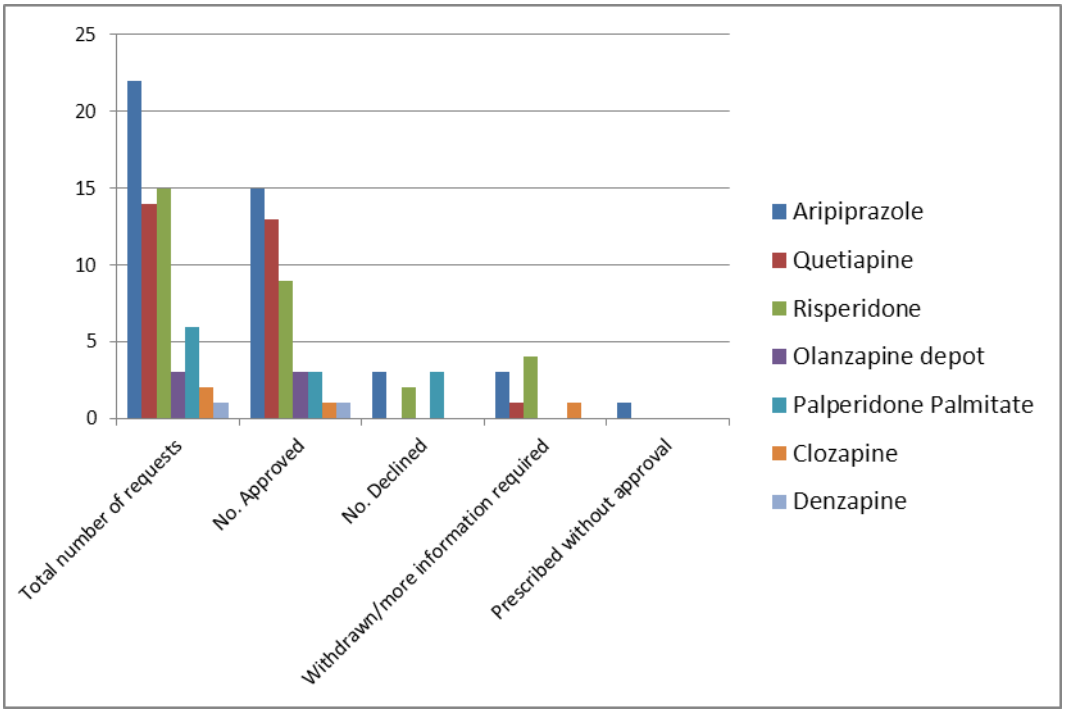


Antipsychotic Named Patient Requests – Table 3

Antipsychotic Named Patient Requests

	Total number of requests	No. Approved	No. Declined	Withdrawn/more information required	Prescribed without approval
Aripiprazole	22	15	3	3	1
Quetiapine	14	13	0	1	0
Risperidone	15	9	2	4	0
Olanzapine LAI	3	3	0	0	0
Palperidone LAI	6	3	3	0	0
Clozapine	2	1	0	1	0
Denzapine	1	1	0	0	0
Total	63	45	8	9	1

Antipsychotic Named Patient Requests – Graph 2



4.4 Product Updates

The Medicines Management Group receives updates at each meeting. The Group received in total, 60 product updates throughout the course of the meetings. The report details changes in product formulations, updates of undesirable effects, interaction with other medicinal products, special warnings and precautions for use, contraindications and supply problems for products relevant to prescribing within CWP.

In addition, a communication bulletin was circulated highlighting on-going supply problems with hyoscine hydrobromide tablets and mirtazapine 45mg tablets and advised on alternative preparations. Other disseminated bulletins provided details on new drug interactions with the cholesterol lowering medicine simvastatin and risks of impulsive disorders with some medicines used in Parkinson's disease.

4.5 NICE Clinical Guidelines/Technology Appraisals

The Group looks at the medicine component of any technology appraisals (TAs) and clinical guidelines (CG) applicable to our service users/carers. This is brought to the Group by the Research and Effectiveness Manager. In line with the work plan all the medicine components of NICE Clinical Guidelines (CG) and Appraisals (TA) are rated using the red/amber/green system and are reviewed at each meeting. There are currently 17 TAs applicable (end of March 2014) to CWP, all of these are rated as 'Green'. There have been 2 CGs over the last 12 months which have been reviewed for medicines components these are CG159 Social Anxiety Disorder and CG160 Feverish illness in

children. Current work includes the development of pathways for our electronic patient record integrating NICE standards.

4.6 Incident Reporting of Medication Errors

Graph 3 below illustrates the number of reported medicine-related incidents over the last 12 months broken down by severity. The majority of the incidents fall into category E, and there was one category A and one category B incident in trimester 3.

Graph 3

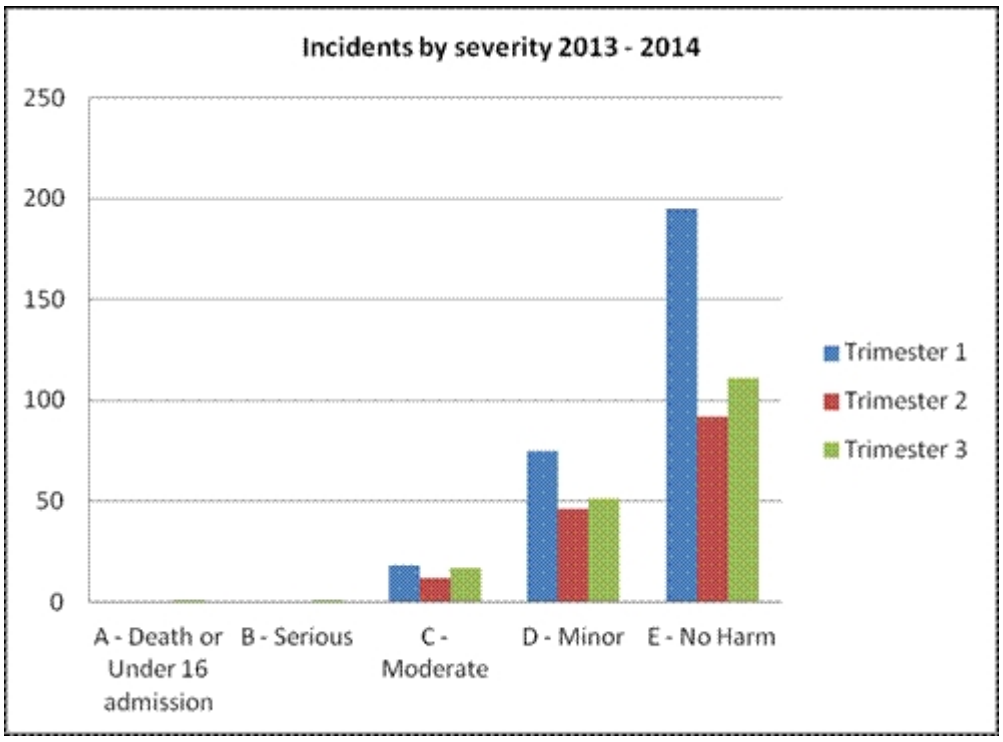


Table 4 below shows the context of this year's medication related incidents, with the previous five years of data. It can be seen that the total number of reported incidents is greater than in previous years. However most cause no harm. A likely explanation for this is the increased awareness to report incidents and the vigilance of staff in carrying this out. CWP encourages staff to report incidents

It is the aim that over time the severity of the incidents should decrease provided we have robust medicines management systems in place across the Trust. This data indicates that we have achieved this goal, given the substantial number of category E incidents, particularly in the context of the categories

.

Table 4

Medication incidents by severity for the years 2008-2014

Year/severity	A	B	C	D	E	Total
2008/9		2	33	103	19	157
2009/10		5	79	272	117	473
2010/11		0	135	253	105	493
2011/12		1	113	216	146	476
2012/13		2	76	173	159	410
2013/14	1	1	47	184	433	666
Totals	1	11	483	1201	979	2675

4.7 Policies/guidelines/patient group directions/leaflets approved for use within the Trust

4.7.1 The following policies/guidelines have been approved and implemented Trustwide

- MP06 – Introduction of New psychotropic medicines and non-formulary named-patient requests – February 2014
- MP10 – Rapid Tranquilisation Policy – February 2014
- MP11 Procedure for the supply of specified medicines to adults after assessment by the psychiatrist for the home treatment teams - September 2013
- MP14 Nicotine Replacement Therapy - September 13.
- MP16 Non-Medical Prescribing Policy - April 2013
- MP23 Alcohol withdrawal management in the inpatient setting - April 2013
- MP24 - Policy for prescribing antipsychotic medication in Bipolar Disorder – February 2014
- Guidance for the Management of Community Opiate Detoxification - September 2013

The Medicines Management Group (MMG) has a process of reviewing the suite of Trustwide medicine policies at each meeting as part of the business cycle to ensure that each policy is reviewed prior to expiry. The default review time frame is now five years for all policies, some medication related policies will be reviewed earlier to take account of any changes in clinical practice.

4.7.2 Patient Group Directions

The following patient group directions have been reviewed and approved for use within the services below:

- Trustwide – two PGDs written by Cheshire and Wirral Commissioning Support Unit were adopted for use within CWP to facilitate the annual influenza immunisation programme and a new programme for immunisation against shingles in people aged 70 and over.
    - Seasonal flu vaccine (revised PGD)
    - Zostavax® (shingles) vaccine (new PGD)

- Occupational health
    - Hepatitis B vaccine (revised)
    - MMR vaccine (revised)
    - Typhoid vaccine (revised)
    - BCG vaccine (revised)

- Drug and Alcohol Services
    - Paracetamol (new)
- CWP West Physical Health
    - Revaxis® (diphtheria/tetanus and inactivated polio) vaccine (revised)
    - Pneumovax II® vaccine (new)
    - Meningococcal C vaccine (revised)

Work is currently underway updating the Trust's PGD policy in line with NICE medicine practice guidelines and PGD competency frameworks that were published in August 2013 and January 2014 respectively. The intention is also to combine PGDs where the same medicine/vaccine is used across services rather than having a PGD for each service. This process will be gradually implemented as PGDs come up for renewal.

4.7.3 Patient Information Leaflets

In 2013/14 the MMG approved a clonidine leaflet for CAMHS. The background to developing this leaflet was the one available from the choice and medication website did not cover all the indications the medication can be prescribed for. The audience for this leaflet are parents of the children clonidine has been prescribed to.

A sleep hygiene information leaflet for healthcare professionals was approved by the MMG. This leaflet would form part of an intervention for a clinical/health professional to discuss with patients. This leaflet was developed in response to a request from primary care to support sleep hygiene discussions with patients.

A leaflet on swapping and stopping temazepam was also developed and approved by the MMG. The leaflet was produced to support primary care with an evidenced based tool for reviewing the medication and furthermore in response to the increased acquisition cost of the temazepam compared to other hypnotic medication. The leaflet also supports the national agenda for a reduction in hypnotic prescribing.

There have been intermittent supply issues with trazodone across the health economy, therefore the MMG produced a healthcare professional leaflet to support primary care with guidance on switching to alternative antidepressants and included within the leaflet was signposting guidance for the management of anxiety produced by the National Institute for Health and Care Excellence.

MMG also approved a patient information leaflet regarding switching from quetiapine modified release to immediate release tablets. This was to support primary care and our community mental health teams in using the most cost-effective formulation of quetiapine.

4.8 Clinical governance and external standards

4.8.1 Care Quality Commission (CQC)

In terms of assurances, the Trust meets the CQC standards for medicines management under Outcome 9. The Trust has registered all clinical services with the Care Quality Commission, with no conditions placed on its registration. The Trust continues to monitor compliance with policies in

relation to medicines management via the annual audit programme and via review of incidents, as outlined in the relevant sections of this annual report.

2013 National Community Mental Health Patient Survey: Results for medicines related questions continue to be better than the national average. No significant negative changes were noted by CQC but the survey results highlighted two areas for improvement. The first; only half of the respondents were 'definitely' given information about medication in a way they could understand and the second; almost a quarter of people responding had not had their medication reviewed in the past 12 months. MMG is working to ensure that provision of information and review of treatment are embedded into treatment pathways. This is being carried out through input into the medicine element of pathways that are being uploaded on CareNotes Assist.

CQC visits: One CQC visit during 2013/14 assessed outcome 9 medicines management (Greenways March 2014). CQC were satisfied with all standards assessed around the safe storage, administration and recording of medicines.

Internal assurance: Outcome 9 has been assessed as part of the trust's programme of unannounced visits to the wards and a pharmacist has been present for the majority of those visits. Any medicines management issues raised have been added to the ward manager's action plan and the progress on the actions monitored by MMG.

4.8.2 National Patient Safety Agency (NPSA)

The NPSA patient safety functions were transferred to NHS England in June 2012 and MMG has continued to monitor compliance with actions in previous NPSA alerts.

In addition the following patient safety alert relevant to CWP has been issued in 2013/14:

- Patient safety alert to improve reporting and learning of medication and medical devices incidents

This patient safety directive has been issued to ensure that all healthcare organisations have systems in place to disseminate learning from incidents and actions to prevent recurrence, that specific members and groups of staff are allocated time to do this and that good practice is shared nationally as well as locally. This is a high priority for the trust and MMG in 2014/15 as the actions need to be completed by September 2014.

4.9 Accountable Officer for Controlled Drugs

The Accountable officer for controlled drugs is the chief pharmacist and as such is a member of the Cheshire, Wirral and Warrington local intelligence network of accountable officers. In line with the NHS England changes from April 2013 the local intelligence network changed such that it mirrored the local area teams. The new network has taken time to embed over the last 12 months due to the size of the geography it covers. The overarching controlled drug accountable officer for the local network is Dr Kieran Murphy, the medical director of the local area team. This network now meets six monthly and the Trust accountable officer provides an occurrence report for each quarter on the controlled drug incidents that have been reported within CWP along with giving assurance that controlled drugs are monitored throughout the Trust in accordance with the Care Quality Commission standards for controlled drugs. The Accountable officer provides two six monthly reports to the MMG on the management of controlled drugs within CWP, the reports for 2013-14 have been approved at MMG. All concerns raised in the reports are minor and relate to standards of practice which are addressed at the time of reporting.

4.10 Pharmacy Services

The clinical pharmacy team have worked hard over the last 12 months, delivering a patient focussed clinical service,. The majority of the team's time is spent in the inpatient settings and in particular on the acute care wards where they strive to ensure all new admissions have their medicines reconciled within 24hours of admission on a weekday and within 72hours on a weekend. The summary of the audit on this demonstrates the effectiveness of this service. The team has continued to support service users in the community setting particularly those with complex needs around medication. The reduction of medicines waste through assessment for ongoing use of medicines on admission has continued and stock control of medicines on the inpatient units is tightly managed by the pharmacy technicians.

From a trustwide perspective, the team have updated medicine policies and reviewed and updated the medicines formulary for mental health. This went live on the internet in March 2013 and the team have continued to assess new medicines and their place within therapy for the Trust. In terms of medicines governance; we have supported clinical service units around the adherence to outcome 9 standards for medicines management by helping to formulate actions from the inpatient safety metrics, learning from unannounced visits and learning from medicine incidents. The team works by dividing its time between front line facing patient requirements and back office clinical support functions.

The quality outcomes of having a pharmacy team are shared quarterly as part of the Trust Quality Report. Over the year some of the outcomes that have featured in the report are around delivering multiple sessions to service users and carers on medication, training and education sessions for clinical staff beyond the e-learning modules on medicines management, as well as external training the team have delivered to the local universities. The team continues to produce the medicines management newsletter which is circulated to staff via the CWP weekly briefing and is on the team's intranet page as well as medicine alerts and medicine communication bulletins to staff via the communications team alerting staff to any pertinent issues about medicines.

The team have continued to work diligently with our preferred supplier of medicines, Lloydspharmacy, over the last 12 months. This has been a difficult year in this area due to the unexpected outcome of the tendering process for ongoing supply of medicines to CWP. We have now re-entered into the tendering process and it is hoped that we will have an outcome to take to the Board of Directors in July. In the meantime we have agreed an extension to the contract with Lloydspharmacy until early January 2015. In terms of notable dispensing incidents; CWP are working with Lloydspharmacy to reduce errors in medicine supply.

2013/14 was once again a successful year for the Pharmacy Team. One of the Lead Pharmacists completed the NHS Leadership Academy's flagship Clinical Leadership Fellowship programme, obtaining a postgraduate certificate in Leadership and Service Improvement from the University of Manchester. Another Lead Pharmacist has recently embarked on another NHS Leadership Academy course – the Mary Seacole programme, which will lead to a similar postgraduate qualification. The Senior Pharmacy Technician graduated in the Chartered Institute of Management (CMI) Level 5 Diploma in Management and Leadership.

A senior pharmacist has contributed to the Centre for Postgraduate Pharmacy Education (CPPE) design day for depression as a subject expert and represented mental health pharmacy at the Royal Pharmaceutical Society (RPS) working group for the Schizophrenia Medicines Optimisation Briefing. The Royal College of Psychiatrists has reported on parity of esteem and the recommendations need to be taken into account when services are commissioned. A senior pharmacist prepared to the lead a discussion group about parity of esteem at the Clinical Pharmacy Congress in London and provided an article about parity of esteem for the congress newsletter.

Extremely positive feedback was received by the team for training delivered on the MRCPsych course at Liverpool University, as well as education sessions with service users through the Recovery

Colleges. Further, one of our pharmacists organised and helped deliver the neurology and psychiatry clinical pharmacy diploma weekend for John Moores University, receiving extremely positive feedback on its content and presentation.

A pharmacist and technician are now integrated into CWP West physical health and community services team, and have recently provided help and support to the Out of Hours service in preparation for their CQC inspection.

4.11 Staff Training in Medicines Management/External Training Delivered

The pharmacy team have engaged with the changes that were made to Mandatory Education and Learning (MEL) that were introduced on the 1st January 2014. We produced the new generic medicines management eLearning package and are working with interested parties on developing the prescriber and occupational health packages.

Pilot work has been undertaken in West, where thirty minute talks on specific topics related to medicine incidents have been delivered on the wards at Bowmere. By facilitating 3-4 talks on a weekly basis, attendance has been good. Lithium and anticoagulants have been covered so far, with diabetes a future topic. The intention is to roll out this ad hoc training to the other localities.

A recent development in the Trust has been the introduction of Recovery Colleges. The pharmacy team have delivered several sessions around the theme of 'getting the most from my medicines'. The pharmacy team continues to speak at various evening meetings for groups throughout Cheshire and Wirral, such as Making Space and Bipolar UK, in order to provide information about medicines to both patients and carers.

Education CWP introduced a medical terminology workshop to their portfolio of courses, in 2013. The pharmacy team have been integral in delivering a large part of the content, and have received very positive feedback.

Once again, the pharmacy team supported 10 pre-registration pharmacists from neighbouring acute trusts, for week long placements. Excellent feedback was received by the teams in all three localities. The team also gave lectures regarding mental health illnesses and their treatments at the pre-registration study day.

In February 2014, Liverpool John Moore's University invited the Pharmacy Department at CWP back for a fourth time to deliver a Psychiatry and Neurology weekend as part of their Postgraduate Diploma in Clinical Pharmacy. One of our Senior Clinical Pharmacists organised and led the weekend, and invited a consultant from CWP and specialist pharmacists from other trusts as guest speakers to diversify the weekend. A service user and carer from CWP gave their perspective and experiences of mental health as the final session, and this proved a very popular, informative and interactive finale for the weekend. Once again, student feedback from those attending the weekend was extremely positive, indicating it was well organised and relevant to their course and practice as pharmacists.

As in previous years, the pharmacy team provided psychopharmacology education to junior doctors on the MRCPsych course organised by Liverpool University. This covered antipsychotics, antidepressants and mood stabilisers. Feedback indicated the lecture material and facilitators were of the highest quality.

The Trust went smoke-free in February 2014. The pharmacy team contributed greatly to this initiative in several ways, such as leading on the review of the Nicotine Replacement Therapy (NRT) policy, ensuring appropriate NRT was stocked on the inpatient wards and presenting at the locality and trustwide nicotine management events for trust staff.

4.12 Non-Medical Prescribing

CWP employs 130 non-medical prescribers (NMPs) of which 23 are independent prescribers and 90 are community practitioner nurse prescribers across physical health services in West Cheshire. 17 are independent prescribers working across mental health in CAMHS, memory clinic, early intervention, home treatment and drug and alcohol services. There were 17 new prescribers registered with the NHS prescribing services for CWP in 2013/14. To support non-medical prescribing in physical health services CWP has two forums: the community practitioner nurse prescribers and independent prescribers which meet on a bimonthly basis. The groups consider professional issues in prescribing and also have guest speakers on a variety of subjects including; dermatology, chronic oedema, inhaler devices, lipid guidelines, the antibiotic formulary and the launch of the heart failure guidelines. Mental health services NMPs meet at least twice yearly as a small forum. Establishment of joint forums is under discussion such that shared learning across mental and physical health can be achieved.

Over the year non-medical prescribers in physical health services have prescribed a total of 1609 items across a variety of medicines with a total cost of £11,965 (table 5 below).

Table 5

Medication type	% of cost	% items
Antibiotics	21	31
Contraception	2	2
Skin care, wounds and urology	66	48
Respiratory	2	2
Laxatives	1	1
Steroids	1	3
Analgesics	1	5
Other	6	8

All CWP non-medical prescribers were invited to the NMP conference at Cheshire View on 25 November 2013. The Conference was well attended by both physical and mental health clinicians and had speakers from HEIs, Yellow Card Centre North West, Cheshire & Merseyside Commissioning Support Unit and Infection Control.

The impact of NMP's continues to contribute to the delivery of the overall vision of CWP '*Leading in partnership to improve health and well-being by providing high quality care'*, with the adoption of the 6Cs forming the Trust's values. Therefore, staff showing care, compassion, courage, communication, competence and commitment demonstrate 'how' we will achieve our vision.

4.13 Research and Audit

An update is provided at each MMG meeting of research recently approved and all research ongoing in the Trust both Portfolio Research and Non-portfolio research. Clinical Trials of an Investigational Medicinal Product (CTIMP) are notified to the MMG as soon as possible. Currently we have one CTIMP trial. This is the ATLAS trial which is to determine whether amisulpride (an antipsychotic) is superior to placebo in the treatment of very late-onset schizophrenia-like psychosis as measured by significant differences between amisulpride and placebo treated groups. We have an informal arrangement with Royal Liverpool and Broadgreen University Hospital NHS Trust to provide research pharmacy services for CWP.

4.13.1 Clinical Audits on medicines

The medicines management audit took place in June 2013 and includes responses from inpatient wards in all localities. Participation by CMHTs improved compared to 2012 and all localities were represented. Overall adherence to the storage and security requirements of the Medicines Policy (MP1) was maintained or improved upon across inpatient wards and community teams in mental and physical health.

There was a marked improvement in awareness of the location of the NPSA alerts folders in the community. Evidencing dissemination of the information could be improved further.

As in 2012, the audit demonstrated compliance with advising inpatients on changes in medication and documenting this in the clinical notes. Documentation is better for inpatients than community patients.. Improvement is needed in evidencing that side effects of medicines are monitored and that advice is given about potential side effects and how they are managed.

Compliance with inpatient medication chart standards had improved from previous years with improvement particularly evident in prescribing as per MP1 which had increased from 89% to 98% compliance. There was also considerable improvement in the responses to questions about omitted and delayed medicines. Rapid tranquilisation guidelines were in place on all relevant inpatient wards but not all of the 7 patients audited received all the recommended interventions. The rapid tranquillisation guidelines will be audited separately in future as the sample size is too small with an annual snapshot. All learning points from the audit were incorporated into an action plan which is monitored by MMG and the next audit will take place in October 2014.

The antibiotic audit was conducted quarterly in 2012/13 in both physical and mental health services. The detail regarding these audits is covered extensively in the infection control sub-section 4.14.

A quarterly controlled drugs audit is conducted on compliance with the controlled drug regulations in all inpatient units and reported through the Accountable Officer's network. This allows CWP to give assurance to the CQC that only authorised staff order controlled drugs, that all balances are correct and that the controlled drugs are stored and documented appropriately.

An audit of MP18 High dose antipsychotic therapy guideline was conducted in December 2013 on inpatient wards. This guideline requires prescribers to identify those patients receiving high dose antipsychotic therapy and provide details of monitoring requirements to ensure patient safety. Fifteen patients were identified as being on high dose antipsychotics. Evidence of on-going physical health monitoring was found for 12 patients but the monitoring forms specified by the policy were only in use for 4 patients. This is the first time this policy has been audited; although overall practice in prescribing was good awareness of and adherence to the policy was not. Actions to improve this and also to improve electronic access to the monitoring form were agreed by MMG and the audit will be repeated annually.

In January/February 2014 the pharmacy team hosted two fourth year Liverpool John Moores University pharmacy undergraduates on 6 week placements to complete audit work. They worked alongside the team to complete two separate audits; one focusing on compliance with CWP's antipsychotic prescribing policy and the other, a collection of baseline data measuring CWP clinical pharmacy standards.

The antipsychotic audit, a repeat from the previous year, demonstrated continued compliance with our policy maintaining a high percentage of prescribing of formulary antipsychotic choices (88% for in-patients and 76% for out-patients). In addition, of the remaining antipsychotics prescribed that were deemed non-formulary, only 5% of these were initiated after the policy was introduced in January

2012, with the remainder commenced prior to policy implementation, thus showing adherence to the policy.

The clinical pharmacy standards audit looked at the level of prescription chart review for in-patients, the documentation on discharge prescriptions of reasons for stopping medicines during admission as a communication tool to GPs and the level of patient education received when new medicines are started in hospital. The pharmacy standards audit revealed that 90% of in-patient prescriptions were reviewed on a daily or weekly basis as defined within our standards. Reasons for discontinuing medicines on discharge prescriptions was documented on 93% of prescriptions where a change had been written; and 77% of patients started on new medicines during their admission received patient education from either pharmacy or ward staff.

4.13.2 Prescribing Observatory for Mental Health (POMH UK)

CWP joined the Prescribing Observatory for Mental Health (POMH UK)[1] in April 2010. This was to enable the Trust to participate in national benchmarking of prescribing in mental health. During 2013/14 the following audits were conducted:

- Lithium monitoring (reaudit). Pre-treatment and ongoing monitoring was audited against national standards for patients on lithium monitored by CWP. There were improvements in

  baseline health checks and ongoing monitoring since the original audit but a reduction in the number of patients given advice about potential side effects and signs of toxicity(from 90% in 2011 to 78% in 2013). This is addressed in the action plan by inclusion in consultant appraisals and by training sessions for community mental health teams
- Prescribing for ADHD in children, adolescents and adults (baseline). This new audit for 2013 looked at the pre-treatment assessment and ongoing monitoring for patients prescribed medicines for ADHD. CAMHS services participated and showed consistent high standards for baseline assessments and health checks and for monitoring of height and weight. Areas highlighted for improvement include assessment of risk of substance misuse, annual review using standardised assessment tool and use of centile charts to ensure measurements of pulse and blood pressure are correct for the age and size of the patient. Copies of charts and assessments have been shared between the teams to ensure that standards are consistent throughout CWP.
- Data has also been collected for two further audit topics during 2013/14- ‘Prescribing of anti-dementia drugs’ and ‘Prescribing of antipsychotics in children and adolescents’. The reports for these audits are not available from POMH at the time of writing so they will be included in the 2014/15 summary.

4.13.3 Medicines reconciliation audit

An annual audit of the Medicines Reconciliation Policy, MP19, Was carried out in September 2013. In 2011 and 2012 100% of patients admitted to the Trust received medicines reconciliation, this reduced slightly to 99% in this audit, with 85 of the 86 admissions receiving medicines reconciliation. The service user who did not have any record of medicines reconciliation was an out of area patient who was not registered with a GP. Medicines reconciliation was done within 24 hours (72 hours at weekends) in 91% of cases and using more than one source of information as recommended by the NICE/NPSA guidelines in 92% of cases.

4.13.4 Patients own drugs (POD) Audit

The POD audit was successfully completed in April 2013. Although the initial savings look slightly lower than previous audits, the amount of admissions seen by the clinical pharmacy team remained constant throughout the trust. We redesigned the form to capture any admissions from our acute trusts. There were very few of these that brought PODs in and those that did were in blisterpack form, and as such

were unsuitable for use. Despite this the clinical pharmacy team managed to save £1388.50 just by assessing PODs. The combined cost savings for the 3 audited months currently stands at £5,852.

4.14 Links with infection, prevention and control (IPC) sub-committee

A senior clinical pharmacist attends the infection, prevention and control sub-committee (IPCSC). Outside of formal meetings the Director of infection, Prevention and Control and the chief pharmacist meet at frequent intervals to discuss topical issues such as winter planning and influenza immunisation, antibiotic usage and audits associated with such.

In line with the Health and Social Care Act 2008 Code of Practice, and our contractual obligations, four point prevalence audits took place over the last year to measure our adherence to the antibiotic formulary that is in place across the Trust for inpatient services. In addition antibiotic usage across CWP West Physical Health was audited using ePACT prescribing reports. Reports of all antibiotic audit findings are discussed at both MMG and IPCSC and the recommendations from the audits are again monitored by both groups. Below summarises the key findings from the antibiotic audits over the last 12 months.

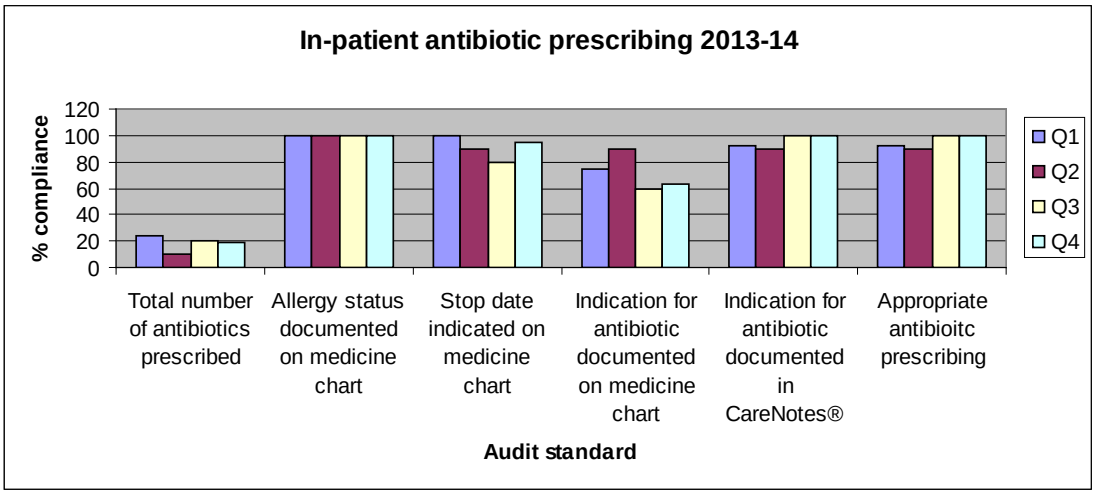
4.14.1 Inpatient services antibiotic formulary adherence

The point prevalence audits on antibiotic usage across the inpatient units were increased to quarterly reporting in 2011 as requirement of the quality contract schedule.

Audits were conducted for one week in June, September, December 2013 and March 2014 and covered the standards necessary for the prudent use of antibiotics in reducing the risk of antibiotic resistance and antibiotic associated adverse effects. Antibiotic prescribing for in-patients followed the NHS Wirral antimicrobial prescribing guidelines for 2013-14.

The graph below (graph 4) shows the antibiotic audit standards measured and their percentage compliance each quarter. It is aimed to achieve compliance of 100% for each of the standard measured. However the total number of antibiotics prescribed in the audit periods was low (June 24, September 10, December 20, March 19) and any variation in practice makes a large difference in the % compliance figure.

Graph 4



Since the quarterly audits were commenced in June 2011, there has been no prescribing of antibiotics to treat *Clostridium difficile*.

The compliance rates for 2013-14 continue the encouraging results seen in the previous year with a sustained 100% compliance with the documentation of allergy status on the medicine chart. It is also possible to report that the average percentage compliance with the documentation of antibiotic indication within CareNotes® has reached 97% this year compared to 87% last year. This is the responsibility of the prescriber, and has shown a significant improvement.
The standard for documenting the stop date on the antibiotic prescription has fallen slightly from an average of 95% (2012-13) to 91% (2013-14).

The standard requiring most improvement moving forward was also identified last year; documenting the indications of the antibiotics on the medicine chart (average percentage compliance being 74% last year and 72% this year).

The most encouraging compliance result has been the sustained 100% appropriate antibiotic prescribing measured in quarter 3 and four of this year. Although non-formulary antibiotics are sometimes prescribed, these have been on the recommendation of the microbiologist and as such are deemed appropriate as specialist advice has been sought prior to prescribing.

The pharmacy team are continually promoting prudent antibiotic prescribing to prescribers through education and induction sessions and activity at ward level. Having easy access to the antibiotic formulary on the Trust intranet and a single page treatment summary of common infections guideline facilitates good antibiotic prescribing.

The results of the audits are shared with MMG and IPC sub committee. Learning from the audits is communicated by the clinical pharmacist's through local education sessions of the junior doctors training and pharmacy communication bulletins.

4.14.2 Physical health services antibiotic formulary adherence

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

Community Matrons – nurse independent prescribers based in the community.
Out of Hours service – A mix of medical (GP) and nurse independent prescribers

Addressing healthcare-associated *Clostridium difficile* infection remains a key issue on which NHS organisations have been mandated to implement national guidance that includes restriction of broad spectrum antibiotics, and in particular second and third-generation cephalosporins, quinolones and clindamycin (see table below).

Table 6 - Propensity of antibiotics to cause *Clostridium difficile* associated disease

Less Risk	Medium Risk	High Risk
Doxycycline	Amoxicillin	Cefalexin
Flucloxacillin	Azithromycin	Cefotaxime
Metronidazole	Clarithromycin	Ciprofloxacin
Nitrofurantoin	Co-amoxiclav	Clindamycin
Penicillin		Ofloxacin
Trimethoprim		
Vancomycin		

West Physical Health antibiotic benchmarking is currently measured against one local and two national measures: (see table 7)

1. Local - compliance with NHS Western Cheshire antibiotic formulary.
2. National - prescribing comparator "Cephalosporins and quinolones % items" This is defined as *"the number of prescription items for cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial items*".
3. National - prescribing comparator "3 days trimethoprim average daily quantity (ADQ)/item" comparator which benchmarks 3 day courses of trimethoprim for uncomplicated urinary tract infections (UTI). An ADQ of 3 equates to a three day course. Levels above this, demonstrate that longer courses have been prescribed, which are often seen in the elderly and in those with complicated urinary tract infections.

Table 7 - compares out of hours prescribers against the national and local benchmarks

	CWP West average 2012-13	Q1 13/14	Q2 13/14	Q3 13/14	Average 13/14 YTD
Out of Hours - all prescribers					
% Formulary antibiotic items (local)	**95**	**97**	**97**	**97**	**97**
% Cephalosporin + quinolone (national)	**7**	**6**	**7**	**6**	**6**
Out of hours - GP only					
% Formulary antibiotic items (local)	**95**	**97**	**97**	**97**	**97**
% Cephalosporin + quinolone (national)	**7**	**7**	**9**	**6**	**7**
Out of hours - NMP					
% Formulary antibiotic items (local)	**96**	**98**	**100**	**100**	**99**
% Cephalosporin + quinolone (national)	**5**	**<1**	**8**	**9**	**6**
Out of Hours - all prescribers					
Trimethoprim ADQ/item (national)	**4.7**	**4.9**	**4.8**	**4.8**	**4.8**

At the time of writing the report, quarter 4 epact data was not available for analysis due to a lag time in the processing of epact data by the NHSBSA.

Overall, prescribing values have improved on 2012-13 results

Table 8 - Comparison of national and local benchmarks:

	Avg value 12/13	Avg value YTD 13/14
CWP Out of Hours - all prescribers		
% Cephalosporin + quinolone	7	**6**
Trimethoprim ADQ/item	4.7	4.8
Western Cheshire CCG		
% Cephalosporin + quinolone	6.0	6.6
Trimethoprim ADQ/item	6.1	6
National		
% Cephalosporin + quinolone	5.3	5.8
Trimethoprim ADQ/item	6.1	6.1

This is the second year of using the national trimethoprim comparator and as can be seen the average value of 4.8 compares favourably to the Western Cheshire CCG value of 6.0 and the national average 6.1 (Apr13–Dec 13).

Data in table 9 compares community matron prescribing against the national and local benchmarks:

Table 9

Community Matrons	CWP Average value 12/13	Q1 13/14	Q2 13/14	Q3 13/14	CWP Average value 13/14
% formulary adherence (local)	**93**	**100**	**100**	**100**	**100**
% Cephalosporin and quinolone prescribing (national)	**8**	**0**	**5**	**12.5**	**6**

Community matron prescribing of antibiotics is low but has reached 100% formulary adherence and sustained this level for the three quarters reported. No figures for the trimethoprim comparator are reported due to low baseline data.

4.15 Emergency planning and business continuity

The pharmacy team are represented on the Emergency Planning sub-committee. Contributions were made to the heatwave plan 2013 with a section on storage of medicines and to the heatwave debrief as the monthly clinic audit showed temperatures in excess of 25 degrees Celsius in rooms where medicines are stored. Temperatures inside the medicine cupboards will be monitored in 2014 during hot weather. Those clinic rooms that are at higher risk of high temperatures have been notified to estates as part of the cool room project. Pharmacy team were also involved in the review of the flu immunisation program for 2013.

4.16 Medicines Management Strategy

The strategy was due to be revised during 2013 and as yet this is outstanding on the business cycle. This work will be progressed over the next financial year now that the Trust's clinical strategies have been approved. The medicines management strategy will aim to complement and support the clinical strategies in their milestones of delivery.

4.17 MMG Business Cycle

The business cycle is reviewed at each MMG meeting to ensure we are on track with the duties bestowed upon us. The change in MMG structure has enabled us to tailor the business cycle to meet the needs of the two meetings such that we focus on interface issues with primary care at the interface meeting and focus on internal issues pertinent to CWP staff only at our internal meetings.

5. CONCLUSION

This report has detailed the work of the medicines management group and the pharmacy team led by the chief pharmacist and associate director of medicines management over 2013-14. The medicines management group will work to the new business cycle set for 2014-15 and report regularly through the integrated governance structures of the Trust.

6. RECOMMENDATIONS

The board of directors is asked to approve the medicines management annual report.

7. REFERENCES

1. POMH-UK website
http://www.rcpsych.ac.uk/crtu/centreforqualityimprovement/prescribingobservatory.aspx

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/15/31)

Report to:	**Board of Directors**
Date of Meeting:	**30th July 2014**
Title of Report:	**Report on the annual appraisal of medical staff 2013-4**
Action sought:	**For Approval**
Author:	**Dr Geraldine Swift, Dr Faouzi Alam and Sarah Carroll**
Presented by:	**Dr Anushta Sivananthan, Medical Director**

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

Distribution

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

Executive director (name and title)	Date signed-off
Dr Faouzi Alam, Medical Director,	23rd July 2014

1. Executive summary

CWP has 103 doctors for whom the RO is responsible. This excludes medical trainees from Deaneries and GPs doing sessions in CWP where the bulk of their work is within primary care.

All doctors with a prescribed connection to CWP have been allocated a trained appraiser; Following an appraisal meeting, the summary form (output) and the doctor's personal development plan (PDP) are documented, signed and sent to the Associate Medical Director of Workforce for quality assurance. This should be done within 28 days in order for the appraisal to be counted as "completed". As of march 2014, 98 doctors (95%) had their appraisal on time but only 66 doctors (64%) had "completed appraisals". Of the remaining 37 doctors, 32 had an appraisal meeting on time but their appraisal outputs were not available within 28 days. Five doctors were not appraised within the parameters of 9-15 months following the date of the last appraisal.

For the 2014-5 appraisal year, The Medical Education Manager will ensure that the outputs are chased more rigorously and matters escalated to the AMD/RO where there is no response.

Overall CWP has reliable, robust systems in place to monitor concerns and address these when they arise. In terms of strengthening systems further, plans are proposed to improve the quality of data that informs the appraisal discussion; to support communication between the appraiser and the appraisee's line manager; to monitor prescribing patterns so as to understand outliers; to introduce electronic appraisal system; and to ensure that CWP has a sufficiently large cohort of trained case investigators to call on should a formal investigation be necessary.

2. Purpose of the report

NHS England requires that each Responsible Officer (RO) submits an annual report to the Board of Directors of his/her Designated Body (DB) on the implementation of appraisal and revalidation.

The report details the uptake of medical appraisal amongst doctors for whom the RO is responsible and provides assurances that there is a system in place to meet General Medical Council (GMC) requirements for appraisal and revalidation for all medical staff for whom the Trust is the Designated Body (DB)

The purpose of the report is also to provide assurance to the Board that there is a system in place to monitor the conduct and performance of doctors within the DB.

The Board or Chief Executive is subsequently required to sign a statement of compliance to be forwarded to Regional Medical Director of NHS England North by 31 August 2014.

In previous years the Board of Directors of CWP has received an annual report from the Responsible Officer; the content of which was directed by NHS England whose aim was to set up a consistent reporting process across DBs and embed the reporting process more firmly into existing governance frameworks within DBs.

Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards / executive teams [delete as applicable] will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

3. Governance arrangements & individual responsibilities

The RO/Medical Director for Effectiveness and Workforce (Dr Faouzi Alam) is responsible for the appraisal, revalidation, conduct and performance of medical staff within CWP.

The Trust has in place the following trained staff to support appraisal and revalidation:

Responsible Officer: Dr Faouzi Alam
Medical Director for Safety and Quality: Dr Anushta Sivananthan
Associate Medical Director for Medical Workforce: Dr Geraldine Swift
Medical Education Manager: Sarah Carroll
Wendy Hinckley: PA to Medical Education Department
30 trained appraisers

The Responsible Officer chairs two groups:

- The Revalidation Panel (comprising Medical Directors, the Associate Medical Director for Medical Workforce and the Medical Education Manager.) The Panel makes 5 yearly recommendations to the GMC on the fitness to practice of doctors for whom the RO is responsible. The recommendations are based on the outcomes of their appraisals over this period. Three choices are available – Recommend, Defer (for a specific time, usually because of lack of evidence but could also be used where concerns are being investigated) and Not-Engaging (with the appraisal process.)

- The decision-making group monitors concerns about the conduct and performance of individual doctors and decides next action. Members are the RO, AMD and Head of HR.

Additionally, the RO, AMD and Medical Education Manager are linked into NHS England training/networking events and meet on alternate months with the Employment Liaison Adviser from the GMC. Updates are provided on latest guidance and informal discussions take place around doctors causing concerns.

The Associate Medical Director, Workforce has devolved responsibility from the RO for medical appraisal and medical workforce matters within CWP. She quality assures the process, reads and signs off all Summary Forms and PDPs, provides training for appraisers and appraisees, and is responsible for ensuring that concerns expressed about the conduct and performance of medical staff are dealt with as per CWP policy.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

The Medical Education Manager is responsible for the administration of the medical appraisal system; monitoring the progress of individuals, ensuring data provided by the Trust is collated and available in good time, that prompts for the return of Summary Forms within timeframe are issued, for escalating matters to the AMD or RO as appropriate and being first point of contact for queries. She provides quarterly and annual medical appraisal audit returns to NHS England. The annual return is embedded at the end of this report.

The Medical Education Manager is also responsible for updating the GMC register of doctors for whom the RO is responsible. She provides administration support to the AMD for medical workforce matters and is a member of the Revalidation Panel.

From this year onwards, medical appraisal audit returns will be submitted to the Workforce and Organisational Developemnt Sub- committee, reporting into the Operational Board. The Executive Team will be asked to consider whether this is the correct course of action.

Policy and Guidance

The relevant policies within CWP are HR9 Handling concerns about the conduct, capability, performance and health of medical staff and HR21 Policy for the annual appraisal of medical staff and both are due to be updated by the Medical Education Manager in response to latest guidance.

5 Appraisal and Revalidation Performance Data

a. Detailed activity levels of appraisal outputs:

- Number of doctors - 103
- Number of completed appraisals – 66
- Number of incomplete appraisals – 32 (because the outputs were outside the 28 day rule)
- Number of doctors not appraised – 5 (an audit has been carried out to establish reasons)
- Number of doctors in remediation and disciplinary processes - 3

b. Appraisers

CWP currently has 30 trained medical appraisers. A training session for both appraisers and doctors being appraised has been held over the past 12 months and it is anticipated that this will continue in future years.

A twice yearly peer group (appraisal support group), facilitated by the AMD is being set up to ensure appraisers receive on-going support and good practice is shared.

4. Quality Assurance

Outline of quality assurance processes:

For the appraisal portfolio:

Review of appraisal folders to provide assurance that the appraisal inputs: the pre-appraisal declarations and supporting information provided is available and appropriate -– provided by the Medical Education Manager.

Review of appraisal folders to provide assurance that the appraisal outputs: PDP, summary and sign offs are complete and to an appropriate standard – provided by the AMD.

· Review of appraisal outputs to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs – appraiser, AMD, MEM.

For the individual appraiser

- An annual record of the appraiser's reflection on appropriate continuing professional development – the appraiser
- An annual record of the appraiser's participation in appraisal calibration events such as reflection on ASG (Appraisal Support Group) meetings – the MEM from 2014 onwards.
- 360 feedback from doctors for each individual appraiser –collected by the MEM, reviewed by the AMD We are currently working on how we will collate and feed back to the appraiser and how it will be calibrated with the feedback for other appraisers.

For the organisation

- Audit of timelines of process of appraisal – maintained by the MEM.
- System user feedback – feedback obtained post-appraisal.
- Review of lessons learned from any complaints – AMD checks for reflections in the appraisal ouputs.
- Review of lessons learned from any significant events – AMD checks for reflections in the appraisal outputs.

Access, security and confidentiality of information

All information is kept securely by the AMD and MEM in locked cabinets and shared drives on the CWP network.

Clinical Governance

The MEM's team provide doctors with data on their activity as recorded in Carenotes, SUIs, complaints, compliments and compliance with mandatory training. Doctors are required to provide further evidence to support all the domains of Good Medical Practice (see medical appraisal policy.)

Revalidation Recommendations

Number of recommendations between April – March : 16

All recommendations were completed on time

Positive recommendations - 16

Deferrals requests - 4

Non engagement notifications - 0

Reasons for all missed or late recommendations – N/A

Recruitment and engagement background checks

Medical recruitment follows national guidance and local policies in respect of constitution of panels and safe employment. All relevant pre-employment checks are carried out in respect of:-

- Identity checks;
- Right to work;
- Professional registration and qualification checks;
- Occupational health checks;
- Criminal record and barring checks.

Audits are regularly carried out to ensure CWP is adhering to the required standards and processes. Where any deficiencies are found actions are put in place to address these.

As equality and diversity awareness training forms part of the trust's essential leaning requirements and is included in recruitment and selection training recruiting managers are aware of the importance of fair processes.

Approval to advertise and recruit to medical vacancies is currently being reviewed to ensure that the medical director has final authorisation for all consultant level posts and additional checks and balancing are being put in place to provide assurance to the medical director in his role as RO that all pre-employment checks have been carried out before newly appointed medical staff commence in post.

The Trust has a separate policy in place to provide assurance that all locum appointments have had the relevant checks undertaken.

Monitoring Performance

Monitoring the performance of each doctor is a process that involves triangulating information from different sources to create an overall picture. These sources include external bodies (eg CQC visits, deanery visits, BMA SAS survey); internal information that is routinely collected by CWP (eg quality dashboards where it is possible to drill down to individual teams and doctors, executive visits to wards and teams or audits of areas such as prescribing); and finally information that is specific to each individual (SUIs, complaints, 360 feedback from colleagues and patients, concerns raised in conversations with CDs or managers)

Responsibility for triangulating this information and noticing any concerns sits with each Clinical Director. Clinical Directors are expected to raise concerns about a doctor immediately they arise with the Associate Medical Director (Medical Workforce) or the Medical Director rather than waiting for the appraisal itself. The Medical Director's team takes every opportunity to stress to all the Trust's doctors and other staff that any concerns about any doctors must be raised as early as possible.

It is the view of the Medical Director's team that appealing to the intrinsic motivation of staff to offer the best possible care within existing resources is an effective way of driving up quality and is necessary alongside processes to monitor performance. Thus in parallel with monitoring any concerns, CWP invests heavily in doctors in terms of resources for their continuing professional development; the in-house leadership programme; and consistent encouragement to take on leadership roles within the organisation.

Responding to Concerns and Remediation

When a concern is raised involving any doctor, the Medical Director's Team initially assesses the facts as known and considers whether there is any obvious risk to patients, using parts 1 and 2 of Maintaining High Professional Standards (MHPS). A decision is then made as to whether to proceed under CWP policies for less serious concerns (eg CWP policies on grievance; dignity at work; raising concerns; managing attendance) or to use parts 3, 4 or 5 of MHPS for more serious concerns about conduct, capability or health. Consideration is always given to discussing with the National Clinical Advisory Service (NCAS) and a conversation with our NCAS advisor always occurs if a formal investigation under parts 3-5 is being considered), and if appropriate, with the GMC Liaison Officer.

No doctor in CWP has been required a formal remediation package over the last year. However advice from NCAS again would be sought if this situation arose.

Currently, at the suggestion of NCAS and with support from the trust, one doctor in CWP has been encouraged to consider a behavioural assessment from NCAS to inform an action plan following an investigation.

Risk and Issues

Some concerns have been recognized in previous annual reports on appraisal and revalidation and continue to pose challenges. These include the difficulty in ensuring the accuracy of the activity data produced by the trust for each doctor and submitted as part of their appraisal portfolio. While many doctors still report significant inaccuracy, it is interesting to note that CAMHs clinicians seem to be happier with their data and this may reflect the effort from some CAMHS clinicians over the last few years to ensure that the IT department have a clearer understanding of what is required. The locality director for Wirral is currently working with IT to try and bring adult CMHT data to a similar satisfactory level.

Another concern previously described is around personal development plans. Appraisers and appraisees continue to struggle to agree plans that have SMART goals and too many PDPs contain vague aspirational statements or suggest merely that doctors should "continue". Moreover the action plan agreed at appraisal is usually not amalgamated with the PDP that each doctor proposes to their peer group and submits to the Royal College of Psychiatrists which tends to focus almost entirely on their educational objectives. Although the "appraisal PDP" and the "Royal College PDP" both cover a twelve month period, the year is often not concurrent with for example, one being submitted in April and the other in September and clearly this does not help.

New issues include the clear directive from NHS England that appraisal should cover the whole of each doctor's practice. While appraisers and appraises are aware of this from their appraisal training, it is still not fully embedded into routine practice. Moreover producing data relating to activity, quality improvement etc with regards to practice outside the trust may be difficult for some doctors especially when it relates to charitable work or private practice that may be on a small scale.

CWP have trained several new appraisers. This is a positive development and one that should help us work towards a situation where appraisers carry out between 5-8 appraisals each year. We have also implemented the advice that each clinician should not be appraised by the same appraiser for more than 3 years in a row. The combination of these factors means that more and more doctors are being appraised by someone who is not their line manager. There are potential risks in that the appraiser and the clinical director may have different information available to them. It is important therefore that we ensure that CDs share information with appraisers prior to the appraisal; and also that there is an agreement that the outputs from appraisal (form 4 and PDP) should be shared with the relevant CD.

CWP require that each doctor completes at least 2 processes of seeking 360 degree feedback from colleagues and patients in a five year period. Our current system is in house and is very good value from that perspective. However it is time consuming both for the clinician and for the Med Ed staff

and so it is important that this workload should be as effective as possible in terms of clarifying for doctors what they are doing well and where they could seek to build on their skills. The current form, like many others, predominantly focuses on asking patients and colleagues to score the doctor on various parameters. In talking with doctors, it is clear that these scores are rarely seen as a reason to change behaviour. Instead it is the free text comments that tend to be most valued by doctors. We have agreed therefore to run a pilot where only comments are sought to see if this is a more powerful method of helping doctors develop their practice.

The process for monitoring performance and responding to concerns has been described above. However many psychiatrists work in relative isolation and do not always have a lot of contact with other medical colleagues. During the year there have been some executive board visits to wards and teams where concern has been raised about the extent to which our systems for monitoring performance pick up on high level issues such as unusual patterns of prescribing. This is an area where CWP is keen to improve performance monitoring further.

Within CWP there are on average between 0 and 3 formal investigations each year carried out within the MHPS framework. We have an excellent cohort of case investigators who have received training in this role from NCAS, however the role is undeniably challenging and time consuming. Few formal investigations are completed within the 4 week time frame recommended and some of this is due to our expectations that clinicians and HR support staff will continue with all of their other activities along with conducting the investigation. It is important therefore that we continue to encourage doctors to access the NCAS training so as to have a large cohort of suitably trained individuals; that the role is recognized and appreciated formally by the trust; and that we review the need to protect the case investigator and HR support from other routine responsibilities where necessary.

Corrective Actions, Improvement Plan and Next Steps

Recommendations	Action	Responsibility	Time frame
1. Strengthen IT systems to produce reliable information for appraisal	Approach in stepwise fashion: firstly Wirral locality director to work with IT lead to focus on CMHT data	Wirral locality director, IT Associate Director	March 2015
2. Ensure each doctor has one clear PDP with SMART goals	Set up appraisers network to build skills in helping doctors set specific, measurable goals Encourage each doctor to have appraisal year running concurrently with PDP year	AMD Med Workforce and Med Ed manager AMD Med Workforce and Med Ed manager	December 2014 As each appraisal date is set
3. Ensure appraisals cover the whole of practice	Regular reminders via appraisers network and appraisal training	AMD Med Workforce and Med Ed manager	July 2015
4. Ensure clear communication between appraisers and clinical directors	Regular reminders via appraisers network, appraisal training and CD meetings	AMD and Med Ed manager	July 2015
5. Maximise effectiveness of 360 feedback	Pilot new 360 feedback form	AMD and Med Ed Manager	July 2015
6. Explore most effective way of monitoring unusual prescribing patterns	Discuss with MDs, AMD and pharmacy associate director	MDs and AMD	March 2015
7. Ensure large enough cohort of trained case investigators	Encourage suitable candidates to seek case investigator training	AMD Med Workforce	July 2015

Recommendations to the Board of Directors

The Board is asked to approve the report, recognizing that it will be shared with the higher level RO along with the annual audit; to approve the statement of compliance confirming that the organisation, as a designated body, is in compliance with the regulations; and support the recommendations for next steps.

5. Appendix 1

NHS England annual organisational audit 2013-4 (NB. This document is slow to open)

T:\01. BoD Committees\Board of Directors\Meetings\2014\140730\Open

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/15/32)

Report to:	**Board of Directors**
Date of Meeting:	**30th July 2014**
Title of Report:	**Nicotine Management Policy Implementation – Board Update**
Action sought:	**For Noting**
Author:	**Bill Woods, Clinical Service Manager**
Presented by:	**Avril Devaney, Director of Nursing**

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

Distribution

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

Executive director sign-off

Executive director (name and title)	Date signed-off
Avril Devaney, Director of Nursing, Therapies and Patient Partnership	21st July 2014

1. Introduction

The purpose of this report is to update the CWP Board on progress with Implementation of the Trustwide Nicotine Management Policy.

2. Summary

The report sets out the key issues with the launch of the new Policy in February 2014 and provides information about ongoing work to support the success of the implementation of same.

3. Actions

Policy Launch and Feedback

A series of Launch Events were held in the three localities within the Trust in February 2014. Each of these Events was targeted to local staff and partner services on the Trust sites of Clatterbridge Hospital at the Wirral, Bowmere Hospital/Countess of Chester Hospital, Chester and Millbrook Unit/Macclesfield District General Hospital at Macclesfield. Each of the Events was supported by the Director of Nursing and Therapies and local Management Leads in the Services. The Events were attended by the local Directors of Nursing and Directors of Public Health. Promoting public health messages and challenging expectations that anyone should be able to smoke on NHS premises was the key message presented in each area. As part of the build up to the launch, various communication methods were used to raise the profile of the Policy and ensure that staff and service users were aware of same.

The National Public Health Lead, Seamus Watson, attended the Events at Wirral and Chester and took the opportunity to meet with staff to help CWP with promotion of the Nicotine Management Policy messages. The Trust Communications Team took photographs and carried out local interviews to ensure maximum publicity of the Policy changes.

NRT Advice and Support

As part of the Policy launch, specific staff training took place with Inpatient staff in the three localities to ensure CWP had sufficient staff members on the Wards to provide NRT advice and appropriate NRT products for Inpatients and new admissions to the Wards. This process was checked via locality audits to ensure that each of the Units had sufficient numbers of staff to provide this advice over the 24 hour/7 day week period. This was established and as part of the audit, area stocks of NRT products were confirmed to ensure each Inpatient area had speedy access to a range of NRT product options. A spot check on all wards was also carried out by the Involvement Representatives from the Trust Wide group and they confirmed that advice and prescribing were readily available across the Trust.

Uptake of NRT products from Inpatients has been less than expected. With the support of the Pharmacy an audit of update of NRT products and expenditure has been put in place. Initial findings of the audit have confirmed that the uptake of NRT support/products has been less than predicted. The initial results of this audit may have been affected by some Wards building up NRT stocks prior to the policy launch so ongoing use of NRT products is being monitored with the Pharmacy Supplier on a monthly basis. Modern Matrons in all areas have been asked to monitor local uptake of NRT products and ensure that access to products and information on same continues to be publicised widely. The issue has also been brought to the attention of the Pharmacy Team to ensure that NRT stock levels are monitored and the Trust Steering Group can receive timely and accurate information regarding same.

The West Health Promotion Lead in the West Cheshire Stop Smoking Service has recently produced an NRT Treatment Guidance document for Ward areas which provides a generic reduction regime. This Guidance is currently being shared for comments.

Training
In addition to pre-launch staff training on NRT advice and support, further staff NRT Prescribing Training for Inpatient staff is being rolled out. Further training with Community staff is also in place to ensure service users continue to understand that CWP sites are Smoke Free. Chester specific plans include local 3 – 6 monthly Brief Intervention Updates to Wards and Teams. This plan has been shared across East and Wirral localities to ensure similar action is taken in all areas of the Trust.

Local Feedback
Initial feedback from localities has been positive overall regarding implementation of Smoke Free policies in each of the Inpatient Units. There have been several comments received about how much more pleasant our grounds and reception areas are now that people are no longer smoking there. The majority of patients who have been admitted since the policy was introduced have been aware of and prepared for the new policy either via the clients Community Care Co-ordinators or through contact with the Home Treatment Team.

Since the launch of the Policy the Trust has been closely monitoring any smoking relating incidents and staff response to same. To-date there has been a small number of incidents which were addressed with individual patients and their Care Teams. These incidents, in the main, relate to patients bringing in smoking materials following leave and smoking in bedrooms. There has not been an increase in verbal or physical aggression following the introduction of the policy. There have been a small number of issues involving clients on Section 17 Leave. These have involved clients requesting to purchase cigarettes or smoking materials as part of their leave from the hospital grounds. These incidents have been monitored and staff are addressing the issue through individual care planning with patients.

There has been one client on the Eastway Unit who has required intensive support from the staff team and external advice and support from the Health Promotion Lead in the West Stop Smoking Service and the West Community Mental Health Clinical Facilitator to help advise the staff team on the best approaches to support. Recent feedback is indicating that this client has significantly reduced their smoking.

There have also some difficulties in the early stages of Implementation of the Policy with staff and visitors to partner organisations continuing to smoke on site. We are continuing to work with our partners to support them to address this. Some specific external areas are also continuing to attract occasional smokers for example, the area beside the Oasis dining room at Bowmere – smokers are being challenged by more confident staff and plans are in place to re-landscape this space to hopefully make it less attractive for smokers.

Trust Action Plans
In order to ensure that the emphasis on being Smoke Free is continued across Services, both the Trustwide and Local Steering Groups for the Implementation of the Nicotine Management Policy are continuing to meet and local areas will continue with developing their action plans. Priorities will be addressed on an ongoing basis. The Communications Team continue to support ongoing messages about sites being Smoke Free and publicise the Policy wherever opportunities for same are presented. It is also planned to continue with wider training events across the Trust and to have a celebration style event to mark progress made which will link in with Wards across the Trust.

Removal of Smoking Paraphernalia
The Trust is currently reviewing the appropriateness of holding cigarettes/lighters and other smoking paraphernalia for clients while they are inpatients in our Services. It appears that patients are expecting staff to 'look after' their cigarettes and lighters and return them when they have leave off site. This is not in the spirit of the policy and there are reports of patients 'binge' smoking whilst on leave and then having nicotine withdrawal symptoms on return to the ward. Essentially we are

continuing to facilitate smoking and the benefits in terms of clinically managing nicotine dependency are not being realised for these patients. This is not in keeping in how we respond to other dependencies including alcohol. The Trustwide Steering Group is looking at ways to address this issue.

NICE Guidance on Smoking Cessation in Secondary Care

New NICE Guidelines were launched in November 2013 giving guidance on smoking cessation in Secondary Care Mental Health Services. The Trustwide Steering Group is currently evaluating the recommendations in this Guidance to ensure that CWP Policy covers same. A number of the recommendations are already in place, however, there are also recommendations on Data Recording, Sale of NRT Products on Hospital Sites, and changes recommended to Service Specifications and Service Level Agreements which specify that staff are trained in delivery of advice on stop smoking that require further development. The Guidance also stipulates that Trusts should be formulating local Policies on the use of nicotine containing products such as electronic cigarettes. The Guidance from the Policy is being reviewed on an ongoing basis through the Steering Group and local action plans to address outstanding recommendations. CWP are also being supported by the Cheshire and Merseyside Tobacco Alliance Health Equalities Group to assess priorities to implement the guidance through completion of the Group's rapid appraisal document and questionnaire.

Interest from other Mental Health Provider Trusts

Eight Mental Health Trusts have recently been in contact with CWP to obtain information and advice on how we implemented the Nicotine Management Policy. Feedback from other Trusts on the advice and information given has been positive and complementary.

This contact has included West London Mental Health NHS Trust, Central and North West London NHS Foundation Trust and Merseycare Trust, who have also travelled to visit, or are about to visit our Services and meet local staff who have been involved in production and launch of the policy. South London & Maudsley NHS Foundation Trust has also agreed to run a joint conference with CWP on the 10th October 2014 at Sycamore House. The conference programme is currently being prepared and will include national speakers, and local feedback on progress with the stop smoking agenda.

The CWP Director of Nursing, Therapies & Patient Partnership has recently presented on CWP progress with the Nicotine Management Policy agenda at the National Mental Health Nurse Directors Conference.

4. Conclusion

Following the formal Launch of the Nicotine Management Policy in February 2014 there has been considerable success with adoption of the Policy across Inpatient Services and other CWP sites. The Trustwide Steering Group for the Implementation of Nicotine Management Policy will continue to oversee the ongoing monitoring and evaluation of the changes and ensure the focus in achieving all the Policy objectives continues.

5. Recommendations to the Board of Directors

The Board of Directors are recommended to note the report.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/15/33)

Report to:	**Board of Directors**
Date of Meeting:	**30th July 2014**
Title of Report:	**Infection Prevention and Control (IPC) Annual Report 2013/2014**
Action sought:	**For Approval**
Author:	**Amanda Miskell, IPC Clinical Nurse Specialist & Maria Nelligan, Director of Infection, Prevention and Control**
Presented by:	**Maria Nelligan, Director of Infection, Prevention and Control**

Strategic Objective(s) that this report covers:

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

Distribution

Version	Name(s)/Group(s)	Date Issued
1	Infection Prevention & Control Sub Committee	10th July 2014 (In minutes)
2	Board of Directors	30th July 2014

Executive director sign-off

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

Infection Prevention and Control Annual Report 2013 / 2014

“Working hard to prevent any avoidable infection, and keeping people safe the first time, and every time”

Glossary

Antibiotic Formulary
A list of approved antibiotics based on evaluations of efficacy, safety, and cost-effectiveness of drugs based on population trends.

Antimicrobials
Antimicrobials are substances which are used in the treatment of infection caused by bacteria, fungi or viruses.

Aseptic Non Touch Technique
Aseptic Non Touch Technique or ANTT is a tool used to prevent infections in healthcare settings.

Assurance Framework
A system for informing their parties that a process of due diligence is in place to assure safety and quality exists within that setting.

Audit
Audit is a quality improvement process that aims to improve service user care and outcomes by carrying out a systematic review and implementing change. This is not necessarily complex and in its simplest form shows compliance with a single protocol. Its value is in showing improvement or maintenance of a high standard. Once an audit has been completed and actions taken, repeating the audit will complete the audit cycle.

Benchmark
A standard or point of reference against which things may be compared.

Best Practice
A best practice is a method or technique that has consistently shown results superior to those achieved with other means, and that is used as a benchmark.

Board
A Board (of Directors) is the executive body responsible for the operational management and conduct of an NHS Foundation Trust. It includes a non-executive chairman, non-executive directors, the chief executive and other executive directors. The Chairman and non-executive directors are in the majority on the Board.

Clostridium difficile Toxin
This is a type of infectious diarrhoea caused by the bacteria Clostridium difficile.

Carenotes
The main clinical electronic care record used within CWP.

Carers
Person who provides a substantial amount of care on a regular basis, and is not employed to do so by an agency or organisation. Carers are usually friends or relatives looking after someone at home who is elderly, ill or disabled.

Catheter Associated Urinary Tract Infection – CAUTI
Catheter associated urinary tract infections comprise a large proportion of healthcare associated infections and can occur whether a person has either a short-term or a long term catheter.

Clinical Commissioning Group – CCG
Clinical Commissioning Groups are groups of GP's that are responsible for designing and commissioning / buying local health and are services in England.

CNS
Clinical Nurse Specialists.

Care Quality Commission – CQC
The Care Quality Commission is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations.

Colonisation
Where an organism is present on or within a person's body but without signs or symptom of disease.

Cross Infection
Cross infection is the transfer of harmful microorganisms. Bacteria and viruses are among the most common. The spread of infections can occur between people, pieces of equipment, or within the body.

CSU
Clinical Support Unit which supports the CCG's.

CWP footprint
This is the geographical areas that CWP provide healthcare to its populations.

DATIX
An electronic record for reporting incidents.

Decolonisation
A method to temporarily or permanently eradicate the body from an organism that is colonising either skin or tissue.

Decontamination
The combination of processes (including cleaning, disinfection and sterilisation) used to make a reusable item safe for further use on service users and for handling by staff.

DH
Department of Health.

DIPC
Director of Infection Prevention and Control. An individual with overall responsibility for infection control and accountable to the registered provider in NHS provider organisations.

ESBL
Extended Spectrum Beta Lactamase.

HCAI
Healthcare Associated Infection.

Health and Social Care Act 2008
The legislation that established the CQC and lays out the framework for its powers and responsibilities

Healthcare
Healthcare includes all forms of care provided for individuals, whether relating to physical or mental health.

Infection
Where the body is invaded by a harmful organism (pathogen) which causes disease or illness.

IPC link practitioners
The Infection Prevention and Control Link Practitioner (IPCLP) will act as a resource and role model in their designated area of work and will liaise with the Trust's Infection Prevention and Control Team (IPCT). The role will help to create and maintain an environment that is safe for service users, visitors and staff.

IPC Pathway
The IPC Team incorporates three pathways which are community, inpatients and external services.

IPCN
Infection Prevention and Control Nurse.

IPCSC
Infection Prevention and Control Sub Committee.

IPCT
Infection Prevention and Control Team.

IPS
Infection Prevention Society.

LD
Learning disabilities.

MDG
Medical Devices Group.

MEL
Mandatory Employee Learning.

MH
Mental Health.

MMG
Medicines Management Group.

MRSA
Meticillin Resistant Staphylococcus Aureus.

MRSA Bacteraemia
Meticillin Resistant Staphylococcus Aureus infection which enters the patients' bloodstream.

Multi Resistant Organisms
Organisms that have a resistance to several groups of antibiotics, typically oral.

Never Events
Is a list of never events which is published by the Department of Health to prevent avoidable harm.

NSC
National Standards of Cleanliness.

PH
Physical Health.

PHE
Public Health England.

PLACE
Patient-led Assessment of the Care Environment.

Post exposure prophylaxis – PEP
Treatment following exposure to prevent further infections or symptoms.

Root Cause Analysis
A process which allows organisations to understand areas requiring improvement in the patient care pathway, and more importantly, identifies and targets actions to minimise the chance of recurrence for future patients

Safety Metrics
A measurement of practice to give assurance and identify gaps.

Service User
Anyone who uses, requests, applies for or benefits from health or local authority services.

Surveillance
Infection surveillance is the continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of infection prevention and control practice. Such surveillance can serve as an early warning system for impending multi resistance or increase in emergence of newer organisms, and allow the team to respond appropriately supporting the health care structure for our population.

Trajectory/ambition
A figure dictated by Department of Health or NHS England.

VRE
Vancomycin Resistant Enterococci. Enterococci are bacteria that are commonly found in the bowel of normal healthy individuals. They can cause a range of illnesses including urinary tract infections, bacteraemia (blood stream infections) and wound infections. This type of bacteria is resistant to the antibiotic, Vancomycin.

1. Introduction

Welcome to the IPC Annual Report 2013/2014 for Cheshire and Wirral Partnership NHS Foundation Trust (CWP). Our Director of Infection Prevention & Control (DIPC) [Maria Nelligan], and her IPC Team (IPCT) continue to work hard to prevent any infections, and are committed to preventing all avoidable infections, keeping our service users, staff, visitors and carers safe from infections, the first time, and every time. Here is a brief synopsis of our achievements this year:

- **No** preventable Meticillin Resistant Staphylococcus Aureus (MRSA) bacteramia infections within our provider services
- **No** preventable Clostridium Difficile Toxin (CDT) infections within our provider services
- **Developed** innovative approaches to drive down infection rates across CWP provider services
- **Increased** service user involvement with the team and increased home visits and one to one support
- **No** identified cross infection cases in service users or staff
- **100%** success in decolonisation of service users with MRSA
- **National** conference speaker and poster presentation
- **National** educational chair for the Infection Prevention Society (IPS)
- **Regional** conference speaker and poster presentation
- **North West (NW)** Educational Officer for the IPS
- **Contributor** to the Nursing Times Journal for online learning
- **Subject Matter Expert** for Core Skills Framework on Infection Prevention & Control
- **Hosted** NW IPS meetings
- **Supporting** the Western Cheshire Clinical Commissioning Group (CCG) in its IPC Senate

This report will demonstrate how CWP meets and exceeds on compulsory requirements and standards, and evidence the commitment the DIPC and IPCT have to protecting our service users, our staff and our populations where possible from infectious diseases and preventable harm.

2. Summary of the Director of Infection Prevention and Control's reports to the Board of Directors

2.1 Frequency/ nature of reporting

The DIPC reports to the Board quarterly, in addition to delivering the annual report. During 2013/14, the Board received concise reports in a timely manner, which detailed a summary of activity for each IPC pathway.

2.2 Decisions made by the Board of Directors

The approval and any recommendations from the Board are communicated directly to the DIPC and are actioned accordingly.

3. Registration requirements with the Care Quality Commission

The Care Quality Commission (CQC) monitors compliance with the Trust registration requirements, to ensure essential standards of quality and safety are met, and ongoing improvements are actively encouraged. The CQC utilises Outcome 8, Essential standards of quality and safety (Care Quality Commission, 2010), which refers to The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance, (Department of Health, 2010) containing ten criterions that healthcare providers are assessed against. CWP declared compliance with the Code of Practice in 2011, and robust documentary evidence is in place to assure the Board and the CQC that the Trust continues to meet the ten criterions.

4. Infection prevention and control governance arrangements

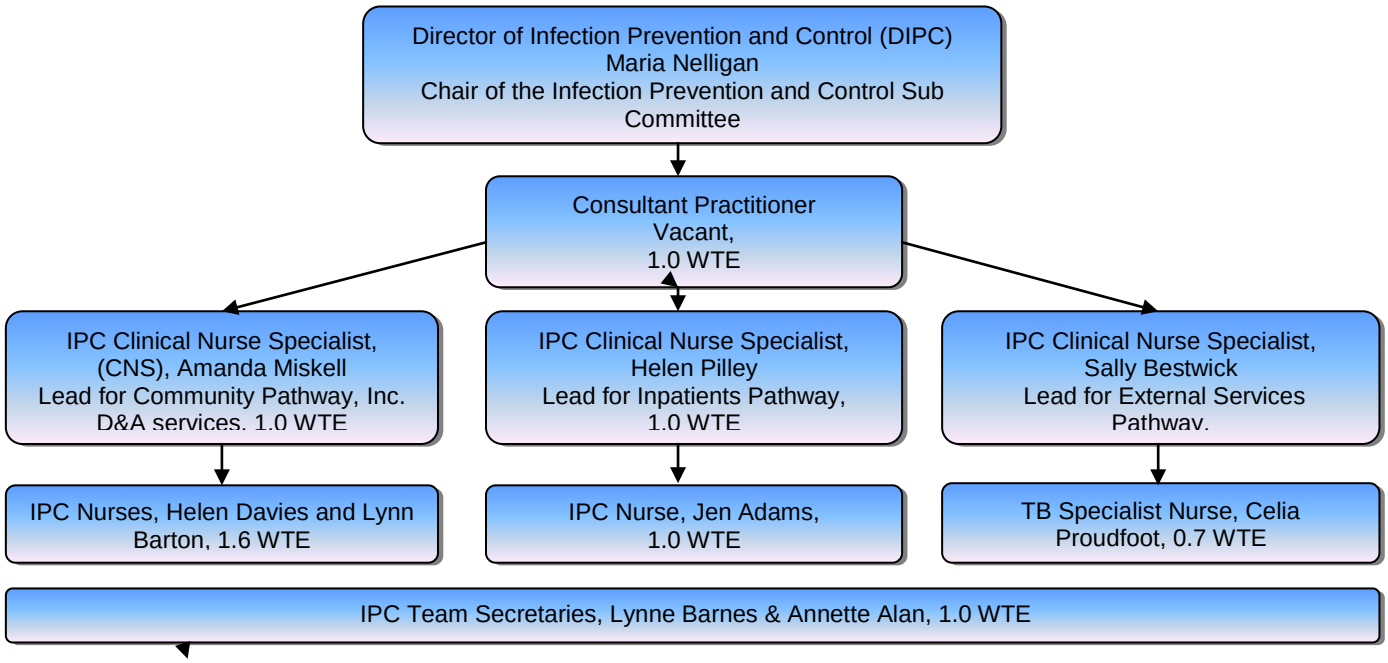
4.1 Arrangements for IPC services

The IPCT have a high profile across the CWP footprint, and also provide support to the Public Health England (PHE) Team of Cheshire West and Chester, Western Cheshire Clinical Commissioning Group (CCG), Support Units (CSU), and Senate.

The IPC service is delivered across three specialist pathways, Inpatient, Community and External Services.

4.2 The Specialist Infection Prevention and Control Team (IPCT)

The IPC team is led by the DIPC, and comprises of Modern Matrons, medicines management, estates and facilities teams, waste manager and the specialist IPC staff as identified below;



4.3 IPC resources

The following resources are available to CWP staff:

- IPC policies – which are reviewed in line with the IPC subcommittee work plan.
- An IPC web page – it is a direct link provided on the CWP intranet home page, updated with new announcements, providing links to the CQC, Health Protection Agency fact sheets, Department of Health (DH) guidelines, and general publications.
- An IPC newsletter – highlighting recommended products, training sessions, and infection prevention control tips and advice. This is also distributed by email to all service areas.
- Library resources – containing over 30 books, providing a range of information under the sub section of IPC for all staff.

4.4 Local IPC groups

Modern Matrons and IPC link practitioners throughout the Trust are supported by the IPCT to deliver the IPC agenda locally. IPC link practitioner groups are well established and based in West Cheshire, Wirral, and East localities of CWP, meeting quarterly to cascade information and address local issues resulting from audit, local incidents/outbreaks, refurbishments, and new builds. The minutes from these meetings are noted at the IPC subcommittee.

During November 2013 the team hosted the 9th annual link IPC study day at Sycamore House which was well attended by IPC link and other staff from all localities and service.

4.5 Infection Prevention and Control subcommittee (IPCSC)

The IPCSC reports directly to the Operational Board and is chaired by the DIPC. Meetings take place five times per year, and all service and relevant heads of service are represented.

4.6 IPC work programme

The work of the IPCSC is detailed in a work programme which is approved by the Board and reviewed at each meeting. Areas of concern are highlighted and escalated when required. The work programme for 2014/2015 is included in the report as Appendix 1.

4.7 Programme of policy review

All IPC policies were reviewed during the 2013/14, either before, or in line with the policy review programme which forms part of the IPCSC workplan.

4.8 Links to the Medicines Management group

A representative from pharmacy is a member of the IPCSC and ensures any infection related issues are raised at the appropriate forum. Reports on antibiotic prescribing across the inpatient and community pathways are included in this report.

4.9 Links to the Health, Safety & Wellbeing subcommittee and Patient Safety and Effectiveness subcommittee

The CNSs attend the Health, Safety & Wellbeing subcommittee, and also work in partnership with the clinical governance manager, and the risk & legal services manager regarding key clinical standards/ risk issues. The DIPC is a core member of the Patient Safety & Effectiveness subcommittee, as well as the Operational Board, and can therefore raise IPC issues directly via these forums.

4.10 Links to the Medical Devices group

The Medical Devices Group (MDG) meets bi monthly, reporting directly to the Patient Safety & Effectiveness subcommittee. The minutes of this group are also received by the IPCSC and Health, Safety and Wellbeing subcommittee.

The MDG is chaired by the Senior Health and Safety Advisor and attended by staff from all service lines including a representative from the IPCT. Contracts are in place for servicing and maintenance of medical devices and equipment with external providers depending on the nature of the equipment.

5. Refurbishments and new builds

The IPCT provide advice and support during refurbishments and new builds across the Trust, including advice for primary care premises to ensure compliance with national guidance (Department of Health, 2012).

6. CWP Safe systems for disposal of sharps

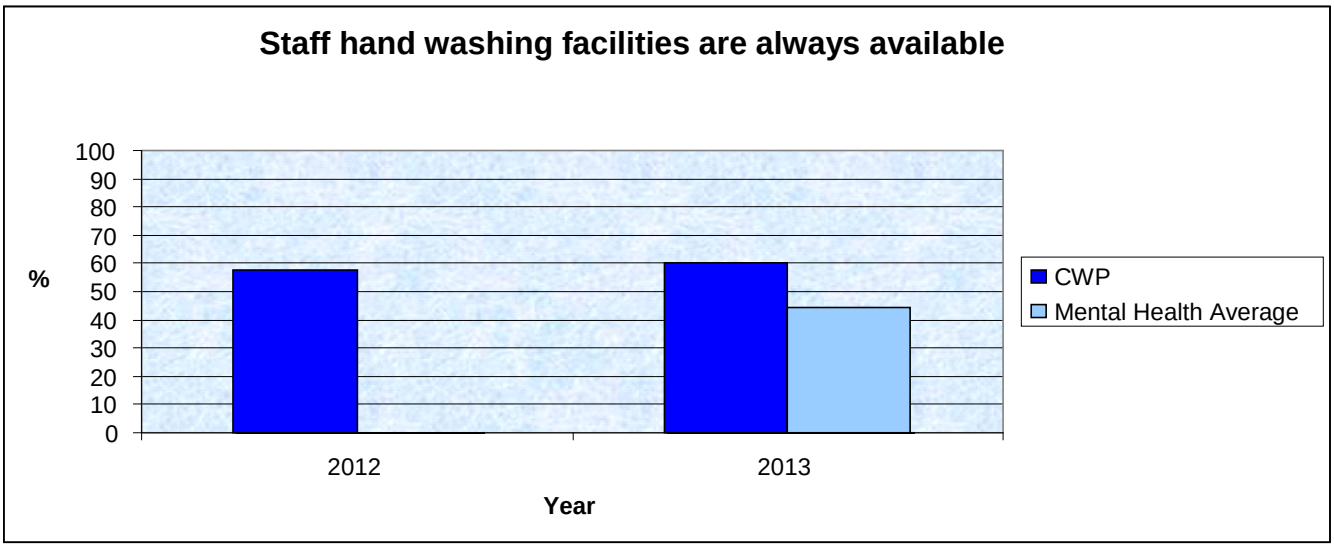
Sharps waste units have been assessed across the organisation and consistent products implemented. Sharps awareness cards have been distributed across the organisation and training continues. The IPCT receive copies of all sharps injuries that are reported via DATIX. All reported injuries are investigated by the IPCT to ensure that Trust policy was followed and to establish if there is any learning from the incident, which is then cascaded via educational forums and used to inform future practice.

7. Hand decontamination

CWP IPCT remains committed to increasing hand hygiene compliance and the IPCT continues to actively promote hand hygiene, via Trust induction, mandatory employee learning (MEL) and at other events.

8. Infection Prevention and Control and the National Staff survey - 2013

The annual national staff survey in 2013 identified that the percentage of staff stating that hand washing materials are always available increased from 59% in 2012 to 60%, remaining above the national average in MH Trusts of 54% in 2013, and in the Best 20% of all MH trusts.

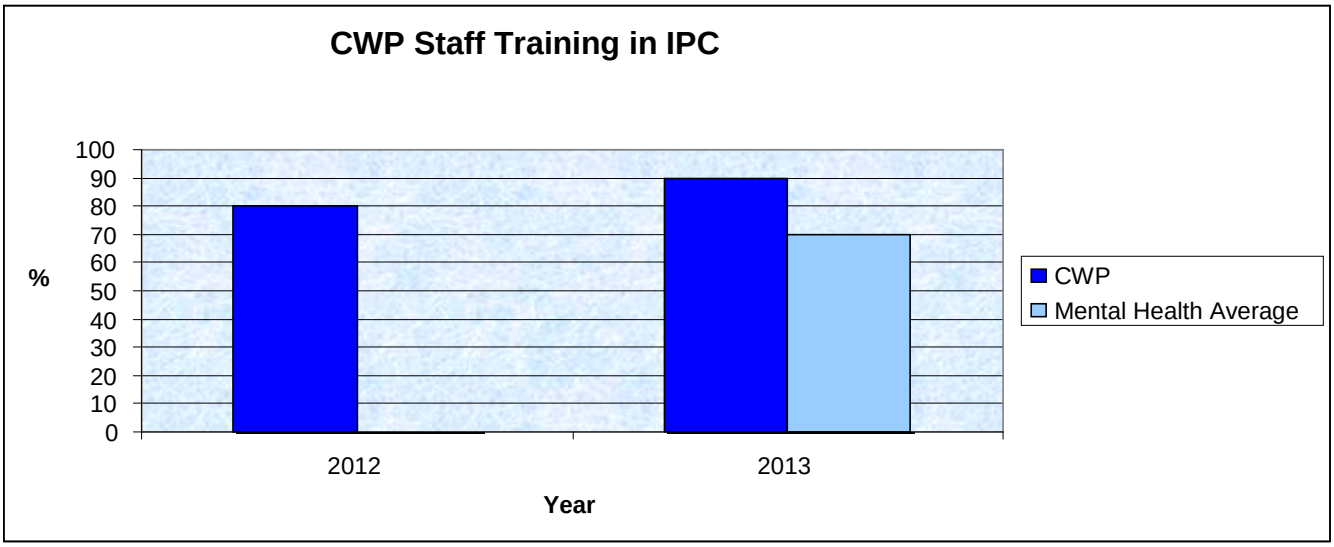


9. Learning and development activity

9.1 Induction and mandatory employee learning

The IPC team have facilitated Induction (12 sessions), Junior Doctors (5 sessions) and Mandatory Employee Learning, Modules 1 (18 sessions), 2 (66 sessions) and 3 (59 sessions), aimed at all CWP employed staff in the following groups: inpatient, community and non-clinical staff.

All training is face to face with figures demonstrating a total of 2380 (70%) for the 2013/14 year, in comparison to 2012/13 which was 2080 (63%). This has been achievable by the IPCT making available to Trust staff in excess of 159 education sessions, all facilitated by the IPCT.



The IPCT also provide Aseptic Non Touch Technique (ANTT) training, as well as High Impact Intervention training to support the Safety Thermometer, NICE guidance, CQC and Quality requirements, thereby supporting compliance the Safety Metrics and Never Events.

In the East locality, additional training was provided for all staff previously employed by Aramark, when the staff became CWP employees in the latter part of 2013. During the period this report covers the IPCT delivered an extra 37 sessions of IPC training

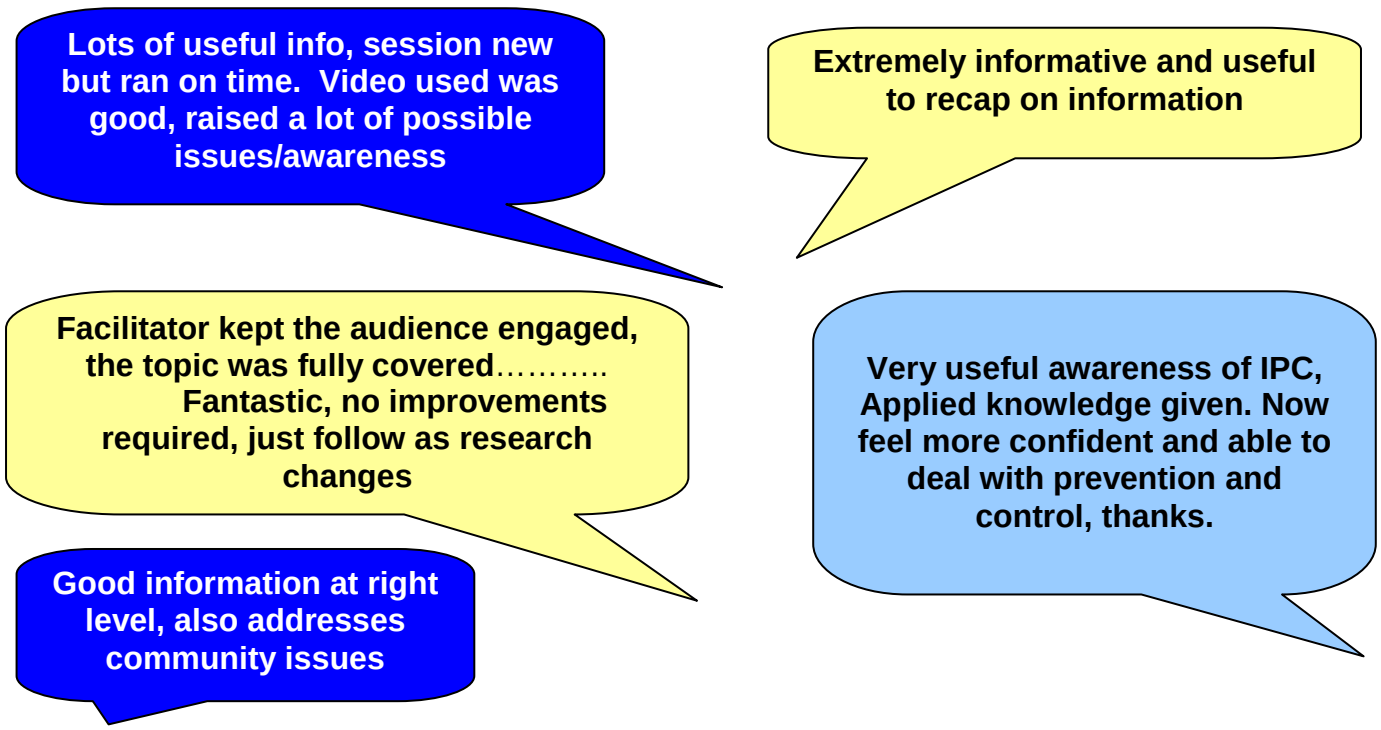
Additional training has also been provided by the IPCT to away days where requested, for example to Thorn Heys and Eastway.

The training sessions delivered by the IPC team incorporate the following guidance as a minimum:

- Everyone's role in relation to IPC and IPCT responsibilities

- Multi Resistant Organisms
- Effective hand decontamination
- Compliance with CQC criteria
- Occupational exposure to blood and/or body fluid, including needle stick injuries and post exposure prophylaxis
- Cleaning of equipment and the general environment
- Contact details for the team when in need of expert advice

The CWP Learning & Development team manages the attendance of all training sessions, and also provide the IPC team with a regular summary report of MEL feedback. Throughout the period of this report, the IPC mandatory training session consistently scores "good" or "excellent". Examples of feedback comments are provided below.



9.2 Continuing professional development of the IPC team

In addition to completion of organisational training requirements, the IPC team attends relevant local and national workshops and conferences, including national and regional Infection Prevention Society (IPS) conferences. Team members are actively involved in the IPS, including representation as the education officer for the North West, National education leads chair and IPS North West conference coordinator for the second consecutive year. All IPCT members hold recognised infection prevention and control qualifications, at BSc level and the CNS's are all in the process of completing their Masters programmes. The IPC secretary is near completion of the AMSPAR qualification. Team members have facilitated and submitted posters at Regional and National Conferences and also spoken at national IPS conference in London during 2013.

10. CWP Inpatient pathway activity - key achievements 2013/14

10.1 Audits

Modern Matron Audit.

The IPCT has supported the Modern Matron Audit programme through attendance at the monthly Modern Matron audits across the Trust. The weekly cleaning lists have generally been fully completed with very few exceptions. Any omissions are addressed via Ward Managers and link nurses to ensure standards are maintained.

Annual Mattress Audit.

This was completed across all inpatient areas in 2013 in accordance with the agreed audit programme. This process identifies damaged mattresses that require replacement, highlighting where damage has been caused by other factors as opposed to normal use. This process enables the DIPC to provide assurance to the Board that service users are cared for in clean, safe environment.

Inpatient Area Audits

During the period this report covers the team carried out 55 audits in inpatient areas. The results are reported back to the IPCSC where areas of good practice are highlighted and appropriate action regarding areas of concern is actioned. See table 1, 2 and 3 below. Results are also included in the corporate report to board.

The team have worked with colleagues in Learning Disability (LD) Services to create a pictorial Infection Prevention and Control audit tool for use in LD Services in conjunction with the IPCT. The aim is to encourage service users' involvement in some aspects of the Annual IPC Audits for In-patient areas and ensure their feedback is integrated into practice.

Table 1 – Audits for 2013/2014 – Wirral (Mental Health)

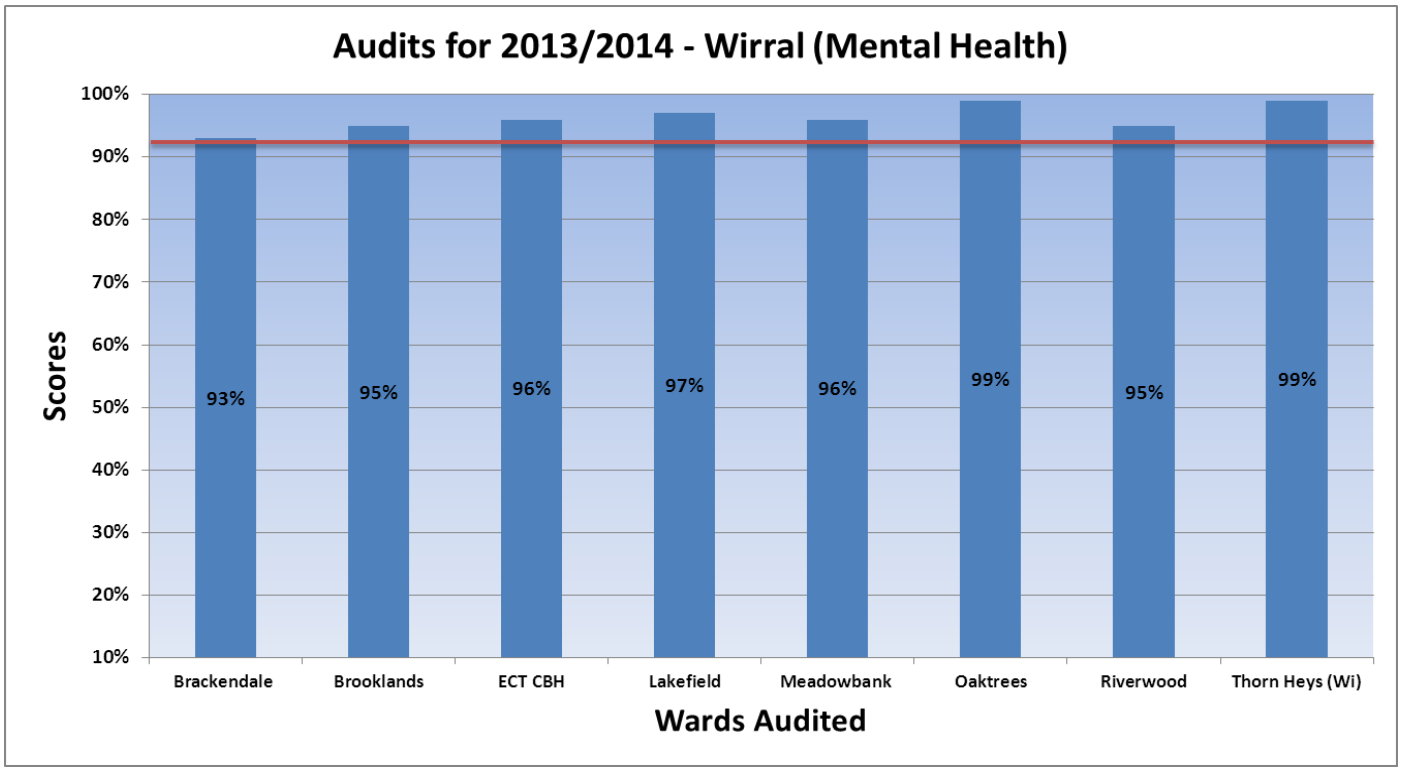


Table 2 – Audits for 2013/2014 – West (Mental Health)

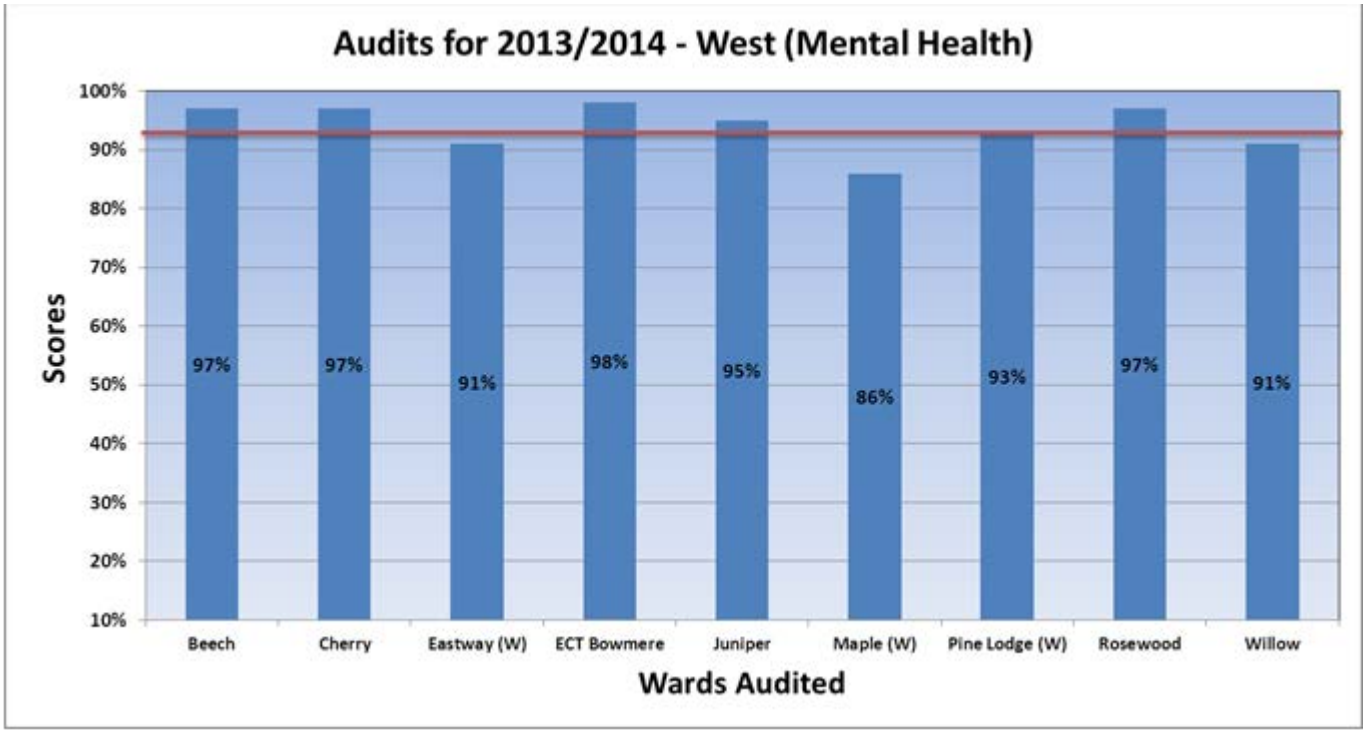
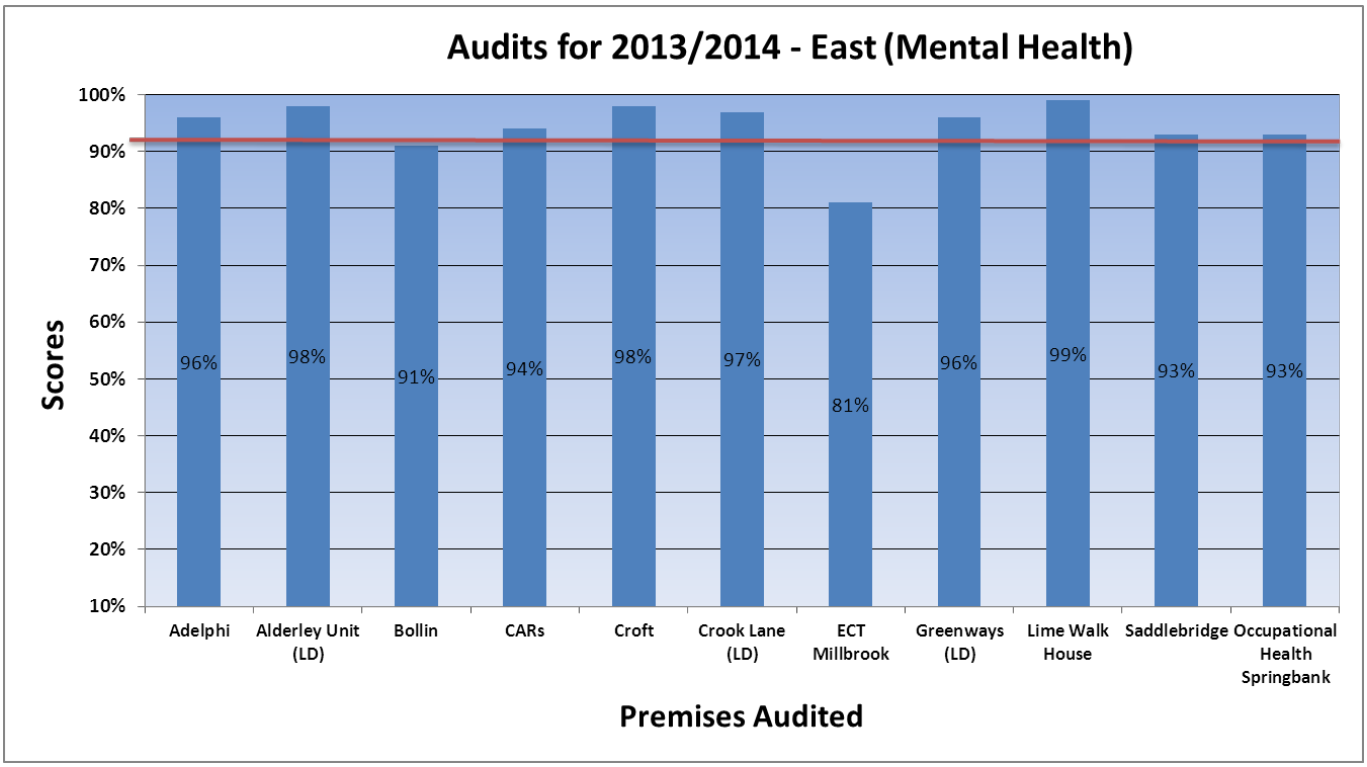


Table 3 – Audits for 2013/2014 – East (Mental Health)



The compliance score was increased from 92 to 93% in April 2013 by the IPCSC to demonstrate continuous improvement. Where an overall score does not reach this, a review is carried out within three months and regularly afterwards until a compliance score is reached. Any risks are placed on the IPCSC risk register and included on the combined IPC, Estates and Facilities C4C work programme.

10.2 Partnership working across the local health economy

In 2013/14 the IPCN in East established links with the IPC Team at East Cheshire Hospitals Trust (ECHT). This has allowed for excellent partnership working with (ECHT) including attendance at the ECHT Infection Prevention and Control Study Days. Forging these valuable links has improved understanding of each other's service. These links will continue to be developed as the ECHT team expands via the recruitment of new staff.

10.3 Promoting the service

The IPCT work hard to provide a high profile across CWP. During the period this report covers the team have particularly focused on supporting the Community Mental Health Teams (CMHTs). This has been achieved by attending CMHT team/business meetings in order to promote good IPC practice and address the specific needs of the teams.

The IPCN in East has been working in partnership with staff on two wards on the Millbrook Unit to support specific work plans set for those wards. This has opportunity has informed IPC practice in these two areas ensuring that service users are cared for in a safe, clean environment.

10.4 New builds

The IPCT have provided expert advice and support to the Alderley new Build project ensuring that the project complies with Hospital Building Note HBN 00-09, Infection Control in the Built Environment. The team look forward to the opening of the new building in 2014.

10.5 Integrated working and support across services

The In-Patient Pathway has been responsible for the completion of additional investigations and reports to support clinical services.

10.6 Service user Involvement

During Global Hand Hygiene Day in 2013 the In-Patient Pathway facilitated activities across CWP involving service users. The aim of these sessions was to make direct links with service users and promote the importance of hand hygiene to their personal health & wellbeing. Activities included competitions, such as cupcake baking, with prizes for all participants. These events were well received by service users.

The IPCN in East has been involved in courses provided by the Recovery Colleges in Macclesfield and Crewe. The aims of the Health Promotion Sessions were to empower service users regarding their health & wellbeing. The IPCN provided a session to raise awareness of how good hand hygiene can directly affect personal health. In addition links were made between the tasks of daily living and infection control measures. The sessions were positively evaluated and more are anticipated for the future.

Across Wirral and West localities the team have supported the Health and Well Being clinics which are run from a variety of resource centres. The sessions provided have been service user led and have included topics such as food safety and personal hygiene.

During 2013 the team supported Occupational Health in running a competition for service users to design a logo that would be reproduced on tabards to be worn by immunisers during the staff seasonal influenza vaccination campaign. There were some innovative designs entered with the eventual winners being service users on Beech Ward and the Alderley Unit.

10.7 Health Care Associated Infection (HCAI) & Surveillance

During the period this report covers there were no cases of Clostridium difficile or MRSA Blood Stream infections reported to the IPCT in inpatient service. This zero figure assures the Board that excellent IPC standards exist in inpatient services, and patients are not harmed by HCAI's.

10.8 Outbreaks inpatient areas

During 2013/14 there were five outbreaks of diarrhoea and/or vomiting that resulted in ward closures in inpatient areas, as follows:

Ward	Date	No of staff /patients affected	Cause identified?	Length of closure
Eastway	April 2013	0/2	No – likely to be viral	3 days
Croft	November 2013	10/5	As above	7 days
Adelphi	December 2013	4/5	As above	7 days
Juniper	January 2014	0/9	As above	4 days

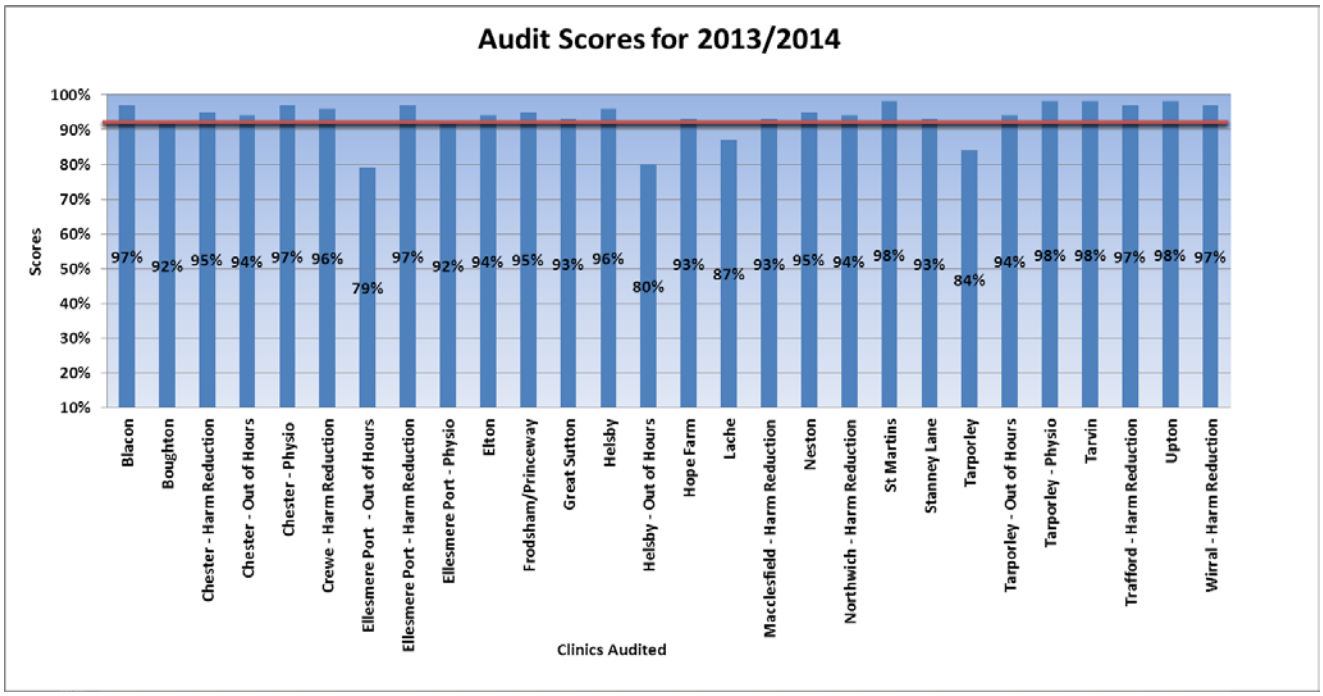
All IPC incidents and outbreaks are routinely reported to the IPCSC and the Board of Directors, ensuring relevant information and good practice is shared and action plans developed where required. The focus of the IPCT is to prevent outbreaks and when they do occur, to reduce the impact of the outbreak on service users and staff. This is achieved by monitoring environmental cleaning standards and hand hygiene and by ensuring staff can identify a potential outbreak which is addressed during Essential Learning. In order to learn from the outbreak and thus inform future practice, post-outbreak review meetings, inviting relevant staff involved, are held for CWP inpatient areas within 5 working days of the end of an outbreak. These meetings include clinical service managers, Modern Matrons, ward managers, temporary staffing, occupational health, practice education facilitator and facilities manager.

11. Community pathway activity - key achievements 2013/14

11.1 Audit

During the period this report covers the team carried out 55 audits in the community setting. The results are reported back to the IPCSC where areas of good practice are highlighted and appropriate action regarding areas of concern is actioned. See table 4 below. For non-compliant areas, the actions are identical to inpatient areas. The compliance score was increased from 92 to 93% in April 2013 by the IPCSC to show a year on year improvement. Where an overall score does not reach this, a review is carried out within three months and regularly afterwards until a compliance score is reached. Any risks are placed on the IPCSC risk register and included on the combined IPC, Estates and Facilities C4C work programme

Table 4 – Audit Scores for 2013/2014



11.2 HCAIs and Surveillance

The IPC team continue to respond and follow up every positive microbiology result requiring intervention and action, 509 in total for this year. These consist of Meticillin Resistant Staphylococcus Aureus (MRSA), Clostridium difficile, ESBLs, and a mixture of other organisms that require varying amounts of support to GPs, patients, carers and other care providers.

In addition, all MRSA Bacteraemia infections and Clostridium difficile infections in Western Cheshire locality are investigated by completing either a Post Infection Review (PIR) or Root Cause Analysis (RCA) as part of the contractual obligation for our commissioners (40 in total).

During 2013/14 we have also seen a rise in Multi Resistant Organisms including Carbapenemase-Producing Enterobacteriaceae (CPE). A response to the national alert sent to Chief Executive Officers in February 2013 has been addressed by the DIPC, communicating the IPCT response to same.

This is also the second consecutive year in the previous five recorded, that the Western Cheshire HCAI rates for clostridium difficile toxin infections have decreased coming under ambition for the second consecutive year.

Mandatory Reportable Infections – Western Cheshire community population

	MRSA infections	ESBL E. coli' UTIs	E.coli Bacteraemia	MSSA Bacteraemia	MRSA Bacteraemia	Clostridium difficile
2011 - 2012					6	61
2012 - 2013	20	249	135	21	4	40
2013 - 2014	52	417	149	24	6	34

The team work closely with the Consultant in Public Health and pharmacy teams in supporting the antibiotic formulary in response to microbiology results. Surveillance activity has shown between 9% and 55% total resistances to oral antibiotic treatments for ESBL infections (as in table above). This work is ongoing in terms of communications with microbiologists, pharmacists and GPs.

11.3 MRSA screening and decolonisation for Western Cheshire pre-operative patients

The community IPCT also support the decolonisation process for MRSA positive pre-operative patients referred from the Countess of Chester Hospital as part of the Service Specification on behalf of Western Cheshire CCG. For the period April 2013 to March 2014, 67 patients have been referred for MRSA decolonisation or suppression treatment. All patients in receipt of the MRSA screening are included in patient satisfaction surveys and continually receive a positive response – some patient feedback comments are included below.

Every aspect of my contact with the IP&CT was excellent – I think they are wonderful!

Excellent service & details presented. Everyone polite & factual. Well done.

A very caring and efficient service.

They explained everything proficiently and gave me total re-assurance.

11.4 Catheter associated urinary tract infection

The IPCT have worked tirelessly in developing and supporting the implementation of NICE guidance and CQC requirements with regards to Catheter Associated Urinary Tract Infections. This has included the continuing monitoring of all catheterised patients in the community setting with provider input, on average 250, supporting the introduction of a safety metric, product masking, training, staff meetings, communications, and updating the 10 week catheter pathway.

11.5 Physical health in mental health education

Since September 2012, although the PH trainers have finished in post, bespoke physical health in mental health training has continued with regards to risk assessments, clinical inpatient support and the ongoing maintenance and development of care notes assist.

The IPCT continue to work collaboratively with colleagues from CWP West Physical Health providing continence and tissue viability support and now have joint policies relating to assessments, procedures and policies. This also includes the implementation of Aseptic Non Touch Technique (ANTT) across the Health Economy and new patient information leaflets for Urinary Catheters and MRSA.

11.6 Service user involvement in IPC

The team consistently respond to, and request information from patients to support their involvement in any care provision. This has led to more home visits to support patients, and patient involvement in all RCAs and PIRs. Patients have the opportunity to complete an evaluation questionnaire anonymously about the MRSA service. Patient information leaflets are monitored and changed in response to service user feedback. The team now offer patients two hour time slots to prevent visiting outside of allocated times.

12. External Services, including Tuberculosis (TB) Pathway activity – key achievements 2013/14

The external services pathway has worked closely with colleagues from other organisations such as the Public Health England, CQC and local authorities; including Environmental Health Officers to ensure an effective response to public health issues where IPC support, investigation, advice and training have been required. Where required, further investigation, contact tracing and follow up have been managed to ensure IPC is considered across the health economy preventing avoidable harm for both the local population along with visitors to the area.

12.1 Advice and support

IPC advice, support and training have been facilitated for GP practices, along with other external services including Tarporley War Memorial Hospital and the Hospice of the Good Shepherd.

The Practice Nurse IPC Link forum is now well established and includes guest speakers and educational sessions for relevant subjects including immunisation and tissue viability. This forum is well attended and allows appropriate information to be shared which facilitates relevant infection prevention and control practice to become embedded, reducing the risk of healthcare acquired infection and highlighting required standards for compliance to Care Quality Commission (CQC) registration requirements which has been of particular interest to Practice Nurses during this last year as CQC Inspections commenced within GP practices.

12.2 Care home infection prevention and control support

Apart from ensuring effective outbreak management within care homes, IPC advice and support has been provided for a wide range of incidents and concerns within the care home settings including the increased incidence of patients being identified as having Vancomycin Resistant Enterococci (VRE) results following screening in acute hospital. This has generated a number of concerns which has required proactive management to ensure care home staff are aware of required infection control standards. VRE has been included as an educational session with in the well-established IPC Care Home Link Forum where other topics have included outbreak management, hand hygiene and management of sharps injuries.

Close working within the IPCT ensures appropriate support and investigations are completed in relation to RCAs, and ongoing reactive work regarding laboratory results, which supports education and awareness rising amongst staff in the management of urinary tract infections and related antibiotic prescribing.

12.3 Outbreaks within the Western Cheshire health economy

Outbreak management forms an integral part of the health protection/external services pathway within the IPCT. Support, guidance and co-ordination for any outbreak situation within Western Cheshire is provided to external providers, including care homes, nurseries, and schools, ensuring management of outbreak situations are in line with Public Health England Guidance and reporting structures.

There were 19 outbreaks of gastrointestinal illness in care homes during 2013/14 compared to 29 during the previous year, all of which were managed in accordance with national guidelines. All outbreaks were managed in accordance with Public Health England guidance, and relevant organisations were informed and updated daily. All care homes having been affected by outbreaks have been offered follow up meetings to reflect on the management of the incidents, and training provided to ensure compliance with IPC standards. Outbreak management has also been discussed at the care home IPC link group forum to enhance knowledge around this important area. Gastrointestinal outbreaks resulted in care homes registered in Cheshire West and Chester, with the exception of those in Vale Royal, being closed to admissions for a total of 140 days. The days closed ranged from 3 – 13 days. Data indicates 140 residents' were symptomatic along with 97 staff. This demonstrates the importance of ensuring effective infection prevention and control systems, including relevant training for staff are in place within homes.

Close working relationships with colleagues within Public Health teams and local authorities facilitated distribution of Public Health England guidance to all schools across the Western Cheshire footprint. Those affected by outbreaks received support and advice for, pupils, parents and staff to ensure effective IPC measures were introduced. A number of schools/ nurseries and other childcare facilities have been supported during 2013-14 during outbreaks or incidents relating to;

- Gastrointestinal illness
- Threadworms
- Chickenpox
- German measles
- Scarlet fever
- Hand Foot and Mouth disease

12.4 Tuberculosis Service

Activity within the TB Service has continued to increase over the past 4 years. The introduction of IGRA as the preferred test for TB exposure in addition to Mantoux testing prior to BCG vaccination has resulted in an overall increase in testing for TB exposure up from 248 in 2010-11 to 346 in 2013-14.

There has been an increase in the number of Western Cheshire staff requiring BCG vaccination as a direct consequence of the national BCG vaccination being stopped in 2005.

The service continues to ensure the latest NICE guidelines are met, including the latest guidance related to the management of TB in 'hard to reach' groups. In response to this guidance there has been increased communication with drug and alcohol services and community pharmacies. Two drop in clinics has been set up for TB screening, one at the local homeless hostel and another at the Nurse led clinic at the Countess of Chester hospital.

The TB service is always trying to improve the identification of people who would benefit from TB screening/BCG vaccination, as such new entrants are now identified by new GP registration as well as by arrival at Health Control Units; and the identification of babies who are eligible for neonatal BCG vaccinations has also been enhanced by way of improved antenatal screening. This increased activity within the TB service has been delivered within the same number of resources provided by the TB

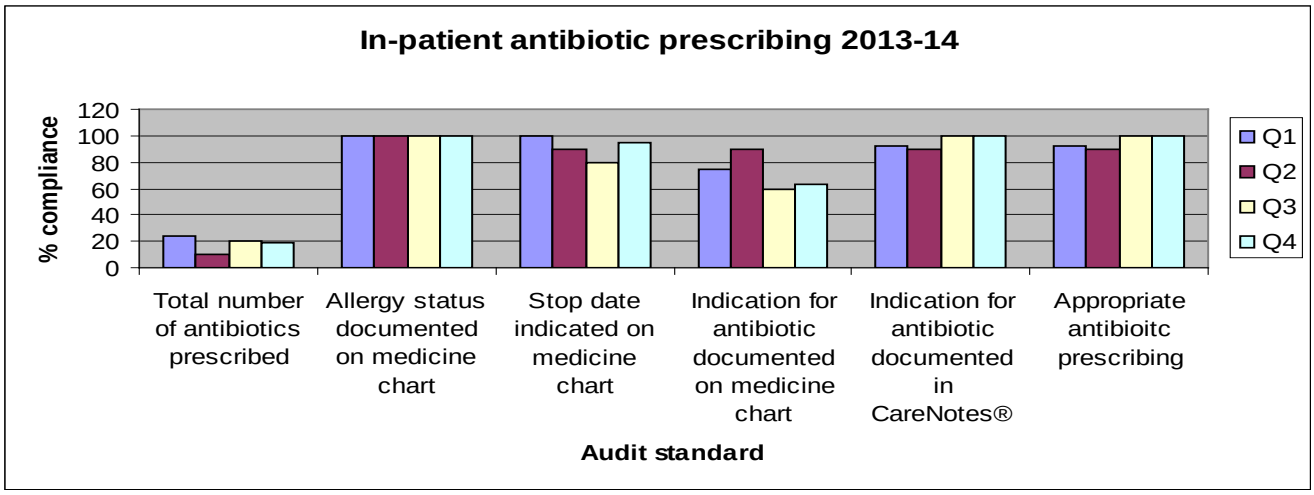
specialist nurse supported by the IPCT. The DIPC will raise the issue with the Director of Public Health to identify a way forward.

13. Inpatient services antibiotic audit 2013/14

The point prevalence audits on antibiotic usage across the inpatient units were increased to quarterly reporting in 2011 as requirement of the quality contract schedule.

Audits were conducted for one week in June, September, December 2013 and March 2014 and covered the standards necessary for the prudent use of antibiotics in reducing the risk of antibiotic resistance and antibiotic associated adverse effects. Antibiotic prescribing for in-patients followed the NHS Wirral antimicrobial prescribing guidelines for 2013-14.

The graph below shows the antibiotic audit standards measured and their percentage compliance each quarter. It is aimed to achieve compliance of 100% for each of the standard measured. However the total number of antibiotics prescribed in the audit periods was low (June 24, September 10, December 20, March 19) and any variation in practice makes a large difference in the % compliance figure.



Since the quarterly audits were commenced in June 2011, there has been no prescribing of antibiotics to treat *Clostridium difficile*.

The compliance rates for 2013-14 continue the encouraging results seen in the previous year with a sustained 100% compliance with the documentation of allergy status on the medicine chart. It is also possible to report that the average percentage compliance with the documentation of antibiotic indication within Carenotes has reached 97% this year compared to 87% last year. This is the responsibility of the prescriber, and has shown a significant improvement. The standard for documenting the stop date on the antibiotic prescription has fallen slightly from an average of 95% (2012-13) to 91% (2013-14).

The standard requiring most improvement moving forward was also identified last year; documenting the indications of the antibiotics on the medicine chart (average percentage compliance being 74% last year and 72% this year).

The most encouraging compliance result has been the sustained 100% appropriate antibiotic prescribing measured in quarter 3 and four of this year. Although non-formulary antibiotics are sometimes prescribed, these have been on the recommendation of the microbiologist and as such are deemed appropriate as specialist advice has been sought prior to prescribing.

The pharmacy team are continually promoting prudent antibiotic prescribing to prescribers through education and induction sessions and activity at ward level. Having easy access to the antibiotic formulary on the Trust intranet and a single page treatment summary of common infections guideline facilitates good antibiotic prescribing.

The results of the audits are shared with MMG and IPCSC. Learning from the audits is communicated by the clinical pharmacist's through local education sessions of the junior doctors training and pharmacy communication bulletins.

13.1 Community West PH antibiotic prescribing 2013/14

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

- Community Matrons – nurse independent prescribers based in the community.
- Out of Hours service – A mix of medical (GP) and nurse independent prescribers.

Addressing healthcare-associated *Clostridium difficile* infection remains a key issue on which NHS organisations have been mandated to implement national guidance that includes restriction of broad spectrum antibiotics, and in particular second and third-generation cephalosporin's, quinolones and clindamycin (see table below)

Propensity of antibiotics to cause *Clostridium difficile* associated disease

Less Risk	Medium Risk	High Risk
Doxycycline	Amoxicillin	Cefalexin
Flucloxacillin	Azithromycin	Cefotaxime
Metronidazole	Clarithromycin	Ciprofloxacin
Nitrofurantoin	Co-amoxiclav	Clindamycin
Penicillin		Ofloxacin
Trimethoprim		
Vancomycin		

CWP West Physical Health antibiotic benchmarking is currently measured against one local and two national measures:

- Local - compliance with NHS Western Cheshire antibiotic formulary.
- National - prescribing comparator "Cephalosporins and quinolones % items" This is defined as "the number of prescription items for cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial items".
- National - prescribing comparator "3 days trimethoprim average daily quantity (ADQ) /item" comparator which benchmarks 3 day courses of trimethoprim for uncomplicated urinary tract infections (UTIs). An ADQ of 3 equates to a three day course. Levels above this, demonstrate that longer courses have been prescribed, which are often seen in the elderly and in those with complicated urinary tract infections.

Results
Data below compares out of hours prescribers against the national and local benchmarks outlined above.

	CWP West average 2012-13	Q1 13/14	Q2 13/14	Q3 13/14	Average 13/14 YTD
Out of Hours - all prescribers					
% Formulary antibiotic items (local)	**95**	**97**	**97**	**97**	**97**
% Cephalosporin + quinolone (national)	**7**	**6**	**7**	**6**	**6**
Out of hours - GP only					
% Formulary antibiotic items (local)	**95**	**97**	**97**	**97**	**97**
% Cephalosporin + quinolone (national)	**7**	**7**	**9**	**6**	**7**
Out of hours - NMP					
% Formulary antibiotic items (local)	**96**	**98**	**100**	**100**	**99**
% Cephalosporin + quinolone (national)	**5**	**<1**	**8**	**9**	**6**
Out of Hours - all prescribers					
Trimethoprim ADQ/item (national)	**4.7**	**4.9**	**4.8**	**4.8**	**4.8**

At the time of writing the report, quarter 4 epact data was not available for analysis due to a lag time in the processing of epact data by the NHSBSA.
Overall, prescribing values have improved on 2012-13 results

Comparison of national and local benchmarks:

	Avg value 12/13	Avg value YTD 13/14
CWP Out of Hours - all prescribers		
% Cephalosporin + quinolone	7	**6**
Trimethoprim ADQ/item	4.7	4.8
Western Cheshire CCG		
% Cephalosporin + quinolone	6.0	6.6
Trimethoprim ADQ/item	6.1	6
National		
% Cephalosporin + quinolone	5.3	5.8
Trimethoprim ADQ/item	6.1	6.1

Community Matrons	CWP Average value 12/13	Q1 13/14	Q2 13/14	Q3 13/14	CWP Average value 13/14
% formulary adherence (local)	**93**	**100**	**100**	**100**	**100**
% Cephalosporin and quinolone prescribing (national)	**8**	**3**	**10**	**10**	**8**

This is the second year of using the national trimethoprim comparator and as can be seen the average value of 4.8 compares favourably to the Western Cheshire CCG value of 6.0 and the national average 6.1 (Apr13–Dec 13).

Community matron prescribing of antibiotics is low but has reached 100% formulary adherence and sustained this level for the three quarters reported. No figures for the trimethoprim comparator are reported due to low baseline data.

14. Estates Department contribution to the IPC work programme

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

- Health Building Note 00-09 (Department of Health, 2013 -which supersedes and replaces all versions of Health Facilities Note 30) and covers the importance of a clean, safe environment for all aspects of Healthcare.
- Health Technical Memorandum 04 01, The Control of Legionella, hygiene, "safe" hot water, cold water and drinking water systems." Part A: Design, installation and testing and Part B: Operational management. (Department of Health (DOH) 2006). CWP's 'control of Legionella' closely adopts the requirements of the above HTM.

  Estates are also currently looking to see if any amendments are required to our management of this issue in light of the very latest guidance to come out of the HSE in the form of an Approved Code of Practice L8 4th edition and HSG 274 Part 2 both of which were published in April 2014. The key areas for noting are summarised below.

14.1 Legionella compliance with legislation

The control of legionella is covered by the legal requirements of the Health & Safety at Work Act 1974 concerning risks from exposure to legionella and guidance on compliance with the relevant parts of the Management of Health and Safety at Work Regulations 1999. Legionella is managed and controlled by the estates department, following CWP policy, IC 17, Control of Legionella and for safe water services. The estates department continues to employ the services of ZetaSafe Ltd, who provide professional legionella services and undertake two yearly legionella risk assessments on Trust properties. This service also provides for provision of internet based legionella database storage and reporting for statutory test results. There is also a three monthly review of test results, control measures and procedures to ensure compliance with current legislation. Estates Operational Service continually undertake legionella tests throughout the Trust estate, with 90.00% of tests being within specified limits for the last 12 months. A test is classified as outside of specified limits if it is as little as 1/10 of one degree above or below the set parameter. The majority of out of specification readings are corrected within a day, therefore the risk is minimal and acceptable.

14.2 Capital programme Works

Whilst the capital programme only includes limited projects, specifically aimed at addressing IPC, all new build and major refurbishment projects are designed in full accordance with the latest Building Regulations, and British Standards together with the latest HTM guidance specifically in relation to Infection Prevention and Control and with consideration to the IPC audits. Standard details include:
PVC wall cladding in lieu of tiles.
Sheet vinyl flooring with coved skirting and welded joints.
HTM64 sanitary ware and brassware.
Solid core laminated service panelling to conceal pipe work.

All projects, both new builds and refurbishment, include advice from the IPC team which reflects the latest Health Building Note 00-09 (Department of Health, 2013) which states 'the infection prevention and control (IPC) team should be consulted throughout every stage of a capital project and their views taken into account'.

The end of year position for 2013/14 capital programme was recorded at £5.8m - specific projects to note include:

- Completion of stage 1 Stein Centre refurbishment - £700k
- Alderley Unit – environmental upgrade - £80k
- Eastway – Environmental works £24k
- Soss Moss Phase 2 continuation - £2.4m
- Maple Ward, Bowmere – provision of new seclusion suite - £30k
- Upgrade of seclusion rooms within Bowmere & Springview - £140k

The proposed capital programme for 2014/15 was approved by the Board in January 2014 for expenditure amounting to £12.4m. Specific proposed projects to note include:

- Soss Moss – Phase 2. £2.9m in year spend
- CAMHS Tier 4 New inpatient facility - £1.0m (As part of £14m investment)
- Springview – Environmental Improvements £2.8m
- Eastway – Environmental Improvements - £200k
- Croft Ward Millbrook – Environmental / Clinical works - £350k
- Relocation of Drug & Alcohol services to Stein centre - £250k

14.3 Revenue programme works

The end of year position for the 2013/14 revenue programme was recorded at £868k. Specific projects to note include:

- Decoration and flooring programme – £90k
- PLACE action plan – £55k
- Environmental upgrades - £40k

The proposed revenue programme for 2014/15 was approved by the Board in January 2014 and is set at £250,000. Specific proposed projects to note include:

- Decoration programme - £90k
- PLACE action plan - £55k
- Environmental upgrades - £40k
- Control of Legionella - £5k (This element only relates to Legionella risk assessments on new capital works)

The above planned works will be prioritised to address works arising within year through the IPC team environmental audits - which will be responded to as quickly as possible. Estates service have also agreed a recurring planned replacement programme for ward based washing machines, dryers , dishwashers and EBME equipment in order to enable finance to plan for this recurring expenditure and avoid periods of downtime when these facilities are unavailable to wards due to breakdown. The equipment budget has been set at £86k for 2014/15.

14.4 Physical health west capital and operational revenue programme

The operational capital and operational revenue programme for 2013/14 included £205k of environmental upgrade works across numerous properties. In direct response to CWP IPC audits of Physical health West properties, a further £30k was invested from the minor works budget to address specific action points. As from 01/04/2013 the ownership of this estate transferred to NHS Property Services. CWP continue to manage this estate on their behalf until 30/09/2014 when NHS Property services will oversee their own capital / revenue programmes**.**

15. Waste management

CWP is committed to reducing the impact of environmental pollution and minimising infection risks related to any of its activities, including the disposal of healthcare waste. A statutory duty of care under the Environment Protection Act (1991) applies to everyone in the waste management chain. It requires producers and others who are involved in the management of the waste to prevent its escape, and to take all reasonable measures to ensure that the waste is dealt with appropriately from the point of production to the point of final disposal.

The development of new waste management strategies and closer working practice with the IPCT, health and safety advisors, and facilities management has promoted better practice and understanding regarding Infection Prevention and control in the Waste Management chain.
The existing Trust waste policy is current under review in the light of the updated document issued by HTM 07-01 Safe Management of Healthcare Waste V2 March 2013. The updated version places an emphasis on a drive to address the carbon impact related to waste through resource efficiency, transport impacts and disposal arrangements

- the integration of new sector guides on GPs and dental practices as well as incorporating Health Technical Memorandum 07-06: 'Disposal of pharmaceutical waste in community pharmacies' as a sector guide
- a focus on practical advice and examples for classifying waste, in particular the infectious and offensive waste streams, including case studies to highlight best practice
- a review of the terminology used for healthcare clinical and non-clinical wastes.

The reviewed policy will show clear guidance on the safe handling, storage and disposal of waste, to minimise risks of infection and reduce environmental damage.

15.1 Waste auditing

Waste audits are conducted at least annually in all clinical areas. Where a new service is introduced, a full audit is carried out to assess all types of waste. Waste audits will be always be completed if there are any issues raised through an IPC audit and any that have been highlighted in specific areas. CWP have had issues in the following areas:
Temporary closure on sharps bins in between use
Sharps bins not signed off with name of clinic or ward
Sharps bins not closed off properly before disposal
Pre- Acceptance waste audits were completed 2013/14 on all sites that produce less than 500 kg of hazardous waste. In 2014 Annual Pre–Acceptance Audits are to be submitted to Trust's healthcare waste contractors and the Environment Agency. In house Waste audits will continue to be completed as part of the cleanliness monitoring by domestic supervisors. Finding from the audits are summarised and sent to relevant manager and IPC with action points to be completed if necessary. All clinical Staff are reminded of best practice especially when assembling, handling and closing sharps bins. All other waste streams are addressed through verbal education in localities and posters displayed in relevant areas.

16. Cleaning services

The Trust's operational cleaning services are led by the Head of Facilities who is responsible for implementing the Trust's cleaning strategy, and reports to the Associate Director of Infrastructure Services. The Head of Facilities is supported in her role by a Deputy, 2 Senior Facilities Manager and a Facilities Manager, plus the relevant operational structures. CWP has a Facilities team in each locality and the team comprises of managers and supervisors, who are responsible for the co-ordination of services and the monitoring of quality.

The majority of cleaning services provided to CWP properties are provided in-house. These include:

- Bowmere Hospital and associated sites
- Springview
- Health Centre and clinics in Cheshire
- Stein Centre
- Wirral Community
- Ashton House Site
- Millbrook and associated sites
- Soss Moss site

First Eclipse provided contracted cleaning services to the following sites:

- Aqua House.
- Hawthorns Winsford.
- Chester Gates.
- Vale Royal House Winsford.
- Marsden House and the Eating Disorders service at St Anne's Street

In addition West Cheshire Cleaning Services provided services to The Oaks, Sycamore House and Princeway.

16.1 Monitoring Arrangements

To monitor compliance with the Trust's cleaning standards, the Facilities department uses computerised software called Credits 4 Cleaning. The monitoring of the quality of the service is carried out in accordance with the National Standards of Cleanliness (NSC) for the NHS. In respect of quality control, the system uses handheld PDAs to enable supervisors and managers to monitor the cleaning service provided against 49 task areas listed in the NSC. There are plans to move to a system that will integrate with the new Estates Helpdesk which will therefore automatically report any failures which can then be actioned by the Estates Team more efficiently– these results are also reported at the IPC sub committee and the Operational Board in accordance with the Trust's cleaning strategy. CWP achieved an average of 97% performance compared against the national standards.

The cleanliness monitoring demonstrates that the standards are being maintained across all sites Trust-wide and there has been very little deviation in the overall scores achieved this year. All actions raised as a result of the audits are rectified within guidelines outlined in the NSC. The team continues to work closely with the ward and departmental teams to ensure any issues are addressed and action plans in place as well as ensuring high standards are maintained during any building works.

16.2 Patient-led Assessment of the Care Environment (PLACE)

The first round of PLACE visits were completed during 2013 with good involvement from patient representatives which provided a wider range of perspectives and comments which were fed back to the NHS Information Centre. Overall the Trust properties received good scores which were above the national average. Action plans were completed after the PLACE process was complete to improve the areas identified. The second round of PLACE commenced in March 2014 and will be on-going until June 2014 with the scores being released to Trusts in September. Again so far the Trust has received excellent patient representative involvement.

17. Conclusion

Infection prevention and control remains a priority for CWP. The IPCSC and IPCT continue to maintain and improve on the implementation, maintenance, and improvement of IPC standards. The Trust is committed to working towards excellence in IPC practice. This report highlights the partnership working and continuous improvements last year and the work programme for 2014/15 is set out below for Board approval.

18. Recommendations

The Board is asked to approve the Infection Prevention and Control Annual Report for 2013/14 and the work programme for 2014/15.

19. Appendix 1

IPC Work Programme 2014/15.

T:\01. BoD Committees\Board of Directors\Meetings\2014\140730\Open

20. References and associated documents.

Care Quality Commission (2009) Guidance about compliance: Summary of regulations, outcomes and judgment framework. London: CQC. Available from: http://www.cqc.org.uk/_db/_documents/Summary_of_regulations_outcomes_and_judgement_framework_FINAL_081209.pdf

Care Quality Commission (2010) Guidance about compliance: Essential standards of quality and safety. London: CQC. Available from: http://www.cqc.org.uk/sites/default/files/media/documents/gac_-_dec_2011_update.pdf

Department of Health (2006) HTM 04-01: Water systems: the control of Legionella, hygiene, "safe" hot water, cold water and drinking water systems. Part A: Design, installation and testing. Available from: https://publications.spaceforhealth.nhs.uk/

Department of Health (2006) HTM 04-01: Water systems: the control of Legionella, hygiene, "safe" hot water, cold water and drinking water systems. Part B: Operational management. Available from: https://publications.spaceforhealth.nhs.uk/
Department of Health (2006) HTM 07-01: Environment and sustainability: safe management of healthcare waste. This guidance also applies to offensive/ hygiene and infectious waste produced in the community from non-NHS healthcare sources. Available from: https://publications.spaceforhealth.nhs.uk/

Department of Health (2007) HTM 01-01: Decontamination of reusable medical devices: Part A – Management and environment. London: DH. Available from: https://publications.spaceforhealth.nhs.uk/

Department of Health (2007) HTM 03-01: Heating and ventilation systems: Specialised ventilation for healthcare premises. Part A – Design and validation. Available from: https://publications.spaceforhealth.nhs.uk/

Department of Health (2007) HTM 03-01: Heating and ventilation systems: Specialised ventilation for healthcare premises. Part B – Operational management and performance verification. Available from: https://publications.spaceforhealth.nhs.uk/

Department of Health (2007) Improving cleanliness and infection control. Professional Letter from the Chief Nursing Officer. London: DH. Available from: www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefnursingofficerletters/DH_080053.

Department of Health (2010) gateway 14720, Water sources and potential for infection from taps and sinks. Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_119168.pdf

Department of Health (2010). The Health and Social Care Act 2008; Code of Practice on ythe prevention and control of infections and related guidance. London: DH. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216227/dh_123923.pdf

Department of Health (2013). Health Building Note 00-09: Infection control in the built environment. London. DH. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170705/HBN_00-09_infection_control.pdf

Health and Safety Executive (2009) Managing offensive/hygiene waste. London: HSE. Available from: www.hse.gov.uk/pubns/waste22.pdf

National Institute for Health and Clinical Excellence (2012) Tuberculosis – hard to reach groups. London: NICE Available from: http://guidance.nice.org.uk/PH37/Guidance/pdf

National Institute for Health and Clinical Excellence (2012) NICE Clinical guideline 139. Infection : Prevention and control of healthcare-associated infections in primary and community care. Available from http://www.nice.org.uk/nicemedia/live/13684/58656/58656.pdf

National Patient Safety Agency (2007) Safer practice notice 15: Colour coding hospital cleaning materials and equipment. Available from: www.nrls.npsa.nhs.uk/resources/patient-safety-topics/environment/?entryid45=59810

National Patient Safety Agency (2010) The national specifications for cleanliness in the NHS: Guidance on setting and measuring performance outcomes in primary care medical and dental premises. London: NPSA. Available from: www.nrls.npsa.nhs.uk/resources/?entryid45=75241

National Prescribing Centre (2011) Key Therapeutic topics. Available from: http://www.npc.nhs.uk/qipp/resources/qipp_key_therapeutic_topics_july11_version3.1.v2.pdf

World Health Organisation (2009). WHO Guidelines on Hand Hygiene in Health Care: First Global Patient Safety Challenge. Clean Care is Safer Care. Available from: http://whqlibdoc.who.int/publications/2009/9789241597906_eng.pdf

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document Reference (2014/15/34)

Report to:	**Board of Directors**
Date of Meeting:	**30th July 2014**
Title of Report:	**Ward Daily Staffing Levels (June 2014)**
Action sought:	**To Note**
Author:	**Maria Nelligan, Deputy Director of Nursing**
Presented by:	**Avril Devaney, Director of Nursing, Therapies and Patient Partnership**

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

Distribution

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

Executive director sign-off

Executive director (name and title)	Date signed-off
Avril Devaney, Director of Nursing, Therapies and Patient Partnership	22nd July 2014

1. Purpose

This report details the ward daily staffing levels during the month of June 2014. This 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.

2. Background

CWP undertook a comprehensive review of ward staffing levels between Oct and Dec 2013. A programme has been established to take forward the recommendations from the review including staffing levels and a programme of continuous improvement. The Director of Operations is the lead executive for the programme supported by the Director of Nursing who has overview of the Ward Staffing work stream and reports directly to the Board of Directors in line with the NQB requirements.

3. Content

The planned and actual hours for registered nurses (RN) and clinical support workers (CSWs) are compared on a ward by ward shift by shift basis for both days and nights. The template used has been supplied by NHS England for submission to UNIFY and CWP have submitted the June 2014 data before the required deadline of 15 July 2014. In addition to this data comments from the localities have been supplied in relation to any shortfalls in staffing.

4. Actions

CWP Ward Managers(WM) plan for adequate staffing levels on a shift by shift basis supported by Modern Matrons and Clinical Services Managers. If, however, the required levels are not achieved staff follow an escalation procedure to source additional staffing. Should this be unsuccessful staff then review and evaluate the work of the team and put in place actions to mitigate harm to patients. These measures will include reviewing the workload for the day, prioritising patient interventions, review of non-direct care and cancelling non-essential patient care activities. Additionally the Ward Manager (WM) and staff from the Multi-Disciplinary Team (MDT), such as Occupational Therapists (OT), are also available if required to support nursing staff to deliver planned care. A recruitment drive is in place to increase Registered Nurses and Clinical Support Workers in both substantive posts and the Trust Bank.

5. Recommendations to the Board of Directors

The Board of Director are recommended to note the report.

5. Data for June 2014

	Ward	Day				Night				Fill Rate				Comments
		Registered nurses		Care Staff		Registered nurses		Care Staff		Day		Night		
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - RNs (%)	Average fill rate - care staff (%)	Average fill rate - RNs(%)	Average fill rate - care staff (%)	
East	Adelphi	1193.5	1163	1169	1165.5	701.5	667	859	834	97.4%	99.7%	95.1%	97.1%	WM has regularly worked in the clinical team to maintain safe staffing levels.
East	Alderley Unit	941.5	931.5	1391.5	1451	678.5	598	701.5	793.5	98.9%	104.3%	88.1%	113.1%	Some patient activities have had to be re-arranged to maintain safe staffing levels.
East	Bollin	896.5	896.5	1565.4	1372.2	697.5	674.5	851	816.5	100.0%	87.7%	96.7%	95.9%	WM has regularly worked in the numbers to maintain safe staffing levels.
East	CARS	830.5	812	872.3	821.3	690	644	655.5	598	97.8%	94.2%	93.3%	91.2%	Staff from the wider MDT have supported the unit when needed.
East	Croft	1373.8	1298.6	1357.8	1131.3	759	763.5	1478.5	1315.5	94.5%	83.3%	100.6%	89.0%	OT's and staff from other wards have supported the unit when short-staffed
East	Greenways A&T	1107	1142.5	1786	1553.5	690	678.5	690	689.5	103.2%	87.0%	98.3%	99.9%	WM has regularly worked in the clinical team to maintain safe staffing levels.
East	LimeWalk Rehab	944.5	921.5	959	914	644	622.5	701.5	704.5	97.6%	95.3%	96.7%	100.4%	
East	Saddlebridge	1049	987.5	1035.5	1020	690	598	690	786	94.1%	98.5%	86.7%	113.9%	Additional CSW s covered shortfalls in RN to maintain safe staffing levels.
Wirral	Brackendale	757.5	746	1014.5	939.5	621	609.5	759	770.5	98.5%	92.6%	98.1%	101.5%	
Wirral	Lakefield	890.5	885.5	1066.5	1040.5	690	690	690	676.5	99.4%	97.6%	100.0%	98.0%	
Wirral	Meadowbank	993.5	976.5	1855	1767.5	655.5	632.5	1414.5	1391.5	98.3%	95.3%	96.5%	98.4%	
Wirral	Oaktrees	788	770	1474.5	1408	598	621	491	502.5	97.7%	95.5%	103.8%	102.3%	
West	Beech	1184.5	1012	690	667	690	621	690	621	85.4%	96.7%	90.0%	90.0%	The nursing team worked additional hours to support workload.
West	Brooklands	876.5	721	1306	1172.5	678.5	586.5	931.5	901	82.3%	89.8%	86.4%	96.7%	Staff worked additional hours when required. RN shortfalls were covered by additional CSW's .
West	Cherry	799.9	805	945.5	858.5	690	575	690	667	100.6%	90.8%	83.3%	96.7%	RN shortfalls were covered by additional CSW's .
West	Eastway A&T	860	825	713	665.5	586.5	586.5	448.5	448.5	95.9%	93.3%	100.0%	100.0%	
West	Juniper	1104	916	770.5	816.5	713	559.5	437	517.5	83.0%	106.0%	78.5%	118.4%	RN shortfalls were covered by CSW's . The nursing team worked additional hours to support workload.
West	Maple Ward	962	881.5	1034.2	900.7	437	437	1023.4	1012	91.6%	87.1%	100.0%	98.9%	Staff accessed support from the wider MDT.
West	Pine Lodge (YPC)	778	736	1495	1008.5	609.5	413.5	1092.5	1196	94.6%	67.5%	67.8%	109.5%	The nursing team worked additional hours to support the workload.
West	Rosewood	1025	886.4	1451	1098	437.5	449	668	622	86.5%	75.7%	102.6%	93.1%	Rosewood staff support other areas within Bowmere where patient acuity and need was higher. Rehabilitation activities did however need to be shortened on occasions.
West	Willow PICU	768.5	769	1008	982	655.5	517.5	736	943	100.1%	97.4%	78.9%	128.1%	On a number of occasions RN shortfalls were covered by additional CSW's.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/15/36a)

Report to:	**Board of Directors**
Date of Meeting:	**30 July 2014**
Title of Report:	***Monitor* Quality Governance Framework and NHS provider licence criteria – self assessments**
Action sought:	**For APPROVAL and NOTING**
Author:	**David Wood, Associate Director of Safe Services**
Presenting Executive:	**Tim Welch, Director of Finance**

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

Distribution

Version	Name(s)/Group(s)	Date Issued
1	D Wood to L Hulme for Board of Directors	21.07.2014

Executive director sign-off

Executive director (name and title)	Date signed-off
Tim Welch, Director of Finance	21.07.2014

1. Purpose of the report

In April 2013, *Monitor* published 'Quality governance: How does a Board know that its organisation is working effectively to improve patient care?' The guidance is designed to support *Monitor*'s Quality Governance Framework. This forms part of the *Monitor* Risk Assessment Framework. The guidance aims to help Boards understand what is required of a trust's internal assurance mechanism for assuring the organisation wide processes for governing quality, with a view to improve decision making and to support Boards in discharging their responsibilities to improve care for patients. This report details the quarter 1 *Monitor* quality governance self assessment.

The report also confirms the *Monitor* NHS provider licence criteria, as they apply at the start of 2014/15, following the quarter 4 self assessment against selected criteria where either a review of position was required or the criteria required the Trust to "comply or explain".

2. Discussion

2.1 *Monitor* Quality Governance Framework standards – self assessment

Monitor's guidance sets out a series of questions for Boards to consider and to assess the assurance on quality governance systems and processes. These are:

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

As part of the quarterly submission process to *Monitor*, the Board receives an updated quality governance self assessment, which enables a quarterly view on the Quality Governance Framework. *Appendix 1* details that all quality areas are assessed as being 'green'. All the quarterly returns assist the Board in undertaking a full annual assessment at the end of the financial year.

2.2 *Monitor* NHS provider licence criteria

The licence contains obligations for the Trust that allows *Monitor* to fulfil its duties. Since it enables *Monitor* to continuously oversee the way that CWP is governed, assessment against the provider licence criteria aims to help the Board in confirming the accuracy of requirements and rules that CWP is required to comply with as a license holder. The *Monitor* NHS provider licence criteria, as they apply at the start of 2014/15, are detailed in the **T drive**. The quarter 4 self assessment against selected criteria that was reported to the 28 May 2014 meeting of the Board of Directors will be reviewed twice per year, firstly at six months [end of quarter 2] and then again at year end as part of a full annual self assessment.

3. Recommendations to the Board of Directors

The Board of Directors is asked to:

- **Discuss** and **approve** the quarter 1 *Monitor* quality governance self assessment, as per *Appendix 1.*
- **Confirm** that it has noted the full list of *Monitor* NHS provider licence criteria and thereby the governance obligations of the Trust.

Appendix 1: *Monitor* Quality Governance Framework – self assessment quarter 1 2014/15

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

Strategy		**Q1 2014/15 self assessment (RAG) rating**
1a	Does quality drive the trust's strategy?	GREEN
1b	Is the Board sufficiently aware of potential risks to quality?	GREEN
Capabilities and culture		
2a	Does the Board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?	GREEN
2b	Does the Board promote a quality-focused culture throughout the Trust?	GREEN
Processes and structure		
3a	Are there clear roles and accountabilities in relation to quality governance?	GREEN
3b	Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	GREEN
3c	Does the Board actively engage patients, staff and other key stakeholders on quality?	GREEN
Measurement		
4a	Is appropriate quality information being analysed and challenged?	GREEN
4b	Is the Board assured of the robustness of the quality information?	GREEN
4c	Is quality information being used effectively?	GREEN

The RAG rating is explained below:

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

Appendix 1 – Quality Governance Self assessment evidence as at Q1 2014/15

T:\01. BoD Committees\Board of Directors\Meetings\2014\140730\Open

Appendix 2: Full list of *Monitor* NHS provider licence and criteria

T:\01. BoD Committees\Board of Directors\Meetings\2014\140730\Open

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/15/36b)

Report to:	**Board of Directors**
Date of Meeting:	**30 July 2014**
Report:	**Monitor Quarter 1 Submission**
Action sought:	**FOR DISCUSSION & APPROVAL**
Author:	**Neil Griffiths, Acting Head of Performance and Information** **David Wood, Associate Director of Safe Services** **Andy Harland, Deputy Director of Finance** **Louise Hulme, Head of Corporate Affairs** **Jo Watts, Head of Compliance**
Presented by:	**Tim Welch, Director of Finance**

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

Distribution

Version	Name(s)/Group(s)	Date Issued
1	Neil Griffiths to Tim Welch	08 July 2014

Executive director sign-off

Executive director (name and title)	Date signed-off
Tim Welch, Director of Finance/Deputy Chief Executive	23rd July 2014

1. Purpose of the report

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

- An updated assessment against Monitor's Quality Governance Framework, highlighting any outstanding actions.
- To request that the Board considers the content of the Quarter 1 submission and considers the declarations required in the submission to Monitor.

2. Summary

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

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

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

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

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

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

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

3. Discussion

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

The Board is also asked to note that the Trust has met all Monitor performance targets and that the Trust received two inspections by the Care Quality Commission (CQC). These were a re-inspection of Springview which confirmed that the Trust is now compliant with Outcomes 5 and 21 and an announced inspection for the GP Out of Hours service in Chester and Ellesmere port. The formal report is awaited but the verbal advice from this inspection was that the service was fully compliant.

3.1 Finance

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

In addition we can report there are no financial fails in our Q1 submission.

3.2 Governance

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

Quality Governance Framework statement

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

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

The template for Q1 does not require the Trust to make a Quality Governance declaration per se. To support the Board in deciding which declaration it wishes to make a review of the Trust's position against the Quality Governance Framework has been undertaken for Q1. This information has been included to ensure the completeness of the information available for Board members. The usual sources of assurance in this regard are:

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

All quality areas remain green. The overall assessment for Q1 is outlined below. The comprehensive assessment is detailed in the paper to Board entitled "*Monitor Quality Governance Framework – self assessment*".

Strategy		**Q1 2014/15 self-assessment (RAG) rating**
1a	Does quality drive the trust's strategy?	**GREEN**
1b	Is the Board sufficiently aware of potential risks to quality?	**GREEN**
Capabilities and culture		
2a	Does the Board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?	**GREEN**
2b	Does the Board promote a quality-focused culture throughout the Trust?	**GREEN**
Processes and structure		
3a	Are there clear roles and accountabilities in relation to	**GREEN**

	quality governance?	
3b	Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	GREEN
3c	Does the Board actively engage patients, staff and other key stakeholders on quality?	GREEN
Measurement		
4a	Is appropriate quality information being analysed and challenged?	GREEN
4b	Is the Board assured of the robustness of the quality information?	GREEN
4c	Is quality information being used effectively?	GREEN

The RAG rating is explained below:

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

Performance against targets declaration

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

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

The table below details the Trust's current performance and intended submission against the applicable targets set within Monitor's Risk Assessment Framework. The figures in brackets are figures for Quarter 4.

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

Target	Threshold	Quarter 1 Performance [Quarter 4]
Care Programme Approach (CPA) follow up within 7 days of discharge	>95%	95.94% [97.89%]
Care Programme Approach (CPA) formal review within 12 months	>95%	96.10% [96.19%]
Minimising delayed transfers of care	<=7.5%	0.63% [2.09%]
Admissions had access to crisis resolution home treatment teams	>95%	98.75% [98.90%]

Target	Threshold	Quarter 1 Performance [Quarter 4]	
Meeting commitment to serve new psychosis cases by early intervention teams	>95%	114.63%	[128.46%]
Data completeness: identifiers	>97%	99.51%	[99.51%]
Data completeness: outcomes	>50%	86.94%	[85.69%]
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	Achieved	[Achieved]
Community care - referral to treatment information	50%	100%	[100%]
Community care - referral information	50%	96.86%	[96.31%]
Community care - activity information	50%	91.38%	[92.47%]
Risk of, or actual, failure to deliver mandatory services	Yes/No	No	[No]
CQC compliance action outstanding (as at 31 March 2014)	Yes/No	No	[No]
CQC enforcement action within last 12 months (up to 31 March 2014)	Yes/No	No	[No]
CQC enforcement notice currently in effect (as at 31 March 2014)	Yes/No	No	[No]
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at 31 March 2014)	Yes/No	No	[No]
Major CQC concerns or impacts regarding the safety of healthcare provision (as at 31 March 2014)	Yes/No	No	[No]
Trust unable to declare ongoing compliance with minimum standards of CQC registration	Yes/No	No	[No]
Unable to maintain, or certify, a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements	Yes/No	No	[No]

Care Quality Commission

In Quarter 3, the Trust declared minor concerns relating to Outcome 5 – Meeting Nutritional Needs and Outcome 21 – Records following the inspections to Springview and Bowmere Hospital during Quarter 3. The Trust have confirmed to the CQC that all actions have been completed as required to meet compliance and received a further unannounced visit to Springview Hospital on 18th June 2014, during this visit the Inspector confirmed that the Trust is now compliant with Outcomes 5 and 21 for Springview Hospital. We are currently awaiting a further inspection to Bowmere Hospital to review compliance with Outcome 21.

Results of any elections

There were no governor elections in Q1 2014/15.

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

The Council of Governors have appointed Dr James O'Connor as a Non-Executive Director on the Board of Directors for a three year term of office which commenced on 1st May 2014.

Non-Executive Director, Stephen McAndrew has resigned from the Board of Directors due to accepting a post at another organisation. Due to the nature of the organisation, Stephen McAndrew's resignation has been taken with immediate effect. The Council of Governors approved the recommendation of the Nominations Committee to appoint Rebecca Burke Sharples as Non-Executive Director for a three year term of office commencing 1st August 2014, subject to references.

There have been three resignations from the Council of Governors: Dr Gavin Newby, Staff Governor; Rosalind Davison, Service User/Carer Governor; and Derek Seber, Public Governor. These resignations are due to individual circumstances.

Pam Smith has been appointed as West Cheshire CCG Governor in the Partnership Governor Constituency.

4 Recommendations to the Board of Directors

The Board is asked to **consider** and **confirm** its final intention in relation to the Quarter 1 submission to Monitor. If the Board is unable to verify its decision at the Board meeting, the Board should seek further clarification to inform their decision before the actual submission date of 31 July 2014.

5 Appendices

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

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(Document Reference 2014/15/37)

Report to:	**Board of Directors**
Date of Meeting:	**30th July 2014**
Title of Report:	**Monitor Well-led Framework for Governance Reviews**
Action sought:	**For Note**
Author:	**Louise Hulme, Head of Corporate Affairs**
Presented by:	**Louise Hulme, Head of Corporate Affairs**

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

Distribution

Version	Name(s)/Group(s)	Date Issued
1	Tim Welch, Director of Finance	21st July 2014

Executive director sign-off

Executive director (name and title)	Date signed-off
Dr Anushta Sivananthan, Medical Director: Quality, Compliance and Assurance	21st July 2014

1. Purpose of the report

To update the Board on recent guidance issued from Monitor in May 2014 regarding the new 'Well-led Framework for Governance Reviews.'

2. Information

2.1 The Framework

Monitor's Risk Assessment Framework serves as guidance for trusts in complying with their Continuity of Service and governance Licence conditions. Under the 'Risk Assessment Framework' and in line with the Code of Governance, Monitor expects that NHS foundation trusts will now carry out an external review of their governance every three years.

The framework is built along the lines of the existing 'Quality Governance Framework', with 4 domains, 10 high level questions and a body of 'good practice' outcomes and evidence base that organisations and reviewers can use to assess governance.

The 4 domains for the framework are set out in the table below, with the 10 questions that Board's must assess themselves against as part of the governance review.

Strategy and Planning	Capability and Culture	Process and Structures	Measurement
1. Does the Board have a credible strategy to provide high-quality, sustainable services to patients and is there a robust plan to deliver?	3. Does the Board have the skills and capability to lead the organisation?	6. Are there clear roles and accountabilities in relation to board governance (including quality governance?)	9. Is appropriate information on organisational and operational performance being analysed and challenged?
2. Is the Board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?	4. Does the Board shape an open, transparent and quality-focused culture?	7. Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	10. Is the Board assured of the robustness of information?
	5. Does the Board support continuous learning and development across the organisation?	8. Does the Board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?	

Underpinning the 4 domains and 10 questions are a number of outcomes and good practice examples which Boards can use as part of the review process.

2.2 Frequency/ Scope/Review Teams

Under the Risk Assessment Framework, NHS Foundation Trust Boards are required to undertake a governance review every three years. There is no mandatory timetable within this period, as long as the gap between governance reviews is no longer than three years.

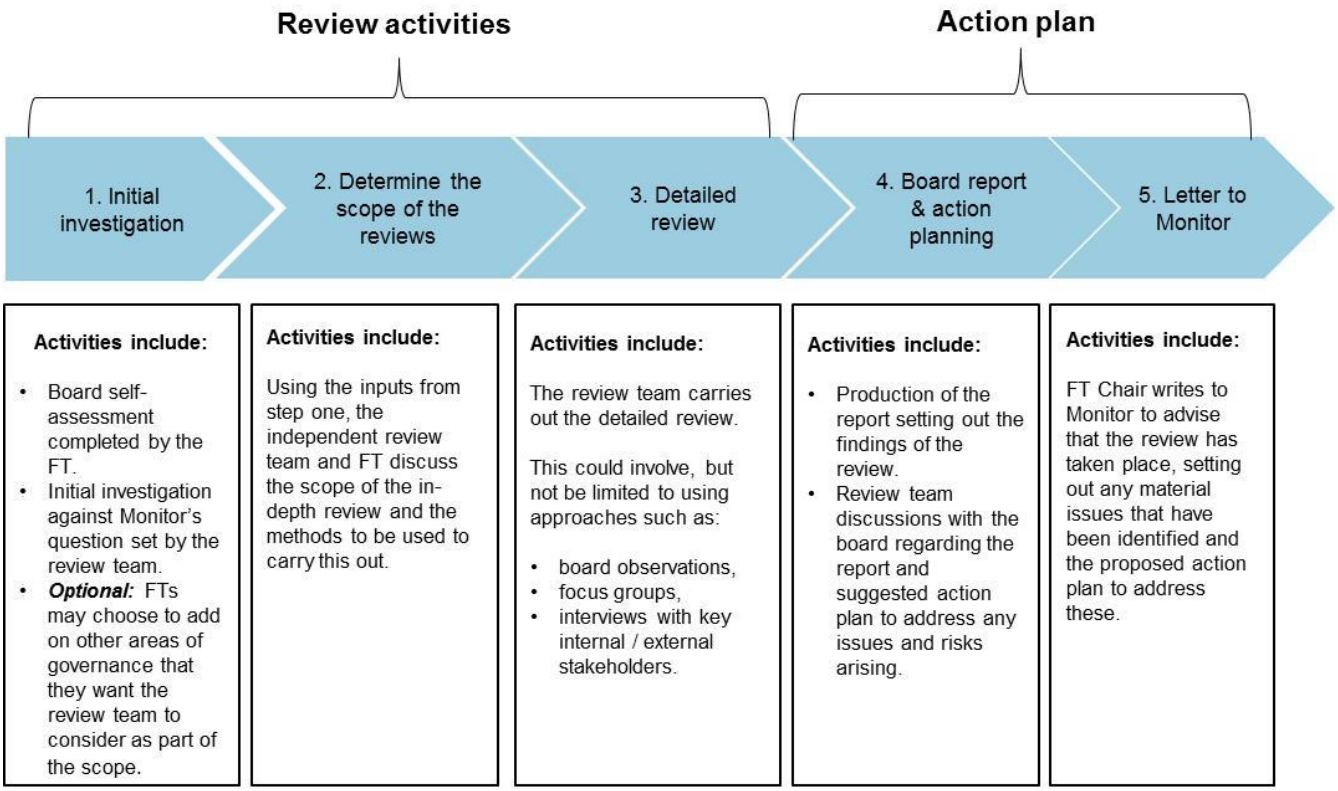
Trusts must inform their Relationship Manager when the Trust has scheduled a governance review and the organisation it has selected to undertake the work.

The scope of the review will be based on the 4 domains and 10 questions set out in the guidance as a starting position; however Trusts have the flexibility to add to the scope or change the emphasis to reflect their knowledge of the Trust or any evidence of areas requiring specific scrutiny. This could also be informed by findings from internal or external audit or findings from evidence underpinning the Annual Governance Statement or Corporate Governance Statement.

To carry out the review, Monitor recommends that independent reviews should be used to ensure objectivity. Monitor also recommends that reviewers should not have undertaken audit or governance related work for the Trust within the last three years. Reviewers must also be independent of Foundation Trust Boards and should have experience of evaluating leadership at Board level, governance arrangements, have some knowledge of the health care sector and have some specialist experience.

2.3 The Review Process

The table below sets out the suggested steps to undertaking the review.



In undertaking the review, there are a number of suggested methods and tools available which will be determined by the Trust. These will include desktop review of relevant documents, one to one

interviews with key staff, stakeholder surveys, focus groups, Board and Committee/sub-Committee observations, a Board skills inventory and output from a Board self-assessment.
In terms of the scoring criteria for the review, Monitor suggest that the approach taken to score the quality governance assessment undertaken quarterly by Trusts is used, this being the Green, Amber/Green, Amber/ Red, Red scoring framework. Trusts are free to develop their own scoring mechanisms but these must be sufficient enough to ensure that any issues and concerns are identifiable and prioritised.

2.4 Selection of a Reviewer

Boards will be required to assure themselves that the selected provider can undertake the review and provide a robust and reliable judgement of its governance.

Monitor have provided a suggested criteria to support Trusts in selecting their provider. These include:

- a clear and concise understanding of the purpose and objective of the review, and its significance to NHS foundation trusts, a solid understanding of how to carry out a rigorous governance review, covering the specific areas detailed in the board governance review framework, and an appropriate range of tools and approaches to carry out the work.

- relevant experience and skills to carry out the work to include, a multidisciplinary team experienced in all aspects of the review, knowledge of the health care sector, and knowledge of the Monitor licence framework and regulatory framework that the Trust operates in.

- the ability to manage the review process, including project management, capacity and any understanding of any conflicts of interest.

2.5 Previous Trust governance reviews.

The Trust has undertaken review of governance previously. The last review was undertaken by KPMG in December 2011 with a Quality Governance review undertaken in February 2012. In light of this, it will be necessary that the Trust begins to progress its plans for the governance review later in 2014. This will include the need to go out to tender given the potential costs of the review. Indications from the Trust's involved in the pilot reviews suggest that review costs are in the region of £50k.

A further report will be brought to the September Board of Director meeting to update on the progress in planning the governance review and the development of a specification for the review.

3. Recommendations to the Board of Directors

- That the Board of Directors note the content of the report

4. Appendices (preferably URLs)

Link to document Well-led framework for governance reviews: guidance for NHS Foundation Trusts.

T:\01. BoD Committees\Board of Directors\Meetings\2014\140730