Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting of the Foundation Trust Board of Directors

Wednesday 29th July 2015 at 13.00

Boardroom, Redesmere

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
15/16/28	Apologies for absence	Receive apologies	Verbal	Chair	1 min (1300)
15/16/29	Declarations of Interest	Identify and avoid conflicts of interest	Verbal	Chair	2 min (1301)
15/16/30	Minutes of the previous meetings held 27th May 2015	Confirm as an accurate record the minutes of the previous meetings	Written minutes	Chair	2 mins (1303)
15/16/31	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	2 mins (1305)
15/16/32	Board Meeting business cycle 2015/16	Confirm that agenda items provide assurance that the Board is undertaking its duties	Written	Chair	3 mins (1307)
15/16/33	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	10 mins (1310)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
15/16/34	Chief Executive's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	10 mins (1320)
MATTERS FOR APPROVAL/ DECISION					
Strategy					
15/16/35	Corporate Assurance Framework and Risk Register	To approve current Corporate Assurance Framework and Risk Register	Written Report	Medical Director	10 mins (1330)
15/16/36	Zero Harm strategy 14/15 outcomes	To review progress of Zero Harm strategy	Presentation	Medical Director	15 mins (1340)
Measurement					
15/16/37	Board Dashboard – June 2015	To review Trust performance	Written Report	Deputy Director of Finance	10 mins (1355)
15/16/38	Q1 15/16 Quality Governance assessment	To review quality governance performance for Q1	Written Report	Medical Director	10 mins (1405)
15/16/39	Q1 15/16 Monitor declarations and submission	To approve the declarations and Q1 submission to Monitor	Written Report	Deputy Director of Finance	10 mins (1415)
15/16/40	Trust Provider Licence: • Declarations 4,5 and 6 required the Licence	To note the submission of statements to Monitor	Written Report	Deputy Director of Finance	5 mins (1425)
Capability and Culture					

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
15/16/41	Comprehensive review of staffing (six monthly report)	To review ward staffing levels	Written Report	Director of Nursing, Therapies and Patient Partnership	20 mins (1430)
Process and Structures					
15/16/42	Daily Ward Staffing figures (May and June 2015)	To note the Daily Ward Staffing Figures	Written Report	Director of Nursing, Therapies and Patient Partnership	10 mins (1450)
15/16/43	Infection, Prevention and Control Annual Report 2014/15	To note the 2014/15 Annual Report	Written Report	Director of Infection, Prevention and Control	10 mins (1500)
15/16/44	Safeguarding Children and Adults Annual Report 2014/15	To note the 2014/15 Annual Report	Written Report	Director of Nursing, Therapies and Patient Partnership	10 mins (1510)
15/16/45	Doctors' Revalidation, Appraisals and Concerns Annual Report 2014/15	To note the Annual Report approve the declarations to NHS England	Written Report	Medical Director	10 mins (1520)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
15/16/46	Health and Safety Annual Report 2014/15	To note the 2014/15 Annual Report	Written Report	Director of Nursing, Therapies and Patient Partnership	10 mins (1530)
15/16/47	Medicines Management Accountable Officer Annual Report 2014/15	To note the 2014/15 Annual Report	Written Report	Medical Director	10 mins (1540)
Governance					
15/16/48	Proposed changes to Trust Constitution	To approve the proposed changes to the Trust Constitution approved by the Council of Governors July 2015	Written Report	Head of Corporate Affairs	10 mins (1550)
15/16/49	Audit Committee reporting: • Chair's Report of meeting held 30th June 2015	Review Chair's Report and any matters for note/ escalation	Written	Chair of Audit Committee	5 mins (1600)
15/16/50	Quality Committee reporting : • (Meeting of 1st July rearranged to 4th August 2015)	Review Chair's Report and any matters for note/ escalation	Written	Chair of Quality Committee	5 mins (1605)
15/16/51	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair/ All	5 mins (1610)
15/16/52	Any other business	Consider any urgent items of other business	Verbal or written	Chair	2 mins (1615)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
15/16/53	Review of meeting https://www.surveymonkey.com/s/XN5ZLNC	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair/All	2 mins (1617)
15/16/54	Date, time and place of next closed meeting: **Wednesday 30th September 2015, Boardroom, Redesmere.**	Confirm arrangements for next meeting	Verbal	Chair	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Minutes of the Board of Directors Meeting
Wednesday 27th May 2015
Boardroom, Redesmere commencing at 2.30pm

PRESENT	Mike Maier, Deputy Chair and Non-Executive Director Sheena Cumiskey, Chief Executive Dr Faouzi Alam, Medical Director Dr Jim O'Connor, Non-Executive Director Lucy Crumplin, Non-Executive Director Avril Devaney, Director of Nursing Ron Howarth, Non-Executive Director Dr Anushta Sivananthan, Medical Director Andy Styring, Director of Operations Rebecca Burke – Sharples, Non-Executive Director	
IN ATTENDANCE	David Harris, Director of HR and Organisational Development Louise Brereton, Head of Corporate Affairs Andy Harland, Deputy Director of Finance Amanda Miskell, Acting Head of Infection, prevention and Control (for item 15/16/21) Tania Stanway, Clinical Director, CAMHS (for item 15/16/08) Bella – CAMHS young advisor (for item 15/16/08) Joe – CAMHS young advisor (for item 15/16/08) Peter Wilkinson, Public Governor Phil Jarrold, Service User/ Carer Governor Rob Robertson, Public Governor Derek Bosomworth, Member of the Public	
APOLOGIES	David Eva, Chair Fiona Clark, Non-Executive Director Tim Welch, Director of Finance	
	MINUTES	**ACTION**
15/16/01	**WELCOME AND APOLOGIES FOR ABSENCE** The Deputy Chair, Mike Maier welcomed all to the meeting. Apologies were noted from David Eva, Tim Welch and Fiona Clark.	
15/16/02	**DECLARATIONS OF INTEREST** There were no declarations of interest noted.	
(15/16/08)	**CAMHS – OVERVIEW OF FUTURE IN MIND** *(The Deputy Chair announced that this item would be taken earlier on the agenda).* Tania Stanway, Clinical Director from CAMHS, Bella and Joe (young advisers) provided the Board with an overview of the National Future in Mind framework. A lengthy discussion ensued regarding the key recommendations from the framework and those that the young advisors felt would have the most	

	impact on young people. These included recommendations for schools, commissioning, early years, support for children and young people from disadvantaged backgrounds, improved access to services and improving data and standards. The Board extended their thanks to Tania, Bella and Joe for attending the Board meeting and providing an interesting and informative view on the strategy. *(Tania Stanway, Bella and Joe left the meeting)*	
15/16/03	**MINUTES OF THE PREVIOUS MEETING HELD 25th MARCH 2015** One amendment was required to item 14/15/114 of the minutes. The reference should read that CWP were the first to implement NICE guidelines around the smoke-free policy. The date on the heading of the minutes was incorrect and required amending. Subject to the amendments, the minutes of the meeting held **25th March 2015** were **approved** as a correct record.	
15/16/04	**MATTERS ARISING AND ACTION POINTS** With regard to the two outstanding actions, 14/15/122 was ongoing and 14/15/126 had been completed. It was noted that the Zero Harm strategy update would be deferred until the July 2015 meeting.	
15/16/05	**BOARD BUSINESS CYCLE 2015/16** The Board noted the business cycle for 2015/16.	
15/16/06	**CHAIR'S ANNOUCEMENTS** The Deputy Chair announced: **Annual Report, Accounts and Quality Account 2014/15** The Board of Directors approved the Annual Report, Accounts and Quality Account 2014/15 in the closed meeting. This is held in the closed meeting as the Trust is unable to publish the documents until permitted to do so following parliamentary receipt. The outcome of the audit for the financial statements was an unqualified (clean) opinion and for the use of resource, also an unmodified, clean conclusion. Clean opinions were issued on the indicators audited as part of the Quality Account. **Trust recognition for carer support** CWP has received its second gold star from the national Carers Trust, recognising the CWP's commitment to improving support for unpaid carers and their families. **Mymind website accolade** CWP has been recognised once again for its innovative children's mental health website. It has been shortlisted in the 'Value and Improvement in Communication' category at the Health Service Journal (HSJ) Value in	

	Healthcare Awards 2015. **CWP again ranked in Top 100 Best Places To Work in the NHS** CWP has made the grade in the Health Service Journal's (HSJ) survey of the 100 Best Places To Work in the NHS in 2015. The Trust, which retains its place having appeared in the 2014 list, has also shortlisted in the 'Best Place To Work – Mental Health Trust' category at the HSJ Best Place To Work Awards on July 7 in Birmingham. **CWP service director achieves prestigious leadership accolade** Julie Critchley, CWP West service director, has been presented with an award in Executive Leadership following the completion of an intensive 12-month programme. Julie was presented her award for completing the Nye Bevan programme – a course designed for senior leaders within the NHS to support drive change at the highest level - by NHS England Chief Executive Simon Stevens. **Refurbishment programme East Cheshire** There is currently a programme of refurbishment taking place across East Cheshire inpatient areas.	
15/16/07	**CHIEF EXECUTIVE'S ANNOUCEMENTS** Sheena Cumiskey announced the following: **Vanguard developments and strategic partnerships** Sheena Cumiskey reminded Board members that the Trust is a key partnership in the 5 Year Forward View vanguard developments in West Cheshire and Wirral. In West Cheshire, a range of work is underway which include exploring pilots to understand how we can further develop integrated teams with a specific focus on support to the older population in the first instance. In Wirral, one of the key areas of work is a focus on population health which is an approach to understand how partners can change the burden of disease in a population, starting with a focus on prevention. A further vanguard opportunity has been announced by NHS England. This is looking opportunities around different healthcare systems to pilot sustainable hospitals. This is in its early stages at present. In East Cheshire, work is continuing to look at new models of care through the Connecting Care work in Vale Royal and South Cheshire and Caring Together in East Cheshire. This is not a vanguard site but work is continuing to progress which CWP remain close to. **Director of Nursing, Therapies and Patient Partnership** Sheena Cumiskey announced that Avril Devaney is due to go on adoption leave within the next few months. An interim appointment has been made to cover the post for a six month period. Arrangements are currently being finalised by HR.	
15/16/10	**PODIATRY CONSULTATION OUTCOME** Andy Styring reminded Board members of the recently concluded public	

	consultation on podiatry services. The proposed service changes and approach to consultation had been agreed by the Board in September 2014. Andy Styring advised that a comprehensive consultation process had been undertaken. The results received were reviewed by the University of Liverpool. Overall, the responses from the consultation indicated support for option 2 which was to improve podiatry provision for people with a high level of needs. This would be done by changing the eligibility criteria for accessing podiatry services meaning that those with a lower level of need would be directed to self-care options. The Head of West Cheshire CCG has written to NHS England to advise on the outcomes of the consultation. The next stage of the process is for the outcomes to the presented to the CCG Governing Body for approval following approval by the CWP Board of Directors. The changes to the services are due to be implemented from September 2014. The CWP Operational Board will have oversight of the implementation of the podiatry operational plan as this is implemented in the autumn. Lucy Crumplin queried how confident the Board could be that the service can respond to the high need population. Andy Styring confirmed that this was the case and reminded that the new approach is to support people to move towards self-care while targeting services at those who require specialised case. The Board resolved to: • **note** the completion of a formal consultation and broad support for Option 2. • **approve** implementation of Option 2, subject to appropriate approval at CCG meetings and a robust implementation plan monitored by CWP West Senior Management Team.	
15/16/11	**Q4 QUALITY REPORT** Dr Anushta Sivananthan introduced the Q4 Quality report and highlighted the following issues: • There has been full achievement of quality priorities for patient safety, experience and effectiveness. • Innovation – mental health services in East Cheshire have worked with Active Cheshire to provide gym training which is acting as a social and therapeutic programme for service users. • The CWP case study exemplifying integrated care teams including social workers as part of the 'All together better' programme. • An innovation register is now in place which is managed by the Effective Services team who will support services to progress their ideas and bring to fruition. The Board resolved to **note** and **endorse** the Quality Committee approval of the report.	

15/16/12	**CORPORATE ASSURANCE FRAMEWORK AND RISK REGISTER** Dr Anushta Sivananthan introduced the report and drew attention to the risk register and the revised corporate assurance framework. Dr Anushta Sivananthan drew attention to the following key risk issues: • No new risks added have been added to the register in the period. • Further work is required to revise the staffing risk. This has been discussed at the Ward Staffing Programme Board and the Quality Committee. David Harris, Director of HR and OD is working with the risk leads to rework the risk and make alignment to the workforce transformation risk which looks at similar issues. • The risk treatment plan for the physical conditions risk is progressing and is showing a positive impact on mitigating the risk. There is an outstanding issue with the physical health CQUIN for 2014/15 in that the Trust has not met the requirements for achievement. This is a national CQUIN for15/16 and the monitoring of this will play into the risk treatment plan. It was noted that the Audit Committee had some initial discussions on the risk to the Trust from cyber threats. Audit Committee members felt that there was further work to do on modelling the cyber risk and this will report back to the Committee in June 2015. The Board resolved to **approve** the report and the amendments to the risk register	
15/16/13	**BOARD PERFORMANCE DASHBOARD: APRIL 2015** Andy Harland introduced the report and highlighted the typographical mistake in the report around the continuity of services risk rating. The current position is that the Trust is reporting a small deficit as planned by the end of April. It was noted that the IAPT target is below achievement levels for both 6 and 18 weeks. There are plans in place to address this. This will become a mandated indicator from Q3. Sickness absence has improved for the second month but it is too early determine whether this is a trend. Audits have been undertaken in clozaril clinics and these have identified some issues. Andy Styring is following up on what is behind these issues and the significance of the audit findings. **Action:** Andy Styring to report to the Board on the factors behind the clozaril clinic audits. It was also noted that the exceptions identified on the contract dashboard for Wirral IAPT are related to over-delivery in some areas but there are waiting times in the areas where services are not fully commissioned. The Board resolved to **approve** the report and the Board dashboard.	**ASt**

15/16/14	**TRUST PROVIDE LICENCE:** • **2014/15 SELF ASSESSMENT** • **DECLARATIONS REQUIRED BY GENERAL CONDITION 6 OF THE LICENCE** Louise Brereton introduced the report. The first part of the report referred to the six monthly self-assessment of the provider licence compliance. Louise Brereton advised that in from 2015/16 Audit Committee will be undertaking a role in overseeing provider licence compliance on a quarterly basis. A recent audit has been undertaken by the internal auditors on Trust compliance with the licence. This received significant assurance. It was agreed that the Trust is maintaining compliance with the licence condition. Louise Brereton advised that the Board are required to approve the declarations require by general condition 6 of the licence for submission to Monitor. This concerns availability of resources. The Board of Directors resolved to: • **note** the 2014/15 self-assessment of Provider Licence compliance. • **approve** the Declaration required by General Condition 6 of the Provider Licence.	
15/16/15	**MENTAL HEALTH ACT: ACTIVITYSUBMISSION TO THE DEPARTMENT OF HEATLH** Dr Anushta Sivananthan introduced the report which sets out the Trust compliance with the Mental Health Act (MHA). It was noted that S136 detentions have decreased due to the street triage work in localities. Dr Anushta Sivananthan confirmed that CWP performance is broadly comparable with other Trusts The Board noted their duties in terms of maintaining oversight of application of the Mental Health Act in the Trust. It was noted that performance for 15/16 will be impacted by the implementation of the newly revised code of practice The Board resolved to **note** the report.	
15/16/16	**CQC INTELLIGENT MONITORING REPORT** Dr Anushta Sivananthan introduced the report which sets out a combination of datasets looking at where the Trust performs well and areas for improvement. An area identified for improvement is how the Trust responds to clinical alerts. The current process is to assess the impact, put the mitigations in place and then assess to ensure they are taking effect which can take a significant period of time. Avril Devaney commented that this issue had been discussed at the last	

	Health, Safety and Well-being subcommittee and it was agreed that actions need to be SMART, be embedded in a timely manner. The Board agreed that this needed to be taken forward swiftly. **Action:** AD to ensure actions from clinical alerts are taken forward in a timely matter by the Health, Safety and Well-being subcommittee and to look at the last reporting period and assess how well previous actions have been taken forward and how SMART they were. The Board resolved to **note** the report.	**AD**
15/16/17	**LEARNING FROM EXPERIENCE REPORT** Avril Devaney introduced the Learning from Experience summary report and reminded that the full report with analysis was discussed at the May Quality Committee. It was noted that the narrative around falls should read that the incidents have decreased not increased as stated. The Board resolved to **approve** the report and recommendations therein.	
15/16/18	**DAILY WARD STAFFING LEVELS REPORT (APRIL 2015)** Avril Devaney introduced the report and reminded Board members that the report is produced in accordance with NQB standards. Where wards have had incidents of lower than planned staffing levels, comments from ward managers have been included on how safety levels have been maintained. It was noted that the six monthly comprehensive review of ward staffing reviews the impact of staffing issues in more detail. The Operational Board is also maintaining oversight of the risk around staffing and the plans in place. A discussion ensued regarding the need to fully understand the impact of staffing issues on the quality of care and particularly in light of the ongoing difficulties in East and West Cheshire regarding recruitment. A query was raised as to the meaning of the term 'over-recruitment.' David Harris clarified that this was about rolling recruitment and use of the bank when vacancies are not immediately available. If a candidate is interviewed but there is no specific post for them at that time, they are made an offer of a post on the basis that there will be one shortly. It was noted that there is national recruitment issue regarding nurses, although this actually extends to other clinical professionals additionally. Dr Jim O'Connor commented that the staffing and recruitment issues triangulate with the supervision and appraisal rates and that close oversight of quality in light of this is paramount. The Board resolved to **note** the report.	
15/16/19	**QUALITY GOVERNANCE 2014/15 ASSESSMENT** Dr. Anushta Sivananthan introduced the report and drew Board members' attention to the quarterly quality governance assessment. There were no	

	concerns relating to the Trust's quality governance processes. Of the four domains of the QGAF, three are rated as green. The measurement domain is rated as amber-green. Actions are in place for this in line with the data improvement framework. The Board resolved to **approve** the report.	
15/16/20	**REGISTER OF INTERESTS (DIRECTORS AND GOVERNORS)** Louise Brereton introduced the report detailing the register of interest for Directors and Governors. The Board noted that the registers are published on www.cwp.nhs.uk. The Board resolved to **note** the report and the Registers of Interest and Governors (*Amanda Miskell joined the meeting)*.	
15/16/21	**Q4 INFECTION, PREVENTION AND CONTROL (IPC) REPORT** Mike Maier welcomed Amanda Miskell to the meeting. Amanda Miskell drew attention to the key issues in the Q4 report. These were: • Juniper ward was closed for 22 days to new admission due to an outbreak of influenza A. All patients made a full recovery. The virus was a mutated strain meaning that the vaccination did not provide protection. The majority of people infected were older people so while it did not prevent flu; the vaccination did prevent the illness from becoming too severe. • There was an outbreak of influenza B in West Cheshire. The impact of this was lessened due to the uptake of vaccinations. • An updated code of practice for IPC was due in April 2015. CWP responded to the consultation and await the final version. An assurance framework is in place to respond to the forthcoming new standards. The Board of Directors resolved to **note** the report. (*Amanda Miskell left the meeting)*	
15/16/22	**RECOMMENDATIONS FROM THE SAVILLE INQUIRY** Avril Devaney informed the Board that Andrea Hughes, Deputy Director of Nursing has led a task and finish group to recommendations arising from the Kate Lampard QC report. Drawing attention to the assurance framework, the majority of the actions are rated as green denoting that they are on track. Some actions are rated as amber including action 7 regarding DBS checks undertaken on a three yearly basis. Other safeguards are also in place for this to mitigate any risk here. Regarding the recommendation on internet usage, the Trust's media policy covers this to an extent but this does not covers smart phone access and usage so this requires some further work. With regard to the checking of agency staff, there is some work to do to ensure all agency staff are checked especially in cases where managers	

	go directly to agencies. There is a need to ensure managers are aware of their obligations to ensure staff are appropriately checked. It was noted that bank workers are subject to checks from NHS employers. The assurance framework has also identified some further work to be taken forward on ensuring consistency of the process around employment checks and the need to review the recruitment and retention policy. Actions are now in place to ensure that any celebrity visitors are checked prior to entering Trust premises. It was noted that the actions around temporary staffing will be addressed sooner than set out in the assurance framework as this are being taken forward by the Non-Direct Care Programme Board. Ron Howarth queried whether CWP has any learning from recent events at Stepping Hill hospital. Avril Devaney commented that the CWP recruitment policy stipulates that candidates must provide original documents with photocopies being unacceptable. It was noted that the work undertaken on the Savile Inquiry has to be reported to Monitor by 15th June 2015. The Board resolved to **approve** the report.	
15/16/23	**CQC STATEMENT OF PURPOSE** Dr Anushta Sivananthan introduced the report which identifies the premises where the Trust are delivering services from. Due to the fact that several services are moving locations, this is subject to change and is updated regularly. The Board resolved to **note** the report.	
15/16/24	**REVIEW OF RISK IMPACTS OF ITEMS DISCUSSED** There were no further items of risk for discussion.	
15/16/25	**ANY OTHER BUSINESS** There were no further items of business raised for discussion. Mike Maier invited comments from the members of the public gallery. Sheena Cumiskey reminded those in the public gallery that the Trust CQC visit w/c 22nd June 2015 and advised of the opportunities for stakeholders to be involved in focus groups to provide comments via the listening boxes which will be available in Trust locations.	
15/16/26	**REVIEW OF MEETING** Board members felt that the meeting had been effective. Board members noted that the Board effectiveness review for 2014/15 was underway and Board members would be contacted to complete individual assessments shortly.	
15/16/27	**DATE, TIME AND PLACE OF NEXT MEETING** Wednesday 29th July 2015, 1pm, Boardroom, Redesmere.	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Action points from Board of Directors Meetings
29th July 2015

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
25.03.15	14/15/122	**UPDATE ON OPERATIONAL PLAN 2015/16 AND CLINICAL STRATEGIES** it was agreed that Governors have a key role to play in terms of representing the Trust and lobbying on the Trust's behalf on these issued. **Action:** Work to be undertaken with Governors to take forward this agenda.	Sept 2015	TW/DE/ LB	This will be taken forward following the general election and CQC inspection	In progress
27.05.15	15/16/13	**BOARD PERFORMANCE DASHBOARD: APRIL 2015** Audits have been undertaken in clozaril clinics and these have identified some issues. Andy Styring is following up on what is behind these issues and the significance of the audit findings. **Action:** Andy Styring to report to the	June 2015	ASt	Update circulated to Board members 2.06.15	Closed

		Board on the factors behind the clozaril clinic audits.				
27.05.15	15/16/16	**CQC INTELLIGENT MONITORING REPORT** **Action:** AD to ensure actions from clinical alerts are taken forward in a timely matter by the Health, Safety and Well-being subcommittee and to look at the last reporting period and assess how well previous actions have been taken forward and how SMART they were.	AD	July 2015	Discussed at Health, Safety and Well-being Subcommittee June 2015	In progress

Cheshire and Wirral Partnership NHS Foundation Trust
Board of Directors meeting Business Cycle 2015/16

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

No:	Agenda Item	Executive Lead	Responsible Committee/ Subcommittee	29/04/2015 Seminar	27/05/2015	24/06/2015 Seminar	29/07/2015	30/09/2015	28/10/2015 Seminar	25/11/2015	17/12/2015 Seminar	27/01/2016	24/02/2016 Seminar	30/03/2016
Well Led Domain 1: Strategy														
1	**Operational Plan 2016-17approval of submission**	Director of Finance	Operational Board											✓
2	**Trust Clinical Strategies 2016/17**	Director of Operations	Operational Board											✓
3	**Monitoring implementation of Clinical Strategies/ Operational Plan 15/16**	Director of Operations	Operational Board				✓			✓		✓		✓
4	**Approve Integrated Governance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee					✓						
5	**Receive Quarterly Quality Reports**	Medical Director Compliance Quality and Regulation	Quality Committee		✓			✓		✓		✓		
6	**Strategic Risk Register and Corporate Assurance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee		✓		✓	✓		✓		✓		✓
7	**Strategic Plan 2014-2019 monitoring**	Director of Finance	Operational Board					✓						
Well Led Domain 2: Capability and Culture														
8	**National Annual Patient Survey Report 2014/15 and Action Plan**	Director of Nursing, Therapies and Patient	Operational Board					✓						
9	**Single Equality Scheme and Equality Act Compliance**	Director of Nursing, Therapies and Patient	Operational Board					✓						
10	**Avoidable Harm / Zero Harm strategy reporting**	Medical Director Compliance Quality and Regulation	Quality Committee					✓						✓
11	**Staff survey 2014/15**	Director of HR and OD	People and OD subcommittee (Operational											✓
12	**Six monthly staffing review**	Director of Nursing, Therapies and	Quality Committee/ Operational Board				✓					✓		
Monitor Well Led Domain 3: Process and Structures														
13	**Receive and Approve Quarterly Monitor returns**	Director of Finance	N/A	✓			✓		✓			✓		
14	**Receive Learning from Experience Report executive summary**	Director of Nursing, Therapies and Patient	Quality Committee		✓			✓				✓		
15	**Assessment of Quality Governance**	Medical Director Compliance	Quality Committee		✓		✓		✓			✓		
16	**Declarations of Interest: Directors and Governors**	Chair	Audit Committee		✓									

17	**CEO /Chair Division of Responsibilities**	Chair	N/A											✓
18	**Care Quality Commission Registration Report**	Director of Finance	Operational Board										✓	
19	**Receive Quarterly Infection Prevention Control Reports**	Director of Infection Prevention and Control	Infection, Prevention and Control subcommittee (Quality Committee)		✓			✓		✓			✓	
20	**Director of Infection Prevention and Control Annual Report 2014/145 inc PLACE**	Director of Infection Prevention and Control	Infection, Prevention and Control subcommittee (Quality Committee)				✓							
21	**Safeguarding Children Annual Report 2014/15**	Director of Nursing, Therapies and Patient Partnership	Quality Committee				✓							
22	**Safeguarding Adults Annual Report 2014/15**	Director of Nursing, Therapies and Patient Partnership	Quality Committee				✓							
23	**Accountable Officer Annual Report inc. Medicines Management 2014/15**	Medical Director Compliance Quality and Regulation	Medicines Management Group (Quality Committee)				✓							
24	**Health and Safety Annual Report and Fire 2014/15 and link certification**	Director of Nursing, Therapies and Patient Partnership	Health, Safety and Well-being subcommittee (Operational Board)				✓							
25	**Receive Appraisal Annual Report 2014/15 and annual declaration of medical revalidation**	Medical Director of Effectiveness and Medical Workforce	People and OD subcommittee (Operational Board)				✓							
26	**Emergency Planning Annual Report 2014/15**	Director of Nursing, Therapies and Patient Partnership	Emergency Planning subcommittee (Operational Board)					✓						
27	**Monthly Ward Staffing update**	Director of Nursing, Therapies and Patient	Quality Committee		✓		✓	✓		✓			✓	✓
28	**Provider Licence Compliance**	Director of Finance	Audit Committee		✓					✓				
29	**Security Annual Report 2014/15**	Director of Operations	Health, Safety and Well-being subcommittee (Operational Board)					✓						

30	**Mental Health Act annual reporting**	Medical Director Compliance Quality and Regulation	Compliance, Assurance and Learning subcommittee (Quality Committee)					✓						
31	**Receive Research Annual Report 2013/14**	Medical Director Effectiveness Medical Education	Operational Board					✓						
	Monitor Well Led Domain 4: Measurement													
32	**Information Governance 14/15 Toolkit**	Medical Director	Records and Clinical Systems Group (Quality Committee)											✓
33	**Board Performance Dashboard**	Director of Finance	Operational Board		✓		✓	✓		✓		✓		✓
	Governance													
17	**Receive minutes and Chair's Report of the Quality Committee**	Non Executive Director	N/A		✓		✓	✓		✓		✓		✓
18	**Receive minutes and Chair's Report of the Audit Committee**	Non Executive Director	N/A		✓		✓	✓		✓		✓		✓
34	**BOD Business Cycle 2014/15**	Chair	N/A		✓		✓	✓		✓		✓		✓
35	**Approve BOD Business Cycle 2015/16**	Chair	N/A											✓
36	**Review Risk impacts of items**	Chair/All	N/A		✓		✓	✓		✓		✓		✓
37	**Chair's announcements**	Chair	N/A		✓		✓	✓		✓		✓		✓
38	**Chief Executive announcements**	Chief Executive	N/A		✓		✓	✓		✓		✓		✓

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Corporate assurance framework – update report
Agenda ref. no:	15/16/35
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	29/07/2015
Presented by:	Dr Anushta Sivananthan, Medical Director – Executive Lead for Quality

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

REPORT BRIEFING

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

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

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

The Board of Directors monitors and reviews the corporate assurance framework and receives assurances on risk via the Quality Committee. This is a key component of the Trust's integrated governance strategy which provides assurance regarding the quality and safety of the services that the Trust provides. The Quality Committee is the designated committee for risk management operationally. The Quality Committee was due to meet the week after the announced trustwide CQC inspection in, due to organisational effort being prioritised to facilitate this, the meeting has been rescheduled to 4 August 2015 (see below for further information). Therefore, the Board of Directors should note that this update report has on this occasion not been presented to the Quality Committee prior.

The Audit Committee undertakes in-depth reviews of strategic risks as part of its remit to review the effectiveness of integrated governance and internal control Trust-wide. At its next meeting, it will request assurances of the effectiveness of the risk treatment plans for the risks in relation to the management of physical health conditions and the ligature points/ environment risk and an update on the recent scoping work undertaken on the cyber threat risk.

Assessment – *analysis and considerations of options and risks*

Key updates

- No new risks have been identified since the last update report.
- One risk has been rescored. This is the *'loss of current services due to risks associated with the market environment and the potential for commissioners to seek further competitive tendering for clinical services*' which has been increased to a current risk score of 9. This is due to an increase in the consequence scoring due to current tendering exercises in the CWP West locality which, if lost, would result in moderate financial loss to the Trust (between £25,000 – £100,000) as per integrated governance framework thresholds.
- The risk description of the current *'Risk of harm to patients and staff due to staffing levels across inpatient services in the three localities'* has been incorporated into a remodelled workforce risk – *Failure to maintain (and predict the need for) the right number of staff with the right skills/ attitudes in the right place at the right time could impact on the Trust's ability to deliver a safe and effective service against changing needs* (previously *Capacity and skills of the workforce to respond to emerging and new models of care provision and evidence based interventions*). The current risk score is 20.
- Following the last Quality Committee meeting request, a more robust risk treatment plan for the Safeguarding risk has been developed.
- As per the output of the Quality Committee's annual review of effectiveness 2014/15, to be more robustly assured of ongoing quality improvement in critical risk areas, the Quality Committee is implementing its business cycle provision to receive an in-depth review of selected strategic risks. For the meeting on 4 August 2015, it will receive an in-depth review of the risk – *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'* due to gaps in control raised regarding data quality in preparation for and during the announced CQC trustwide inspection. All other risks now have a target risk score review date to trigger a scheduled in-depth review to ensure the continuing dynamism of the review of the risks to the Trust's strategic objectives.
- As at July 2015, the Trust has 10 red rated risks on the strategic risk register, a reduction from 11 during the last report to Board.

Corporate assurance framework – outlines controls and assurances (available at appendix 1/ T drive).

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

The Board of Directors is asked to **review**, **discuss** and **approve** the amendments that have been made to the strategic risk register and corporate assurance framework.

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	22/07/2015

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

Appendix no.	Appendix title
1	Risk Register and Corporate assurance framework

Corporate Assurance Framework (summary)

Updated:
21 July 2015

Risk no.	Current risk description	Origin/ source	Date initial risk added	Target risk score review date
1	Risk of harm to patients due to staff competency to manage changing physical health conditions	Incident report	20/01/2011	October 2015
2	Adults, children and young people are not protected through practitioners not implementing safeguarding practices and principles	External recommendations	01/12/2011	October 2015
3	The inability of staff to manage the occurrences of slips, trips, and falls of patients resulting in patient injury	Incident report	11/05/2010	March 2016
4	Vacant			
5	Risk of harm to patients due to CARSO risk assessment not being completed as per policy	Incident report	05/07/2013	January 2016
6	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	Incident report	11/05/2010	October 2015
7	Risk of harm to patients due to ligature points and environmental risks within the inpatient setting	Risk assessment/ incident report	11/05/2010	December 2015
8	Fragmentation of commissioning leading to fragmented patient pathways and therefore risks to delivery of good quality patient care and outcomes	Strategic plan 2014/19	05/11/2014	December 2015
9	Risk of adverse clinical incident due to quality of record keeping and dual record keeping systems (electronic and paper)	Incident report	11/05/2010	February 2016
10	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.	Locality risk registers	11/05/2010	December 2015
11	Failure to maintain (and predict the need for) the right number of staff with	Strategic plan 2014/19	05/11/2014	March 2016

Risk no.	Current risk description	Origin/ source	Date initial risk added	Target risk score review date
	the right skills/ attitudes in the right place at the right time could impact on the Trust's ability to deliver a safe and effective service against changing needs			
12	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	External/ independent recommendation	11/05/2010	February 2016
13	Loss of current services due to risks associated with the market environment and the potential for commissioners to seek further competitive tendering for clinical services	Strategic plan 2014/19	05/11/2014	December 2015
14	Risk of not being able to deliver planned financial risk rating due to incomplete CIP resulting in potential breach of terms of authorisation and reputational damage	Locality risk registers	11/05/2010	December 2015
15	Risk of breach of Trust Licence as a result of external scrutiny	External recommendations	07/12/2011	October 2015

Strategic Objective: 1. Deliver high quality, integrated and innovative services that improve outcomes

Risk Owner: Medical Director Quality
Risk Lead: Associate Director of Nursing & Therapies (Physical Health)

Risk appetite: 3

Risk 1: Risk of harm to patients due to staff competency to manage changing physical health conditions

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	5	25	4	5	20	3	5	15

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Physical healthcare network looking at areas such as physical health in mental health and pressure ulcers ▪ Physical health zero harm group in CWP West (which includes review of pressure ulcer care) ▪ Physical health pathway and policy ▪ Essential learning ▪ Patient safety metrics ▪ Falls policy and pathway; falls risk assessment tool (cross reference with risk 3) ▪ Healthcare quality improvement programme 2015/16	▪ Training reports to Patient Safety & Effectiveness Sub Committee ▪ Safety metrics reporting ▪ Learning from Experience reporting ▪ Participation in mental health physical healthcare CQUIN ▪ Assurance Framework completed including triangulation of complaints, incidents and concerns. ▪ Clinical Audit Programme 2015/16 ▪ Training in Physical Health ▪ Benchmarking CWP performance against NICE Guidelines, Safety Thermometer etc ▪ Localities have scoped resources, training, support and equipment	▪ Gaps in relation to new policy and pathway implementation in relation to healthcare monitoring ▪ 2015/16 national CQUIN in relation to physical health to be published and may identify gaps ▪ Commissioners supported the archive of the pressure ulcer specific strategic risk (05/11/2014), however ongoing assurance is required via review at physical healthcare network to ensure care being delivered is evidence based and that standards are continuously improving	Physical healthcare assurance framework to be further reviewed to provide assurance around pressure ulcers, falls and other physical health risks Associate Director of Nursing & Therapies [Physical Health] August 2015 Cardiometabolic assessment national CQUIN data collection commences 1 October 2015 – localities to undertake gap analysis based on previous year's performance and report to Patient Safety & Effectiveness Sub Committee [escalating to Board as appropriate] Locality Service and Clinical Directors August 2015

	needed to implement the national CQUIN 2015/2016 – this was reported to PSEC in February 2015 ▪ Physical healthcare assurance framework reviewed and approved – June 2015		

Strategic Objective: 1. Deliver high quality, integrated and innovative services that improve outcomes

Risk Owner: Director of Nursing, Therapies and patient partnership
Risk Lead: Associate Director of Nursing (Physical Health)

Risk appetite: 2

Risk 2: Adults, children and young people are not protected through practitioners not implementing safeguarding practices and principles.

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	5	25	4	4	16	3	4	12

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Safeguarding policies: ▪ Adult safeguarding policy ▪ Children's safeguarding policy ▪ Mandatory Essential Learning policy ▪ Policy for management of investigations ▪ Policy for management of complaints/ concerns ▪ How to raise and escalate concerns policy including whistleblowing ▪ Health records policy ▪ Incident reporting and management policy ▪ Supervision policy ▪ Visiting of patients by children on adult wards ▪ Prevent assurance framework ▪ Audit programme 2015/16	▪ Learning from experience and incident reporting ▪ Safeguarding exception reporting to Quality Committee ▪ Contractual requirements within NHS standard contract regarding 100% access to supervision and 80% compliance with statutory and mandatory training ▪ Inspection report from CQC safeguarding and looked after children January 2014 – completion of action plan approved by designated nurse ▪ Trustwide Safeguarding Sub Committee minutes, business cycle and terms of reference ▪ Training needs analysis of compliance with intercollegiate guidance	▪ CWP current benchmarked position indicates that a review of current controls in relation to e.g. seclusion/ segregation, restraint, DoLS requires review and/ or improvement to be assured that improper/ incorrect applications are not safeguarding concerns ▪ Current red complaints in CWP East require investigation by the Trust (in parallel to local authority investigation) ▪ Clinical audit plan requires close monitoring to ensure remains on track ▪ Training compliance with Prevent below requirement ▪ New guidance for Prevent required to be implemented ▪ Full impact of Care Act not known	Implement findings from identified quality improvement projects (e.g. "accelerating restraint reduction", seclusion audit, DoLS training gap analyses) Medical Director Quality/ Associate Director of Safe Services End September 2015 Implement action plan following investigations of red complaints in East locality CWP East locality management End September 2015 Ensure links between Trustwide Safeguarding Sub Committee and Patient Safety and Effectiveness Sub Committee (for Mental Capacity Act) are effective

▪ MHA visits ▪ MIAA programme ▪ Link to LSABs and LSCBs ▪ Safeguarding flow chart displayed on all wards and community teams ▪ Locality safeguarding groups ▪ Essential learning ▪ Patient safety metrics ▪ Healthcare quality improvement programme ▪ Compliance visits ▪ Practice audits ▪ CQC visits ▪ Monitoring of safeguarding performance	▪ Monthly tracker of safeguarding training ▪ CCG Self Assessment for Safeguarding Adults and Children ▪ Completion of Section 11 audit and feedback and action plan ▪ Monitoring of Prevent implementation – quarterly reporting to NHS England ▪ Compliance/inspection reports internal ▪ Quarterly performance reports to LSABs and LSCBs ▪ MIAA reports and action plans ▪ Benchmarking reports to Operational Board	▪ Capability and capacity within workforce in relation to front line safeguarding practice requires strengthening within localities	Associate Director of Nursing & Therapies [Physical Health] End March 2016 Strengthen locality safeguarding groups through membership representation from the Safeguarding Specialist Nurses Head of Safeguarding End September 2015 Ensure compliance reaches 85% across all levels of safeguarding training Service Directors End March 2016 Strengthen the monitoring of action plans by locality groups with robust updates to Trustwide Safeguarding Sub Committee Locality group chairs End October 2015 Continue to work closely with LSABs and sub groups to monitor impact of Care Act Members of LSABs and sub groups End October 2015 Develop the Safeguarding Practitioner Links programme across all localities Named Nurses Safeguarding End September 2015

Strategic Objective: 1. Deliver high quality, integrated and innovative services that improve outcomes

Risk Owner:	**Medical Director Quality**
Risk Lead:	**Associate Director of Safe Services**

Risk appetite: 3

Risk 3: The inability of staff to manage the occurrences of slips, trips, and falls of patients resulting in patient injury.

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	5	20	4	4	16	3	4	12

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Falls policy and pathway ▪ Fall Safe care bundle is in place across all wards ▪ Falls risk assessment tool developed for older persons and service users who are known to have a risk of falls ▪ Healthcare quality improvement programme ▪ Links with PCT falls co-ordinators ▪ Patient safety metrics ▪ Falls Task and Finish group ▪ Negotiation of community falls CQUIN for 2015/16 for West and Wirral – this will also be mirrored in East ▪ Wards are currently using the FRAT as guidance, however, all patients over 65 are considered to	▪ External assurance received from acute falls nurse specialist who undertook a review of falls prevention and management. The review found that CWP has a robust system in place for falls management, however, sometimes locally these systems are not always fully implemented. ▪ Ongoing monitoring of proportion of harm/ no harm reporting via the Learning from Experience report ▪ Audit Committee has undertaken two in-depth assurance reviews of the risk during 2014 to agree target risk score of 12 ▪ University of Stirling's Dementia Services Development Centre work re dementia care	▪ Local implementation of environmental improvements and training ▪ FRAT remains incorporated currently within the falls care bundle	Develop and implement falls training needs analysis for inpatient and community teams, factoring in strengthening falls risk assessment process with holistic assessment of needs Head of Clinical Governance July 2015 Ensure residual gaps re environment is ongoing as part of capital programme and that work has commenced higher risk areas prioritised Head of Estates/ Head of Clinical Governance September 2015 (deferred from June 2015, assurance framework in place, any deviation will b reported to next

be a falls risk on the inpatient units	environments		Operational Board before confirmation of completion of this action) Falls policy is currently being up-dated which includes a risk formulation plan based on a holistic assessment Head of Clinical Governance July 2015 To identify an accelerating falls reduction quality improvement programme Head of Clinical Governance Terms of reference to be confirmed July 2015

Risk 4: Archived 21/07/2015
Placeholder – currently vacant

Strategic Objective: 1. Deliver high quality, integrated and innovative services that improve outcomes

Risk Owner: Medical Director Quality
Risk Lead: Clinical Directors

Risk appetite: 3

Risk 5: Risk of harm to patients due to CARSO risk assessment not being completed as per policy

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	4	20	4	4	16	3	4	12

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Clinical risk management policy ▪ Essential learning ▪ Patient safety metrics ▪ Effective Care Planning Lead in situ ▪ Zero Harm strategy implementation plan ▪ Care co-ordination policy ▪ Appointed clinical care planning lead ▪ Ward manager task and finish groups	▪ Patient safety metrics reporting ▪ Data quality/ completeness reporting to wards and teams ▪ Learning from experience and incident reporting ▪ Compliance visits ▪ Critical issues escalated to Patient Safety & Effectiveness Sub Committee	▪ Services not sustaining over 99% completion rates ▪ Further assurance needed on quality of CARSO assessments prior to re-modelling ▪ Care co-ordination policy approved at April 2015 Patient Safety & Effectiveness Sub Committee, agreed a further review by end of 2015 calendar year based on feedback from training, further work around advance statements and an integrated checklist for care planning needs – to better align with standards around formulation of risk and clinical risk standards	Audit on a case by case basis end of September 2015, where no completed CARSO summary, to understand what might be the individual clinician or managerial issues preventing completion. Clinical Audit Coordinator September 2015 Second/ further review of care co-ordination policy that was approved in April 2015 to be undertaken based on feedback from training, further work around advance statements and an integrated checklist for care planning needs – to better align with standards around formulation of risk and clinical risk standards Effective Care Planning Lead December 2015

Strategic Objective: 1. Deliver high quality, integrated and innovative services that improve outcomes

Risk Owner: Director of Nursing, Therapies and Patient Partnership
Risk Lead: Associate Director of Safe Services/ Service Directors

Risk appetite: 3

Risk 6: 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

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	4	20	4	4	16	3	3	9

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Incident reporting and management policy ▪ Complaints management policy ▪ Essential learning ▪ Quality assurance group with Non Executive Director review ▪ Weekly meeting of harm with senior oversight (Director of Nursing, Therapies and Patient Partnership and Medical Director) ▪ Learning from experience report ▪ Commissioner serious incident meetings ▪ Healthcare quality improvement programme ▪ SUI Board report	▪ Learning from experience reporting ▪ Compliance, Assurance & Learning Sub Committee review of completion of serious incident investigations ▪ Quality Committee review of Regulation 28 learning ▪ Board review of level 3 investigations ▪ Audit Committee in-depth review of current assurances March 2015 ▪ The governance of ensuring duty of candour is recorded ▪ Significant assurance received from Internal Audit regarding incident reporting and management	▪ Incident reporting and management policy does not reflect standards agreed with commissioners ▪ Agreement required on formal performance management of investigations ▪ Repeated learning themes ▪ Capacity in the Trust to meet contractual timeframes (as per NHS England guidance)	Full review of incident reporting and management policy (including a governance and assurance framework) post publication of NHS England guidance Head of Clinical Governance July 2015 (deferred from May 2015 with agreement of Quality Committee to allow discussion of NHS England guidance with commissioners and agree consensus) 2015/16 contracts to agree performance management standards Head of Clinical Governance July 2015 (deferred from April 2015 to align with scheduled discussions with commissioners) Scope appointment of clinical expert

			champion for serious incidents and bank of investigation officers Director of Nursing, Therapies & Patient Partnership/ Head of Clinical Governance August 2015 (deferred from July 2015, job descriptions developed, currently being considered by Executive Team)

Strategic Objective: 1. Deliver high quality, integrated and innovative services that improve outcomes

Risk Owner: Director of Operations
Risk Lead: Associate Director Infrastructure Services/ Head of Capital & Property Management

Risk appetite: 2

Risk 7: Risk of harm to patients due to ligature points and environmental risks within the inpatient setting

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	5	25	4	5	20	3	5	15

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Environmental clinical risk assessment policy ▪ Seclusion and segregation policy reviewed against new MHA Code of Practice guidance, including associated education programme ▪ Board approved capital programme in place ▪ Patient safety walkrounds ▪ Cascade of safety alerts ▪ Suicide prevention action group meeting ▪ Suicide prevention strategy/ assurance framework ▪ Zero Harm strategy ▪ Compliance visits ▪ Patient safety metrics ▪ Testing protocol for door top alarm system ▪ Operational risk registers monitor	▪ Works completed (October 2014) regarding en-suite door top alarm systems and clinical risk management of dressing gown cords ▪ Patient safety metrics reporting ▪ Staff trained and guidance provided on the technical aspects of the en-suite door top alarm system ▪ Reporting to Operational Board on locality risks ▪ Reporting to Patient Safety & Effectiveness Sub Committee on outputs of suicide prevention strategy work ▪ Continuous improvement of patient environment ▪ Significant investment in ligature remedial work over the last 4	▪ No formal link between HoNOS score and self-harm risk and/ or sudden new or sudden emergence of known risk factors to self ▪ Alignment of clinical and environmental risk management to be further enhanced ▪ Review required of the standard of rooms which being used as an emergency contingency measure for seclusion purposes	Task and finish group to review current policy to ensure observation and environment standards are aligned and HoNOS score of 4 scoped/ operationalised as a trigger for clinical risk management plans when self-harm risk and/ or sudden new or sudden emergence of known risk factors to self. Consultant Nurse Acute Care July 2015 (deferred from April 2015 to July 2015 following level 3 recommendation to Board) Monthly Seclusion task and finish group to review current gaps in control in relation to standard of rooms for seclusion Patient Safety & Effectiveness Sub Committee

local controls ▪ Estates network ▪ Monthly seclusion task and finish group (from May 2015) ▪ Peer benchmarking groups: CAMHS Secure Eating Disorder Learning Disability ▪ New build – secure services and CAMHS Tier 4 unit ▪ Ligature points are risk assessed by a process involving systematic examination of identified areas including external reviews of estate re ligatures ▪ Each ward has a ligature “floor map” of all the bedrooms and bathrooms and identifies any potential ligature points – this supports staff when allocating bedrooms to facilitate clinical risk assessment and management ▪ Safeguards (flow chart setting out escalation procedures) for seclusion incidents	years		First meeting May 2015, currently ongoing – first report to Patient Safety & Effectiveness Sub Committee August 2015

Strategic Objective: 1. Deliver high quality, integrated and innovative services that improve outcomes

Risk Owner:	**Chief Executive**
Risk Lead:	**Director of Operations**

Risk appetite: 4

Risk 8: Fragmentation of commissioning leading to fragmented patient pathways and therefore risks to delivery of good quality patient care and outcomes

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	4	16	3	4	12	3	3	9

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Existing discussion and engagement with commissioners and partner organisations, including across key complex patient pathways and populations and to take account of extensive change in commissioning structures ▪ Quality assurance, improvement and governance mechanisms in place and routinely assessed to promote delivery of good quality patient care and outcomes – including NICE guidance, outcome, care pathway variance reporting ▪ Establishment of integrated provider/ commissioning model across all CCGs ▪ Integrated provider models and	▪ Tender opportunity assessment tool has been developed. This will link to the tender opportunity standard operating procedures and the associated process maps. This will also be directed by the clinical localities strategic ambitions and their local business development plans. ▪ Initial local responses to contracting strategy (operational plan 2015/16) ▪ Programme Assurance Board for Integrated Provider Hub ▪ Memorandum of Understanding with Wirral commissioners	▪ Lack of full understanding of emerging commissioning structures, processes and culture in respect of: - Better Care Fund - Specialised Commissioned Service - Public Health Commissioned Services ▪ Associated risks to financial sustainability ▪ Inability to influence availability of commissioning budgets (Local Authority or CCG) ▪ Lack of commissioning of effectiveness pathways of care for people with emotionally unstable personality disorder resulting in inappropriate admissions to acute mental health wards	Strategic influence with commissioners via existing forums Director of Operations Locality Service Directors, Clinical Directors, Extended Board of Directors membership Immediate and ongoing Building upon opportunities presented by Vanguard, IPH, integration with CWaC provider services All strategic leaders and clinical leaders Immediate and ongoing Mitigate lack of full understanding of emerging commissioning structures, processes and culture All strategic leaders and clinical

partnerships, e.g. via pathfinder model ▪ Establishing even better strategic partnerships with commissioners and providers to maximise adverse impact upon services to citizens ▪ Vanguard; provider partnerships ▪ Active partner in the Vanguards in Wirral and West Cheshire ▪ Key partner in Connecting Care and Caring Together			leaders - cascade through CWP Immediate and ongoing Robust mechanisms around tendering ensuring capacity at senior level to respond to changes in commissioning intentions Corporate and Operational services/ Effective Services Department July 2015

Strategic Objective: 1. Deliver high quality, integrated and innovative services that improve outcomes

Risk Owner:	**Medical Director Quality**
Risk Lead:	**Associate Director of Performance & Redesign**

Risk appetite: 4

Risk 9: Risk of adverse clinical incident due to quality of record keeping and dual record keeping systems (electronic and paper)

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	4	16	4	4	16	3	4	12

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Record keeping policy ▪ Information Governance Toolkit ▪ Healthcare quality improvement programme ▪ IT enabled programme board ▪ Records and information systems group review of clinical systems priorities (effectiveness and functionality) with dual record keeping risk ▪ CQC visits	▪ Reporting to Patient Safety & Effectiveness Sub Committee on outputs of audits ▪ Reporting of progress against dual record keeping action plan to Patient Safety & Effectiveness Sub Committee ▪ CQC compliance in relation to records ▪ Reduction in Datix incidents/ RCA reports identifying dual record keeping as a contributing factor in clinical incidents	▪ Processes supporting IT enabled transformation programmes are outstanding ▪ Clinical systems training not mandatory for new starters	Correlation of clinical systems priorities with the dual record keeping risk – also tie into review of system effectiveness and functionality Records and Clinical Systems Group Phase 1: Scoping exercise to identify clinical data held on shared drives/ manually Phase 2: process mapping Phase 3: review of process mapping to identify possible solutions for the removal of dual storage of clinical data Phase 1: August 2015 Phase 2: August 2016 Phase 3: January 2017 Clinical system provider to develop audit of alerts process Timeframe to be confirmed by supplier

			Interim audit in place, process to review alerts audit to be developed. September 2015

Strategic Objective: 3. Be a model employer and have a caring, competent and motivated workforce

Risk Owner:	**Director of Nursing, Therapies and Patient Partnership**
Risk Lead:	**Associate Director of Nursing & Therapies (Mental Health)**

Risk appetite: 2

Risk 10: 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.

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	4	20	4	4	16	3	4	12

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Essential learning and induction policy ▪ Trust training strategy in place responsive to corporate services review, planning priorities, Francis/ Berwick reports, CWP always events framework ▪ Approved essential learning programme approved by October 2013 Operational Board ▪ E-learning and rolling half days available ▪ Essentials 1 target in place: 85% to take into account turnover and other absences and longitudinal targets have been agreed (to 90% over two years) ▪ New 'Education Governance Group' to enable partnership working	▪ 2014/15 CWP performance dashboard identifying continuous improvements in essential learning compliance Trustwide ▪ Compliance data reviewed at People and Organisational Development Sub Committee and feeds into quality dashboard (Quality Committee), performance reviews and supervision/ appraisal (via 'trigger reports') ▪ Audit Committee has undertaken an in-depth assurance review of the risk during 2014 to agree target risk score of 12 by December 2015 ▪ Human Factors training events have been run throughout 2014/15. Over 100 staff have been trained to become 'culture	▪ Reported gaps in current essential learning programme content, e.g. fire, safeguarding, physical health in mental health, suicide training, psychological interventions, dementia, personality disorder, human factors, risk assessment, care planning, specifics for district nurses, clinical supervision ▪ Essential learning policy needs to reflect the Essentials framework training needs analysis that was agreed by POD Sub Committee in May 2015 ▪ Assurance around capacity of training schedule to meet demand	Delivery plan for training programme to be implemented Associate Director of Nursing and Therapies (Mental Health) Ongoing Review essential learning policy and align to new training needs analysis Education CWP for approval at POD Sub Committee July 2015 Develop a forward training schedule to outline capacity versus demand Education CWP reporting to POD Sub Committee August 2015

▪ Action plan in place re review of the essential learning programme ▪ Extended hours to support e-learning at training venues ▪ Development of 12 hour days for inpatient staff introduced to increase compliance ▪ Monthly trigger reports provided to service managers that includes current position and DNA rates	carriers' throughout CWP. During 2015, there are additional plans to extend this group and numbers so that the Human Factors message is embedded within CWP. ▪ Training venue in Macclesfield introduced February 2014 to facilitate improved compliance		

Strategic Objective: 3. Be a model employer and have a caring, competent and motivated workforce

Risk Owner:	**Director of Human Resources and Organisational Development**
Risk Lead:	**Associate Director of Nursing & Therapies (Mental Health)/ Heads of Human Resources, Workforce Planning, Education**

Risk appetite: 4

Risk 11: Failure to maintain (and predict the need for) the right number of staff with the right skills/ attitudes in the right place at the right time could impact on the Trust's ability to deliver a safe and effective service against changing needs.

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	5	25	5	4	20	3	4	12

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Bank and agency usage reported to Operational Board ▪ Process in place for vacancy approval and filling ▪ Strategic Objective One of the Trust People and Organisational Development (POD) Strategy specifically addresses this risk - We attract and develop skilled, knowledgeable and innovative people who live out our Values ▪ People Planning Group established to oversee resourcing activity across Trust, this includes management of agency and locum staff and management of activity in relation to these staff – reporting to POD Sub Committee ▪ Recruitment processes revised to	▪ Investors in people assessment recognised good practice in a range of associated areas ▪ National benchmarking work re skill mix ▪ Ward staffing review identifying capacity issues and focusing recruitment activity ▪ Recruitment activity (numbers recruited) remains high ▪ Specific recruitment interventions produced for hotspot areas e.g. CWP East ▪ Comprehensive staffing review for nursing inpatients completed and approved by Board of Directors ▪ OT review completed and presented to the June 2015 Project Group	▪ Lack of confidence in data which indicates the size of the "gap" (i.e. current and anticipated vacancies) undermines assurance ▪ Lack of proactive workforce planning means that targeted recruiting ahead of need and to prioritised areas is undermined ▪ Lack of triangulation of data in reporting does not aid understanding of inter-dependencies or impact of controls ▪ Focus is currently on ward staffing but the risk applies to all service delivery areas and there is a lack of information on the "gaps in controls" in those other	▪ Embed People Planning Group ▪ Complete implementation of TRAC system ▪ Embed the new integrated Resourcing Team ▪ Expand the Temporary Staffing arm of the Resourcing Team to include control of all agency staff hire/ spend and supply of bank staff to service delivery areas other than just the wards ▪ Complete 2015/16 round of Workforce Planning ▪ Implement the recommendations of the report into Strategic Resourcing to establish a pool of suitable candidates ▪ Task and Finish Group to continue to deliver action plan for

ensure that they are safe and that all the necessary checks and risk assessments are carried out (in response to the Saville Inquiry) ▪ TRAC online recruitment system implementation commenced ▪ Creation of one integrated Resourcing Team commenced (at final consultation stage) ▪ Review carried out on options for strategic resourcing – report produced and to be discussed at POD Sub Committee on 11/05/2015 ▪ Task and Finish Group set up to address sick absence levels ▪ Programme of education and learning interventions designed to meet clinical and non-clinical skills and knowledge needs based on a TNA ▪ Trust workforce plan produced and submitted to Health Education England informed by clinical strategies ▪ Essential learning features as a Trust KPI and is scrutinised via Trust's governance processes ▪ Ward staffing monthly and six monthly review reports published.		areas ▪ Agency spend on staffing has increased. ▪ Assurance of inpatient staffing levels being fully implemented ▪ Whilst recruitment issues are being addressed, sickness levels remain a concern	reducing sickness absence ▪ Revised report tools to enable increased use of triangulation ▪ Increase use and analysis of exit interviews to aid understanding of turnover People and Organisational Development Sub Committee to configure its business cycle to enable implementation of the recently approved strategy and to capture above actions. People and Organisational Development Sub Committee July 2015 Financial Recovery Plan paper (including ward staffing costs) to Board of Directors Director of Finance July 2015

Strategic Objective: 5. Improve quality of information to improve service delivery, evaluation and planning

Risk Owner: Director of Finance
Risk Lead: Associate Director of Performance and Redesign

Risk appetite: 4

Risk 12: 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

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	4	20	4	4	16	3	4	12

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Data quality improvement framework detailing data quality roles and responsibilities ▪ Five year strategic plan re better use of information ▪ Data quality reporting from clinical systems to localities for sense check ▪ IT enabled project board ▪ Data Quality Project Lead in post leading on implementation of data quality improvement framework to accelerate improvement	▪ Clinical coding and information governance audits detailing compliance ▪ Progress reported in 'measurement' section of Monitor quality governance framework self assessment ▪ Quality Account external audit 2013/14 received no qualifications (currently in progress for 2014/15) ▪ CWP performance dashboard reporting ▪ Implementation plan agreed at operational Board – March 2015 ▪ Data Quality project Lead in place – with effect from May 2015	Implementation plan required for data quality improvement framework to assure that the required systems, processes, competencies and gatekeeping arrangements are in place to operationalise the framework (this will identify forward actions to address specific gaps) Data quality issues raised during preparations for and during CQC inspection June 2015 Governor selected Quality Account indicator 2014/15 has gaps in control (as expected, hence the selection to inform risk treatment plan) in relation to data quality and completeness	Review of all data extracts from the data warehouse that support our contractual and mandatory reporting requirements Data Warehouse Manager November 2016 Concerns with data quality identified during CQC inspection (June 2015) Quality Committee to undertake an in-depth review of risk and risk treatment plan (Associate Director of Performance & Redesign) August 2015 Improvement plan to improve data quality/ completeness for national IAPT indicators for 2015/16 (quarter 3)

			Associate Director of Performance & Redesign September 2015

Strategic Objective: 5. Improve quality of information to improve service delivery, evaluation and planning

Risk Owner:	**Director of Finance**
Risk Lead:	**Associate Directors of Effective Services and Performance and Redesign**

Risk appetite: 4

Risk 13: Loss of current services due to risks associated with the market environment and the potential for commissioners to seek further competitive tendering for clinical services

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
3	4	12	3	3	9	1	3	3

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Clinical and financial review and involvement throughout tender process ▪ Ability to influence commissioners via close working relationships ▪ History of good performance ▪ Robust Standard Operating procedures developed by Effective Services to respond to tender opportunities ▪ A non-direct care cost review is currently being undertaken and this will help to identify any gaps in current tendering processes and skills	▪ Clinical and financial review and involvement throughout the tender process ▪ Executive Director sponsor assigned to each tender ▪ 'Black hat' meeting undertaken in advance of tender submission ▪ Executive Director sign off of tender submission ▪ It is acknowledged that this risk score is likely to be volatile based on market environment	▪ Lack of business development strategy ▪ Bid writing constraints ▪ Contract management capacity constraints ▪ Costing and pricing capacity ▪ Current tendering exercises in the CWP West locality of value £25,000 - £100,000	Monitor impact of Service Improvement Framework to address the gaps in controls, to guide localities, mitigate governance issues associated with sub contracted services, and to bring about consistency to mitigate the volatility of the risk score Business Development and Innovation Sub Committee/ Effective Services Department Ongoing throughout 2015/16

Strategic Objective: 6. To sustain financial viability and deliver value for money

Risk Owner:	**Director of Operations**
Risk Lead:	**Service Directors**

Risk appetite: 4

Risk 14: 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

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	4	20	3	4	12	2	4	8

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Budget statements detail CIP ▪ Quarterly financial risk rating to Monitor ▪ Quarterly performance reviews address financial issues ▪ Associate Director of Performance and Redesign leading CIP management process/ tracking of CIP delivery ▪ Strengthened financial infrastructure via locality accountants ▪ Board approved operational plan including 2014/15 CIP plans ▪ Monthly reporting to Operational Board ▪ CIP forward planning events held in August 2014 to start the 2015/16 process ▪ Impact assessment process	▪ Impact assessment of service redesign as part of the annual planning processes ▪ CWP performance report monthly monitoring ▪ Regular monitoring via CIP steering group ▪ Internal audit programme mapped to financial strategy ▪ Audit Committee and Quality Committee overview ▪ Weekly reporting to Exec team ▪ Formal review in quarterly Performance Reviews with services	▪ Quality of CIP plans ▪ Plans off track ▪ Uncertainty of commissioning intentions ▪ Inability to influence the overall budget available to commissioners	To continue to review quality of CIP plans and those off track (as part of 2015/16 efficiency targets) Associate Director of Performance and Redesign Ongoing 2015/16 Agree strategic service plans with commissioners based either on disinvestment from CWP or reinvestment to deliver wider systemic efficiencies Service Directors Ongoing 2015/16

▪ Associate Director of Performance & Redesign and Director of Operations meeting with Service Directors to review progress ▪ Development of Integrated Provider/ Commissioning Hubs to manage service re-design; delivery in a more strategic manner ▪ Shared planning via emerging Vanguard model ▪ Review and redesign of non-direct clinical care services to achieve greater efficiencies			

Strategic Objective:	7. Be recognised as an open and progressive organisation that is about care, well-being and partnership

Risk Owner:	Chief Executive
Risk Lead:	Associate Director of Safe Services

Risk appetite:
2

Risk 15: Risk of breach of the Trust Licence as a result of external scrutiny

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	5	20	3	4	12	2	4	8

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Integrated Governance Framework ▪ Internal audit plan ▪ External scrutiny by other agencies ▪ Regular patient surveys ▪ Provider licence self-assessment process in place reporting to Board ▪ Increased visibility of compliance against Provider Licence through quarterly reporting to Audit Committee	▪ Quality dashboard/ locality data pack reporting ▪ Regular meetings with commissioners to review contractual performance ▪ All registered locations are currently compliant ▪ Currently no concerns in relation to CQC compliance ▪ Monitor governance rating Green ▪ Audit Committee undertook in-depth review of this risk at May 2014 meeting (risk score 10 identified, subsequently amended to 8) ▪ Current CQC intelligence monitoring report highlights CWP as a low risk organisation ▪ April 2015 – internal audit of compliance received significant assurance	▪ CQC announced inspection scheduled w/c 22 June 2015 (assurances pending)	Development and implementation of post CQC action plan focusing on immediate issues post inspection Head of Compliance July 2015 Await and respond to CQC draft report providing assurance to archive risk or otherwise Head of Compliance September 2015

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	The CWP Zero Harm approach to quality – progress against year 1 key quality indicators and forward plan of developmental areas
Agenda ref. no:	15/16/36.
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	29/07/2015
Presented by:	David Wood, Associate Director of Safe Services

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

REPORT BRIEFING

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

The Trust's approach to quality, its Zero Harm aspirations, is about ensuring that there is a focus on continuous improvement in the delivery of patient safety and effective care that brings about positive patient experience. The Board of Directors endorsed and invested in this approach in January 2014. An operational implementation plan is reviewed at each meeting of the Quality Committee to ensure sound progress against the Trust's quality goals. Additionally, to give the Board a view of its return on investment, a three year framework was developed, with annual indicators, to facilitate the Board in reviewing progress against annual "way points". Progress against the year one indicators demonstrates a number of positive markers, suggesting that the Trust is on the "way" to continuously improving the quality of care by tackling unwarranted risks and variation. This will be reviewed formally again next year, against the year 2 indicators, additionally the presentation to the Board of Directors today explores a number of areas of focus and development for the year ahead.

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

The Board of Directors approved a 3–5 year forward strategy in January 2014, committing to an aspiration of continuously improving the quality of care by tackling unwarranted risks and variation. This was in response to the Berwick (2013) root-and-branch review of patient safety, which found that most healthcare organisations at present have very little capacity to analyse, monitor or learn from safety and quality information. The annual review of progress against the year one "way points" framework, developed to assess the effectiveness of the first year of the strategy, was scheduled for the July meeting in the Board's business cycle given that the majority of the initial investment required recruitment to posts, which were recruited to half way through 2014. In addition to an annual review of progress against the identified "way points", each Quality Committee receives updates against the implementation plan for the forward strategy.

Assessment – *analysis and considerations of options and risks*

Appendix 1 details status against each identified year one quality key performance indicator.

Indicators that demonstrate positive progress towards the Trust's long-term quality aspirations include:

- Improvements to no harm incident reporting over the last four months (safety).
- Improvements to ratings achieved by wards/ teams as part of the Trust's compliance visits (effectiveness).
- Performance in relation to feedback from people who access the Trust's services (experience).

Indicators that demonstrate where further focused attention is required include:

- Improvements to serious incident investigatory timeframes (safety).
- Development of an enabling plan to ensure adequate staff training in relation to CPA, HoNOS and CARSO (effectiveness).
- Through the Trust's values work, a focus on the communication domain of the 6Cs (experience).

As detailed in the presentation being received at today's meeting of the Board of Directors, areas of focus for year two of the forward strategy include:

1. Vision/ culture (safety)

Promoting CWP as a 'safe' (high reliability) healthcare organisation defined in terms of safety culture and teamwork. This includes enabling safety critical behaviour through an understanding and application of Human Factors principles and robust quality improvement efforts.

2. Delivery of meaningful outcomes for people accessing CWP's services (effectiveness)

Using meaningful and simple outcome measures, e.g. HoNOS, to continuously review (and therefore amend where necessary) whether plans of care are working or delivering as anticipated outcomes.

3. Strengths, needs and aspirations (experience)

A commitment to getting care planning right, promoting collaboration (and communication) between people accessing CWP's services and clinical teams, the currency to achieving recovery being strengths, needs, aspirations and risks.

Overall, the Trust is on track with its long-term quality aspirations and now requires re-calibration to ensure the continuing appropriateness of these goals, informed by/ as detailed above. Key to the continuing success of the Trust's aspirations will be ensuring a renewed focus on continuous quality improvement. The Quality Committee, in its role for ensuring that that the strategic priorities for quality improvement are identified, implemented and monitored, is discussing approaches to driving continuous quality improvement further and faster at its next meeting on 4 August 2015. This will be reported to the next meeting of the Board of Directors via the Quality Committee Chair.

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

To **discuss** and **note** the progress against the year one "way points" identified for the Zero Harm forward quality strategy and **endorse** the continuing approach for year two.

Who/ which group has approved this report for receipt at the above meeting?	Board of Directors – business cycle requirement

Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Board of Directors	22/07/2015

Appendices provided for reference and to give supporting/ contextual information:	
Appendix number	Appendix title
1	Zero Harm progress report – year 1 quality key performance indicators

Appendix 1: Outputs of continuous quality improvement – Year 1 Zero Harm key performance indicators

Performance key:

RAG	Definition
●	Meeting or exceeding expectations.
●/ ●	Partially meeting expectations but confident of capacity to improve against key performance indicator within reasonable timeframe.
●/ ●	Partially meeting expectations but some concerns of capacity to improve against key performance indicator within reasonable timeframe.
●	Not meeting expectations.

Performance outputs:

	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
1. CPA and effective lead			
1.1 Appoint a CPA and effective lead	a. CPA review outcomes reviewed in performance reviews from April 2014 for *all points of discharge* [i.e. from inpatient stay or CWP services]. Baseline identified for above.	Performance against CPA (Care Programme Approach) targets is monitored at the performance reviews.	●
	b. Continuous increase in proportion of clinical staff	Baseline commences from trimester 1 of 2015/16, when the new Effective Care Planning, Clinical Risk and CARSO (Clinical Assessment of Risk to Self and Others) module was launched. The number of clinical staff who completed this new module in trimester 1 was 196/ 15% of	●/ ●

	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
	and managers receiving training/ development in techniques/ approaches, e.g. team working; CPA and associated relevant training; monitoring and review; situation specific approaches [as a minimum, all staff trained in CPA, HoNOS and CARSO by end year three].	the total number of clinical staff. Local individual awareness sessions are also being delivered on a bespoke basis. Team working and situation specific approaches currently forms part of Human Factors training, a sustainability plan to deliver this training over subsequent years is being developed between Education CWP, Organisational Development and Safe Services Department – Year 2 indicators will be set then.	
	c. Continuous reduction in variable use of CPA within and between teams, including continuous improvements	CPA patients receiving follow up contact within seven days of discharge from psychiatric inpatient care = 98.2% (baseline). The percentage of all service users on CPA who have had their care plan reviewed within the last 12 months = 95.59% (baseline). Currently meeting national targets but with variability in performance range across teams which will be monitored as team level data via locality data packs.	●/ ●

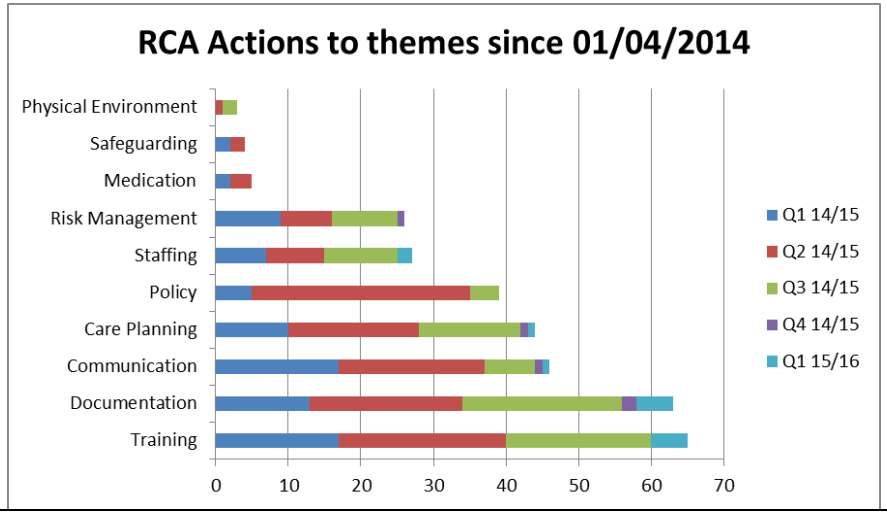
	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
	in national CPA targets: - CPA patients receiving follow-up contact within seven days of discharge from psychiatric inpatient care - The percentage of all service users on CPA who have had their care plan reviewed within the last 12 months		
	d. Continuous improvement in feedback from CWP compliance	In October 2014, the assessment process for CQC (Care Quality Commission) inspections changed to review key questions rather than essential standards and, as such, the CWP compliance visits were amended to reflect this. This means a direct review of continuous improvement is not possible, however, between July 2013 and the end of June 2014 for the essential standard of the care and welfare of people who use services, 58% of outcomes	●

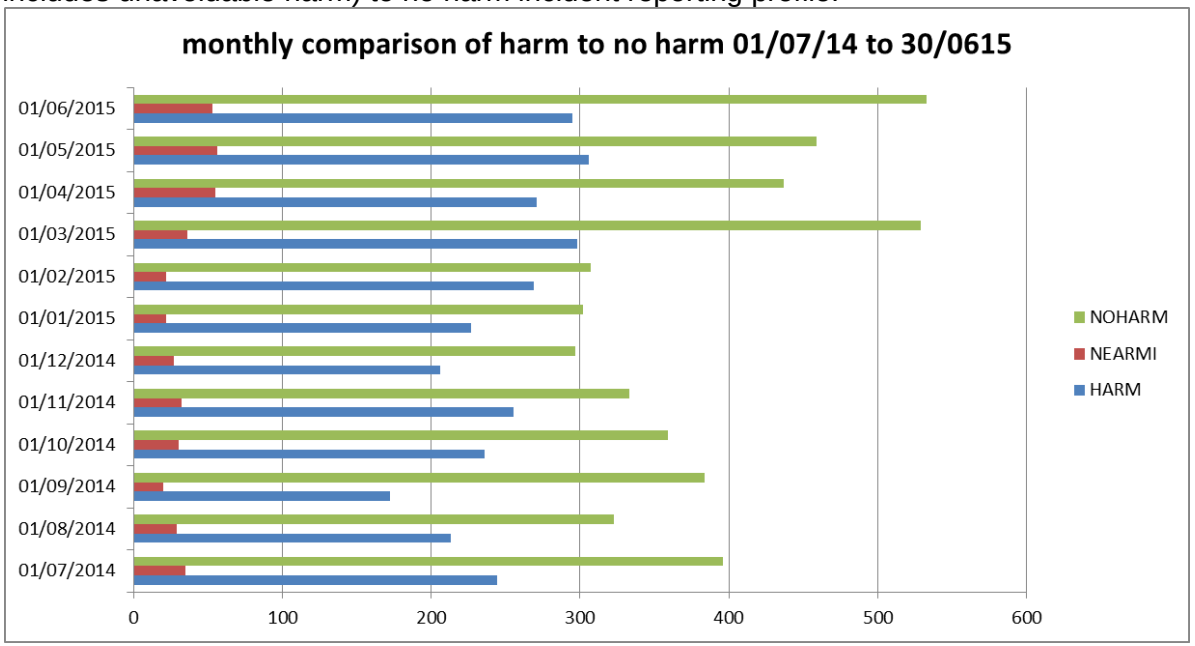
	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
	visits/ equivalent desktop review for essential standard of quality and safety 'care and welfare of people who use services'	were rated as green. Between July 2014 and the end of June 2015 for the essential standard of the care and welfare of people who use services or the key question of whether services are caring, 65% of outcomes were rated as green, good or outstanding, which represents an improvement.	
	e. Continuous improvement in feedback and/ or rating from the CQC for the safe and effective care components as per the "CQC action plan for safe and effective care 2010 – 15"	Since the end of June 2014, the Trust has received two visits from the CQC; a follow-up review of compliance to Bowmere Hospital in August 2014 and a trustwide inspection in June 2015. The visit to Bowmere confirmed compliance in relation to records management which had previously been an area identified for improvement. The Trust is awaiting the formal feedback and rating from the trustwide inspection in June 2015.	●/ ●
	f. Continuous improvement in feedback from people who use CWP's services [local	A number of different surveys routinely seek feedback from people who access the Trust's services. The **Friends and family test** (FFT) is a national survey which invites patients to identify whether they would recommend the Trust to friends and family. Between the period October 2014 and March 2015, 93% of people who participated said they were either 'Extremely likely' or 'Likely' to recommend CWP services to family and friends. The **National Patient Survey** took place between February and June 2014. The survey	●/ ●

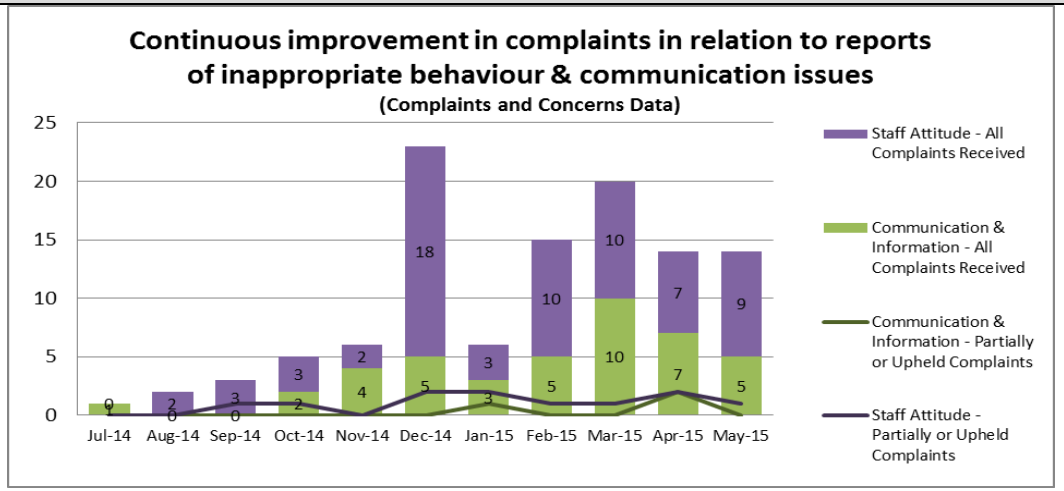
	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
	and national survey feedback] in relation to the co-ordination of their care	targeted people who used community mental health services between 1 July and 30 September 2013. Nationally, CWP achieved top survey results overall, and were top in four out of the nine categories. Furthermore, CWP scored better than expected in 11 questions. In particular overall respondents felt that their care was co-ordinated, signposting to other services was good, and the recovery approach was appreciated. **Annual carers' survey** (June 2014). Feedback identified that improvements are required in offering an assessment of carer needs and access to specific material related to their rights and support. In direct response to this feedback, two half day training sessions were offered to carer link workers in secondary mental healthcare. Information made available to carers was updated, and carer link workers were identified at ward level to offer advice and support. In recognition of the strong partnership working with carers and care organisations, CWP was awarded a second Triangle of Care gold star in March 2015. The Trust's **Inpatient survey** was conducted across all CWP localities between 11 – 14 August 2014. 61% of patients who participated felt either fully or mostly involved in decisions and 72% felt that the care was meeting their needs. 80% felt that they had been treated with dignity and respect all the time by professionals and 70% responded that if at any time they needed help and advice whilst they were on the ward, they received it. 74% rated the quality of services they received on the ward as excellent.	
2. Celebrating success and promoting good practice			
2.1 Delivery of the clinical effectiveness and patient experience priorities for 2013/14 with respect to the development of patient pathways	a. Delivery of the clinical effectiveness and patient experience priorities for 2013/14 with respect to the development of patient pathways	A number of clinical pathways are live in CAREnotes Assist to facilitate consistent service delivery. New Clinical Networks have been established to help drive improved outcomes and patient experience via effective care pathways. Average HoNOS (Health of the Nation Outcome Score) outcome data from October 2014 – May 2015 is being reviewed for inpatient wards for each of the 4 factors or negative well-being indicators.	●/ ●
2.2 Continue to promote what	a. Continuous improvement	Baseline assessment and implementation of NICE (National Institute of Health and Care Excellence) guidance is an integral function of the new CWP Clinical Networks established	●/ ●

	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
works well with respect to the delivery of NICE guidance through the work of the NICE champions	in the number of work plans available on the intranet detailing how the NICE champions plan to assess and improve the implementation of NICE guidance	in 2014/15. NICE guidance is now categorised to ensure that priority focus is given to the most relevant guidance for CWP services. Action plans will be agreed at individual locality level recognising that differing commissioning arrangements can lead to different actions to ensure compliance.	
2.3 Establishment of an intranet site to celebrate and promote good practice	a. Place "Big Book of Best Practice 2014" on a dedicated intranet site b. Continuous increase in the number of good practice stories c. Continuous improvement in the number of positive media stories d. Continuous improvement in number of external	▪ Best practice case studies are submitted by staff via the intranet (which increased from 25 in 2013/14 to 85 in 2014/15). The Big Book of Best Practice, which promotes a selection of these case studies, ideas and innovative ways of working to deliver safer and more effective care, included 40 case studies for 2014/15. Over 230 people attended the Best Practice annual showcase in 2014, with 88% of people describing the event as excellent/ professional. ▪ Media coverage (including social media activity) has included: Chester and Flintshire Chronicle and Ellesmere Port Pioneer stories relating to Rosewood's Nursing Times Award shortlist. Signal One FM feature on increased investment in CAMHS (Child and Adolescent Mental Health) services in East Cheshire. Widespread coverage for Suicide Prevention Day supported by a media interview for Dee/ Silk FM with Dr Sivananthan. CWP's top performance in the CQC Community Mental Health Survey. Drink wise campaign. 'Street triage' approach to mental health issues. Plans submitted for a new CAMHS new build mental health facility. Relaunch of substance misuse services in East Cheshire. Investment of £340,000 to improve inpatient facilities for people with dementia in East Cheshire (Millbrook).	●/ ●

	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
	publications	▪ Trade coverage: HSJ (Health Service Journal) published article on #CWPZeroHarm on 23.10.2014.	
2.4 Ensure that the outputs of clinical audit activity, through action plans, identify recommendations to spread good practice and accelerate excellence	a. Re-audit [or equivalent monitoring] demonstrates sustained good practice and spread of excellence to other areas	A "Healthcare Quality Improvement team" was implemented from March 2015 to support localities in driving continuous improvement from the outputs of audit. A key focus of this programme is to ensure links between the findings from audit and other quality improvement work and to ensure that recommendations include the recognition and sharing of good practice. This has enabled collaboration on a number of projects and the development of improved action plans, for example inpatient areas maintaining 100% compliance in relation to the storage and security aspects of the Trust's medicines policy.	●/ ●
3. Support for meta-analysis			
3.1 Appoint a quality surveillance function	a. Routine avoidable harm reporting to inform baseline	Three locality Quality Surveillance Support Managers have been appointed. In September 2014, a report outlining a review of incidents reported was undertaken in respect of agreeing a baseline of avoidable harm. The review outlined that there is not currently an identified definition of 'unnecessary avoidable harm'; historic and present approaches require each incident to be considered on an individual basis following the application of root cause analysis (RCA) methodologies. This itself is limited since currently, an appraisal of the part that Human Factors plays in either contributory or causal components of incidents, e.g. shortfalls in compliance with policy, systems and processes is not routinely considered. In order to simplify the baseline for Year 2, it will be assumed that where RCA findings indicate that all applicable Trust policies and/ or NICE guidelines or other best practice have not been followed, that the incident is categorised as 'avoidable harm'. The implementation of a Human Factors questionnaire into incident reporting, and new national definitions that are being developed as reliable measures of avoidable hospital death rates and severe harm will support the identification of avoidable harm incidents and inform the baseline during Year 2.	●/ ●
	b. Continuous reduction in recurrent learning	Baseline interrogation of the actions following serious incidents from 2013/14 identified ten 'learning themes'. All actions from completed RCA investigations, since 01/01/2014, have been categorised to one of these ten themes.	●/ ●

	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
	themes from serious untoward incidents, including regulation 28 action required	At the end of the first year, this new data source is providing information on learning themes and is a vehicle by which reduction in recurrent learning themes can be measured. The graph below demonstrates baseline, demonstrating a reduction in the recurrence of learning themes particularly from quarter 3 of 2014/15, and also an early view of changes to learning themes. 	
	c. Continuous reduction/ no contractual breaches for completion of serious incident investigatory processes	Baseline for serious incident investigatory report completion, 01/07/2014 – 30/04/2015: February = 1 breach March = 2 breach Nil breaches bar above.	●/ ●

	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
	d. Continuous reduction in error provoking situations – continuous increase in ratio of harm to no harm incident reporting	Heinrich charts are included in the Locality Data Packs for teams to see their harm (this includes unavoidable harm) to no harm incident reporting profile.  The last four months are showing an increase in 'no harm' incident reporting, which is a positive indicator of a Trust's patient safety culture.	●/ ●
	e. Continuous improvement in patient experience feedback/ complaints in relation to reports of inappropriate behaviour/ more	The majority of complaints in relation to inappropriate behaviour and/ or communication relate to staff attitude (63%) rather than communication/ information (37%). The graph below demonstrates baseline.	●/ ●

	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
	effective/ clear/ concise communication	 Patient experience feedback has increased considerably since the introduction of the Friends and Family Test (FFT). Between August 2014 and May 2015, the amount of positive feedback has tripled. This trend is likely to continue as FFT becomes embedded.	
	f. Continuous reduction in litigation costs [liability for harm]	Baseline: from 01.04.2014 to 31.03.2015 the overall amount spent on settled clinical negligence claims was £742,770.	●
4. Peer review of complex needs and supporting efficiency			
4.1 Complex Recovery, Advice and Consultation team to support acute care and community teams to manage complex cases	a. Continuous reduction in admissions/ need for acute beds [as ratio to aftercare – enhanced community care/ support packages]	Baseline: January 2014 – January 2015, a reduction in patients' average lengths of stay by 9 days and for those requiring inpatient rehabilitation by 34 days. The team has also worked with 135 individuals in out-of-area inpatient care including secure services to improve quality and safety.	●

	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
	b. Continuous improvement in successful outcomes for people using services, which demonstrate moves to greater independence	Baseline: January 2014 – January 2015, a reduction in patients' average lengths of stay by 9 days and for those requiring inpatient rehabilitation by 34 days. The team has also worked with 135 individuals in out-of-area inpatient care including secure services to improve quality and safety.	●
5. Organisational development			
5.1 Fully adopt the principles of the incident decision tree. Review the capability policy and procedure so that the Trust applies fairness where there are performance issues but these are addressed more quickly to mitigate unintended consequences for people who use the Trust's services	a. Approved incident decision tree in place	Consideration has been given to an appropriate decision tree by the Head of HR and Head of Clinical Governance. This work is still ongoing as research with the HR Deputies Network has shown that this is not something that is currently in use elsewhere but that would be welcomed. Final meeting to be had to complete the first draft tree. Input will be sought from managers with experience of the process. Amendments will then be made and the decision tree incorporated into the Capability Toolkit.	●/ ●
	b. Fully adopt the principles of the incident decision tree in the capability policy	Policy was reviewed in February 2015 and procedure checked for efficiency and fairness. Reference to the Capability Toolkit is made in the policy currently so no further adaptations required for the decision tree. Any additional references will be made when the policy is due for review in Quarter 4 2015/16.	●

	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
5.2 Commission AQuA to independently review recruitment processes, with a brief to minimise process but also to move the focus from process to flexible and sophisticated approaches to recruitment based on service needs and priorities.	a. Independent review and recommendations implemented, with demonstrable decrease in process steps and timeframes and in-built flexibility	Independent review of process undertaken by Organisational Development consultant in line with the People Services Improvement Programme (PSIP). In addition to this, an independent Recruitment Consultant was commissioned to review overall strategy. Process mapping of current and future state showed clear efficiencies that could be made in both length of time to recruit and the number of steps and handoffs. Future state process will begin week commencing 20 July in line with the transition to the new People Services structures for Resourcing and embedding of the TRAC system for Recruitment. Recommendations of Recruitment Consultant are under review and a paper was issued to the Director of People and Organisational Development. The Head of Resourcing is organising a workshop with key stakeholders to discuss the relative merits of the approach and, should the recommendations be taken forward, an action plan is expected to be produced by Quarter 3 2015/16.	●/ ●
	b. MIAA re-audit to assure of significant assurance	MIAA (Mersey Internal Audit Agency) are expected to re-audit in Quarter 3 2015/16 at which point definitive assurance will be provided. However, their advice on key elements of the revised process has been sought to enable all requirements to be met.	●
5.3 Roll out values based recruitment to key clinical posts to ensure recruitment of staff who can best demonstrate affinity to the Trust's adopted values and behaviours	a. Three year values based recruitment plan in place with continuous increase in the comparative number of recruits subject to assessment of values as part of interview	To facilitate the roll-out of a values based recruitment approach, the skill-mix within the Trust's Resourcing function has been increased and consideration given to the areas of training required to up-skill staff on selection techniques and methodologies so that they can become expert advisers in this area. Further thinking needs to be completed on the delivery of this training and the team's continuing professional development. A behaviour framework is in development. The baseline figure for values based recruitment is 6 recruits in the past year (10 since the programme began in May 2013).	●/ ●

	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
	processes		
5.4 Review the job description template to focus on competence, knowledge, attributes, values and behaviours Review the appraisal policy and procedure so that objectives for staff are explicitly tied into Trust objectives Scope training in HR/ basic employment law for all line managers Scope training to enhance the skills of managers in having difficult conversations with staff	a. Job description and appraisal template reviewed and implemented	**Job description template** All approved job descriptions are now located on the intranet and newly approved job descriptions are added as soon as they have been through the Agenda for Change process. The template will be reviewed in line with the Values Based Management approach to the employee's journey starting with Attraction & Selection methodologies. **Appraisal template** This now includes reference to the 6Cs as the Trust's values. The whole Performance Management process is currently under review, of which the appraisal template forms one part, and a paper will be submitted to Operational Board in September 2015 with recommendations for the future.	●/ ●
	b. Continuous improvement in patient experience feedback/ complaints in relation to staff	Patient experience feedback captured between July 2014 and June 2015 has seen a reduction in staff attitude complaints. There were 97 staff attitude complaints raised during this period in comparison to 352 staff attitude complaints raised between July 2013 and June 2014. Embedding 6Cs behaviours and values across the Trust, training localities in local resolution, and learning from previous complaints have contributed to the continuous improvement in patient feedback in relation to staff.	●
	c. Continuous improvement in the number of 'second tier' and above HR investigatory processes	Baseline: between June 2014 and June 2015 there were 25 disciplinaries of which 5 were escalated to the next tier (appeals).	●
5.5 Dedicated human factors trainer	a. Continuous reduction in error provoking situations	See 3.1.c	●/ ●

	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
	continuous increase in ratio of harm to no harm incident reporting		
	b. Continuous improvement in patient experience feedback/ complaints in relation to reports of inappropriate behaviour/ more effective/ clear/ concise communication	See 3.1.e	🟠/ 🟢
	c. Continuous reduction in litigation costs [liability for harm]	See 3.1.f	🟢
5.6 The core responsibilities of the professional and clinical leadership roles should be captured as part	a. Trust's operating/ performance management framework/ integrated governance	The effective operation of the Trust's integrated governance strategy is assessed annually by the Trust's Quality Committee in reviewing its effectiveness over the previous year, this was deemed to be effective during 2014/15. The Annual Governance Statement, presented to the Audit Committee and Board and effectiveness reviewed by internal auditors, confirms that the integrated governance framework is fit for purpose and, alongside the corporate Assurance Framework, provides the Board with evidence based assurances on the way in which it manages the organisation at a strategic level.	🟢

	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
of the Trust's operating/ performance management framework/ integrated governance strategy	strategy continuously operating effectively as per identified monitoring arrangements		
	b. Performance reviews consistently operate in accordance with a demonstrable accountability model for each action identified in relation to both good and poor variance	Format of performance review reporting reviewed and developed to ensure comparison between quarters is possible. Performance review summary reports submitted every quarter, highlighting key themes, challenges and any issues for escalation to Operational Board. New Board corporate performance reporting process established in 2014. Reviewed in March 2015 and new format of reporting piloted in July 2015 piloting a key lines of enquiry style document for responses to be provided by the lead service director or clinical support service Associate Director.	●/ ●
5.7 Training for managers to include supporting staff in continuous improvement, celebrating good practice, and encouragement to deliver innovative solutions to	a. Continuous increase in the number of good practice stories	See 2.3.c	●/ ●
	b. Continuous increase in proportion of staff receiving training/ development in techniques/	Year on year increase in the number of staff undertaking continuous improvement training with AQuA has been seen over the last 4 years. 2011/12 = 14 2012/13 = 18 2013/14 = 40 2014/15 = 61	●

	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
complex problems	approaches in relation to continuous improvement, e.g. PDSA		
	c. 'Innovation register' demonstrates continuous improvement in the number of innovative practices that are registered and also evidence of spread	Quick link to "Your Good Ideas" added to CWP intranet to capture staff ideas and innovation. Innovation Competition was launched in November 2014 and received 17 submissions. A further 40 ideas were submitted in the second round of the competition and these are all being followed up by Effective Service Managers. A Trust Intellectual Property Policy has been drafted and intellectual property for 2 new products has been protected. The innovation register has been updated to include these.	●
5.8 Training in the understanding of the importance of clinical risk assessment [CARSO]/ management/ formulation, care planning and HoNOS More effectively develop and deliver individual and system accountability for quality of	a. Continuous increase in proportion of clinical staff and managers receiving training/ development in techniques/ approaches, e.g. team working; CPA and associated relevant training;	See 1.1.b	●/ ●

	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
CARSO, care planning and HoNOS	monitoring and review; situation specific approaches [as a minimum, all staff trained in CPA, HoNOS and CARSO by end year three].		
	b. Supervisory processes reviewed to ensure capture of CARSO, CPA and HoNOS – for caseload discussion	The supervision policy and handbook identifies the benefits and requirements for robust clinical supervision which should include discussion re clinical practice and the review of clinical performance. In addition the Effective Care Planning Lead has outlined key actions which will take forward the effective development and delivery for individual and system accountability through clinical and managerial supervision process. Development of Effective Care Planning 'z card' information leaflet.	●/ ●
	c. Continuous reduction in recurrent learning themes from serious untoward incidents, including regulation 28 action required	See 3.1.b	●/ ●

	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
6. Collective continuous improvements			
6.1 Specific targets/ thresholds/ tangible outputs against these expected continuous improvements that are expected as a result of the implementation of the combined proposal will be developed as part of the three year implementation plan	a. Continuous promotion of meaningful recovery	The recovery concept promotes hope, opportunity and control in every aspect of a patient's journey. As part of face-to-face induction, an introduction to the recovery concept is provided to all new CWP staff, by a patient and carer with lived experience, who use their own journey to illustrate their interactive presentation. Feedback from those who attend the session is very positive. The three recovery colleges, operating in each locality, continue to grow and extend their outreach. Over 500 students in total attended in the past year and completed courses over a range of subject areas. Courses included understanding and managing sleep problems, promoting wellbeing, managing money and moving forward, a course that encourages students to set personal, meaningful, obtainable goals. Six voluntary peer support workers regularly attend wards across all three localities. All peer support workers have completed accredited training covering the recovery concept, wellness action plans and an introduction to coaching. Peer support workers provide patients with the opportunity to plan their recovery journey with people who have lived experience and can provide empathetic support. A bi monthly peer support group monitors progress and shares best practice.	●/ ●
	b. Continuous improvements to the delivery of co-ordinated, patient centred, outcome focussed care	An effective care plan forms the centre of co-ordinated patient centred care. A care planning lead has been appointed to promote all aspects of care planning, including monitoring the recording of plans in CAREnotes, and the provision and monitoring of care planning training. Effective care planning is part of mandatory training for all clinical staff in CWP, and refresher training to teams is also in progress. The training has been received very well by individuals and teams alike. Work is under way to update the trustwide advanced planning policy. Once this has been agreed, implementation of the policy will be monitored to ensure that the wishes of patients are appropriately discussed, recorded and understood.	●/ ●
	c. Better prediction and forecasting to intelligently	A Locality Data Pack has been developed during Year 1 to commence an approach to intelligent analysis. The corporate performance dashboard is under review as detailed previously. It is envisaged that over the next year better prediction and forecasting will be implemented	●/ ●

	Year 1 indicators	Year 1 progress	Is Year 1 progress meeting expectations?
	inform service improvement, service development, inform commissioning intentions, and support early warning processes.	as reports for Quality Committee and Operational Board are developed – this will be discussed at the August 2015 meeting of the Quality Committee.	
	d. Continuous promotion of safe and effective care	▪ Quality surveillance support managers have been appointed in each locality to provide teams with business intelligence and insight, to help services support the needs of local communities better. ▪ A Trustwide care planning lead has been appointed to help to deliver the right care, promote shared decision making and implement the 'house of care'. ▪ Each locality is now able to access the CRAC (complex recovery and assessment) team. The CRAC team support complex cases, to reduce length of stay on acute wards and out of area placements. ▪ Education and training opportunities have been made available as part of #CWPZeroHarm including courses on Human Factors and care planning. ▪ Zero Harm has been further promoted via CWP Essential on the following dates: 4 July 2014, 17 & 24 October 2014, 23 January 2015, 30 April 2015. ▪ Best Practice Showcase and the launch of the 2014 Big Book of Best Practice took place on 30 September 2014. ▪ Staff roadshows took place in April 2015; they were aligned with #CWPZeroHarm messages to support clinical understanding with frontline staff.	●

Appendix 1 - CWP Corporate Performance Dashboard Open Board Version	July 2015

The Board are asked to note the following key lines of enquiry

Trustwide

1 The Trust financial position is in deficit and behind plan; a separate paper is on the board agenda.

West

2 Staffing levels at Cherry Ward for the month are reported as being at 90% which is 2 standard deviations from the Trust average, which is of concern.
3 There has been an increase in the number of complaints received, including 3 amber complaints.
4 Gatekeeping performance was at 86.7% for June against a target of 95%.
5 The IAPT waiting times for referral to treatment within 6 weeks were marginally below the 75% target, at 74.7%.
6 The IAPT waiting times for referral to treatment within 18 weeks were below the 95% target, at 84.1%.
7 Sickness absence rates on the inpatient units remain high.
8 8 locations in the West locality failed to achieve 93% compliance on their IPC audits.

Wirral

9 One red complaint received.
10 Sickness absence rates on the inpatient units remain high
11 There has been one mixed sex accommodation breach reported.
12 Bank spend due to acuity on IP wards.
13 Focusing on delivery of remaining amber and red CIP schemes.
14 Maintaining existing tight control of non pay budgets.

East

15 The IAPT waiting times for referral to treatment within 6 weeks were below the 75% target, at 47.7%
16 The IAPT waiting times for referral to treatment within 18 weeks were below the 95% target, at 88.8%
17 There has been one mixed sex accommodation breach reported.

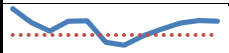
CWP Board Dashboard

Reporting Month: June 2015

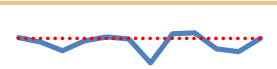
Exception Reports

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

	Previous month	Current month	Trend
Monitor Targets - 7	↑	↓	
Finance			
Income & Expenditure	↓	→	
CoSRR (Monitor Target)	→	→	
Cashflow	↓	↓	
Cost Improvement	↑	↑	£165k achieved in Jun £431k achieved YTD £73k ahead of plan

Inpatient Metrics	Bed occupancy rate	Ward staffing levels
Previous Month	**88.86%**	Planned Shifts **7,498** Actual **7,023 (93.67%)**
Current Month	**88.70%**	Planned Shifts **7,221** Actual **6,991 (96.82%)**
Trend		

For a key to arrows and RAG statuses, please see Page 2 of dashboard

	Target	Previous month	Current month	Trend
Workforce				
Essentials 1	85%	→	↑	
Appraisals (including medical staff)	85%	↓	↑	
Safeguarding	80%	→	↑	
Supervisions	85%	↑	↑	
Sickness	< 4.5%	↓	↑	
Disciplinary	TBC	→	↑	
Patient Experience				
Complaints per 1000 episodes	< 2.17	↑	↑	
Staff Raising Concerns	TBC	↓	↑	
Customer Satisfaction	80%	**Process for data collection in development. Reporting expected to be in place Q2 2015/16**		
Family & Friends Test		**Process for data collection is developed, and recording has commenced. Reporting to be in place by end of Q2 2015/16**		

Waiting Times Indicators	Target	Previous month	Current month	Trend
Early Intervention (2 weeks)	50%	**65.45%**	**74.24%**	**Insufficient data for trending; available September 2015**
IAPT (6 weeks)	75%	**58.97%**	**58.82%**	
IAPT (18 weeks)	95%	**89.03%**	**88.59%**	
Allied Health Prof'ls (18 weeks)	95%	**98.41%**	**98.05%**	

CWP Board Dashboard

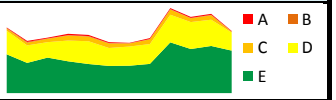
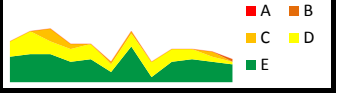
Reporting Month: June 2015

Exception Reports

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Risks	Number of risks						Number of new risks added to register	Number of risks archived from register
	Red		Amber		Green			
	Current	Trend	Current	Trend	Current	Trend		
Strategic	10	→	4	→	1	→	0	0
Clinical Services	16	↓	41	↑	4	↑	3	0
Corporate Support	In development - being piloted by Performance and Redesign							

Key for dashboard			
↑	Improvement in performance	GREEN	Above target
→	Stable performance	AMBER	Within 5% of target
↓	Decline in performance	RED	Below target

Incidents	Category A&B (SUIs)		Category C&D (Mild / Moderate harm)		Category E (No harm)		Trend
	Previous month	Current month	Previous month	Current month	Previous month	Current month	
Mental Health Services (inc LD)	↑	↓	↓	↓	↓	↓	
West Physical Health Services	↓	↓	↓	↓	↓	↑	
Clinical Support Services	→	↑	↓	↓	↓	↓	

Quality	Previous month	Current month	Trend
Patient Safety Composite Score	→	→	
Staff Experience	Process for data collection in development. Expected to be in place Q2 2015/16		

Infection Prevention and Control	Previous audit compliance	Current audit compliance	Trend
Infection Control	12/13 passed 95% compliance	9/13 passed 93% compliance*	↓

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

* Eight further areas audited for the first time in June 2015, 4 passing and 4 failing compliance (average score 91%)

Board Dashboard - Glossary

Back to top

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

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

Theme	Link to Strategic Objectives	Definition	Threshold	RAG Status	Trigger for exception report to Board	Reviewing Group/ Person	Submission Frequency
Staff Experience	3 and 7	Overall rating for staff survey	= > the rate for previous year and organisational ranking in national survey	Green = rate =/higher than the rate for the previous year Amber = ranking in national survey reduced Red = rate lower than previous year	Exception reports will be provided when the position is reported as Amber or Red.	TBC	Annual
Raising Staff Concerns	3 and 7	Number of staff concerns captured through raising concerns process				TBC	Monthly
Sickness	3	Rolling staff sickness levels	=< national benchmark rate	Green = rate that is below 4.5% Amber = between 4.5% and 5.5% Red = 5.5% or higher	Exception report and action plans will be provided when the position is reported as Amber or Red.	ODE/WOD	Monthly
Disciplinary	3	Current number of staff subject to disciplinary process	TBC			TBC	Monthly
Bed Occupancy rate	1 and 5	Average bed occupancy rate for the month	TBC		All incidents where occupancy is significantly below or above plan will be reported to board	In Patient Ward Review Programme	Monthly
Number of closed wards	1 , 5 and 7	Number of wards closed within the month	>0		All reported ward closures will require an exception report and action plan	In Patient Ward Review Programme/ Execs	Monthly
Ward Staffing levels:	1 , 5 and 7	Actual v Planned staffing levels	Actual staffing level is below plan		All incidents where staffing is significantly below or above plan will be reported to board	In Patient Ward Review Programme/ Execs/ Board	Monthly
Waiting times	1 , 5 and 7	Number of community physical health patients waiting for their first appointment with an Allied Health Professional	95% within 18 weeks	Red = Less than 90% compliance Amber = 90-95% compliance Green = 95% compliance	Reported as Amber or Red		Monthly
Risks	1 and 7	Provides overview of the current risks managed by the trust and movements in risk status	New red rated risk identified	Not applicable	Any new red risks should be reported to board by exception	Quality	Monthly

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

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

CWP Objectives

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Monitor Quality Governance Framework self assessment – quarter 1 2015/16
Agenda ref. no:	15/16/38
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and approval
Date of meeting:	29/07/2015
Presented by:	Dr Anushta Sivananthan – Medical Director/ Executive Lead for Quality

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

REPORT BRIEFING

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

To provide an update on the Trust's current quarter 1 position with respect to the *Monitor* Quality Governance Framework. Scrutiny against this framework provides the Board of Directors with assurance that the organisation is working effectively to improve patient care. The quarter 1 self-assessment concludes that there are **no concerns regarding the Trust's quality governance arrangements**, however improvements are required to return the 'Measurement' (use of data/ data quality domain) to 'green' (currently 'amber/ green'). Actions to achieve this are identified within *Appendix 1* and also aligned with the strategic risk register. Ratings are reviewed each quarter and further actions identified if the said quality area has not returned to 'green'.

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

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

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

Assessment – *analysis and considerations of options and risks*

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

Appendix 1 details that all quality areas are assessed as being 'green' this quarter, with the exception of the 'Measurement' domain whose quality areas are assessed as 'amber/ green'. This equates to the Trust's current summative score of 1.5 [a score greater than 3.5 would indicate concerns regarding a Trust's quality governance arrangements].

A number of improvement actions have been identified in *Appendix 1*, irrespective of the rating of the quality areas, demonstrating the Trust's aspiration to achieve continuous improvements to quality.

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

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

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	22/07/2015

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

Appendix no.	Appendix title
1	Self assessment evidence against *Monitor* Quality Governance Framework as at Q1 2015/16

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Appendix 1.1: *Monitor* Quality Governance Framework – self assessment quarter 1 2015/16

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 1.2*, detailing information used to formulate this assessment and areas that may required further development, with suggested actions.

QUALITY AREA/ WELL-LED DOMAIN		Self assessment (RAG) rating 2015/16	
Strategy		**Q1**	
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?	**AMBER/**	**GREEN**
4b	Is the Board assured of the robustness of the quality information?	**AMBER/**	**GREEN**
4c	Is quality information being used effectively?	**AMBER/**	**GREEN**
SUMMATIVE SCORE		**1.5**	

The rating scale is explained below:

RAG	Indicative score [based on *Monitor*'s rating scale]	Definition
Individual scores		
GREEN	0.0	Meets or exceeds expectations. Many elements of good practice. No major omissions.
AMBER/ GREEN	0.5	Partially meets expectations but confident in management's capacity to deliver green performance within reasonable timeframe.
AMBER/ RED	1.0	Partially meets expectations but some concerns on capacity to deliver within a reasonable timeframe.
RED	4.0	Does not meet expectations.
Overall score		
GREEN	0.0 – 3.5	No concerns regarding quality governance arrangements.
RED	4.0 – 5.0	Concerns regarding quality governance arrangements.

Appendix 1.2 – Self assessment evidence against *Monitor* Quality Governance Framework as at Q1 2015/16

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q4 with update	Further actions for completion by end Q2 2015/16
1. Strategy				
1a: Does quality drive the Trust's strategy?	• Quality is embedded in the Trust's overall strategy. ▪ Overall vision '*Leading in partnership to improve health and well-being by providing high quality care'.* ▪ The Trust's vision and strategy comprises a number of Trustwide quality goals covering patient safety, clinical effectiveness and patient experience which drive year on year improvement. ▪ Quality goals reflect local as well as national priorities, reflecting what is relevant to patients and staff – forward planning events and working with commissioners and other local scrutineers on development of quality priorities help identify priorities. ▪ Overall Trustwide quality goals link directly to goals in localities/ services [which will be tailored to the specific service] – as part of annual and strategic plans and clinical strategies. • Quality goals are communicated as part of the Quality Account, regular quality reporting, via Clinical Directors at Quality Committee [via	**GREEN**	None.	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q4 with update	Further actions for completion by end Q2 2015/16
	a quality dashboard], and as part of clinical service performance reviews. • CWP performance dashboard has quality section.			
1b: Is the Board sufficiently aware of potential risks to quality	• The Board regularly assesses and understands current and future risks to quality and is taking steps to address them. Risks are aligned to annual and strategic plans. • The Board regularly reviews quality risks in an up-to-date strategic risk register and corporate assurance framework, which has been mapped to the strategic objectives for the Trust. • The strategic risk register is supported and fed by quality issues captured in locality/ service risk registers – there is a process of escalation in place for 'red' rated risks on the clinical service risk registers to be considered for inclusion on the strategic risk register. • The risk register covers potential future external risks to quality [e.g. new techniques/ technologies, competitive landscape, demographics, policy change, funding, regulatory landscape] as well as internal risks – risks are aligned to the annual planning process, which looks at external risks.	**GREEN**	None.	Governance framework to be developed for locality data packs to be developed with explicit links to locality risk registers to ensure a responsive and joined up approach to registering, monitoring and escalating potential risks to quality. **Medical Director [Quality]/ Associate Director of Safe Services**

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q4 with update	Further actions for completion by end Q2 2015/16
	• There is clear evidence of action to mitigate risks to quality – actions on the risk register are monitored by the Safe Services Department. • Proposed initiatives are rated according to their potential impact on quality [e.g. clinical staff cuts would likely receive a high risk assessment] – service change/ new service developments are subject to quality impact assessments. • There is an appropriate mechanism in place for capturing frontline staff concerns.			
2. Capabilities and culture				
2a: Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	• The Board is assured that quality governance is subject to rigorous challenge, including full NED engagement and review – NEDs chair Quality Committee and Audit Committee. • Board development programme in place. • Board seminars in place which allow time to debate issues on quality and assurance – this has included "well-led". • Board members have attended training sessions covering the core elements of quality governance and continuous improvement.	**GREEN**	Board seminar to be scoped and delivered [April 2015] as a follow up to the annual risk training for senior managers in 2013/14 in relation to Human Factors to ensure the underpinning principles of communication and teamwork are debated to support delivery of the quality agenda. *Board seminar delivered April 2015.* **Medical Director [Quality]/ Associate Director of Safe Services** **COMPLETED**	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q4 with update	Further actions for completion by end Q2 2015/16
2b: Does the Board promote a quality focused culture throughout the Trust?	• Quality Committee chaired by NED, attendance by Executive team and other NEDs. • The Board takes a proactive approach to improving quality [e.g. it actively seeks to apply lessons learnt in other Trusts and external organisations]. • The Board regularly commits resources [time and money] to delivering quality initiatives – e.g. QIPP agenda discussions, zero harm continuous quality improvement cultural programme. • The Board is actively engaged in the delivery of quality improvement initiatives [e.g. some initiatives led personally by Board members]. CQUIN monies reinvested into QIPP and continuous quality improvement programmes. • NED involvement in compliance visit schedule. • Staff are encouraged to participate in quality/ continuous improvement training and development – the Trust has reviewed its essential learning programme underpinned by patient safety following Berwick review and also the zero harm implementation plan is underpinned by a learning and development programme. • Staff feel comfortable reporting harm and errors [these are seen as	**GREEN**	Patient safety cultural assessments to be rolled out during quarters 2 and 3 [this has been amended to July 2015 to align with Board business cycle] at ward and team levels to inform baseline in order to demonstrate shift of culture during way points of the zero harm continuous improvement cultural programme. *Organisational baselines have been scoped using the current and previous NHS staff surveys and incident reporting associated questions. Appropriate cultural assessments will be scoped and implemented as per ongoing Zero Harm implementation plan and have been formalised/scheduled in year 2 "way points" framework.* **Safe Services Department supported by zero harm 'culture carriers' in partnership with ward and team managers** **COMPLETED**	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q4 with update	Further actions for completion by end Q2 2015/16
	the basis for learning, rather than punishment] – positive feedback from staff survey, which is reviewed at Operational Board level and National Reporting and Learning System data stating that CWP reports incidents in line with other Trusts in its benchmarked cluster. • Staff are entrusted with delivering the quality improvement initiatives they have identified [and held to account for delivery – link to annual and strategic plans]. • Internal communications [e.g. monthly newsletter, intranet, notice boards] regularly feature articles on quality – quarterly quality report, three times per year learning from experience report.			
3. Structures and processes				
3a: Are there clear roles and accountabilities in relation to quality governance?	• Each and every Board member understands their ultimate accountability for quality – discussed at Board seminars and as part of the self assessment process and signed off by Board as part of the Annual Governance Statement. • The governance structure is in place within the Trust with committees/ sub committees with clear terms of reference, outlining roles and responsibilities in relation to quality.	**GREEN**	Review areas for improvement identified within the locality well-led assurance frameworks and deliver a programme of seminars during the 2015/16 to support Clinical Directors with their roles and accountabilities in relation to quality governance. *In conjunction with the Head of Organisational Development and also clinical support services departments, a schedule will be developed*	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q4 with update	Further actions for completion by end Q2 2015/16
	• Quality is a core part of main Board meetings, both as a standard agenda item and as an integrated element of all major discussions and decisions. • Quality performance is discussed in more detail each month by a quality focused Board sub committee. Quality Committee meets every two months but any issues requiring discussion in relation to quality are brought to Operational Board which meets monthly.		*detailing development activities for Clinical Directors, aligned to service line management principles.* **Medical Director [Quality]/ Associate Director of Safe Services** **IN PROGRESS**	
3b: Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	• Boards are clear about the processes for escalating quality performance issues to the Board – performance dashboard in place. • Process for escalation of risks to the Board is outlined in Integrated Governance Strategy. • Process for escalation of incidents to Board is outlined in incident reporting and management policy – level 3 incidents reported to Board and actions followed up by Quality Committee. • Robust action plans are put in place to address quality performance issues [e.g. including issues arising from serious incidents and complaints] – monitored by Compliance, Assurance and Learning Sub Committee.	**GREEN**	None.	Framework to be developed and implemented to escalate performance in relation to quality issues [as identified by the Compliance, Assurance & Learning Sub Committee] to clinical service performance reviews. **Medical Director [Quality]/ Associate Director of Safe Services**

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q4 with update	Further actions for completion by end Q2 2015/16
	• Lessons from quality performance issues are well-documented and shared across the Trust on a regular, timely basis - communicated via learning from experience report. • There is a proactive healthcare quality improvement programme in place aligned to national audit priorities, contractual requirements and quality priorities identified by the Trust. • There is also scope for undertaken reactive audits/ re-audits linked to risks. • There is an internal audit programme in place, which links to quality. • An error reporting process is in place.			
3c: Does the Board actively engage patients, staff and other key stakeholders on quality?	• Quality outcomes are made public [and accessible] regularly, and include objective coverage of both good and poor performance – quality report and learning from experience report presented to public Board. Inpatient safety metrics results presented on all inpatient wards for staff/ patients/ visitors to see. • The Board actively engages patients on quality, e.g. - Patient feedback is actively solicited, made easy to give and based on validated tools,	**GREEN**	None.	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q4 with update	Further actions for completion by end Q2 2015/16
	e.g. surveys, patient stories, video diaries, PALS, real time patient experience. - Patient views are proactively sought during the design of new pathways and processes - via surveys/ focus groups, attendance at annual planning events. - All patient feedback is reviewed on an ongoing basis, with summary reports reviewed regularly by the Board – learning from experience report looks at patient feedback via PALS/ complaints. - The Board regularly reviews and interrogates complaints and serious incident data – via the learning from experience report three times per year and standing agenda items reviewing SUIs/ complaints. - The Board uses a range of approaches to 'bring patients into the Board room', e.g. patient stories. • Staff are encouraged to provide feedback on an ongoing basis, as well as through specific mechanisms – staff blog, annual staff survey, training feedback. • The Board actively engages all other key stakeholders on quality,			

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q4 with update	Further actions for completion by end Q2 2015/16
	e.g. - Quality performance is clearly communicated to commissioners to enable them to make educated decisions via contract meetings, reports. - Feedback from PALS and local Healthwatch organisations is considered - Healthwatch commentary on the Quality Account, feedback from annual planning events, consultations on new service developments etc. - For care pathways involving GP and community care, discussions are held with all providers to identify potential issues and ensure overall quality along the pathway - Trust working with clinical commissioning groups and via clinical networks. - The Board is clear about Governors' involvement in quality governance – with meetings structure in place. • Public consultation sought on service changes identified as part of annual and strategic planning priorities.			
4. Measurement				
4a: Is appropriate quality information	• The Board reviews a monthly 'dashboard' of metrics outlined	**AMBER/ GREEN**	Development of locality data packs as a maturation of the	Current corporate performance dashboard to

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q4 with update	Further actions for completion by end Q2 2015/16
being analysed and challenged?	within the performance dashboard. • The Quality Committee reviews quality and safety metrics displayed in a quality dashboard. • Quality information can be analysed and challenged at the individual team level – as part of CAREnotes reporting and data quality/ control. • External assessment/ data delves take place as part of Quality Account auditing and external and internal audit programmes.		Trust's approach to continuous quality improvement and quality reporting. These will amalgamate the qualitative information from the current quality dashboard with a number of other qualitative data items such as CQC mental health intelligence information, the mental health minimum data set and service specific indicators. This will strengthen the reporting of trends in relation to quality improvement and quality assurance and strengthen challenge by the Quality Committee. *Scheduled to be implemented across all wards and teams by end quarter 1 2015/16. Quality Committee will receive a progress report at its August 2015 meeting which will also outline a framework of how the quality information contained in these packs will be analysed and challenged.* **Safe Services Department/ Performance & Redesign Team** **IN PROGRESS**	be reviewed to ensure that it contains appropriate [including risk adjusted] quality information that is usable and can be subject to critical challenge in order to facilitate continuous quality improvement. **Medical Director [Quality]/ Associate Director of Safe Services**
4b: Is the Board	• There are clearly documented,	**AMBER/**	Review of assurance processes	Further actions to be

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q4 with update	Further actions for completion by end Q2 2015/16
assured of the robustness of the quality information?	robust controls to assure ongoing information accuracy, validity and comprehensiveness: - Roles and responsibilities in relation to data quality are outlined within the Trust's Data Quality Policy. - Assurance on data quality given to Board via Information Governance Toolkit scores and independent review of Quality Account. - Clinical audit programme driven by national audits, with processes for initiating additional audits as a result of identification of local risks [e.g. incidents]. - Electronic systems are used where possible, generating reliable reports with minimal ongoing effort. - Information can be traced to source and is signed off by owners – gate keeping process in place within the Trust. • There is clear evidence of action to resolve audit concerns: - Action plans are completed from audit [and subject to regular follow-up reviews] – Trustwide action plans monitored by Compliance, Assurance and Learning Sub	**GREEN**	within the performance and information function to scope the extent of any residual organisational risks in relation to the robustness of quality information associated with data sources – due to manual checks of data sourced for the NHS Benchmarking Network's voluntary participation in the 2013/14 Mental Health Benchmarking exercise [adult and community mental health services]. Outcome will inform self-assessment RAG rating for quarter 2. *A data quality improvement framework [for better quality data and business intelligence] has been approved by the Operational Board, October 2014. The current corporate assurance framework identifies further assurance being sought of the robustness of quality information. An implementation plan to assure the Board of Directors [as part of its duties to monitor via the quarterly Monitor quality governance framework self-assessment] that the required systems, processes, competencies and gatekeeping arrangements are in place to operationalise the*	identified following an in-depth review of this quality area at the 4 August 2015 meeting of the Quality Committee. **Associate Director of Performance & Redesign**

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q4 with update	Further actions for completion by end Q2 2015/16
	Committee. - Re-audits are undertaken to assess performance improvement.		*framework was presented to March 2015 Operational Board.* *Operationalisation of the above is in progress and will continue to be monitored as an action through this self assessment. An action from the last self-assessment was to appoint a Data Quality Project Lead post to lead implementation of data quality improvement framework. This post was recruited to in quarter 1 and specific actions will be identified following an in-depth review at the 4 August 2015 meeting of the Quality Committee – see 'further actions' column.* **Associate Director of Performance & Redesign, Acting Head of Performance & Information and Acting Senior Information Analyst supported by Medical Director for Quality, Associate Director of Safe Services and Head of Compliance.** **COMPLETED**	
4c: Is quality information being used effectively?	• Information in quality reports is displayed clearly and consistently – ongoing development of CWP performance dashboard [as per 4a]	**AMBER/ GREEN**	Development of a "document of understanding" defining the roles, responsibilities and expectations across teams in	Review of all data extracts from the data warehouse that support contractual and mandatory reporting

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q4 with update	Further actions for completion by end Q2 2015/16
	and quality dashboards [also as per 4a]. • Information is compared with target levels of performance [in conjunction with a R/A/G rating], historic own performance and external benchmarks [where available and helpful]. • Information being reviewed is the most recent available, and recent enough to be relevant, e.g. inpatient bed/ ward review, West star chamber reports with Monitor. • 'On demand' data is available/ sought for the highest priority metrics. • The Trust is able to demonstrate how reviewing information has resulted in actions which have successfully improved quality performance, e.g. inpatient safety metrics and care bundles continue to demonstrate sustained improvements.		relation to data provision to support the subsequent effective use of quality information. This will be achieved by the development of a data set owned and used at ward and team level to enhance the management of their day to day business. September 2014 meeting of the Quality Committee will consider. *Quality Committee agreed the above at its January 2015 meeting. The operational roll out of locality data packs was deferred to the end of quarter 1 2015/16, see action identified for quality area 4a.* **Quality Surveillance Support Managers in partnership with service and clinical leads** **IN PROGRESS** Review of all data extracts from the data warehouse that support contractual and mandatory reporting requirements *This action has been captured and monitoring transferred to*	requirements **Associate Director of Performance & Redesign**

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q4 with update	Further actions for completion by end Q2 2015/16
			the corporate Assurance Framework, further an in-depth review of this strategic risk is scheduled for the 4 August 2015 meeting of the Quality Committee. **Associate Director of Performance & Redesign** **COMPLETED**	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Monitor Q1 Submission
Agenda ref. no:	15/16/39
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/07/2015
Presented by:	Andy Harland, Deputy Director of Finance

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

REPORT BRIEFING

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

The purpose of this report is to update and inform the Board of Directors on the Trust's Quarter 1 2015-16 position in relation to the key areas of Monitor's Risk Assessment Framework which require quarterly submissions.

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

Monitor's Risk Assessment Framework (updated March 2015) (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 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.

Assessment – *analysis and considerations of options and risks*

Finance – the Trust expects to maintain a continuity of service rating of 3 over the upcoming 12 months
Quality Governance - The measurement area section is currently rated amber/green. Plans are in place, which are on track, to return them to Green performance from Amber/ Green. All other indicators are green [strategy, capabilities and culture and processes and structure].
Performance – all performance indicators for Quarter 1 were met.
CQC - There are currently no outstanding compliance actions for the Trust.

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

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 30 July 2015.

Who/ which group has approved this report for receipt at the above meeting?	Tim Welch, Director of Finance
Contributing authors:	Anne Casey, Head of Performance and Information David Wood, Associate Director of Safe Services Andy Harland, Deputy Director of Finance Louise Brereton, Head of Corporate Affairs Jo Watts, Head of Compliance

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Mandy Skelding-Jones	17 July 2015

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

Appendix no.	Appendix title
1	Full report

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:To brief the Trust Board on the Trust position in respect of Monitor indicators and compliance, as of Quarter 1 2015-16

- 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 March 2015) (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 CQC has undertaken a Trustwide inspection of services during the week of the 22nd June 2015. The Trust is expecting the draft inspection report towards the end of August 2015.

3.1 Finance

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

3.2 Governance

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

Quality Governance Framework statement

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

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

The template for 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 Learning from Experience report
- The Quality report
- The CWP corporate performance dashboard – both private board and public versions
- Internal and external / independent audits
- Various specialist sources of assurance such as clinical audit, PLACE environmental reports, infection control, safeguarding etc.

The quality areas for strategy, capabilities and culture, and processes and structure remain green. The measurement area has plans in place, which are on track, to return them to Green performance from Amber/ 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 2015/16 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?	AMBER /	GREEN
4b	Is the Board assured of the robustness of the quality information?	AMBER /	GREEN
4c	Is quality information being used effectively?	AMBER /	GREEN
SUMMATIVE SCORE		1.5	

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

<u>Performance against targets declaration</u>

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 2014-15.

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

Target	Threshold	Quarter 1 Performance	[Quarter 4]
Care Programme Approach (CPA) follow up within 7 days of discharge	>95%	99.05%	[99.36%]
Care Programme Approach (CPA) formal review within 12 months	>95%	95.58%	[95.0%]
Minimising delayed transfers of care	<=7.5%	0.88%	[0.71%]
Admissions had access to crisis resolution home treatment teams	>95%	97.61%	[96.50%]
Meeting commitment to serve new psychosis cases by early intervention teams	>95%	126.02%	[113.82%]

Target	Threshold	Quarter 1 Performance	[Quarter 4]
Data completeness: identifiers	>97%	99.56%	[99.56%]
Data completeness: outcomes	>50%	84.28%	[85.64%]
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%	96.93%	[96.90%]
Community care - activity information	50%	91.56%	[91.45%]
Risk of, or actual, failure to deliver mandatory services	Yes/No	No	[No]
CQC compliance action outstanding (as at 30 June 2015)	Yes/No	No	[No]
CQC enforcement action within last 12 months (up to 30 June 2015)	Yes/No	No	[No]
CQC enforcement notice currently in effect (as at 30 June 2015)	Yes/No	No	[No]
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at 30 June 2015)	Yes/No	No	[No]
Major CQC concerns or impacts regarding the safety of healthcare provision (as at 30 June 2015)	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	N/A	[No]

Care Quality Commission

There are no outstanding compliance actions for the Trust.

Results of any elections

A by-election was held during quarter 1. The election opened on the 8th April and concluded on the 5th June 2015. Five seats were vacant as follows; 1x Public – out of area seat, 1x Public – Cheshire East Seat, 2x Service User/Carer Seats, and 1x Staff - Medical seat. Two contested elections were held and two new Governors have been welcomed to the Council of Governors; Joan Roberts – Service User / Carer Governor and Robert Walker – Public Cheshire East Governors.

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

There have been no changes to the Board of Directors during quarter 1. The recruitment process has commenced for the Non-Executive Director and will conclude in quarter 2.

As above, two new Governors have joined the Council during quarter 1. The Trust also received two resignations during quarter 1; Brenda Jones – Service User Carer Governor and Steve Buckley – Staff Therapies Governor. Cheshire West and Chester Council have now also advised that Carol Gahan will be appointed as Partnership Governor in place of Brenda Dowding.

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 30 July 2015.

5 Appendices

Appendix 1: Monitor's Risk Assessment Framework (published August 2013, updated March 2015)

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

Please note that in March 2015 a revised Risk Assessment Framework was published for 2015-16; all references are now to the 2015-16 Risk Assessment Framework.

Three new Access Time indicators are now included in the Monitor Risk Assessment Framework:

- Early intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral (Target: 50%)

- People with common mental health conditions referred to the Improving Access to Psychological Therapies (IAPT) programme will be treated within 6 weeks of referral (Target: 75%)

- People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral (Target: 95%)

Foundation trusts will be required to start reporting the two Access Time indicators for IAPT from Q3 2015-16. The access time indicator for Early Intervention in Psychosis is required to be reported from Q4 2015-16.

Appendix 2: Monitor quarterly submission template

Click to go to index

Declaration of risks against healthcare targets and indicators for 201516 by Cheshire and Wirral Partnership NHS Foundation Trust

Targets and indicators as set out in the Risk Assessment Framework (RAF) - definitions per RAF Appendix A
NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

	Key:	Threshold or target YTD	Scoring Per Risk Assessment Framework	Annual Plan: Risk declared	Annual Plan: Scoring Per Risk Assessment Framework	Quarter 1: Performance	Quarter 1: Declaration	Quarter 1: Comments / explanations	Quarter 1: Scoring Per Risk Assessment Framework
	must complete may need to complate								
Target or Indicator (per Risk Assessment Framework)									
Referral to treatment time, 18 weeks in aggregate, admitted patients	i	90%	N/A	N/A		0.0%	Not relevant		N/A
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	i	95%	N/A	N/A		0.0%	Not relevant		N/A
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	i	92%	1.0	N/A	0	0.0%	Not relevant		0
A&E Clinical Quality - Total Time in A&E under 4 hours	i	95%	1.0	N/A	0	0.0%	Not relevant		0
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	i	85%	1.0	N/A		0.0%	Not relevant		
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation	i	90%	1.0	N/A	0	0.0%	Not relevant		0
Cancer 62 Day Waits for first treatment (from urgent GP referral) - pre local breach re-allocation	i					0.0%			
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - pre local breach re-allocation	i					0.0%			
Cancer 31 day wait for second or subsequent treatment - surgery	i	94%	1.0	N/A		0.0%	Not relevant		
Cancer 31 day wait for second or subsequent treatment - drug treatments	i	98%	1.0	N/A		0.0%	Not relevant		
Cancer 31 day wait for second or subsequent treatment - radiotherapy	i	94%	1.0	N/A	0	0.0%	Not relevant		0
Cancer 31 day wait from diagnosis to first treatment	i	96%	1.0	N/A	0	0.0%	Not relevant		0
Cancer 2 week (all cancers)	i	93%	1.0	N/A		0.0%	Not relevant		
Cancer 2 week (breast symptoms)	i	93%	1.0	N/A	0	0.0%	Not relevant		0
Care Programme Approach (CPA) follow up within 7 days of discharge	i	95%	1.0	No		99.1%	Achieved		
Care Programme Approach (CPA) formal review within 12 months	i	95%	1.0	No	0	99.6%	Achieved		0
Admissions had access to crisis resolution / home treatment teams	i	95%	1.0	No	0	97.6%	Achieved		0
Meeting commitment to serve new psychosis cases by early intervention teams OLD measure - use until Q1 2016/17	i	95%	1.0	No	0	126.0%	Achieved		0
Ambulance Category A 8 Minute Response Time - Red 1 Calls	i	75%	1.0	N/A	0	0.0%	Not relevant		0
Ambulance Category A 8 Minute Response Time - Red 2 Calls	i	75%	1.0	N/A	0	0.0%	Not relevant		0
Ambulance Category A 19 Minute Transportation Time	i	95%	1.0	N/A	0	0.0%	Not relevant		0
C.Diff due to lapses in care (YTD)	i		1.0	N/A	0	0	Not relevant		0
Total C.Diff YTD (including: cases deemed not to be due to lapse in care and cases under review)	i					0			
C.Diff cases under review	i					0			
Minimising MH delayed transfers of care	i	<=7.5%	1.0	No	0	0.9%	Achieved		0
Meeting commitment to serve new psychosis cases by early intervention teams NEW measure (from Q3 2015/16)	i	50%				0.0%	Not relevant		
Improving Access to Psychological Therapies - Patients referred within 6 weeks NEW measure (from Q4 2015/16)	i	75%				0.0%	Not relevant		
Improving Access to Psychological Therapies - Patients referred within 18 weeks NEW measure (from Q4 2015/16)	i	95%				0.0%	Not relevant		
Data completeness, MH: identifiers	i	97%	1.0	No	0	99.6%	Achieved		0
Data completeness, MH: outcomes	i	50%	1.0	No	0	84.3%	Achieved		0
Compliance with requirements regarding access to healthcare for people with a learning disability	i	N/A	1.0	No	0	N/A	Achieved		0
Community care - referral to treatment information completeness	i	50%	1.0	No		100.0%	Achieved		
Community care - referral information completeness	i	50%	1.0	No		96.9%	Achieved		
Community care - activity information completeness	i	50%	1.0	No	0	91.6%	Achieved		0
Risk of, or actual, failure to deliver Commissioner Requested Services		N/A		No			No		
Date of last CQC inspection		N/A		N/A			22/06/2015	The CQC has undertaken a Trustwide inspection of	
CQC compliance action outstanding (as at time of submission)		N/A		No			No		
CQC enforcement action within last 12 months (as at time of submission)		N/A		No			No		
CQC enforcement action (including notices) currently in effect (as at time of submission)		N/A		No			No		
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	i	N/A	Report by Exception	No			No		
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	i	N/A		No			No		
Overall rating from CQC inspection (as at time of submission)	i	N/A		N/A			N/A	The CQC has undertaken a Trustwide inspection of	
CQC recommendation to place trust into Special Measures (as at time of submission)		N/A		N/A			No		
Trust unable to declare ongoing compliance with minimum standards of CQC registration		N/A		No			No		
Trust has not complied with the high secure services Directorate (High Secure MH trusts only)		N/A		N/A			No		
Results left to complete: 0	i						0		
Checks Count: 0	i								
Checks left to clear: 0	i						OK		
Service Performance Score	i				0				0

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Provider Licence – Declarations 4,5 and 6
Agenda ref. no:	15/16/40
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	27/05/2015
Presented by:	Louise Brereton, Head of Corporate Affairs

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

REPORT BRIEFING

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

The report sets out the Provider Licence declarations 4, 5 and 6 submitted to Monitor on 30 June 2015.

Declaration 4 is the corporate governance statement required in accordance with the Risk Assessment Framework

Declaration 5 is the certification on allied health science centres and governance

Declaration 6 is the certification confirming training provided to governors.

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

The Health and Social Care Act introduced the requirement for providers of NHS services to hold a licence. NHS Foundation Trusts had licences issued and these were enforced by Monitor from April 2013. The licence sets out various conditions for providers of NHS services and specific obligations for NHS foundation trusts. The licence is one of Monitor's main monitoring tools and the conditions give powers for regulating providers.

On an annual basis, the Board of Directors is required to confirm a number of declarations required by the Licence.

Assessment – *analysis and considerations of options and risks*

The declarations set out above were shared and confirmed with the Board of Directors in June 2015 electronically to enable submission to Monitor on 30 June 2015. This was due to the cancellation of the Board meeting in June 2015.

With regard to declaration 4 (corporate governance statement) appendix 1 sets out the assurance mechanisms in place to ensure compliance with the declaration.

With regard to declaration 5 (allied health science centres and joint ventures) the Trust confirms this declaration should this arrangement pertain to the Trust in the future

With regard to declaration 6, the Trust confirms there is a training programme in place for governors to enable them to discharge their duties.

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

The Board of Directors is requested to:

- **Note** the Provide Licence Declarations 4,5 and 6 confirmed by the Board in June 2015 and submitted to Monitor on 30 June 2015

Who/ which group has approved this report for receipt at the above meeting?		36T
Contributing authors:		Louise Brereton, Head of Corporate Affairs
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
36T	36T	36T

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1&2	Declarations 4,5 and 6 Full Licence Conditions Document (T Drive)

2

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	June 2015: Second Six Monthly Ward Nurse Staffing Establishment review
Agenda ref. no:	15/16/41
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/07/2015
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

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

REPORT BRIEFING

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

This report details the findings of the Six Monthly Review of Ward Nursing Staffing Establishment completed in May 2015 in line with NHS England and the National Quality Band (NQB) requirements. The report uses the template agreed by the Cheshire and Merseyside Directors of Nursing.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
The is the second six monthly ward staffing report producd in line with NHS England and NQB requirements. This report is received and discussed by the Operational Board. In order to comply with NHS England and NQB requirements these reports and the trusts performance are also published on CWP and NHS Choices websites.

Assessment – *analysis and considerations of options and risks*
See full report.

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

Who/ which group has approved this report for receipt at the above meeting?	Operational Board
Contributing authors:	Maria Nelligan, Deputy Director of Nursing, Julie Anne Murray, Practice Education Lead, Anne Casey, Programme Manager

Distribution to other people/ groups/ meetings:

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

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

Appendix no.	Appendix title
35T	35T

(15_16_41) June 2015: 2nd Six Monthly Ward Nurse Staffing Establishment Review

1 Introduction

This report details the findings of the Six Monthly Review of Ward Nursing Staffing Establishment completed in May 2015 in line with NHS England and the National Quality Band (NQB) requirements. The report uses the template agreed by the Cheshire and Merseyside Directors of Nursing.

1.1 Background to the ward nurse staffing review

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

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

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

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

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

- The data examined for each ward included:
    - current ward MDT establishments,
    - rosters,
    - skill mix ratios,
    - bank usage,
    - sickness,
    - incidents,
    - uptake of education and
    - supervision/appraisal compliance.

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

2. Summary of key recommendations and actions from the December 2014 1st 6 monthly ,nurse staffing establishment review

2.1 Recommendations from the previous review are highlighted below

- Adelphi – an uplift of 0.35 WTE RN and 2.93 WTE CSW brings Adelphi wards staffing levels in line with the other 2 open-age acute wards; reflecting the higher number of beds and the ward environment.
- Bollin – an uplift of 1 WTE CSW to enhance the meaningful activity on the ward by allowing the assistant practitioner protected time to deliver a daily programme for patients.
- Juniper – an uplift of 0.23 WTE RN is needed to support the on-going pressure of out-patient ECT. This is not reflected in the occupancy figures however pre and post ECT care is delivered to out-patients on the ward.
- Saddlebridge – an uplift of 2.57 WTE CSW to further support enhanced meaningful activities on and off the ward
- Maple and Pine Lodge require uplift in order to maintain staffing levels recommended in 2013. This is due to the move from 11.25 hour long shifts to 11.5 hour long shifts in order to align to other wards.

- Juniper, Lakefield and Lime Walk require an additional RN on duty at weekends and nights to support the carer advice line, this equates to an additional 3.23 WTE band 5 RN on each of the 3 wards. This carer advice line has a significant impact on these wards and wards report that they routinely receive calls within hours. The 2013 review recommended that an alternative to these lines be introduced however they remain in place at this time. This is currently under review by the Director of Operations and a solution has not been identified trust wide as yet.

- Brackendale, Juniper and Adelphi – increase band 6 RNs by 1 WTE to reflect the complex patient mix, band 5 RNs would be reduced by 1 WTE.
- Brooklands – trainee assistant practitioner post, to focus on physical well-being, to be developed from existing band 3 CSW post through uplift.
- Pine Lodge – temporary increase band 6 RNs by 3.03 WTE to allow for one band 6 on each shift until the unit is relocated from the current stand-alone site. The band 5"s would be reduced by 3.03WTE.
- Maple and Pine Lodge to consider recruiting a band 6 learning disability nurse to work across both wards within the current establishment.
- The 2013 staffing review recommended that an increase in the number of band 6 RNs, with skills and competencies in complex assessment and care planning, was needed on dementia and eating disorders wards. This recommendation from the 2013 review has not been fully implemented but there are plans being developed to address this.

This can be summarised as follows:

	B6	B5	B3/4
East	1	2.58	6.5
West	4.03	-0.1	0.23
Wirral	1	3.23	0
Trust total	**6.03**	**5.71**	**6.73**

2.2 Actions from December 2014 1st 6 monthly Ward Staffing Review

The Ward Staffing Programme Board, supported by the Ward Staffing Project Team, continues to progress in taking forward the recommendations of the previous ward staffing reviews. An on-going rolling recruitment programme has been in place. The original staffing report identified that an additional 18 WTE RNs were needed alongside the 30 WTE RN vacancies at that time to meet the recommended staffing levels; therefore a total of 47 WTE RNs were needed. The December 2014 report showed that although 68 WTE RNs had been recruited to wards during 2014, 60 WTE had left post during that time period; leaving a gap of 20 WTE at the time of the December 2014 review. Similarly in the period between the Dec 2014 and the May 2015 review, despite the rolling recruitment programme, there remains a gap of 14 WTE RNs.

The establishments agreed in the original review are now reflected in the ward budgeted establishments. However the review team have been advised by finance that the amended skill mix and uplift to establishments, recommended in the December 2014 1st six monthly review, are not reflected in current ward budgeted establishments. The Director of Nursing, Therapies and Patient Partnerships is following this up with the executive team as to date no additional resources have been identified over and above the £1.7m already invested (actual cost over £2.5m) .

The WM T&F group continue to meet monthly and the following initiatives have been taken forward:

- The implementation of a new values based model of clinical supervision, this is currently being rolled out across the wards. It will also be rolled out to community teams in due course.
- Uniforms were agreed and rolled out to all wards with the exception of rehabilitation and low secure wards who are piloting uniforms before a decision is made regarding the way forward and CAMHS who are considering an alternative.
- Improvements to Carenotes system were agreed and will be taken forward.

3. Methodology

This second six-monthly ward staffing review was undertaken in May 2015. It was agreed with Ward Managers not to review the establishments in the same way as previously carried out as most wards were in the process of recruitment and establishing new teams; additionally the establishment recommendations from the last six monthly review have yet to be implemented. Instead an engagement approach was taken where by the Associate Director of Nursing Maria Nelligan visited all the wards and spoke staff regarding staffing issues.

4. Results

The themes from the visits and feedback from staff are as follows:

- **Recruitment potential impact on care**
  Recruitment to posts were at different stages within the recruitment process. In the trust, with the exception of the East wards, managers and staff were confident these would be filled. Difficulties in recruiting registered nurses in East were raised on number of occasions. Staff were aware of the efforts locally and corporately to address these. It was raised that a lot of clinical time is required to sort out staffing at weekends particularly in the East.

- **Staff Morale**
  Staff on duty during the visits were positive about the future and reported that they felt well supported in their roles.

- **Access to CPD and training**

Newly registered nurses were complementary about their preceptorship programme and opportunities to access training for their development moving forward. One newly registered nurse had difficulty in accessing care notes training and this was followed up with a view to local arrangements being put in place to prevent any future re-occurrence.

- **Innovations to practice**
  A number of the wards had newly registered nurses who had initiated some new practice these included time-tabling 1 to 1 session with their primary nurse each week (Bollin) and allocation of staff to patients and other activities on a shift bases (Juniper). These nurses stated they were encouraged to follow through new ideas.

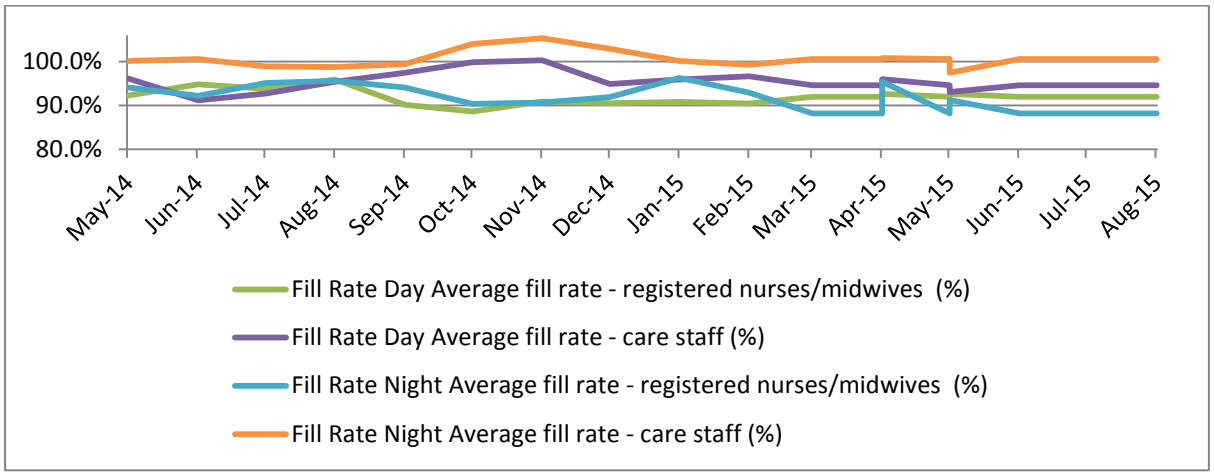
- **Nicotine management policy**
  Some difficulties in implementing the policy were raised and these issues are being followed up locally.

- **Preparations for CQC inspection**
  Staff were positive about the imminent inspection as it was an opportunity for highlighting good practice as well as an opportunity to learn. They felt supported locally and corporately.

5. Quality & Safety

This section identifies how wards are maintaining safe staffing levels, the potential impacts and the actions being undertaken currently, alongside future recommended actions, to minimise potential negative impacts.

The CWP reports submitted to UNIFY over the past 12 months show that ward staffing actuals have generally ran at over 90% of planned staffing as shown in the graph below:



5.1 Interventions to maintain safe staffing levels

There are 3 key interventions that contribute to maintaining safe staffing levels firstly, effective rostering, secondly the use of temporary staff to backfill shortfalls and thirdly actions taken by ward staff to mitigate against the potential impact of unfilled shifts.

5.1.1 Effective rosters

CWP use an e-rostering system to promote effective rosters. Roster effectiveness, as reported by the roster administrator at the beginning of each roster cycle, examines the following:

- Management of annual leave
- Unfilled shifts
- Additional shifts created (exceeding roster template)
- Unused and over contracted hours

Although there has been an improvement in rostering over the past few years the fact that the wards have not yet got to a point where their staff in post matches their establishment, has caused difficulties in achieving high quality effective rosters this is reported to General Managers and WMs monthly. For the next roster period commencing 06 July 2015 roster RAG ratings wards had 3 red, 15 amber and 5 green rosters. A further 3 wards did not have their rosters planned at the point of reporting. Increased vacancies will mean that WMs are unable to produce effective e-rosters.

5.2 Temporary staffing - bank and agency use

In order to maintain safe staffing levels the following temporary staffing has been used to maintain safe staffing levels during the six month periods June-November 2014 and December 2014 – May 2015.

Locality	Jun-Nov 14			Dec 14 -May 15		
	Temp Staffing (TS) shifts filled	TS WTE used	% of Total Planned Hours on Ward covered by TS	Temp Staffing (TS) shifts filled	Temp Staffing (TS) WTE used	% of Total Planned Hours on Ward covered by TS
East	3249	32.7	17%	3875	41.1	20%
West	2591	30.7	19%	2757	33.9	19%
Wirral	2469	26	24%	2433	25.4	21%
Trustwide	**8309**	**89.4**	**20%**	**9065**	**100.4**	**20%**

- Agency has been used in West and East but as a percentage of overall temporary staffing usage this has been low at 1.7% of filled hours for Jun-Nov 2014 and 2.8 % of filled hours for Dec 14-May 15. Temporary staffing report that agency usage has been negligible since May 2015.

- Adelphi, Croft, Greenways, Meadowbank and Oaktrees have had high bank usage (over 5WTE) over both time periods. For Greenways bank is used to staff income generating beds and therefore, when these are filled, Greenways bank usage is planned to be high.

- The main booking reasons for bank are vacancies, sickness and high clinical observations. This is corroborated by the data below which relates to May 2015:

May-15	Sickness Rates (WTE)		Vacancies (WTE)		Sickness +Vacancies(WTE)		Total sickness + vacancies (WTE)	Bank usage (WTE)		Total bank usage (WTE)
Locality	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff		Registered Nursing Staff	Non Registered Nursing Staff	
East	12.5	13.3	8.9	-9.5	21.4	3.8	25.2	5.8	32.2	38
West	3.2	8.9	13.8	10.4	17	19.3	36.3	8.9	19.7	28.6
Wirral	9	9	4.7	2.2	13.7	11.2	24.9	6	20.5	26.5
Trustwide	**24.7**	**31.2**	**27.4**	**3.1**	**52.1**	**34.3**	**86.4**	**20.7**	**72.4**	**93.1**

This demonstrates that sickness has the biggest impact on staffing levels followed by vacancies. Therefore lowering sickness levels should have a significant impact on improving the stability of ward teams and help prevent the 'downward spiral' described below in 5.3.1. There is an Absence Task & Finish (T&F) group, led by the Head of HR, currently undertaking the deep delve into sickness absence with the aim of identifying themes and potential solutions to support local managers. Likewise the proactive action of planned over recruitment, previously agreed by the Board of Directors, is expected to also contribute to minimising the impact of staff turnover thus contributing to the improvement of staffing levels as a whole.

- Bank clinical support workers have been completing the care certificate since September 2015. From Sep 2015 healthcare students will need to complete the care certificate within their first year. It is being considered that this alongside placement governance may enable ward managers to fast track students into bank CSW posts.

- Temporary staffing have recruited 46 external (or internal from non-nursing posts) nursing staff since Dec 2014. Eighteen are in post and the remaining 28 are in the recruitment process. Eighty four internal applicants have also applied for the bank since Dec 2014 with 75 in post and 9 awaiting assignment numbers.

5.3 Maintaining safe staffing – themes identified from CSM monthly reports

As previously stated the trust has generally achieved 'actual staffing' of over 90% of 'planned staffing'. This does however leave around 10% of staffing hours unfilled. Unfilled hours can result in undesirable staffing levels and this can potentially affect patient outcomes and staff well-being. In 2005 Lankshear published a systematic review of international research that looked at the relationship between nurse staffing and patient outcomes and found that '*higher nurse staffing and richer skill mix (especially of registered nurses) are associated with improved patient outcomes'.* Rafferty (2007) found that poorer nurse staffing levels resulted in higher burn-out rates and job dissatisfaction amongst nurses. Additionally Kane's (2007) systematic review found that the studies examined evidenced that 'the studies show an association between increased RN staffing and lower rate of ……. adverse patient events'. Therefore achieving a high fill rate against planned staffing helps mitigate against these potential negative impacts. These issues will be considered when the Head of HR reports the findings of the Absence T&F group.

There have been 67 datix reports relating to staffing levels from March – May 2015. Despite these and the unfilled hours reported to UNIFY CWP's Clinical Service Manager (CSM) Monthly Reports on the ward daily staffing levels have given assurance that safe staffing levels have been maintained. The monthly reports have identified a number of recurrent

themes that have highlighted the ways in which ward staff have ensured that these safe staffing levels have been maintained. These themes have the potential to impact on patient and staff experience; the Board of Directors has asked that these be quantified following the last six-monthly report which was reported to board in Jan 2015 and requested details as part of this review and report. The table below demonstrates this quantifiable data over the past 4 months:

Theme	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**
Nursing staff working additional hours – either by not taking a break or working beyond the end of their shift.	151 hrs	400 hrs	155 hrs	349 hrs
Nursing staff cross covering wards to maintain safe staffing	459 hrs	509 hrs	556 hrs	850 hrs
Skill mix being compromised due to RN backfill being covered by CSWs	119 shifts	126 shifts	42 shifts	53 shifts
WM not retaining supernumerary status	352 hrs	198 hrs	47.5 hrs	70 hrs
Multi-disciplinary teams supporting nursing staff in delivering planned care	20 hrs	15 hrs	15 hrs	20 hrs
Patient care being prioritised over non-direct care activities such as mandatory training, supervision and appraisal resulting in these being cancelled and rearranged.	12 sessions	30 sessions	18 sessions	13 sessions
Patient activities supported by nurses either cancelled (or not rearranged) or shortened due to staffing levels.	3 sessions	28 sessions	10 sessions	5 sessions

The potential impacts of the accumulative effect of these recurring themes include:

5.3.1 Potential impact on patient safety

There is evidence to suggest that risks to patient safety significantly increase when nurses work over 12 hours (Kings College, 2013). This corroborates with the Health and Safety Executive advice that for the first 8 or 9 hours of a shift the risk of errors, accident and injury is constant, there is a slight rise after 8-9 hours up until 12 hours however after 12 hours the risk doubles (HSE, 2012). Additionally it has been identified that fatigue resulting from long hours, lack of rest breaks during shifts and insufficient rest periods between shifts contributes to an increased risk of errors and is a recognised contributing factor in patient safety incidents (RCN, 2012). Therefore it is reasonable to conclude that the recurrent incidences of nurses working additional hours either by working through their break or beyond the end of the shift may significantly increase the potential risk to patient safety. When this occurs staff are given time off in lieu.

5.3.2 Potential impact to staff well-being

Nurses working long hours and lack of rests have the potential to contribute to increased pressure, burn-out, stress and lower job satisfaction (Sherward et al, 2005). The RCN (2010) report that this subsequently *'creates a downward spiral as morale declines and sickness absence increases; leaving fewer staff available to work and creating even more pressure on existing staff. Nurses under more pressure are more likely to want to leave, taking with them valuable experience of working in that specific area for that particular employer; thus leaving a skills gap which can be difficult and costly to fill, and which ultimately results in service impairment.'* Additionally Boorman (2009) noted that '*Healthier staff, teams that are not disrupted by sickness, or where staff are not under undue stress, and lower turnover rates all contribute both to the quality of care given to patients and to patient satisfaction. By contrast, where staff are unhappy and unhealthy, where there are high sickness rates, high turnover and high levels of stress, there are likely to be poorer outcomes and poorer patient experience'.* We need to analyse substantive staff working bank and absence patterns to identify whether these are linked.

In addition to the themes reported it has been recognised nationally that incidences of having 1 RN on duty has the potential to increase pressure on nurses. Therefore, as agreed with the Board of Directors, since March 2015, wards have been reporting on incidents of 1 RN being on duty.

Locality	March		April		May	
	1 RN on days	**1 RN on nights**	**1 RN on days**	**1 RN on nights**	**1 RN on days**	**1 RN on nights**
East	23	4	8	6	4	26
West	8	3	0	5	0	5
Wirral	12	8	0	11	1	8
Trust	**43**	**15**	**8**	**22**	**5**	**39**

As a percentage of shifts across the trust over the past 3 months this works out as 3% of day shifts and 4% of night shifts. However the biggest concern would be where this is occurring repeatedly on the same ward and this is the case for 2 wards. Saddlebridge had 20% of day shifts and 16% of night shifts with one RN on duty in the past 3 months and Meadowbank had 1 RN on duty for 24% of nightshifts. Additionally the Safe Staffing Alliance (2013), recommend that RN-to-patient levels should never fall below 1:8 during the day. The ward staffing levels agreed by the Board of Directors following the 2013 review ensure that CWP wards have the minimum daytime RN to bed ratio of 1:8 however when there is only one RN on duty this ratio is unlikely to be met.

To support ward staffing as a whole and mitigate against issues that can potentially contribute to a negative impact on staff well-being action needs to be taken to minimise the occurrence of these themes and in addition the incidences of 1 RN on duty. This can only be done through achieving the staffing levels recommended in the previous ward staffing reviews. The support provided by to OT teams should be acknowledged as a mitigation factor when looking at safer staffing.

5.3.3 Potential for reduced satisfaction in relation to patient experience

Although reduced satisfaction in relation to patient experience is a potential impact factor there have been no reports of direct negative outcomes for patients as a result of staffing levels. With creative management practices it is the non-direct care activities that are reduced to ensure that patient care needs are met. Feedback from patients on wards is good e.g. Through Patient Led Assessment of Care Environment (PLACE) and CQC visits.

5.4 Current actions underway to support safer staffing

Action 1	All localities have recruitment action plans in place to counteract recruitment difficulties with actions including rolling recruitment, planned over recruitment to proactively maintain substantive staffing levels, forward planning to 'grow our own' RNs through widening the access and assistant practitioner schemes. Wirral and West are least affected by RN shortages however East are significantly affected (see appendix 2 for detailed one page profile)
Action 2	A deep-delve into sickness levels is currently being led by the Head of HR supported by a T&F group.
Action 3	The values based supervision model being adopted by wards is designed to enable meaningful supervision to be carried out in short time blocks.
Action 4	Temporary staffing continues with a rolling recruitment drive, as with substantive recruitment, the new TRAC system will help manage bank recruitment moving forward with the expectation that this streamlines and expedites the process.
Action 5	Continue with planned over recruitment of RNs linked with staff turnover rates as agreed by board of directors.
Action 6	In support of the work initiated by the Director of Finance, a detailed piece of analysis is being carried out on four wards namely Eastway, CARS, Willow and Brackendale .The purpose of this work is to triangulate data drawn from E-Roster, ESR, Blacklight and other relevant systems with a focus on: • Annual leave • Sick absence • Vacancy rates • Rosters • Bank and Agency usage In doing this the aim is to obtain a detailed, evidence-based understanding of the extent to which staffing resource is being deployed effectively and efficiently and to identify themes that contribute to shortfalls and so priorities for further action. This work will therefore support the next stages of the Ward Staffing Review in terms of providing a greater depth of understanding of some of the issues and the areas that need most urgent focus.

6. Supernumerary Ward Managers

CWP has had supernumerary ward managers for a number of years. Ward staffing daily reporting monitors the number of hours that WMs are not supernumerary has been identified in the section above.

7. Care Contact Time

Safe services are leading on the capture of this data and it has been agreed with the Director of Nursing Therapies and Patient Partnerships that the initial data collection will be undertaken in July 2015 and will report to the Ward Staffing Project Group.

8. Challenges & Risks

The challenges and potential risks in relation to safe staffing have been well documented in previous reports to the Board of Directors and include the recruitment of RNs and length of recruitment. In addition there are action plans in place locally which are overseen by service directors and GMs. The on-going financial resourcing of additional staff is a pressure which needs to be addressed and this is being undertaken by the Director of Finance who will report on this separately.

The associated risks are incorporated in the trust risk register and the trusts strategic assurance framework (which was reviewed at the June 2015 Ops Board) and is monitored by the Quality Committee, Operations Board and Board of Directors.

9. Recommendations & Next Steps

- To implement the recommendations from the previous 6 month staffing review
- To consolidate and monitor new establishments in terms of effectiveness and review in November 2015
- To implement the contact time data collection and reporting July/Aug 2015
- To analyse in depth sickness absences and bank usage
- To align staff in post and establishments to allow greater efficiencies and data from e-roster as vacancies are filled
- To review e-rostering to promote effective and efficient rostering practices by the introduction of a programme of rapid improvement.
- To examine substantive staff working bank above the European Working Time Directive and analyse any link to absence and action accordingly
- Introduce incident reporting of staff working through their break or working beyond the 11.5 hour shift

10. References

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Appendix 1 Ward Nurse Staffing Establishments – Recommended June 2015 *(same as Dec 2014 recommendations)*

Ward	Beds	Days		Nights		RN : patient ratio (days)	RN: patient ratio (nights)
		Registered	Non-registered	Registered	Non-registered		
Open age acute							
Adelphi	23	3.7	3	2	3	1:6.2	1:11
Brackendale	20	3	3	2	2.5	1:6.7	1:10
Juniper	20	3.1	3	2	2	1:6.5	1:10
Adult acute							
Bollin	23	3.7	3	2	3.4	1:6.2	1:11.5
Beech	22	4	3	2	2	1:5.5	1:11
Lakefield	20	3	3	2	2	1:6.7	1:10
Organic							
Croft	14	4	4	2	3.8	1:3.5	1:7
Cherry	11	4	3	2	3.8	1:2.8	1:6.5
Meadowbank	13	3	5	2	4.5	1:4.3	1:6.5
PICU							
Willow	7	2.7	2.3	2	2	1:2.6	1:3.5
Brooklands	10	2.4	3.7	2	2	1:4.2	1:5
CAMHS							
Maple	14	3	4	2	3	1:3.5	1:7
Pine	12	3	3	2	2	1:4	1:6
Eating disorders							
Oaktrees	14	3.6	3	2	1	1:3.9	1:7
Secure services							
Alderley	15	3	4	2	2	1:5	1:7.5
Saddlebridge	15	3	4	2	2	1:5	1:7.5
Recovery							
CARS	15	2.7	3.3	2	2	1:5.6	1:7.5
Lime Walk	20	4	3.1	2	2	1:5	1:10
Rosewood	18	3.7	4.3	2	2	1:4.9	1:9
LD A&T							
Eastway	9	3	2	2	1	1:3	1:4.5
Greenways	8	3	2	2	1	1:2.7	1:4

NB 1) Patients per RN per shift excludes supervisory Ward Manager.

2) Numbers on days and nights are average over week reflecting daily fluctuations.

Appendix 2

Ward Staffing Summary - May 2015

		Fill Rate (%)				Staff in Post (FTE)		Establishment (FTE)		Vacancies Against Establishment (FTE)		Vacancies as a Proportion of Establishment (%)		Vacancies Actively Recruiting To (FTE)		Candidates Ready to Start (FTE)		Bank Usage (FTE)		Sickness Absence Rates (%)		Essential Learning Complaince (%)		Appraisal Compliance (%)		Supervision Compliance (%)	
		Day	Night	Day	Night																						
	Ward	Registered Nursing Staff		Non Registered Nursing Staff		Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff
East	Adelphi	87.4%	100.0%	92.8%	94.1%	14.91	11.97	15.04	12.17	0.13	0.20	0.86%	1.64%	-	-	2.00	-	0.54	5.20	8.2%	1.9%	90%	82%	86%	100%	87%	92%
	Alderley Unit	97.5%	101.9%	99.6%	97.1%	11.92	17.00	13.52	16.09	1.60	-0.91	11.83%	-5.66%	-	-	2.00	-	0.31	1.95	8.7%	10.9%	75%	82%	100%	71%	42%	59%
	Bollin	91.3%	120.8%	91.9%	89.0%	15.40	18.53	15.79	16.03	0.39	-2.50	2.47%	-15.60%	-	-	1.00	-	0.46	5.38	10.4%	14.1%	82%	86%	82%	85%	54%	44%
	CARS	95.2%	90.3%	97.8%	99.1%	11.01	15.74	13.82	13.22	2.81	-2.52	20.33%	-19.06%	-	-	2.00	-	1.72	2.48	18.4%	0.3%	98%	88%	92%	92%	50%	62%
	Croft	97.4%	95.2%	84.2%	90.0%	15.95	20.75	15.39	19.54	-0.56	-1.21	-3.64%	-6.19%	-	-	1.00	-	0.72	6.24	2.2%	4.9%	86%	80%	71%	59%	56%	48%
	Greenways A&T	89.2%	101.7%	103.7%	95.0%	13.90	11.00	14.90	10.70	1.00	-0.30	6.71%	-2.80%	-	-	2.00	-	1.26	6.11	13.0%	11.1%	84%	90%	43%	67%	50%	33%
	LimeWalk Rehab	97.6%	100.0%	94.5%	92.2%	13.51	14.12	16.09	12.87	2.58	-1.25	16.03%	-9.71%	2.00	-	-	-	0.41	1.58	0.4%	18.9%	92%	99%	86%	93%	71%	67%
	Saddlebridge	95.8%	98.2%	92.3%	98.5%	12.53	14.48	13.52	13.52	0.99	-0.96	7.32%	-7.10%	-	-	2.00	3.00	0.38	3.29	35.1%	25.5%	86%	71%	60%	11%	36%	43%
										8.94	-9.45							5.78	32.24								
Wirral	Brackendale	77.5%	95.0%	100.4%	115.0%	11.72	11.38	13.52	13.81	1.80	2.43	13.31%	17.60%	-	-	3.00	1.00	1.40	1.70	7.1%	11.2%	87%	88%	82%	92%	92%	92%
	Lakefield	99.9%	100.0%	90.1%	145.9%	12.15	14.67	13.52	12.52	1.37	-2.15	10.13%	-17.17%	-	-	-	-	0.74	1.83	0.0%	4.9%	87%	86%	75%	100%	92%	100%
	Meadowbank	74.8%	80.9%	129.2%	108.9%	11.79	20.24	13.52	23.87	1.73	3.63	12.80%	15.21%	-	-	-	-	1.21	8.74	2.2%	10.8%	71%	72%	92%	85%	92%	95%
	Oaktrees	99.3%	93.4%	94.3%	103.4%	14.00	13.57	15.04	12.06	1.04	-1.51	6.91%	-12.52%	-	-	-	-	1.74	3.52	15.0%	23.6%	88%	82%	92%	92%	91%	77%
	Brooklands	94.0%	101.8%	94.3%	124.2%	13.41	14.61	12.12	14.39	-1.29	-0.22	-10.64%	-1.53%	-	-	1.00	-	0.90	4.70	0.0%	10.2%	62%	76%	82%	93%	73%	86%
										4.65	2.18							5.99	20.48								
West	Beech	93.7%	89.8%	89.3%	96.8%	13.38	13.92	16.09	12.52	2.71	-1.40	16.84%	-11.18%	-	-	1.00	-	0.42	0.28	9.9%	5.6%	70%	86%	91%	89%	50%	50%
	Cherry	90.4%	84.6%	91.3%	89.8%	15.29	10.94	16.09	15.09	0.80	4.15	4.97%	27.50%	-	-	1.00	3.00	1.49	3.18	15.9%	9.1%	67%	58%	73%	78%	92%	83%
	Eastway A&T	95.9%	106.1%	105.6%	90.5%	15.00	10.05	14.90	11.47	-0.10	1.42	-0.67%	12.38%	-	-	-	-	0.67	7.08	20.7%	12.4%	81%	69%	86%	67%	33%	25%
	Juniper	88.7%	84.0%	95.6%	97.1%	10.00	12.53	13.52	12.52	3.52	-0.01	26.04%	-0.08%	-	-	3.00	-	1.85	0.61	4.1%	6.7%	67%	82%	60%	50%	75%	54%
	Maple Ward	95.7%	110.4%	88.3%	98.6%	14.50	14.70	14.29	17.20	-0.21	2.50	-1.47%	14.53%	1.00	-	-	-	0.84	1.82	0.0%	0.2%	80%	72%	70%	77%	64%	71%
	Pine Lodge (YPC)	93.0%	102.5%	98.8%	101.4%	12.50	12.92	14.29	13.46	1.79	0.54	12.53%	4.01%	1.00	-	1.00	-	0.47	0.99	2.1%	9.0%	74%	71%	67%	50%	87%	75%
	Rosewood	95.9%	78.3%	82.0%	107.3%	11.61	17.40	15.39	19.31	3.78	1.91	24.56%	9.89%	1.00	-	1.00	-	0.92	0.84	6.7%	7.2%	89%	73%	83%	80%	55%	57%
	Willow PICU	104.4%	70.0%	92.2%	122.4%	12.36	9.45	13.82	10.76	1.46	1.31	10.56%	12.17%	-	-	3.61	-	2.25	4.88	5.2%	27.9%	79%	77%	92%	88%	18%	33%
								304.18	**303.12**	**13.75**	**10.42**	**4.52%**	**3.44%**	**5.00**	**0.00**	**26.61**	**7.00**	**8.91**	**19.69**								

Ward Staffing Summary - June 2015

	Ward	Fill Rate (%)				Staff in Post (FTE)		Establishment (FTE)		Vacancies Against Establishment (FTE)		Vacancies as a Proportion of Establishment (%)		Vacancies Actively Recruiting To (FTE) (vacancy advert up to offer stage)		Candidates offered / Ready to start (FTE) (offered pending checks)		Ready to start with start date booked (FTE)		Bank Usage (FTE)		Sickness Absence Rates (%)		Essential Learning Complaince (%)		Appraisal Compliance (%)		Supervision Compliance (%)	
		Day	Night	Day	Night																						
		Registered Nursing Staff		Non Registered Nursing Staff		Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff	Registered Nursing Staff	Non Registered Nursing Staff
East	Adelphi	94.8%	98.0%	93.7%	97.1%	15.91	11.97	15.04	12.17	-0.87	0.20	-5.78%	1.64%			1.00				0.60	6.20	14.14%	1.33%	90%	83%	93%	100%	35%	46%
	Alderley Unit	98.7%	95.8%	100.0%	98.5%	11.92	16.00	13.52	16.09	1.60	0.09	11.83%	0.56%			1.00	1.00	1.00	1.00	0.20	2.90	7.27%	2.94%	84%	95%	90%	69%	67%	76%
	Bollin	97.4%	100.0%	93.4%	101.5%	15.40	17.03	15.79	16.03	0.39	-1.00	2.47%	-6.24%			2.00		2.00		0.30	4.00	6.49%	12.72%	80%	91%	100%	92%	43%	44%
	CARS	97.6%	100.2%	93.9%	99.0%	12.01	16.06	13.82	13.22	1.81	-2.84	13.10%	-21.48%	1.00		1.00				1.70	2.60	11.91%	0.22%	96%	89%	83%	92%	42%	81%
	Croft	94.3%	89.4%	91.6%	90.5%	15.95	20.75	15.39	19.54	-0.56	-1.21	-3.64%	-6.19%							0.10	4.70	3.38%	5.30%	84%	83%	100%	76%	94%	95%
	Greenways A&T	92.2%	99.5%	95.0%	112.9%	13.90	11.00	14.90	10.70	1.00	-0.30	6.71%	-2.80%			2.00				1.20	4.00	0.98%	11.67%	93%	97%	31%	67%	85%	100%
	LimeWalk Rehab	99.2%	97.5%	91.7%	95.9%	13.43	15.12	16.09	12.87	2.66	-2.25	16.53%	-17.48%							0.30	1.60	6.59%	14.32%	97%	97%	79%	83%	86%	61%
	Saddlebridge	96.4%	107.1%	65.0%	98.8%	9.53	14.48	13.52	13.52	3.99	-0.96	29.51%	-7.10%			1.00	1.00			0.00	4.00	31.40%	15.06%	91%	83%	67%	13%	30%	23%
Wirral	Brackendale	102.4%	97.8%	103.3%	94.2%	12.45	12.38	13.52	13.81	1.07	1.43	7.91%	10.35%			3.00				1.30	1.40	7.92%	10.40%	92%	88%	91%	91%	83%	92%
	Lakefield	88.1%	96.7%	98.3%	103.3%	13.42	14.67	13.79	12.52	0.37	-2.15	2.68%	-17.17%							0.80	1.30	1.24%	13.27%	85%	91%	77%	100%	40%	31%
	Meadowbank	94.6%	93.0%	90.0%	100.0%	12.79	20.24	14.52	23.87	1.73	3.63	11.91%	15.21%							1.10	4.30	0.21%	11.46%	79%	79%	100%	100%	21%	38%
	Oaktrees	103.4%	92.2%	106.7%	117.8%	14.92	13.57	15.04	12.06	0.12	-1.51	0.80%	-12.52%							1.70	5.80	12.70%	15.37%	79%	88%	92%	87%	86%	88%
	Brooklands	98.7%	100.0%	98.7%	112.4%	12.41	13.61	12.12	14.39	-0.29	0.78	-2.39%	5.42%							0.50	4.60	4.22%	15.67%	79%	85%	91%	93%	69%	43%
West	Beech	94.9%	97.8%	93.1%	100.0%	14.46	12.92	16.09	12.52	1.63	-0.40	10.13%	-3.19%			1.00				0.50	0.50	0.22%	2.06%	75%	95%	91%	89%	38%	92%
	Cherry	87.1%	93.8%	88.9%	90.1%	15.29	11.94	15.87	14.89	0.58	2.95	3.65%	19.81%			1.00	2.00			2.30	2.70	9.58%	8.20%	71%	60%	91%	80%	25%	46%
	Eastway A&T	98.1%	99.6%	100.0%	100.0%	14.00	12.05	14.10	11.47	0.10	-0.58	0.71%	-5.06%	1.00						0.40	5.30	7.83%	11.01%	90%	77%	71%	67%	33%	31%
	Juniper	93.9%	94.4%	93.5%	100.0%	12.77	12.53	13.52	12.52	0.75	-0.01	5.55%	-0.08%			2.00		1.00		1.80	1.60	9.01%	7.80%	61%	88%	100%	90%	29%	36%
	Maple Ward	84.0%	92.6%	116.0%	112.7%	15.50	14.70	14.29	17.20	-1.21	2.50	-8.47%	14.53%							1.00	1.10	1.06%	0.00%	85%	85%	90%	78%	80%	57%
	Pine Lodge (YPC)	94.5%	95.7%	101.9%	103.6%	12.50	12.92	13.79	12.46	1.29	-0.46	9.35%	-3.69%	1.00	1.00			1.00		0.70	2.40	8.24%	7.27%	84%	83%	85%	73%	63%	75%
	Rosewood	97.9%	100.0%	100.0%	100.0%	12.53	18.40	15.39	17.81	2.86	-0.59	18.58%	-3.31%			2.00				0.60	0.70	9.84%	7.11%	86%	83%	85%	89%	54%	39%
	Willow PICU	96.1%	100.4%	91.2%	101.5%	12.47	10.45	13.82	10.76	1.35	0.31	9.77%	2.88%			3.00	1.00			0.90	5.30	1.60%	5.87%	83%	90%	83%	88%	83%	78%
								303.93	**300.42**	**20.37**	**-2.37**	**6.70%**	**-0.79%**	**3.00**	**1.00**	**20.00**	**5.00**	**5.00**	**1.00**	**18.00**	**67.00**								

3 RNs East ready for start date but date/ward not yet indicated to recruitment

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Ward Daily Staffing Levels June 2015
Agenda ref. no:	15/16/42
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/07/2015
Presented by:	Avril Devaney

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

REPORT BRIEFING

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

This report details the ward daily staffing levels during the month of June 2015.The planned and actual hours for registered nurses (RN) and clinical support workers (CSWs) for June 2015 have been submitted to UNIFY using the template supplied by NHS England (appendix 1). The themes arising within this monthly submission continue to mirror those that have arisen previously. These themes identify how patient safety is being maintained on a shift by shift basis.

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

The monthly reporting of daily staffing levels is a requirement of NHS England and the National Quality Board in order to appraise the Board and the public of staffing levels within in-patient units. CWP undertook a comprehensive review of ward staffing levels between Oct and Dec 2013 with 6 monthly follow up reviews in May 2014, December 2014 and May 2015. The ward staffing project group, chaired by the Director of Nursing, Therapies and Patient Partnership, continues to take forward the recommendations from the initial review relating to staffing levels and continuous improvement measures. The Board of Directors, in line with the NQB requirements, will continue to receive monthly reports on Ward Daily Staffing Levels and also reports on the six monthly reviews that the trust are required to undertake.

Assessment – *analysis and considerations of options and risks*

During June 2015 patient safety on in-patient wards was maintained by nurses working additional unplanned hours, cross covering across wards, the multi-disciplinary team and ward manager supporting nursing staff in the delivery of planned care and patient care being prioritised over non-direct care activities. These themes have been quantified from Feb-May 2015 and analysed as part of the 6 monthly review report; submitted to Operations Board in July 2015.

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

The Board of Directors are recommended to note the report.

Who/ which group has approved this report for receipt at the above meeting?	Ward Staffing Project Team
Contributing authors:	Maria Nelligan

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
Click here to enter text.	Click here to enter text.	Click here to enter text.

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

Appendix no.	Appendix title
1	Ward daily staffing

15_16_42_Appendix 1 June 2015 UNIFY submission with additional comments

Ward		Day				Night				Fill Rate				Comment
		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 - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	
East	Adelphi	1398	1124	1698.5	1412.5	756.5	722	1294	1156	80.40%	83.20%	95.40%	89.30%	The WM has worked within the clinical team and non-direct care activities were cancelled to maintain safe staffing levels
	Alderley Unit	956	946	1322.5	1277.5	644	597.5	759	747.5	99.00%	96.60%	92.80%	98.50%	Nursing staff worked additional hours, non direct care activity was cancelled and skill mix was altered to maintain safe staffing levels
	Bollin	1293	1210	1657.5	1455.5	747.5	552	1450.5	1210	93.60%	87.80%	73.80%	83.40%	Nursing staff worked additional hours to maintain safe staffing levels
	CARS	976.25	934.75	1437.5	1400	690	569	706	729	95.70%	97.40%	82.50%	103.30%	Nursing staff worked additional hours to maintain safe staffing levels and staff cross covered other wards
	Croft	1276	1207	2077.5	1682.5	752	708.75	1825	1643	94.60%	81.00%	94.20%	90.00%	Nursing staff worked additional hours to maintain safe staffing levels and staff cross covered other wards
	Greenways A&T	1318.5	1257	1348.5	1383.5	713	667	713	690	95.30%	102.60%	93.50%	96.80%	Non direct care activity was cancelled to maintain safe staffing levels
	LimeWalk Rehab	897.25	848.3	1248	1161	617	602	757	734	94.50%	93.00%	97.60%	97.00%	Nursing staff worked additional hours to maintain safe staffing levels and staff cross covered other wards
	Saddlebridge	615	558	1462	1436.5	575	494.5	828	828	90.70%	98.30%	86.00%	100.00%	Nursing staff worked additional hours and skill mix was altered to maintain safe staffing levels
Wirral	Brackendale	1095	1084	1069.5	972	713	713	713	701.5	99.00%	90.90%	100.00%	98.40%	Nursing staff worked additional hours and skill mix was altered to maintain safe staffing levels
	Lakefield	1071	1114	1035	908.5	736	736	1000.5	1000.5	104.00%	87.80%	100.00%	100.00%	Nursing staff worked additional hours to maintain safe staffing levels and staff cross covered other wards
	Meadowbank	876	743.5	2205.5	2174	713	449	1851.5	1955.5	84.90%	98.60%	63.00%	105.60%	Nursing staff worked additional hours and skill mix was altered to maintain safe staffing levels
	Oaktrees	1166	1214	1309	1253	713	713	519.5	516.5	104.10%	95.70%	100.00%	99.40%	*
	Brooklands	1101	1108	1278.5	1238.5	744	743	893.5	902	100.60%	96.90%	99.90%	101.00%	*
West	Beech	1386	1230.5	1115.5	1000.5	713	690	713	713	88.80%	89.70%	96.80%	100.00%	Nursing staff worked additional hours to maintain safe staffing levels and staff cross covered other wards
	Cherry	1290	1018.75	1196	1035	770.5	598	989	920	79.00%	86.50%	77.60%	93.00%	Nursing staff worked additional hours to maintain safe staffing levels and staff cross covered other wards
	Eastway A&T	1199.25	1138.5	1433	1410	628	559	836.5	842	94.90%	98.40%	89.00%	100.70%	Nursing staff worked additional hours to maintain safe staffing levels and staff cross covered other wards
	Juniper	1200.5	1051	1046.5	1046.5	609.5	575	839.5	828	87.50%	100.00%	94.30%	98.60%	Non direct care activity was cancelled and skill mix was altered to maintain safe staffing levels
	Maple Ward	1226.5	996.5	1161	1137	609.5	644	759	793.5	81.20%	97.90%	105.70%	104.50%	The WM has worked within the clinical team, nurses worked additional hours and some patient activities were cancelled to maintain safe staffing levels. Staff cross ocvered other wards.
	Pine Lodge (YPC)	1264.5	1119.4	1000.5	847	598	563.5	724.5	759	88.50%	84.70%	94.20%	104.80%	The WM has worked within the clinical team, nurses worked additional hours and some patient activities were cancelled to maintain safe staffing levels. Staff cross ocvered other wards.
	Rosewood	1122	1129.5	1468.5	1468.5	494.5	483	770.5	770.5	100.70%	100.00%	97.70%	100.00%	*
	Willow PICU	917.5	878	1115.5	1000.5	644	563.5	782	782	95.70%	89.70%	87.50%	100.00%	The WM has worked within the clinical team and nurses have worked additional hours to maintain safe staffing levels
Trust wide		23645.25	21910.7	28686	26700	14181	12942.75	19724.5	19221.5	92.70%	93.10%	91.30%	97.40%	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Infection Prevention & Control Annual Report for 2014/2015
Agenda ref. no:	2015/16/43
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/07/2015
Presented by:	Director of Infection Prevention & Control

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

REPORT BRIEFING

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

Please find 2014/2015 annual report for Infection Prevention and Control (IPC). This is a mandatory requirement and once approved by the Board of Directors will need to be made available to the public. The report summarises the performance of the IPC team throughout the fiscal year 2014/2015, and gives assurance to the board regarding compliance with our CQC registration.

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

The Director of IPC or deputy delivers an annual report regarding IPC activity and any assosciated risks to the board. This highlights areas of good practice, performance to date, any identified gaps and the work programme for 2015/2016.

Assessment – *analysis and considerations of options and risks*

Multi resistant organisms continue to rise. This is now monitored jointly, as is antimicrobial stewardship, by the IPC team and pharmacy on a weekly basis for all our inpatient areas.

Community audits remain our concern regarding compliance with the agreed 93%. These are identified on the IPCSC risk register and are monitored regularly until compliant.

CWP was successful in winning the IPC (inc. TB) contract for Western Cheshire & Vale Royal Clinical Commissioning Groups via Cheshire West & Chester Council commencing October 2014.

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

The Board is asked to approve the Infection, Prevention and Control Annual Report for 2014/2015 and the work programme for 2015/2016.

Who/ which group has approved this report for receipt at the above meeting?		Infection, Prevention and Control Subcommittee
Contributing authors:		Amanda Miskell
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Chief Executive	July 2015

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1	IPC Annual report 2014/15 and IPC work programme 2015/16.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(15_16_43) Infection, Prevention and Control Annual Report 2014/15

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.

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.

CWaC
Cheshire West & Chester Council

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
Health Care 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 Gov.uk.

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 Director of Infection Prevention and Control (DIPC) Annual Report 2014/2015 for Cheshire and Wirral Partnership NHS Foundation Trust (CWP). Our Director of Infection Prevention & Control (DIPC) and the IPC Service continue to work hard to prevent infections, and are dedicated to preventing all avoidable infections, "keeping service users, staff, visitors and carers safe from infections, the first time, and every time". This report will demonstrate how CWP meets, and exceeds on the mandatory and contractual requirements.

In October 2014 the CWP IPCT was successful in securing the IPC contract for providing services for the health and social care services including TB, for Western Cheshire CCG & Vale Royal CCG via CWaC. To address the new contract there has been some staff changes in the IPCT, and a new IPC structure (Integrated Service) which was communicated to all CWP staff via the CWP home page in December 2014. This new contract will provide the team with varied development opportunities, including clinical professional development, and for the organisation, succession planning, and business continuity. It also gives CWP an opportunity to tender for future business, across a varied range of provider services.

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

We are committed to continuing care past the sign off date.
We are compassionate in all our contact with patients, carers and colleagues.
We share experiences and learning in the team to maintain competences.
We are committed to speaking out when needed to protect our patients and colleagues.
We ensure the values are incorporated into each team meeting and as a minimum we include competence, care, compassion, communication and are committed to our team work programme.
We have the courage to challenge ANY behaviour that puts our services users or staff at risk.

Below is a brief summary of the IPC team accomplishments and how we have raised the profile of both CWP and the IPC Service this year:

- **No** preventable Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections within our provider services
- **No** preventable Clostridium Difficle Toxin (CDT) infections within our provider services
- **Have** been actively involved in Public Health England (PHE) task and finish group regarding antimicrobial stewardship, and have implemented weekly meeting with our mental health (MH) pharmacy colleagues
- **Increased** service user involvement within the team and increased clinical visits
- **Actively** involved in the safety metrics and Zero harm agenda regarding urinary and vascular devices
- **Achieved** a zero number of identified cross infection cases in service users or staff
- **Provide** support to the physical health (PH) agenda for inpatient areas
- **Integral** to emergency planning support regarding Ebola and pandemic infectious outbreak
- **Came** in the top 20% of trusts nationally in IPC training (Staff Survey)
- **Regional** Physical Health in Mental Health member for the Value and Context of Nursing
- **"Super User"** advisor for the National Infection Prevention Society (IPS) Quality Improvement Tools
- **National** conference speaker and national poster presentations for the third consecutive year
- **National** educational chair for the Infection Prevention Society (IPS)
- **Active** members of Mental Health IPS Special Interest Group
- **Successful** appointment to the IPS National Education and Professional Development Committee (2 year term, commenced December 2014)
- **Regional** conference speaker and poster presentations at regional and local conferences, including neighbouring trusts inc:- COCH, Wirral CT and Manchester
- **Regional** IPS conference chair

- **North West** Regional Educational Officer for North West IPS (a 4 year term, which ended February 2015)
- **Co-author** of the Nursing Times online, isolation training package with particular emphasis on Mental Health
- **Member** of the North West Sepsis group
- **North** West IPS meetings hosted at CWP, raising our profile
- **Supporting** the Western Cheshire Clinical Commissioning Group (CCG) in its IPC Quality agenda

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

2.1 Frequency/nature of reporting

In addition to delivering the annual report the DIPC produces a report to the Board quarterly. During 2014/15, the Board received succinct reports in accordance with the business cycle, which highlighted areas of practice and development, including arrangements for IPC.

2.2 Decisions made by the Board of Directors

The approval and any recommendations from the Board are communicated directly to the DIPC following presentation of Quarterly and Annual Reports 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. A "new" code was made available in January 2015 for consultation; this has yet to be published. However, a summary of assurances against additional requirements was developed to reflect the new requirements and the Board was briefed as part of Quarter 4 Report. The IPCSC assurance framework was also updated.

4. Infection Prevention and Control governance arrangements

4.1 Arrangements for IPC services

The IPCT have a high profile within Clinical Services 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 Board were appraised of the arrangements in Quarter 4 Report.

4.2 The Infection Prevention and Control Integrated Service

The IPC team is led by the DIPC, including internally, Modern Matrons, Medicines Management, Estates and Facilities teams, Waste Manager and the IPC team.

4.3 IPC resources

The following resources are available to CWP staff:

- The team
- IPC policies – which are reviewed in line with the IPCSC work plan.
- An IPC web page – a direct link provided on the CWP intranet home page, updated with new announcements, link minutes, useful codes, links to the CQC, Public Health England (PHE) fact sheets, Gov.uk guidelines and all other relevant publications. The team have developed

this important resource during 2014/15 and it now incorporates a wealth of other supporting information for all staff to access. This page is regularly updated and feedback on areas for development actioned as required.

- An IPC newsletter – highlighting recommended products, training sessions, and infection prevention control tips and advice.
- 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. These groups continue meet on a quarterly basis across the localities. These meetings provide an excellent opportunity to cascade and disseminate key IPC guidance to staff. An education element is also incorporated to promote Continuing Professional Development (CPD), supporting the Trust's vision and strategic objectives. All services are invited to nominate a representative to attend these meetings and minutes are notes at IPCSC and are accessible via the IPC Intranet page. The minutes from these meetings are noted at the IPC subcommittee.

The IPCT hosted their 10th annual IPC study day in November 2014 with in excess of 50 members of staff attending from a wide variety of CWP services. As in previous years this event provided an excellent platform for learning and networking with colleagues. The IPCT were able to secure the support of several outside speakers to provide an engaging and thought-provoking event. We look forward to facilitating this event again in 2015.

4.5 Infection Prevention and Control subcommittee (IPCSC)

The IPCSC reports directly to the Quality committee, and is chaired by the DIPC. Meetings take place five times per year, and all services and localities 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 Committee meeting. Areas of concern are highlighted and escalated when required. The work programme for 2015/2016 is included in the report as Appendix 1.

4.7 Programme of Policy Review

All IPC policies were reviewed during the 2014/15, in line with the policy review programme which forms part of the IPCSC work plan.

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. In conjunction with the pharmacy department the IPCT took a new and innovative approach to raising awareness in relation to anti-microbial resistance and AMR day in November 2014. The team had three public facing stands in Winsford, Ellesmere Port and Chester offering information, advice and resources.

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

The team attend the Health, Safety & Wellbeing subcommittee, and the Patient Safety & Effectiveness subcommittee, and can therefore raise IPC issues directly via these meetings.

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 a member of the IPCT attends these meetings.

4.11 Links to the Emergency Planning Subcommittee

During 2014-15 a major potential risk emerged around Ebola. In line with NHS England expectations and working alongside CWP's Emergency Planning team the IPC team monitored and circulated regularly Cabinet Office briefings. Additionally, a group was set up with neighbouring NHS Trusts in order to share best practice from an IPC, emergency planning and communications perspective. Supplementary actions were undertaken such as producing Ebola and Influenza specific flow charts for our front line reception areas and some specific guidance information published on the IPC intranet pages. In October 2014 IPC and the Emergency Planning team attended a desk-top simulation exercise in Liverpool organised by NHS England and PHE. Learnings and best practice was disseminated as appropriate. Additionally, Infection Prevention and Control attend and contribute to the Bi-Monthly Emergency Planning Sub Committee meetings which are chaired by Julie Critchley, CWP West Service Director.

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 and the audit programme. The IPCT have continued to work in partnership with CWP Estates in relation to the new Alderley unit, the refurbishment of Lakefield Ward and the plans for the new young person's inpatient unit, ensuring compliance with Hospital Building Note 00-09.

6. Safe Systems for Disposal of Sharps

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, Essential 1 Learning and at all other events and opportunities.

8. Infection Prevention and Control and the National Staff Survey - 2014

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.

This question was not asked in 2014; however CWP came within the top 20% of organisations again for the following question regarding training, "Infection control (e.g. guidance on hand-washing, MRSA, waste management, disposal of sharps / needles)", with 87% of staff answering yes, and the national average being 75%. The question was also asked, "I have a clean work space", 78% of respondents said yes, the national average being 77%. This is an area the locality IPC nurses are investigating via observational visits, at least weekly to inpatient areas. See published results below:

National Average	CWP Average	CWP East	CWP West	CWP Wirral	CWP Clinical Support Services

1d	**Have you had any training, learning or development (paid for or provided by your organisation), in the following areas? Infection control (e.g. guidance on hand-washing, MRSA, waste management, disposal of sharps / needles).**	75%	87%	88%	89%	85%	87%
40h	**Patients / service users always have access to clean toilets and bathrooms.**	81%	83%	84%	82%	85%	80%
33b	**I have a clean work space. (Agree)**	77%	78%	79%	74%	74%	89%

9. Education CWP activity

9.1 Induction and Essential Learning

The IPC team have facilitated Induction (17 sessions), Junior Doctors (5 sessions) and Essential learning (76) to 2308 staff including the support of our e-learning package demonstrating 75% of all CWP staff currently in post. This is positive outcome when compared to previous years 2380 (70%) for the 2013/14 year, and 2080 (63%) for 2012/13. The IPCT also provide Aseptic Non Touch Technique (ANTT) training, supporting compliance the Safety Metrics and Zero harm.

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

Throughout the period of this report, the IPC sessions consistently scores "good" or "excellent".

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 third consecutive year. All IPCT members hold recognised infection prevention and control qualifications, at BSc level and the specialist nurses are all in the process of completing their MSc programmes. One of the team is enrolled on the Manchester Infection Prevention and Control Course which will further develop their knowledge and skills in relation to Infection Prevention and Control.

10. Inpatient Activity

10.1 Audits

Modern Matron Audits

The IPCT has supported the Modern Matron Audit programme across the trust, which includes clinical practice, environment and IPC standards. The Modern Matron audit results is presented to IPCSC. 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.

Inpatient Area Audits

During the period this report covers the team carried out audits on all inpatient areas with the appropriate follow up and support. All inpatient areas achieved above the compliance score of 93%. During the period this report covers the IPCSC approved the procurement of an electronic audit tool collate and produce audit data. The team use this mobile electronic audit device to capture audit data and provide a swift dissemination of results and action plans to the area audited. The audit tool used is national recognised and incorporates the Infection Prevention Society Quality Improvement Tools. The team welcome this investment into what is a core component of their work programme. This audit tool has enables the team to upload and produce meaningful audit results and actions plans in a more timely fashion, resulting in faster reporting and response to areas of concern, ensuring that all service users are cared for in a safe, clean environment. The IPCT completed the inpatient audit programme for 2014/15 ahead of schedule to enable any recommended work to be completed and ensuring that every inpatient area was audited, producing a report and action plan which is tabled at IPCSC.

Following the joint work with Learning Disabilities in 2013/14 to produce an audit tool suitable for service users, several audits were carried out in the East locality with the support of service users keen to participate. Their involvement provided a valuable learning opportunity for the IPCT and contributed to the action plan produced following each audit. Results are reported back to the IPCSC where areas of good practice are highlighted and appropriate actions regarding areas of concern is actioned and documented. See table 1, 2 and 3 below.

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

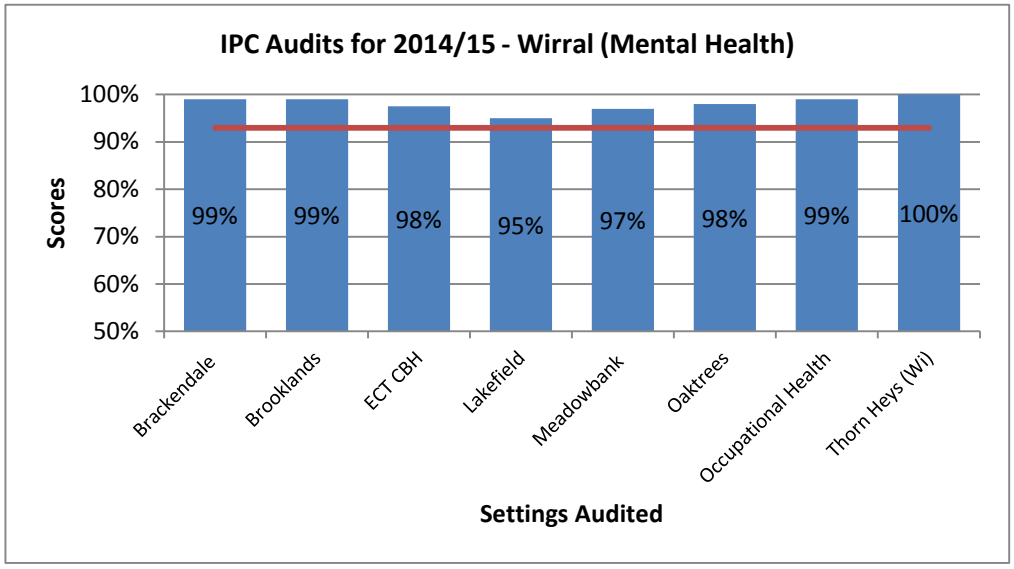


Table 2 – Audits for 2013/2014 – West (Mental Health)

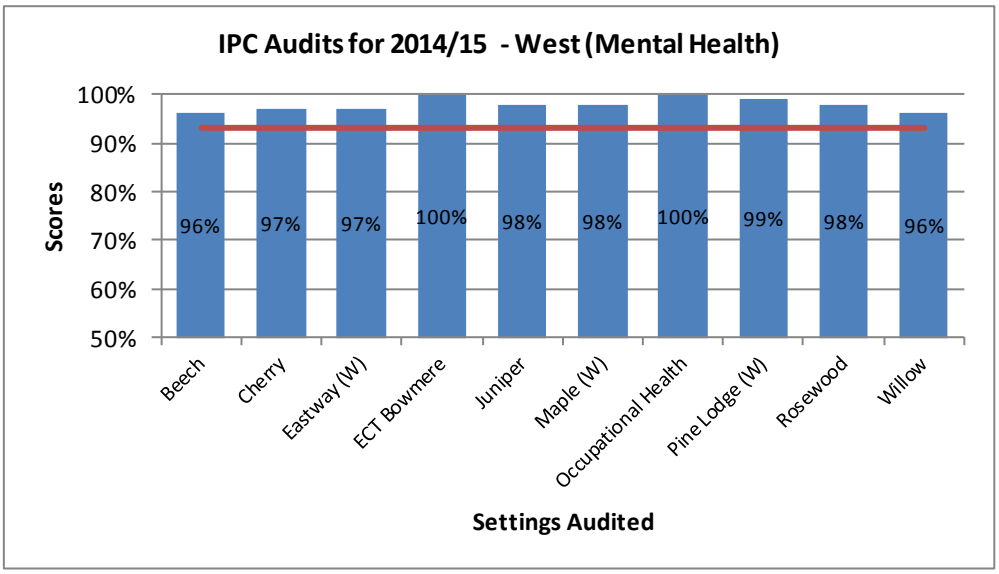
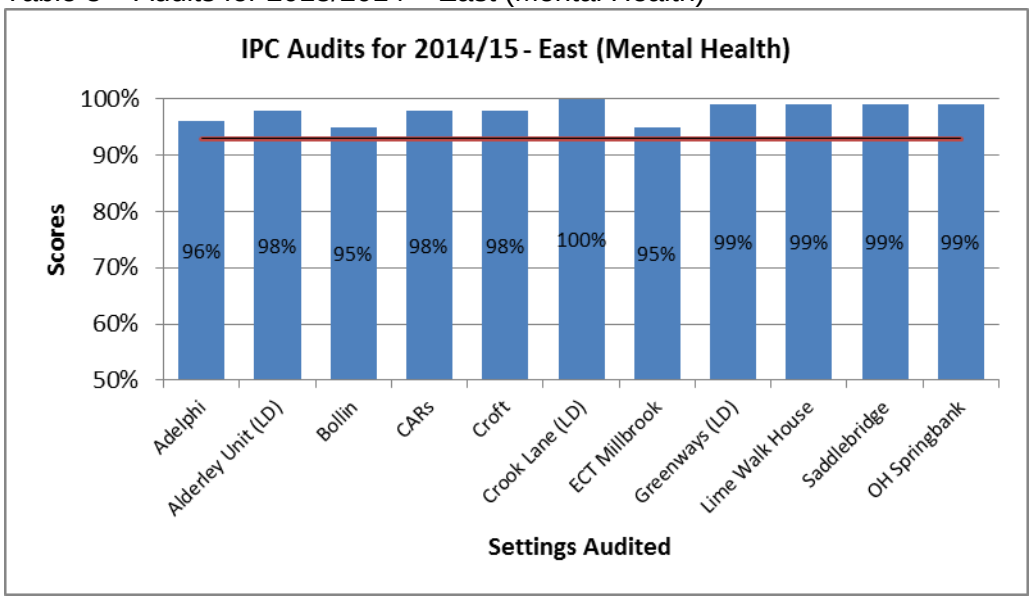


Table 3 – Audits for 2013/2014 – East (Mental Health)



10.2 Partnership working across the local health economy

The IPCT has close links with secondary and primary care colleagues in IPC and local authorities and public health teams where required. The CWP IPCT support new IPC colleagues by offering "placements" to other IPCTs and PHE. Forging these valuable links has improved understanding of each other's service. Most work has been with Mersey Care, Manchester, Mid

Cheshire Hospital Trust, Countess of Chester, Wirral CT team and Cumbria Partnership Trust, including being guest speakers at each other's training events. This has provided an opportunity to develop partnership working, benefiting service users and staff.

10.3 Promoting the IPC Service

The IPCT work hard to provide a high profile across our footprint. We have good relationships with PHE, CCGs and our colleagues in other health provider settings, and are seen as a focus of support and innovative practice.

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.

10.5 Integrated Working and Support across Services

The IPCT support investigations and reports to clinical services and one of the team is the professional advisor for nursing in West. These included completion of a Peer Review for the East locality, and assisting the Audit department with the PH Audit across the East In-patient Services. During the period this report covers the team was nominated as investigating officer for two Human Resource investigations.

10.6 Service User Involvement

The team have continued to work with both the Recovery Colleges and the Occupational Therapy Department to facilitate health promotion training. In the Recovery Colleges as part of the Physical & Mental Health Promotion Course, the team continued to take part by presenting sessions that aim to show how the principles of infection prevention & control can be used to maintain aspects of personal health. The overarching aim of the session was to provide information to stimulate discussion, and improve knowledge of attendees own physical health. Sessions are planned for continuation in 2015, following positive feedback from attendees in 2014.

In the Low Secure Services, the team have worked with the OT Department, and as part of their 'Looking After Myself' work with service users, presenting a session around health promotion. The sessions concentrated on information relevant to infection prevention and control, which could be carried over into everyday life for service users, empowering them to protect their own health, including the challenges encountered with living in a shared environment.

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

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 if 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 experience post-outbreak meetings are held for CWP inpatient areas within 5 working days of the end of an outbreak. These meetings may include clinical service managers, modern matrons, ward managers, temporary staffing, occupational health, practice education facilitator and facilities manager.

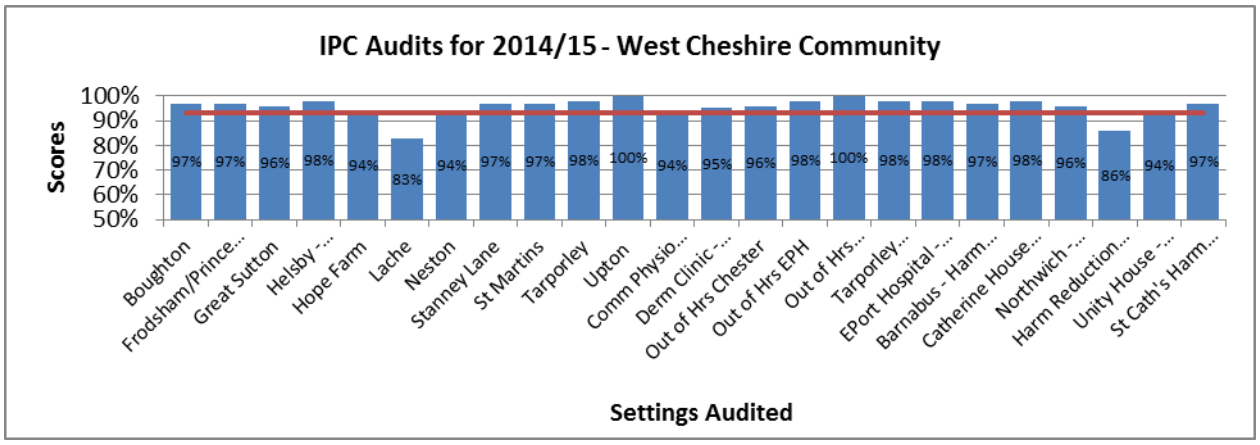
During 2014/2015 there was an Influenza Outbreak on a West ward which resulted in a prolonged period of closure. The IPCT managed the outbreak and all affected service users and staff made a full recovery. This was followed by a post outbreak meeting and noted at March 2015 IPCSC. The IPCT nominated the staff at Bowmere for going the extra mile due to the hard work and commitment of all the staff involved.

11. Community Activity

11.1 Audit

During the period this report covers the team carried out audits on all community areas with the appropriate follow up and support. Results are reported back to the IPCSC where areas of good practice are highlighted and appropriate actions regarding areas of concern is actioned and documented. There are some areas of concern in the community, however these are currently on the IPCSC risk register and continually followed up by the IPCT.

Table 4 – Community Audit Scores



11.3 Service User involvement in IPC

The team consistently respond to, and request feedback 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 and patient information leaflets are monitored and changed in response to service user feedback**.**

11.4 Safety Metric/Zero harm for Invasive Devices

The West PH Care Team Community Safety Metrics programme incorporates standards which help to measure compliance against the CWP ‘always / never events’ framework in relation to wound care, pressure ulcers and catheter care. In 2014/15 the metrics were completed in November 2014 and March 2015. The majority of teams have demonstrated acceptable levels of compliance across the categories. However, when teams score less than 100% compliance the team completes an action plan using SMART principles to ensure that the action is specific, measurable, agreed upon, realistic and time-based. The key items for compliance have been Pressure Ulcers, Wounds and Urinary Catheters.

11.5 Catheter Associated Urinary Tract Infection

The IPCT have worked tirelessly in developing and supporting the implementation of NICE guidance EPIC 3 (2014) and CQC requirements with regards to Catheter Associated Urinary Tract Infections. This has included the continuing monitoring of all catheterised patients in the community setting with CWP input, on average 270 patients, supporting the introduction of a safety metric, product masking, training, staff meetings, communications, and updating the 10 week catheter pathway.

11.6 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.

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

The 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 2014 to March 2015, 42 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. This service has now been handed back to the COCH.

11.8 Influenza Immunisation Activity

Five members of the IPCT completed their update of the Immunisation training, in order to be able to support the annual staff influenza vaccination campaign during 2014/15. The team worked in partnership with the Trust's Occupational Health to deliver the vaccine across all localities**.**

This year the service directors agreed to a locality based delivery model with each locality responsible for setting up their own delivery mechanisms to better meet the needs to their staff. Delivery to the remaining staff was coordinated via the occupational health service.

Despite the national 75% uptake target, CWP agreed a more pragmatic target based on previous uptake and instead aimed to vaccinate at least 52% of staff which would represent a 10% improvement on the previous year. Sufficient vaccine stock was purchased to achieve the internal target and in the event demand for the vaccine exceeded supply, the delivery model supported the purchase of 'flu vouchers' for distribution to the remaining staff requesting vaccination. These vouchers could then be redeemed at a number of third party pharmacies.

The vaccine was available to all staff however the first month of the programme targeted those staff with direct access to service users (i.e. Doctors, Qualified nurses, other professionally qualified staff and Support to Clinical staff. In total, 58 immunisers (21 new, 10 refresher and 27 core) were identified to deliver the programme. A training plan to support the planned model was agreed with L&D in order to ensure sufficient new and refresher vaccinator training was available.

To mitigate against any possible manufacturer delays, the vaccine order was requested via 2 manufacturers. 'Core' clinics were set up across the trust during October and November and delivered by suitable qualified immunisers with further 'mop-up' clinics available via occupational health during December and January.

In addition, opportunistic vaccination was offered by all immunisers within the workplace. Key messages to staff centred on the benefits of vaccination to themselves, their family and to service users. Vaccination was also incentivised by free entry into a prize draw to win a number of Acer tablets and also by the provision of 1 day free passes to the Total Fitness Centres.

Despite a large number of locality based clinics and access to vaccination within the workplace, vaccination rates within CWP this year have been particularly low with overall uptake below the national (75%) and internal (52%) targets as well as being less than the previous year of (42%).

Staff Group	Staff	Administered	%
Doctors	124	44	**35%**
Registered Nurse	1328	515	**39%**
Professionally Registered Other	381	130	**34%**
Support to Clinical Staff	1683	530	**31%**
Inform Total	**3516**	**1219**	**35%**
Other	775	242	**31%**
Total	**4291**	**1461**	**34%**

For the first time, the proportionally highest uptake within staff groups came from registered nurses with 75 more qualified nurses being vaccinated this year than last year whereas vaccination levels for doctors was the lowest level for more than 6 years.

Several contributory factors have been suggested in respect of the low uptake including the unusually mild weather during the first couple of months of the campaign, general staff apathy towards the flu vaccination, a higher proportion of staff reporting 'sore arms' following immunisation and ongoing myths linked to the vaccine causing flu however further feedback from staff is needed to better understand the full reasons for the low uptake.

CWP is consistently challenged to meet the national targets in respect of seasonal flu uptake for staff. The current locality model has not increased overall vaccine uptake across the trust despite extensive planning. Previous staff surveys have suggested about half of staff want to access the vaccine from within the workplace whereas the remainder would prefer to access the vaccine outside of the trust at a more suitably convenient location such as a community pharmacist.

It is important that any future flu programme adequately meets the needs of staff in order to promote the highest uptake possible. Current flu planning efforts are disproportionate to the outcomes achieved via the delivery models and an alternative model is therefore required. With this in mind, the FPG recommend the 2015 staff seasonal flu campaign should be delivered using a hybrid model as outlines below:

- Purchase sufficient quantities of flu vouchers for distribution to all staff via September payslips. A proportion of these vouchers should be negotiated on a sale or return basis;

Support staff to access vaccination using the vouchers in the following ways:

- External pharmacy
- Staff can take the voucher to any of the approved pharmacies where it can be redeemed against seasonal flu vaccination.
- Internal OH department

- Staff can 'redeem' the voucher internally via one of the OH departments and receive their vaccination there. Vouchers used in this way can then be returned to supplier for refund.
- Introduce system of feedback, controlled by mangers (similar to that via the Sitrep process) that requires managers to complete a regular return confirming who in their team has redeemed the voucher. Data returned in this way can then be uploaded into the CWP Flu Database from which information to support monthly Immform submissions can be drawn.

12. Wider Community Services / West Cheshire CCG & Vale Royal CCG Contract from Oct'14

In October 2014 the IPCT were successful in being awarded the contract to provide IPC and tuberculosis (TB) services across the Cheshire West and Chester Council (CWaC) footprint, which includes both West Cheshire CCG and Vale Royal CCG, namely to the following services:

- **General Practitioners**
- **Care Homes**
- **Child care providers**
- **Dentist**
- **Optometrists**

Donald Read, Consultant for Public Health for CWaC, stated in March 2015

"*Since taking over commissioning responsibility for the CWP Infection Prevention and Control service in October 2014, Cheshire West and Chester Council Public Health team has developed a close working relationship and a collaborative approach to the Infection Prevention and Control agenda. This process allows for a 'whole system' approach to identifying and sharing lessons learned and common themes identified from investigations and provides a forum to jointly discuss feedback from the Clinical Commissioning Group. The IPC team are also active members of the Infection Control Network and the Care Home Quality group, both forums led by CWAC Council. This collaborative approach alongside regular and timely communication from the IPC team in relation to HCAI monitoring and infectious disease outbreaks, combine to create a robust collaborative approach to infection prevention and control in Cheshire West and Chester*".

The team 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.

The IPC team continue to respond and follow up every positive microbiology result requiring intervention and action, 488 in total for this year. However this doesn't include the new contract activity which has been in place since October 2014 for Vale Royal CCG. This data nationally was sporadic, but for Q4 we saw 3 Clostridium difficile Infections and 16 ESBL UTIs. 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 (42 in total).

During 2014/15 we have continued to see a rise in Multi Resistant Organisms including MSSA, gram negatives such as E.coli and Carbapenemase-Producing Enterobacteriaceae (CPE). Clostridium Difficile infection rose during 2014/15 and two extraordinary meetings were coordinated by the IPCT

with key stakeholder attendance. After two large investigations no trends were identified and no cases were found to be avoidable.

Mandatory Reportable Infections – Western Cheshire community population (Vale Royal will be included next year).

	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
2014 – 2015	88	356	152	29	1	43

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 19% and 36% 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.

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, St. Cyril's 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 Multi resistant organisms. 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

Between December 2014 and February 2015 the Western Cheshire Health Economy experienced and outbreak of influenza affecting 15 care homes. This was deemed as exceptional activity with Western Cheshire experiencing high numbers of outbreaks in comparison to neighbouring communities. There has been no rationale identified for this, however the team has been recognised as prompt first line responders and managing this activity to an exceptionally high standard.

Every home was risk assessed individually by the IPCT and guidance sought from PHE. Each home met the definition of an outbreak as outlined in point 2 and was subsequently closed to admissions, discharges and transfers. The IPCT provided the following support to each affected care home:

- Minimum daily contact including telephone advice and visits where appropriate
- Where applicable, and on the advice of PHE viral swabs were collected from affected residents, the results of which are outlined in point 5.
- Support and guidance in relation to cleaning and other key IPC precautions

On the guidance of PHE the residents, and where applicable, staff in 13 of the homes were treated or given prophylactic anti-viral therapy to reduce transmission and impact of the illness. This therapy was prescribed by the GPs the residents and staff were registered with. It is acknowledged that this was significant additional workload for the GPs and their support and collaboration in this matter is noted.

The following data demonstrates the impact of this outbreak:

Mean length of home closure	12.1 days,
Mean number of residents in the home	43.6
Mean number of affected residents	11.6
Mean number of staff in the home	49.9
Mean number of affected staff	3.2

The results below list the causative organisms identified in the viral swabs collected by the IPCT:

Organism	Number of Care Homes
Influenza A	9
Influenza B	1
Rhinovirus	1
Nil	4

There have also been 11 outbreaks of gastrointestinal illnesses reported to the IPCT in care homes during the period this report covers. In 5 of these outbreaks the causative organism was confirmed as norovirus. All of the outbreaks were managed in accordance with Public Health England Communicable Disease Outbreak Management. 2 schools and 1 childcare provider reported outbreaks of diarrhoea and/or vomiting to the IPCT. A causative organism was not identified on any of these 3 occasions however, the IPCT offered support and guidance until the outbreaks were declared over.

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.

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. Full report can be found as Appendix 2.

12.5 CWaC IPC Audit Programme

This commenced in October 2014 as part of the agreed Key Performance Indicators (KPI) for Care Homes and GP practices across Vale Royal and Western Cheshire CCGs. The IPCT has met and

exceeded the audit requirements as agreed. No premises have fallen below the 70% threshold. Where possible audits are carried out unannounced, however, it is acknowledged that clinical need may mean an area is not accessible on a particular day therefore the team work in partnership with care providers to identify dates and times that may not be acceptable.

12.6 CWaC IPC Training Programme

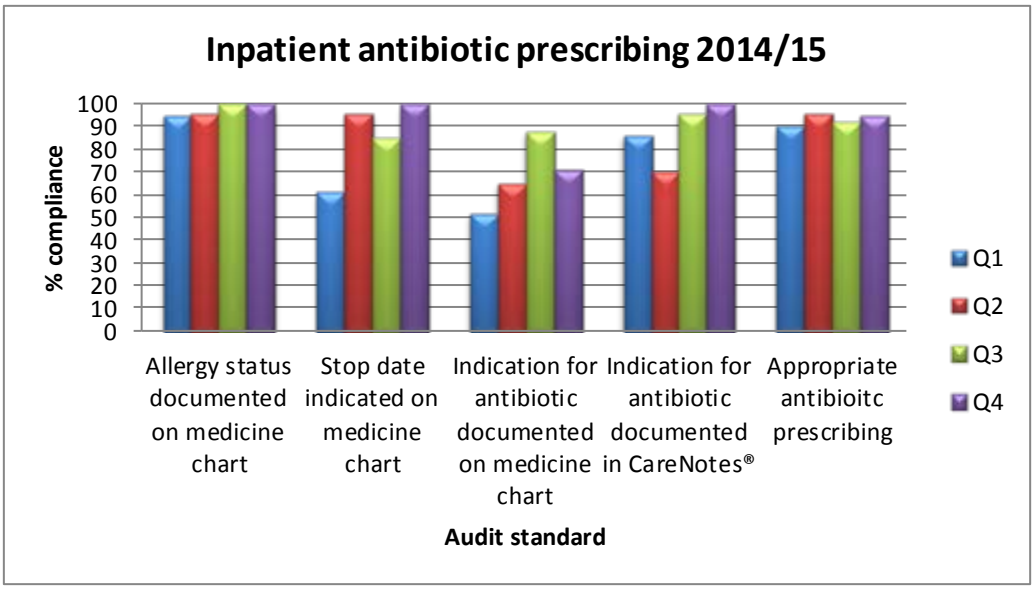
In collaboration with Education CWP IPC training has been offered to all services across the CWAC footprint. The aim of this training has been to raise Infection Prevention and Control standards. This training has included face to face training at Sycamore House covering the principles of Infection Prevention and Control and a whole study day covering a wide range of IPC topics. This training has been well evaluated by participants. The IPCT have also supported and facilitated learning at rolling half days/protected learning time in Western Cheshire and Vale Royal Clinical Commissioning groups.

13. Inpatient Services antibiotics audit 2014/15

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 2014 and March 2015 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 current NHS Wirral antimicrobial prescribing guidelines.

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 standards measured. However the total number of antibiotics prescribed in the audit periods was low (June 21, September 23, December 26, March 21) and any variation in practice makes a large difference in the percentage compliance figure.



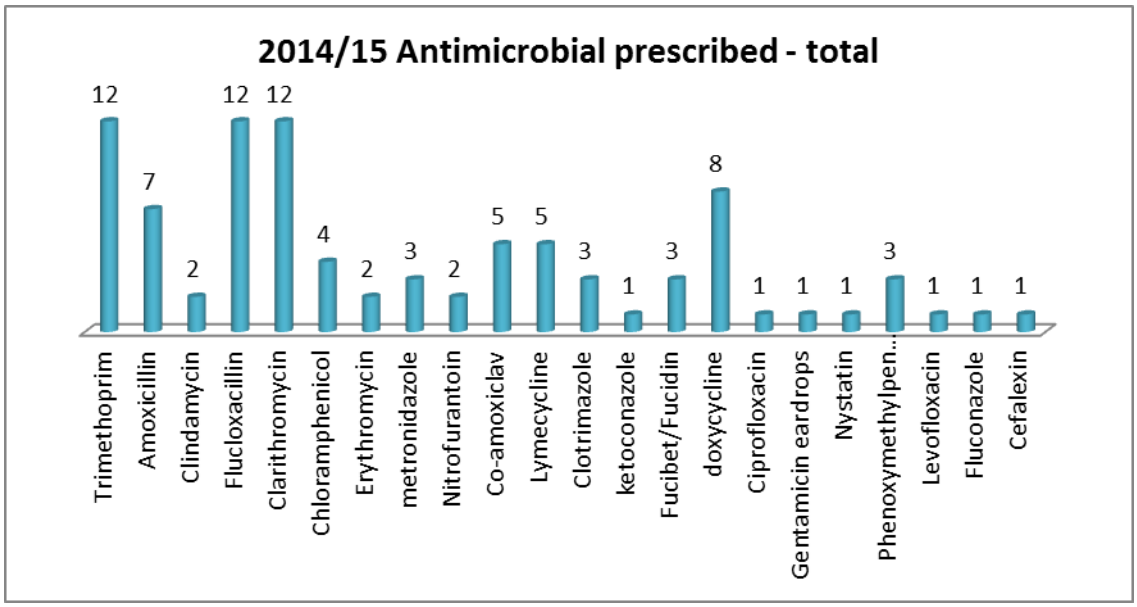
Since the quarterly audits were commenced in June 2011, there has been no prescribing of antibiotics to treat *Clostridium difficile* within the audit weeks.

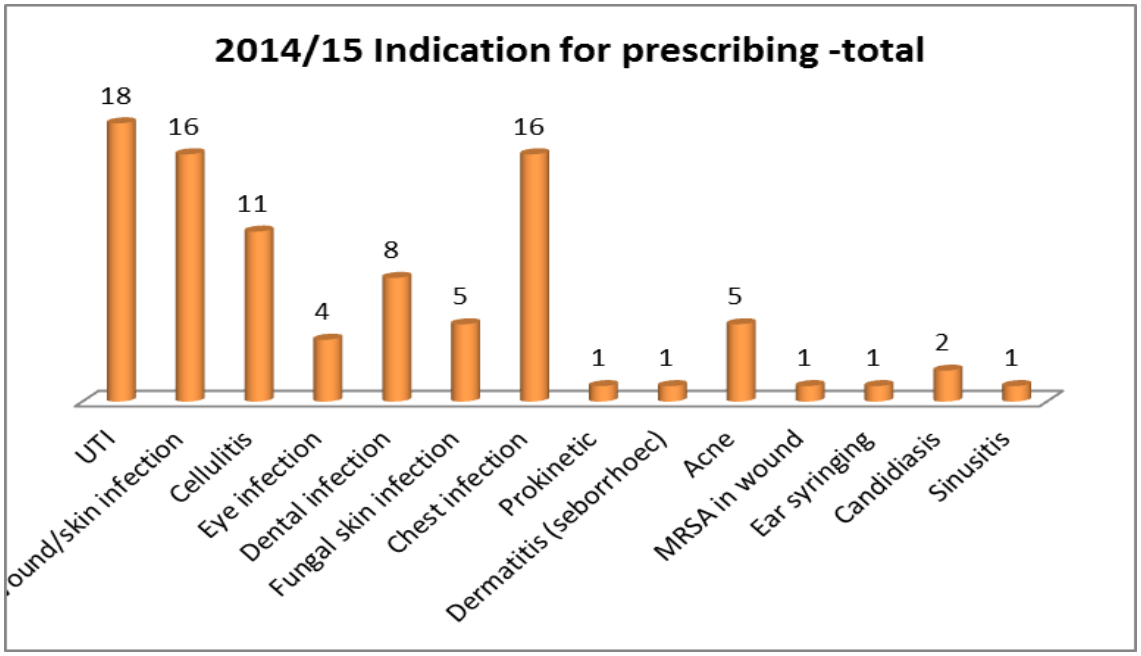
Allergy status documentation dropped below 100% for the first time in two years for quarters one and two, but then improved to, and was maintained at 100% for the second half of the year. There was a decrease in the average for the recording of stop dates or course lengths, on the medicine chart from 91% in 2013-14 to 86% this year; and the average for the recording of indication on the medicines

chart dropped slightly from 72% in 2013-14 to 69% this year. Another decrease was seen in the documentation of indication within the CareNotes® system, recording at an average of 96% for 2013-14 and 88% this year. The results from the individual quarters indicate that quarters one and two produced lower percentage compliance rates with the audit standards, but did improve significantly during quarters three and four. The standard requiring most improvement moving forward was also identified last year; documenting the indications of the antibiotics on the medicine chart with average percentage compliance being 74% last year and 72% this year.

The audits this year have continued to demonstrate that appropriateness of antibiotic prescribing has been maintained at 90% or above. 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 antibiotics that have been deemed inappropriate usually involve the prescribing of erythromycin as an alternative to penicillin in penicillin allergy, when the formulary choice is often clarithromycin, and the topical use of fusidic acid for skin infections, when this is a non-formulary option in secondary care.

The following show the different antimicrobials prescribed and the indications for prescribing for 2014-15.





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.

For 2015/16, CWP will be adopting the West Cheshire Antimicrobial prescribing guidelines for use within both in-patient and physical health community services, and the in-patient audit criteria is being reviewed to include the antimicrobial stewardship principles of 'Start smart Then focus'.

13.1 Community West Physical Health antibiotic prescribing 2014/15

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

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

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 West Cheshire antibiotic formulary.
- National comparators:

- 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”. Cephalosporins and quinolones have a higher propensity to cause *Clostridium difficile* associated disease. Prescribing of these antimicrobials cannot be totally eliminated due to sensitivities and resistance, so the target is to keep usage as low as possible and in line with West Cheshire CCG and national levels.

- Prescribing comparator “3 days trimethoprim average daily quantity (ADQ)/item” which benchmarks 3 day courses of trimethoprim for uncomplicated urinary tract infections (UTIs). An ADQ of 3 equates to a three day course of 200mg twice daily. 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. The target is to be towards 3 and in line with local and national levels.

Results

Data below compares out of hour’s prescribers and community matrons against the national and local benchmarks outlined above.

	CWP West average 2013-14	**Q1 14/15**	**Q2 14/15**	**Q3 14/15**	**Average 14/15 YTD**
Out of Hours - all prescribers					
% Formulary antibiotic items (local)	**97%**	**98%**	**99%**	**98%**	**98%**
% Cephalosporin + quinolone (national)	**6%**	**5%**	**5%**	**5%**	**5%**
Out of hours - GP only					
% Formulary antibiotic items (local)	**97%**	**98%**	**99%**	**98%**	**98%**
% Cephalosporin + quinolone (national)	**7%**	**5%**	**6%**	**5%**	**5%**
Out of hours - NMP					
% Formulary antibiotic items (local)	**100%**	**100%**	**99%**	**98%**	**99%**
% Cephalosporin + quinolone (national)	**5%**	**2%**	**3%**	**5%**	**3%**

Out of Hours - all prescribers					
Trimethoprim ADQ/item (national)	**5.0**	**5.0**	**4.0**	**5.0**	**5.0**

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 been maintained at a high level and consistent with the previous year's results.

Comparison of national and local benchmarks:

	Average value 13/14	**Average value YTD 14/15**
CWP Out of Hours - all prescribers		
% Cephalosporin + quinolone	6%	**5%**
Trimethoprim ADQ/item	5.0	5.0
Western Cheshire CCG		
% Cephalosporin + quinolone	6.6%	5.57%
Trimethoprim ADQ/item	6.0	5.72
National		
% Cephalosporin + quinolone	5.8%	4.95%
Trimethoprim ADQ/item	6.1	5.83

This is the third year of using the national trimethoprim comparator and the average value of 5.0 compares favourably to the West Cheshire CCG value of 5.72 and the national average 5.83.

The percentage of cephalosporin and quinolone prescribing as a total of all antibiotic prescribing, 5% is also in line with local, 5.57% and national average results, 4.95%.

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.

Community Matrons	**CWP Average value 13/14**	**Q1 14/15**	**Q2 14/15**	**Q3 14/15**	**CWP Average YTD 14/15**
% formulary adherence (local)	**100**	100	100	100	100
% Cephalosporin and quinolone prescribing (national)	**4.4%**	<1	<1	<1	<1

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:-

1. 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.

2. 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 legionella risk assessments on Trust properties where required following significant infrastructure changes or when new premises are acquired. The Estates Department has written a site specific scheme of control for each inpatient premises which reflects the initial ZetaSafe risk assessment. This service also provides for provision of internet based legionella database storage and reporting for statutory test results on ZetaSafe2. There is also a three monthly review of test results, control measures and procedures to ensure compliance with current legislation and these results are published at the Infection Prevention Control Sub Committee.

Estates Operational Service continually undertake legionella tests throughout the Trust estate, with 87.84% 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. The annual test result report records an overall compliance level of 87.84% which falls slightly short of the department's target. The shortfall is related to a new build premises, Princeway HC where there are design and installation concerns being addressed by the contractor.

The IPCSC oversee this requirement and provide a Forum for Water Safety.

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 2014/15 capital programme was recorded at £12.6m - specific projects to note include:

Completion Stein Centre refurbishment - £400k
Soss moss Phase 2 completion - £3.2m
Upgrade of seclusion rooms within Bowmere & Springview - £476k
Creation of new bedroom on Maple Ward £126k
Continuation of Springview ward refurbishment £2.7m
Commencement of CAMHS new build £700k
Inpatient catering re-design £262k
Saddlebridge reinstatement and upgrades £279k

The proposed capital programme for 2015/16 was approved by the Board in January 2015 for expenditure amounting to £12.4m. Specific proposed projects to note include:

CAMHS Tier 4 New inpatient facility - £12.0m (As part of £14m investment)
Springview – Environmental Improvements £500k
Backlog maintenance £120k

14.3 Revenue Programme Works

The end of year position for the 2014/15 revenue programme was recorded at £805k. Specific projects to note include:

- Decoration and flooring programme – £148k
- PLACE action plan – £132k
- Environmental upgrades - £65k
  - **Croft refurbishment £40k**
  - **Millbrook environmental works £34**

The proposed revenue programme for 2015/16 was approved by the Board in January 2015 and is set at £600,000. Specific proposed projects to note include:

- **Decoration programme - £140k**
- **PLACE action plan - £65k**
- **Control of Legionella - £5k (This element only relates to Legionella risk assessments on new capital works)**
- **Continuation refurbishment of Croft Ward £300k**

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 £71k for 2015/16.

14.4 Physical health west capital and operational revenue programme
The operational capital and operational revenue programme for 2014/15 included £419k 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.

15. Waste Management

CWP's commitment in minimising infection risks related to any of its activities, including the disposal of healthcare waste, reducing the impact of environmental pollution, fulfils their statutory duty of care under the Environment Protection Act (1991). Waste Management strategies now in place continue to promote closer working practice with the IPC Service, Health and Safety advisors and Facilities management which in turn promotes a better understanding of Infection Prevention and Control in the Trust's Waste Management chain. A Waste Management Handbook has been produced in line with a new HTM 07-01, which has been approved by the Health & Safety Sub Committee. The Waste Policy has also been reviewed in light of the above and re-coded HS1 from GR29 and the Waste Management Audit Tool has been updated.

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 and 2 Senior 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:

- Hawthorns Winsford.
- 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 for Cleaning

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. The department are currently in the process of moving 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)

PLACE visits continue to have excellent involvement from patient representatives which have provided a wide range of perspectives and comments supporting improvements in the patient environment. These comments are submitted to the Health and Social Care Information Centre (HSCIC). Comments from these visits form the Facilities action plane for the year and ensure funding and improvements into the areas that matter to patients.

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 2015/16

20. Appendix 2

TB Report 2014/2015

21. Appendix 3

References and associated documents

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	2014/15 Annual Report Safeguarding Adults and Children (including Children in Care)
Agenda ref. no:	15/16/44)
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/07/2015
Presented by:	Avril Devaney Director of Nursing Therapies and Patient Partnership

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

REPORT BRIEFING

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

This report sets out the performance and activity of CWP in relation to safeguarding responsibilities for both adults and children during 2014/15.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
This report provides assurance to the CWP Board in relation to Safeguarding responsibilities

Assessment – *analysis and considerations of options and risks*
Performance against the previous years objectives is included and the objectives for the coming year 2015/16 are set out.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board is asked to accept this report and it's recommendations

Who/ which group has approved this report for receipt at the above meeting?	Trust-wide Safeguarding Sub-committee
Contributing authors:	Val Sturgess/ Satwinder Lotay/General Managers of Localities

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
Click here to enter text.	Click here to enter text.	Click here to enter text.

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

Appendix no.	Appendix title
Click here to enter text.	Click here to enter text.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

(15_16_44) CWP Safeguarding Adults and Children (including Children in Care) Annual Report 2014/15

Contents

1. Purpose of the Report

The purpose of this report is to provide Cheshire and Wirral Partnership (CWP) Board with assurance of safeguarding responsibilities in relation to key legislation and guidance for both children and adults. It sets out the activity and performance of CWP during 2014 – 2015 for both adult and children safeguarding including Looked after Children also referred to as Children in Care.

The report provides assurance of how the Trust has met requirements as a regulated provider, under Regulation 13 of the Health and Social Care Act 2008, The Care Act 2014, The Children Acts of 1989, 2004, Working Together to Safeguard Children 2015, Promoting the Health of Looked After Children 2015.

2. Summary

CWP provides a diverse number of services for both adults and children. These include mental health inpatient and community services, learning disability services, substance misuse services, Child and Adolescent Mental Health Services (CAMHS), Adult Physical Health Services and Children's Public Health Services. These services are commissioned by Clinical Commissioning Groups (CCGs) and/or Local Authority Public Health Commissioners.

Safeguarding activity continues to increase across all public sector services. During the last year, health services have responded to a number of national policy strategies and initiatives. These have included the implementation of the Prevent strategy as part of the Government's counter terrorism strategy CONTEST, development of reporting mechanisms for Female Genital Mutilation (FGM), regional and local responses to Child Sexual Exploitation (CSE), the introduction of the Modern Slavery Act and the response to forced marriage and honour based violence. The recognition and responses to domestic abuse has continued to grow and the Multi Agency Risk Assessment Conference (MARAC) process has developed and now incorporates listings of hate crime and consideration of cases brought under Claire's Law legislation.

Central for CWP Adult Safeguarding has been the preparation for the change in response to the Care Act 2014 that came into practice on 1st April 2015. CWP has responded to the requirements brought about by this legislation in relation to co-operation with Local Authority processes, engagement with Safeguarding Adult Boards and ensuring CWP is able to respond to requests from the Local Authority to undertake management reviews and investigations as requested. The continued implementation of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) has further impacted on CWP policy and activity over the last year.

During 2014/15 CWP has been involved in tendering processes for new and existing business including public health services commissioned by Local Authority and other services for both children and adult services. The mobilisation of new services and exiting contracts has had an impact on safeguarding activity and demand across the Trust. The impact of service provision moving to different health Trusts and sometimes to non-NHS providers, along with different commissioned services within the Local Authorities has opened new areas of challenge to ensure safeguarding practice is maintained across organisational boundaries. This will continue to be an area where safeguarding risk needs to be identified and mitigated as the service provision landscape alters. CWP will continue to work closely with Local Safeguarding Boards and Commissioners to ensure safeguarding practice remains robust across different providers.

The Standard NHS contract incorporated into contracts with CCGs is monitored through the self-assessment audits and completion of Safeguarding Assurance Frameworks/dashboards. The indicators for these frameworks continue to increase and adult frameworks are now more established within contracts. There has been increased scrutiny of indicators to monitor performance from CCGs and Designated Nurses for both adults and children.

Central to effective safeguarding practice has been to ensure staff are trained and competent, this has been reflected in the contracting frameworks over the last year. The 'Safeguarding Children and Young people: roles and competences for health care staff' intercollegiate document published in March 2014, has informed the development of roles, competencies and practice for CWP staff and alignment of training requirements during 2014/15. This will continue into 2015/16 as the competency framework for safeguarding is further developed and monitored within CWP.

Safeguarding governance arrangements and practice within CWP have continued to evolve in an integrated way. This has ensured that the 'think family' approach is embedded across shared areas of practice such as domestic abuse and substance misuse. Safeguarding Adults Boards have moved onto a statutory footing under the Care Act and CWP continues to work closely with the Boards to ensure best practice from the Children's Boards and engagement with sub-groups is continued. CWP is in a position to share learning and best practice across the Safeguarding Boards that it is involved with.

The report is structured to provide the overarching Trust – wide perspective on safeguarding responsibilities followed by three sections to reflect performance and activity within each of the CWP localities – West Cheshire, East Cheshire and Wirral. Each locality has its own focus on key priorities that are informed by both the services provided in the locality and the key priorities of the Local Safeguarding Boards. The report includes a review of performance against the previous years priorities and the final section of the report sets out those for the coming year.

3.Trust Wide Activity and Performance

3.1 Safeguarding Leadership & Accountability

The CWP Trust 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 the Local Safeguarding Children's Boards. The Director of Nursing is supported by the Associate Director of Nursing and Therapies (Physical Health), who is a member of the Local Safeguarding Adult Boards. The Associate Director has line management responsibility for the CWP Safeguarding Service.

Following a service review, the Head of Safeguarding is now a permanent post and has responsibility for the Safeguarding Service. This role also incorporates the Named Nurse for Adult Safeguarding for CWP and as such is accountable to the Director of Nursing. The Named Nurse for Safeguarding Children is accountable to the Director of Nursing.

The Trust Safeguarding Service is made up of a number of specialised teams. These include the Nurse Specialists for Safeguarding Children, Children in Care (Looked after Children), Child Death Overview Panel/Paediatric Liaison, and Nurse Specialists for Safeguarding Adults and a Safeguarding Nurse for domestic abuse. The Children's services are managed by the Named Nurse for Children, and the Adult Service is managed by the Named Nurse for Adults. The service is supported by a safeguarding administrative team. The Trust also has 3 Named Doctors for Safeguarding Children, one in each locality of the Trust, all of whom are consultants working in CAMHS.

The Named Nurses and Doctors are responsible for ensuring policies and training are in place and compliant with national guidance and policy. The Named Nurses are members of a number of LSCB and LSAB sub groups (supported by the nurse specialists).

3.2 Safeguarding Governance Arrangements & Assurance

The meeting structure within CWP supports the governance arrangements to ensure assurance is provided to the Trust Board. The Trustwide Safeguarding Sub-committee incorporates both adult and child safeguarding and is chaired by the Director of Nursing, Therapies and Patient

Partnership. It has been established by the Quality Committee to provide assurance that Safeguarding responsibilities are being met through the activities of the Trust. The Sub-committee monitors all elements of safeguarding responsibilities, including the monitoring and reviewing of action plans, approval of safeguarding policies for both adults and children, monitoring of Trust audit programme for safeguarding, monitoring of compliance with Safeguarding Assurance Frameworks and training programmes including compliance levels. It also reviews the work of the Local Safeguarding Boards and sub-groups via update reports and briefings.

Each locality of CWP has a Safeguarding Operational Group established and chaired by a General Manager. The groups provide assurance in relation to safeguarding practice and activity through reports to the Trust-wide Safeguarding Sub-committee which highlight risks and mitigations against those risks.

3.3 Board Assurance Framework – Risk Register

Risks on the CWP Board Assurance Framework relating to Safeguarding are reviewed, mitigated and monitored by the Trust-wide Safeguarding Sub-committee. During 2014/15 the Board Assurance Framework during 2014/15 has included the Safeguarding risk that staff may not have the competency and skill to manage safeguarding practice through adequate levels of training compliance. During the year, in response to increased levels of training compliance, this risk has been re-modelled to reflect the need for positive assurance that safeguarding practice is being implemented. As such the risk level has remained the same, although the risk has altered.

The Trust has established a Prevent Steering Group to oversee the implementation of the Prevent strategy. The Associate Director of Nursing and Therapies (Physical Health) is the named strategic lead for Prevent. This group oversees the assurance framework and action plan for Prevent implementation across the Trust. This group reports risks and exceptions to the Trust wide Safeguarding Sub-Committee.

CWP provides assurance to commissioning CCGs and Designated Nurses for both adults and children via completion of Safeguarding Assurance Frameworks. They include data submissions in relation to training, supervision and data for Looked After Children.

The annual self-assessment for both adult and children's safeguarding is undertaken each year and submitted to CCGs for scrutiny.

Safeguarding Assurance meetings are established between CWP and CCGs and meet quarterly. These meetings provide opportunity for scrutiny and challenge, to identify areas of risk and areas of good practice.

3.4 Safeguarding Adult Activity

CWP Nurse Specialists for Safeguarding Adults receive enquiries for advice and support from CWP staff in relation to safeguarding issues. The outcome of these discussions may result in the concern that has been raised, being managed locally within the service or in referral to Local Authority Safeguarding Services.

Table 1: Activity for the last 3 years across adults safeguarding.

Activity - Adults	2014/15	2013/14	2012/13
Number of enquires/contacts to CWP Safeguarding Team (adults)	1335	904	612
Number of referrals to Local Authority where safeguarding adults team have received notification	78	121	Not captured

Table 1 illustrates that the total number of adult safeguarding enquiries made to the CWP Safeguarding Adult Team has increased significantly over the last year. Although direct comparison of last year's data cannot be made as reporting systems had only been partly implemented in 2013/14, the data is valid in indicating an increase in activity and this increase is reflected across all locality areas.

CWP welcome this increase in contact with the Nurse Specialists as it demonstrates that staff are identifying and seeking advice on management of concerns in relation to safeguarding practice. CWP recognise that high levels of recognition of concerns raised, reflects a high patient safety culture. Raising those concerns indicates that staff are recognising risk and implementing appropriate intervention and care planning for the service user ensuring their safety and wellbeing.

There is a decrease in the number of referrals made by CWP to Local Authority Safeguarding Services. This may be in part due to the increase in the concerns raised with Nurse Specialist that have resulted in concerns being managed locally within the service, resulting in effective measures being put in place to safeguard the adult at risk. However, during 2015/16 this will be explored further to triangulate data within CWP and with services directly to ensure that staff are accurately identifying adults who are at risk and are acting upon their concerns appropriately.

3.4.1 Safeguarding Children Activity

Table 2: Activity for the last 3 years across childrens safeguarding

Activity – children	2014/15	2013/14	2012/13
Number of referrals made to Social Care	98	108	192
Number of Practitioners attending / reporting into Child Protection Conferences	410	387	335
Number of CWP practitioners involved with TAF/CAF cases	On average 113 practioners per month involved with CAF/ TAF	Not captured	Not captured

The number of referrals made to childrens social care has decreased. This may be partly explained by way of practitioners undersanding and therefore making appropriate detailed referrals. In addition there has been an increase in use of the Common Assessment Framework/Team around the Family (CAF/TAF) process across Cheshire. The data collection for the CAF/TAF has been strengthened across the Trust, with further work to capture the data from Wirral locality continuing. There was an increase in the numbers of practitioners attending and/or reporting into Child Protection conferences, which strengthens multi-agency decision making in relation to safeguarding children. There has been a increase in attendance from adult mental health practitioners.

The Safeguarding Children Team has become actively involved with the Child Sexual Exploitation (CSE) agenda across all the localities to ensure better safeguarding of children. This has had a significant impact on the workload of the team. The Nurse Specialists gather information on cases and have attended 30 multiagency CSE case meetings on behalf of CWP across localities. It is already evident that as the awareness of CSE increases, volume of work relating to safeguarding children and young people is increasing. Data quality on CSE is being strengthened across the Trust.

3.5 Multi-Agency Risk Assessment Conferences (MARAC)

During 2014/15 CWP Safeguarding has continued to support the MARAC. During 2014/15 Nurse Specialists have attended 80 MARAC which have reviewed 1814 cases referred into the MARAC from all agencies from both adults and children.

There has been a significant increase in the number of cases presented at MARAC which has increased the demand on the service, (table 3) with the most significant increase for Wirral.

Within West, MARAC children's data is also collected in relation to children from GPs in addition to CWP children's services. This ensures that children are better safeguarded as information is appropriately shared to inform decision making in relation to safety planning for children.

Table 3: MARAC Activity

Locality	2014/15 MARAC	2014/15 Cases	2013/14 MARAC	2013/14 Cases
West Locality	30	505	18	469
East Locality	24	363	24	324
Wirral Locality	26	946	26	597
Total	80	1814	68	1390

3.6 Safeguarding Training

Within CWP effective safeguarding practice is underpinned by a robust training programme for all staff working within the Trust. The Training Needs Analysis undertaken by CWP Education identifies the level of training required for each staff group within the organisation. Safeguarding training is part of the Trust's mandatory training programme. The intercollegiate document provides the guidance for the level of training required for each staff group to maintain competence in safeguarding practice.

Training is provided both as e learning packages and face to face training delivered by Specialist Safeguarding Nurses. Staff can also access safeguarding training external to the Trust. Content of the training is reviewed by the Safeguarding service and changes and additions in response to national policy, guidance and local arrangements are approved by the Trust Wide Safeguarding Sub-committee.

Compliance with training is monitored by the Trust wide Safeguarding Sub-committee. Locality safeguarding groups are responsible for ensuring compliance rates are maintained at a local level. See table 4 for compliance during 2014/15 and end of year position.

Table 4: Safeguarding Training Compliance Rates for CWP 2014/15

Safeguarding Training 2014/15	**Number of Sessions Delivered**	**Wirral**	**West**	**East**	**CSS (clinical support services)**	**Trustwide Compliance Rate as at 31/3/15**
Level 1	E-learning (and face to face sessions for volunteers)	84%	87%	89%	91%	88%
Level 2	E-learning	81%	86%	90%	90%	86%
Level 3	8	93%	94%	81%	89%	92%
Level 4 Not delivered by CWP - External courses attended						Named nurse & FNP Supervisor 100% Named Dr 66 %(2 out of 3)

All training is evaluated by participants and table 5 includes examples of comments made by practitioners following attendance at level 3 training.

Table 5: Sample of feedback following training:

From Level 3
"Able to identify potential victims of CSE and what to do"
"Helps me in recognising signs, listening, being able to educate parents and children"
"More aware of indicators and need for direct communication around CSE"
"Increase my awareness of CSE and the indicators of grooming".
To explore areas in choice appointments and partnerships".
"Be more aware of toolkits to identify indicators"
"Very thought provoking – good refresher of safeguarding issues"
"Listening appropriate language to explore past safeguarding issues"
"To continue to listen and hear what is being shared with me"
"Be aware and alert for safeguarding issues in what the clients tell and don't tell"

3.7 Prevent Strategy

CWP continues to develop it's response to the Prevent agenda. The Prevent Wrap awareness sessions for CWP staff have continued throughout 2014/15 and were incorporated into CWP Education induction and mandatory training programme which commenced in July 2014.

The Safeguarding Service has developed an assurance framework and action plan to ensure compliance with the standards and guidance published by NHS England in February 2015: Prevent Training and Competencies Framework. Training compliance is monitored by the Trust Wide Safeguarding Sub-committee and reported to NHS England quarterly. The 3 localities are held to account in terms of compliance with Prevent awareness. Table 6 sets out end of year compliance. CWP has plans in place to ensure compliance is increased to 85% by the end of 2015/16. In addition, all intelligence and referral activity concerning children, young people and adults who may be at risk of radicalisation are reported to NHS England quarterly.

Table 6: Summary of Prevent Wrap Awareness Sessions

	Total no. of sessions including induction for new starters	Total no.	Total no. compliant	Total % compliance at 31/3/15
Clinical staff	31	2281	1280	56%
Non clinical staff	31	951	138	15%

3.8 Safeguarding Supervision

Safeguarding Children Supervison is available for all staff groups across CWP.

The Family Nurse Partnership (FNP) 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 supervison for both supervisiors. At the FNP annual Board report to the FNP national unit, CWP was praised for implementing a robust tripartite supervision model. (A model which involves FNP supervisor, FNP nurse and safeguarding children nurse specialist). 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.This gives practitioners insight into each other's roles and expertise. During 2014-2015 the safeguarding children team delivered a total of 388 individual safeguarding supervision sessions across CWP footprint (this excludes group supervision sessions and ad-hoc telephone supervision). Many of the sessions included more than one case being discussed.

In response to the CQC Safeguarding inspection visit to Cheshire West and Chester in January 2014, CWP has strengthened access to safeguarding supervision for adult mental health professionals. The safeguarding team have co-ordinated an electronic booking system for local 'clinic' style safeguarding supervision sessions to improve access and efficiency across the CWP footprint.

There has also been a programme to strengthen the capability and capacity of the workforce in relation to safeguarding practice. This has been through the Safeguarding Practice Link (SPL) programme.

Safeguarding Practice Links (SPL) have been introduced as a pilot in both Wirral and East localities. Staff are trained practitioners working within their teams. They have been nominated by their managers to develop both their leadership and practice skills. The main function of the SPL is to promote an awareness of safeguarding issues within their team and to signpost their colleagues in respect of their safeguarding concerns and practice. In addition they will promote the requirements of safeguarding supervision. The SPLs have all received a training session pertinent to their locality's needs and at the present time they are promoting their role through team meetings and promotional material. The Safeguarding team are supporting them with this process. The SPLs commit to an update and group supervision bi-monthly where relevant issues can be raised and current information relating to safeguarding issues can be cascaded. In addition to this the SPLs are encouraged to access safeguarding supervision if necessary.

3.9 Serious Case Reviews/ Learning Reviews for Children

During 2014/15 there has been 1 Serious Case Review (SCR) that was commenced by Cheshire West and Chester LSCB in which CWP services have been involved. A further case considered by Serious Case Review panel has met the criteria for review and commenced May 2015.

There is currently an action plan from a previous SCR (Child G) which is nearing completion. There have been a number of multiagency reviews with which CWP have been involved and are summarised in Table 7. Action plans developed in response to SCRs are reviewed at the most appropriate Safeguarding Operational Groups and are overseen and monitored by the Trustwide Safeguarding Sub- Committee.

Table 7: Summary of Reviews that CWP Involved with 2014/15

Type of Review	Local Authority and Board Responsible	Services Involved from CWP
Serious Case Review (Child G)	Wirral LSCB	Adult Mental Health & CAMHS
Critical Case Review Child 2	Wirral LSCB	CAMHS
Practice Learning Reviews PLR 10,11 and 12	Cheshire West and Chester LSCB	A number of services
Multi Thematic Review	East Cheshire LSCB	CAMHS

3.10 Serious Case Reviews/Domestic Homicide Reviews Adults

There have been no adult Serious Case Review (SCR) with CWP involvement during 2014/15. Two Domestic Homicide Reviews (DHR) have been completed in which CWP had service involvement. The recommendations and resulting action plans for each of the individual DHRs have been reviewed by the relevant Safeguarding Operational Group and monitored by the Trustwide Safeguarding Sub Committee.

Actions undertaken by CWP in response to DHR recommendations have included: strengthening record keeping in relation to safeguarding practice, delivery of specific training in relation to domestic abuse and ensuring risk assessment processes are robust.

Table 8: Serious Case Reviews/Domestic Homicide Reveiws Adults

Type of Review	Local Authority and Board Responsible	Services Involved from CWP
Domestic Homicide Review (Adult A and Z)	Cheshire East LSAB	Liaison Psychiatry and Alcohol Services
Domestic Homicide Review (Adult B)	Cheshire East and Preston LSAB	Increasing Access into Psychological Therapies (IAPT)

3.11 Inspections / Reviews

CWP's current registration status with the Care Quality Commission (CQC) is: '**registered and licensed to provide services'**. The Trust has no conditions on its registration and CQC has not taken enforcement action against the Trust during 2014/15.

The Trust has participated in **3** investigations or reviews by CQC 2014/15, which were in relation to the following areas: review of compliance of GP Out of Hours Service and follow up reviews of compliance for Springview and Bowmere.

The outcome of the GP Out of Hours Service review was that the service was compliant across all CQC key questions. Follow up reviews of both Springview and Bowmere found compliance with the standards reviewed.

The Trust has not been involved in any OFSTED inspections during 2014/15, however it has continued to support and implement the East Cheshire Improvement Plan following the inspection of local authority arrangements for the protection of children. The Director of Nursing, Therapies and Patient Partnership is a member of the Improvement Board.

3.12 Assurance Process and Audits

Compliance audit with Safeguarding Children policy was undertaken during 2014/15. The audit demonstrated staff were completing supervision, there was effective record keeping and that they had made appropriate referrals. However, following up the outcome of referrals was not always pursued in a timely manner and the safeguarding team were not notified of outcomes.
CWP participate in multi agency audits. These audits have shown that the escalation process has not been embedded into practice. These issues will be a focus for training and for case auditing during 2015/16.

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.

During 2014/15 Safeguarding Adult Nurse Specialists completed a Domestic Abuse/ MARAC audit of CWP response to domestic abuse and referral processes. The findings from the audit identified staff have a good understanding of the domestic abuse agenda and the referral process into MARAC. Good practice was demonstrated by staff referring victims who were not open to CWP, but were alerted to domestic abuse by the perpetrator who was open to CWP services.

Effective multi-agency and partnership working was identified in all of the cases and proportionate risk information was shared in a timely manner

Internal assurance is supported via serveral methods including In-patient Safety Matrices and unannounced compliance visits.

CWP have submitted Safeguarding Assurance Frameworks for both adults and children to the following CCGs : NHS West Cheshire, NHS Vale Royal, NHS East Cheshire and NHS South.

The Annual Self-Assessment audit of Safeguarding Standards for Children and Adults has also been completed and submitted to CCGs as part of contractual requirements. Action plans in response to the audit and section 11 audit, have been developed and implemented over 2014/15.

Processes are in place to review reported safeguarding incidents via the Datix reporting system. CWP Safeguarding Team receive notification of all serious incidents reported within the Trust through close liason with CWP Safe Services team.

During 2014/15, 2 serious complaints from East Locality have been investigated. CWP has completed internal investigations for both cases, have responded to families and have instigated action plans to address all aspects within the recommendations. These action plans are being monitored by Trust Wide Safeguarding Sub-committee.

3.13 Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS)

During 2014/15 CWP has continued to work to strengthen practice in relation to Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS).

Since the Supreme Court Ruling against West Cheshire, CWP has developed processes to monitor the application and authorisations for DOLS and has provided further guidance and training for staff to ensure a more pro-active approach to MCA.

The following sets out the number of standard authorisations granted by Local Authorities and the number of CWP self-authorised urgent DOLS authorisations during 2014/15.

Table 9: Authorisations of DOLS

DOLS authorised	**2014/15**
Standard authorisations granted by Local Authorities	53
Urgent authorisations (self-authorised by CWP)	67

3.13.1 Training and support for staff

CWP has worked in collaboration with North West Clinical Support Unit to develop an e learning package that incorporates both MCA and DOLS training for staff. This will be implemented during 2015/16.

CWP commissioned training in addition to mandatory MCA/DOLS training in the form of 2 full days sessions facilitated by Aftathought and Hill Dickinson.

CWP has developed 2 types of ‘z’ cards – 1 for MCA and 1 for DOLS that have been distributed to clinical staff that provide a brief summary of key facts for MCA and DOLS.

3.13.2 Monitoring MCA and DOLS data

During 2015/16 CWP aims to strengthen data collection on applications and authorisations for DOLS through developments within the Carenotes recording system.

3.14 Progress on Key Objectives for 2013/ 2014

The table below identifies the objectives set out in 2014/15 Annual Safeguarding Report and the evidence of achieving these objectives. Some of this work will continue into 2015/16.

Objectives	Evidence of Achievements
To continue to work closely with all Safeguarding Boards and align the objectives of the respective boards with those of the Trusts Safeguarding objectives	Representation from CWP in place for all LSCBs and LSABs. Sub groups of these boards have representation from CWP. Key priorities of the Safeguarding Boards are incorporated in to the working priorities of CWP.
To proactively share findings of audits and reviews with the respective safeguarding boards.	CWP have participated in single agency and multi agency audits as requested by the Safeguarding Boards. CWP have responded to requests for internal audits completed by the Trust.
To strengthen the Safeguarding Audit Program to include qualitative case audits covering Safeguarding Children, Safeguarding Adults and Domestic Abuse.	The audit programme for 2014/2015 has included audits to review more qualitative aspects of cases.
To ensure the compliance rates for Safeguarding Training is continually exceeding the minimum requirement and deliver bespoke training tailored to specific staff groups/ services.	CWP achieved required compliance rates by end of year. Compliance has been monitored at each of the Trustwide Sub-committees. Where monitoring has indicated gaps in compliance remedial action has been taken to respond flexibly to ensure staff are trained and therefore have the necessary skills to practice. A number of bespoke Level 3 training sessions have been undertaken in response to local priorities or national agendas e.g. child sexual exploitation. The Safeguarding Assurance Framework provided monthly to cheshire CCGs monitors compliance and for Wirral CCG a training report was provided
Monitor the compliance rate of the HealthWrap Training (PREVENT) and Mental Capacity Act and take appropriate action if identified.	Compliance with healthwrap training has been monitored consistently by Trustwide Safeguarding Sub-committee. The adult Safeguarding Assurance Framework includes this data and is provided quarterly to CCGs and Designated Nurses. Compliance of MCA training is monitored by the Adult SAF
Named Nurse/ Head of Safeguarding to work closely with the Mental Capacity Act Lead	Named Nurse and Head of Safeguarding continues to work closely with those who have responsibility in relation to MCA.
Following the publication of the updated intercollegiate document *"Safeguarding children and young people: roles and*	The intercollegiate document has been reviewed. Training has been reviewed to assess the impact on current training practice. Work continues in 2015 /2016 to move towards full compliance with this guidance.

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 for CWP	This objective will be taken forward into the audit programme for 2015/16.
To undertake a review of the Safeguarding Department	This was completed with a paper submitted to Director of Nursing and Therapies which resulted in an increase in resources to the safeguarding service. The recommendations will be taken forward with CCG partners to work together to address the resources required to continue to provide a Safeguarding function to meet the increasing demands in activity.
Future safeguarding reports to Board to be made available in East to read format	This will be taken forward into 2015/16 with Engagement and Participation work to ensure accessibility of reports to Board. This will include engagement withYoung Advisors in East locality.
To explore systems and processes for gaining feedback from children and adults and their families and carers on CWP safeguarding input into their care	The Trust has commenced the implementation of the Friends and Family Test over the last year. More specific feedback from families will be incorporated into the audit programme for 2015/16. Nurse specialist planned to work with participation engagement services.
To respond to the recommendations/actions identified in each of the localities	The key areas of focus for each locality have been summarised in the Annual Report

4.0 Locality Activity and Performance

CWP is organised into 3 localities – West, East and Wirral. Each locality has a range of services for both children and adults, community services and in-patient provision.

Each locality has differing needs and priorities relating to the services it provides and the different service users. All require effective safeguarding leadership and practice and work in partnership with other agencies and Safeguarding Boards.
Each locality section is set out below and describe the key priority areas, challenges and improvements made over the last year.

What is clear across all, is the increasing complexity of services and increasing need to develop effective relationships across all mulit-agency providers.

The CWP Safeguarding Service works across all localities to ensure compliance with regulatory frameworks, the local Safeguarding Boards and Clinical Commissioning Groups pertinent to each locality area.

CWP continues to support multi-agency partnership working and membership of Safeguarding Boards across all localities is contained in Appendix A.

4.1 East Locality Report

4.1.1 Concerns /Referrals to Social Care for Children

CWP Safeguarding team monitors and reviews all child protection referrals that have been made into Social Care. During 2014/15, 12 referrals were made to Childrens Social Care. All the referrals have been reviewed by the safeguarding nurses and were appropriate.

The TAF data for East locality was not robustly reported upon and this is an area to be strengthened during 2015/16.

The number of concerns/ enquires raised for safeguarding adults in East locality is detailed in table 10.

Table 10 The number of concerns/enquiries made to CWP safeguarding team for adults at risk

Service	2014/15	2013/14
Adult Mental Health	228	214
Learning Disabilities	111	120
CAMHS	2	8
Drug & Alcohol	11	9
IAPT	2	2
TOTAL	**354**	**353**

CWP provide services in other locality areas which are managed by East locality within CWP. There have been 5 enquiries received from the services based in Trafford, 2 enquiries received from the service based in Warrington and 1 enquiry from the service based in Bolton.

4.1.2 Participation Child Protection Conferences

During 2014/15, CWP safeguarding children team received copies of all 178 initial case conference invitations . The number of initial case conferences with clients known to CWP services and therefore attended by CWP was 45 (25% of cases - an increase by 12% from the previous year).

4.1.3 Participation in Child Sexual Expolitation

CWP have been represented by the Nurse Specialist for Safeguarding Children at 8 CSE operational group meetings.

4.1.4 Adult Protection Conferences/ Strategy meetings/Professional meetings

There have been 2 ongoing Adult protection case conferences with which CWP have been involved. CWP staff continue to attend Strategy and Professional meetings in relation to Safeguarding Adults. During the year, CWP responded to a major incident involving Saddlebridge Unit. CWP completed an internal investigation which was submitted to the Local Authority Strategy meeting in December 2014. The resulting action plan has been monitored by CWP Operational Board.

4.1.5 Domestic Abuse

CWP participated in the MARAC process in Cheshire East and have attended 24 MARACS where 363 cases were discussed. This is an increase in cases of 11% on 2013/14 activity. CWP have participated in a MARAC multi agency case audit to examine how MARAC impacts on the family whilst identifying good practice and learning outcomes for all partner agencies. The Adult Nurse Specialist contributed to Her Majesty's Inspectorate of Constabulary (HMIC) reflective review of a domestic abuse case which reviewed the individual's progress through the criminal justice system and multi-agency response.

CWP have continued to participate in the Cheshire East Domestic Abuse Partnership (CEDAP) MARAC Steering Group.

4.2 Key Innovations and Developments for East Locality

4.2.1 Partnership working in Domestic Abuse

East Locality was successful in contributing to a bid by Cheshire Without Abuse (CWA) for innovation funding to develop the Domestic Violence Perpetrator programme. This resulted in a two year funding stream for three facilitators to work on the programme to strengthen the links with CWP East's mental health and substance misuse services. The aims of this programme are to support earlier detection of issues relating to a person's mental health, appropriate referral to the right service and improved communication and joined up working between services. The development of this programme and recruitment to the posts is underway and will be carried forward as a key area of development during 2015/16.

The Adult Nurse Specialists and Domestic Abuse Practitioner are developing a training package with the Coordinator of Domestic Abuse Family Safety Unit (DAFSU) to facilitate mental health awareness sessions to the Independent Domestic Violence Advocates (IDVAs).

4.2.2 Participation and Engagement – Young Advisors

Last year's annual report described the future plans to establish a group of Young Advisors in East locality. Child and Adolescent Mental Health Services (CAMHS) in the East locality have a well-established programme of engagement with service users in all areas of service design, development and delivery. Young people have worked with CAMHS to raise mental health awareness in local schools, sharing their lived experience with CCGs and NHS England and working closely with recruitment processes within CWP.

CWP has become the first health trust in the country to adopt the Young Advisors social enterprise model to empower young people to influence local decision making and service improvement. 12 young people who access CAMHS have now completed nationally accredited training to form an established group of Young Advisors for CWP. Aged between 15 and 21, Young Advisors are trained agents of social action who guide local authorities, housing associations and other local partners about what it is like for a young person to live, work, learn and play in their neighborhood.

CWP Young Advisors have been commissioned to work on 23 projects. Examples of this work locally and nationally include: commissioning of East Cheshire Sexual Health Services, working on the councils 'Vision for Crewe', working with Dementia Care services to give a perspective on young people's understanding of dementia and working with the Canal and Riverside Trust to develop their website and app to make it more inclusive for young people.

4.2.3 Training

East locality has worked in partnership with CWP Safeguarding Service to plan Safeguarding Level 3 training during 2014/15. The training was responsive to the needs of staff and was delivered by external agencies. The key topic areas covered were Child Sexual Exploitation, historic abuse from the perspective of an adult and neglect training. Feedback from the training is highlighted in table 5.

CWP contribute to the LSCB training to ensure expertise within CWP is shared to strengthen the multi-agency workforce. Within East locality the Nurse Specialist for Safeguarding Children contributes to the LSCB training that covers mental health issues, drugs and alcohol and domestic violence - 'toxic trio' training.

4.2.4 Involvement in Thematic Review of Suicides

Following the thematic review of suicides within East Cheshire a number of work streams were developed across multi-agency partners in response to the recommendations.

The work streams with which CWP East have been involved with include the following:

- Establishment of suicide and self-harm prevention group – CAMHS 0-16 team have membership of this group and will continue to work collaboratively with partners to implement and monitor the suicide and self-harm prevention plan based on current government guidelines.
- Contribution to training programme for suicide and self-harm – CWP East CAMHS was awarded funding from East Cheshire CCG following feedback from Young Advisors on their experience of services when they were in crisis. This funding is to develop and deliver training to A and E department, paediatric wards and GP surgeries. It is anticipated that an additional amount of funding will enable a Primary Mental Health Worker to work with Young Advisors to develop and deliver this training to a level that will meet the recommendation of the review.
- Review of CAMHS in East Cheshire – level of provision, access, joint working with other agencies – CAMHS management have been working closely with commissioners to provide evidence of the service areas requiring increased resource. There has recently been an agreed increase in investment of 1 whole time equivalent Case Manager Therapist for Vale Royal and South 0-16 team and the same investment for the 16-19 teams. There has been increased resource provision from East CCG for the 16 – 19 service.
- Future planning on suicide prevention and self-harm to include views of young people – see the Young Advisors work described above

4.2.5 Future Actions and Recommendations

The following areas of work will be progressed during 2015/16:

- Ongoing work with LSCB in the new structure of sub groups
- Named nurse to attend newly formed Safeguarding Children Operational Management Group and attend case review/audit sub group as well as CSE. Sub group
- For CAMHS to continue on various work streams in response to the multiagency recommendations from the thematic review.

4.3 West Locality Report

4.3.1 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.

4.3.2 Paediatric Liaison and Child Death Overview Report

The Nurse Specialist for Paediatric Liaison plays an essential role in the sharing of appropriate information between Acute Trusts and CWP services by communicating directly with Health Visitors, School Nurses and other community health practitioners.
The Nurse Specialist for Paediatric Liaison has regular contact with the Countess of Chester NHS Foundation Trust (COCH) Safeguarding and Domestic Abuse Team.

There is a robust communication pathway between the COCH Acute Trust and Paediatric Liaison Nurse Specialist in order to communicate any identified high level concerns for children and families attending any of the hospital departments.

Relevant community practitioners are informed of any child that has been referred by the health care practitioner as identified children with child protection plans; child in need plans or those with looked after status. This prompt liaison improves multi agency and multi professional communication thus enhancing positive outcomes for children and families.

The attendance of adults presenting to Accident or Emergency or hospital departments with any issue, which may increase the vulnerability factors for children are communicated promptly. This includes information following referrals to Children's Social Care arising from the attendance of an adult, for example following domestic abuse incidents, self-harm and a range of mental health issues.

COCH Midwifery Service communicates with the Nurse Specialist directly. For example, information regarding women attending and undergoing therapeutic termination of pregnancy, those who have experienced still births or mothers attending the COCH Labour Ward with any identified vulnerabilities. This information is communicated securely to the relevant Community Practitioners. To ensure effective timely communication happens and transfer of care can be planned and seamless.

The COCH neo natal and paediatric ward staff will communicate with the nurse specialist directly. The ward staff highlight admission of those children with child protection, child in need or looked after status, and will also highlight admission to the unit for very young babies, children admitted due to mental health concerns and self-harm and children with newly diagnosed acute or chronic conditions such as malignancies, diabetes or epilepsy which may impact on their long term health and wellbeing and may impact on the wider family functioning. All admissions to the COCH neonatal unit are referred to the nurse specialist. This information when received is liaised to the relevant Community Practitioners.

Table 11: Figures for liaison and Child death from April 2014 –March 2015

Month	April 14	May 14	June 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Total
Child Deaths	1	0	0	1	0	0	0	1	0	2	1	0	**6**
Neo natal deaths	0	1	0	0	2	1	0	0	0	0	0	0	**4**
Complex liaison from COCH- Chester and Ellesmere Port area	31	36	32	31	22	30	19	28	33	29	29	35	**355**
Complex liaison from COCH Flintshire area	10	10	11	11	8	6	13	15	9	1	5	7	**106**
Complex liaison out of area	1	3	2	6	2	4	0	2	0	0	3	2	**25**
Liaison- neonatal unit	32	37	37	42	43	45	42	56	64	31	38	31	**498**
Liaison paediatric ward	29	34	43	43	25	52	58	67	50	48	33	51	**533**
Liaison –urgent Care unit	0	1	0	0	0	0	0	1	0	0	0	0	**2**
Liaison- Out of Hours	8	2	1	6	2	2	2	0	1	2	2	0	**28**
									Total of all Liaison (excludes out of area hospital				**1557**

During 2014/15, the paediatric liaison service has dealt with daily reports in relation to the following:

- COCH Accident and Emergency department - **11,535** visits to the department by children up to the age of 16 years.
- Chester Urgent Care Unit - **2,749 visits** to the department by children up to the age of 18 years
- COCH Neonatal unit - **498** admissions

- COCH paediatric ward - **533** paediatric liaison referrals

- North West Ambulance Service (NWAS) – 81 referrals to Social Care notified to liaison service and communicated to relevant practitioners

Additionally out of area referrals are communicated to the relevant health services. The mobilisation of the 5-19 service commissioned by Cheshire West and Chester which includes Vale Royal and Neston has increased the activity and demand for the Paediatric Liaison Service.

Missing children identified via the Cheshire West and Chester LSCB are reviewed by the Nurse Specialist and forwarded as appropriate to community practitioners for wider awareness.

The nurse specialist attends quarterly regional liaison meetings. Effective regional communication and information sharing is valuable and ideas are shared and developed to increase the effectiveness of the Paediatric Liaison role, processes and learning and enhance the public health messages across the regional footprint.

The CWP has a Service Level Agreement with Betsi Cadwallader Health Board to provide a liaison service covering Flintshire. A recent report was developed for Flintshire which enabled a retrospective analysis of complex liaison (2013/2014) and demonstrated that the majority of complex Flintshire liaison referrals were identified as Safeguarding. The analysis complex liaison from COCH for Flintshire total 104. Of the 104 complex liaison referrals 86 (83%) were identified as Safeguarding.

4.3.3 Training

Quarterly updates and induction training are delivered by the Nurse Specialist for Paediatric Liaison to community practitioners working in physical health services, to ensure a good understanding of the paediatric liaison and Child Death Overview Panel (CDOP) roles and to ensure that effective links are established with practitioners.

4.3.4 Child Death Overview Panel

The nurse specialist is a core member of the Pan Cheshire Child Death Overview Panel (CDOP) There have been 4 meetings in the Pan Cheshire forum during 2014/15. with an additional half day meeting to review cardiac deaths specifically, with the attendance of a cardiac paediatrician from Alder Hey NHS Foundation Trust to provide a specialist view. There has also been specialist input for review of neonatal deaths.

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.

During 2014/15 there have been 10 child deaths. The nurse specialist has been part of the Sudden Unexpected Death in Infant or Child (SUDIC) protocol response and has attended rapid response meetings as required. The nurse specialist has coordinated the health response to the Pan Cheshire CDOP panel in a timely way whilst providing supervision to the CWP staff involved and signposting them to staff services if required for additional support.

The nurse specialist has provided health information when requested to out of area CDOPs as requested for children resident out of area but in receipt of CWP services e.g. CAMHS.
Information has been cascaded to staff in response to areas highlighted by the Pan Cheshire CDOP – eg Safe Sleep information and training. The Nurse Specialist has been requested to support the development of multi-agency safe sleep training by the LSCBs.

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.

The nurse specialist attends quarterly regional CDOP meetings and has been part of the Pan Cheshire CDOP group to review and update the SUDIC protocol. Effective regional communication and information sharing is imperative to enable parity across the footprint. Ideas and learning can be shared and developed to increase the effectiveness of the CDOP process and development.

4.3.5 Children in Care (Looked After Children)

The Children in Care team has faced a number of challenges during 2014/15. This has included changes in staff and the associated loss of specialist knowledge and the mobilisation of the 5-19 service in January 2015, in addition to an upward trend across the locality of children coming into care. The numbers of Children in Care show an overall increase, including the number of children aged 16 plus years, where the Nurse Specialist is the identified health professional.

Table 12 indicates the number of children in care within the CWP footprint as at 31/3/15. Previous year's figures are also shown for a direct comparison and it can be seen that this is an overall increase by 46% compared to last year. This increase in number of Children in Care has had a direct impact on increasing the number of statements being requested from CWP services for Public Law Outline and Care Proceedings. This has resulted in an increase workload for the Nurse specialists and Named Nurse in supporting staff in producing high quality reports for court in a timely manner to ensure full health information is available for the courts to make a timely decision for children.

The Children in Care Nurse Specialists have provided clinical supervision for Health Visitors and School Nurses in respect of children on their caseload with Looked after Children status. However due to staff vacancies this has not been provided proactively but responsive to staff requests.

The Nurse Specialists provide training at least every quarter for all Health Visitors, School Nurses and Family Nurses recruited to CWP (and staff returning from extended leave). Staff understand the importance of promoting the health of Looked after Children and the role they have to improve health outcomes for children.

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.

Table 12: Number of Children in Care residing within CWAC as known to CWP

	2014/15	**2013/2014**	**2012/2013**
Cheshire West and Chester Local Authority Looked After Children	506	286	260
Children Looked After by other Local Authorities living in West	132	108	100
Total Number of Cheshire West and Chester Local Authority Looked After Children Placed Out of Area	154	135	138
Total Number of Children in Care Living within Cheshire West and Chester local Authority Boundary	**484**	**261**	**222**

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 Independent Reviewing Officers 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 service users.

The challenge for the service is the increase in number of Children in Care and specifically the increase in those over 16 years old. Further investment made by CWP has allowed the service to recruit a Band 6 Nurse for Children in Care (due to commence in July 2015) and an administrator to support the team (commenced in February 2015) to address this. It is also important to note that there has been a dramatic increase in the number of children who are subject to a care order currently residing with a parent (70 as at end of March 2015).

4.3.6 Reviews and Audits

CWP continues to participate within the Practice Learning Reviews and Audits and has participated in the LSCB Case audit programme. CWP have been involved in 2 SCR panel meetings and both cases met the criteria for an SCR. One SCR has commenced with the other due to start. In both cases the Named Nurse is supporting the practitioners throughout the 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.

4.3.7 Concerns /Safeguarding Referrals for Children and Adults

CWP Safeguarding team monitors and reviews all child protection referrals that have been made into Social Care. There have been 41 referrals made by services in the West locality. All the referrals have been reviewed by the safeguarding nurses.

Adult concerns and enquiries have increased during 2013/14 as detailed in table 13.

Table 13: The number of concerns/enquiries made for adults at risk - West

Service	**2014/15**	**2013/14**
Adult Mental Health	283	247
CAMHS	3	1
Drug and Alcohol Services	9 until 31st January 2015	8
Learning Disabilities	93	52
Home intensive Team	2	6
Aging Well (District nursing)	0	7
Total	**390**	**321**

4.3.8 Participation Child Protection Case Conferences

Table 14 illustrates the activity for child protection for the West locality. There has been an increase in activity for CWP services compared to 2013/14.

Table 14: Number of conferences attended

Service	2014/15	2013/14
Number of initial child protection conferences	105	82
Number of review child protection conferences	247	170
Number of reports provided for Child protection conferences	438	379

4.3.9 Early Support and Team Around the Family (TAF)

During 2014/15 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. The data for the number of CWP practitioners involved within the CAF / TAF process is showing an average of 103 practitioners per month with the majority from the Starting Well Services. The TAF process captures the voice of the child, ensuring the wishes and feelings of children receiving early support inform outcomes.

CWP have a 1 WTE Band 7, currently seconded into the multi-agency Early Support Access Team (ESAT) service of CWAC.

4.3.10 Child Sexual Exploitation

CWP have seconded a Nurse Specialist for Child Sexual Exploitation into the newly formed Multi-agency Team for CSE. This nurse will provide health advice to the team and also undertake assessments on young people who are at risk of CSE as well as coordinating health information from all health partners and provide multiagency training. The input from the Nurse Specialist ensures that the health needs of young people are addressed to improve health outcomes.

4.3.11 Adult Case Conference

There have been no adult case conferences known to CWP during 2013/14. However, staff continue to attend Strategy and Professional meetings.

4.3.12 Domestic Abuse

CWP participated in the MARAC held in Cheshire West (including Vale Royal). CWP have attended 30 MARACS. There has been an increase of 40% in the number of MARACS attended in the last 12 months. In 2013/14, 18 MARACS were attended. The number of cases referred into MARAC by agencies has also increased to 505 from 469 cases. The Safeguarding Children Nurse Specialists are now attending the Vale Royal MARACs following the mobilisation of the 5-19 Service in January 2015 to ensure information about children is shared and appropriate safeguards are in place for children.

4.3.13 Supervision

In order to strengthen the clinical supervision within the Starting Well services for cases at level 3 on the continuum of need model, 27 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 who have completed this supervision training will provide supervision for staff managing TAF cases.

Safeguarding supervision continues to be provided across the locality by the safeguarding children team.

4.3.14 Service User Feedback

Service user involvement is an essential part CAMHS service in West and has an active service user group. Service users have interviewed CAMHS Managers regarding the service, contributed to recruitment processes and are meeting with the safe school partnership staff to discuss on line internet safety. CAMHS have presented nationally regarding the Children and Young People Increasing Access to Psychological Therapies (CYPIAPT). CAMHS interventions include choice and partnership with young people in setting goals jointly to ensure a partnership approach to care.

The Family Nurse Partnership (FNP) continually seeks out service user feedback at key parts of their programme and the FNP Annual Report reflects case studies and feedback from clients.

Service user feedback in both adults and children's safeguarding 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.

4.3.15 Service Developments for West Locality

4.3.16 Adult Mental Health Services

CWP West adult mental health services have continued to develop over the last year. The Recovery and Review service model for community teams is now established with a single point of access for mental health referrals. There are stronger links between the Recovery College and Community Mental Health Teams (CMHT) to ensure more effective and co-ordinated care for service users.

Teams have continued to improve their safeguarding practice in relation to children through improved work with children's social care. This has included working closely with Social Workers, attending case conferences and Team around the Family (TAF) meetings to ensure concerns in relation to adult mental health and the impact on children is fully understood.

4.3.17 Primary Care Mental Health Services

The Primary Care Mental Health Service (PCMHS) has strengthened the transition between children's and adults mental health services. PCMHS accepts referrals from young people over the age of 16 and has developed protocols with the 16-19 service to ensure effective management of young people during this transition period. A recent development has been to have a Child and Adolescent Psychiatrist overseeing the care of young adults who remain in PCMHS to ensure that their care needs are fully met. A number of staff within the service have had additional training in relation to working with young adults in recognition of the specific needs and vulnerabilities of this group of service users.

4.3.18 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 are offered access to the School Nursing service 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.

4.4 Wirral Locality Report

CWP Wirral continues to support multi-agency working to address the complex issues for service users. This has included membership of a Multi-agency Action 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.

4.4.1 Safeguarding Training

Wirral locality has delivered level 3 Safeguarding training on Child Sexual Exploitation. Wirral locality is participating in the pilot for Safeguarding Practice Links (SPL) described earlier to ensure the capability of the service to safeguard both children and adults is strengthened.

4.4.2 Concerns/ Safeguarding Referrals - Children

CWP Safeguarding team monitors and reviews all child protection referrals that have been made into Social Care. During 2014/15, 28 referrals were made to Social Care. During 2013/14 this was 25. All the referrals have been reviewed by the safeguarding nurses and were appropriately referred into social care.

4.4.3 Concerns/ Safeguarding Referrals for Adults

The number of concerns/ enquires raised for safeguarding adults in Wirral is detailed in Table 15. During 2014/15 there were 181 concerns/enquiries received by CWP safeguarding adult team. Challenges continue to exist for practitioners in managing processes for reporting on systems for both CWP and Wirral Local Authority. This will be taken forward during 2015/16.

Table 15: The number of concerns/enquiries made for safeguarding adults at risk

Service	2014/15	2013/14
Adult Mental Health	161	173
CAMHS	1	4
Drug and Alcohol	5	6
LD /CAMHS	14	9
Total	**181**	**192**

4.4.4 Participation Child Protection Case Conferences

CWP Safeguarding Team began to receive notification of initial child protection conferences. This has enabled CWP to ensure that appropriate representation is made at the case conferences and allows CWP Safeguarding team to proactively offer safeguarding children supervision. From April 2015, robust data should be available for scrutiny regarding CWP participation in child protection work.

4.4.5 Child Sexual Exploitation

The Named Nurse/ Nurse Specialist for Safeguarding Children has been attending the CSE operational meetings for CSE in the Wirral Locality on behalf of CWP services. To ensure support and help is co-ordinated for children and their families

Wirral locality staff have attended regular update training provided by the Local Authority. This allows them to take an active role in making appropriate safeguarding and gateway referrals as well as taking part in TAF processes and instigating these through completion of CAFS and being lead professionals. Staff frequently attend TAF and liaise closely with family support workers, school learning mentors, school nurses as well as social workers

4.4.6 Adult Protection Case Conferences

CWP Safeguarding Team has not been notified of any adult safeguarding case conferences being held. CWP staff continue to attend Strategy and Professional meetings.

4.4.7 Audit

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 learning from the audits are shared and disseminated across services.

4.4.8 Service Developments

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*".*

Work has been undertaken this year to ensure that all Adult Mental Health Services "think family" and consider impacts upon children when caring for an adult. This has included work with adult teams (in particular psychiatric liaison and home treatment teams) to develop post-natal management plans for patients who are known to become unwell after giving birth, which include thinking about and planning for any child safeguarding issues in advance.

CAMHS have developed robust internal risk management and safeguarding procedures to ensure issues are raised and discussed and safeguarding practice is strengthened.

Wirral is piloting the Safeguarding Practice Lead (SPL) programme described earlier and to date 17 staff have been identified and trained.

Partnership work is integral part of CAMHS, who work closely with local agencies, sharing information where appropriate and attending multiagency meetings to ensure that young people and families receive the most appropriate support. Staff work alongside education (through learning mentors), local authority, social workers and community paediatrics. Staff attend TAF, CIN and LAC meetings as required, and are also involved in the new EHSC plans.

CAMHS have developed a training menu for external agencies so that they can enhance their knowledge of mental health difficulties and support the young people they work with. The "Kidstime" project has led to partnership working between CAMHS and Wirral Youth Theatre and has provided a service to young people and their parents/carers. CAMHS have worked in partnership with local schools to run the peer mentoring project which has led to increased awareness of mental health. CAMHS have a social care partnership team with separate referral processes who work alongside colleagues in social care , and accept referrals directly from them for Looked After Children, those who have a child protection plan or a child in need plan

4.4.9 Service User Feedback

CAMHS use Friends and Family questionnaires for both carers and children to ensure the experience of service users is captured and informs service improvement.

CAMHS utilise the Youth Advisory Partnership Group to ensure effective involvement of young people to shape service development. They have advised on the design and implementation of a range of events, campaigns and services and have helped to produce youth-friendly documents and resources.

4.4.10 Future Recommendations

To continue to respond to the practitioners concerns regarding the complexity of navigating multiple systems when reporting safeguarding adult concerns, by monitoring safeguarding activity through audit and the new safeguarding practice leads within teams.

It has been identified that future reporting still needs to be strengthened across a number of areas 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.

To continue to develop and train safeguarding practice leads and roll out to all adults and children's teams across Wirral.

Table 16: 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**

4.4.11 Adult Protection Case Conferences

CWP Safeguarding Team has not been notified of any adult safeguarding case conferences being held. CWP staff continue to attend Strategy and Professional meetings.

4.4.12 Domestic Abuse

CWP Safeguarding have attended and participated in all 26 MARAC meetings held on the Wirral. A total of 946 cases were listed, averaging 36 cases per listing. 24 of these referrals were made to MARAC by CWP Safeguarding (as they are responsible for the triage and loading of any referrals completed by CWP staff onto the electronic referral system). 10 of these referrals came from the CWP Drug and Alcohol Service, which was no longer provided by CWP from January 2015, with the remaining 14 referrals coming from mental health services.

4.4.13 Hate Crime – CWP Safeguarding have contributed to, but not attended, all 12 Wirral Hate Crime MARAC listings. A total of 366 cases were listed, averaging 30 cases per listing. No referrals were made by CWP.

5. Trust Wide Objectives for 2015/16

The following objectives have been identified as key areas for development for the coming year:

- Develop opportunities for children, young people and their families to give feedback on their experience of CWP's approach to safeguarding
- Launch and implement the new level 3 safeguarding Children training programme
- Review of the Safeguarding Practitioner Link pilot
- Strengthen the safeguarding audit programme to evidence improvements in practice and learning from SCR, PLR and case audits.
- To undertake a survey of staff experience of utilising CWP Safeguarding service.
- To continue service development of the Children in Care Team
- For the Named Nurse for Safeguarding children (with the Children in Care Team) to implement the guidance "Promoting the health of children in care and the intercollegiate guidance document.
- To work with CCGs to address the increasing pressure on the Safeguarding Service to ensure appropriate resources
- To work in partnership with all Safeguarding Adult Boards to respond to the introduction of the Care Act 2014.
- In response to the integrated agenda between Health and Social Care, the Head of Safeguarding will support the General Managers into ensure safeguarding arrangements are robust.

These objectives reflect the current and emerging agendas across the locality areas and reflect national and Safeguarding Board priorities as well as internal objectives specific to CWP.

6. Conclusion

CWP has continued to work in partnership across each of the local Safeguarding Boards for both adults and children. The Trust has worked closely with the Adult Boards as they have prepared for their statutory responsibilities under the Care Act in place from 1st April 2015.

The Trust has assessed compliance with regulatory standards in relation to children through completion of the Section 11 Audit self-assessment. The Trust has completed a self- assessment against adult standards based on the 6 principles of adult safeguarding. For Children in Care the report has demonstrated how it has met the statutory guidance

The report demonstrates how CWP has responded to the key objectives set for 2014/15. A number of these objectives will be taken forward into 2015/16 as work progresses in key areas.

7. Recommendations

The Board are asked to approve the 2014/15 Annual Report on Safeguarding Adults and Children (including Children in Care) and to note the work of the Safeguarding Team and the three localities.

Appendix A – CWP Membership of Safeguarding Boards and Sub Groups

CWP EAST LOCALITY

Table 1: CWP Representation at Boards and Sub Groups

East Cheshire LSCB Board	Director of Nursing, Therapies and Patient Partnership
East Cheshire LSAB Board	Associate Director of Nursing and Therapies
Training & Development Sub group (Joint)	Nurse Specialist for Safeguarding
Case Review Sub group (Joint)	Nurse Specialist for Safeguarding Adults & Children
CEDAP Commissioning & Development Sub group	Nurse Specialist for Safeguarding Adults
Information and Quality Assurance Sub group	Nurse Specialist for Safeguarding Adults
Domestic Abuse Sub group	Nurse Specialist for Safeguarding Children
LSCB CSE Sub group	Nurse Specialist for Safeguarding
LSCB Performance Management & Quality Assurance Sub group	Named nurse/ Specialist for Safeguarding Children

CWP WEST LOCALITY

Table 2 : CWP Representation at Boards and Sub Groups

CWaC LSCB Board	Director of Nursing, Therapies and Patient Partnership
CWaC LSAB Board	Associate Director of Nursing and Therapies
CDOP Child Death Overview Panel (Pan Cheshire)	Liaison Nurse Specialist for Safeguarding Children
LSCB CSE Missing from Home	Nurse Specialist for Safeguarding Children
LSCB Performance Management Quality Assurance Sub group	Named Nurse for Safeguarding Children
Learning and Development sub group (Joint)	Named Nurse for Safeguarding Children
LSAB Quality and Assurance Sub group	Nurse Specialist for Safeguarding Adults
LSCB Safeguarding Children Operations Management Sub group	Named Nurse / Nurse Specialist for Safeguarding Children
Domestic Abuse Partnership Strategic Management group	Nurse Specialist for Safeguarding Adults

CWP WIRRAL LOCALITY

Table 3: CWP Representation on Boards Sub Groups

Wirral LSCB	Director of Nursing, Therapies and Patient Partnership
Wirral SAPB	Associate Director of Nursing and Therapies
LSCB Performance and Quality Assurance Sub group	Named Nurse for Safeguarding Children
SAPB Serious Case Review Sub group	Nurse Specialist for Safeguarding Adults
Learning & Development Sub group (Joint)	Nurse Specialist for Safeguarding Adults and Named Nurse for Safeguarding Children
Safeguarding Adult Policy Sub group	Nurse Specialist for Safeguarding Adults
LSCB Policy Procedure and Performace Sub group	Nurse Specialist for Safeguarding Adults
LSCB Child Sexual Exploitation	Named Nurse for Safeguarding Children
Staying Safe Group (Childrens Trust)	Named Doctor for Safeguarding

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Annual Medical Appraisal report
Agenda ref. no:	15/16/45
Report to (meeting):	Executive Board
Action required:	Discussion and Approval
Date of meeting:	28/07/2015
Presented by:	Dr Faouzi Alam, Medical Director

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

REPORT BRIEFING

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

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

Following the AOA, designated bodies are encouraged to produce a status report and review their organisation's developmental needs in this area.

The board is asked to receive this status report and complete a statement of compliance (appendix 1) , submitting it to NHS England by 30/9/2015.

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

The systems for appraisal and revalidation and responding to concerns have all gone reasonably smoothly over the last year.
It has become clear that the workload for the Medical Education Manager had become untenable so this post has now been reorganised to comprise a Med Education Manager (looking primarily at training) and a Medical Workforce manager (looking after appraisal and revalidation).
The new electronic appraisal system (SARD) has been rolled out and is garnering positive feedback.

Assessment – *analysis and considerations of options and risks*

1. Recommendations on doctors' fitness to practice
31 recommedations for revalidation were made to the GMC between 1/4/14 and 31/3/2015: these include 4 people who were formally deferred all of whom later had positive recommendations. 5 appraisals were approved as missed or incomplete of which 2 were officially on leave (maternity and longterm sick) and 3 were so late being undertaken or signed off they were outside the 15 month window.
2. Arrangements for medical appraisal
We now have 33 appraisers, of whom 16 were newly trained over the last 12 months. 4 doctors have attended appraisee training in the last year. Systems for assuring the quality of appraisals has been tightened up with regular opportunities for appraisers to share good practice and more reliable systems to identify problems in prescribing and use of MHA.
3. Arrangements for responding to concerns
There have been 3 formal investigations into doctors' practice over the last year.

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

The Board is asked to approve this report and the Chief Executive is asked to sign the attached statement of compliance and return it to the medical Education manager who will forward it to NHS England.

Who/ which group has approved this report for receipt at the above meeting?	Click here to enter text.
Contributing authors:	Geraldine Swift, Faouzi Alam, Sarah Carroll

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
Click here to enter text.	Click here to enter text.	Click here to enter text.

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

Appendix no.	Appendix title
1	Doctors' Revalidation, Appraisal and Concerns Annual Report 2014)15

(15_16_45) Doctors' Revalidation, Appraisal and Concerns Annual Report 2014/2015

This appendix contains a more detailed analysis on the recommendations made regarding:

1. CWP's doctors' fitness to practice;
2. Arrangements for and outcomes of medical appraisal;
3. Arrangements for and outcomes of responding to concerns involving doctors.

For brevity, it does not cover background information on appraisal or individuals' responsibility except where this has changed compared to last year's report.

1. Recommendations on Fitness to Practice

CWP has 98 doctors for whom Dr Alam as RO is responsible: 83 consultants, 14 SAS doctors and 1 doctor on a short-term contract. This excludes medical trainees from Deaneries and GPs doing sessions in CWP where the bulk of their work is within primary care.

31 recommendations for revalidation were made to the GMC between 1/4/2014 and 31/3/2015. 4 doctors were deferred, all of whom subsequently received positive recommendations and counted in the 31 above. The main reasons for deferral were around providing more evidence: in particular garnering 360 feedback from patients can be a challenge for some doctors when their patient group involves people who are acutely unwell or cognitively impaired. All recommendations were completed on time and there were no notifications for non-engagement.

2. Appraisal

a. Activity levels of appraisal:

NHS England have brought in new categories for counting appraisals in recognition of the fact that minor issues regarding timing are not necessarily of concern –e.g. "1b" appraisals include situations where the appraisal is completed but there is a delay of more than 28 days before the doctor and appraiser sign it off. Approved incomplete appraisals are also not necessarily a problem: in CWP's case, 2 of these were doctors who were on leave (maternity leave and longterm sick leave respectively) whereas 3 represent doctors who were so late being undertaken or signed off that they were outside of the 15 month period and these are obviously more of a concern.

- Number of completed appraisals where all went fully according to plan (1a) – 76
- Number of completed appraisals where there were minor problems in timing (1b) - 17
- Number of approved incomplete appraisals – 5
- Number of unapproved incomplete appraisals – 0

The new categories mean that one cannot directly compare with last year. However in 2013/14, 32 doctors fell outside the 28 day sign off period (so would count as 1b in this year's classification system) and 5 doctors did not have an appraisal. This improvement reflects the medical workforce in

CWP becoming more familiar with the increasing rigour expected in appraisal, as well as the hard work of the Medical Education and Workforce Office in supporting doctors to meet these expectations.

b. Appraisers

Training sessions for both appraisers and doctors being appraised were held over the past 12 months. 16 new appraisers were trained and 4 appraisees. CWP now has 33 appraisers in total which is more than we strictly need: however doctors who attend training as an appraiser tend to become more enthused about the appraisal process and this impacts on their own appraisal. Thus it is anticipated that offering appraiser and appraisee training will continue in future years.

A twice yearly peer group (appraisal support group), facilitated by the AMD has been set up as per the plans in last year's annual report and has met twice. Such a group is recommended by NHS England and is to ensure that appraisers receive on-going support and good practice is shared.

c. Quality Assurance of Appraisal

Outline of quality assurance processes:

For the appraisal portfolio:

- Review of all 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 (MEM).
- Review of all 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.
- Since last year and in line with plans in last year's report, we have introduced new checks where data on prescribing outliers is routinely sought from pharnacy; and we also now seek information from MHA office on any problems in the use of MHA. This information is requested by the MEM and uploaded to the appraisal portfolio.
- The recommendations from NHS England that each doctor is appraised for a maximum of 3 years by a single appraiser has meant that more and more doctors have an appraiser who is not their line manager. This offers a fresh pair of eyes and a different approach for the appraisee. It can mean that if there were challenges or difficulties during the year that the appraisee does not bring up at appraisal, then the appraiser might not know of their existence. This was picked up by the MEM and AMD in a few instances and appraisers and appraises were asked to have a further conversation before the appraisal was signed off.

To avoid this complication, we have introduced a new system where a CD who is not appraising one of their own doctors is now automatically notified of the appraisal date. The CD is asked to highlight any instances of outstanding practice or concerns that have occurred during the year to the appraiser and appraisee.

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.

d. Themes from Appraisals 2014/15

In general CWP doctors engage well with appraisal. A few doctors need a lot of support and prompting from MEM to prepare and almost always this relates to more general organisational difficulties rather than a rejection of the appraisal system.

For revalidation, NHS England highlight the importance of 6 key areas (feedback from colleagues and patients, SUIs and complaints/compliments, quality improvement and continuing professional development). Appraisals in CWP and the summaries of the appraisals are consistent in covering these areas.

Several specific areas have been identified where progress has been made but there is still room for improvement. These include:

- Encouraging doctors not just to include data in their portfolio but to make sense of their own data through reflection and discussion
- Supporting doctors to make their PDP objectives more specific, measurable and within an agreed time frame
- Collecting and analysing information from their work outside CWP with the same rigour as that within CWP – whether private practice or voluntary work

e. New developments in appraisal in 2014/2015

Aside from the developments referred to above, the other changes within appraisal have been the introduction of the SARD electronic appraisal system and the introduction of a new 360 feedback form.

SARD was introduced in Spring 2015 with doctors beginning to store their appraisal information on it: the first completed appraisals occurred after the period covered in this report. Initial feedback is very encouraging – doctors report finding it easy to use and intuitive. Some training sessions have been set up but the majority of doctors do not find that they need to attend specific training. All appraisals in 2015 will be completed using the SARD system.

The new 360 feedback form was introduced in response to observations that a scored system does not help doctors understand well what they are doing well or where they may need to make changes. The majority of doctors score very highly so the system does not discriminate well between performance that is good and that which is excellent. As a result there was a consensus among doctors that the additional remarks were the most useful aspect. The new forms therefore avoid all scoring , instead asking for comments about what the doctor is doing well and where the doctor may need to make changes. In general staff feel this has been a helpful development: we will continue to seek feedback and amend the form as appropriate.

f. Plans for 2015/2016

Last year we had planned to improve feedback to appraisers: because of resource issues, this did not prove possible. These plans will now be implemented in 2015/16 and include:

- An annual record of the appraiser's reflection on their appraisal practice and appropriate continuing professional development
- An annual record of the appraiser's participation in appraisal calibration events such as ASG (Appraisal Support Group) meetings – the MEM from 2014 onwards.
- 360 feedback from appraises 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.
- Feedback from the quality assurance of appraisals, with each appraiser receiving a 3 yearly report on strengths and challenges of their appraisals and completed form 4's.

3. Concerns Involving Doctors

a. Monitoring Concerns

Monitoring the performance of each doctor is a process that involves triangulating information from different sources to create an overall picture.
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; the new Schwartz Rounds currently running on the Wirral and about to extend to the East; and consistent encouragement to take on leadership roles within the organisation.

Feedback from doctors has suggested that the information on complaints is not always reliable. Sometimes doctors say that they were not aware that a complaint was made against them until they see it at appraisal. At other times doctors bring information on complaints to appraisal which had not been picked up in routinely collected data.

CWP has a robust system for investigating and dealing with complaints. However when a complaint is initially made, doctors are not always named (e.g. it may be a complaint against the whole team which may or may not include the doctor personally) and therefore the complaints department may not flag up the doctor's name when information is requested from them for appraisals. Moreover it may be some way into the investigation that it becomes clear whether a doctor has personal learning or not from the complaint. Finally the process of feeding back the outcome from a complaint investigation to the CD and down to the doctor involved may need to be tightened up.

Weekly meetings are held by the complaints department, the MD (Quality) and the Director of Nursing looking at all complaints. It has been agreed that from next year the Medical Workforce Manager (MWM) will review the minutes of these meetings and monitor the cases where doctors are involved,

feeding this information back to the appropriate CD and ensuring that the information is included in appraisal folders.

b. Responding to Concerns and Remediation

Number of formal investigations involving doctors: 3
Concerns which did not proceed to formal investigations: 1
Doctors reviewed by GMC: 3

The number of formal investigations is in line with previous years.
All cases were discussed with the GMC liaison officer: the three doctors involved in formal investigations and the doctor where there were concerns but no formal investigation was triggered were discussed with NCAS.
Of the 3 cases involved with the GMC, 1 was a self-referral and 1 followed a patient complaint – in both these cases the GMC did not see any need to proceed to a formal investigation. The third case involved a doctor who was reported to the GMC in the period before this report. He is now due to go to a GMC tribunal. He is no longer in the employ of CWP but CWP staff are involved in providing evidence to the GMC.

One doctor was referred for an NCAS behavioural assessment – this related to a formal investigation from before the period covered in this report. The referral was suggested by our NCAS advisor: however when the referral was made, NCAS decided that they would not be able to add anything useful. This referral was a stressful process for the doctor involved and time consuming for the doctor and AMD. However NCAS commented that our action plan was comprehensive and effective which is why they turned down the referral and the doctor involved was ultimately pleased not to have to go through another process so overall there were positives.

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.

We have 16 Case Investigators, an excellent cohort who have received training in this role from NCAS. 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.

4. Other developments

In CWP the tasks of managing medical appraisal and revalidation evolved as part of the Medical Education Manager's role. However the demands associated with appraisal and revalidation have increased as the process has become more rigorous whilst the workload in medical education has also increased.
In the last year it was therefore decided to split the role into 2 posts –Medical Education Manager and Medical Workforce Manager. This report therefore refers to MEM for the work done over the last year and MWM for the work planned for next year. The two incumbents will continue to work closely together. This development will enable the MWM to liaise more closely with HR and the Complaints Department.

5. Corrective Actions, Improvement Plan and Next Steps

Recommendations	Action	Responsibility	Time frame
1. Move to completely electronic system for appraisals	SARD has now been introduced – training and support available through SARD itself and MEM	MWM, AMD	March 2016
2. Ensure appraisals cover the whole of practice	AMD to contact all appraises if information on work outside CWP is not included in appraisal summary Continue with regular reminders via appraisers network and appraisal training	AMD and MWM	March 2016
3. Ensure clear communication between appraisers and clinical directors	Survey of CDs to check this is happening reliably	AMD and MWM	Nov 2015
4.Maximise effectiveness of new 360 feedback	Survey of appraises re new form	AMD and MWM	Nov 2015
5. Provide feedback to appraisers regarding their effectiveness	Set up system to provide 3 yearly feedback to all appraisers	AMD and MWM	March 2016
6. Ensure large enough cohort of trained case investigators	Encourage suitable candidates to seek case investigator training	MD (workforce)	July 2016
7. Quality assure the reliability of information relating to complaints being discussed with doctors and included in appraisal portfolios	Routine scrutiny of minutes from complaints meeting to identify if doctors are personally involved and conveying this information to CDs	MD (workforce) and MWM	March 2016

Recommendations

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.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Health, Safety and Fire Annual Report
Agenda ref. no:	15/16/46
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/07/2015
Presented by:	Avril Devaney – Director of Nursing, Therapies and Patient Partnership

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

REPORT BRIEFING

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

The report summarises 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.

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

The Health, Safety and Wellbeing Sub-Committee is attended by Managers and Staff Side representatives and meets on a bi-monthly basis. The sub-committee reports into the Operational Board and is required to submit an annual report of their progress against their terms of reference, as well as submitting chairs summaries of each meeting held.

The attached report outlines the work completed during the year in relation to matters of health and safety, Trust compliance with alert systems and Fire safety. It also outlines future priorities.

Assessment – *analysis and considerations of options and risks*

The report provides an overview of the sub-committees progress against a number of key areas. The sub-committee will continue to monitor progress against its terms of reference and escalate matters to the Operational Board as necessary. The sub-committee has also identified some key priorities for 2015-2016 which are detailed in section 4 of the report.

This report has been received by the Operational Board at the July 2015 meeting.

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

The Board of Directors are asked to note the contents of this report, in particular the increase in fire evacuation exercises carried out.

Who/ which group has approved this report for receipt at the above meeting?	Avril Devaney, Director of Nursing, Therapies and Patient Partnership
Contributing authors:	Lyn Ellis, Senior Health and Safety Advisor

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Justin Pidcock – Head of Estates	07.05.2015

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

Appendix no.	Appendix title
1	Health, Safety and Fire Annual Report 2014/15

(15_16_46) Health, Safety and Fire Annual Report – 2014 - 2015

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 in accordance with 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 and more recently, display screen equipment and workplace assessments.

The Health, Safety and Wellbeing Sub Committee (HSWSC) which is attended by Managers and Staff side representatives feeds into the Operational Board. It is chaired by the Director of Nursing, Therapies and Patient Partnership 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. The Environment Strategy Steering Group have had their Terms of Reference approved by the Health, Safety and Wellbeing Sub Committee and the bi-monthly meeting minutes will also feed into the Sub Committee

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 for buildings
- 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) including Estates and Facilities Alerts and Notifications
- Chair of the Medical Devices Group and joint management of the Medical Devices and Equipment contract
- Display screen equipment and workplace assessments

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 and monitoring incidents on a daily basis that are reported on the Datix system.

A total of 10 Health, Safety and Security assessments were carried out during the financial year, all in-patient areas are due for reassessment in Quarter 2 of 2015. Health Centres and Physical Health clinics will be assessed during Quarter 3 and Quarter 4 and resource centres now require an assessment every 2 years

The main gaps identified related to

- completion and review of workstation assessments in accordance with the Display Screen Equipment Regulations- (1992 as amended 2002)

Assessments of workstations are a requirement in law. The training programme for display screen equipment will shortly be available as an E-Learning package via an external provider as prepared by the Head of Occupational Health. The policy for display screen equipment has been under review by the Head of Occupational Health, this has now passed to the Health and Safety team. Staff are provided with a self-assessment form as part of the Health and Safety report completed after Health, Safety and Security 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 were reviewed in 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 proposed programme for assessments are scheduled on a risk assessed basis. An assessment of in-patient units will take place annually and other areas every 2 years with reactive visits taking place as required.

The Local Security Management Specialist role sits in Education CWP, the security element of the assessments requires review in line with the requirements of NHS Protect.

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 2014- March 2015 there was a further decrease of RIDDOR reports from the previous year that needed to be reported to the HSE. 18 incidents were reported to the HSE for this period.

In 2013-2014, there were 21 incidents that required reporting to the Health and Safety Executive. During the previous year, 2012-2013, there were 26 incidents reported.

For 2014-2015 CWP have recorded the lowest reportable number of RIDDOR incidents for the 10 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 25 per year.

There had been a marked reduction in RIDDOR 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 rose to 6 incidents. During 2014- 2015, the number of reportable incidents has again decreased to 1.

The number of Violence/Physical assault incidents to be reported to HSE had decreased from 20 incidents during 2012-2013 to 9 incidents during 2013-2014; however, this has risen slightly to 12 incidents for 2014-2015. This will be further reported in the annual security report which will be prepared by the Local Security Management Specialist.

CWP have not received any visits from the Health and Safety Executive although 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) for the previous year (2013-2014).
The HSE 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 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 2014)

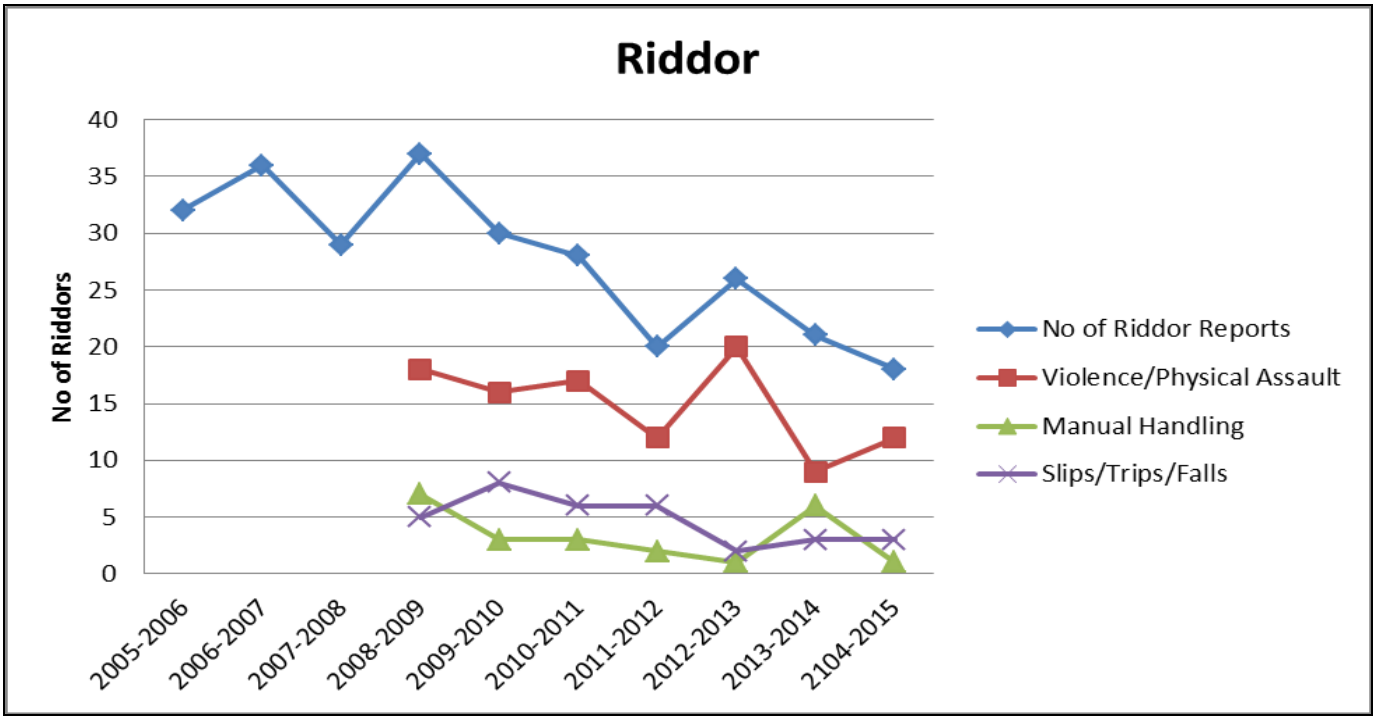
RIDDOR Reported incidents for CWP- annually 2005-2015

2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015
32	36	29	37	30	28	20	26	21	18

Classification of RIDDOR Reports to the Health and Safety Executive since 2009

Classification of Incident	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	Number Reportable to HSE 2014-2015
Violence/Physical Assault	16	17	12	20	9	12
Manual Handling	3	3	2	1	6	1
Slips, trips and falls	8	6	6	2	3	3
Struck by an object		1		1		1
Exposure	2	1			1	
Cuts	1			1	1	
Twisting injury (knee) (wrist)				1		1
Collision					1	
Total	**30**	**28**	**20**	**26**	**21**	**18**

RIDDOR reports made to HSE 2005-2015



RIDDOR Incidents per quarter 2014-2015

Classification of Incident	Qu 1	Qu 2	Qu 3	Qu 4	Total for year
Violence/Physical Assault	4	3	1	4	12
Manual Handling		1			1
Slips, trips and falls	1	2			3
Other type of injury- Cut/ Struck/Collision	1		1		2
Total for Year					18

2.3 Medicines and Healthcare Products Regulatory Agency (MHRA)

The MHRA is the government agency responsible for ensuring that medicines and medical devices work, and are acceptably safe. The MHRA is an executive agency of the Department of Health. Adverse incidents relating to medical device failure or malfunction should be reported to the MHRA.

There were no incidents recorded relating to medical devices that needed reporting to the MHRA by CWP and this has now been the case for 4 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 Central Alerting System Policy is due for review in June 2016.

The National Patient Safety Alerting System (NPSAS) was 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 2015 had produced 26 NHS England Patient Safety Alerts.

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

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

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

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

Stage One Alert: Warning (W)

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

Stage Two Alert: Resource (Re)

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

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

Stage Three Alert: Directive (D)

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

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 no longer 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 were 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 resulted in a sharp increase in alerts received via the CAS function from 91 to 177.

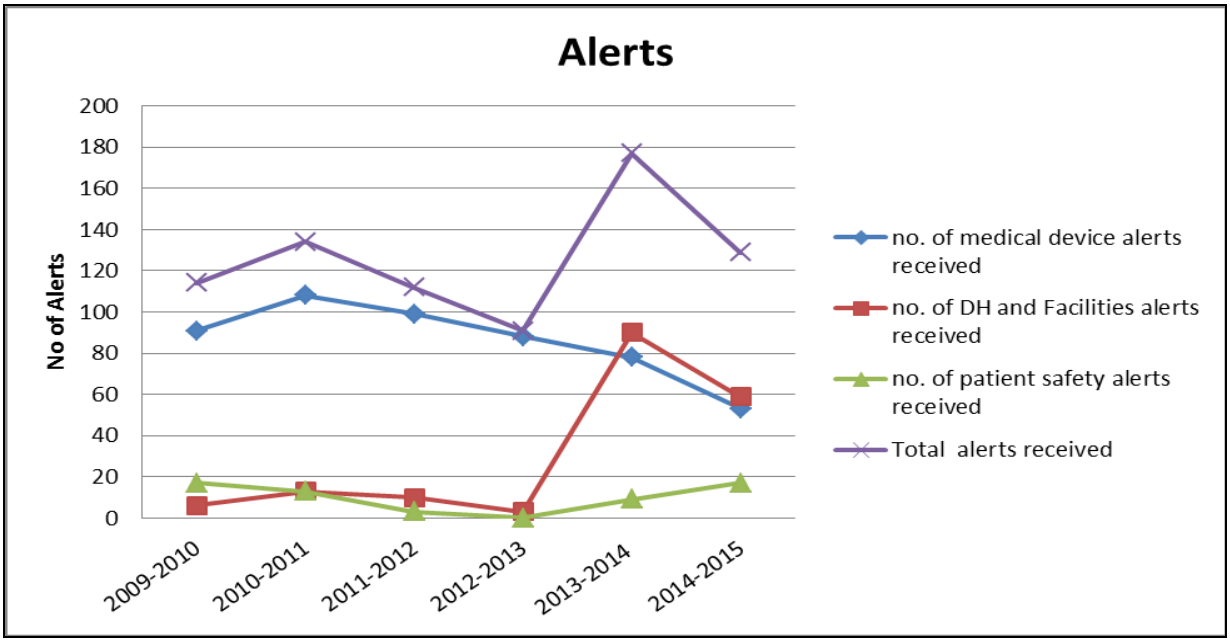
Monthly CAS Data is now available on NHS England website and shows all responses to alerts due for completion on or before 31st March 2015 issued by NHSE and outstanding NPSA Alerts.
All NHS Trusts are monitored on their alert responses and actions by the Care Quality Commission.

Summary of alerts received by CWP - April 2014- March 2015

All alerts received by CAS Officer	129
Medical Device Alerts	53
DH Estates and Facilities Alerts (and updates)	59
NHS England	17
Alerts with 'No action required'	34
Alerts with 'Action required- Ongoing'	8
Alerts with 'Action complete'	87
Total	129

At the end of the reporting period (**31.03.15),** CWP had 8 alerts with actions required or their relevance to the Trust being assessed and still within the timeframe for completion.
A total of 95 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 during 2013-2014 and this was due to the publication of Estates and Facilities Alerts and notifications relating to electrical equipment.
Contingency plans have been put in place in the absence of the CAS Officer and 2 deputies are now allocated this role.

2.5 Medical Devices and Equipment

Following the completion of TCS (Transferring Community Services) there was 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 was 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 complied 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 one of 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 Business Support Manager Infrastructure Services and the Senior Health and Safety Advisor. A physical health trainer commenced in June 2014 and works closely with the Senior Health and Safety Advisor and the Business Support Manager Infrastructure Services in a program to standardise medical devices equipment.

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 is with an external provider who also checks bedrails. The contract applies to inpatient areas and is managed and monitored by CWP Estates department, any issues and concerns are reported via Medical Devices Group and Health, Safety and Wellbeing Sub Committee.

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 New equipment for use in training

Following a successful funding bid by Education CWP funding was secured for the provision of equipment to be used in training; this included new equipment for manual handling. A new Oxford hoist, slide sheets and slings have been purchased along with a Mangar Elk Emergency Lifting cushion to ensure continued updates can be delivered to staff during their training.

2.65. Proposed new training venue

A move to a proposed new training venue due to take place in September 2015 will enable manual handling training to be delivered from a permanent venue in Chester and will be fitted out to allow physical health skills to be delivered along with manual handling. This new venue will be located in the 1829 building on the Countess of Chester Health Park site.

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, electrical safety, 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. Estates activity risk assessments for many related tasks including work at height are available for staff and staff receive training in safe systems of work.
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. The Estates Health and Safety Group develop and review any new risk assessment documents.

Safety related Training Figures in Estates Department

Training	No of staff requiring training	No of staff completed training	Percentage compliance
Legionella	7	5	72%
Asbestos	34	29	85%
Work at Height	27	25	93%
Vibration at work	22	21	96%
Electrical Safety/ PAT- Portable Appliance Testing	5	4	80%
COSHH (Control of Substances Hazardous to Health)	34	32	94%
Pesticides (grounds and Gardens)	10	8	80%

There are also 8 staff within the Estates Department who have completed First Aid at Work Training**.**
The Estates Statutory Standards and Compliance group are responsible for ensuring that all CWP premises are designed and maintained in accordance with all relevant legislative requirements, 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 CWP West Physical Health Services premises. The proposal for 2015-2016 is to integrate all relevant information into MICAD IPR Asbestos module (Internet Property Register) (IPR) to enable improved controls.

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.
The policy for the Control of Contractors has been reviewed this year and will meet all the requirements of the revised CDM Regulations (Control (Design and Management) Regulations 2015.

All the above management is in full compliance with the regulations and covers water quality.

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 reviewed during the year starting 1st April 2014 – 31st March 2015. 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 or for buildings that are not the responsibility of CWP that external parties or landlords are informed of their obligations.

Generally, fire safety provisions, both active and passive are of a very good standard throughout the Trust. CWP are in receipt of an Estates and Facilities Alert via the CAS system. This is a reminder regarding testing of fire and smoke dampers and ensuring the integrity of fire stopping. A plan has been developed to meet the requirements of the alert and any work required will be starting shortly with any urgent matters being dealt with first.

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 12 In-Patient units are located on the Intranet. (Alderley, Bowmere, Crook Lane, Eastway, Greenways, Lime Walk House, Millbrook, Pine Lodge, Saddlebridge, Springview, Thornheyes Bungalow and CARS Ward (old Alderley).

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'.

The new build 'Alderley' has been:-

- Fire risk assessed
- A new fire strategy has been produced and place on the intranet
- A full fire drill has taken place with patients and staff
- Fire induction training has been carried out
- Cheshire Fire and Rescue Service have carried out a fire audit of the premises
- Fire Wardens have been trained by a Trust Fire Advisor

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 two dates per year. The Fire Advisors attend the drills and both oversee and direct the evacuation drills. This is an improvement on the previous year when only 1 fire evacuation exercise was carried out per in-patient unit.

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.

Alderley (new build) has had 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.

This method has been fitted in Eastway and has allowed a voice over to be provided without any disturbance or alteration to the wiring system.

2.84 Fires

A total of 8 fires were reported on the Datix system for the period 1st April 2014 – 31st March 2015.

4 were caused by service users, started with matches or lighters.
All were confined to a bedroom
3 fires were caused as a result of lack of care whilst cooking.
1 fire occurred in a garden skip

This showed an overall reduction of 4 fires in patients' bedrooms.

2.85 Unwanted Fire Signals (UwFS)

A total of 36 unwanted fire signals were reported on the Datix system for the period 1st April 2014 – 31st March 2015.

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

- Suspected smoking inside building = 5
- Misuse of aerosols = 1
- Malicious operation of manual alarm point by service user = 10
- Faults on system = 5
- Cooking =1
- Steam from shower = 4
- Contractor created dust = 1
- Smoke from cooking = 1
- Patient tampered with smoke detector = 1
- Lightning = 1
- Failed to inform fire service before test = 1
- E cigarette operated detector = 1
- Not known = 4

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 2015-2016

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 continue to develop evidence based recording system to ensure governance of incident management in relation to health and safety incidents.

2. Coordination between the Business Support Manager Infrastructure Services 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 continue to ensure that all relevant areas are displaying the new style Health and Safety Law Poster.

5. All in- patient areas will be assessed using the Health Safety and Security template in the coming 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.

8. Management and monitoring of compliance with display screen equipment will be incorporated into the work plan for the health and safety advisors.

9. Fire safety training will be delivered on a 3 yearly basis via E Learning to all Community staff (Mental Health and Physical Health) including Out of Hours Staff.

5.0 Recommendations

The Board of Directors is asked to note the contents of this report, in particular the increase in fire evacuation exercises carried out.

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)
Control (Design and Management) Regulations 2015.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Medicines Management Annual Report 2014-15
Agenda ref. no:	15/16/47
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/07/2015
Presented by:	Dr Anushta Sivananthan

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

REPORT BRIEFING

Situation – *a concise statement of the purpose of this 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 standards set by the Care Quality Commission (CQC) for the management of medicines which are monitored under the five domains of: Are services safe, effective, caring, responsive to people's needs and well led?

This report covers the year April 2014 – March 2015 inclusive.

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

This report details the activity and progress that have been made by the Medicines Management Group (MMG) against the group's annual business cycle (appendix 1).

Assessment – *analysis and considerations of options and risks*

The report outlines the achievements made during the financial year 2014-15

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

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

Who/ which group has approved this report for receipt at the above meeting?	Medicines Management Group 11/06/15
Contributing authors:	Various from MMG membership

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Patient Safety and Effectiveness Sub-Committee	18/06/15

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

Appendix no.	Appendix title
1	Medicines Management Annual report 2014-15

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 standards set by the Care Quality Commission (CQC) for the management of medicines which are monitored under the five domains of: Are services safe, effective, caring, responsive to people's needs and well led?

This report covers the year April 2014 – March 2015 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 (appendix 1). 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 patient safety 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

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 ten times over the 12 months of 2014 -15. Meetings have been held in the Trust Board offices and Sycamore House. Attendance at meetings and all declarations of interest from members are detailed in appendix 2.
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 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), AWMSG (All Wales Medicines Strategy Group) 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 formulary was reviewed and updated in July 2014.

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

CWP in-patient antimicrobial prescribing was previously allied to the adopted formulary from Wirral Clinical Commissioning Group, this has now changed. CWP have now adopted the Western Cheshire primary care antimicrobial guidelines as the template for empirical prescribing within the Trust, this adoption was ratified in March 2015.

The empirical prescribing of antimicrobial medicines within community care physical health services Western Cheshire is still 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 2014 for the years 2015-17. 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 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
Aripiprazole LAI (Abilify Maintena®)	Maintenance treatment of schizophrenia in adult patients stabilised with oral aripiprazole.	Non-formulary within CWP.

CWP antipsychotic policy (MP22) was launched in January 2012. 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 particularly in relation to risperidone long-acting injection.

Quetiapine modified release tablets and aripiprazole are non-formulary for both psychosis and bipolar affective disorder. Immediate release quetiapine is an appropriate formulary choice in both bipolar affective disorder and in the management of psychotic conditions.

CWP antipsychotics policy (MP24) for antipsychotic choices in bipolar affective disorder was ratified in February 2014 by the MMG. This policy is currently being updated to take into consideration NICE guideline CG185 (bipolar affective disorder) and also the non-formulary status of aripiprazole within CWP. 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.

In addition to monitoring inpatient adherence to the formulary, the pharmacy team review reports on outpatient prescribing from FP10 prescriptions. The information gleaned from these reports is shared with the locality directors and Clinical Directors to monitor adherence and address non-adherence with the Trust formulary.

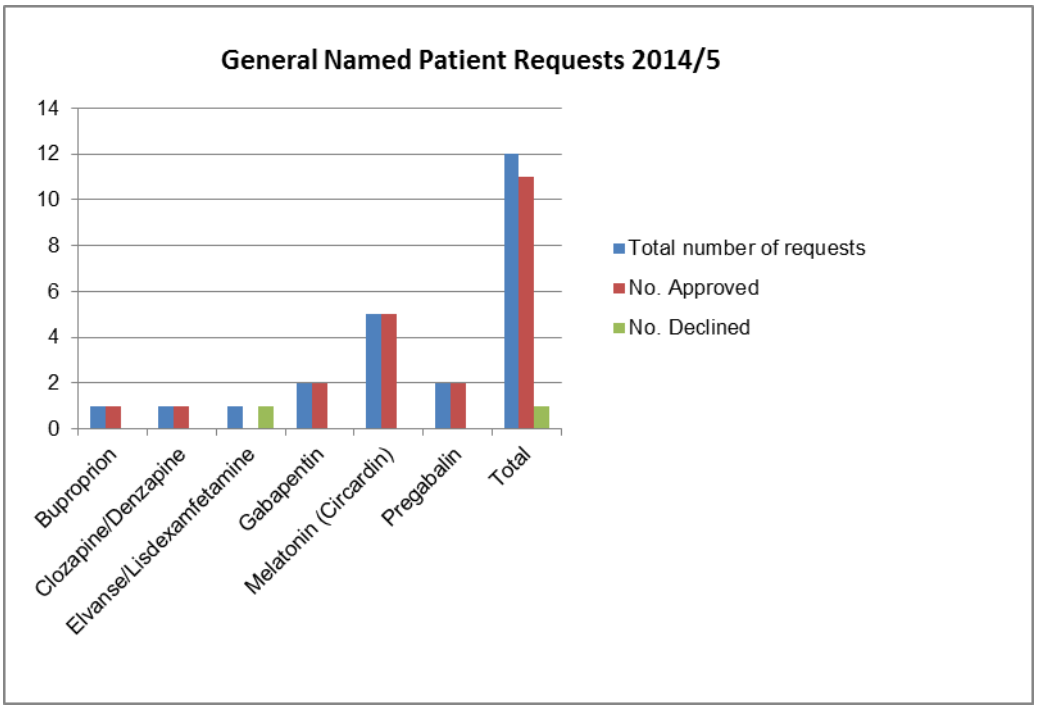
This information is also used to inform the clinical service performance reviews where if there is continuous non-adherence to recommendations made by the pharmacy team regarding formulary medicines an action plan will be drawn up to address the issues raised.

4.3 Named patient/non-formulary requests

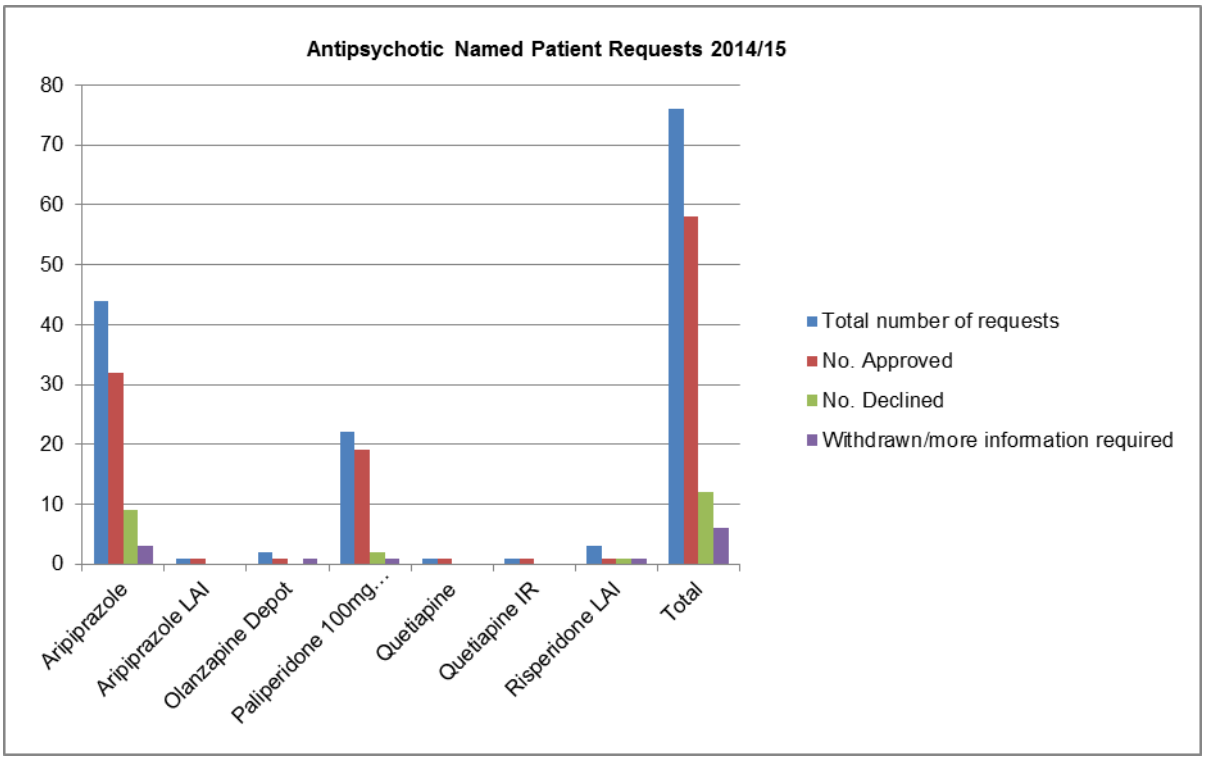
There have been several requests during the year for non-formulary medicines. All requests are summarised in the graphs below. These are divided into general non-formulary requests and antipsychotic non-formulary requests.

In all approved cases the MMG request feedback from the consultant prescriber on progress with the treatment every three months such that the MMG can be reassured that the treatment continues to be beneficial to patient care. During this year the feedback mechanism has been updated to a proforma that the consultants complete, this has been an effective change as it has increased consultant feedback.

Graph 1: General Named Patient Requests



Graph 2: Antipsychotic Named Patient Requests 2014/15



4.4 Product Updates

The Medicines Management Group receives updates at each meeting. The Group received in total, 70 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.
Next year the product updates will be circulated via Trustwide communication bulletins.

In addition, communication bulletins and alerts were circulated highlighting important supply and/or clinical information for the following:

- Tramadol oral preparations – change in controlled drug legislation
- Dexamethasone injection – change in labelling
- Procyclidine injection – supply shortage
- Pipothiazine depot – discontinuation of product
- Haloperidol oral preparations and injection – changes to maximum recommended dosage
- Domperidone – interactions with other medication

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 18 TAs applicable (end of March 2015) 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 CG179 Pressure Ulcers and CG185 Bipolar in children. Current work includes the development of pathways for our electronic patient record integrating NICE standards.

4.6 Incident Reporting of Medication Errors

Graph3 below illustrates the number of reported medicines-related incidents over the last 12 months broken down by severity. The majority of the incidents fall into category E. It can be seen that there were no category A or B medication incidents during this time period.

Graph 3

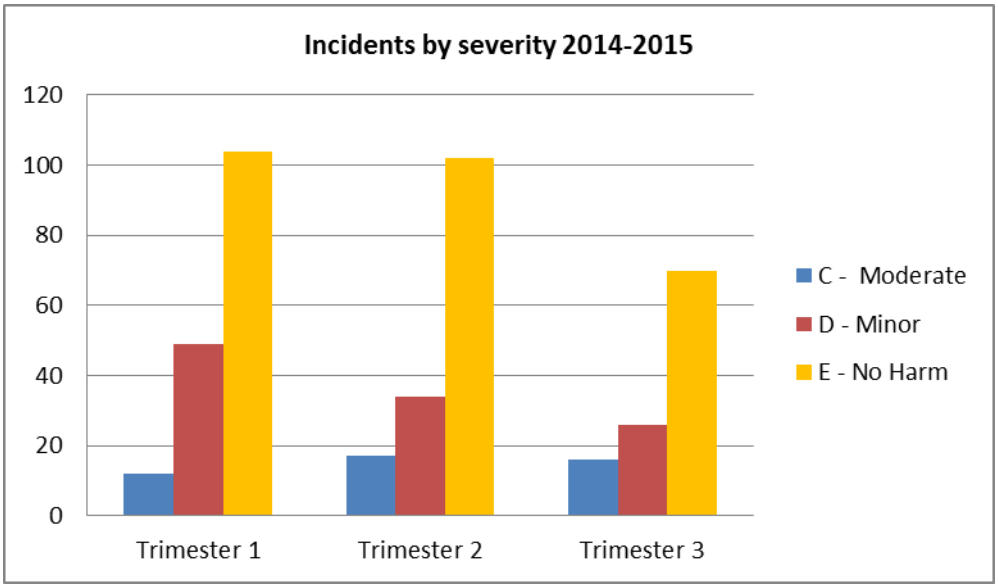


Table 2 below shows the context of this year's medicines-related incidents, within the previous six years of data. It can be seen that the total number of incidents has fallen, when compared to the previous year. A more cohesive approach to reducing medication incidents, as evidenced by Medicines Management Group minutes and Learning from Experience reports is the likely reason for this.

Table 2: Medication incidents by severity for the years 2008-2015

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
2014/15			45	109	276	430
Totals	1	11	528	1310	1255	3105

4.6.1 Trends in reported medicine related incidents

Graph 4 below details the number of incidents per sub-category, over the three trimesters. It can be seen that there are three sub-categories associated with spikes in frequency:

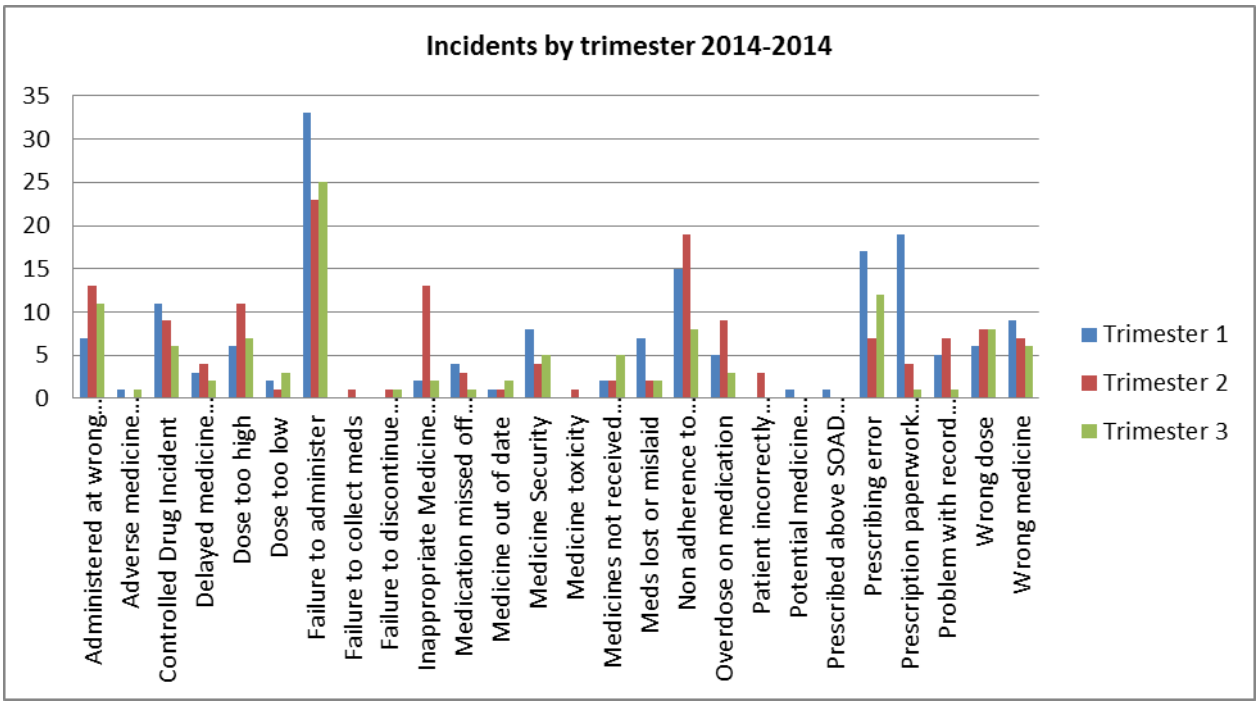
- Failure to administer
- Non-adherence to policy / procedures
- Prescribing error.

Work has continued in addressing the frequency of failure to administer incidents in 2014/15. A significant improvement has been made when compared with previous years, indicating that practice has improved. Good practice continues to be shared by teams, in order to continuously improve.It should be noted that the frequency of incidents for the past two trimesters has been similar, indicating the need for a renewed campaign in 2015/16 in order to reduce the number of incidents further still.

The non-adherence to policy / procedure sub-category contains a diverse range of incidents. Work was done to identify themes from the data.

Prescribing errors are diverse, in terms of the medicines involved. Analysis showed a greater frequency of incidents associated with admission. Incidents are discussed with the prescriber to ensure learning is achieved

Graph 4 - Number of incidents by sub-category per trimester



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

- MP02 – Patient Group Directions (PGDs)- September 2014
- MP10 – Rapid Tranquilisation Policy – September 2014
- MP25 - Administration and checking of medicines by Assistant Practitioners– September 2014

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 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

As patient group directions have come up for renewal within the Trust, the PGD subgroup has reviewed existing PGDs written regionally by Cheshire and Wirral Commissioning Support Unit/ North West Commissioning Support Unit and reviewed their appropriateness for recommending their adoption for use within CWP. Our main services that utilise PGDs are:

- Occupational Health
- Drug and Alcohol Service
- School nursing
- Physical health community services
- Physiotherapy

The following existing patient group directions have been written by Cheshire and Wirral Commissioning Support Unit & North West Commissioning Support Unit and adopted and approved for use within CWP:

- Revaxis® (diphtheria/tetanus and inactivated polio) vaccine (existing PGD)
- MeaslesMumpsRubella MMR vaccine (existing PGD))

The following revised patient group directions have been written and updated by Cheshire and Wirral Commissioning Support Unit & North West Commissioning Support Unit and adopted and approved for use within CWP:

- Meningococcal C vaccine
- Seasonal flu vaccine – annual influenza programme
- Zostavax® (shingles) vaccine – annual new and catch up programme in people aged 70 and over
- Human papilloma virus HPV vaccines – annual programme in school girls

Where regional patient group directions are not available, or not appropriate for adoption, a new PGD has been written. The following new patient group directions have been written by CWP services and approved for use:

- Drug and Alcohol Services
  - Topical 2% fusidic acid cream (new)
  - Chlordiazepoxide capsules (new)
  - Naloxone injection (revised)

The Trust's PGD policy was updated and approved in line with NICE medicine practice guidelines. A baseline assessment was completed and revisited after policy approval to ensure action points from the assessment had been completed or addressed.

4.7.3 Patient Information Leaflets

In February 2015, MMG re-approved for use 33 easy read medication leaflets. These leaflets were originally developed by the Learning Disability service, as an alternative to the easy read medication leaflets available through the Choice and Medication website. Minor amends only were required, and the leaflets were re-approved for use for a further 3 years.

4.8 Clinical governance and external standards

4.8.1 CQC visits

CQC inspection of out of hours service run by CWP in June 2014 found that there were appropriate systems in place to protect patients from the risks associated with medicines. Medicines were managed appropriately and safely at both the out of hours service at Ellesmere Port hospital and at the 1829 Building. Stocks of medicines were monitored and records held of usage. Audits were undertaken of appropriate use and prescribing of medication. Prescription pads were secure and safety systems were in place to minimise any risks. Home visits are undertaken from the 1829 Building, CQC inspectors checked medication bags used in vehicles for home visits and found medication to be safely managed and maintained.

4.8.2 Overview medicines governance

The Trust has registered all clinical services with the Care Quality Commission, with no conditions placed on its registration, the CQC intelligent monitoring report in November 2014 found no evidence of risk in medicines use. 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.

4.8.3 2014 National Community Mental Health Patient Survey

Results for medicines related questions continue to be the same as or better than the national average. There has been particular improvement in the number of people receiving an annual review of their medicines and a slight increase in the number of people who were given information about medication in a way they could understand. The provision of information that people feel is accessible and easy to understand has also formed part of the medicines management audit and wards and teams who do not display the availability of leaflets targeted for improvement.

4.8.4 Internal assurance

Safe, effective and responsive use of medicines is assessed as part of the trust's programme of compliance visits to the wards and community teams and a pharmacist has been present for the majority of those visits. Any medicines management issues raised have been added to the ward/team manager's action plan and the progress on the actions monitored by safe services team.

4.8.5 NHS England Never Events

The never events framework was reviewed by NHS England during 2014/5 and MMG fed back comments on medicines elements via the CWP response from the Head of Clinical Governance. The revised never events list was published in March 2015 and contains two medicines elements relevant to CWP, wrong route of medication and overdose of insulin due to incorrect device. There have been no medicines related never events at CWP.

4.8.6 NHS England Patient Safety Alerts

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. Actions for the Patient safety alert to improve reporting and learning of medication and medical devices incidents (March 2014) were completed during 2014/15 and a medicines safety officer has been appointed with joint funding from and accountability to the pharmacy team and localities.

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. The Accountable officer provides two six monthly reports to the MMG on the management of controlled drugs within CWP, the reports for 2014-15 have been approved by MMG. The majority of 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 (section 4.13.2.8). 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. The integration of a pharmacist and technician into the west Cheshire physical health teams has been well received and has been providing an invaluable service to all the physical health teams in terms of improving their standards of practice regarding the handling of medicine.

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. The tender process of last year was completed and Lloyds pharmacy were re-awarded the contract for a three year term which commenced in January'15 with the option of two further years add on. One new aspect of the contract is to pursue the move to an onsite dispensing pharmacy model. This was approved by the Operational Board in October 2014. The operation of the service from the old training room in Bowmere commenced in May'15 after completion of the refurbishment of the room into a functional pharmacy dispensary. In terms of notable dispensing incidents; these have improved over the year and are tightly monitored monthly by the senior pharmacy technician and chief pharmacist via the contract monitoring meetings. We have an escalation plan in place to address such incidents via the monthly contract meetings and through the superintendent's office.

4.11 Staff Training in Medicines Management/External Training Delivered

As in previous years the pharmacy team in the East have delivered several sessions at Crewe and Macclesfield Recovery College around the topics of psychotropic medicines and their effects on physical health as well as sessions on "Understanding your medicines". All of these sessions were well received with very good feedback.
The pharmacy team have also contributed to several sessions on clozapine treatment for carers and nursing home staff which were found to be very valuable and received good feedback.

A recent development in 2014 has been the commencement of pharmacy input and support to the Musculoskeletal Service in the West. This consists of delivering regular talks to a group of service users on medicines management and the usage of analgesia. Sessions also involve one to one time with service users and feedback showed that service users are finding them very beneficial.

Once again, the pharmacy team supported 6 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 2015 Liverpool John Moore's University invited the Pharmacy Team back for the fifth time to facilitate the Psychiatry and Neurology Study Weekend for their Postgraduate Diploma in Clinical Pharmacy. Sessions were delivered by two clinical pharmacists, a consultant psychiatrist who delivered the dementia session and a guest speaker who delivered the neurology session. The final session of the study weekend was delivered by a CWP service user and carer who were able to share their perspective and experiences of mental health with the students. This session once again proved to be very interactive, popular and informative for the students. The study weekend received very

good feedback indicating that it was interesting, well-structured and of great value to the students' practice.

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.

Thirty minute teaching sessions were set up for nurses at the Bowmere wards with topics identified through incidents and policy updates. These have also been rolled out in East and the data, through registering these training sessions on ESR, is that 125 members of staff have attended sessions on clozapine, insulin & diabetes, hypertension and lithiumDoctor's induction training continues to be provided for each new intake in a face to face session which has been extended to 75 minutes to accommodate the information about rapid tranquillisation more effectively.

4.12 Non-Medical Prescribing 2014/15

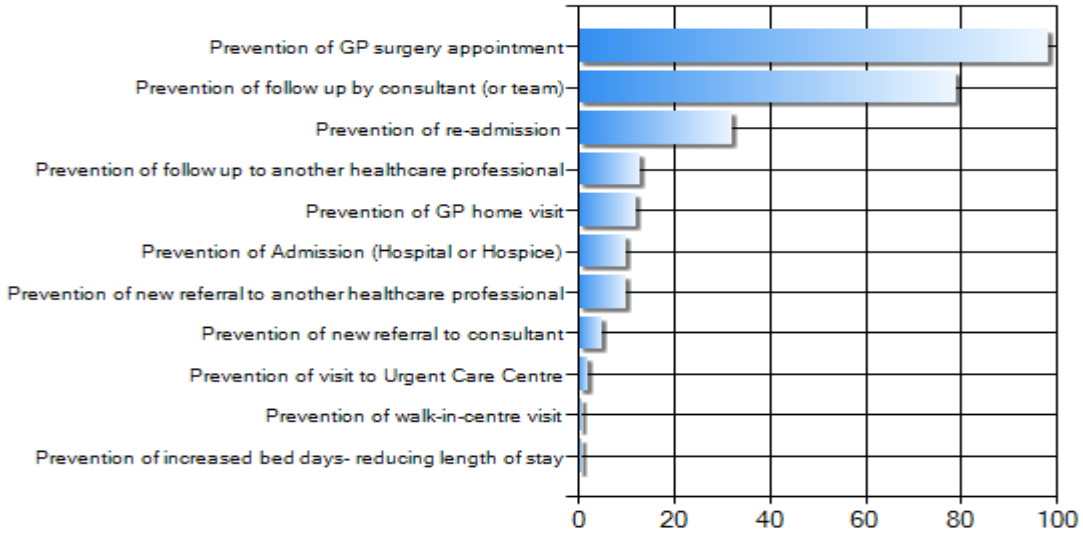
The trust employs a total of 170 non-medical prescribers (NMPs) who work across both physical and mental health services.

The table below illustrates the breakdown of our NMPs within the organisation.

Service	**Number of Prescribers**
Adult and Older People Mental Health	15
CAMHS	1
Memory Clinic	2
Drug and Alcohol Services	3
Independent prescribers in physical health	37
Community practitioner nurse prescribers physical health (mainly health visitors)	112

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; Using NICE quality standards, epilepsy, urinary tract infections, inhaler devices, the antibiotic formulary. The groups utilise the single competency framework at the sessions to support practitioners to provide evidence of their competence. In mental health services a peer support group was established this year which aims to support all those prescribers working across the various mental health disciplines trustwide. The longer term aim is to merge the forums and peer support group so that more shared learning can take place that cuts across any physical and mental health barriers. This will then correlate more effectively with the Trust vision around integrated services for people we care for.

The NMPs have contributed to the Health Education England NMP Clinicians Audit Report in which NMPs reported that following best represents the impact of NMP consultation. Further work will be required in the development of NMP roles to support the Trust in the implementation of the Transformation agenda. The Chart below demonstrates some of the patient benefits CWP NMPs have delivered this year.



Professional issues with non-medical prescribers are addressed through the professional nurse leadership group and any issues related to medicines management are raised through the MMG by the designated NMP member of the group. The Trust NMP lead is currently the Chief Pharmacist who is supported professionally by the Associate Director of Nursing (MH) for mental health issues and the Associate Director of Nursing (PH) for physical health issues.

4.13 Research and Clinical Audit

4.13.1 Research

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 two CTIMP trials. 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 also have Benemin which used minocycline in patients with psychosis to see if it improves negative symptoms. We have an informal arrangement with Wirral University Hospital Foundation NHS Trust to provide research pharmacy services for CWP.

4.13.2 Clinical Audits on medicines

4.13.2.1 Medicines management annual audit

Inpatient areas have maintained 100% compliance in relation to the storage and security aspects of the medicines policy (MP1) and additionally 100% compliance has been achieved in over half of the areas with regards to NHS Protect. For two consecutive years there has been a decrease of compliance to 75% from 100% in 2012 with respect to storage and security of medications and fridge temperatures.

For a consecutive year, the audit demonstrated 100% compliance on the provision of leaflets on medication and their side effects for community patients. However, there has been a decrease of 5% from 100% compliance on inpatient wards. There have been significant improvements in the community demonstrating in the clinical notes that the service user has been informed of the potential side effects of medication (increase of 29%), that the side effects are monitored and that advice has been given on their management. A slight improvement is reflected in inpatient areas, but not to the

same extent; further work needs to be done to achieve greater compliance as the figures are still low at 49%.

The inpatient prescription audit showed improvement particularly in prescribing and administration of regular and when required (prn) medicines where compliance with the audit standards was between 98% and 100%.

All learning points from the medicines management audit were incorporated into an action plan which is monitored by MMG and the next audit will take place in September 2015

4.13.2.2 Antibiotic Audits

The antibiotic audit was conducted quarterly in 2014/15 in both physical and mental health services. The detail regarding these audits is covered extensively in the infection control sub-section 4.14.

4.13.2.3 Controlled Drugs Audits

A quarterly controlled drugs audit is conducted on compliance with the controlled drug regulations in all inpatient units and the GP out of hours service as these are the units that handle controlled drugs on a regular bases, in addition quarterly monitoring of controlled drugs in the drug and alcohol service is monitored via quarterly meetings to review medicine usage within the service. Results of such audits and in particular non-compliances with controlled drug standards are reported through the Accountable Officer's network. The NHS Protect ward self-assessment which was conducted for the first time in 2015 also looked at storage of controlled drugs and highlighted the issue of separate storage of patients own controlled drugs. This is an action that is currently being addressed within our inpatient units.

4.13.2.4 High dose antipsychotic therapy audit

An audit of MP18 High dose antipsychotic therapy (HDAT) guideline was conducted in December 2014 on inpatient wards. Seventeen patients were identified as being on high dose antipsychotics. 65% of these patients had an HDAT form and evidence of ongoing monitoring; these results are an improvement on 2013 in terms of use of the form. There is a reduction in the number of patients actually having evidence of ongoing physical health monitoring. Compliance was high with other aspects of the policy including documentation of the rationale for high dose therapy and a treatment plan (94% and 88% respectively). This is echoed in the results from the national audit of schizophrenia in which documentation of rationale for high dose antipsychotic therapy in CWP was well above the national average. One limitation of the HDAT audit is that the majority of patients on high dose antipsychotics are in the community and have not been included.

4.13.2.5 Audit links with Liverpool John Moore's University pharmacy faculty

In January/February 2015 the pharmacy team hosted two fourth year Liverpool John Moore's 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 an internal repeat of the 2013 POMH lithium audit with a larger sample size. Formulary antipsychotic prescribing for in-patients was recorded at 97% (88% in 2014 and 85% in 2013) and for out-patients was 92% (76% in 2014 and 75% in 2013). Of the remaining antipsychotic prescribing deemed non-formulary (5% of total) compliance with the non-formulary Medicine Management Group approval request process was recorded at 80%. In addition, the audit recorded physical health checks (physical examination, blood tests and ECG) in those patients prescribed antipsychotics. Results were seen in 96% of in-patients and 75% of out-patients for physical examination and blood tests, and 33% for ECG. The lithium audit showed that CWP did not have 100% adherence to the audit standards and thus the current guidelines concerning lithium

monitoring and initiation. This audit has identified areas for improvement within the Trust particularly thyroid function and weight monitoring.

4.13.2.6 Junior doctor audits and trust audit programme

The pharmacy team have provided audit tools and support to the clinical audit team programme of junior doctor audits. During 2014/5 data has been collected for audits of the rapid tranquillisation policy and the accuracy of medicines information in discharge summaries.

4.13.2.7 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. Reports were received for 'Prescribing of anti-dementia drugs' and 'Prescribing of antipsychotics in children and adolescents' this year although data was collected in 2013/14 so they are included in this summary.

- *Prescribing anti-dementia drugs*. This is the first time CWP has participated in this audit which measured compliance with the NICE dementia guidelines CG042. Older people's teams from East and Wirral participated and performed well in baseline and ongoing global assessment, and carer involvement. Areas identified for improvement are: cardiovascular risk assessment before prescribing anti-dementia drugs, formal assessment of cognition on review and review of tolerability of medication. It should be noted that CWP results were the same as or above the total national sample for all standards - results have been fed back to the teams for action planning.
- *Prescribing antipsychotics in CAMHS*. This is the second re-audit of this topic looking at rationale for prescribing, baseline and ongoing physical health monitoring, documentation of review of efficacy and side effects. Again CWP compliance with all standards was above the total national sample; areas identified for improvement include ensuring physical health and side effect monitoring occurs every 6 months and baseline measurement of metabolic risk factors. Results have been fed back to the teams for action planning.
- *Prescribing for people with a personality disorder*. This is the first time CWP has participated in this audit, standards are derived from relevant recommendations in the NICE guideline CG078 on borderline personality disorder (2009) and look at appropriateness of medicines prescribed, length of time used and review. Use of antipsychotics, hypnotics and benzodiazepines in CWP is similar to the national sample, however, the proportion of people taking these medicines for longer than the recommended 4 weeks is higher and improvements are needed in documentation of review of treatment. Action plans have been developed by participating teams and the results and action plans shared with all adult teams.

4.13.2.8 Medicines reconciliation audit

An audit of the Medicines Reconciliation Policy, MP19, was carried out in September 2014. Results showed an improvement on the 2013 audit with 100% of patients receiving medicines reconciliation. Medicines reconciliation was done within 24 hours (72 hours at weekends) in 92% of cases and using more than one source of information as recommended by the NICE/NPSA guidelines in 95% of cases. While these core standards have improved since 2013 there has been a decline in quality of documentation on the medicine chart and in the timeliness of pharmacist check of the prescription after medicines reconciliation and these will be the focus for improvement in the coming year.

4.13.2.9 Patients own drugs (POD) Audit

The POD audit was conducted in September 2014. During the audit there were 146 admissions, 44% of service users brought PODs in with them. These service users brought in a total of 325 PODS of which 298 (93%) were suitable for reuse; this is the highest suitable reuse level audited. Unfortunately the percentage of service users that do bring in their own medicines continues to decline. It may be necessary for the Clinical Pharmacy team to re-launch a PODs reuse campaign and it is important that all staff enforce the message that service users POD's should be brought in on admission or by family, carers etc. This can be achieved by continuing to deliver the medicines management training not just at ward level but also within our CMHTs and home treatment teams. The audit will be conducted again in 2015 by a different member of the pharmacy team who has been tasked with continuing to monitor the usage of PODs.

4.13.2.10 Winterbourne medicines programme

Following the publication of "transforming Care: a national response to Winterbourne View Hospital", NHS England asked NHS Improving Quality and partners to test new ways to ensure the safe, appropriate and optimal use of medication for people with learning disabilities and behaviours that can challenge, so that lives can be improved. The learning disabilities services at CWP were asked to work with NHS Improving Quality on the winterbourne medicines programme. The initial findings provide baseline understanding of current practice in learning disabilities across CWP. Of the sampled group from three community LD teams (N=131), 66% of the patients were on psychotropic medicines. Quality standards based on documentation in notes were met consistently (at least 80% of the sample) in blood tests prior to medicines being started, information provided on medicines, monitoring when required use of medicines, side effect monitoring, risk assessment, careplan, yearly review, capacity assessment and application of best interest principles. Recommendations from the programme of work have been prioritised and actions are being taken to address key gaps before re-audit.

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

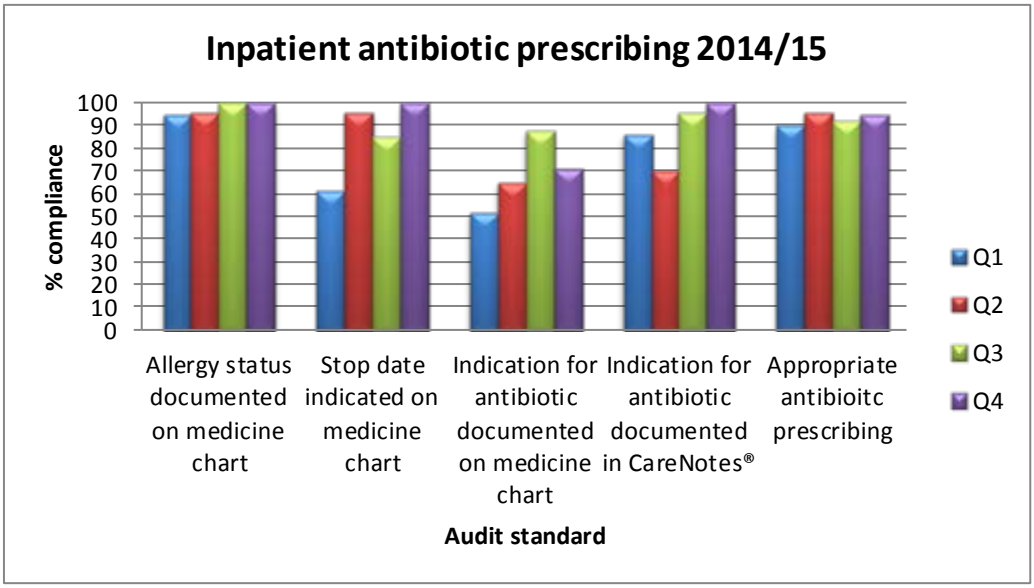
A senior clinical pharmacist attends the infection, prevention and control sub-committee (IPCSC) and works alongside the IPC team to review antibiotic usage and audit results, contributing to the Trust influenza immunisation programme and promotion of the antibiotic formulary. The pharmacy and IPC teams joined forces in manning public stands as part of the International Antimicrobial Awareness Day in November 2014, which was regarded as a successful event.

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 2014-15

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.

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 standards measured. However the total number of antibiotics prescribed in the audit periods was low (June 21, September 23, December 26, March 21) and any variation in practice makes a large difference in the percentage compliance figure.



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

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

The audits this year have continued to demonstrate that appropriateness of antibiotic prescribing has been maintained at 90% or above.

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 pharmacists through local education sessions of the junior doctors training and pharmacy communication bulletins.

For 2015/16, CWP will be adopting the West Cheshire Antimicrobial prescribing guidelines for use within both in-patient and physical health community services, and the in-patient audit criteria is being reviewed to include the antimicrobial stewardship principles of ‘Start smart Then focus’.

4.14.2 West Cheshire Physical Health Services Antibiotic Prescribing 2014-15

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

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

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)

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

- Local - compliance with NHS West Cheshire antibiotic formulary.
- National comparators:
    - 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". Cephalosporins and quinolones have a higher propensity to cause *Clostridium difficile* associated disease. Prescribing of these antimicrobials cannot be totally eliminated due to sensitivities and resistance, so the target is to keep usage as low as possible and in line with West Cheshire CCG and national levels.
    - Prescribing comparator "3 days trimethoprim average daily quantity (ADQ)/item" which benchmarks 3 day courses of trimethoprim for uncomplicated urinary tract infections (UTIs). An ADQ of 3 equates to a three day course of 200mg twice daily. 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. The target is to be towards 3 and in line with local and national levels.

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

	CWP West average 2013-14	**Q1 14/15**	**Q2 14/15**	**Q3 14/15**	**Average 14/15 YTD**
Out of Hours - all prescribers					
% Formulary antibiotic items (local)	**97%**	**98%**	**99%**	**98%**	**98%**
% Cephalosporin + quinolone (national)	**6%**	**5%**	**5%**	**5%**	**5%**
Out of hours - GP only					

% Formulary antibiotic items (local)	**97%**	**98%**	**99%**	**98%**	**98%**
% Cephalosporin + quinolone (national)	**7%**	**5%**	**6%**	**5%**	**5%**
Out of hours - NMP					
% Formulary antibiotic items (local)	**100%**	**100%**	**99%**	**98%**	**99%**
% Cephalosporin + quinolone (national)	**5%**	**2%**	**3%**	**5%**	**3%**
Out of Hours - all prescribers					
Trimethoprim ADQ/item (national)	**5.0**	**5.0**	**4.0**	**5.0**	**5.0**

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 been maintained at a high level and consistent with the previous year's results.

Comparison of national and local benchmarks:

	Average value 13/14	**Average value YTD 14/15**
CWP Out of Hours - all prescribers		
% Cephalosporin + quinolone	**6%**	**5%**
Trimethoprim ADQ/item	**5.0**	**5.0**
Western Cheshire CCG		
% Cephalosporin + quinolone	**6.6%**	**5.57%**
Trimethoprim ADQ/item	**6.0**	**5.72**
National		
% Cephalosporin + quinolone	**5.8%**	**4.95%**
Trimethoprim ADQ/item	**6.1**	**5.83**

This is the third year of using the national trimethoprim comparator and the average value of 5.0 compares favourably to the West Cheshire CCG value of 5.72 and the national average 5.83.

The percentage of cephalosporin and quinolone prescribing as a total of all antibiotic prescribing, 5% is also in line with local, 5.57% and national average results, 4.95%.

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.

Community Matrons	**CWP Average value 13/14**	**Q1 14/15**	**Q2 14/15**	**Q3 14/15**	**CWP Average YTD 14/15**
% formulary adherence (local)	**100**	**100**	**100**	**100**	**100**

% Cephalosporin and quinolone prescribing (national)	**4.4%**	**<1**	**<1**	**<1**	**<1**

4.15 Medicines Management Strategy

A productive session on medicines management was held at the Clinical Engagement and Leadership Forum (CELF) in June 2014, this was aimed at reviewing what the clinical services require in terms of medicines management support to deliver the objectives within the locality clinical strategies. Following on from this consultation, further consultation was had within the pharmacy team and the clinical services cumulating in a revised medicines management strategy.

The revised medicines management strategy is in draft and due to be approved by MMG in April'15 and subsequently signed off at Operational Board. The medicines management strategy aims to complement and support the clinical strategies in their milestones of delivery.

4.16 MMG Business Cycle

The business cycle for 2014-15 is illustrated in appendix 1. 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 2014-15. The medicines management group will work to the new business cycle set for 2015-16 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

8. APPENDICES

Appendix 1: MMG Business cycle 2014 -15

Appendix 2: Attendance and Declarations of interest 2014 -15

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Appendix 1

MEDICINES MANAGEMENT GROUP

Business Cycle April 2014 - March 2015

		For discussion/decision	Owner	For noting	Owner
Apr-14	**Internal**	Policies for approval	Various authors		
		Overdue Policy MP15 Protocol for the Administration and Monitoring of Buccal Midazolam as Rescue Medication in Prolonged Epileptic Seizures, Status Eplilepticus and Seizure Clustering for Adults with Learning Disabilities (Issue 1)	Fiona Couper	Task & finish group progress reports	Various
		NPSA alerts - action plans - Various plans	Various authors	New clinical trials/research with medicines	Pat Mottram
		New products for approval	Abiola Allinson	Product Updates	Abiola Allinson
		Risk register exception report for MMG	Fiona Couper	Medicine policies – tracker review each meeting	All
		Review of Medicines incidents from DATIX	Steven Buckley		
		Annual review of clinical incidents related to omitted and delayed medicines / loading doses / LMWH (each April)	Kath Jones		
		NICE Report	Pat Mottram		
		Annual review of MMG TOR	Fiona Couper		
		MMG to review all high risk medication errors coming into CWP during their meetings from Datix	All		
		For discussion/decision	**Owner**	**For noting**	**Owner**
May-14	**Interface**	New products for approval	Abiola Allinson		
		New policies/guidelines for approval	Various authors		
		Medicines priorities update on progress	All		
		Primary care issues from each locality/CCG	All		
		Final Days Care Pathway feedback - one year on	Karen Herbert		

		For discussion/decision	Owner	For noting	Owner
Jun-14	Internal	Policies for approval	Various authors	Task & finish group progress reports	Various authors
		Overdue Policy MP15 Protocol for the Administration and Monitoring of Buccal Midazolam as Rescue Medication in Prolonged Epileptic Seizures, Status Eplilepticus and Seizure Clustering for Adults with Learning Disabilities (Issue 1)	Fiona Couper	New clinical trials/research with medicines	Pat Mottram
		Risk register exception report for MMG	Fiona Couper	Product Updates	Abiola Allinson
		Review of Medicines incidents from DATIX	Steven Buckley	Medicine policies – tracker review each meeting	All
		Medicines Management annual report	Fiona Couper		
		Quarterly Antibiotic audit report (March audit) and Physical Health input	Kath Jones/Karen Herbert		
		PGDs for approval	Karen Hebert		
		Six monthly Accountable Officer report on controlled drugs (Q3 & Q4)	Fiona Couper		
		MMG to review all high risk medication errors coming into CWP during their meetings from Datix	All		
		POMH Audit – Summary Report and Agreed Action Plan from CAMHS for MMG June 2015			
		Update for never Events Framework - revised never events framework to be added to business cycle for June2015			
		For discussion/decision	**Owner**	**For noting**	**Owner**
Jul-14	Interface	Policies for approval	Various authors	Pathways	Various authors
		New products for approval	Abiola Allinson	Shared care issues	Various authors
		Primary care issues from each locality/CCG	All	Annual Medicines Management Report Post BOD	Fiona Couper
		Medicines priorities update on progress	All		
August 2014 - no meeting					
		For discussion/decision	**Owner**	**For noting**	**Owner**
Sep-14	Internal	Patient Safety alerts - action plans	Various authors	Task & finish group progress report	Various authors
		Risk register exception report for MMG	Fiona Couper	New clinical trials/research with medicines	Pat Mottram
		Review of Medicines incidents from DATIX	Steven Buckley	Product Updates	Abiola Allinson
		NICE six-monthly report	Pat Mottram	Medicine policies – tracker review each meeting	All
		Quarterly Antibiotic Audits (June Audit) and Physical Health input	Kath Jones/Karen Herbert		
		NMP Annual Review	Maria Nelligan		
		MMG to review all high risk medication errors coming into CWP during their meetings from Datix	All		
		PGDs for approval	Karen Herbert		
		Medicines Management Awareness Training report	Steven Buckley		

		For discussion/decision	Owner	For noting	Owner
Oct-14	**Interface**	Policies for approval Various authors	Various authors	Task & finish group progress reports	Various authors
		New products for approval	Abiola Allinson	Product Updates	Abiola Allinson
		Primary care issues from each locality/CCG	All		
		Medicines priorities update on progress	All		
		For discussion/decision	**Owner**	**For noting**	**Owner**
Nov-14	**Internal**	Policies for approval Various authors	Various authors		
		Risk register exception report for MMG	Fiona Couper	Task & finish group progress reports	Various authors
		Review of Medicines incidents from DATIX	Steven Buckley	New clinical trials/research with medicines	Pat Mottram
		Annual Horizon scanning report on new medicines/medicine patent expiries/NICE impact on medicines for 2015-2016	Abiola Allinson	Product Updates	Abiola Allinson
		6 monthly Accountable officer report on controlled Drugs (Q1 & Q2)	Fiona Couper	Medicine policies – tracker review each meeting	All
		MMG to review all high risk medication errors coming into CWP during their meetings from Datix	All		
		PGDs for approval	Karen Herbert		
December 2014 - no meeting					
		For discussion/decision	**Owner**	**For noting**	**Owner**
Jan-15	**Interface**	Policies for approval Various authors	Various authors		
		New products for approval	Abiola Allinson		
		Annual Horizon scanning report on new medicines/medicine patent expiries/NICE impact on medicines for 2015-2016	Abiola Allinson		
		Primary care issues from each locality/CCG	All		
		Medicines priorities update on progress	All		
		For discussion/decision	**Owner**	**For noting**	**Owner**
Feb-15	**Internal**	Policies for approval	Various authors	New clinical trials/research with medicines	Pat Mottram
		MMG business cycle 2015/16	Fiona Couper	Product Updates	Abiola Allinson
		Quarterly Antibiotic audit report (Dec audit) and Physical Health input	Kath Jones/Karen Herbert	Medicine policies – tracker review each meeting	All
		NICE 6 monthly report	Pat Mottram	Task & finish group progress reports	Various authors
		PGDs for approval	Karen Herbert		
		Risk register exception report for MMG	Fiona Couper		
		Review of Medicines incidents from DATIX	Steven Buckley		
		MMG to review all high risk medication errors coming into CWP during their meetings from Datix	All		
		Medicines Management Annual Audit Report - now for April	Kath Jones		
		Medicines Management Awareness Training report	Steven Buckley		

		For discussion/decision	Owner	For noting	Owner
Mar-15	**Interface**	Policies for approval	Various authors		
			Abiola Allinson		
		Primary care issues from each locality/CCG	All		
		Medicines priorities update on progress	All		
		For discussion/decision	**Owner**	**For noting**	**Owner**
ad hoc	**ad hoc**	CAS Patient Safety alerts		Medicine related audits	Various authors
		Medicine alerts/Medicines Communication Bulletins	Abiola Allinson	Learning from incidents related to medicines	Various authors
		Medicine Safety publications	Kath Jones	Care pathways medicine components	Various authors
		POMH-UK audit reports	Kath Jones		
		NICE guidance related to medicines	Pat Mottram		
		Exception reporting of overdue Trust-wide action plans allocated to the MMG	Fiona Couper		

Appendix 2: Attendance and Declarations of interest 2014-15

Internal MMG			Interface MMG		
Member	**Number of meetings attended**	**Declaration of interest**	**Member**	**Number of meetings attended**	**Declaration of interest**
Abiola Allinson	5/6	April 14 - AA attended a conference sponsored by Janssen-Cilag Ltd	Abigail Cowan	2/4	
Andrew Weaver	2/6		Abiola Allinson	3/4	January 15 - AA attended a Lurasidone meeting in December 2014
Carys Jones	3/6		Andrew Weaver	1/4	
David Appleton	1/6		Andy Dunbavand	4/4	
David Young	3/6		Barbara Perry	0/4	
Fiona Couper	6/6	April 14 - FC attended Pharmacy Management National Seminar for England sponsored by various companies	Becky Birchall	4/4	
Francis Cook	0/6		David Young	0/4	
Gill Bale	0/6		Fiona Couper	4/4	
Helen Leyland	1/6		Francis Cook	0/4	
Iain Wells	5/6		John Oates	1/4	
Janet Durrans	1/6		Jose Ferran	1/4	
Jose Ferran	3/6		Maria Nelligan	1/4	
Joy Fenna	3/6		Mark Dickinson	4/4	May 14 - MD advised the group of his declaration of interest in his work with D.B. Ashbourne who are releasing a branded generic of quetiapine MR. October 14 - MD made a declaration of interest regarding DB Ashbourne for Ebesque XL. MD also declared his interest locally also and was not involved in the decision to approve its use locally or within CWP.
Karen Herbert	1/6		Pauline Roberts	1/4	
Kate Chapman	0/6		Peter Arthur	1/4	
Katharine Jones	4/6		Sarah Proctor	2/4	
Linda Johnstone	0/6		Steve Buckley	2/4	March 15 - SB attended a NW Pharmacy Meeting sponsored by Sunovion in October 2014.
Lynn Clark	2/6		Victoria Vincent	1/4	
Maria Nelligan	0/6				
Pat Mottram	3/6	April 14 - PM made declarations of interest with Roche, Otsuka and Lundbeck			
Paula O'Toole	1/6				
Rachel Jervis	4/6				
Sarah Proctor	3/6				
Steve Buckley	4/6				
Sumit Seghal	1/6				
Susan Haden	3/6				
Vikram Palanisamy	3/6				

Cheshire and Wirral Partnership NHS
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STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Proposals from Membership and Development Sub-Committee of the Council of Governors – Proposed constitutional changes
Agenda ref. no:	15/16/48
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/07/2015
Presented by:	Louise Brereton, Head of Corporate Affairs

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

REPORT BRIEFING

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

The Council of Governors recently tasked the Membership and Development Sub Committee with considering potential changes to the Constitution. The reason for this was two-fold; firstly, in respect of the changes to the Model Election Rules, and secondly, in light of recent difficulties to successfully recruit to a full Council.

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

The paper outlines the options considered by the Membership and Development sub committee on behalf of the Council and makes a number of recommendations to the Council of Governors for consideration and decision.

The Council of Governors will be discussing these proposals at the next Council meeting on 24th July 2015

Assessment – *analysis and considerations of options and risks*

The Membership and Development sub committee gave consideration to the following potential Constitutional changes :-

- The inclusion of the new Model Election Rules to enable electronic voting
- The number of Public Members Seats
- The number of Service User / Carer Seats
- The continued inclusion of an out of area seat within the public constituency
- The constituencies included within the Constitution
- The qualifying period for members who wish to become Governors
- Representation of young members

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

Subject to the approval of the proposals by the Council of Governors at their meeting, the Board of Directors are recommended to approve the recommendations and the proposed changes to the Trust Constitution.

Who/ which group has approved this report for receipt at the above meeting?		Membership and Development Sub-Committee
Contributing authors:		Rob Robertson – Chair of M&D
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
Click here to enter text.	Council of Governors	14 July 2015

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1	Proposed amendments to the Trust constitution

Item: 15_16_49_Appendix 1

Proposals from Membership and Development Sub-Committee on behalf of the Council of Governors.

Proposed amendments to the Trust Constitution

Purpose and Background

The Council of Governors recently tasked the Membership and Development Sub Committee with considering potential changes to the Constitution. The reason for this was two-fold; firstly, in respect of the changes to the Model Election Rules, and secondly, in light of recent difficulties to successfully recruit to a full Council.

The paper outlines the options considered by the Membership and Development sub committee on behalf of the Council and makes a number of recommendations to the Council of Governors for consideration and decision.

Considerations

The Membership and Development sub committee gave consideration to the following potential Constitutional changes:

- The inclusion of the new Model Election Rules
- The number of Public Members Seats
- The number of Service User / Carer Seats
- The continued inclusion of an out of area seat within the public constituency
- The constituencies included within the Constitution
- The qualifying period for members who wish to become Governors
- Representation of young members

Discussion and Conclusions

1. Inclusion of the New Model Election rules

The Membership and Development sub committee were informed that the new Model Election Rules were now published. These move Foundation Trusts to adopt electronic voting methods as well as preserving the option to vote by post.

All new Foundation Trusts are required to adopt the rules from their first election however all foundation trusts are being encouraged to use the new rules in order to broaden the voting methods for elections which may impact on increasing the turnout of votes for the elections. It is felt that the Council should approve the adoption of the new rules.

A copy of the model election rules is available at http://www.nhsproviders.org/resource-library/model-election-rules-word-version/?preview=true

The Membership and Development sub committee, therefore concluded that the new model election rules should be included in the Constitution and future elections need to adopt electronic voting processes.

2. The Number of Governors in Public and Service User / Carer Constituencies

Following on from governor recruitment difficulties during 2014 that led to a need for additional elections, COG asked the Membership and Development sub committee to review the Governor Constituencies (COG meeting September 2014) .

There is some recent evidence in Cheshire East that members who are Service Users or Carers have chosen to be elected as Public Governors. This has occurred whilst there were vacancies for Service User/ Carer Governors.

Given the above, the constitutional change recommended to the Council of Governors is to increase the number of governors in the constituency of Public Governors from 7 to 9 and reduce the number in the Service User/Care constituency from 12 to 10 as per table 1 (which also reflects in the changes to constituency numbers in 2013).

Table 1

	NUMBERS		**of GOVERNORS**
Constituency	**Pre 2013**	**Current**	**RECOMMENDATION From NOVEMBER 2015**
+Public	10	7	**9**
+Service user/Carer	9	12	**10**
+Staff	6	7	**7**
***Local Authority**	3	3	**3**
***University**	1	1	**1**
***Partnership**	4	4	**4**
Total	33	34	**33**

Note

+ Elected; * Appointed

Public Governors represent members from three geographical areas of the Trust and members from outside the boundary of the Trust. The proposed allocation of Public Governors is per Table 2. The sub committee acknowledged that Out of Area Members are not proportionately represented.

Table 2

Public Constituency	**Number of Members**	**Proposed new allocation of Governors**
WIRRAL	3251	3
CHESHIRE EAST	2426	2
CHESHIRE WEST	3297	3
OUT of AREA	1589	1

3. The Continued inclusion of an Out of Area Seat within the Public Constituency

Recent experience is that the role of Out of Area Governor has been inactive. The Sub Committee sought advice as to the purpose of this Public Governor role. Consideration was given to the recent growth in services that are being delivered outside the boundary of CWPT. The conclusion of this was to propose no change.

4. The Constituencies included in the Constitution

In view of the recent recruitment difficulties, the sub committee considered the possibility of combining the Public and Service User / Carer Constituencies. This would result in only two constituencies for elected governors; i.e. Staff and Public. This is a usual arrangement for Hospital Foundation Trusts. A minority of Non Hospital Foundation Trusts in England (16 out of 42) have a Service User/Care constituency.

This is perhaps an issue that requires more in-depth consideration by the full Council. The sub committee, therefore, recommends that this is not included in any constitutional change for this year, and proposes that wider discussions are held to consider this further.

5. Qualifying Period for Members who wish to become Governors

There is again evidence in recent elections of individuals who are not yet members of the Trust or who have not been members of the Trust for 12 months expressing an interest in nominating themselves to become Governors. Unfortunately, due to the current Constitution, we have had to reject their applications until the qualifying period has been met.

The Membership and Development sub committee, therefore, recommends that the qualifying period is reduced from 12 months to 3 months. If this is approved, Members will not have to wait for 12 months before seeking election to be a governor. The opportunity will be available 3 months after becoming a member.

6. Representation of Young Members

Success of Children and Adolescent Mental Health Service (CAMHS), is fundamental to the Trust. There are around 500 members under the age of 21. The Membership and Development sub committee took the view that young members interests are underrepresented. This led to meeting representatives of young people e.g. Young Advisers and asking if they are interested in contributing to the governance of the Trust. Attendance by two young people at the COG meeting in May 2015 confirmed that there is a genuine interest.

The Membership and Development sub committee has recently made strong links with the Participation Workers in each of the localities. It is apparent that young people are very much involved in the work of the Trust and the Membership and Development sub committee is currently exploring how we as a Council can make better links with these forums in order to more effectively represent their views.

In terms of electing young people to the Council, there may still be some work for the Council to progress such as considering the time that our meetings are held to better meet the needs of young people. However, in view of introducing young people to the Council the Membership and Development sub committee propose that young members be actively invited and encouraged to attend the Council of Governors meetings in an observational capacity.

The Council are asked to consider the above, however this will not form part of the formal Constitutional changes.

Recommendation to the Council of Governors

The Council of Governors is asked to consider and agree the following changes to the Trust Constitution:-

1. To confirm their acceptance of the new model election rules.
2. To agree an increase by two seats to the Public Constituency (7 to 9) and a decrease by two seats to the Service User / Carer Constituency (12 to 10).
3. To agree the proposed geographical spread of the Public Constituency seats.
4. To agree a reduction to the qualifying period of members who wish to become Governors from 12 months to 3 months.

The Council of Governors is also asked to consider and agree the following (however, this will not form part of the formal Constitutional change):-

1. To actively invite and encourage young members to attend the Council of Governors meetings in an observational capacity.
2. To decide if further debate is required to consider combining the Service User / Carer and Public Constituencies, resulting in two Constituencies for elected Governors; i.e. Staff and Public.

Cheshire and Wirral Partnership NHS
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CHAIR'S REPORT
AUDIT COMMITTEE
30 June 2015

The following is a summary of issues discussed and any matters for escalation from the June 2015 meeting of the Audit Committee:

Review of individual strategic risk

The Committee did not undertake a risk review at the June 2015 meeting and requested that the next in-depth review at the September 2015 meeting will focus on assurances from the physical health/ environmental risks and an in-depth overview of the modelling of the cyber threat risk.

Internal Audit progress update
The Audit Committee received an update on the outcomes of recent audits including an audit on serious and untoward incidents (SUIs) which had received significant assurance. The Quality Committee will receive the revised SUI policy at the August 2015 meeting.

External Audit technical update
KPMG provided a technical briefing providing an update on regulatory and policy matters recently announced. This included a focus on Monitor consultation on the risk assessment framework and the potential impact of the proposed metrics.

Integrated Governance Framework strategy
The Audit Committee received an update on some of the changes to the integrated governance strategy. This mainly pertained to improvements to the committee structure and reporting lines undertaken subsequent to the 2014/15 review of committee effectiveness.

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

Minutes of the meeting held 30th June 2015