Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting of the Foundation Trust Board of Directors
Wednesday 26th July 2017
Romero Centre, Macclesfield
1.30pm

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
17/18/21	Apologies for absence	Receive apologies	Verbal	Chair	1 min (1330)
17/18/22	Declarations of Interest	Identify and avoid conflicts of interest	Verbal	Chair	2 min (1331)
17/18/23	Minutes of the previous meeting held 24th May 2017	Confirm as an accurate record the minutes of the previous meetings	Written minutes	Chair	2 mins (1333)
17/18/24	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 (1335)
17/18/25	Board Meeting 2017/18 business cycle	Confirm that agenda items provide assurance that the Board is undertaking its duties	Written	Chair	3 mins (1337)
17/18/26	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	10 mins (1340)
17/18/27	Chief Executive's announcements *(including overview of items discussed in closed meeting)*	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	10 mins (1350)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
MATTERS FOR APPROVAL/ DECISION					
Operational Performance/ Finance & Use of Resources					
17/18/28	Operational Plan and Performance dashboard: June 2017 data	To note performance	Written Report	Deputy Director of Finance	15 mins (1400)
Strategic Change					
17/18/29	Strategic Risk Register and Assurance Framework	To note updated assurance framework and risk register	Written Report	Medical Director	15 mins (1415)
Quality of Care					
17/18/30	National Quality Board Mortality reporting guidance overview	To note report and requirements	Written Reports	Director of Nursing, Therapies and Patient Partnership	15 mins (1430)
17/18/31	Safer Staffing: • a. Six monthly report • b. Daily ward staffing figures: May & June 2017	To note the ward staffing reports	Written Report	Director of Nursing, Therapies and Patient Partnership	30 mins (1445)
Governance					
17/18/32	Data Security, Caldicott3 and the new General Data Protection Regulation (GDPR).	To note new forthcoming requirements	Written Report	Medical Director	10 mins (1515)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
17/18/33	Annual Report 2016/17: Safeguarding Children and Adults	To note report	Written Report	Andrea Hughes, Deputy Director of Nursing	10mins (1525)
17/18/34	Annual Report 2016/17: Infection, Prevention and Control	To note report	Written Report	Andrea Hughes, Deputy Director of Nursing/ Director of IPC	10 mins (1535)
17/18/35	Annual Report 2016/17: Medicines Management	To note report	Written Report	Medical Director	10 mins (1545)
17/18/36	Matters of Governance: • a. Guardian of Safe Working hours (Junior Doctors) quarterly declaration • b. Medical Appraisal and Revalidation • c. Fit and Proper Persons Register of Checks and Declarations • d. Register of Seals 2016/17	To approve declaration To approve declaration To note register To note register	Written Reports	Medical Director Medical Director Director of People and OD Head of Corporate Affairs	15 mins (1555)
17/18/37	Audit Committee reporting: • Chair's report of meeting held 4 July 2017	Review Chair's Report and terms of reference and any matters for note/ escalation	Written Report	Chair of Audit Committee	3 mins (1610)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
17/18/38	Quality Committee reporting : • Chair's report of meeting held 5 July 2017	Review Chair's Report and any matters for note/ escalation	Written Report	Chair of Quality Committee	3 mins (1613)
17/18/39	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair/ All	5 mins (1616)
17/18/40	Any other business	Consider any urgent items of other business	Verbal or written	Chair	2 mins (1621)
17/18/41	Review of meeting	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair/All	2 mins (1623)
17/18/42	Date, time and place of next meeting: **Wednesday 27th September 2017, Boardroom, Redesmere**	Confirm arrangements for next meeting	Verbal	Chair	1625

Cheshire and Wirral Partnership NHS Foundation Trust
Board of Directors meeting Business Cycle 2017/18

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

No:	Agenda Item	Executive Lead	Responsible Committee/ Subcommittee	26/04/2017 Seminar	24/05/2017	28/06/2017 Seminar	26/07/2017	27/09/2017	25/10/2017 Seminar	29/11/2017	20/12/2017 Seminar	31/01/2018	28/02/2018 Seminar	28/03/2018
Strategic Change														
1	**Chair and CEO report and announcements**	Chair	N/A		✓		✓	✓		✓		✓		✓
2	**Strategic Risk Register and Corporate Assurance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee		✓			✓				✓		✓
Quality of Care														
3	**Learning from Experience Report executive summary**	Director of Nursing, Therapies and Patient Partnership	Quality Committee		✓			✓				✓		
4	**Quality Improvement Report**	Medical Director Compliance Quality and Regulation	Quality Committee		✓			✓				✓		
5	**CQC Community Patient Survey Report 2016/17 and Action Plan**	Director of Nursing, Therapies and Patient Partnership	Operational Board					✓						
6	**Zero Harm strategy**	Medical Director Compliance Quality and Regulation	Quality Committee									✓		
7	**Staff survey 2017/18**	Director of HR and OD	People and OD subcommittee (Operational Board)											✓
8	**Freedom to speak up six monthly report**	Director of Nursing, Therapies and Patient	Operational Board					✓						✓
9	**Receive Quarterly Infection Prevention Control Reports**	Director of Infection Prevention and Control	Infection, Prevention and Control subcommittee		✓			✓		✓		✓		
10	**Director of Infection Prevention and Control Annual Report 2016/17 inc PLACE**	Director of Infection Prevention and Control	Infection, Prevention and Control subcommittee (Quality Committee)				✓							
11	**Safeguarding Children Annual Report 2016/17**	Director of Nursing, Therapies and Patient	Safeguarding subcommittee				✓							
12	**Quartely Safeguarding Report**	Director of Nursing, Therapies and Patient Partnership	Safeguarding subcommittee				✓	✓		✓		✓		

13	**Safeguarding Adults Annual Report 2016/17**	Director of Nursing, Therapies and Patient	Safeguarding subcommittee				✓								
14	**Accountable Officer Annual Report inc. Medicines Management 2016/17**	Medical Director Compliance Quality and Regulation	Medicines Management Group (Quality Committee)				✓								
15	**Monthly Ward Staffing update**	Director of Nursing, Therapies and Patient Partnership	Quality Committee		✓		✓	✓		✓		✓			✓
16	**Receive Research Annual Report 2016/17**	Medical Director Effectiveness Medical Education and Medical Workforce	Operational Board					✓							
17	**Receive Medical Appraisal Annual Report 2016/17 and annual declaration of medical revalidation**	Medical Director of Effectiveness and Medical Workforce	People and OD subcommittee (Operational Board)				✓								
18	**Care Quality Commission Registration Report**	Director of Finance	Operational Board									✓			
Finance and Use of Resouces															
19	**Receive Annual Report, Accounts and Quality Account**	Director of Finance	Audit Committee (Quality Committee for QA)		✓										
Operational Performance															
20	**Information Governance 2017/18Toolkit**	Medical Director	Records and Clinical Systems Group (Quality Committee)												✓
21	**Health and Safety Annual Report (inc. Fire) 2016/17**	Director of Nursing, Therapies and Patient Partnership	Health, Safety and Well-being subcommittee (Operational Board)					✓							
22	**Security Annual Report 2016/17**	Director of Operations	Health, Safety and Well-being subcommittee					✓							
23	**Central Cheshire Integrated Care Partnership (CCICP) reporting**	Director of Operations	Operational Board		✓		✓	✓		✓		✓			✓
24	**Equality Act Compliance**	Director of Nursing, Therapies and Patient Partnership	Operational Board					✓							
25	**Board Performance Dashboard**	Director of Finance	Operational Board		✓		✓	✓		✓		✓			✓
Governance															

26	**Register of Sealings**	Director of Finance	Audit Committee				✓								
27	**Provider Licence compliance review and Approval of Licence Declarations**	Director of Finance	Audit Committee		✓										
28	**Statutory Registers: Directors and Governors**	Chair	Audit Committee		✓										
29	**CEO /Chair Division of Responsibilities**	Chair	N/A		✓										
30	**Integrated Governance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee					✓							
31	**Minutes and/or Chair's Report of the Quality Committee**	Non Executive Director	N/A		✓		✓	✓		✓		✓			✓
32	**Minutes and/or Chair's Report of the Audit Committee**	Non Executive Director	N/A		✓		✓	✓		✓		✓			✓
33	**Audit Committee annual effectivenes review**	Non Executive Director			✓										
34	**BOD Business Cycle 2017/18**	Chair	N/A		✓		✓	✓		✓		✓			✓
35	**Approve BOD Business Cycle 2018/19**	Chair	N/A												✓
36	**Review Risk impacts of items**	Chair/All	N/A		✓		✓	✓		✓		✓			✓

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Minutes of the Board of Directors Meeting
Wednesday 24th May 2017
Redesmere, Countess of Chester Health Park, Chester
1.00pm

PRESENT	Mike Maier, Chair Andrea Campbell, Non-Executive Director Dr Jim O'Connor, Non-Executive Director Lucy Crumplin, Non-Executive Director Sheena Cumiskey, Chief Executive Avril Devaney, Director of Nursing, Therapies and Patient Partnership David Harris, Director of People and Organisational Development Edward Jenner, Non-Executive Director Andy Styring, Director of Operations Tim Welch, Director of Finance Sarah McKenna, Non-Executive Director Rebecca Burke-Sharples, Non-Executive Director Dr Anushta Sivananthan, Medical Director, Quality, Compliance and Assurance
IN ATTENDANCE	Louise Brereton, Head of Corporate Affairs Katherine Wright, Associate Director Communications and Engagement Andrea Hughes, Deputy Director of Nursing (for item 17/18/10) Sean Boyle, Partnership Governor (from item 17/18/08) David Seiber, Mental Health UK
APOLOGIES	Dr Faouzi Alam, Medical Director

	MINUTES	ACTION
17/18/01	**Apologies for absence** Mike Maier welcomed all to the meeting and advised that the meeting was a meeting held in public. Apologies were noted from Dr Faouzi Alam. The meeting was quorate.	
17/18/02	**Declarations of Interest** None was declared.	
17/18/03	**Minutes of the previous meeting held 29th March 2017** The minutes of the last meeting held 29th March 2017 were reviewed. The minutes of the meeting held 29th March 2017 were **approved** as a correct record.	
17/18/04	**Matters arising and action points** 16/17/138: The six monthly report is due to report to the Board in July 2017 which will take account of these issues. Action closed. 16/17/142: Action being progressed by the People and OD Sub-Committee. Action closed.	

17/18/05	**Board Meeting 2017/18 business cycle** The business cycle was reviewed. It was noted that some items had been deferred due to the IT outage caused by the cyber-attack. This will report to future Board meetings	
17/18/06	**Chair's announcements** The Chair announced the following: **National cyber-attack IT update** CWP was one of NHS Trusts affected by the NHS cyber-attack on Friday 12 May and the days that followed. Almost all Trust systems are now back online. Thanks were extended to the IT and Emergency Planning teams for their hard work in resolving this issue and to clinical staff for continuing to provide excellent care without access to electronic patient records, booking systems and other key online tools. Our business continuity plans worked well and it was confirmed that no patient data was lost during the cyber-attack with clinical services continuing uninterrupted. CWP remains in major incident mode whilst the recovery phase continues. All members of the Trust Board appreciate that the recovery phase will take time. It has been a challenging few days, but also a wonderful reminder of all the things that make CWP such a great place to work and receive care; dedicated, resourceful and committed staff who put the care of patients first. **Awareness campaigns** The Trust has been proud to mark Mental Health Awareness Week, International Nurses Day and Dementia Awareness Week. There were many celebrations and activities across the Trust. These campaigns are useful tools for recognising staff efforts and raising awareness of the important work we do as a Trust. **Ancora House** Estates and Facilities celebrated a double award win at this year's Design in Mental Health Awards for their excellent work in developing Ancora House – our purpose-built CAMHS unit in Chester, which opened in September last year. The Trust was named winner in the 'Project of the Year' and 'Service User Engagement' categories at the national awards in Birmingham. **Trainee Nursing Associates impress Health Education England** Earlier this month we welcomed senior officials from Health Education England to Sycamore House in Ellesmere Port, where they met some of our Trainee Nursing Associates and learnt more about Cheshire and Wirral's Nursing Associate programme. The event was a huge success, with HEE Chairman Sir Keith Pearson praising the person centred nature	

	of the programme and current trainees. Thanks were given to our senior nursing team, the University of Chester and our partner Trusts across Cheshire and Wirral who are working collaboratively and effectively to produce a fantastic pilot programme. **Manchester incident** CWP and NHS responses to recent national incidents were commended. The Board took a moment in reflection to remember those involved.	
17/18/07	**Chief Executive's announcements** *(including overview of items discussed in closed meeting)* Sheena Cumiskey provided an overview of the discussions in the closed Board meeting. These included: • Developments in local system working • The CWP response to the global cyber attack • Progressing the CWP forward view • M1 2017/18 financial performance. • 0-19 'Starting Well' tender mobilisation in West Cheshire. **Staff engagement work** An overview was given on recent breakfast meetings with Sheena Cumiskey held at Saddlebridge and the Stein Centre Teams. The sessions are proving a very useful opportunity to engage with staff and discuss topical issues. More sessions are planed over the next month.	
17/18/08	**Annual Reporting 2016/17:** • **Annual Report and Accounts** • **Quality Account** Mike Maier introduced the Annual Report, Accounts and Quality Account 2016/17 for approval and invited Rebecca, Burke Sharples, Interim- Chair of the Audit Committee to comment on the conclusion of the annual audit and review of the documents undertaken by the Audit Committee on 23.5.17. Rebecca provided an overview of the discussions at the Audit Committee and advised Board members that the external auditors, KPMG had issued the following: • For the Financial statements and Use of Resources audit, clean, unqualified opinions have been issued. • For the Quality Account, clean opinions have been issued for the audit of content and indicators. Reporting on the financial statements audit, the main risk area identified is around valuations and the timeliness of the revaluation survey. With regard to the Quality Account, clean opinions have been issued for both content and indicators. Should the locally selected indicator have required an opinion, these would also have been clean. Rebecca Burke-Sharples provided an overview of the recommendations arising from the audit. These included:	

	• The requirement for clearer audit trails for provisions to ensure these meet the criteria for IAS 37. • Cost improvement programme– KPMG were satisfied with the end position and the use of non-recurrent monies to reach the planed position; however there is an expectation that the new efficiency strategy must address the residual efficiency gap in year. Tim Welch advised that to ensure the Statement of Comprehensive Income (SoCI) reconciles to the NHSI position an additional table will be added into the accounts to set this out, which will also aid public understanding when published. This addition has been agreed by KPMG. The final position at end 2016/167 was confirmed to be £80k deficit, minus exceptional items. Including exceptional items, this was confirmed £6.5m deficit. It was noted that this is fully explained in the Annual Report. The Trust ended the year with a Use of Resources rating of 2 and in Segment 1 overall. Dr Anushta Sivananthan provided an overview of the Quality Account, including the quality priorities for 2017/18. Some of the feedback from external bodies is still awaited for the Quality Account. Should this arrive prior to submission, then it will be included. Should this not arrive in time, a note will be included in the final document. The Board noted that following approval at the meeting today, work will continue to refine the Annual Report, Accounts and Quality Account. This will focus on presentational issues only. Submission is required by 31 May 2017 and the process will involve review of the final documents and any changes by Sheena Cumiskey, with final approval for submission to be provided by both Sheena and Mike Maier. Thanks were extended to Tim Welch and his team for their work on the Accounts and to Louise and colleagues for the production of the Annual Report. Thanks were also extended to Matt Rowan, KPMG for his work on the audit. The Board of Directors **approved** the Annual Report, Accounts and Quality Account 2017/18	
17/18/9	**Operational Plan and Performance dashboard: April 2017** Tim Welch presented the performance dashboard for month 1. There were no exceptions to escalate. The Board of Directors **noted** the report. (Andrea Hughes joined the meeting)	
17/18/10	**Freedom to Speak up Guardian: annual report** The Chair welcomed Andrea Hughes to the meeting. Andrea Hughes presented the report and highlighted the following key points: • There are increasing requirements from the National Guardian's Office on Freedom to Speak Up.	

	• A smart phone app is in development for Freedom to Speak Out which is designed to ensure all staff have an easy access facility available for reporting issues. • 15 Freedom to Speak Up ambassadors have been trained. The ambition is to recruit 50 ambassadors across the Trust. • 12 concerns were reported in 2016/17 representing a decrease from last year however these are relatively small numbers so are largely inconclusive. Andrea Hughes provided an overview of themes raised. All concerns are investigated and are responded to. The recent staff survey results provide helpful reassurance that progress is being made. Rebecca Burke-Sharples commented that the Trust benefits significantly from Andrea Hughes' expertise taking the lead for Freedom to Speak Out. It was also noted that although national performance on the staff survey is very positive, only 51% of staff feel they are treated fairly as a result of reporting. This needs consideration by communications and organisational development to ensure we continue to challenge perceptions and to ensure staff feel like they are always treated equally and fairly. Andrea Hughes commented on her attendance at team meetings to raise awareness and the potential to link into the Deanery and Medical Education to raise awareness amongst medics. The Board **noted** the report. (Andrea Hughes left the meeting)	
17/18/11	**Learning from Experience: Executive Summary report** Avril Devaney presented the report and highlighted that the National Quality Board has launched the national guidance on learning from deaths. Avril Devaney and Dr Jim O'Connor will be the patient safety director and Non-Executive Director respectively to take oversight of progress. An internal group will be established which will review the guidance and ensure the Trust compliance. This will report back to the Board at regular intervals. The Board **noted** the report.	
17/18/12	**Quality Improvement Report** Dr Anushta Sivananthan presented the report and highlighted a number of key points: • Work undertaken to improve the uptake of Hepatitis B vaccinations and other blood borne virus for those in substance misuse services and those who maybe at a greater risk. • Work to embed a person centred approach to clinical care across services, particularly demonstrated through the young people's takeover challenge. The Board noted the report.	

17/18/13	**Safer Staffing: Daily Ward Staffing figures: March & April 2017** Avril Devaney presented the report and reminded Board members that the report is presented in accordance with National Quality Board requirements. Avril Devaney advised Board members that the six monthly staffing report will be presented to the Board in July 2017. This will comprise of four parts and will give Board members increased insight into staffing levels across the Trust. The Board noted that Dr Jim O'Connor had recent met with Gary Flockhart to discuss concerns arising from staff working additional hours. Assurance was provided that this was not causing any adverse impacts on staff or patients. The Board **noted** the report.	
17/18/14	**Matters of Governance:** • **a. Provider Licence 2016/17 review and declarations (G6 &CoS7 and FT4)** Louise Brereton advised Board members that the six monthly review of the licence had been undertaken. It was confirmed that the Trust is compliant with the Licence. The Board considered the Licence declarations G6, CoS7 and FT4. The Board confirmed and **approved** the following declarations: • Condition G6: Systems in place for licence compliance, NHS constitution and NHS Act • Condition FT4: compliance with governance standards and objectives, including provision of governor training • Condition CoS7: certification of the reasonable expectation that the required resources to deliver services are available. • **b. Chair and CEO division of responsibilities** The Board reviewed the Chair and Chief Executive division of responsibilities. The Board **approved** the report • **c. Statutory Registers** - **Directors** - **Governors** - The Board **noted** the 2016/17 Registers of declared interests for Directors and Governors.	
17/18/15	**Audit Committee reporting:** • **Chair's report of meeting held 2nd May 2017** • **AC Annual Report 2016/17**	

	• **2017/18 Terms of Reference** Edward Jenner summarised proceedings of the last meeting. There were no matters of exception. The Terms of Reference were reviewed and agreed. The Board resolved to **receive** the Chair's Report, **note** the Annual Report of the Committee and to **approve** the Terms of Reference.	
17/18/16	**Quality Committee reporting :** • **Chair's report of meeting held 3rd March 2017** • **QC Annual Report 2016/17** • **2017/18 Terms of Reference** Dr Jim O'Connor gave an overview of the Quality Committee meeting. There were no matters of escalation. The Terms of Reference were reviewed and agreed. The Board resolved to **receive** the Chair's Report, **note** the Annual Report of the Committee and to **approve** the Terms of Reference.	
17/18/17	**Review of risk impacts of items discussed** Mike Maier offered members of the public in attendance the opportunity to ask questions. A discussion ensued on staffing levels, delayed transfers of care and service integration.	
17/18/18	**Any other business** None was raised.	
17/18/19	**Review of meeting** All agreed the meeting had been effective.	
17/18/20	Date, time and place of next meeting: **Wednesday 26th July,9.30am Romero Centre, Macclesfield**	

Signed

Mike Maier, Chair

Date:

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Action points from Board of Directors Meetings
July 2017

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
29/03/17	16/17/135	**Well-led governance review** LB to draft letter to NHSI on behalf of the Trust Chairman.	7.4.17	LB	Letter to Simon Elliot sent 8.4.17	Closed
29/03/17	16/17/138	**Daily Ward Staffing figures January/February 2017** Follow up previous discussions on community staffing dashboard with Gary Flockhart and also explore ways to make the monthly staffing report more reflective of risks issues such as working additional unplanned hours.	April 2017	DH/ AD/ GF	Issued discussed by DH with GF who is taking this forwards as part of the Safer Staffing work.	Closed
29/03/17	16/17/142	**Junior Doctors quarterly declaration** Dave Harris to look into rostering issues for junior doctors and to continue to progress centralising bank for medics	April 2017	DH	Ian Porter (Guardian of Safe Working) put in contact with Head of Resourcing and People Information to inform ongoing development of e-rostering. Draft proposal for medical bank submitted to Medical Director and Director of POD for comment prior to submission to Ops Board. Paper scheduled for July Ops Board	Closed.
Meeting of 24th May 2017- no actions arising						

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Operational Plan 2017/18- delivery indicators dashboard June data]
Agenda ref. no:	17/18/28.
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	26/07/2017
Presented by:	Tim Welch, Director of Finance/Deputy Chief Executive

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which 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
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 Operational Plan 2017/18 sets out the Trust's approach to activity, quality, workforce planning and financial planning.

The dashboard attached in **appendix 1** reflects the key performance indicators (KPIs) defined to enable the Board to monitor the delivery of the Operational Plan and the Trust's strategic objectives and any risks to achievement. This report relates to June 2017 Performance.

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

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

Assessment – *analysis and considerations of options and risks*

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

The dashboard reflects month 3 with the following metrics being off track from the indicative baseline:

- Priority project 4: Redesign Adult & Older People MH Services Central and East; and
- Priority project 5: LD Transforming Care;
- SO3: 3.2 100% contractual targets met

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

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

The Board are recommended to **note** the May 2017 Board Operational Plan dashboard.

Who/ which group has approved this report for receipt at the above meeting?	Tim Welch, Director of Finance
Contributing authors:	Click here to enter text.

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Tim Welch	14/07/17

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	June 2017 Board Operational Plan Dashboard. Operational Plan 2017/18 – Delivery Indicators/ Board KPIs

Appendix 1: Trust Dashboard

	Indicator	Outturn 2016/17	Target or Thresholds for escalation	Target	May-17	Jun-16	Q1	General Comment
Strategic Objective 1 – Quality								
SO1: 1.1	Patient safety: The target for improvement is a 10% increase in the number of D&E incidents reported, based on numbers reported at the start of Trimester 1 of this year. The indicator is shown as a rate per 1,000 episodes of care.	58.6 per 1,000 episodes	Red: Below 2016/17 outturn Amber: better than 2016/17 outturn Green: above 2016/17 target(64.5)	75.6	58.6	62.2	65.4	Please note outturn position has been updated to reflect position as at the end of 2016/17.
SO1: 1.2	Patient experience: Demonstrable increase in the uptake of the Friends and Family Test (FFT) each quarter	Average 216 (per month)	237 per month	324.5			785	Baseline may change, following the setting of the baseline at Q1
SO1: 1.3	Clinical Effectiveness: Demonstrable improvement in the Trustwide average bed occupancy rate, excluding leave, for working age adult wards	93.19%			91.85%	88.77%	91.83%	
Strategic Objective 2: People and OD/ Approach to workforce								
SO3: 2.1	Capacity: % of staff vacancies (Contracted)	5.31%	4.15%		3.63%		4.05%	Please note outturn position has been updated to reflect position as at the end of 2016/17.
SO3: 2.2	Competence: % of staff receiving annual appraisal (via new proposed framework)	97.6%	100.0%					Please note outturn position has been updated to reflect position as at the end of 2016/17.
SO3: 2.3	% staff absence due to sickness	5.04%	Above annual plan projection for 3 months		5.15%	5.31%	5.46%	Performance measurement against Annual Plan Trajectory. Please n
Operational Performance / Priority areas								
SO3: 3.1	100% of the 13 NHSI operational performance targets achieved (including waiting times)	100%	100%	100%	93%	100%	100%	Please note outturn position has been updated to reflect position as at the end of 2016/17.
SO3: 3.2	100% Contractual targets met	324 (98.1%)	100%	100%	97.8%	95.7%		Wirral CCG - 8 indicators have been red for 3 or more months West Cheshire CCG Physical Health - 2 indicators have been red for 3 or more months
	CQUIN performance quarterly review	TBC	100%					Reporting for this indicator will be two months after the end of a quarter
SO3: 3.3	Priority project 1: West Physical Health Financial Recovery Plan	N/A	Delivery of Key Milestones					
SO3: 3.4	Priority project 2: Starting Well 0-19 services	N/A	Delivery of Key Milestones					
SO3: 3.5	Priority project 3: CAMHS T4	N/A	Delivery of Key Milestones					
SO3: 3.6	Priority project 4: Redesigning Adult & Older Peoples MH Services In Central and East Cheshire	N/A	Delivery of Key Milestones					Project Plan delayed and off track - OSC deferred Consultation proposal
SO3: 3.7	Priority project 5: LD Transforming Care	N/A	Delivery of Key Milestones					Project Plan delayed - Time delays due to non-realisation of historic CIP and delayed public consultation
Strategic Objective 6: Financial Planning								
SO6: 1	Use of resources		Use of Resources [UoR] score of 3 or 4		3	3	3	Further detail is available in Finance Report

Appendix 2: Trust Dashboard Reporting Framework

Op Plan ref	Indicator	Target or Thresholds for escalation	Base line	Reporting and Frequency	Reporting Months	01/04/2017	01/05/2017	Director Lead	Operational Lead	Risk Register/ CAF ref
Strategic Objective 1 – Quality										
SO1: 1.1	Patient safety: The target for improvement is a 10% increase in the number of D&E incidents reported, based on numbers reported at the start of Trimester 1 of this year. The indicator is shown as a rate per 1,000 episodes of care.	10% improvement in reporting of low and no harm incidents **Escalation Thresholds** Red: Below 2016/17 outturn Amber: better than 2016/17 outturn (58.6) Green: above 2016/17 target (64.5)	Red: Below 2016/17 outturn Amber: better than 2016/17 outturn Green: above 2016/17	Learning from Experience report Every 4 months	May August January April	Quality Committee	Trend line	Anushta Sivananthan/ Avril Devaney/ Jim O'Connor	David Wood	Risk 6 – learning from incidents (red 16)
SO1: 1.2	Patient experience: Demonstrable increase in the uptake of the Friends and Family Test (FFT) each quarter	10% improvement in Trustwide uptake of FFT	300 per month	Quality Improvement Report Quarterly	July October February April	Patient and Carer Experience Sub Committee	? Trajectory for improvement	Avril Devaney/ Fiona Clark/ Jim O'Connor	Liz Matthews	Risk 5 – feedback from learning (red 16)
SO1: 1.3	Clinical Effectiveness: Demonstrable improvement in the Trustwide average bed occupancy rate, excluding leave, for working age adult wards	Improvement to 85% by KH03's month 12 (December 2017)	93.19%	Continuous Improvement Report Monthly	May-March	Quality Committee	TBA	Faouzi Alam/Anushta Sivananthan/ Jim O'Connor/ Lucy Crumplin	Claire James	
SO3: 2.1	Capacity: % of staff vacancies	4.15%	5.31%	Any quarter in which each of the three months the staff vacancy rate is above the base line position	By exception	People and OD subcommittee	Chairs escalation	David Harris	Viv Williamson	Risk 11 – staffing (rated red 20)
SO3: 2.2	Competence: % of staff receiving annual appraisal (via new proposed framework)	100% of available eligible cohort	98%	Any quarter in which each of the three months the appraisal rate is below the baseline position	Quarterly	People and OD subcommittee	Performance against plan chart or variance from plan	David Harris	Hayley Rigby	Risk 11 – staffing (rated red 20)

SO3: 2.3	% staff absence due to sickness	5.30%	5.04%	Any quarter in which each of the three months the sick absence rate was % above the profile set out in the annual plan.	By exception	People and OD sub committee	Variance from target trend line	David Harris	Chris Sheldon	Risk 11- staffing (rated red 20)
Operational Performance / Priority areas										
SO3: 3.1	100% of the 13 NHSI operational performance targets achieved (including waiting times)	100%	87%	Any occasion where the compliance with any monitor target is missed for 3 consecutive months	By exception	Operational Board	Achievement trend line	Andy Styring/ Tim Welch	Service Directors	Risk in scope re. IAPT delivery
SO3: 3.2	100% Contractual targets met	100%	Avg 97.04%	Any occasion where the same target for any contractual KPI is missed for 3 consecutive months	By exception	Operational Board	Achievement trend line	Andy Styring/ Tim Welch	Service Directors	Risk in scope re. IAPT delivery
	CQUIN Achievement of milestones	(100% of CQUIN Milestones achieved)		Report quarterly on CCG confirmed achievement against milestones	By exception	Operational Board	written report	Andy Styring/ Tim Welch	Service Directors	Risk 14 Financial performance/ CIP delivery (rated red 16)
SO3: 3.3	Strategy priority 1: CAMHS T4	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	April - March	Operational Board	Delivery of Key Milestones	Andy Styring	Sharon Vernon	Risk 13 – tendering of services (rated amber 12)
SO3: 3.4	Strategy priority 2: West Cheshire 0-19 services	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	April - March	Operational Board	Delivery of Key Milestones	Andy Styring	Val Sturgess	Risk 13 – tendering of services (rated amber 12)

SO3: 3.5	Strategy priority 3: Local implementation of the transforming Learning Disability services strategy	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	April - March	Operational Board	Delivery of Key Milestones	Andy Styring	Kate Fleming	
SO3: 3.6	Strategy priority 4: Physical Community Services (South & Vale Royal contract)	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	April - March	Operational Board	Delivery of Key Milestones	Andy Styring	Karen Moore	Risk 13 – tendering of services (rated amber 12)
SO3: 3.7	Strategic priority 5: Developing potential options for enhancing inpatient provision	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	April - March	Operational Board	Delivery of Key Milestones	Andy Styring	Suzanne Edwards	
SO3: 3.8	Strategic priority 6: West Financial Recovery Plan	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	April - March	Operational Board	Delivery of Key Milestones	Andy Styring	Jane Palombella	Risk in scope re. IAPT delivery
Strategic Objective 6: Financial Planning										
SO6: 1	Use of resources	Use of Resources [UoR] score of 3 or 4	Plan	Monthly	April - March	Trust Board		Tim Welch/ Mike Maier/ Rebecca Burke Sharples	Andy Harland	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Corporate assurance framework and strategic risk register – update report
Agenda ref. no:	17-18-29
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	26/07/2017
Presented by:	Dr Anushta Sivananthan, 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	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 update 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 progress against the mitigating actions identified against the Trust's strategic risks and the controls and assurances in place that act as mitigations against each strategic risk. **As at July 2017, the Trust has 4 red and 5 amber rated strategic risks. 3 strategic risks are currently in scope. 1 strategic risk is suggested for archive.**

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 strategic 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 undertakes individual in-depth reviews of risks, with the Audit Committee undertaking periodic reviews of risk treatment processes for individual risks on an escalation/ enquiry basis.

Assessment – *analysis and considerations of options and risks*

New risks/ risks in-scope

- The *risk of failure to deliver elements of the Learning Disabilities Transforming Care Programme, resulting in potential impacts on patient care* has been added to the risk register (risk 6). The supporting risk treatment plan requires further work, however it should be noted that the pace of navigating this risk is quite rightly being implemented operationally to ensure quality and manage risk in real time.
- The longstanding in-scope *risk that the CWP workforce not having sufficient capability (capacity, confidence, competence) and resilience to deliver place-based systems of care* has now been modelled as a new risk to consolidate a number of workforce related risks that were associated but which were either in-scope, or detailed on the risk register but with a limited risk treatment plan. This risk has now been re-modelled to: *risk that the CWP workforce may not have sufficient capability (capacity, confidence, competence) to deliver place-based, person-centred care* (risk 11). This now has a comprehensive risk treatment plan, led by the Director of People and OD, with a completion date of December 2017.
- Three risks are in-scope. (1) The *risk of IT infrastructure failure resulting in a number of potential impacts including on patient care*. This is being re-considered in response to the cyber-attack. (2) The *risk of harm and/ or liability associated with the management of challenging behaviour in community settings due to training and policy deficits* was raised as an incident by the Challenging Behaviour/ Autism Specialist Nurse and is under review by the Clinical Education Team and the Safe Services Department. (3) The *risk to the delivery of safe and effective core community mental health services in the Central and East locality due to current available resource and lack of investment.* This was raised as an issue at the Executive Directors meeting on 4 July 2017 and will be scoped alongside the current risk 2 (Central & East service redesign).

Amended risk scores or re-modelled risks

Risk 12a and 12b has been rescored to 12 from 16 on the basis of the completion of much of the risk treatment plan and the opinion from the annual external audit, reducing the likelihood to a score of 3. An additional action has been added to the risk treatment plan around MHSDS dataset submission to mitigate risks arising from the lack of completeness of the data set.

Archived risks

- As above, risk 16 *The risk of insufficient junior doctor cover to be able to provide safe and therapeutic care to inpatients, 24 hours a day, 7 days a week* is suggested for archive as any residual issues have been covered by the re-modelling of risk 11 as above.
- All archived risks continue to be monitored, allowing for escalation back to the strategic risk register if required. This includes the *risk of breach of CQC regulations*, which is currently archived but being actively monitored. The next report will consider the Trust's position in relation to compliance with CQC associated regulations regarding EMSA standards. Quality improvement work is due for completion at the end of July 2017; the outcome will determine whether there is a need to re-escalate/ re-model this risk.

Exceptions – overdue risk treatment action points

An exception report is provided in the corporate assurance framework (4th tab) – no overdue actions to report.

Strengthening the identification of new risks

The Trust is currently working with the CQC and a number of other trusts on the prototype 'CQC Mental Health NHS Insight' report. Once this prototype report is populated with validated measures, CWP will use this as an early warning framework and actively use this intelligence to risk rate key lines of enquiry for consideration of them as risks to the Trust's strategic objectives.

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

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

Who/ which group has approved this report for receipt at the above meeting?		Board of Directors – business cycle requirement
Contributing authors:		L Brereton, D Wood
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Board of Directors	19/07/2017

Appendices provided for reference and to give supporting/ contextual information:	
Appendix no.	Appendix title
(attachment to agenda email)	Corporate assurance framework and risk register (click here)

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	National Guidance on Learning from Deaths
Agenda ref. no:	17-18-30
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	26/07/2017
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	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	No
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
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*

In March 2017, the National Quality Board published the first edition of the National Guidance on Learning from Deaths' to help standardise and improve the way that NHS trusts identify, report, review, investigate and learn from deaths, and engage with bereaved families and carers.

The NQB requires that the Boards of NHS trusts be responsible for ensuring the delivery of effective 'mortality governance' processes, with the following requirements for 2017/18 ahead of further developments in subsequent years. For 2017/18, this includes assurance of:

- Adoption of **effective and reasonable** methodology for undertaking case record reviews of high quality.
- The offer of **timely, compassionate and meaningful engagement** with bereaved families and carers.
- **Demonstration of learning**, which is acted upon and shared across the Trust to improve care and is reported in the Quality Account 2017/18.
- **Regular reporting in relation to deaths**, reviews, investigations and learning to the Board, which should be appropriately **challenged**.

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

The purpose of reviews and investigations of deaths, in which problems in care might have contributed, is to learn in order to prevent recurrence.

The Director of Nursing, Therapies & Patient Partnership is the 'patient safety director' responsible for the learning from deaths agenda. The Quality Committee Chair is the Non-Executive Director responsible for oversight of the process. These members of the Board have a duty to constructively challenge the unitary Board on the robustness and defensibility of decisions in ensuring clinical quality controls and systems of risk management, to ensure that the Board works towards achieving the highest standards in mortality governance.

Assessment – *analysis and considerations of options and risks*

Currently, all unexpected, inpatient and learning disability deaths are deemed as 'serious incidents' and are subject to a patient safety review. A Quality Improvement approach will be undertaken to help measure the impact the requirements of this work will have on the quality of learning and capacity at a local and corporate level.

Currently, the NQB guidance is limited to requirements on individual NHS trusts and is "likely to be updated to include wider providers of NHS care and whole healthcare systems". The Safe Services Department are collaborating with trusts within the STP and LDS footprints to encourage a whole systems approach. The Associate Director of Safe Services from CWP and Director of Patient Safety from Mersey Care NHS Foundation Trust delivered a presentation on 'Mortality in Mental Health' to the North West Directors of Nursing and Chief Nurses meeting on 19 July to encourage early debate in this area. Further, CWP has been invited to an inter-agency mortality workshop on 27 July, facilitated by Mazars, to review the national guidance, and agree a plan to enhance inter-agency working. Within CWP, a **mortality task and finish group** has been established to:

1. Develop and pilot methodology, using PDSA cycles (Plan, Do, Study, Act), to identify and review deaths associated with problems in care to focus efforts on identifying and integrating learning.
2. Nominate, educate and skill-up clinical reviewers who will undertake and record structured case record reviews.
3. Further strengthen current approaches to engaging with bereaved families and carers.
4. Identify effective means of acting on learning so that it demonstrably improves the quality of care.
5. Undertake an impact assessment of the national requirements, which includes the processes above and being assured that staff have protected time, to inform new ways of working and any resource requirements.

The current policy, processes and toolkits that support how we learn from deaths and engage with bereaved families and carers, will be reviewed and in September 2017 (as per NQB requirements).

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

The Board are asked to **discuss** and **note** the contents of this report and to be aware of the responsibilities outlined in the 'National Guidance on Learning from Deaths'.

Who/ which group has approved this report for receipt at the above meeting?	A Devaney
Contributing authors:	L Parker, A Jones, D Wood

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors – meeting in public	19/07/2017

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

Appendix no.	Appendix title
N/A	N/A

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Safer Staffing Six Monthly Review
Agenda ref. no:	17-18-31a
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	19/07/2017
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	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*
This report has been produced to provide Board members with details of the findings of the Safer Staffing six month review, covering November 2016 to April 2017, in line with NHS England and the National Quality Board [NQB] requirements. The information in this report is based on meetings with staff members, safer staffing group meetings, desk top review, and analysis of data.

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

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

Assessment – *analysis and considerations of options and risks*

The report details findings from actions agreed at the Operational and Trust Boards in January 2017 in relation to:

- Ward reviews, Hurst National Pilot and Benchmarking
- Impact on breaks
- Follow up actions relating to deep dive and e-roster update
- Widening the consideration of MDT in relation to Safer Staffing (OT update)
- Conclusion and Recommendations

One of the key areas of focus of the review has been on quality and quality benchmarking. As per the previous six monthly review, the general consensus from ward managers and clinical service managers is that the staffing establishment is fit for purpose to provide high quality care. It is recognised that contingency planning is required specifically for Adelphi and Greenways which is described further within the report.
Further exploration is required for CAMHS wards which will be undertaken in the next six monthly reviews.

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

The Board of Directors is asked to **approve** the recommendations and approach to future work streams as set out in appendix 1: "Six Monthly Safer Staffing Review"

Who/ which group has approved this report for receipt at the above meeting?	Avril Devaney
Contributing authors:	Gary Flockhart and Anne Casey

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1 2	Operational Board	July 2017

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

Appendix no.	Appendix title
1	Safer Staffing Six Monthly Review
2	Ward fill rates October 2016 to May 2017

Appendix 1 May 2017 Six Monthly Ward Staffing Review

1 Introduction

This report has been produced to provide Board members with details of the findings of the Safer Staffing six month review, covering November 2016 to April 2017, in line with NHS England and the National Quality Board [NQB] requirements. The information in this report is based on meetings with staff members, safer staffing group meetings, desk top review, and analysis of data.

The report summarises key actions completed to date and further action required based on the findings of the review.

In March 2017 NHS Improvement [NHSI] published draft national guidance specific to mental health. "Safe, sustainable and productive staffing in mental health services" is a draft improvement resource to help standardise safe, sustainable and productive staffing decisions in mental health services. CWP has participated in the national consultation including workshops held by NHSI adopting the principles of the national guidance in relation to safer staffing:

- Right staff
- Right skills
- Right place, right time
- Measure and improve
- Reporting

One of the key areas of focus of this review has been on quality and quality benchmarking. As part of the consultation during the review, ward managers and clinical service managers continue to report the impact of secondments and restrictions in practice during Human Resource (HR) investigations and the requirement to backfill or cover these posts which is considered within the 'Truth on a page' report and discussed at the safer staffing group meeting which occurs every six weeks.

The general consensus from ward managers and clinical service managers is that staffing establishments are fit for purpose to provide high quality care. It is recognised that contingency planning is required specifically for Adelphi and Greenways which is described further within the report.

Further exploration is required for CAMHS wards which will be undertaken in the next six monthly reviews.

1.1 Background to the Ward Nurse staffing review

Since the initial review presented to Board in January 2014 there have been 6, six monthly follow up reviews (including this one). Additionally, monthly reports have been provided to the Board of Directors from June 2014 onwards. In order to comply with NHS England and NQB requirements these reports and the Trust's performance are also published on CWP and NHS Choices websites. The Director of Nursing continues to have oversight of ward

staffing levels and reports directly to the Board of Directors in line with the NQB requirements.

The May 2017 review was carried out by the Associate Director of Nursing and Therapies (MH and LD) with support from the Head of Performance and Information, Nurse Consultant in Adult Acute Care (MH) and Senior Occupational Therapists. CWP adopted the approach from the initial staffing review which recommended the continuous improvement of workforce practices alongside considering safe staffing levels in relation to nursing, the wider Multi-Disciplinary Team (MDT) and other professions.

The reviewers met with representatives from wards including General Managers, Clinical Service Managers, Ward Managers, Modern Matrons, 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 last review. The areas discussed covered the range of factors impacting on nursing care challenges and the delivery of high quality care. The ward representatives were challenged on areas of practice and assumptions in order to support the resulting conclusions and recommendations.

The review team undertook analysis of the information available and have made recommendations to the Board within this report.

The review team have continued to engage with the Mental Health safer staffing national programme being led by NHS Improvement.

2 Report findings

The report consists of a number of reviews and analysis encompassing a comprehensive programme of work in relation to safer staffing progressed since November 2016 and reviewed in May 2017, comprising the following areas:

2.1 Ward reviews, Hurst National Pilot and Benchmarking

Methodology

The six-monthly ward staffing review was undertaken in May 2017. The review included both qualitative and quantitative data and methodology, following the Telford Model which uses a consultative approach based on professional judgement and using the Hurst safer staffing pilot outcomes data.

Hurst Tool outcomes

The Trust initially completed the Hurst Tool Safer Staffing Pilot across six wards, with Dr Keith Hurst reporting the Trust were within the top 10% of Acute Wards nationally for our quality scores. Following on from this the quality audit has been completed on all wards, with the exception of Bollin, Rosewood, Limewalk, Alderley and Greenways which will be completed in the subsequent six month period. The data was analysed by Dr Keith Hurst and the quality scores reported back based on discreet areas the audit focusses on:

- Assessing
- Planning
- Implementing
- Evaluating
- Ward Centred
- Overall

The quality audits were completed by the Consultant Nurse in Acute Care and a Lead Occupational Therapist.

The trust is seeking clarification from Dr Hurst with respect to the weighting and/or methodology applied when deriving the overall quality scores to understand the scoring, for example Juniper ward.

Whilst carrying out the audit themes emerged which were not being addressed by staff. These themes have been discussed with individual ward managers and during the service improvement days and strategies are being developed to implement change.

For example:-

- Inconsistent recording of allergies
- Inconsistent recording of section rights for relatives
- Inconsistent side effect monitoring
- Inconsistent recording of employment and financial status of patients.
- Inconsistent review of Care Plan at the CPA review.
- Inconsistent discharge planning within the care plan and clinical notes.

Table 1: Overall Quality Scores

Quality Score Results	Overall
Lakefield	94%
Brackendale	85%
Meadowbank	95%
Oaktrees	94%
Juniper	80%
Cherry	97%
Beech	94%
Adelphi	89%
Croft	95%
Saddlebridge	97%
Coral	83%
Indigo	84%
Willow	81%
Brooklands	94%
Bollin	To be completed
Rosewood	To be completed
Limewalk	To be completed
Alderley	To be completed
Greenways	To be completed

2.1.1 Acute wards [Bollin, Beech and Lakefield]

	Assessing	Planning	Implementing	Evaluating	Ward Centred	Overall
Bollin	N/A	N/A	N/A	N/A	N/A	N/A
Beech	97%	91%	94%	95%	95%	94%
Lakefield	89%	92%	97%	89%	100%	94%

Findings
• The management teams are keen to have a flexible unit wide approach to manage change to meet clinical need. • The Hurst pilot has given us additional themes which have been discussed with individual ward managers and during the service improvement days, strategies are being developed to implement change. • The review found that consistency between the acute wards needs to be improved, with findings shared and improvement work underway via the inpatient service improvement forum.
Action
• The safer staffing group to continue to review and to consider “truth on a page” (staffing, vacancy attendance figures) on a six weekly basis to ensure that variance between wards is identified and acted upon. • The inpatient service improvement forum (lead by Consultant Nurses) will continue to develop service improvement initiatives.

2.1.2 Open age acute wards [Adelphi, Juniper and Brackendale]

	Assessing	Planning	Implementing	Evaluating	Ward Centred	Overall
Adelphi	85%	80%	94%	93%	100%	89%
Juniper	78%	87%	85%	98%	84%	80%
Brakendale	85%	75%	85%	93%	100%	85%

Findings
• Following the previous staffing review, the management team for Adelphi ward are looking to strengthen leadership in and out of hours and providing additional support to ensure that there is safe and sustainable leadership cover.
Action
• Board are asked to note that Adelphi continues to have consistently higher bank use to support increased observations; inclusive of physical health needs and environmental challenges and should be supported to use additional bank shifts to maintain safer staffing levels where required.

2.1.3 Organic wards [Croft, Cherry and Meadowbank]

	Assessing	Planning	Implementing	Evaluating	Ward Centred	Overall
Croft	87%	91%	100%	95%	100%	95%
Cherry	97%	94%	97%	94%	100%	97%
Meadowbank	95%	98%	95%	100%	98%	95%

Findings
• Croft ward reported the need to undertake a piece of work in relation to staffing numbers and expectations. Work is being undertaken in relation to falls prevention technologies and how the technology can support staff rather than being solely reliant on therapeutic observations.
Action
• To continue to monitor safer staffing fill rates, take mitigating actions to backfill and escalate concerns as appropriate.

2.1.4 CAMHS wards [Coral and Indigo]

	Assessing	Planning	Implementing	Evaluating	Ward Centred	Overall
Coral	70%	83%	88%	76%	100%	83%
Indigo	77%	74%	91%	81%	98%	84%

Findings
• The quickly changing acuity on the wards can prove challenging at times in sourcing additional staff above the usual staffing levels. • The changes to the service specification means the two wards are working as a unit. Work is underway to improve the communication between the wards to ensure that the teams see themselves as a whole unit. • Appointment of nurse consultant has enabled the review of current practice in terms of care planning with a view to making it more effective and meaningful. This in turn allows staff to be freed up to spend more time supporting young people.
Action
• Following the quality analysis, it has been agreed the Consultant Nurse for CAMHS would lead on completing the activity analysis with staff on both wards. • At present there is limited information regarding CAMHS wards within the database due to the speciality of the service. Dr Keith Hurst has suggested completion of the full staff activity/acuity and ward manager's audit on both CAMHS Wards at CWP which would become the bench mark for safer staffing nationally.

2.1.5 Eating Disorder ward [Oaktrees]

	Assessing	Planning	Implementing	Evaluating	Ward Centred	Overall
Oaktrees	92%	92%	95%	92%	98%	94%

Using the Hurst tool a detailed review of Oaktrees ward was undertaken. In addition to the quality audit, staff activity data was also collected across day and night staff.

As an Eating Disorders ward Oaktrees has no quality benchmarks to compare against at present and the quality outcomes and staff activity results have been benchmarked against 145 acute admission wards.

Key Findings

Occupancy and Dependency/Acuity
Oaktrees has proportionally more high dependent patients due to it being an eating disorder ward and its complexity of physical health and mental health co-morbidities. Consequently, the workload index is above average which puts it in the category of a "high work-load" ward.

Staff Activity-Direct Care Activity
Oaktrees has a higher ratio of direct care time than the UK average for all wards and has a high focus on nutrition as we would expect, this reflects the ward ethos.

Indirect Care Activity
Findings show that the time spent working indirectly with patients was close to that of an admission wards average. Time spent on handover and report writing is higher than admission wards.

Associated work
Oaktrees has more registered practitioners than admission wards however Oaktrees practitioners spend a third less time on associated work (i.e. more direct care time) than admission wards which is seen as encouraging and indicates a well led ward with right skill mix of staff.

Personal time
Personal time is two thirds lower than average, however it is essential that staff have breaks. This is under review by the Ward Manager on Oaktrees and changes have been put in place to ensure staff do take breaks. This is being closely monitored. Sickness absence for the ward has reduced significantly.

Service Quality
Oaktrees quality scores reflects a well led team which has focused on clinical education and support networks this has increased staff confidence and enhanced specialist skills.

Time Out
Oaktrees are on average lower that admission wards it is noteworthy that ward staff integrate with Physical Health wards in the management of severely ill patients and a sharing of skills knowledge and expertise that enhances the quality of care delivered.

Staffing
Recommended staffing figure feels appropriate from the results to provide high quality care. It is suggested that more support workers may be a consideration however due to the specialists skills required on the ward further staffing would need be qualified staff to compliment the needs of the patients and ward team.

Findings
• The team reported the benefits of having RGN's as part of the ward establishment and would look to increase the number if recruitment was successful. • The Ward Manager reports increased clinical time and working with the wider MDT. • As a Regional Eating Disorder Specialist ward, Oaktrees is the first to be included in the mental health dependency/acuity, activity, quality and staffing database as part of the Hurst model. It is noteworthy that ward staff integrate with Physical Health wards in the management of severely ill patients and a sharing of skills knowledge and expertise is evident in the quality of care delivered.
Action
• Explore recruitment, retention, professional development and work plans for RGN's working in specialist roles within the eating disorder service.

2.1.6 Rehabilitation and Recovery wards [Limewalk House and Rosewood]

Findings
• Limewalk House reported challenges in terms of changes in administration support staff, and the need to strengthen leadership which is currently being addressed. • Rosewood reported referrals and gatekeeping can create a pressure for clinical staff. The referrals are managed by the clinical team as there is currently no allocated outreach worker resource to undertake this role. This post is currently being advertised. The ward reported limited Psychology time for the Unit. At present there is no Unit Psychologist and discussions are being held to support this.
Action
• To continue to support the ward team whilst leadership is strengthened, take mitigating actions where necessary and escalate concerns as appropriate.

2.1.7 Saddlebridge and Alderley

	Assessing	Planning	Implementing	Evaluating	Ward Centred	Overall
Saddlebridge	95%	99%	98%	93%	100%	97%
Alderley	N/A	N/A	N/A	N/A	N/A	N/A

Findings
• Saddlebridge reported some clinical challenges during the review period in relation to maintaining safer staffing in relation to clinical activity (transfer to acute hospital and increased observations). Which has meant the clinical leads have been unable to take their management days in order the cover the ward. • Since the last review, however, Saddlebridge has been able to cut back on bank usage, thus reducing overspend, and reported no issues with the establishment. However, the ward reported a high number of registered nurse vacancies during the period which they are working to resolve.
Action
• To continue to monitor safer staffing fill rates, take mitigating actions to backfill and escalate concerns as appropriate.

2.1.8 PICU Wards [Willow and Brooklands]

	Assessing	Planning	Implementing	Evaluating	Ward Centred	Overall
Willow	78%	64%	82%	82%	100%	81%
Brooklands	89%	92%	97%	89%	100%	94%

Findings
• The Ward Manager has reported spending increased clinical time which is aiding best practice being shared. • Willow ward have needed additional staff to manage high observations.
Action
• The results of the Hurst Tool safer staffing pilot have been discussed with the Clinical Service Managers and Psychiatric Intensive Care Unit service is already undergoing a programme of changes to working practices and the audit results are being taken into consideration during this process.

2.1.9 LD Assessment and Treatment Units [Eastway and Greenways]

Findings
• The review found that Greenways are requiring additional staff to manage the needs of patients occupying additionally commissioned beds. • It was agreed that the Hurst Tool would be used to undertake some additional modelling over the next 6 months. The 3 phases which would be undertaken were a Quality Audit completed by a Consultant Nurse and OT, Dependency Scoring by the ward team and activity follows for 2 days and 1 night shift.
Action
• It has been agreed with Finance that 9.00 wte additional staff will be employed substantively to allow the ward to be proactively staffed to manage level 3, 1:1 observations for 2 service users occupying the additionally commissioned beds 24/7. • The ward was successful in becoming Quality Network for Inpatient Learning Disability (QNLD) accredited which automatically places the service on the preferred provider list. Ongoing accreditation has financial implications which will be raised with Finance in order to ensure that this is factored in to the additionally commissioned bed income and also discuss this with operational leads in order that this can be considered as part of the transforming care work. • The focus of the Assessment and Treatment workstream should be around both planned and unplanned treatments which will feed into the transforming care work.

Proposed Service Redesign Central and East

As part of the 5 year forward view (FYFV) there has been discussion into possible redesign of mental health services in Central and East. This process has caused some anxiety within the inpatient teams and there is an ongoing risk that staff will seek employment elsewhere, there may be challenges in recruitment which may have an adverse effect on sustaining safe staffing levels. This has been raised as a risk within operational services and is being monitored closely should this become unsustainable. The management team in Central and East meet on a weekly basis to review staffing requirements including potential shortfalls. The clinical service managers, ward managers and resource managers identify a responsive allocation of resource.

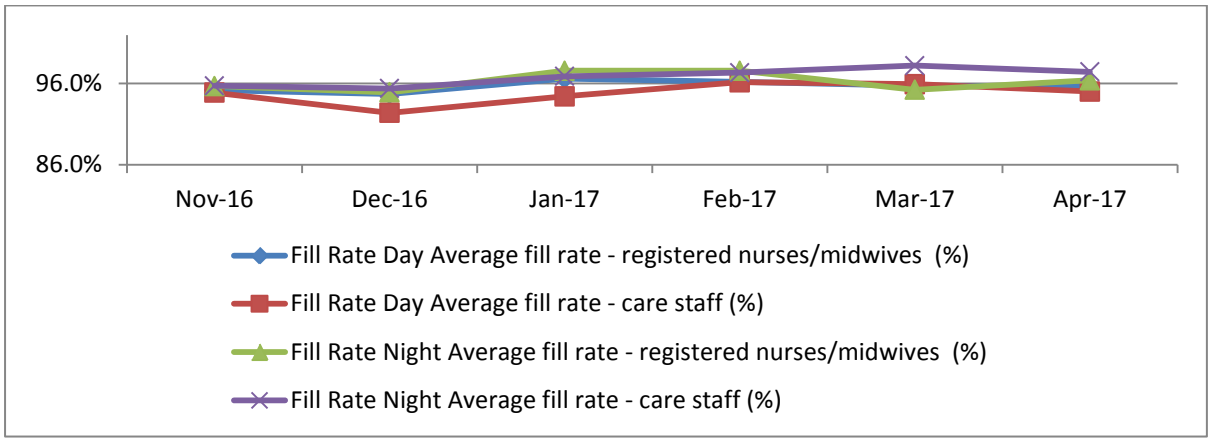
2.2 Impact on Breaks (November 2016 - onwards)

To further enhance analysis of impact, the Resource Managers report on staff activities cancelled due to staffing levels/clinical activity. This was raised via the health roster project group from November 2016 and will be reported into future safer staffing groups to examine any trends or outliers, this will also inform clinical presence visits by the Associate Director of Nursing and Therapies (MH & LD). Following reports into the safer staffing group there is an increased awareness into monitoring breaks. An escalation of breaks form has been introduced to allow analysis and understanding of why staff are not taking breaks to ensure that action is taken/plans are in place to proactively manage staff breaks to support their health and wellbeing.

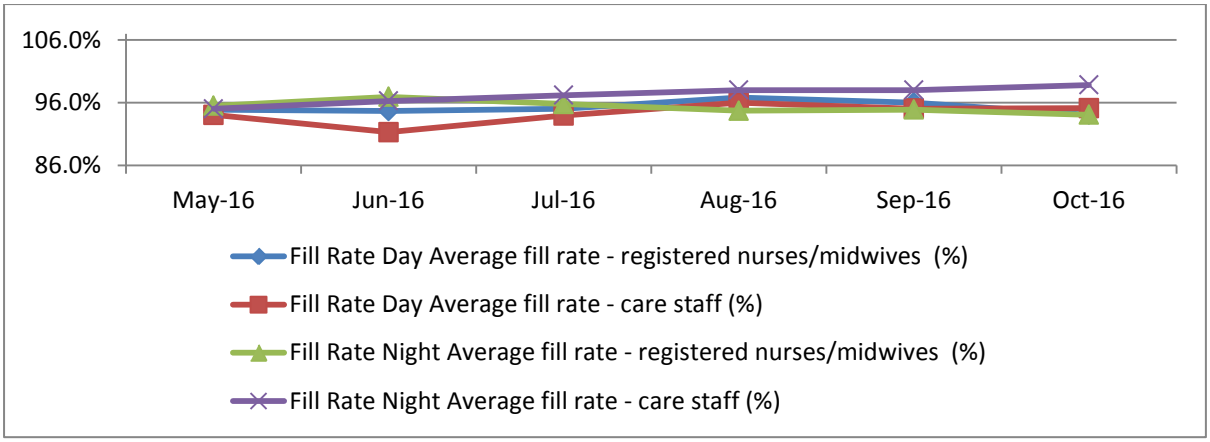
Quality and Safety

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 from November 2016 – April 2017 demonstrate that ward staffing actuals have been over 90% of planned staffing as shown in the graph below:



This is broadly comparable with the previous 6 months reporting period [May 2016 – October 2016]



Interventions to maintain safe staffing levels

The action taken by the Board in agreeing the safe staffing levels recommendations from the initial review alongside the subsequent work of the programme board and ward teams has had a significant impact in ensuring that CWP wards are safely staffed. On an on-going basis there are a further four key interventions that contribute to maintaining safe staffing levels. Firstly, effective rostering (see section 2.3), secondly the use of temporary staff to backfill shortfalls, thirdly, actions taken by ward staff to mitigate against the potential impact of unfilled shifts, and the involvement of the Multidisciplinary Team, "more than just nursing".

Temporary Staffing Activity:

From November 2016 - April 2017 the following details temporary staffing activity:

Locality	Total Hours Requested	Total Hours Filled	Bank/Agency Fill Rate (%)	% of Total Planned Hours on Ward covered by Bank/Agency	WTE filled by Bank	WTE filled by Agency	Total WTE filled
East	41804	32138	77	17	33	0.1	33
West	44043	31173	71	20	31	0.7	32
Wirral	23569	18798	80	14	19	0	19
Trustwide	**109417**	**82110**	**75**	**17**	**83**	**0.8**	**84**

Bank use has fallen from 87 WTE May – Oct 2016 to 84 WTE in this current six monthly review. This is compared to 118 WTE 12 months prior to the original staffing review. Agency use has been 0.8 WTE during this time and the agency bookings were within NHS Improvement rules. On average over the six month reporting period, based on booking reasons used by the wards, 15% of requests were due to vacancy, 26% due to sickness, 20% due to other absence reasons and 40% due to increased workload reasons.

Recruitment:
The table below indicates the establishments, vacancies and numbers in recruitment as at April 2017. The average recruitment time from vacancy created to contract letter was 45.5 days in April 2017 which has fallen from 60 days since the introduction of new recruitment software, Trac, in June 2015. Also during this time the Resourcing team have developed an attraction strategy, regularly attend careers and jobs fairs and are strengthening the recruitment presence in social media. On average over the reporting period vacancies as a proportion of establishment have been 8.23% for registered nurses and 5.75% for clinical support workers.

Trust Wards	Current WTE [budgeted establishment]	Current WTE [Staff in post]	Staffing differential	Current WTE in recruitment (from out to advert to start date booked)
Registered Nurses	290.49	268.88	21.61	22.92
Clinical Support Workers	291.24	278.17	13.07	7.8

Actions taken by ward staff
Each month Clinical Service Managers report on the actions taken to maintain safe staffing levels on wards. The same themes arise each month and include:

- Nursing staff working additional hours – either by not taking a break or working beyond the end of their shift.
- Nursing staff cross covering wards to maintain safe staffing.
- RN shifts being backfilled by CSWs when RN cover cannot be sourced.
- Ward Managers working in the numbers rather than supernumerary status.
- Multi-disciplinary teams supporting nursing staff in delivering planned care.
- Patient care being prioritised over non-direct care activities such as mandatory training, supervision and appraisal.
- Patient activities being cancelled or shortened due to nurse staffing levels.

The above themes have previously been raised at Operational Board and are consistent with previous reports.

Managing challenges and risks
Whilst wards at times struggle to achieve maximum fill rates, in order to support the wards to maintain staff staffing the following are in place to identify issues relating to safe staffing levels or risks relating to staffing and to enable escalation and resolution:

- Locality data packs
- Exception reporting on a monthly basis to Operational Board via key lines of enquiry for localities [KLOE'S]
- Ward escalation process for safe staffing
- Truth on a Page.

Triangulation of evidence
Since the last ward staffing report the Operational Board performance report has been reviewed this involved a review of the locality risk registers to understand areas of risk. The review was undertaken in collaboration with Service Directors, relevant Directors and Associate Directors and updated focussing on key measures related to local operational risks, the aim of the report is to support continuous improvement. The report provides a dashboard view, of performance over time and enables triangulation of key metrics such as attendance rates, vacancy rates, admission levels numbers of SUIs and number of available harm incidents.

2.3 Follow up actions relating to deep dive and E-Roster Update

The Healthroster update has been implemented with the following objectives delivered:-

- Upgrade Health Roster version 9 to version 10 including Bank Staff and Employee On Line modules
- Renewed support contract with system supplier
- Review and update essential system elements in order to ensure outdated or defunct configurations are removed/addressed, for example system rules, user access model and booking reasons
- Analyse time owing position and put plan in place to address balances (MIAA high risk rating)
- Train system users in the differences between versions 9 and 10
- Implement system backups in version 10 (MIAA high risk rating).

The following objective remains outstanding with the final draft of the policy circulated for comment and consultation in June 2017:-

- Update the CWP roster policy following standard consultation processes.

A key area of development with the new system is enhancing predictable and non-predictable risk to safer staffing. The implementation of the new software is enabling the development of a dashboard which will be received and reviewed by the safer staffing group. The first draft of the dashboard will be available by August 2017 for review and further discussion. The improved workforce analytics will help services provided assurances to Board that rostering has been done effectively by being able to better demonstrate not only the demand/supply ratio but also the rational for any increased demand i.e. patient driven or workforce driven.

2.4 Widening the consideration of MDT in relation to Safer Staffing (OT update)

Following on from the Occupational Therapy review presented at People Organisational Development Sub Group (POD) meeting it was agreed to include OT within the safer staffing review. The Hurst Tool staff analysis tool was carried out in each OT department covering Wirral, Chester and Macclesfield. These figures are currently with Dr Keith Hurst for analysis and will be presented at the next six monthly review.

3 Conclusion and Recommendations

The review team would like to acknowledge the commitment within clinical services to ensure the ongoing provision of high quality care and in their work supporting the safer staffing six monthly review. The board are respectfully requested to consider and approve the following recommendations:

1. To note the content of the report and the key recommendation that ward establishments should be sustained at current levels to maintain safer staffing.

2. To continue to progress relevant workstreams as detailed within the Safer Staffing Working Group in particular in relation to:

    - The next six monthly safer staffing review.
    - Linking in with national work programmes in relation to safer staffing.

3. There should be recognition and acceptance that due to environmental constraints and high levels of observations required to meet physical and mental health needs, Adelphi requires to use varying degrees of bank use and is proactively booking bank shifts to ensure the increased observations to support safe and effective care and the ongoing safer staffing requirements.

4. The next six monthly review period will revisit and detail variance across structures and band profiles to support trustwide benchmarking. In line with the emerging direction of travel with the CWP forward view, within acute inpatient care there will be a focus on reviewing staffing across units in comparable wards, and utilising staffing tools such as the Hurst Model and work in relation to ensure consistent staffing whilst maintaining an element of flexibility. There is also a need to ensure that local managers have the ability to manage staff across wards within and potentially across units to respond to varying levels of acuity and staffing challenges that may arise. The concept of the use of super rosters to facilitate this will be explored.

5. Undertake activity follows in relation to occupational therapy, specifically looking at support in relation to adult acute wards and maintaining safer staffing.

Appendix 2

Month and Year of Data	Locality	Ward	Day				Night				Fill Rate			
			Registered midmives/nurses		Care Staff		Registered midmives/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 (%)
Nov- 16	East	Adelphi	1296	1192	963.25	927.75	724.5	713	1173	1069.5	92.0%	96.3%	98.4%	91.2%
Dec-16	East	Adelphi	1264.75	1092.25	1184	1099.5	717.5	717.5	1253	1099.5	86.4%	92.9%	100.0%	87.7%
Jan-17	East	Adelphi	1393.5	1347.5	1369.5	1152.5	717.5	728.5	1466.5	1317	96.7%	84.2%	101.5%	89.8%
Feb-17	East	Adelphi	1147	1052.5	1035.5	993.5	627.5	616	1166	1120	91.8%	95.9%	98.2%	96.1%
Mar-17	East	Adelphi	1227.54	1171	1174	1115.5	724.5	724.5	1414.5	1322.5	95.4%	95.0%	100.0%	93.5%
Apr-17	East	Adelphi	1179.8	1019	1095.9	1050	690	678.5	1344.5	1252.5	86.4%	95.8%	98.3%	93.2%
Nov-16	East	Alderley Unit	926	840.5	1426	1315	678.5	598	701.5	736	90.8%	92.2%	88.1%	104.9%
Dec-16	East	Alderley Unit	1092	1018	1390.5	1224.5	713	713	713	690	93.2%	88.1%	100.0%	96.8%
Jan-17	East	Alderley Unit	1205	1225	1302	1186.5	747.5	747.5	713	690	101.7%	91.1%	100.0%	96.8%
Feb-17	East	Alderley Unit	1050.5	1021	1296.85	1274	632.5	609.5	655.5	690	97.2%	98.2%	96.4%	105.3%
Mar-17	East	Alderley Unit	1213.5	1128	1431	1351	713	667	713	736	93.0%	94.4%	93.5%	103.2%
Apr-17	East	Alderley Unit	1211.5	1180.5	1506.5	1408.5	690	678.5	770.5	774.5	97.4%	93.5%	98.3%	100.5%
Nov-16	East	Bollin	1278.5	1257	1305	1307	770.5	748.5	1352	1321	98.3%	100.2%	97.1%	97.7%
Dec-16	East	Bollin	1262	1262	1473	1484.5	770.5	774.5	1476.5	1495	100.0%	100.8%	100.5%	101.3%
Jan-17	East	Bollin	1471	1392.5	1474.5	1414	724.5	713	1660.5	1476.5	94.7%	95.9%	98.4%	88.9%
Feb-17	East	Bollin	1194	1117	1488.5	1432	650	638.5	1402	1375	93.6%	96.2%	98.2%	98.1%
Mar-17	East	Bollin	1277	1154.5	1567	1518	705.5	705.5	1426	1414.5	90.4%	96.9%	100.0%	99.2%
Apr-17	East	Bollin	1244	1184	1550	1453.5	742	723	1304.5	1270	95.2%	93.8%	97.4%	97.4%
Nov-16	East	CARS	867	782	996.5	858	667	622.8	402.3	458.8	90.2%	86.1%	93.4%	114.0%
Dec-16	East	CARS	236.5	227.5	264.5	232.5	161	149.5	115	92	96.2%	87.9%	92.9%	80.0%
Nov-16	East	Croft	1153.5	1029	1537	1298.5	701.5	627	1570.1	1315.6	89.2%	84.5%	89.4%	83.8%
Dec-16	East	Croft	1054.5	870.5	1717.5	1394.5	747.5	575	1453	1318.5	82.6%	81.2%	76.9%	90.7%
Jan-17	East	Croft	1047	983	1651	1381.5	704.5	617	1502.5	1450.5	93.9%	83.7%	87.6%	96.5%
Feb-17	East	Croft	916	885.5	1470	1304	621	544	1357	1307.5	96.7%	88.7%	87.6%	96.4%
Mar-17	East	Croft	1038.5	982	1604	1562	698	655.5	1564	1459.5	94.6%	97.4%	93.9%	93.3%
Apr-17	East	Croft	1166	958.75	1403.1	1560	690	621	1483.5	1359.5	82.2%	111.2%	90.0%	91.6%
Nov-16	East	Greenways	1183	1047	1872.5	1705	690	529	1345.5	1316.5	88.5%	91.1%	76.7%	97.8%
Dec-16	East	Greenways	1123.2	1049.45	1835.5	1441.65	713	736	1345.5	1161.5	93.4%	78.5%	103.2%	86.3%
Jan-17	East	Greenways	1170.5	1061.5	1630.5	1528	713	736	1403	1294	90.7%	93.7%	103.2%	92.2%
Feb-17	East	Greenways	1053	892	1497	1512.5	644	609.5	1265	1184.5	84.7%	101.0%	94.6%	93.6%
Mar-17	East	Greenways	1254.5	1052.5	1297.5	1308.5	713	575	805	920	83.9%	100.8%	80.6%	114.3%
Apr-17	East	Greenways	1220	1163	1669	1335.5	690	632.5	1035	1012	95.3%	80.0%	91.7%	97.8%
Nov-16	East	LimeWalk	1161.5	927.5	892.04	863.5	688.5	665.73	724.5	650	79.9%	96.8%	96.7%	89.7%
Dec-16	East	LimeWalk	1165.5	833	1075.4	1004.5	690	667	770.5	726	71.5%	93.4%	96.7%	94.2%
Jan-17	East	LimeWalk	1102	996	1022	929	672	660.5	724.5	727.5	90.4%	90.9%	98.3%	100.4%
Feb-17	East	LimeWalk	970.5	934.5	937.25	910.25	644	621	644	632.5	96.3%	97.1%	96.4%	98.2%
Mar-17	East	LimeWalk	1138	1109.5	1081.75	990	696	660.5	713	667	97.5%	91.5%	94.9%	93.5%

Apr-17	East	LimeWalk	994.5	931.65	1065.5	910.5	684	661	701.5	665	93.7%	85.5%	96.6%	94.8%
Nov-16	East	Saddlebridge	1006	1001.5	1259	1259	609.5	618	828	759.5	99.6%	100.0%	101.4%	91.7%
Dec-16	East	Saddlebridge	994.5	930.75	1529.5	1383.5	753.5	615.5	954.5	740.5	93.6%	90.5%	81.7%	77.6%
Jan-17	East	Saddlebridge	1019	957.5	1620.5	1554.5	897	851	897	874	94.0%	95.9%	94.9%	97.4%
Feb-17	East	Saddlebridge	878.5	855.5	1350	1332.25	644	632.5	713	701.5	97.4%	98.7%	98.2%	98.4%
Mar-17	East	Saddlebridge	1004	946.5	1318	1288.5	678.5	678.5	747.5	736	94.3%	97.8%	100.0%	98.5%
Apr-17	East	Saddlebridge	990	917	1253.5	1195.5	678.5	609.5	701.5	736	92.6%	95.4%	89.8%	104.9%
Nov-16	West	Beech	1400.5	1373.5	1023.5	926.5	670	658.5	719	681.5	98.1%	90.5%	98.3%	94.8%
Dec-16	West	Beech	1481.5	1467.5	1009	966	701.5	667	724.5	672	99.1%	95.7%	95.1%	92.8%
Jan-17	West	Beech	1345.5	1249.5	1086	1050	678.5	678.5	724.5	715.5	92.9%	96.7%	100.0%	98.8%
Feb-17	West	Beech	1326	1314.5	890.5	844	621	621	667	663	99.1%	94.8%	100.0%	99.4%
Mar-17	West	Beech	1423	1395	1109	1033	655.5	655.5	759	744.5	98.0%	93.1%	100.0%	98.1%
Apr-17	West	Beech	1449.5	1426.5	1035	995.5	690	690	724.5	713	98.4%	96.2%	100.0%	98.4%
Nov-16	West	Cherry	1418.25	1413.5	832	826	747.5	718.5	954.5	897	99.7%	99.3%	96.1%	94.0%
Dec-16	West	Cherry	1292.25	1219.25	975	899	768.5	731	943	862.5	94.4%	92.2%	95.1%	91.5%
Jan-17	West	Cherry	1349	1305.25	1053	1053	736	736	954.5	943	96.8%	100.0%	100.0%	98.8%
Feb-17	West	Cherry	1207	1184	954.5	937	632.5	632.5	920	908.5	98.1%	98.2%	100.0%	98.8%
Mar-17	West	Cherry	1302.75	1246.25	1047	1035.45	701.5	632.5	885.5	885.5	95.7%	98.9%	90.2%	100.0%
Apr-17	West	Cherry	1205.5	1182.5	1100	1057	655.5	655.5	1012	969.5	98.1%	96.1%	100.0%	95.8%
Nov-16	West	Coral	972	968.5	1265	1175	483	506	966	954.5	99.6%	92.9%	104.8%	98.8%
Dec-16	West	Coral	1062	1043	1368.5	1302.5	589.5	589.5	1218.5	1218.5	98.2%	95.2%	100.0%	100.0%
Jan-17	West	Coral	1089	1085	1368.5	1364	586.5	563.5	1230.5	1253.5	99.6%	99.7%	96.1%	101.9%
Feb-17	West	Coral	868.5	864.5	1359	1336	499	499	1046.5	1012	99.5%	98.3%	100.0%	96.7%
Mar-17	West	Coral	1036	1036	1468	1456.5	555.5	521	1265	1276.5	100.0%	99.2%	93.8%	100.9%
Apr-17	West	Coral	1017.5	971.5	1424.5	1459	644	586.5	1265	1265	95.5%	102.4%	91.1%	100.0%
Nov-16	West	Eastway A&T	817	787.5	1118.5	1095.5	648	636.5	954.5	954.5	96.4%	97.9%	98.2%	100.0%
Dec-16	West	Eastway A&T	946	907.5	1091	1048.5	586.5	540.5	1046.5	1046.5	95.9%	96.1%	92.2%	100.0%
Jan-17	West	Eastway A&T	932.5	899	1074	1074	529	529	920	920	96.4%	100.0%	100.0%	100.0%
Feb-17	West	Eastway A&T	648.25	640.75	1171	1164.5	392.5	381	887	887	98.8%	99.4%	97.1%	100.0%
Mar-17	West	Eastway A&T	814.5	814.5	1251	1239	461.3	461.3	954.5	910	100.0%	99.0%	100.0%	95.3%
Apr-17	West	Eastway A&T	1070.5	1059	1027.5	982.5	494.5	494.5	936	908	98.9%	95.6%	100.0%	97.0%
Nov-16	West	Indigo	1029	1025.5	1150	1091	552	552	862.5	828	99.7%	94.9%	100.0%	96.0%
Dec-16	West	Indigo	1057	1034	1149	1114.5	667	667	920	920	97.8%	97.0%	100.0%	100.0%
Jan-17	West	Indigo	1162.5	1105	1138.5	1115.5	621	586.5	1115.5	1150	95.1%	98.0%	94.4%	103.1%
Feb-17	West	Indigo	829.2	817.7	1115	1069	517.5	517.5	920	920	98.6%	95.9%	100.0%	100.0%
Mar-17	West	Indigo	956.75	960.25	1088	1088	586	528.5	896.5	896.5	100.4%	100.0%	90.2%	100.0%
Apr-17	West	Indigo	1014.5	1056	1016	901	634.5	600	690	678.5	104.1%	88.7%	94.6%	98.3%
Nov-16	West	Juniper	1475.5	1399	963	879.5	687	677	711.5	652	94.8%	91.3%	98.5%	91.6%
Dec-16	West	Juniper	1418.5	1368	861.5	797.5	621	621	786	769	96.4%	92.6%	100.0%	97.8%
Jan-17	West	Juniper	1353	1331	995	952.5	697.5	697.5	701.5	699.5	98.4%	95.7%	100.0%	99.7%
Feb-17	West	Juniper	1283.5	1268	871.5	838.5	629	629	690	675.8	98.8%	96.2%	100.0%	97.9%
Mar-17	West	Juniper	1406.5	1399	1060	1048.5	717	717	770.5	770.5	99.5%	98.9%	100.0%	100.0%
Apr-17	West	Juniper	1458	1441.5	837	834	713	701.5	736	736	98.9%	99.6%	98.4%	100.0%
Nov-16	West	Rosewood	1045.5	1022.5	1135.5	1135.5	502.5	502.5	874	874	97.8%	100.0%	100.0%	100.0%
Dec-16	West	Rosewood	941.5	971.5	1331.5	1293.5	491	491	897	897	103.2%	97.1%	100.0%	100.0%

Jan-17	West	Rosewood	1108.5	1097	1365	1337.5	671	671	759	724.5	99.0%	98.0%	100.0%	95.5%
Feb-17	West	Rosewood	893.5	870.5	1115.5	1115.5	537	537	747.5	722	97.4%	100.0%	100.0%	96.6%
Mar-17	West	Rosewood	1020	1020	1289.5	1192	519.5	517.5	882.5	882.5	100.0%	92.4%	99.6%	100.0%
Apr-17	West	Rosewood	931.5	931.5	1461	1449.5	633.75	633.75	735	735	100.0%	99.2%	100.0%	100.0%
Nov-16	Wirral	Brackendale	1112	1068.5	874.5	863	713	713	678.5	678.5	96.1%	98.7%	100.0%	100.0%
Dec-16	Wirral	Brackendale	1080	1084	900.5	860.75	713	701.5	713	713	100.4%	95.6%	98.4%	100.0%
Jan-17	Wirral	Brackendale	1063.5	1046.5	850	815.5	738.5	747.5	701.5	690	98.4%	95.9%	101.2%	98.4%
Feb-17	Wirral	Brackendale	1006.5	987.5	866.5	843.5	644	644	644	632.5	98.1%	97.3%	100.0%	98.2%
Mar-17	Wirral	Brackendale	1014.5	1003	983.5	960.5	714	702.5	783	748.5	98.9%	97.7%	98.4%	95.6%
Apr-17	Wirral	Brackendale	983	932	934	899.5	690	617.5	713	701.5	94.8%	96.3%	89.5%	98.4%
Nov-16	Wirral	Brooklands	1089	1055.5	1155	1130	698	698	915	892	96.9%	97.8%	100.0%	97.5%
Dec-16	Wirral	Brooklands	1003.5	947.5	1238	1230	718	689	1129	1118	94.4%	99.4%	96.0%	99.0%
Jan-17	Wirral	Brooklands	1042.25	1041	1457.5	1457.5	669.5	611.25	1207.5	1207.5	99.9%	100.0%	91.3%	100.0%
Feb-17	Wirral	Brooklands	910	910	1223.5	1200.5	633	598.5	1017	1004.5	100.0%	98.1%	94.5%	98.8%
Mar-17	Wirral	Brooklands	1115.55	1051	1376	1363.5	728.5	696	1174.6	1134.1	94.2%	99.1%	95.5%	96.6%
Apr-17	Wirral	Brooklands	964	968	1299	1303.5	698	694	1114.5	1115.5	100.4%	100.3%	99.4%	100.1%
Nov-16	Wirral	Lakefield	1039.5	1038.5	920	920	700	688.5	690	609.5	99.9%	100.0%	98.4%	88.3%
Dec-16	Wirral	Lakefield	975.75	915.75	1017	925	713	575	705.5	717.1	93.9%	91.0%	80.6%	101.6%
Jan-17	Wirral	Lakefield	1021	961.5	928	893.5	713	655.5	713	724.5	94.2%	96.3%	91.9%	101.6%
Feb-17	Wirral	Lakefield	1024	978	784	692	644	621	655.5	621	95.5%	88.3%	96.4%	94.7%
Mar-17	Wirral	Lakefield	1013	990	1177	1050.5	713	667	701.5	713	97.7%	89.3%	93.5%	101.6%
Apr-17	Wirral	Lakefield	1018.5	909.5	992	934.5	690	655.5	697	639.5	89.3%	94.2%	95.0%	91.8%
Nov-16	Wirral	Meadowbank	1094	1082.5	1523	1503.5	690	690	1226	1191.5	98.9%	98.7%	100.0%	97.2%
Dec-16	Wirral	Meadowbank	1127.9	1116.4	1482.5	1381	690	678.5	1161.5	1161.5	99.0%	93.2%	98.3%	100.0%
Jan-17	Wirral	Meadowbank	1160	1160	1284.5	1159	736	706.5	989	925.5	100.0%	90.2%	96.0%	93.6%
Feb-17	Wirral	Meadowbank	1092.5	1064	1174	1141	667	644	905	801.5	97.4%	97.2%	96.6%	88.6%
Mar-17	Wirral	Meadowbank	1124	1135.5	1535.5	1476.5	724.5	713	1191	1081	101.0%	96.2%	98.4%	90.8%
Apr-17	Wirral	Meadowbank	1027.5	1027.3	1605.5	1583	701.5	690	1299.5	1288	100.0%	98.6%	98.4%	99.1%
Nov-16	Wirral	Oaktrees	1011.5	950.5	1430.5	1326.5	690	563.5	345	333.5	94.0%	92.7%	81.7%	96.7%
Dec-16	Wirral	Oaktrees	1082	1070.5	1180	1139	690	598	379.5	414	98.9%	96.5%	86.7%	109.1%
Jan-17	Wirral	Oaktrees	1139.5	1105	1363	1265	713	701.5	494.5	471.5	97.0%	92.8%	98.4%	95.3%
Feb-17	Wirral	Oaktrees	917.5	794.5	1548.25	1323.75	678.5	678.5	529	494.5	86.6%	85.5%	100.0%	93.5%
Mar-17	Wirral	Oaktrees	1223	1048.5	1313.75	1089.5	742.5	639	471.5	494.5	85.7%	82.9%	86.1%	104.9%
Apr-17	Wirral	Oaktrees	1137.5	1042.5	1009	796.5	690	690	345	322	91.6%	78.9%	100.0%	93.3%
Nov-16	Wirral	Willow PICU	1197.75	1177.25	785	770.5	713	693.5	713	735.5	98.3%	98.2%	97.3%	103.2%
Dec-16	Wirral	Willow PICU	1196	1220.5	782	740.5	713	724.5	724.5	701.5	102.0%	94.7%	101.6%	96.8%
Jan-17	Wirral	Willow PICU	1143.5	1180.5	828	793.5	766.5	755	816.5	828	103.2%	95.8%	98.5%	101.4%
Feb-17	Wirral	Willow PICU	1050.5	1050.5	874	875.5	644	632.5	759	770.5	100.0%	100.2%	98.2%	101.5%
Mar-17	Wirral	Willow PICU	1233	1218	770.5	759	747.5	736	816.5	805	98.8%	98.5%	98.5%	98.6%
Apr-17	Wirral	Willow PICU	1066.5	1066.5	805	782	724.5	724.5	678.5	678.5	100.0%	97.1%	100.0%	100.0%

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Ward Daily Staffing Levels May and June Data 2017
Agenda ref. no:	17-18-31b
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	26/07/2017
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	No
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
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 ward daily staffing levels during the month of May and June 2017 following the submission of the planned and actual hours of both registered nurses (RN) and clinical support workers (CSWs) to UNIFY (appendix 1). The themes arising within these monthly submissions continue to mirror those that have arisen previously. These themes identify how patient safety is being maintained on a shift by shift basis.

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

The monthly reporting of daily staffing levels is a requirement of NHS England and the National Quality Board in order to appraise the Board and the public of staffing levels within in-patient units.
A number of recommendations are made within the latest six monthly report including consistency checking, national benchmarking, and widening the consideration of the multi-disciplinary team role within safer staffing. These recommendations are currently being followed through and will be monitored via the Safer Staffing group led by the Associate Director of Nursing [Mental Health and Learning Disability] and are reported on in the next 6 monthly report which is also being presented at July board meeting.

Assessment – *analysis and considerations of options and risks*

During May 2017 the trust achieved staffing levels of 95.7% for registered nurses and 94.7% for clinical support workers on day shifts and 96.7% and 96.9% respectively on nights. During June 2017 the trust achieved staffing levels of 96% for registered nurses and 94.4% for clinical support workers on day shifts and 97.9% and 95.9% respectively on nights.

To note:

- In May 2017 staffing levels on the following wards fell below expected variation: Croft, at 76%, Greenways, at 83% and Oaktrees, at 86.4%; and
- In June 2017 staffing levels on the following wards fell below expected variation: Alderley Unit, at 85.8%, Croft at 84.3% and Greenways at 75.9%.

Where 100% fill rate was not achieved patient safety on in-patient wards was maintained by nurses working additional unplanned hours, staff cross covering across wards, the multi-disciplinary team and ward manager supporting nursing staff in the delivery of planned care and patient care being prioritised over non-direct care activities. Appendix 2 and 3 details how wards, who did not achieve overall staffing of 95%, maintained patient safety.

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

The Board of Directors are recommended to note the report.

Who/ which group has approved this report for receipt at the above meeting?	Gary Flockhart, Associate Director of Nursing [MH and LD]
Contributing authors:	Anne Casey, Head of Performance and Information

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Gary Flockhart, Associate Director of Nursing [MH and LD] Avril Devaney, Avril Devaney, Director of Nursing, Therapies and Patient Partnership	17/07/2017 17/07/2017

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 May 2017
2	Ward Daily Staffing June 2017

	Ward	Day				Night				Fill Rate				Safe Staffing was maintained by:
		Registered		Care Staff		Registered		Care Staff		Day		Night		
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	
East	Adelphi	1344	1296	1180	1078	743.5	712.5	1282.5	1206.5	96.4%	91.4%	95.8%	94.1%	Staff cross covered from other wards. Altering skill mix. Nursing staff working additional unplanned hours.
	Alderley Unit	1174.5	1102.5	1700	1563	690	692.5	805	763.5	93.9%	91.9%	100.4%	94.8%	Altering skill mix. Nursing staff working additional unplanned hours.
	Bollin	1382	1292.5	1586.5	1389.5	707	707	1442	1315.5	93.5%	87.6%	100.0%	91.2%	Staff cross covered from other wards. Altering skill mix. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	Croft	1189.5	904.5	1791	1722.5	713	621.5	1437.5	1404	76.0%	96.2%	87.2%	97.7%	Staff cross covered from other wards. Altering skill mix. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	Greenways A&T	1246	1266	1574	1314.75	713	690	1069.5	1023.5	101.6%	83.5%	96.8%	95.7%	Staff cross covered from other wards. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	LimeWalk Rehab	1106.5	1059.5	1013.5	854.25	697	637	754	721	95.8%	84.3%	91.4%	95.6%	Altering skill mix. Staff cross covered from other wards.
	Saddlebridge	987.5	965.5	1327	1307	690	609.5	736	805	97.8%	98.5%	88.3%	109.4%	Altering skill mix. Staff cross covered from other wards. Nursing staff working additional unplanned hours.
Wirral	Brackendale	1046.5	1056	897	897	759	736	678.5	646	100.9%	100.0%	97.0%	95.2%	*
	Brooklands	1039.5	994	1256	1256	747.5	713	1000.5	920	95.6%	100.0%	95.4%	92.0%	Staff cross covered from other wards. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	Lakefield	1019	932	978.75	921.25	713	678.5	690	655.5	91.5%	94.1%	95.2%	95.0%	Staff cross covered from other wards. Nursing staff working additional unplanned hours.
	Meadowbank	1167	1133	1429.5	1383.5	713	667	1194	1182.5	97.1%	96.8%	93.5%	99.0%	*
	Oaktrees	1183	1145.75	927	800.5	713	701.5	356.5	356.5	96.9%	86.4%	98.4%	100.0%	Altering skill mix. Staff cross covered from other wards. Nursing staff working additional unplanned hours.
	Willow PICU	1163	1142	917.5	906	732.5	732.5	885.5	839.5	98.2%	98.7%	100.0%	94.8%	*
West	Beech	1388.5	1353	1069.5	994	701.5	701.5	736	694	97.4%	92.9%	100.0%	94.3%	Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	Cherry	1243.5	1184.5	1168	1168	699	699	1081	1058	95.3%	100.0%	100.0%	97.9%	*
	Eastway A&T	1115	1057.5	1077.75	1062.25	419	419	1077.75	1077.75	94.8%	98.6%	100.0%	100.0%	*
	Juniper	1544.5	1498.5	1005	993.5	759	747.5	831	811.5	97.0%	98.9%	98.5%	97.7%	*
	Coral	1241	1229.5	1067.5	1067.5	577	577	979.6	979.6	99.1%	100.0%	100.0%	100.0%	*
	Indigo	975	963.5	1096	1096	514	502.5	1052	1041.5	98.8%	100.0%	97.8%	99.0%	*
	Rosewood	1084	1052	1356.5	1355.5	621	621	793.5	793.5	97.0%	99.9%	100.0%	100.0%	*
	Trustwide	23639.5	22627.75	24418	23130	13622	13166	18882.35	18294.85	95.7%	94.7%	96.7%	96.9%	

	Ward	Day				Night				Fill Rate				Safe Staffing was maintained by:	
		Registered		Care Staff		Registered		Care Staff		Day		Night			
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)		
East	Adelphi	1196.5	1063.5	1121.5	1011	694	680	1102	1044.5	88.9%	90.1%	98.0%	94.8%	Staff cross covered from other wards. Altering skill mix. Nursing staff working additional unplanned hours.	
	Alderley Unit	924	792.5	1610	1566	678.5	678.5	701.5	690	85.8%	97.3%	100.0%	98.4%	Altering skill mix. Nursing staff working additional unplanned hours.	
	Bollin	1335	1218	1395	1268.5	690	690	1299.5	1223	91.2%	90.9%	100.0%	94.1%	Altering skill mix. Nursing staff working additional unplanned hours.	
	Croft	1177.5	992.5	1653	1643	690	621.5	1518	1426	84.3%	99.4%	90.1%	93.9%	Altering skill mix.	
	Greenways A&T	1273	1266	1918	1456	690	632.5	1253.5	984.5	99.5%	75.9%	91.7%	78.5%	Staff cross covered from other wards. Altering skill mix. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.	
	LimeWalk Rehab	1077.5	1085.5	1086	1024.5	652.5	651	709.5	670	100.7%	94.3%	99.8%	94.4%	Staff cross covered from other wards. Altering skill mix.	
	Saddlebridge	975.5	927.5	1276.5	1250.15	690	667	690	701.5	95.1%	97.9%	96.7%	101.7%	Altering skill mix. Nursing staff working additional unplanned hours.	
Wirral	Brackendale	960	908.5	1010.5	930	696	696	667	621	94.6%	92.0%	100.0%	93.1%	Staff cross covered from other wards. Altering skill mix. Nursing staff working additional unplanned hours.	
	Brooklands	1032.5	1032.5	1287	1275.5	690	690	874	839.5	100.0%	99.1%	100.0%	96.1%	*	
	Lakefield	1187.5	1161	1051.5	985.5	690	678.5	851	839.5	97.8%	93.7%	98.3%	98.6%	Staff cross covered from other wards. Altering skill mix.	
	Meadowbank	1080	1057	1361	1234.5	690	667	1058	1035	97.9%	90.7%	96.7%	97.8%	*	
	Oaktrees	1103.5	1014	897	770.5	690	678.5	425.5	414	91.9%	85.9%	98.3%	97.3%	Ward Manager working in the clinical team. Nursing staff working additional unplanned hours. Altering skill mix.	
	Willow PICU	1081.5	1081.5	913	913	717.5	683	751.5	736	100.0%	100.0%	95.2%	97.9%	*	
West	Beech	1408	1368.5	1089	1066	713	713	770.5	770.5	97.2%	97.9%	100.0%	100.0%	*	
	Cherry	1286	1231	1173	1173	805	782	1173	1138.5	95.7%	100.0%	97.1%	97.1%	*	
	Eastway A&T	1230.9	1230.9	920.5	892.5	466.5	466.5	956.5	949	100.0%	97.0%	100.0%	99.2%	*	
	Juniper	1258	1246.5	1046.5	1035	707.5	707.5	797.5	774.5	99.1%	98.9%	100.0%	97.1%	*	
	Coral	1153.53	1126.8	1154.5	1127	580	570	874.05	874.05	97.7%	97.6%	98.3%	100.0%	*	
	Indigo	1136.5	1139.5	966.5	966.5	570	570	843.5	843.5	100.3%	100.0%	100.0%	100.0%	*	
	Rosewood	1195	1195	1208.5	1208.5	581.75	581.75	771.25	771.25	100.0%	100.0%	100.0%	100.0%	*	
	Trustwide	23071.93	22138.2	24138.5	22796.65	13382.25	13104.25	18087.3	17345.8	96.0%	94.4%	97.9%	95.9%		

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Data Security, Caldicott 3 and the new GDPR action plan.
Agenda ref. no:	17/18/32
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	26/07/2017
Presented by:	Dr Faouzi Alam, Medical Director & Caldicott Guardian

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	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
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*

To update the Board of Directors regarding the Data Security, Caldicott 3 and the new General Data Protection Regulation (GDPR action plan).

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

The Care Quality Commission (CQC) undertook a review of data security in the NHS, and in parallel Dame Fiona Caldicott, the National Data Guardian (NDG), was asked to develop new data security standards and a method for testing compliance against these. A national draft compliance tool has been published for consultation and the final version will form part of the revised information governance toolkit. The NDG was also asked to recommend a new consent model for data sharing in the NHS and social care, commonly known as Caldicott 3. The NDG has undertaken a national consultation for the consent model and the final model is awaited. A CWP working group consisting of Caldicott/IG/ICT and Clinical Systems Managers have produced a combined action plan for compliance with the data security standards and the new consent model. It also incorporates the new General Data Protection Regulation (GDPR), due to come into force in May 2018. The new GDPR will require organisations to have a new Data Protection Officer (D.P.O.) role.

Assessment – *analysis and considerations of options and risks*

The working group have updated the Data Security, Caldicott 3 and the new GDPR action plan to incorporate elements of the MIAA cyber security audit along with work which has arisen from the recent global cyber-attack. The NDG/GDPR part of the action plan is RAG rated and currently there are 15 actions which are rated green and 9 which are rated amber. The amber actions are either work in progress or awaiting national developments. The draft national data security compliance tool is also being used as a baseline assessment of where we are currently compliant/non-compliant to inform the actions to be included in the current action plan, in preparation for the next working group meeting on 24th August.

NHS England was due to issue a briefing to CEOs regarding accountability and the role of the new D.P.O. in April 2017, however this has not been received to date. The NDG consent model is also still awaited.

The Records and Information Systems Group will continue to monitor compliance with the action plan as a standing agenda item. Any variance will be escalated to the Patient Safety & Effectiveness Sub-Committee.

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

- The Board of Directors is recommended to **note** the update.

Who/ which group has approved this report for receipt at the above meeting?	Dr Faouzi Alam, Medical Director & Caldicott Guardian
Contributing authors:	Gill Monteith, Records & Information Governance Manager

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Dr Faouzi Alam, Medical Director & Caldicott Guardian	27/06/2017

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	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Safeguarding Annual Report – 2016-2017
Agenda ref. no:	17/18/33
Report to (meeting):	Board meeting
Action required:	Information and noting
Date of meeting:	27/07/2017
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	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	No
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	No
Well-led services	No
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
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	
35T	

REPORT BRIEFING

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

This is an annual report to the board to give the Board assurance that CWP are meeting their safeguarding responsibilities, an overview of Safeguarding activity during 2016-2017 and a position statement on the implementation of key objectives set.

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

The report supports the quarterly reports to Board in providing continuing assurance of how the Trust has met its responsibilities and requirements as a regulated provider under Regulation 13 of the Health and Social Care Act 2008, The Care Act 2014 , The Children Acts of 2004 and 1989 and statutory guidance. The report is inclusive of the quarter four report.

Assessment – *analysis and considerations of options and risks*

CWP have been involved in safeguarding inspections by Care Quality Commission and the Office for Standards in Education, Children's Services and Skills (OFSTED) which highlighted good practice by CWP; for the young advisor work and CAMHS LD signposting and areas for further improvement such as practitioners not always utilising evidence based assessment tools.

Safeguarding children activity during the year has increased significantly in terms of frontline staff involvement in case conferences. Overall increased activity associated with requirements of the Courts, undertaking Serious adult/Case reviews and practice learning reviews has been significant.

The Trust achieved an end of year training compliance 89% overall. The Trust continues to work in partnership with LSCBs to deliver support and deliver training across the health and social care economy and is working intensively to support Wirral LSCB following the OFSTED rating of inadequate.

The two risks identified on the corporate risk register in April 2016; implementing learning from the sexual abuse inquiry and changes relating to broadening the level 3 requirement for clinicians training were reviewed and closed in year when actions were complete.

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

The Board of Directors is recommended to:

- **discuss** the impact of increased safeguarding activity across CWP services
- **note** the progress and achievement of 2016/17 objectives
- **discuss** and **agree** the objectives for 2017/18

Who/ which group has approved this report for receipt at the above meeting?		Trustwide Safeguarding Sub committee
Contributing authors:		Satwinder Lotay
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
0.1	Trustwide Safeguarding Sub committee	May 2016

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
1	Safeguarding Annual Report 2016-2017.

17/18/33 Appendix 1

CWP Safeguarding Adults and Children (including Children in Care) Annual 2016/17 Board Report (includes Quarter 4 Activity)

Contents

1.0 Purpose Of The Report

This annual report to the board is to give the Board assurance that CWP are meeting their safeguarding responsibilities, provide an overview of Safeguarding activity during 2016-2017 and a position statement on the implementation of key objectives set.

The report supports the quarterly reports to Board in providing continuing assurance of how the Trust has met its responsibilities and requirements as a regulated provider under Regulation 13 of the Health and Social Care Act 2008 , The Care Act 2014 , The Children Acts of 2004 and 1989 the statutory guidance Working Together to Safeguard Children, 2015 and Promoting the Health of Looked After Children, 2015. The report is inclusive of the quarter four report.

2.0 Summary

CWP continues to meet our responsibilities across the safeguarding agenda including PREVENT, Modern Slavery, Domestic Abuse, Harmful Practices, Sexual Exploitation as well as Adult Safeguarding and Safeguarding Children. CWP continues to respond to a high volume of case review consideration across all local authorities in which CWP delivers services.

Central to effective safeguarding practice is ensuring staff are trained and competent, this has been reflected in the contracting frameworks. To support continued learning, CWP staff are regularly updated on the changing landscape in addition to producing shared learning bulletins to share the learning from case reviews and audits.

Safeguarding governance arrangements and practice within CWP continues to develop in an integrated way. This year CWP board have received regular updates of safeguarding activity and performance throughout the year. The CWP Safeguarding strategy 2017-2020 has been launched and is underpinned with the principles of “Think Family” and “Person Centredness.” The number of Safeguarding Practice Links (SPL) identified across the trust has increased, and the uptake of group supervision has increased. The SPL now has a focus on all aspects of safeguarding practice (i.e. now includes adult safeguarding issues). CWP have also strengthened safeguarding children induction to key services and introduced the safeguarding screening function onto CARENOTES to help assist practitioners identify safeguarding issues.

CWP continues to work closely with the respective Local Safeguarding Children Board (LSCB), Local Safeguarding Adult Board (LSAB) and Domestic Abuse Boards and ensures engagement with appropriate subgroups is maintained. This will become crucial for the forthcoming year as LSCBs begin to plan the implementation of aspects of the Children and Social Work Act 2017 which ends LSCBs and prompts the formation of a new body.

The report is structured to provide the overarching Trustwide perspective on safeguarding responsibilities and performance. The report will then review performance against the previous year’s priorities. The final section of the report sets out the objectives for the forthcoming year.

3.0 Safeguarding Leadership and Accountability

The Director of Nursing, Therapies and Patient Partnership champions Safeguarding and represents the Trust on the LSCBs. The Associate Director of Nursing and Therapies (physical health) represents the Trust at LSABs and supports the Director for Nursing. The CWP safeguarding structure for CWP can be found in Appendix 1 There have been no changes this year in the senior management/ Named Professionals of the service.

4.0 Safeguarding Governance Arrangements and Assurance

The Quality committee has established the Trustwide Safeguarding subcommittee to provide assurance that safeguarding responsibilities are met through the activities of the Trust in line with the terms of reference (see Appendix 2 for the safeguarding governance

structure). The Trusutwide Safeguarding Subcommittee has strengthened areas in the business cycle in 2016/17 by ensuring Multi Agency Public Protection Arrangements (MAPPA) and Mental Capacity Act (MCA) and Deprivation of Liberty (DoL) reports and updates a received by the subcommittee on a regular basis.

CWP provides assurance to commissioning CCGs and Designated Nurses for Safeguarding via completion of Safeguarding Assurance Frameworks (SAF). This includes data submissions in relation to training, supervision and safeguarding activity. In addition, the annual self-assessment for both adult and children's safeguarding is undertaken and submitted for scrutiny to the CCGs. Quarterly safeguarding assurance meetings between CWP and CCGs provide opportunity for scrutiny and challenge to identify areas of risk and areas of good practice. Feedback for the safeguarding adult self-assessment 2015/16 was received from the Cheshire CCGs and CWP were commended for the audit submission. All areas were RAG rated green. The self-assessment for children (which incorporates the Section 11 audit has been completed and the resultant continuous improvement plan is being implemented.

Mersey Internal Agency Audit undertook a Safeguarding Audit this year, with the final report issued in July 2016. It concluded that processes in CWP provided significant assurance. All recommendations have been acted upon and no actions are outstanding.

5.0 Board Assurance Frameworks- Risk Register

The risks relating to safeguarding on the CWP Board Assurance Framework are reviewed, mitigated, and monitored by the Trustwide Safeguarding Sub-committee. In April 2016, two risks had been identified; one in relation to compliance with the new intercollegiate document (Safeguarding Children Intercollegiate 2014) changes in relation to broadening the requirement for clinicians to undertake safeguarding training at level 3 and the other in Implementing the learning from Sexual Abuse Inquiry (previously known as Goddard) and Bradbury Investigation. The risks were regularly reviewed and updated. The risks were closed when all actions had been completed and by January 2017 there were no corporate safeguarding risks on the board register.

6.0 Safeguarding Activity

6.1 Safeguarding Adults

CWP Nurse Specialists for Safeguarding Adults receive enquiries for advice and support from CWP staff in relation to safeguarding issues. In quarter 4 there have been 327 enquires.

During 2016-17 the overall figures for safeguarding adult enquiries has been 1177 which is comparable to last year. Of these enquiries 68 referrals have been made to the local authority in comparison to 74 referrals made to the Local Authority in 2015/16.

Safeguarding adult team have recently commenced collating supervision data which will be reported upon from 2017/18.

6.2 Safeguarding Children

The early help agenda continues to be embedded with a wide range of staff across CWP engaged with the Common Assessment Framework (CAF)/Team Around the Family (TAF) process.

The number of children social care referrals in 2016/17 was 115 compared to 121 in 2015/2016.

CWP continue to be engaged within the Child Protection Process. CWP staff have attended 784 case conferences in total, this is a significant increase from 410 in 2014/15. This in part is due to a more robust process that allows the safeguarding team to identify whether CWP

staff are involved in an identifed case and if so ensure that they are invited to the intial child protection case conferences. In addition to this, CWP have provided information for a further 244 conferences where CWP had information regarding the family but were not actively involved at the time. There is no data for the previous year around this as the provision of this information to conference is a new process.

The safeguarding children team have supported 133 staff members in the provision of court statements for public court proceedings in 2016/17, this is considerably higher than the 55 provided in 2015/16.

The Safeguarding children team continue to be actively involved with the Child sexual Exploitation agenda across the localities. During 2016/17 the Nurse specialists have attended 36 CSE meetings compared to 33 last year. In addition the Named nurse and Head of Safeguarding have continued to be involved with 2 complex CSE investigations on the Wirral.

The number of enquiries made to the safeguarding children team for quarter 4 is 346. This is a decrease from quarter 3 where there were 482 calls received. This data collection is a new process and therefore data for the full year is not available (only 9 months) Conclusions and comparisons can therefore not be drawn this year.

Safeguarding children supervision uptake remains high with 225 cases being discussed within this reporting period. Overall 756 cases have received face to face supervision by the safeguarding children team, this is similar to the 793 cases that were supervised in 2015/2016.

6.3 Mental Capacity Act and Deprivation of Liberty Safeguards

CWP has continued to strengthen practice in relation to Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS). CWP has developed processes to monitor the application and authorisations for DOLS and has provided guidance and training for staff to ensure the requirements of the MCA are met. Table 1 provides the compliance figures for MCA and DOLs training, this figure was not captured in 2015/16.

Training	**%compliance on 31st March 2017**
Mental capacity and DOLS	81%

DOLS Figures	**2015/16**	**2016/17**
Urgent authorisations (self-authorised by CWP)	**81**	**40**
Standard applications	**231**	**139**
Standard Authorisations	**8**	**12**

Table 2: Summary of DOLs authorised across CWP

Table 2 sets out the number of standard authorisations granted by Local Authorities and the number of CWP self-authorised urgent DOLS authorisations. The number of urgent and standard applications has reduced when compared to the previous year. This may be due to the use of the Mental Health Act rather than DoLS within a mental health hospital setting. Most standard applications are made by the respite units of Thorn Heys and Crook lane, however the reduction shown is as a result of multiple periods of respite for up to four months being named on applications to reduce the volume of paperwork. Local authorities continue to struggle in meeting the demands of DoLS and have procedures in place to prioritise applications dependant on the individual's residence.

6.4 PREVENT

In quarter 4, CWP have made one referral via the Prevent route, which has been discussed at the respective Channel Panel. The Safeguarding Nurse specialists provide representation on behalf of CWP to the Channel Panel meetings across Cheshire and Wirral. CWP have made a total of 4 referrals compared to 3 the previous year. CWP have

attended a total of 16 Channel meetings, which is a marked increase from the year before when only 9 had been held.

6.5 Multi Agency Public Protection Arrangement

CWP continue to develop public protection strategies to further support previous work in this area. MAPPA training is now embedded within the mandatory (E-Learning) Safeguarding package for all clinical staff members. A MAPPA enhanced training package for senior clinical staff is to be implemented later in 2017 to support clinical staff in this area of public protection. MAPPA coordination across the Cheshire and Merseyside National Probation Service (NPS) Policing localities is now facilitated by the Specialist Forensic Lead in CWP and to ensure consistency in service direction, staff support networks and policy implementation. Victim liaison is also coordinated across CWP and now forms part of the MAPPA policy trust wide. With the recent amendments to the National MAPPA guidance, work to update CWP Policy (CP53), to reflect the amendments and support public protection has commenced. The recent internal MAPPA clinical audit will act to support developments and benchmarking internally and to support Strategic planning locally.

6.6 Domestic Abuse

CWP continues to attend and support Multi Agency Risk Assessment Conference (MARAC) meetings, which operate across Cheshire East, Cheshire West and Wirral. CWP have increased the pool of MARAC representatives to support the safeguarding Nurse Specialists in managing the process. The number of meetings attended by CWP is comparable to last year with CWP attending 86 MARAC meetings.

CWP continues to support the respective Domestic Abuse Partnership Boards and subgroups across Cheshire and support Domestic Abuse subgroups in Wirral.

6.7 Children in Care

There has been a significant change in January 2017 within the Children in Care service with CWP becoming responsible for the Vale Royal CCG area, which included the transfer of the Nurse Specialist joining CWP from the previous provider.

The team continue to provide training at Level 3 for Health Visitors, School Nurses & Family Nurses to ensure quality health assessments are undertaken. They also contribute to the Level 2 Safeguarding Training programme for CWP staff to ensure all CWP have an understanding of Children in Care. The Nurse Specialists also participate induction training for foster carers in Cheshire West and Chester (CWAC) local authority area, to ensure they have an understanding of the health needs of this most vulnerable group.

The Nurse Specialists continue to provide child in care supervision for Health Visitors, School Nurses, Children in Care Nurse and other CWP practitioners who seek supervision for Children in Care cases. In 2016/17 287 cases were discussed at supervision. Nurse Specialists receive supervision from Named Nurse Safeguarding Children.

The Children in Care Team have a responsibility for overseeing the requests for Review Health assessments ensuring they are undertaken in a timely manner and of a high quality. The team works closely with CWAC Social Care to ensure the health data of children in care is robust. CWP have been instrumental in revising the multiagency Children in Care Policy, which was launched in August 2016.

Monthly reporting of activity relating to children in care continues to be reported to the respective CCGs using the SAF. Overall, in 2016-17, CWP staff have completed 354 Reveiw Health Assessments.

Following on from a recommendation from the Serious Case Review (SCR) for Child B, a number of processes and pathways have been strengthened with social care to ensure information sharing is more robust and timely. The children in care team are working collaboratively with the local authority and health providers to ensure the health needs for unaccompanied asylum seekers who have come to CWAC Local Authority are identified and have been care planned appropriately.

6.8 Child Death and Paediatric Liaison

The Nurse specialist for health visitor liaison plays an essential role in the sharing of appropriate information between Acute Trusts' (primarily The Countess of Chester NHS Foundation Trust) Accident and Emergency departments, Neonatal units, Paediatric wards and other hospitals and departments out of this area and CWP services by communicating directly with Health Visitors, School nurses and other community health practitioners.

The nurse specialist attends regional liaison meetings. Effective regional communication and information sharing is valuable and ideas can be shared and developed to increase the effectiveness of the liaison role, processes and learning. The valuable contribution that the Liaison nurse brings in ensuring continuity of care for children has been noted in external reports.

Child Death Overview Panel

The nurse specialist is a core member of the Pan Cheshire Child Death Overview Panel (CDOP). The panel reports on its findings with reference to the review of the child deaths across Cheshire, identification of trends and statistics and identification of public health issues.

The nurse specialist coordinates the health response to the CDOP panel in a timely 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. Additionally supervision to CWP staff involved and signposting them to staff services if required is also provided.

The Pan Cheshire CDOP has facilitated a training day to raise awareness to frontline professionals around the child death process. The day was very well attended and received excellent feedback.

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

7.0 Safeguarding, Looked After Children and Prevent Training

A robust training programme for all staff working within CWP underpins effective safeguarding practice. Compliance rates for training are scrutinised at Trustwide safeguarding subcommittee and localities are held to account. This is replicated at locality level with services. The Safeguarding, Looked After Children and Prevent Training compliance rates are detailed in the respective tables below. The level three safeguarding children training compliance has increased by 22% in quarter 4 from 66% to 88%.

The level 1 and level 2 Safeguarding family training has been updated to reflect changes in guidance and to incorporate learning from case reviews. It now also includes information about MAPPA. The Head of Safeguarding provided safeguarding training to CWP board in April 2016 (level 6).

Table 3 Safeguarding Training Compliance Rates for CWP at end of March 2017

Safeguarding Training	Trustwide Compliance Rate at End of March 2017
Level 1 (children and adults includes domestic abuse)	89%
Level 2 (children and adults includes domestic abuse)	89%
Level 3 (safeguarding children only)	88%
Level 4	83% (5 out of 6 staff)

nb the outstanding level 4 training has now been completed

Table 4: Looked After Children Compliance Rate for CWP 2016/2017

Looked After children 2015/16	Trustwide Compliance Rate
Level 1 & 2	**89%**
Level 3 –Undertaking Quality Health Assessments (Health Visitors, 5-19 and FNP only)	**96%**
Level 4	**100%**

The Prevent Workshop to raise awareness and prevention (WRAP) training for CWP staff is mandatory and the compliance as at end of March 2017 are detailed in Table 5 .

Table 5: PREVENT WRAP Training Compliance on 31 March 2017

PREVENT	Trustwide Compliance Rate as at 31/03/2017
Level 1 and 2	77%
WRAP 3 (level 3)	89%

8.0 Serious Case Reviews/ Serious Adults Reviews/ Domestic Homicide Reviews

During 2016/17 there has been one adult SAR, commissioned by Trafford LSAB in which CWP services have been involved. The respective action plans have been implemented to ensure recommendations are progressed. The SAR from Worcestershire LSAB was published and CWP has worked with agencies in addressing the multi-agency recommendations.

CWP have actively participated in one Practice learning review for Adult safeguarding with the resulting action plan being implemented by the appropriate safeguarding locality group and overseen by Trustwide safeguarding subcommittee (CWP are awaiting the final overview report). Two cases have been referred for case consideration by CWP.

CWP have also been involved in 4 children's Serious Case reviews in 2016/17. All the SCRs are still in progress and have not yet been published. One case was referred in by CWP. CWP have actively participated in 11 critical case/practice learning reviews and have provided comprehensive chronologies.

This year, CWP have strived to continue with their Safeguarding Practice Link programme where the importance of safeguarding advice and documentation of this has been a feature of learning requirements in both a CQC inspection and a serious case review. A recent audit evidenced that staff were accessing safeguarding advice and documentation was consistent across records for this. In addition, escalation of cases into the local authority has been a key feature of all three LSCBs and of a recent serious case review. The escalation process is now part of the level 3 training programme and CWP safeguarding have committed to monitoring the performance data around this issue. Other areas of learning from both CQC inspections and serious case reviews are the disguised compliance of families, risk assessments and ensuring all children's details are collected.

The safeguarding team continue to be proactive in cascading relevant learning from inspections, serious case reviews and public safeguarding matters via shared learning bulletins, cwp essentials and on occasion at individual team events.

9.0 Inspections

During quarter four CWP have not been involved in any inspections. In July 2016, there was a Safeguarding CQC Inspection of East Cheshire and South Cheshire CCGs. CWP services were included within this inspection. The report was published in December 2016. The final report highlighted two excellent practice examples delivered by CWP; young advisors work and CAMHS LD signposting. CWP are implementing an action plan in response to the inspection which will be monitored and overseen both internally and by the respective CCGs.

Wirral Local Authority and Wirral LSCB have had an Ofsted inspection in the final report published in September 2016 was rated as Inadequate. CWP have been working with agencies to address the recommendations from this report. The Director of Nursing, Therapies and Patient Partnerships has been co-opted as member of the Improvement Board and the named nurse was actively involved in developing Wirral's threshold document and provided training to over 400 staff across the locality at 3 different conferences about this.

10.0 Assurance Process and Audits

The 2016/17 Safeguarding Audit Programme has been completed. The learning themes from these audits are summarised in Box 1.

Box 1: Summary of outcomes from CWP Safeguarding Audits

Safeguarding Children

- There is inconsistent practice across the Trust in terms of how safeguarding children supervision is recorded.
- Children services generally evidence the Child's Lived experience.
- Quality assurance of social care referrals have demonstrated that generally they have all information that is required.

Looked After Children

- Quality assurance audits undertaken by the children in care service demonstrates high quality assessments are being maintained an evidence of engagement with child/ young person involved.
- Review health assessments are not always received in a timely manner form external health providers.

Safeguarding Adults

- Staff have a good understanding of identification of risk and the process that is required to be followed in ensuring that the case is managed appropriately in referring it to the Local Authority.
- The majority of cases referred to the Local Authority were accepted as referrals indicating that the threshold for referral criteria was understood by staff.
- Staff did not always complete a datix incident form when a referral to Local Authority is made.

CWP have also participated in numerous multi-agency case audits. These audits have demonstrated that practitioners are not always utilising evidence based assessment tools, for example, the graded care profile (used for assessment for neglect).

Internal assurance is supported via several methods including unannounced compliance visits.

Processes are in place to review reported safeguarding incidents via DATIX reporting system. Head of Safeguarding receives notification of all serious incidents reported within the Trust.

11.0 Review of Trust Wide Objectives for 2016/17

Progress of the objectives is as follows:

Reviewing and implementing the intercollegiate document for adult safeguarding- This is currently on hold following the withdrawal of the document.

Preparing for Goddard inquiry and reviewing the lessons from Bradbury Investigation and implement learning within CWP. Review has been completed and an action plan is being implemented.

Safeguarding Strategy for CWP to be refreshed- this is now published.

Align CWP priorities with the respective safeguarding boards on Wirral, Cheshire West and Chester and Cheshire East. The priorities have been reviewed and CWP have aligned the work plan accordingly.

Promote the use of evidence assessment tools to support safeguarding practice. The training has been implemented and work to ensure this is embedded is progressing.

Continue to work with services in ensuring robust safeguarding processes are in response to the integrated agenda. This work has commenced.

12.0 Objectives for 2017/18

To work with the respective boards to embed learning from case reviews and evidence based practice.
To promote and embed the safeguarding strategy
To support and promote the work of the Truth Project
Continue to work with services in ensuring robust safeguarding processes are in place in response to the integrated agenda

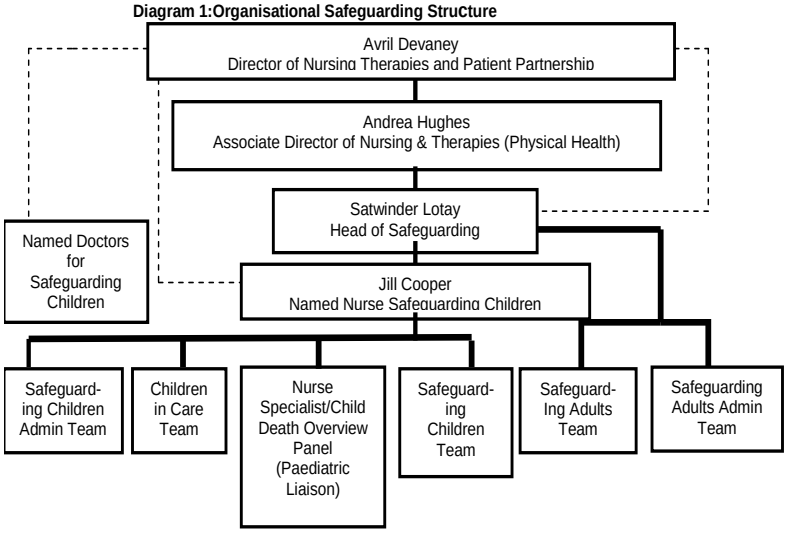
13.0 Conclusion

CWP has continued to work in partnership across each of the local Safeguarding Boards for both adults and children. Safeguarding activity continues to remain at a high level across the organisation. The report demonstrates how CWP has met its requirements and statutory duties and has responded to the key objectives set for 2016/17 and outlines the ones set for 2017-18.

Appendix 1

CWP Safeguarding Structure

Diagram 1:Organisational Safeguarding Structure



------- Accountability line

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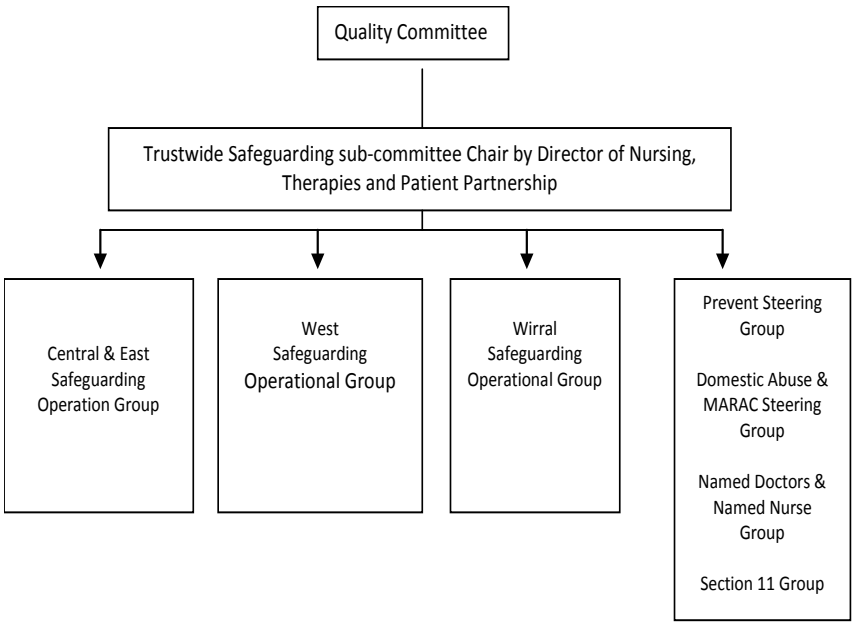
Appendix 2

CWP Safeguarding Governance Arrangements



Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Infection Prevention and Control Annual report 2016/17
Agenda ref. no:	17-18-34
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	26/07/2017
Presented by:	Andrea Hughes, Director of Infection, Prevention and 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	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
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	
35T	

REPORT BRIEFING

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

This is an annual report to the board to give the Board assurance that CWP are meeting their infection prevention and control responsibilities, an overview of infection prevention and control activity during 2016-2017 and a position statement on the implementation of key objectives set.

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

The report supports the quarterly reports to Board in providing continuing assurance of how the Trust has met its responsibilities and requirements as a regulated provider under the Health and Social Care Act 2008, Code of Practice for health and adult social care on the prevention and control of infections and related guidance (Department of Health 2015)and CQC Regulation 12 and 15

This report is inclusive of quarter four report.

Assessment – *analysis and considerations of options and risks*

The annual report is a comprehensive paper that demonstrates and evidences assurances relating to the infection prevention and control governance arrangements and the CWP commitment to infection prevention and control. It discusses highlights and achievements from 2016/17 including No preventable methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections, No preventable Clostridium Difficile Toxin infections in our services and zero number of identified cross infection cases in service users or staff this is set against an improving performance of compliance with antibiotic prescribing. In addition the report provides an update to the Board on the sepsis care improvement programme and the IPCs activity to support influenza immunisation which achieved an increase of 6.3% on 2015/16

The paper also highlights the increasing activity of advice to frontline clinicians and the joint working approach with estates and facilities

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

The Board of Directors is recommended to:

- **Note** the IPC achievements as shown in the report and discuss the impact of increased IPC activity across CWP services and the further work required to achieve compliance with antibiotic prescribing.
- **Note** the progress and achievement of 2016/17 objectives, discuss and agree the objectives for 2017/18

Who/ which group has approved this report for receipt at the above meeting?		Andrea Hughes
Contributing authors:		Julie Spendlove
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Chief Executive / Director of Nursing	11.07.17

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 2016/17

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

INFECTION PREVENTION & CONTROL

ANNUAL REPORT

2016 - 2017

CONTENTS

1. Introduction

The purpose and content of this annual report is to provide an overview of the Infection Prevention and Control (IPC) activities from April 2016 to 31st March 2017, and to highlight service achievements and the progress made against the priorities outlined in the Infection Prevention and Control Sub Committees (IPCSC) work programme.

High standards of infection prevention and control are crucial to reduce infection, and infection risks, in all health care facilities across Cheshire and Wirral Partnership NHS Foundation Trust (CWP). To support this, the IPC Integrated Service, which consists of the CWP Infection Prevention and Control Team (IPCT) and Cheshire West and Chester (CWaC) IPCT colleagues, continues to work hard to prevent all avoidable infections and reduce the risk of resistant organisms across our Health & Social Care footprint.

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

We encourage communication with our staff by being visible in the localities, having link practitioners, providing newsletters and attending key meetings.

We provide patient – centred care.

We have the courage to challenge ANY behaviour that puts our services user, carers, visitors or staff at risk.

We are dedicated to maintaining the competence required in relation to preventative IPC practice.

We are compassionate in all our contact with patients, carers and colleagues.

We are committed to preventing ANY avoidable infection.

Below is a brief summary of the IPCT highlights and achievements, and how we continue to raise the profile of both CWP and the IPC Integrated Service.

- **No** preventable Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections within our provider services
- **No** preventable Clostridium Difficile Toxin (CDT) infections within our services
- **Actively** working collaboratively with Public Health England (PHE) on local Public Health issues and antimicrobial stewardship.
- **Achieving** a zero number of identified cross infection cases in service users or staff (excluding small round structured virus outbreaks)
- **National** conference speakers and poster presentations for FIFTH consecutive year
- **National** Education Professional and Development Committee member for the Infection Prevention Society (IPS)
- **Active** members of national Mental Health IPS Special Interest Group
- **North West** IPS Education Officer role for second year of a two year term.
- **North West** IPS Deputy Communications Officer role
- **Regional** conference speakers and poster presentations at regional conferences,
- **Member** of the North West Sepsis group
- **North** West IPS and PHE meetings hosted at CWP, raising our profile for IPC
- **New** team structure providing succession planning and developmental opportunities within the team

- **Collaborative** working with AQUA (Advancing Quality Alliance) to implement sepsis awareness across CWP

2. Summary of the Director of Infection Prevention and Control's (DIPC) report to the Board of Directors (BoD)

In addition to the annual report the DIPC delivers a quarterly report produced by the Nurse Consultant. During 2016/17, the Board received concise reports in accordance with the business cycle, which highlighted areas of good practice and areas requiring development. The approval and any recommendations from the Board are communicated directly to the DIPC.

3. Care Quality Commission (CQC)

The CQC assess IPC standards against the Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance (Department of Health, 2015). The IPC assurance framework for 2016/17 demonstrates full compliance with these standards and also includes Water Safety and Antimicrobial Stewardship.

4. Infection Prevention and Control (IPC) governance arrangements

The IPCT has a high profile within Clinical Services and Support Services across the CWP footprint and also provide support to the Cheshire and Merseyside Public Health England (PHE) Team, Public Health in Cheshire West and Chester Council (CWAC), Western Cheshire Clinical Commissioning Group (CCG), Vale Royal CCG and Clinical Support Units (CSU).

4.1 Infection Prevention and Control subcommittee (IPCSC)

The IPCSC reports directly to the Quality committee, and is chaired by the DIPC or Nurse Consultant. Meetings take place five times per year, and all services and localities are represented. A review of the frequency of the IPCSC meetings has been undertaken and a decision made to reduce the meetings to quarterly. This will align the meetings with the quarterly reports required and reduce the numbers of meetings per year.

4.2 The IPC Integrated Service

Following a review of the IPC service, the structure of the IPC team has responded to provide a more efficient service across the three localities and other CWP teams for mental health, learning disabilities and harm reduction services. The DIPC has overall accountability for the IPCT, which is led by the Nurse Consultant and supported by a lead nurse, a specialist nurse and two locality IPC nurses, one of whom also supports tissue viability across all the inpatient wards.

5.0 CWP's commitment to IPC 2016 -2020

This document is now a working strategy until 2020 and was presented to board in September 2016 as part of the Quarter 1 DIPC report. The commitment supports the person centred framework and the on-going IPC achievements to reduce avoidable healthcare-associated infection. The Board of Directors receives regular progress reports on the initiatives that are in place. The key objectives and plans for monitoring improvement are highlighted within the commitment and this is supported by the Infection Prevention and Control Subcommittee (IPCSC) work programme and assurance framework.

This commitment supports effective and meaningful infection prevention and control practice of all employees within CWP. It also ensures that effective measures for prevention and control of infection are integrated into the trust core business, planning and delivery.

5.1 IPC Link Groups

Modern Matrons and IPC link practitioners throughout CWP are supported by the IPCT to deliver the IPC agenda locally. IPC link practitioner groups are well established in each locality. These groups meet on a quarterly basis and provide an excellent opportunity to cascade and disseminate key IPC

guidance and updates to operational staff. An education element is also incorporated to promote continuing professional development (CPD).

The IPCT held their 13th annual IPC study day in December 2016 with in excess of 40 members of staff attending from a wide variety of CWP services. As in previous years this event provided an excellent stage 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, and look forward to facilitating this event again in November 2017. The topics presented included Sepsis; Antimicrobial Resistance and Stewardship; Invasive Devices; Flu Vaccination; The Deteriorating Patient; Urinary Tract Infections; Wound Referrals and Dressings.

5.2 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 continue to work in collaboration and partnership with CWP Estates in relation to any plans and works carried out within CWP, ensuring compliance with Hospital Building Note 00-09.

5.3 Safe systems to prevent needle stick and exposure incidents

The team review all incidents to reduce risk and promote good practice in relation to needle stick injuries (NSI) and have provided training and posters to all staff to support safer processes. Exposure incidents are potentially high risk, and preventative training and resources are ongoing.

5.4 Inoculation Incidents 2016

	CWP - East	CWP – Physical Health West	CWP - West	CWP - Wirral	Grand Total
Inoculation Injuries: Needlestick Incidents, Bites and Scratches 2016 -2017	9	12	8	1	30
Inoculation Injuries: Needlestick Incidents, Bites and Scratches 2015 – 2016	4	5	16	7	32

There appears to be a decrease in exposure incidents across the localities, this is a downward trend overall since 2015-2016, of approximately 6.25%. However there is a significant rise in incidents in both East (44% increase) and Physical Health West (41% increase). The main cause of needle stick injuries are from insulin pens and the use of safety needles for insulin pens will be reviewed during 2017/18. Safety sharps are not widely used across CWP, as legislated by the Health and Safety Executive (HSE) in 2013. This will be reviewed during 2017/18 together with a cost analysis and proposal for the Operational Board.

5.5 Outbreaks

All IPC incidents and outbreaks are routinely reported to the IPCSC and the BoD, 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, hand hygiene and by ensuring staff can identify a potential outbreak which is addressed during Essential Learning.

	Central and East	West	Wirral
Number of outbreaks	1	5	5
Outbreak cause	Diarrhoea and vomiting	Diarrhoea and vomiting	Diarrhoea and vomiting x 3 Influenza x 2
Average number of patients affected per ward	4	5	5
Average number of staff affected per ward	3	3	2
Average number of days ward closed	3	4	5

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 include clinical service managers, modern matrons, ward managers, temporary staffing, occupational health, practice education facilitator and facilities manager where appropriate. Learning from these outbreaks is given as feedback to the teams and used with in future training. There were 11 outbreaks during 2016 – 2017 compared to 6 the previous year. These numbers remain low and patterns of outbreaks are difficult to predict as they tend to follow the national epidemiological trends which vary year on year.

5.6. Hand Decontamination

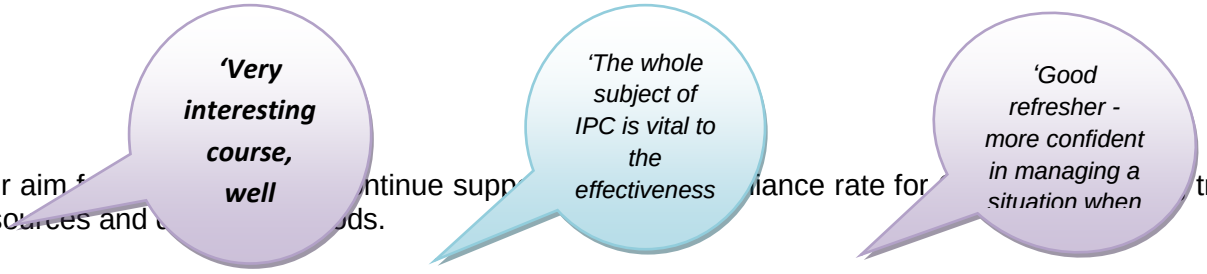
IPCT continues to actively promote hand hygiene, via observational activities in the workplace, trust induction, Essential 1 Learning and at all other events and opportunities.

The IPCT continue to work closely with colleagues from the Facilities Department and the main Trust supplier for hand hygiene products to ensure cost effective and appropriate hand hygiene facilities are accessible to all CWP staff, patients and visitors.

6. Education

6.1 Induction and Essential Learning (EE1)

The IPC team have facilitated 12 Induction sessions during 2016-2017 and 85 EE1 sessions (Essential Education). This has resulted in 2543 staff having received IPC and hand decontamination training. Overall 80% of clinical staff (including domestic staff) received IPC training in year and 83% of non-clinical staff received training giving a CWP compliance rate of 81%. The team strive to improve compliance by providing extra sessions, targeting low compliance areas and attending key clinical meetings. Throughout the period of this report, the IPC sessions consistently scores “good” or “excellent” in feedback from participants.



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6.2 Continuing Professional Development of the IPC team

In addition to completion of organisational training requirements, the IPC team attends relevant local, national workshops and conferences, including national and regional Infection Prevention Society (IPS) conferences. All IPCT members hold recognised infection prevention and control qualifications at BSc level and the lead and specialist nurses are all in the process of completing their MSc programmes.

The new Consultant Nurse / Head of IPC who commenced her post in February 2017 is a registered general nurse educated to Masters level and who also has a post graduate certificate in education (PGCE) along with specific infection control and communicable disease qualifications.

7. IPC Audits

During the period this report covers the team carried out audits on all inpatient clinical areas**.**

All inpatient areas have achieved above the compliance score of 93% during 2016/17 (see Appendix).

Results are reported back to the Ward Manager, Modern Matron, Estates and Facilities managers, and the IPCSC where areas of good practice are highlighted and appropriate actions regarding areas of concern is actioned and documented on the risk register if necessary.

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.

8. Service User Involvement

IPC nurses are involved In the Recovery Colleges by presenting sessions that aim to show how the principles of IPC can be used to maintain aspects of personal health

9. Health Care Associated Infection (HCAI)

During 2016 – 2017 there were no cases of MRSA Blood Stream infections reported to the IPCT in inpatient service.

This figure assures the Board that excellent IPC standards exist in inpatient services, and patients are not harmed unnecessarily by HCAI's**.**

10. Surveillance and Zero harm

The key items for community services are the surveillance and identified risks associated with Pressure Ulcers, Wounds and Urinary Catheters.

All patients with stage two or above wounds in community Physical Health services are screened for MRSA.

The IPCT support and collate all the information for Urinary Catheters in the community where patients are in receipt of community nursing. The nursing teams are supported to use the 10 week catheter pathway, and Aseptic Non Touch Technique (ANTT). Training in ANTT is now provided via e learning.

Inpatient MH services have shown an increase in the number of patients requiring support for tissue viability, which is inclusive of self-harm wounds, cuts and post-operative surgical sites. This could be due to the increased visibility of and access to the IPC / Tissue Viability Nurse working within the IPCT. The IPC nurses are also visible across the three localities, and have had numerous face to face

interactions with staff and service users throughout the year and approximately 270 telephone contacts across all localities.

The categories in the table below show approximate contacts and rationales:

	Central & East		West		Wirral		PH West	
	16/17	15/16	16/17	15/16	16/17	15/16	16/17	15/16
MRSA advice/screening and treatments	153	90	102	27	175	116	258 (10 week catheter pathway)	257
Invasive Devices	35	14	20	11	31	28	317	269
Skin Integrity	114	62	103	43	72	49	7	12
Antimicrobial Prescribing	161	122	175	131	176	128	4	19

10.1 Catheter Associated Urinary Tract Infection (CAUTI)

The IPCT continue to support the Trust response to 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 250 patients, and offering support through product masking, training, staff meetings, communications, and updating the 10 week catheter pathway.

10.2 Skin-Tunnelled Central Catheter (Hickman) and Peripherally Inserted Central Line (PICCs)

The IPC service continues to work collaboratively with other healthcare providers across the Western Cheshire footprint during on the development of guidance and competencies to support these devices, based on national guidance including NICE and EPIC 3. Patient information leaflets and a PICC passport are now used, allowing continuity and consistency for both patients and staff when more than one care provider is involved in a patients care.

11. Sepsis

Sepsis claims 44,000 lives annually in the UK, and costs the NHS an estimated 3.5 billion pounds. Evidence shows that early intervention saves lives and can also reduce the length of hospital stay for patients. An appropriate response to sepsis can save an extra 100 lives per year and £1.25 million annually. Urgent basic care can make a real difference between survival and death.

A Sepsis Care Improvement Programme (SCIP) group has been developed. This group includes a Director lead, lead co-ordinator and other professionals relevant to the success of this project.

Key Aims for SCIP.

- To minimise delay for CWP patients with signs of sepsis, in accessing acute care, by having a high level of awareness and a simple but effective process that enables the recognition of the early signs of sepsis.

- To improve awareness of sepsis across all of our services through a programme of education to all patient facing staff.

A Pilot Programme is being prepared and is due for launch in August 2017, across two areas – an inpatient elderly ward and the GP out of hours service. The pilot will run for three months when it will be evaluated and any changes required will be made before a phased roll out of the programme across the trust.

A Sepsis newsletter has been circulated and a Sepsis update has been included in mandatory EE1 IPC Training.

The sepsis work within the Trust has been presented as part of the AQuA Programme and also to the Infection Prevention Society (IPS) Northwest Branch. An abstract has been submitted to the IPS to present the sepsis work in poster format at the IPS Conference in Manchester in September 2017.

12. Influenza Immunisation Activity

Members of the IPCT completed training to support the annual staff influenza vaccination campaign during 2016/17. The team worked in partnership with the Trust's Occupational Health to deliver the vaccine across all localities**.** CWP reached a total of 57.8% of face to face staff vaccinated which was an improvement of 6.3% on the previous year.

For 2017, the national CQUIN targets for Health & Wellbeing of Staff in the NHS continue and the flu immunisation target for all Trusts remains 75% of face to face staff vaccinated by the 31 December 2017. The IPCT will support the Occupational health team again in their delivery and will also support with the immunisation update training.

13. Antimicrobial Resistance (AMR) Strategy and CWP work

AMR has risen over the last 40 years and the inappropriate use of antimicrobials is a key contributor. The consequences of AMR include increased treatment failure for common infections and decreased treatment options where antibiotics are vital. Antimicrobial stewardship is crucial in combating AMR and is an important element of the UK Five Year Antimicrobial Resistance Strategy.

AMR remains a high priority within the Trust and antimicrobial stewardship represents an organisational and system-wide approach to promoting and monitoring the prudent use of antimicrobials by:

• optimising therapy for individual patients;
• preventing overuse and misuse; and
• minimising the development of resistance at patient and community levels.

The CWP IPPCT continues to be proactive in raising awareness in judicious prescribing of all antimicrobials across clinical settings and maintaining compliance to the responsibilities in line with The Code of Practice (2015) which is monitored via the IPCSC.

13.1 Inpatient Services antibiotic audit 2016/17

Antibiotic prescribing on the inpatient wards is audited and compliance to prescribing reported quarterly into the IPCSC. The most common infections treated on the CWP inpatient wards are urinary tract infections, respiratory infections and skin infections.

513 antibiotic forms were collected during 2016/17. 402 prescriptions were written by CWP medical staff and 111 from other providers eg prior to admission. 279 of these prescriptions complied with formulary, 21 were prescribed according to sensitivities following laboratory culture and 20 on the advice of a microbiologist. This demonstrates a compliance rate for CWP medical prescribers, prescribing correctly to formulary, as 84%. The national target is 95%. Further collaborative work with pharmacy and medical team is required to improve this figure.

Quarter 1 to Quarter 4 2016-2017		Wirral	West	East	Not noted	Total	% audit compliance
Total number of prescriptions issued		176	175	162		513	
Allergies documented on medication chart	Yes	172	174	160		506	99%
	No	4	1	2		7	
Indication for prescription Noted	Yes	174	171	160		505	98%
	No	2	4	2		8	
Follows	Formulary	92	90	97		279	54%
	Sensitivities	7	6	8		21	4%
	Microbiology Advice	8	6	6		20	4%
	Commenced by other provider	49	30	32		111	22%
	None	18	34	15		67	13%
Indication and stop date/length of course/ long term prophylaxis indicated on medication chart	Yes	142	150	124		416	81%
	No	32	18	30		80	
Indication and stop date/length of course/ long term prophylaxis indicated on care notes	Yes	127	98	109		334	65%
	No	49	70	43		162	

13.2 West Physical Health antibiotic prescribing 2016/17

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

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

- Local: compliance with NHS West Cheshire antibiotic formulary.
- National: compliance with recommendations to keep prescribing of Cephalosporin and quinolone groups of antibiotics to keep usage as low as possible and in line with West Cheshire CCG and national levels.

CWP has continued to prescribe at a level below the national average for these medications and the OOH Service and NMP have maintained a minimum 98% compliance with formulary each quarter.

14. Estates Department Report

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 and covers the importance of a clean, safe environment for all aspects of Healthcare.

2. The Department of Health (DH) Health Technical Memorandum (HTM) 04-01 (2016), Safe water in healthcare premises.

The Estates department is currently reviewing the guidance, and will be implementing amendments as required. The 2016 update of HTM 04-01 is intended to move users of the document towards a holistic management of water systems via Water Safety Groups, Water Safety Plans and other initiatives.

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, which continues to employ the services of ZetaSafe Ltd, who provide professional monitoring software for statutory legionella temperature monitoring. The department also employs various contractors to undertake legionella risk assessments on Trust properties where required. There is 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 statutory legionella temperature monitoring tests throughout the Trust estate, during April 16' – March 17' a total of 21182 temperature tests were undertaken, with 94.56% of tests being within specified limits for the last 12 months. The annual test result report records an overall compliance level of 94.4% which is above the department's target. 5.44% of tests recorded did not meet the required standard and therefore automatically triggered remedial work to ensure compliance moving forward.

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.

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 2016/17 capital programme was recorded at £5.2m - specific projects to note include:

- Completion of CAMHS new build
- Environment / PLACE work plan -£188k
    - Upgrade of public WC's Bowmere,
    - Redecoration of Rosewood & Beech wards Bowmere
    - Replacement of flooring main corridors Bowmere
    - Meadowbank & Brakendale replacement bedroom floors Springview
    - Replacement Brakendale kitchen Springview
    - Delamere House – Internal refurbishement.

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.

14.3 Physical Health West capital and operational revenue programme

In 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. Facilities Service and Waste Report

CWP operational cleaning services are led via the Estates & Facilities services structure and the facilities management team are responsible for implementing the trusts cleaning strategy.

The Facilities Management (FM) function has facilities teams in each locality that report through a structure of supervisory staff members, who are responsible for the co-ordination of services and monitoring of standards in all trust areas in line with National Standards of Cleanliness (2007).

CWP Facilities services are predominantly provided in-house, this helps to ensure that services provided by the FM team are linked to the needs of clinical services. There are a number of locations within CWP that are outsourced. This is only where operationally and commercially practical and there are robust monitoring systems in place to ensure the quality of service provided is the same as the in house team.

15.1 Monitoring Arrangements for CWP in house cleaning service

To monitor compliance in relation to cleaning standards, CWP operate a monitoring system that covers all 49 factors as set out in the National Standards of Cleanliness 2007 approved code of practice.

The overall targets and achievements for cleanliness for all CWP areas for period 2016 - 2017 are listed below (again based on NSC risk ratings):

RISK LEVEL	TARGET RESULT (as set out by National Patient safety agency)	CWP Result
High Risk	95%	98.5%
Significant Risk	85%	96.25%
Low Risk	75%	99.10%

This information is taken from an average of all paper audits completed within 2016-2017

The Facilities management team cleanliness monitoring is supported by monthly Modern Matron walk-rounds that are attended by a senior member of the FM team to undertake a joined up approach with clinical services and address any issues patients or clinicians have with the Facilities services including the environment, this is then actioned by the relevant departments.

CWP FM attend all inpatient IPC audits, areas for action are addressed mostly at the time of audit all other actions are done immediately following the inspection. The facilities team continue to have a good working relationship with all members of the IPC team, taking collaborative approach to ensuring CWP's environments meet all required standards.

Important Note:

Within 2015 - 2016 annual statement on the facilities aspects that relate to IPC agenda, there was a risk highlighted of potential non-compliance with the National Standards of Cleanliness, due to lack of investment in cleaning equipment. It is noted that by working collaboratively with the Finance team funding has been secured for some new equipment. This has meant that CWP are now meeting its obligations to achieve standards in high risk areas.

15.2 Waste Management

The roll out of shared waste and recycling bins has continued at a further four Trust locations in 2016/17. This now includes Churton Resource centre in Chester and Springview at Wirral. The CWP recycling waste project has been continued in Cheshire and the project has resulted in an increase in waste recycling and segregation to approximately 98% as reported by our contractors during 2016-17.

Central recycling points are now in high concentration staff areas across CWP and staff are now participating in recycling and separating general waste at source. This is helping to demonstrate the Trust commitment of seeing waste as a resource.

The WArpit reuse portal for Trust assets has also seen a greater uptake by staff and project managers as items can be claimed instead of purchasing new**.** This efficient system has supported a number of moves around the Trust, supplying desks, furniture and other effects where required. This can help staff see how they can contribute to the Trust's environmental objectives through recycling and reuse and by claiming items that are surplus, therefore making savings from their budget, which can be then utilised elsewhere on other priorities.

15.3 Waste auditing

The CWP Waste audit system is designed to assess compliance with the requirements of Department of Health guidance document Safe Management of Healthcare Waste and to also ensure that waste segregation standards meet the requirements for waste handling and storage. The Trust waste policy HS1 has been updated during 2016 with new guidance on Community Healthcare waste produced by patients and a new process for referral of Home patients for clinical waste collections.

A programme of 6 monthly waste audits is currently being undertaken. The Waste audits, submitted by Facilities domestic supervisors are underpinned by a Waste Audit Schedule maintained by the Waste Manager which also notes any issues or incidents and solutions or outcomes.

16. Patient-led Assessment of the Care Environment (PLACE)

All PLACE inspections are complete for 2017 the results will be published nationally via the NHS information centre in August /September 2017.

The PLACE assessments cover the following areas:

- General Environment condition
- Environment cleanliness
- Food & Hydration – including – Quality/Taste/Temperature
- Privacy & Dignity
- Dementia friendly assessment

Overall the inspections this year have been excellent; the inspection teams are made up of trust volunteers, Trust governors and external agencies for example Health Watch.

Any areas that received a fail or qualified pass were added to the Facilities department action plan, any areas that required input from the Estates management team have been added to Micad for addressing or reported to capital projects team for adding onto their work plan.

17. Conclusion

Infection prevention and control remains a priority for CWP. The IPCSC and IPCT continue to maintain and improve on the application, conservation, and development of IPC standards. The trust is committed to working towards excellence in IPC practice as a best provider, considering our contractual obligation to our external commissioners, CWaC, see Appendix One.

This report highlights the partnership working and continuous improvements last year and the work programme for 2017/18 is set out below for Board approval Appendix Three.

18. Priorities for 2017/18

- Maintain compliance and assurances with the Health and Social care Act (2015)
- Promote hand hygiene week in May 2017
- Deliver a quality IPC Education event to CWP staff in November 2017
- Roll out sepsis awareness across CWP
- Review and standardisation products
- Actively support the staff influenza campaign
- Undertake a Trustwide mattress audit
- Continue to review education delivery to increase uptake of mandatory training
- Review of safety device usage Trustwide

19. Recommendations

The Board is asked to approve the Infection Prevention and Control Annual Report for 2016/17 and the work programme for 2017/18.

20. Appendices

Appendix 1 – IPC glossary

Appendix 2 – CWAC report

Appendix 3 – IPC audit programme

Appendix 4 – IPC work programme

Appendix 5 References

Appendix 6 team structure

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Medicines Management Annual Report 2016-17
Agenda ref. no:	17/18/35
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	26/07/2017
Presented by:	Dr Anushta Sivananthan, 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	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
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 Medicines Management Annual Report for 2016 – 17 describes the progress with the Trust's journey towards improved medicines optimisation as well as providing the Board of Directors assurance with the framework for Medicines Governance across the Trust.

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

This report provides a summary of the activity and progress that has been made by the Medicines Management Group (MMG) against the group's annual business cycle.

Assessment – *analysis and considerations of options and risks*

The progress, achievements and challenges over 2016 – 17 relating to Medicines Management have been highlighted and assurance is provided to the Board of Directors Medicines of the underpinning mechanisms across the Trust to provide high quality, effective and safe services relating to medicines. As we progress further into 2017-18 there is scope to enhance the collaborative work developed over 2016-17 to optimise medicines for patients who access our services, in line with the Trust's strategic objectives as part of the Five Year Forward View for Cheshire and Merseyside.

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

The Board of Directors is recommended asked to **note** the annual report.

Who/ which group has approved this report for receipt at the above meeting?		Medicines Management Group 22/06/17
Contributing authors:		Various from MMG membership
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
Final	Dr. A. Sivananthan	09/07/17

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	Annual Report 2016/17

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Medicines Management Annual Report

2016 - 2017

Lead Author: Jasmeen Islam, Acting Chief Pharmacist & Associate Director for Medicines Management
On Behalf of the Pharmacy Team and the Medicines Management Group

Executive Sponsor: Dr Anushta Sivananthan, Medical Director

July 2017
Version 1

Executive Summary

This report describes progress in 2016/17 with the Trust journey towards improved medicines optimisation for people who access our services. It describes key achievements and challenges in medicines optimisation in the past year and progress with the objectives in the journey to implementing the Trust Medicines Strategy 2015-2019. With a greater focus on medicines optimisation to enhance patient care, this report highlights:

- Improved patient safety, through enhanced management of incidents and learning from these via the Medicines Safety Officer
- Maximising effective use of resources
- Antimicrobial stewardship both for inpatient care and physical health services
- Reduction of patient harm using quality improvement methodologies for medicines optimisation
- Developments in prescribing guidance as ratified by MMG for implementation across services
- The value of the Pharmacy Team in multidisciplinary team working

Key challenges in the past year were:

- Workforce challenges to back-fill maternity leave for part of the year and reduced Senior Pharmacist cover for most of quarter 4, 2016-17, as well as a leaner re-structured team as implemented over 2015 and 2016.
- Agreement of prescribing pathways due to multiple commissioner arrangements eg. ADHD shared care guidance.

In summary, 2016-17 saw good progress with the implementation of the Medicines Strategy and governance framework for medicines management. There is also significant opportunity for further development to continue to enhance and measure patient experience relating to medicines, reduce patient harm, optimise technology where medicines are involved and improve patient outcomes in line with parity of esteem.

A. 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 safe domain.

This report covers the year April 2016 – March 2017 inclusive. The Board of Directors is requested to discuss and approve the annual report.

B. Summary

This report highlights the key Medicines Management (MMG) business cycle outputs over 2016-17, together with additional developments and achievements of the Pharmacy Team over this period.

C. Medicines Management Group

The Medicines Management Group (MMG) is chaired by Dr Sumit Sehgal, Consultant Psychiatrist. The vice-chair is the Chief Pharmacist. The group met five times over 2016-17. Attendance at meetings and all declarations of interest from members are documented.

In June 2016, the external MMG Group of which commissioners attend was re-established as the more informal Interface Sub-Group for Medicines. This group does not have decision making authority and is an operational group with pharmacist leads across CWP and the CCGs/ CSU, which reports to the CCG Area Prescribing /Medicines Management Committees and MMG. The Medicines Safety Sub-Group reconvened in September 2016, meeting on a bi-monthly basis and reports directly to MMG.

The key developments from the MMG business cycle over the last 12 months are detailed in the following 10 sub-sections.

1. Mental Health Medicines Formulary
2. Introduction of New Medicines
3. Named Patient Requests
4. Medicines Safety – Incident Reporting
5. Medicines Related Policies and Guidelines for Use Within the Trust
6. Patient Group Directions
7. Trust Assurance for Controlled Drugs
8. Antimicrobial Stewardship
9. Medicines Reconciliation Audit
10. Quality Improvement: Prescribing Observatory for Mental Health

C1. Mental Health Medicines Formulary

In line with the recommendation from the National Institute for Health and Care Excellence (NICE) the CWP Mental Health formulary is accessible from the Trust public facing website: http://www.cwp.nhs.uk/services-and-locations/services/pharmacy-and-medicines/
The formulary is a reference guide that highlights the formulary decisions approved by the CWP Medicines Management Group in conjunction with Primary Care. Medicine selection is based on evidence of efficacy and adverse effect profile, and prudent considerations around acquisition cost. The formulary was updated over 2016/17 and is now subject to consultation with CCGs.

C2. Introduction of New Medicines

Table 1 below illustrates decisions that have been made regarding applications for medicines:

Table 1: New Medicines

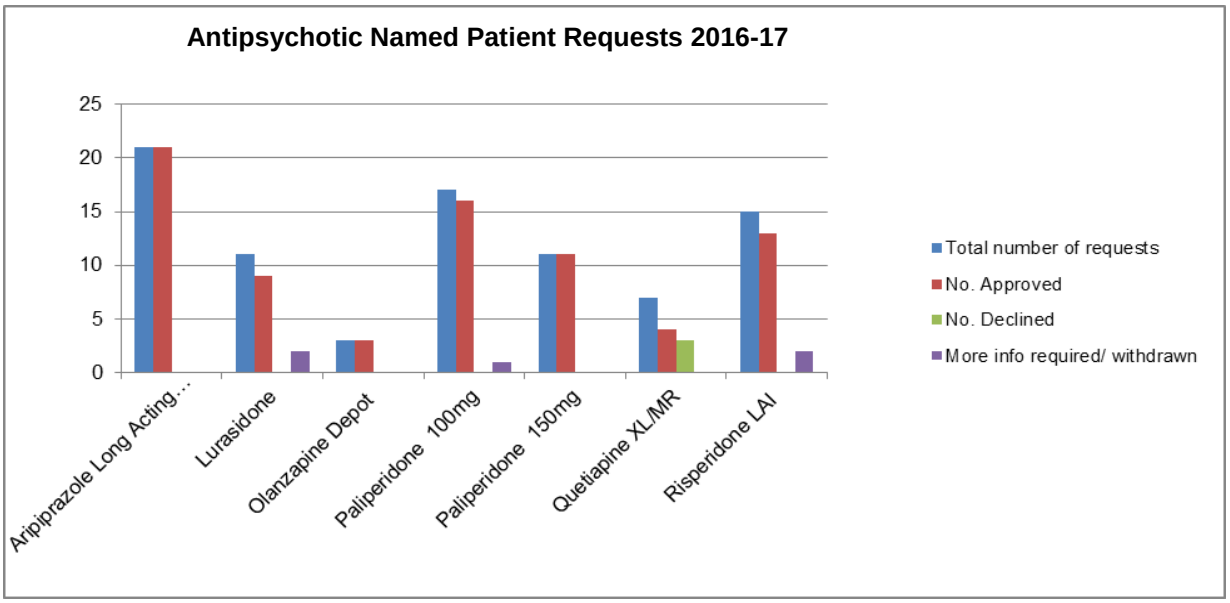
Medicine	Indication	Decision of MMG
Paliperidone 3 monthly depot injection (Trevicta)	Maintenance treatment of schizophrenia in adult patients who are clinically stable on 1-monthly paliperidone palmitate injectable product	Named patient approval required Specialist use only, where prior non-formulary request approval has been gained for the prescribing of Paliperidone 1 monthly formulation. It is expected that the monthly formulation would have been prescribed for at least 6-12 months before a request is made for Trevicta.
Guanfacine	Treatment of attention deficit hyperactivity disorder (ADHD) in children and adolescents 6-17 years old for whom stimulants are not suitable, not tolerated or have been shown to be ineffective	Named patient approval required Specialist use only
Aripiprazole (excluding 30mg tablets, orodispersible tablets and liquid formulations)	Schizophrenia, mania	Formulary status approved
Melatonin	Those individuals who fit the licensed indication for Circadin who have not responded adequately to Z-hypnotics or other hypnotics such as temazepam and whose physical health status in terms of reduction of risks of falls would outweigh the additional cost of this treatment option.	The group agreed that Melatonin should be approved for use in over 55's for inpatients and therefore no named patient requests are required for this age group, pending the development of an agreed pathway with Primary Care

In addition to monitoring inpatient adherence to the formulary, the pharmacy team review reported on outpatient prescribing from FP10 prescriptions through the performance review reporting mechanism over 2016-17.

C3. Named Patient Requests (NPRs)

Throughout the year, MMG have received a total of 114 named patient requests (NPRs), the majority of which were approved for use. These are divided into antipsychotic named patient requests and other named patient requests. In all approved cases, MMG request feedback from the consultant prescriber for assurance that the treatment continues to be beneficial to patient care. The feedback period was recently changed from 3 monthly to 6 monthly intervals.

Graph 1: Antipsychotic Named Patient Requests 2016-17



Graph 2: General Named Patient Requests 2016-17

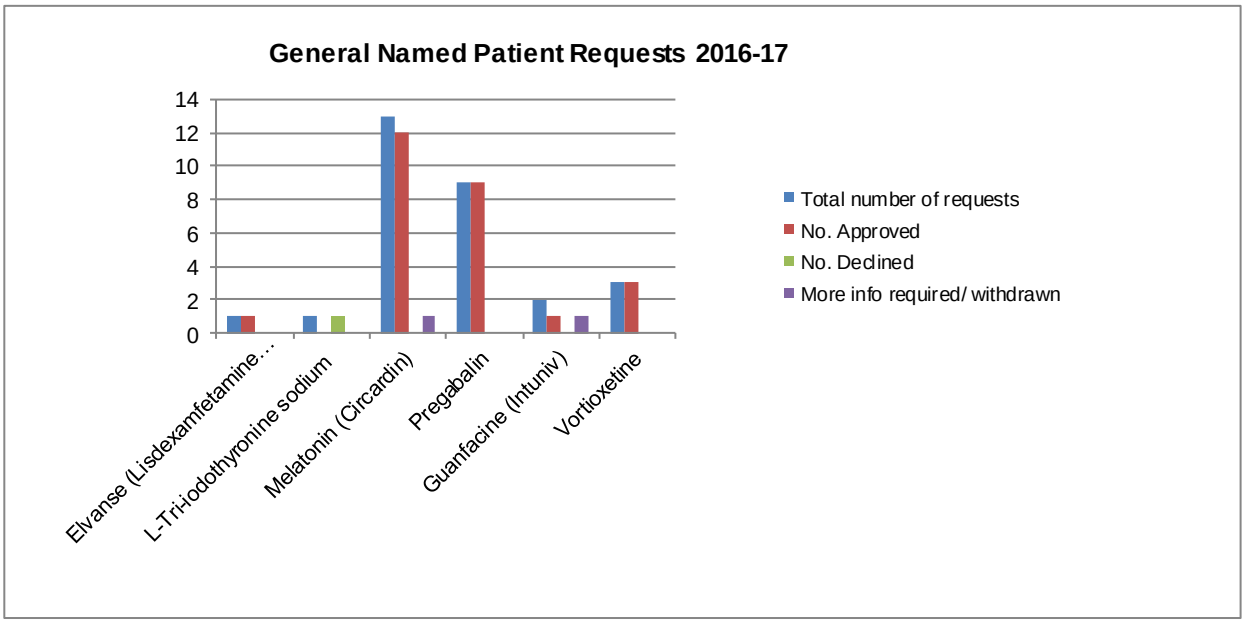


Table1: By Locality

	Number of Named patient requests for antipsychotics and general medicines*	Approved	Declined	More information required/withdrawn
West	**27 (3)**	25 (3)	1 (0)	1
East	**51 (12)**	46 (11)	2 (0)	3
Wirral	**39 (12)**	36 (11)	1 (1)	2

*general medicines are annotated in brackets

C4. Medicines Safety - Incident Reporting

Graph 3 below illustrates the number of reported medicines-related incidents over the last 12 months broken down by severity as obtained from Datix reports. The majority of the incidents fall into category E (No Harm). It can be seen that there were no category A or B medication incidents during this time period.

Graph 3: Medicines Related Incident Reporting

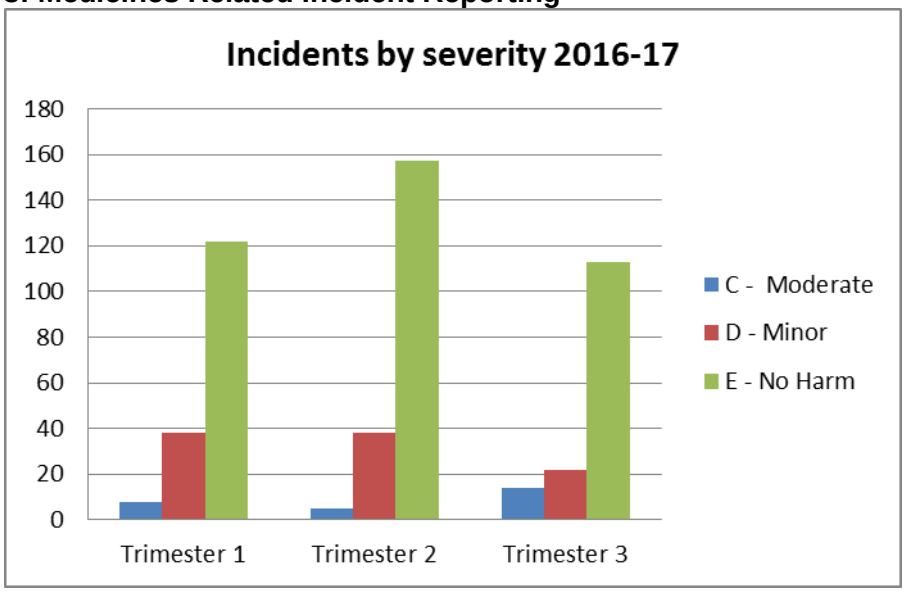


Table 2 below shows the context of this year's medicines-related incidents, within the previous five years of data. The proportion of moderate incidents has continued to decrease over the years. This is in line with the overall pattern of increased low level harm incident reporting for the Trust indicating a positive safety culture.

Table 2: Medication incidents by severity for the years April 2012 – March 2016

Year/Severity	A	B	C	D	E	Total
2012/13	**0**	2	76	173	159	**410**
2013/14	1	1	47	184	433	**666**
2014/15	0	0	45	109	276	**430**
2015/16	0	0	50	126	342	**518**
2016/17	0	0	27	98	392	**517**
Totals	**1**	**3**	**245**	**1336**	**1602**	**2542**

C4.1 Trends in reported medicine related incidents

Graph 4 below details the number of incidents per sub-category over the 12 month period. It can be seen that there are two sub-categories with higher than average frequency:

- Failure to administer (92 *vs 100 in 2015/16*)
- Prescribing error (49 *same as 2015/16*)

Three other sub-categories have similar incidences:

- Inappropriate medicine storage (46 *vs 37 in 2015/16*)
- Controlled drug incidents (43 *vs 38 in 2015/16*)
- Non-adherence to policy / procedures (38 *vs 33 in 2015/16*)

Failure to administer was the highest reported incident in each trimester although the number reported has fallen by 8% from the previous year. Work has continued in addressing the frequency of failure to administer incidents in 2016/17.

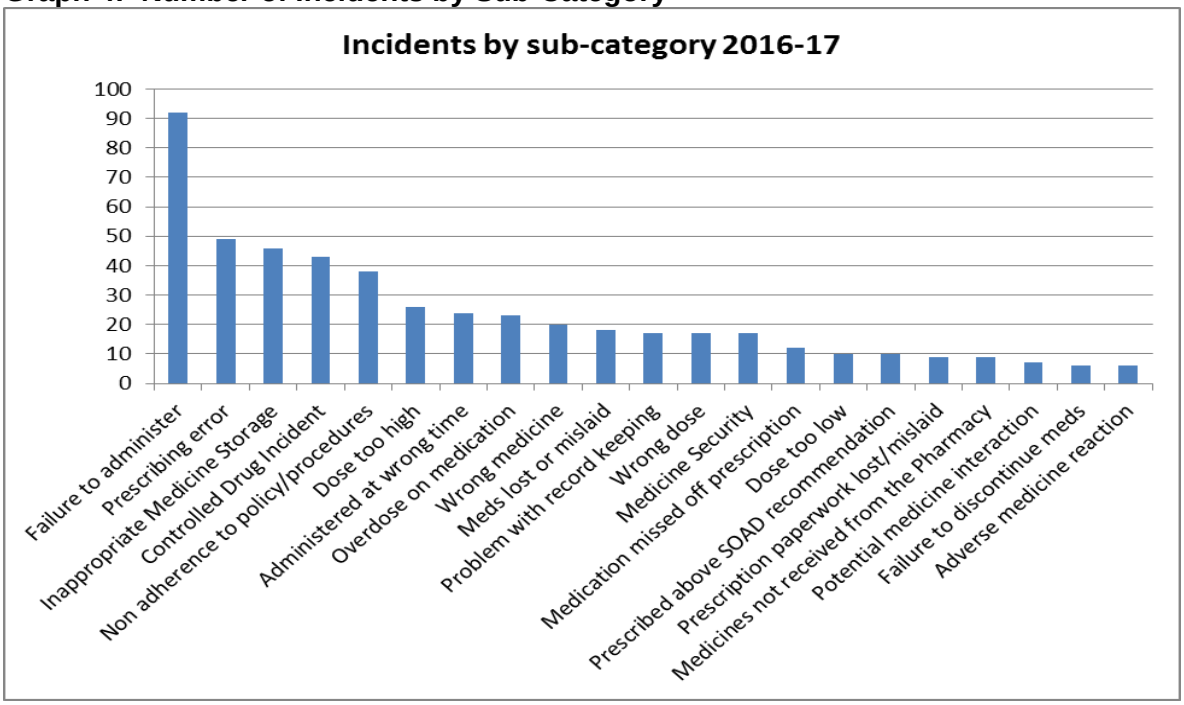
Prescribing errors are diverse, in terms of the medicines involved. This incident category also featured in the top 3 reported incidents in all trimesters. Analysis is quite difficult with the low numbers reported and some prescribing incidents may also be recorded in other sub-categories e.g. wrong dose.

Inappropriate storage incidents featured in the top 3 reported incidents in trimester 3. A number of these incidents are detected during the monthly community and inpatient clinic room standards audit.

Controlled drug incidents featured in the top 3 reported incidents in trimesters 2 and 3. There appears to be no particular pattern to the type of incidents reported. All these incidents are submitted to the local intelligence network on a quarterly basis for further analysis. Controlled drug incidents are taken seriously and investigated at the time of reporting so that any immediate action is taken to safeguard staff and service users. All incidents remain open on the Accountable Officer's report until they are closed.

The non-adherence to policy / procedure sub-category contains a diverse range of incidents. This category has plateaued.

Graph 4: Number of Incidents by Sub-Category



Incidents with a frequency less than 5 occurrences (18 in total) are not detailed on this graph.

The Medication Safety Officer has worked closely with Safe Services to review the current medication reporting codes to ensure that they map correctly to the National Reporting and Learning System. These changes were implemented on April 1st 2017 and reports for future years will reflect these changes and enable more accurate analysis of medication incidents.

C5. Medicines Related Policies and Guidelines for Use Within the Trust

The following policies/guidelines have been developed, approved and implemented across the Trust.

Table 3: Development of Medicines Related Policies and Guidelines

Therapy Area	Date Approved	Reference
Medicines Reconciliation Policy	June 2016	MP19
High Dose Antipsychotic Therapy	September 2016	MP18
Clinical Guidance in Anticoagulant Therapy in Adults	September 2016	MP21
Policy for Prescribing Antipsychotic Medication in Bipolar Disorder	September 2016	MP24
Administration and Checking of Medicines by Assistant Practitioners	September 2016	MP 25
Guidance and Responsibilities for the Prescribing of Medicines to Treat Alzheimer's Type Dementia	September 2016	CC 40
Nicotine Replacement Therapy (NRT) Guidelines	November 2016	MP14
Guidelines for the Prescribing and Administration of Olanzapine Long Acting Injection	November 2016	MP26
Rapid Tranquillisation	March 2017	MP 10

NICE guidelines and Technology Appraisal Guidance is assessed at MMG to ensure a timely uptake in guidance.

C6. Patient Group Directions (PGDs)

The PGD subgroup of Medicines Management Group was re-convened in January 2017 following vacancies across the Team and meets every 2 months. A programme of work is underway to review and update PGDs in line with an agreed schedule.

During 2016/17 PGDs for the following were approved:

a) **Seasonal Flu for active immunisation against influenza to:**
   - Adults and children in accordance with the national immunisation programme
   - All Health and Social Care Workers employed by/working for CWP and employees of any service that receive Occupational Health coverage from CWP

b) **Fucidin cream** for the treatment of primary and secondary skin infection in homeless people in CWP Trust locations / community clinics and non NHS sites where NHS care is provided.

c) **Corticosteroid injections** for use by registered physiotherapists to adults over 18 years of age in physiotherapy clinics and other designated sites in CWP.

d) **Hepatitis B** for adults and adolescents aged 16 years of age and over for use by CWP Drugs & Alcohol Services and Occupational Health Services.

e) **Human Papilloma Virus for** females from 12 years of age, or from school year 8, in accordance with the national immunisation programme.

A database with a schedule expiry dates of PGDs is in place and the re-established PGD Sub-Group has oversight of this, allowing for an assurance mechanism for timely review of PGDs.

C7. Trust Assurance for Controlled Drugs

The Trust Accountable Officer for Controlled Drugs is the Chief Pharmacist & Associate Director for Medicines Management, who has a statutory duty to report to the Local Intelligence Network (LIN). Quarterly reports, compiled from datix reports and CD audits across all inpatient wards and GP Out of Hours are submitted to the LIN and a contribution made to shared learning. Twice yearly controlled drugs reports were discussed at MMG to provide Trust Wide assurance for the prescribing and administration of controlled drugs. All cases were closed for 2016/17.

C8. Antimicrobial Stewardship

Antibiotic audits are conducted quarterly in physical health services and prospectively for all antibiotics prescribed in inpatient mental health services. Any exceptions are discussed at MMG for agreed next steps to mitigate any risks and uphold the Trust's responsibility for antimicrobial stewardship.

A clinical pharmacy technician 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.

In line with the Health and Social Care Act 2008 Code of Practice, all NHS organisations must give assurance that there are measures in place to ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Quarterly reports inform both MMG and IPCSC and are discussed and monitored at both MMG and IPCSC and the recommendations fed back to relevant prescribers.

Inpatient Services

During 2016/17, adherence to the antibiotic formulary within inpatient services was 54% with 29.7% of scripts being commenced by another provider, with areas identified for improvement. 5.4% of decisions were based on microbiology results. Allergies were recorded in 100% of cases and reason for prescribing in 99%. The top three reasons for prescribing an antibiotic were urinary tract infection, cellulitis and a respiratory infection. Prescribing of cephalosporins and quinolones were at acceptably low levels.

Collaborative working with pharmacy and infection prevention and control teams seeks to enhance the prescribing decisions made regarding the use of antimicrobials.

West Cheshire Physical Health Services Antibiotic Prescribing

Adherence to the antibiotic formulary is excellent in GPOOH, with GPs achieving 99% adherence and non-medical prescribers 100%. For cephalosporins and quinolones prescribing rates are 4% for GPs and 2% for NMPs. Antibiotics are not routinely prescribed by NMPs in community clinics.

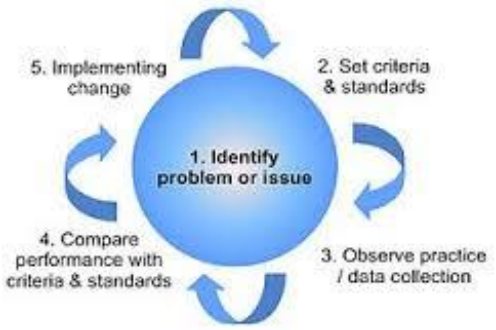
Due to problems with attributing prescribing to Westminster surgery during 2016/17, we do not have data to indicate antibiotic formulary adherence. This issue has since been resolved for 2017.

C9. Medicines Reconciliation Audit

The 2016-17 medicines reconciliation audit was presented to the Medicines Management Group (MMG) in March 2017 and shared with commissioners. Results showed that we continue to complete medicines reconciliation for 100% of our in-patient admissions which has a direct impact on the zero harm strategy. An improvement in the timescales for completion of medicines reconciliation for patients admitted over the weekend is work is progressing.

C10. Quality Improvement: Prescribing Observatory for Mental Health (POMH UK)

The national Prescribing Observatory for Mental Health (POMH-UK) aims to help Specialist Mental Health Trusts improve their prescribing practice.



A CWP steering group for POMH was established in July 2016 reporting to both MMG and Patient Safety and Effectiveness Sub-Committee, comprising of Pharmacy, Healthcare Quality Improvement and three Consultant Psychiatrists with a broad range of portfolios and with representation across all 3 localities.

The group meets bi-monthly and provides Trust wide leadership for the quality improvement approaches to medicines to reduce patient harm and improve effectiveness of medicines, based on the POMH audits being undertaken over the year. The results are disseminated across the Trust and action plans developed based on benchmarked results nationally.

Highlights of the work programme include:

Reducing the Risk of Harm in Women of Child-bearing Potential Prescribed Sodium Valproate
An action plan was developed in July 2016, with additional clinical leadership to the POMH Steering Group provided by Dr Tania Stanway, Chair - Perinatal Mental Health Clinical Network and CWP Consultant Psychiatrist. The action plan included a plan for a systematic review of patients prescribed valproate by clinicians enabled by:

- the provision of data (actioned December 2016)
- electronic alert added to CareNotes (February 2017)
- electronic checklist added to CareNotes (February 2017)
- communication via LCMM / CMB locality meetings and two Trust Wide Communication Bulletins (November 2016 – March 2017)

Additional Quality Improvement Assessments
Clinical Teams undertook the following audits over 2016-17, the results of which have been disseminated to teams in 2017 where the results have been published. Analysis of best practice as well as scope for improvement is undertaken as part of these audits. These include:

a) Prescribing of anti-psychotic medication for people with dementia
CWP was ranked as fourth lowest prevalence of anti-psychotic prescribing in this patient sample, compared with the national sample (6% v 18%) showing evidence of good practice.

b) Monitoring of patients prescribed lithium
The results from the sample audited showed 100% compliance with renal, thyroid function and serum calcium tests. 87% had documented evidence that an ECG was conducted before lithium was prescribed compared to only 29% in 2013. The Trust was one of only 3 other Trusts nationally achieving 100% for patients having 2 or more serum lithium tests undertaken in the previous year.

c) Rapid Tranquillisation (results not yet published)

d) High Dose Antipsychotic Therapy (results not yet published)

D. Clinical Governance and External Standards

Overview Medicines Governance

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. 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. A Chair's report for MMG is provided to Patient Safety and Effectiveness Sub Committee, allowing for escalation of risks.

CQC Re-Visit 2016

Following on from the CQC re-visit in October 2016, the key issue that was highlighted was the stability of medicines in the Medi 365 as a result of temperature increases in the room that it was stored. This has now been addressed and the appliance has now been moved following on from this feedback.

E. National Patient Safety Alerts

We have responded to three patient safety alerts this year from NHS Improvement, namely:

1. Stage 2 resources: Support to minimise the risk of distress and death from inappropriate doses of naloxone
2. Warning alert: Risk of death and severe harm from error with injectable phenytoin
3. Warning alert: Risk of severe harm and death due to withdrawing insulin from pen devices

For all alerts an action plan was devised around actions required by CWP. All alerts were closed within the required time.

F. Medicines Supply Service

The contract with Lloydspharmacy is robustly monitored monthly by the senior pharmacy technician and chief pharmacist via the contract monitoring meetings at which the key performance indicators of the contract are reviewed and discussed. An escalation plan to address any breaches through the superintendent's office is available.

The CWP pharmacy team and Lloydspharmacy continue to work together to improve the medicines supply service for our patients and staff. Throughout the year with the support of CWP pharmacy, Lloyds focus has been on their safer care programme. This is a patient-centred approach to embed a culture of safety and individual ownership of contributions to improve patient care. This has resulted in more joined up working and a significant reduction in medicine errors leaving the pharmacy.

G. Pharmaceutical Interventions and Multi-disciplinary Team (MDT) Working

The pharmacy team are an integral component of inpatient MDTs and undertake pharmaceutical interventions which are recorded in the CareNotes clinical system. Approximately 10% of all interventions by the team relate to reducing the risk of falls due to medication.

H. Community Mental Health Teams / Home Treatment Teams

It is estimated that there were a minimum of 500 queries from the CMHTs / HTTs across the Trust to the pharmacy team. Examples include:

- the risks associated with antipsychotics in complex cardiovascular problems
- choice of long acting injection and named patient medicines requests for a patient with history of falls
- use of medicines in pregnancy and breastfeeding.

The CMHTs have articulated that they value the medicines expertise and advice the pharmacy team give when they ask for advice. Although there is no dedicated pharmaceutical support to the CMHTs, the pharmacy team responds where feasible, to requests from the teams. There is an opportunity and value of having pharmacy staff based within the HTTs and CMHTs to take a proactive role in:

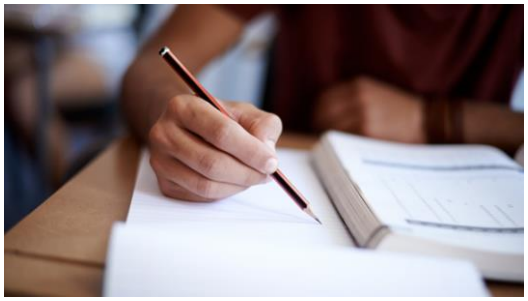
- safe use of medicines
- medicines reconciliation, implementing guidelines and alerts
- initiation of clozapine
- providing advice on choice of medicines to individuals as part of a person centred approach.

A small scale pilot evaluation of potential scope of pharmaceutical input into these teams commenced in 2016 and this will inform the strategic direction of the development of the pharmacy led workforce into CMHTs and HTTs in line with the Trust's objectives.

I. Education Provided to Other Teams

As well as delivering training internally, the Pharmacy Team have facilitated some Recovery Colleague sessions around the topics of psychotropic medicines and facilitated a carer's session for the Early Intervention Team.

In March 2017, our senior clinical pharmacist for West provided a medicines education workshop for carers at the Northwich Making Space Group. The session received excellent feedback.



Feedback received: 'Absolutely brilliant. Jennifer is very knowledgeable and communicates well. I have learned a lot today. Thank you.'…'Extremely good, with interesting comments and ideal content.'… Thank you so much for doing the workshop for us '.

The Physical Health technician in West continues to work with the Active for Life service by delivering talks on optimising analgesia in back pain. Service users find this service very helpful and sessions always receive positive feedback. The Physical Health pharmacist presented a session on Type 2 Diabetes to the West Physical Health Clinical Leads Forum.

The team have also been inputting into the education programme for Non-Medical Prescribers including the delivery of a session on Pharmacokinetics across the Age Continuum at the annual NMP conference enabling the audience to think about the way medicines are handled based on differing patient characteristics and hence reduce the risk of patient harm.

Further NMP training on PGDs, the NMP policy and the self-care agenda has been provided by the pharmacy team.

Each year the team supports six pre-registration pharmacists, from neighbouring acute trusts, for week long placements. Positive feedback was received by the teams in all localities involved. A quote from an Education and Training pharmacist at another Trust stated '*many of the pre-reg applicants specifically state they want to come here because of your rotation'*. The team also gave lectures about mental health illnesses and their treatments at the pre-registration study day.

In early 2017, Liverpool John Moore's University invited the Pharmacy Team back for the seventh time to facilitate the Psychiatry study day for their Postgraduate Diploma in Clinical Pharmacy. In addition, two of the pharmacy team wrote storyboards for dementia and schizophrenia for the community postgraduate diploma.

As in previous years the pharmacy team has provided medicines management training sessions, including antimicrobial stewardship, at the trust-wide junior doctors' induction.

J. Team Development

Within the pharmacy team meetings, team members have been providing CPD sessions which have include updates on anticholinergic load and impact on cognitive impairment, discussion of case studies focussing on depot antipsychotics, as well as recent advances in asthma treatment.

K. Non-Medical Prescribing

The trust employs a total of 140 non-medical prescribers; 25 work in mental health, with the rest working in physical health services. In 2016-17, the Senior Pharmacist in the East Locality completed her Non-Medical Prescribing course.

The table below illustrates the breakdown of our NMPs within the organisation.

Table 4: Non-Medical Prescribers Trust-Wide

Service	Number of Prescribers
Adult and Older People Mental Health	18
CAMHS	3
Memory Clinic	2
Drug and Alcohol Services	2
Independent prescribers in physical health (V300)	30
Community practitioner nurse prescribers physical health (mainly health visitors)	85

The Pharmacy Team holds the register for the NMPs for mental health and the Nursing and Therapies Team holds the register for physical health services.

L. Westminister Surgery

The pharmacist from Well Pharmacy (adjacent to the surgery) holds a Medication Review clinic once a week for patients with chronic and long term conditions. This is a very popular service with the patients who benefit from having their medication optimised. The Senior Clinical Pharmacist for Physical Health supervises this pharmacist and monitors the impact of interventions.

M. Medicines Management Operational Plan 2016-2020

A Medicines Management Operational plan was developed in October 2016 to set out key deliverables required to implement the Medicines Management Strategy 2015-2019.

This has been aligned to organisational objectives and will be updated to reflect advancements in the Trust Strategy. (Please refer to Appendix 1)

N. Five Year Forward View For Cheshire & Merseyside: Medicines Optimisation and Pharmacy

N1. Mental Health and Community Services

A working group to plan, prioritise and take forward medicines related initiatives in line with the Five Year Forward View for Cheshire and Merseyside (5YFV for C&M) objectives, was established in November 2016 by the Pharmacy Team at CWP. This group consists of Leaders in Pharmacy for the following organisations:

- Cheshire and Wirral Partnership Trust
- Merseycare
- 5 Boroughs Mental Health Trust
- Wirral Community Trust
- Local Pharmaceutical Committee

This group has established priorities for aligned working and meets monthly.

N2. Local Delivery System (LDS) Group for Pharmacy

This group consists of Chief Pharmacists across the Local Delivery System aligned to the 5YFV for C&M. This group meets quarterly. The main work plan as per initial developments with this group is focusing on the Acute Sector.

N3. West Cheshire CCG Medicines Strategy Group

The West Cheshire Medicines Strategy Group is chaired by the Medical Director for West Cheshire CCG and includes representation from:

- Finance and MH Commissioner Leads, West Cheshire CCG
- Pharmacy – Countess of Chester Hospital
- Pharmacy – CWP
- Local Pharmaceutical Committee
- Medicines Optimisation Team - Commissioning Support Unit

This group meets bi-monthly and provides the forum for collaborative working across the sectors in relation to Pharmacy and Medicines Optimisation. Equivalent forums of which the CWP Pharmacy Team should attend across other CCGs are being scoped.

O. Highlights for Quarter 1 2017 - 2018

The following are top summary highlights of Quarter 1 2017-18

- The Medicines Management Group has been well attended with excellent Clinical input across the Trust allowing for robust clinical decision making and debate. The Consultant Psychiatrist Lead for MMG has chaired all meetings since February 2017 allowing for robust clinical engagement and enables joint medical and pharmaceutical leadership with the Vice-Chair of the Group. Attendance from all localities has been enhanced with proactive input from all members. This has been a significant improvement.

- Review of Clozapine Prescribing Pathway to enhance patient safety, with wide clinical engagement in the development of the revised pathway, including integration of community and inpatient patient clozapine pathways.

- Workforce remains a challenge, particularly in light of the planned absence in the Senior Pharmacy Team due to illness. A lean in-patient pharmacy team with limited CMHT pharmaceutical clinical provision means that medicines safety has the potential to be optimised further through workforce modelling. This has scope to include enhanced pharmacist / technician roles to mitigate the risks posed by the wider workforce challenges across the Trust. A medicines administration technician post is in development to ease some of the workforce challenges in the Central and East Locality.

- The 5YFV for C&M Pharmacy Mental Health and Community Services Group continues to be led and chaired by CWP. The following have been agreed as the top 10 high priority work-streams for pharmacy led initiatives:
    1. Reduction of cardio-metabolic risk in patients with serious mental illness
    2. High Dose Antipsychotic Monitoring
    3. Clozapine prescribing optimisation.
    4. Low molecular weight heparin discharge from hospital
    5. Dementia friends
    6. Supporting the suicide prevention strategy through the New Medicines Service for antidepressants
    7. Medicines waste
    8. Medicine reconciliation – post 7 day discharge care at community pharmacies
    9. Shared care guidelines/care pathways/formularies
    10. Frail older people, mental health and admissions reduction

- We are working closely with the North West Coast Academic Health Sciences Network and the Local Pharmaceutical Committees across Cheshire and Merseyside to test a web based tool, PharmOutcomes, to enhance clinical dialogue across CWP and Community Pharmacy to enhance patient care and reduce risk in line with the collaborative objectives above. A working Group, including CWP Information Systems, have met twice since March 2017. This work-stream is being led by the Pharmacy Team at CWP.

- A STOMP LD work stream to reduce psychotropic medicines in people with a learning disability has met regularly to develop a plan of action in this area, with representation from local commissioners, consultant psychiatrist and Pharmacy.

- In the absence of ePMA, electronic checklists and alerts for CareNotes have been developed for patient safety critical medicines, such as for high dose antipsychotic therapy, clozapine, and revised cardio-metabolic risk tool.

P. Team Feedback

The Pharmacy team obtains feedback from a wide group of people over 2016-17, a selection of which is provided below:

'I wanted to write an appreciation note for the excellent pharmacy team here. I have been covering acute care wards for 5 weeks now and thrilled with the quality of input from pharmacy team (all of them) re: medication reviews, participation in the ward rounds, advice and in general ensuring good quality prescribing. Thank you' - Consultant Psychiatrist

'It has been a pleasure to work with such lovely, kind hearted and skilled professionals like you. Thanks for all your support and hard work – Nurse

'Clinical pharmacist' has been helpful as always for looking back through a patient's drug history and making recommendations - Junior Doctor on ward

Thank you for providing information about medicines for patient transferred from CWP care in an emergency situation - Pharmacist at Merseycare

I am writing to inform you that I have now passed my NMP course and registered with the NMC … also I want to make you aware how helpful (the Clinical Pharmacist) was during my course, she was supportive and informative…. I want to thank the pharmacy team for all their support – Nurse Prescriber

Q. Conclusion

This report highlights the achievements over 2016-17 and the delivery of the medicines optimisation work plan for the financial year, allowing for the safe and effective use of medicines within the Trust. Value is optimised through the adherence of formulary and the Named Patient Request mechanism. Medicines optimisation and reducing patient harm in line with the Zero Harm Strategy is a common thread underpinning the work-streams outlined in this report.

R. Recommendations

The Board of Directors is requested to:

- **Discuss** the Annual Report
- **Approve** the Annual Report.

Contributors to this Annual Report

Jasmeen Islam	Acting Chief Pharmacist & Associate Director for Medicines Management
Dr Anushta Sivananthan	Consultant Psychiatrist / Medical Director
Claire Whiteside	PA to Chief Pharmacist
Lisa Foulkes	Pharmacy Business Information Officer
Julie Orton	Medicines Safety Pharmacist
Hazel Sharp	Deputy Chief Pharmacist
Ian Winton	Clinical Pharmacy Technician for Physical Health
Lesley Irvin	Senior Clinical Pharmacist, Physical Health Services
Rebecca Hellier	Clinical Pharmacist
Michael Slater	Clinical Pharmacist
Jennifer Southern	Senior Clinical Pharmacist
Bethan Thorpe	Senior Clinical Pharmacist
Nina Geiger	Senior Clinical Pharmacist
Nichola Yates	Senior Pharmacy Technician
Mike Caulfield	Advanced Practitioner for Acute Care (West), Adults And Older Peoples Mental Health
Pat Mottram	Research & Effectiveness Manager, Academic Unit
Dr Sumit Sehgal	Consultant Psychiatrist and Chair of MMG
Dr Jose Ferran	Consultant Psychiatrist & Clinical Director WOAMHS, Older Persons Community Mental Health Team
Dr Sandhya Gaur	Older People Consultant Psychiatrist , Older Peoples CMHT
Iain Wells	Modern Matron, Adult And Older Peoples Mental Health
Chris Turnbull	Ward Manager, A & OPMH

Acknowledgement: Fiona Couper, Chief Pharmacist & Associate Director for Medicines Management currently on planned absence since February 2017 and at the time of writing this report.

Appendix 1

IMPLEMENTATION OF MEDICINES STRATEGY PLAN / PHARMACY TEAM OBJECTIVES
December 2016 - December 2020
This plan may evolve and change over this timeframe
Progress as at June 2017

Pharmacy Team Mission Statement: To enable our clinical colleagues to provide high quality, patient focussed use of medicines

CWP 6C's Checklist	
Care	How am I contributing to our CWP core business of delivering care so that our organisation contributes to the value outcomes for all we care for?
Compassion	How do I ensure my relationships with patients, their carers and my colleagues are based upon empathy, respect and dignity at all times?
Competence	How do I ensure that I have the required knowledge and expertise in order to fulfil my role, and so I keep my skills updated? Do I ask for help and support to improve my competence when I do not feel confident to perform my role or an individual task?
Communication	How am I making sure I listen to the views of patients, their carers and my colleagues and do I take action when I should? Do I effectively communicate to ensure caring relationships and effective team work?
Courage	How do I always do the right thing for the people we care for, their carers and my colleagues? Do I have the personal strength to speak out and raise concerns when required and the vision to innovate and embrace new improved ways of working?
Commitment	How am I committed today and every day to face current and future challenges, to always look at ways to continually improve the care and experience of our patients, their carers and my colleagues?

CWP Strategic Priorities
1. Further development of integrated community services
2. Child and adolescent mental health services (CAMHS) tier 4
3. Developing potential options for inpatient care (including rehab)
4. Transforming care for people with learning disabilities
5. Improving IAPT performance (access to psychological therapies)

Objective / Work Priorities	Rationale	Strategic Driver	Team Members	Stakeholder Liaison	SMART Actions / Key Milestones	Timescales	Progress	Red / Amber/ Green Status
Objective 1. Introduction of electronic prescribing and medicines administration to: - inpatient teams - community teams	Information Technology Enabling	CWP Medicines Management Strategy					Paused due to funding constraints	
Objective 2. Explore and implement alternative communication channels to enable more service users to have access to information about prescribed medicines. Range of information sources to include leaflets, face to face consultation, videos and medicines information apps for smart devices	Information Technology Enabling	CWP Medicines Management Strategy **Further Development of Integrated Community Services - CWP Strategic Priority**	Technicians Senior Clinical Pharmacists Clinical Pharmacists	IT Communications & Engagement Patient & Carer involvement (Liz Matthews)	Explore, prioritise & identify at least two therapy areas / patient groups where patient concordance with medicines is problematic and has an adverse outcome to patient care. Develop an approach to support this group, including signposting to credible sources available electronically.	By December 2017		
Objective 3. Develop a strategy for the team to raise the profile of Medicines Management in CWP, including application for awards	Innovation		Fiona Couper Jasmeen islam Hazel Sharp		tbc	By December 2017 & ongoing	Application submitted for Book of Best Practice wrt POMH workstream. Poster presentation for valpraote being developed for external conference. Attend Board for Annual Report discussions	
Objective 4 Develop a Business Case to enhance pharmacy support Trust-wide to CAMHS with a priority for Ancora House (specialised commissioning) and the Psychopharmacology group, with funding from CAMHS	Zero Harm	Child and adolescent mental health services (CAMHS) tier 4 - CWP Strategic Priority			tbc	tbc		

Objective 5. Undertake a cost benefit appraisal for the use of hand held devices to improve workflow of pharmacy staff on inpatient units for ordering and notes into carenotes, and to increase patient facing consultations post discharge.	Information Technology Enabling	CWP Medicines Management Strategy **Further Development of Integrated Community Services - CWP Strategic Priority**			Undertake a cost benefit appraisal, also seeking funding from national charities/ independent sectors to submit a bid using this for patient facing consultations, smarten the ordering process for medicines, and entering clinical notes into care notes	By December 2017	JI developed paper and for discussion at team meeting in September 2017. Raised with AHSN in June 2017 to scope.	
Objective 6. Implementation of two Healthcare Quality Improvement Projects (HQIPs) and undertake a deep dive of the top 2 areas for improvement for medicines . These should include a) Failure to administer medicines (liaise with Helen Fishwick) b) Reduction of cardio metabolic risk factors to include links with the national CQUIN, diet, health and wellbeing and HDAT to improve quality outcomes for service users.	Continuous improvement culture Sustainability and Transformation Plan Zero Harm	National CQUIN NICE standards for Schizophrenia / Bipolar disease Economic Report for the NHS England Mental Health Taskforce Further development of integrated community services - CWP Strategic Priority	a) Julie Orton (Lead), Locality Lead Pharmacists b) Jasmeen Islam (Lead) & Full Team Sponsor: Fiona Couper	a) Lisa Parker James Partington Helen Fishwick b) Helen Fishwick Claire James David Wood James Partington	The HQIP should include a) a deep dive of the identified issue, b)the development of standards that are set c) a program of multiple and new interventions to sustain improvement which will be tracked via a dashboard to measure improvement The reduction of cardio metabolic risk factors objective should be aligned to the STP footprint including Merseycare and 5 Boroughs PT. The aim is to drive a reduction in premature mortality of patients with SMI by optimised patient cardio-monitoring	March 2017 & ongoing	Agreed metric as part of Trust wide wuality indicator following consultation with clinicians Cardiometabolic form amended to include parameters Now scoping integrated with community pharmacy through use of PharmOutcomes, working with AHSN and LPN	
Objective 7. Work with LQSM (James Partington / Bev Chaucer) and Claire James to obtain a dataset for patient safety critical parameters for medicines monitored over time	Continuous improvement culture	NICE CG 38 **Transforming care for people with learning disabilities - CWP Strategic Priority**	Jasmeen Islam	James Partington Bev Chaucer Claire James	To include: a) Valproate prescribing in women of childbearing potential (target tbc) b) Psychotropics for patients with learning disability c) High Dose Antipsychotics (HDAT)	a) April 2017 b) July 2017 c) Oct 2017	a) and c) complete b) in progress	
Objective 8. Work with Education CWP to explore models of delivering training and education for implementation	Continuous improvement culture Zero Harm	CWP Medicines Management Strategy	Hazel Sharp (Lead) supported by Jennifer Southern, and delivery by all team	Louise Kitchener Gary Flockhart Laurie Van Njerk Matthew Cahill Health education England NW Pharmacy Workforce contact (tbc)	a) **Medical Education:** Understand who the locality tutors to Medics are and identify the link to MRCPsych training including: i) when the training is provided ii) timetable for the year iii) timeslot gaps iv) How to incorporate pharmaceutical learning to the timetable v) What areas are to be covered b) **Nursing Education**: Identify 3 subjects to focus on by asking key nurses, including Matrons where the gaps in knowledge are c) **All clinical staff:** Pharmacy team to implement training on the safe use of medicines and on specific high risk medicines eg lithium and clozapine in line with the CWP education timetable d) Contribute to pre-registration and university undergraduate placements in order to support team resilience and for succession planning. Additionally, understand the requirements for pre-registration intake and explore options for inclusion into the pharmacy workforce.		a) complete b) complete c) in progress Plus additional developments as per HS portfolio of work	

Objective 9. Proactive Contribution to Prescribing Observatory for Mental Health benchmarking audits through expert advisory support and assisting the clinical teams to implement the recommendations. Provide evidence of changes to prescribing trends as a result of implementation of audit action plans by the next audit cycle.	Continuous improvement culture Clinical Audit, benchmarking & research support Zero Harm	CWP Medicines Management Strategy Pharmacy Services Review	Jasmeen Islam	Kate Baxter Dr Gagandeep Singh Dr Taj Nathan Dr Amrith Shetty	Strategic input into ensuring that all POMH audits undertaken are relevant, appropriate including achievable and workable timescales	August 2016 and onwards		
Objective 10. Continue to support CWPs Zero Harm Strategy through quantifiable provision of - medicines optimisation - medicines reconciliation within 24 hours -patient counselling on medicines - medication histories - MDT reviews - prescription review and clinical checks on formulation / product choice - community team queries on medicines - service user / carer groups, well being clinics and recovery college settings Ensure details about pharmaceutical plans are captured into overarching care plans	Direct clinical support to patient care Zero Harm	Pharmacy Service Review & JDs	Lead: Jasmeen Islam - interventions database, Lisa Foulkes Pharmacy Technicians Clinical Pharmacists Senior Clinical Pharmacists		Aim for: a) 100% interventions to be documented in Carenotes b) Refresh interventions report to pull out key measurable interventions by speciality using the raw dataset to maximise outcomes from the analysis of data obtained from Carenotes., with a view to share this with Clinical Services on a quarterly basis. c) Development of an annual report with 5 significant case studies to highlight significant pharmaceutical interventions, at least 5 testimonials /feedback from other colleagues and a consolidation of quarterly reports	By July 2017 January 2018	a) ongoing b) in progress c) in progress
Objective 11. Train at least one pharmacist per year to become a non-medical prescriber to cover mental and physical health, community and home treatment teams and acute inpatients	Non Medical Prescribing People with mental health problems often also receive poorer physical health care. Those with severe mental illness die on average 15-20 years earlier than the general population. They are three times more likely to attend A&E with an urgent physical health need and almost five times more likely to be admitted as an emergency, suggesting deficiencies in the primary care they are receiving Zero Harm	Pharmacy Service Review Priorities for mental health - economic report for the NHS England mental health taskforce Mental Health Taskforce - FYFV King's Fund top 10 priorities for mental health - bringing together physical and mental health **Developing potential options for inpatient care - CWP Strategic Priority** **Further development of inpatient services - CWP Strategic Priority**	Fiona Couper Clinical Pharmacists	Gary Flockhart Andrea Hughes	a) Quantify the impact on expediting the medicines reconciliation and discharge planning processes through Pharmacist non - medical prescribing b) Scope the potential to reduce admissions related to medicines by keeping people in their own homes through NMP interventions. c) Increase the number of pharmacy interventions in community teams and obtain the baseline interventions data from Quarterly report. d) Quantify the financial savings by understanding bed day costs taking into account length of stay, as well as medication review savings	a) December 2017 and onwards b) April 2018? c) Baseline by April 2017.Ongoing quarterly Baseline July 2017 and ongoing	1 x Pharmacist NMP training complete (East locality) Wirral Locality Pharmacist for 2017/18 Business case for Pharmacists in CMHTs/ HTTs to be developed by October 2017, following feedback from East Pilot and CWP strategic objectives fow workforce development	

Objective 12. Work across traditional boundaries to provide specialist input into - Community Pharmacy - Community Teams - Care Homes - CCG commissioned integrated care pharmacy team to collaborate to move towards a reduction of premature deaths in SMI and admissions through medicines optimisation, all aligned to the STP.	Models of Delivery and workforce transformation Zero	CWP Medicines Management Strategy **Developing potential options for inpatient care - CWP Strategic Priority** **Further development of integrated community services - CWP Strategic Priority**	Fiona Couper (Lead) supported by all pharmacy team	LPN LPC (Suzanne Austin, Mel Carroll) Pauline Roberts (MLCSU) Steve King (East Cheshire & MLCSU) Lisa Knight CCG Commissioners	Prepare strategic vision to achieve the objective for agreement by CWP and CCG Boards & Health and Wellbeing Boards in order to deliver the following outcomes and to include eg polypharmacy and HDAT within care homes, and proactive pharmaceutical interventions to optimise patient support. a) Develop an action plan with agreed stakeholders to identify patients with mental health needs at greatest risk of admission and undertake targeted medication review. To include an initial phase of undertaking short 'tests' with rapid evaluation to understand scope and viability b) Seek agreement and develop a plan to undertake a short pilot an initiative with community pharmacy to undertake targeted Medicines Use Review post discharge for patients with mental health problems and agree whether there is potential for further roll out supported by educational strategies such as motivational interviewing c) Work with NHS England and local CCGs to test the scope for physical health monitoring through community pharmacy for	Jul-18	Part of workstream with 5YFV C&M MH group, work in progress	
Objective 13. Review and re-approve trust wide medicines policies and guidelines in line with the policy review schedule	Continuous improvement culture	CWP Medicines Management Strategy	Pharmacy team authors Claire to co-ordinate schedule		To include a review and re-approval of the Medicines Policy.	July 2017 - October 2017	On track	
Objective 14. Review prescribing for physical health services and identify / scope where efficiencies can be made eg medicines, appliances, dressings, GPOOH prescribing	Value for money & CIP	**Further development of integrated community services - CWP Strategic Priority**	Lesley Irvin Ian Winton Lisa Foulkes		**Stage 1:** Review of prescribing data, intelligence gathering, current inefficiencies. Develop an action plan including data and rationale for any changes for both quick wins and areas where further planning is required. **Stage 2:** Progress implementation through prioritisation with timescales	Baseline: March 2017 May 2017 & onwards	On track	
Objective 15. Contribution to the Trust's savings plan through measurable cost efficiency programmes related to medicines optimisation by 3.5 - 4%	Cost Improvement Programme	Pharmacy Service Review	Senior Clinical Pharmacists Lisa Foulkes Senior Team member tbc for (c)	Home Treatment Teams (for re-use of medicines)	a) develop, implement and evaluate a cost improvement strategy to identify savings in scope and value for money through: - benchmarking across other mental health trusts - formulary & guideline monitoring using data from Lloyds - procurement initiatives and analysis of Lloyds dispensing data b) Undertake a monthly inpatient review of budgetary position at locality level & quarterly for CMHTs, liaising with CSMs c)Undertake horizon scanning for new medicines by January 2018 to enable budgetary planning for 2018-19 d) Quantify the cost of medicines for income generating beds and feed this into CSMs for appropriate action.	Development: April 2017 January 2017 and onwards October 2017-January 2018 September 2017	a) benchmarking complete b) On track c) Not yet started d) On track and ongoing	

Objective 16. Understand the scope to innovate and expand the pharmacy service to potentially generate new income in the longer term to include clients in either the 3rd sector, CCGs, individual General Practices, Public Health (including CHAMPS), Local Authorities and working beyond traditional boundaries	Innovation	Further development of integrated community services - CWP Strategic Priority Transforming care for people with learning disabilities - CWP Strategic Priority Winterbourne Review STOMP LD	Michael Slater Jennifer Southern Karina Herp Fiona Morris Fiona Couper Jasmeen Islam Hazel Sharp	Dr Mahesh Odiyoor Dr Rajini Kullu	To include a short pilot / test to undertake pharmacist-led medication review for patients with learning disability and under the care of general practice, bringing in specialist CWP advice where appropriate	By December 2017	In progress as per STOMPLD subgroup to MMG	
Objective 17. Implementation of the controlled drugs work programme	Statutory	Pharmacy Service Review	Fiona Couper / Jasmeen Islam (Lead)		CQC assurance for controlled drugs	Quarterly	On track	
Objective 18. Direct governance support to Lloyds Pharmacy for the ordering of medicines	Supply and procurement of medicines	Pharmacy Service Review	Nic Yates supported by Lisa Foulkes and Fiona Couper / Jasmeen Islam	Helen Sweeney Karen Holmes	Assurance that Lloyds Chemists are adhering to the contract under their KPIs	April 2017 and quarterly ongoing review	On track and all KPIs met	
Objective 19. Produce a report highlighting data relating to mental health relevant to local geography and similar demographics highlighting where medication and / or monitoring can be optimised to reduce admissions across the CWP footprint and take this to an identified relevant forum locally in order to effect a strategic dialogue to optimise patient care	Continuous Improvement Culture	**Further development of integrated community services - CWP Strategic Priority** **Developing potential options for inpatient care - CWP Strategic Priority**	Jasmeen Islam (Lead) Lisa Foulkes	Martin Dowler James partington Mandy Skelding-Jones Anne Casey	Use data sources available nationally and locally eg: - Right Care toolkits & Atlas of Variation - Public Health England profiling tools - NHS benchmarking and identify other data sets available to support this work stream to impact on outcomes on admissions.	By December 2017	Right Care analysis completed at 5YFV for C&M MH Group. Paper development to inform strategic objectives in development	
Objective 20. Review medicine supply service. Currently in a 3 year contract with Lloyds pharmacy, due to finish April 2018 unless we extend by a further 12-24 months.	Supply and procurement of medicines		Nic Yates Fiona Couper	Stephen Wilson Finance Lead Contracts Lead	Service delivery assurance	December 2016 - July 2017	In progress	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Quarterly Report of the Guardian of Safe Working Hours
Agenda ref. no:	17-18-36a
Report to (meeting):	Trust Board of Directors
Action required:	Information and noting
Date of meeting:	26/07/2017
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	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
36T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
36T	

REPORT BRIEFING

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

This report sets out data regarding rotas, locum/agency usage and safe working for the period March – May 2017 inclusive for doctors in training across the trust. It considers current areas of risk and suggested areas of future risk which should be addressed.

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

The implementation of the 2016 contract for Doctors in Training involved the creation of the position of Guardian of Safe Working Hours in order to monitor and provide reassurance of safe working practice related to hours worked. The post is an independent safeguard within the terms and conditions of the contract and comes with a responsibility to provide quarterly and annual reports to the Trust Board.

Assessment – *analysis and considerations of options and risks*

We currently have 22 doctors working under the terms and conditions of the 2016 contract. There are considerable vacancies related to HENW posts not being filled, maternity leave, LTFT and higher trainees completing training.

We have received no exception reports and there have been no issues raised regarding safe working hours or access to educational and training experiences.

Current rota gaps or shifts unfilled through sickness have all been filled with internal locum usage and an internal bank is being formed to assist with this process.

As of August there will be fewer doctors in training in the trust due to more HENW vacancies. LAS positions are currently advertised. Any increase to in-hours on call/bleep holding type work must not impact access to training or educational opportunities. Any changes to current rota frequency or increase in number of locum shifts covered internally will increase the risk of breaches and will therefore require monitoring to ensure safe working.

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

The trust must explore systems available to capture real-time detailed data around hours worked by individual doctors in order to ensure safe working or identify issues early on. The current exception reporting system does not provide the detailed information expected to be provided quarterly to Board and will come with a cost implication as of September. This is currently being looked at.

The trust should consider alternative ways of safe working early in order to avoid pressures in training and safe working in the context of reduced numbers of doctors in training within the trust. This is being considered presently.

Who/ which group has approved this report for receipt at the above meeting?		Dr Ian Porter
Contributing authors:		Dr Ian Porter
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
Full	Junior Doctor Forum	To be brought to meeting

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	Guardian of Safe working Hours Report to the Trust Board for the period December 2016 – February 2017

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Guardian of Safe working Hours Report to the Trust Board for the period March 2017 – May 2017

Report Author: Dr Ian Porter
Guardian of Safe Working Hours

Date of report: 28th June 2017

Executive summary

The following report is the second of the quarterly reports to the Trust board and details the quarter March – May 2017.

There have been no reports made of exceptions from agreed work schedules during the report period. There have been no highlighted areas of concern regarding safe working or access to educational and training opportunities.

The trust must explore systems available to capture real-time detailed data around hours worked by individual doctors in order to ensure safe working or identify issues early on. The current exception reporting system does not provide the detailed information expected to be provided quarterly to Board and will come with a cost implication as of September. This is currently being looked at.

Introduction

The introduction of the 2016 Junior Doctor created the role of the Guardian of Safe Working Hours and ended the previous hours monitoring system, replacing it with a continuous system of reporting exceptions occurring from a previously agreed work schedule aiming to ensure rotas and working hours are safe for Doctors and patients. The Guardian is bound by the terms and conditions of the contract to provide reports to the Trust Board regarding the safety of Doctor's working hours and areas and plans for improvement.

High level data

Number of doctors in training (total):	45
(60 placements in total with HENW and maternity/LTFT vacant posts accounted)	
Number of doctors in training on 2016 TCS (total):	22
Amount of time available in job plan for guardian to do the role:	0.5 PAs per week
Admin support provided to the guardian (if any):	No admin support
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

a) Exception reports (with regard to working hours)

We currently have 22 doctors working under the TCS of the 2016 contract. **We have had no exceptions regarding working hours or access to training/education reported at the time of preparation of the report.**

There is currently a mixed economy of contracts on individual rotas and this pattern will persist for several years as trainees progress onto the new contracts. For this reason there will continue to be a requirement on the trust to conduct traditional hours monitoring exercises for those rotas and trainees.

The latest period of monitoring was completed in May 2017 with unfortunately a very poor response so as to render any information or results invalid. This will be re-run in the near future.

b) Work schedule reviews

There have been no work schedule reviews requested or completed.

c) Locum bookings

Rota gaps are as follows:

Wirral and West 1st on-call – 1.4 WTE (maternity leave and LTFT)

Central and East 1st on-call – 0.4 WTE (LTFT)

Wirral and West higher trainee rota – 5 WTE (placement numbers)

Central and East higher trainee rota – This is operated as a 1in 10 rota. At the beginning of the reporting period there were 2 full time, 1 80% trainee and 2 60% trainees. One of the 60% trainees took OOPE at the end of February and one trainee CCT'd at the end of May. Therefore there are currently 2.6 WTE higher trainees in Central East to populate the rota and gaps produced as a result of the changes are now filled with internal locums. Any other rota vacancies continue to be filled by the Consultant on call acting as second on call. The higher trainee cover is due to reduce further imminently.

i) Bank

Internal locum/bank work has varied across rota and site. Cost for the period March-May inclusive is as follows according to the information given to me to prepare this report:

Higher Trainee: £13,300 (see below narrative)

1st on call rota: £8,586 (£3690 Central/East, £4896 Wirral/West)

The information provided to me to complete this report indicates the following locum shifts over the reporting period:

Higher Trainee: 21 – from locum doctor report used to inform payroll
43 – actual locum shifts reported from rota co-ordinator Wirral/West
7 – actual locum shifts reported from rota co-ordinator Central/East

1st on call rota: 26 shifts (11 Central/East and 15 Wirral/West)

The above higher trainee figures reflect for the first time both Wirral/West and Central/East. Prior to March 2017 there were no locum shifts in Central/East 2nd on call as vacant shifts were filled by the Consultant on Call. The figures also reflect the disparity in data with 29 higher trainee locum shifts apparently not yet financially claimed for, impacting significantly on the rota cost figure quoted above. It is therefore at present impossible to give an accurate figure for cost of locum usage on the higher trainee rota during the report period. The costing for the first on call rotas appears to be accurate.

In addition to the locum usage stated above there have been no occasions whereby the Consultant on call or higher trainee has stepped down to cover the 1st on call rota out of hours.

There have been 2 occasions whereby the in hours 1st on/bleep holder cover has been provided through step down procedure on the Wirral and within Chester. There have been no incidences of step down into the first on call Central/East rota.

During the reporting period, as a result of the placement numbers and vacancies and in order to run a 1 in 10 rota, 44 out of 92 shifts on the 2nd on call rota were covered by the Consultant on call in Central/East.

Reasons for locum usage and step down into the first on call rota are recorded as sickness or maternity leave.

Locum usage within the 2nd on call rota is related to vacancy, LTFT and placement numbers in general when populating a 1 in 10 rota.

ii) Agency

During the reporting period there has been no agency usage to cover 1st or 2nd on call rotas.

d) Locum work carried out by trainees

There is currently no formal process by which internal locum work undertaken by doctors is monitored to ensure safe working hours and EWTD is adhered to. This is more of an issue with the non-resident 2nd on call rota given the large number of locum shifts and guidance previously promised to clarify this is still being finalised between the BMA and NHS Employers.

We do not have a way currently of collecting data regarding doctors completing work for other NHS trusts or agencies outside of their normal practice within CWP.

Doctors joining the trust are informed of the importance and professional responsibility of informing those responsible for their rota and placement of any locum work completed both inside and outside of the trust in order that safe working hours are not breached. The locally used EWTD opt out form has been amended to reflect this.

e) Vacancies

Trust wide data for vacancies for all doctors in training irrespective of contract:

HENW Placement Vacancies by month			
	March	April	May
F1	0	0	0
F2	0	0	0
GPST1/2	0	0	0
CT1/2/3	6	7	7
ST4/5/6	5	5	5
Total	11	12	12

WTE Vacancies by Month (inc LTFT and Maternity Leave)			
	March	April	May
F1	0	0	0
F2	0	0	0
GPST1/2	0.4	0	0
CT1/2/3	9.2	10.2	10.2
ST4/5/6	6.5	6.1	6.1
Total	16.1	16.3	16.3

Regional data for vacancies for all doctors in training irrespective of contract:

HENW Placement Vacancies by month (Chester)			
	March	April	May
F1	0	0	0
F2	0	0	0
GPST1/2	0	0	0
CT1/2/3	1	1	1
ST4/5/6	3	2	2
Total	4	3	3

HENW Placement Vacancies by month (Wirral)			
	March	April	May
F1	0	0	0
F2	0	0	0
GPST1/2	0	0	0
CT1/2/3	2	2	2
ST4/5/6	2	2	2
Total	4	4	4

HENW Placement Vacancies by month (Crewe)			
	March	April	May
F1	0	0	0
F2	0	0	0
GPST1/2	0	0	0
CT1/2/3	2	2	2
ST4/5/6	0	1	1
Total	2	3	3

HENW Placement Vacancies by month (Macclesfield)			
	March	April	May
F1	0	0	0
F2	0	0	0
GPST1/2	0	0	0
CT1/2/3	1	2	2
ST4/5/6	0	0	0
Total	1	2	2

f) Fines

To date there have been no fines levied against the trust.

Issues arising

The junior doctor forum has met now on three occasions in total and has been well attended when held after Wednesday afternoon teaching. Engagement has been good and there have been no issues raised around hours safe working. There have been some ancillary issues which have been raised and addressed.

There have been no exceptions reported during the period March-May inclusive. I am aware however of one issue, a training related exception, that has now been resolved. It was not raised as an

exception despite encouragement that it should be from the Guardian and this raises further concerns that Junior Doctors may be reluctant to raise exceptions for fear of damaging their relationship with their Clinical or Educational Supervisor or damaging their training experience/feedback. This will be further explored and work has been undertaken to encourage engagement with reporting.

The lack of a system to monitor internal locum work undertaken has been highlighted previously to support an argument for implementation of a system of real time monitoring in line with exception reporting. A group has met to discuss this and to look at systems which will facilitate it. This is felt to be of high importance particularly given the increasing vacancies within the trust meaning more locum shifts, likely to be covered internally.

Guidance regarding non-resident on call and exception reporting is still awaited.

As mentioned previously data collection for the compilation of this report is extremely difficult and in particular the data surrounding costs attached to locum usage with the higher trainee rotas is poor and not representative of actual costs as noted above.

As of August there will be fewer doctors in training in the trust due to more HENW vacancies. LAS positions are currently advertised. Any increase to in-hours on call/bleep holding type work must not impact access to training or educational opportunities. Any changes to current rota frequency or increase in number of locum shifts covered internally will increase the risk of breaches and will therefore require monitoring to ensure safe working.

Summary

We currently have 22 doctors working under the terms and conditions of the 2016 contract. There are considerable vacancies related to HENW posts not being filled, maternity leave, LTFT and higher trainees completing training.

We have received no exception reports and there have been no issues raised regarding safe working hours or access to educational and training experiences.

Current rota gaps or shifts unfilled through sickness have all been filled with internal locum usage and an internal bank is being formed to assist with this process.

We continue to await guidance from the BMA and NHS Employers regarding management of exception reports for non-resident on call rotas.

With the data currently available to me it is impossible to calculate the true cost of locum usage on the higher trainee rota. This relates to the manner of data collection. The true figure is expected to be more than double that quoted within the report.

In response to the previous report that Trust has begun to look at a method of real-time data monitoring in order to ensure no breaches with EWTD or 72hr safe working rules.

The trust should be aware of and plan for alternative ways of safe working in the event of increasingly fewer doctors in training in psychiatry, predicted to be a continuing issue over several years to come. The vacancy data clearly shows that it is in fact unfilled posts in psychiatry training that account for vacancies as opposed to Foundation or GPVTS posts.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Annual Medical Appraisal, Revalidation & Workforce report
Agenda ref. no:	17-18-36b
Report to (meeting):	Executive Board
Action required:	Discussion and Approval
Date of meeting:	27/07/2017
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
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*

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 required to produce an annual report, accompanying this document, 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) , for submission to NHS England by 30.9.17

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

The Medical Appraisal Team have worked hard to improve the timeliness of medical appraisal.

In November 2016 CWP's appraisal and revalidation systems and processes were audited by NHS England in the form of Higher Level Responsible Officer Quality Review. This went well and several areas of good practice were highlighted. Three recommendations for further improvement were made. All have been implemented via an action plan which was signed off and returned to NHS England in March of this year.

Assessment – *analysis and considerations of options and risks*

Two recommendations to defer revalidation were made to the GMC between 1/4/16 and 31/3/2017 as both doctors had recently returned from periods abroad. One has since been revalidated and the other is due soon.

Systems for assuring the quality of appraisals have been tightened up along with regular opportunities for appraisers to share good practice. We have 107 doctors in total. 101 were appraised within the year; 6 were not, mainly due to long-term absence.

Two investigations by CWP and two by the GMC took place during the year (not the same two doctors.) There was no action as a result of any.

The admin team have also been involved in medical recruitment to improve timeliness, with good results. However the lack of candidates, in number and quality, is a major challenge currently.

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

The Board of Directors is recommended to approve the report.
Tthe Chief Executive is asked to sign the attached Statement of Compliance for return to NHS England, on behalf of the Board

Who/ which group has approved this report for receipt at the above meeting?	PODSC
Contributing authors:	Geraldine Swift, Sarah Carroll

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
1	Annual Medical Appraisal, Revalidation & Workforce Report 2016-17
2	Statement of Compliance for NHS England 2016/17

17-18-38b Appendix 1

Medical Revalidation, Appraisal and Concerns – annual report 2016-2017

This appendix contains a more detailed analysis on:

1. Recommendations made regarding 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.

1. Recommendations on Fitness to Practice

CWP has 107 doctors for whom Dr Alam is the Responsible Officer: 89 consultants, 14 SAS doctors and 4 doctors on temporary /short term contracts. This excludes medical trainees from Health Education England and GPs doing sessions in CWP where the bulk of their work is within primary care. This is an increase from last year (95 doctors) due mainly to the formation of a medical bank and additional recruitment.

2 recommendations to the GMC regarding revalidation were due between 1/4/2016 and 31/3/2017. Both doctors had recently returned from periods of employment abroad. Both were deferred pending satisfactory appraisal. One was subsequently revalidated in February 2017 and it is anticipated the second doctor will be recommended in November. Both recommendations were completed on time and there were no notifications for non-engagement.

All recommendations for CWP's original cohort have now been made. The second round of revalidation commences in February 2018.

2. Appraisal

a. Activity levels of appraisal:

Setting a timely appraisal is the responsibility of the individual doctor. Ensuring the outputs are completed and signed off within 28 days of the meeting is the joint responsibility of the doctor and appraiser. The appraisal team monitor the process and issue prompts along the way.

In 2014/15, NHS England 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.

In 2016/17 101 doctors were appraised and outputs signed off. Six doctors had an incomplete or missed appraisal approved by the RO. Four doctors had been on long-term absence (maternity/adoption leave and extended periods of sickness.). Two doctors appointed to CWP's bank towards the end of the appraisal year had returned to work after time out of practice. They will be appraised shortly. There were no instances of unapproved incomplete or missed appraisal.

For the 2016/17 appraisal year, the RO asked the appraisal team to support a reduction in the number of Category 1b appraisals (those which occur later than 12 months from the last, but within the appraisal year, and for which the outputs may have been signed off outside of the 28 day standard.)

1.4.16 – 31.3.17	2014/15	2015/6	2016/17
Category 1a Number of appraisals completed within 9-12 months of the last with outputs completed & signed off within 28 days	76	33	75
Category 1b Number of appraisals completed within the appraisal year, but later than 12 months since the last. The outputs may/may not have been completed and signed off within 28 days.	17	40	26
Category 2 Number of approved incomplete appraisals or missed appraisals	5	10	6
Category 3 Number of unapproved, incomplete or missed appraisals	0	0	0

The requested improvement in the Category 1b appraisals was achieved with considerable additional prompting by the appraisal team and appropriate escalation to the Associate Medical Director and the Responsible Officer. We are very aware that in many cases this has placed an extra burden on clinical colleagues who are already coping with the absence of colleagues and junior doctors.

A small number of doctors appraised within the year required exceptionally high levels of prompting and support. The Responsible Officer has written to all but one, who has left the trust, urging them to better prepare for 2017/18.

b. Appraisers

One appraiser training session took place during the appraisal year.

CWP now has 27 appraisers in total, (we have lost 5 this year).which is just about right for our number of doctors but the geographical spread is not equitable. Thus it is anticipated that offering regular appraiser and appraisee training will continue in future years. It is encouraging that we have a waiting list of colleagues who wish to access both types of training.

The appraisal support group facilitated by the AMD and Medical Appraisal and Revalidation Manager (MARM) has continued to meet twice yearly. Attendance is monitored as part of the appraiser feedback and some appraisers will be required to increase attendance during the coming year. The purpose of the group is to provide peer support to appraisers, share good practice, aspire to consistency amongst appraisers and to receive updates and feedback from the NHS England North West appraiser network events.

c. Quality Assurance of Appraisal

Assurance around the quality of information gathered for appraisal:

- The appraisal office upload a considerable amount of data to each doctor's portfolio to corroborate self-declaration regarding involvement in complaints, serious untoward incidents, attendance at peer group/supervision, mandatory training status and sickness absence.
- As a quality driver we have continued to upload data to individual portfolios on prescribing outliers sourced from pharmacy and information from the MHA office on any problems in the use of MHA.
- 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 appraise. As it has become more familiar, it has brought positive feedback The only drawback was if there were challenges or difficulties during the year which the appraisee did not bring up at appraisal, the appraiser would not know of their existence.. Last year we introduced a system where a CD who is not appraising one of his/her own doctors is 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.

  This has bedded down as people have grown used to it. Anecdotally we are aware that it is the doctors who are struggling most where the system is least likely to work effectively – perhaps because the CD finds it difficult to raise concerns in a constructive manner when the appraise is often still under investigation or the disciplinary issue has not concluded. In benchmarking against peers across the North West, it is clear that this triangulation of appraisal with managing medical concerns is an area of difficulty for all trusts and our processes are seen as more developed than most.

Assurances around the quality of the appraisal discussion and the appraisal summary:

- Rolling review of appraisal summaries (one third each year on a 3 year cycle) to provide assurance that the appraisal outputs: ie PDP, summary and sign offs are complete and to an appropriate standard using a quality assurance tool. This also acts as a process of continuous improvement as the AMD reviews 2-3 appraisals by each of ~ 10 appraisers. At the end of the appraisal year, the AMD writes back to all appraisers to highlight the main themes, as well as providing tailored feedback to each of the 10 appraisers reviewed.
- 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, MARM.
- Feedback from appraisee to the appraiser and to the MARM on their experience of the appraisal process

Assurances around the quality of data submitted as the Annual Organisational Audit to NHS England:

- Audit of timelines of process of appraisal – maintained by the MARM.

In November 2016 a Higher Level Responsible Officer Quality Review was undertaken at CWP by colleagues from NHS England in response to the appraisal rate having dropped from 95% to 89% in 2015/6 and limited attendance at the regional programme of network events. The review team were

satisfied that with a relatively small number of doctors, appraisal uptake is more directly hit by maternity leave and absence due to long-term sickness. The team identified 3 areas of good practice. An action plan for 3 areas of improvement/reflection was implemented and updates submitted to NHS England in March 2017.

d. General themes from Appraisals 2016/17

CWP doctors continue to engage well with appraisal and most see it as an opportunity to think about their practice and make plans for the forthcoming year. As always a few doctors need a lot of support and prompting from the MARM and MAA to prepare; always this relates to more general organisational difficulties rather than a rejection of the appraisal system.

Appraisal discussions in CWP and the summaries of the appraisals are consistent in covering the 6 key areas identified by NHS England as being core in revalidation. .

Feedback from appraisers and appraisees as well as reviews of appraisal summaries demonstrate evolution of the process of appraisal in CWP:

- Both appraisers and appraisees are becoming more confident where they each come from a different speciality: it is clear that there can be advantages to this as well as potential challenges.
- Discussion of the previous year's PDP and the extent to which goals have been met is more consistently mentioned in the appraisal summary – although the level of detail and exploration of reasons why goals may no longer have been appropriate or couldn't be met can sometimes still be missing
- Acknowledgement of work outside of CWP is also more consistently discussed with a slow increase in the evidence provided describing such activity and any quality assurance

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

- Encouraging doctors to analyse and critically appraise their own data through reflection and discussion
- Supporting doctors to make their PDP objectives more specific, measurable and within an agreed time frame

New developments in appraisal in 2016/17

A more qualitative approach to 360 feedback from colleagues and service users was trialled last year. This was amended following feedback and the new approach is now well bedded in. It consists of just 2 questions with free text replies – "What does this doctor do well?" and "Can you think of anything this doctor improve on?" There is also the option for general comments. The consensus is that this free text approach is experienced as more meaningful for both those receiving and those giving feedback, and supports doctors in understanding what specifically is valued about their approach and what tangible things they might try to build on.

A workshop on doctors' health was held as part of the appraisers' meetings. This led to another trial of a form developed in a different trust that is used to prompt discussion of health at appraisal meetings. Following feedback, it was agreed that the form did not need to be completed and submitted as evidence as some information may be confidential. Rather the questions are uploaded to SARD, the appraisee considers them which leads to a discussion if appropriate. This trial is now completed and it has been agreed to make this a regular part of appraisal. Participants particularly

liked the question that referred to work/life balance and asked whether they had taken all the leave they were entitled to….!

Finally information about SUIs and complaints as well as questions regarding MHA forms and prescribing patterns are now uploaded to SARD as they occur. This is a sensitive issue – doctors can often feel upset that a perceived allegation is attached to their record without being discussed with them first. However under the previous approach, doctors were asked to make sense of questions that may have been raised months earlier and it was a real challenge to recall what had happened. The AMD and appraisal team are encouraging colleagues to see these issues as queries which would prompt a reflection also attached to SARD to explain what has transpired. For example, if submission of tribunal reports are delayed because the consultant in question is extremely busy with clinical issues, that could be important evidence about their job plan rather than any criticism.

f. Completion of 2015-6 action plan

:**Recommendations**	**Action**	**Responsibility**	**Time frame**	**outcome**
1. ensure appraisals completed in a timely fashion	Monitor the proportion of appraisals classified as 1a, 1b and 2	MARM, AMD	March 2017	completed
2. Support non-medical appraisal in CWP	Set up meetings with OD and HR to share lessons from rolling out medical appraisal	MARM, AMD	March 2017	Not required
3. Quality assure appraisal discussions	Set up appraiser pairs to provide feedback to each other on appraisal meetings	MARM, AMD	March 2017	halted
4. Develop the selection process in recruitment of medical staff	Set up meetings with recruitment	MARM, AMD	June 2017	completed

The plans from last year have been either implemented or modified. The process for rolling out non-medical appraisal was already well advanced by the end of last summer. The appraisal office has made SARD available to one non-medical member of staff in CAMHS but there have been no further requests for access.

Feedback from the Appraisal Network was that other trusts did not find it helpful to set up appraiser pairs to feed back to appraisers – it was experienced by appraisees as intrusive and contravenes the premise that appraisal is a confidential discussion between two doctors. This, together with the logistical challenges experienced by CWP doctors in trying to arrange meetings where all 3 colleagues

were free for each appraisal led to a decision at the following Appraisers' Meeting to postpone this plan as we already have several mechanisms for feeding back to appraisers.

Meetings have taken place to look at the selection process for medical staff. In future we will ask applicants for consultant and staff grade posts to bring their most recent 360 feedback from patients to interview. When there are sufficient applications, the interview process will take 3 parts. The first is an "observer panel", facilitated by Dr Maureen Wilkinson, where several candidates discuss a topic of general interest. The observers are a mix of lived experience representatives and staff from the team in which the doctor would be working. The second stage is a meeting between the doctor and two lived experience representatives, facilitated by the MARM. The doctor will be asked to discuss what is important to them out of work and their patient feedback, focussing on how it has changed their practice. We hope it will allow the lived experienced representatives to form a view as to whether they would want this doctor to look after them. The final part is the traditional interview panel, which will receive feedback from parts 1 and 2. We have not yet been able to run part 1; part 2 ran once and was a useful learning experience. The MARM subsequently met with participation and engagement colleagues to fine-tune the second part of the process.

f. Appraisal plans for 2016/2017

The main focus for 2017/18 will be around the implementation of the Sir Keith Pearson Report on Appraisal and Revalidation, published in January 2017. The key findings from a CWP perspective are:

- Making revalidation more accessible to patients and the public
- Reducing burdens and improving the appraisal experience for doctors
- Increasing oversight of, and support for, short term locums

The GMC is due to publish guidance on this in June 2017 – not available at the time of submitting this report. We anticipate CWP will be in a reasonable position relative to other trusts given our track record but will need to understand better how we can use the guidelines to enhance appraisal and revalidation locally.

3. Concerns Involving Doctors

Two investigations were undertaken within CWP and two (not the same doctors) by the GMC; no action was taken in any.

The pot of trained medical investigators has diminished in the last year. Expressions of interest will be sought from doctors interested in taking on this role, who will receive Maintaining High Professional Standards training. An annual update from Hill Dickinson, as part of their existing agreement with People Services, has been arranged in September 2017 for those already trained.

4. Other developments

The full time Medical Appraisal Administrator is on maternity leave; her post has been backfilled on a part time basis It is too early to know the impact of this reduction of resource but it must not delay timely medical appraisal. If necessary, the MARM and her managers will consider which tasks outside of medical appraisal can be re-assigned.

Four consultant recruitment panels were held during the year for 9 medical posts around the trust. Eight posts were filled. CCICP asked CWP to recruit into a Community Geriatrician post to work in Vale Royal. Unfortunately the successful candidate subsequently declined the post but feedback from CCICP to CWP regarding the recruitment process was extremely positive.

Reflecting the national recruitment picture in psychiatry, interest in CWP posts has been disappointing. The introduction of the NHSI pay cap has put extra pressure on unfilled posts; finding a locum is most often impossible. A medical bank has been set up as part of the resourcing team, 5 doctors have joined. We hope to expand this resource; the MARM brings its availability to the attention of all retiring consultants.

5. Corrective Actions, Improvement Plan and Next Steps

Recommendation	Action	Responsibility	Timeframe
1 Ensure appraisals completed in timely fashion.	Early allocation of appraisers; issue prompts pre and post-appraisal; escalate to RO/AMD when necessary.	MARM, AMD	March 2018
2 Implement recommendation of the Pearson Review – reducing the burden on doctors.	Consider which supporting evidence could be taken out of appraisal (quality not quantity.)	RO, AMD, RO	December 2017
3 Implement recommendation of the Pearson Review – involve patients and families more in revalidation.	Adapt the friends and families survey to request feedback on any aspect of their treatment which was particularly good/requires improvement. Feedback to individual doctors.	AMD, MARM	December 2017

Recommendations

The board is asked to approve this 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 to support the recommendations for next steps.

DR FAOUZI ALAM

Responsible Officer

05 July 2017

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Fit and Proper Persons Regulations
Agenda ref. no:	17-18-36c
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	26/07/2017
Presented by:	David Harris, Director of People and OD

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
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 seeks to update the Board on the range of assurances in place to ensure compliance with the Fit and Proper Persons regulations.

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

The Fit and Proper Persons regulations came into force in November 2014. They require providers to have a general obligation to ensure that they only employ individuals who are fit for their role and they are required to assess the fitness of Directors to ensure that they are of good character, are physically and mentally fit, have the necessary qualifications, skills and experience for the role, and can supply certain information including prior employment information. The Chair is responsible for ensuring that all Directors are 'Fit and Proper'

Assessment – *analysis and considerations of options and risks*

The Trust undertakes a range of checks to ensure compliance with the guidance. For existing Directors, an annual self-declaration is undertaken, in addition to individual checks on the registers of bankrupt and insolvent Directors and the register of disqualified Directors. The register of these checks is attached at appendix 1. The overview of the FPP standards and how the Trust meets these is attached at appendix 2.

From July 2017, all Director appraisals will require with the appraiser (the Chair for Non-Executives and the Chief Executive for Executive Directors) assessing the continued fitness and compliance of Directors with the Fit and Proper Persons test. This will be certified this through the appraisal documentation.

All Directors also undertake a DBS check on a three yearly basis.

Director recruitment processes have also been recently reviewed and confirmed to be compliant with the guidance. This includes the six NHS Employment Check Standards, candidates completing a self-declaration, checks against the disqualified directors and insolvency registers, and full references being sourced for successful candidates

To provide an additional level of assurance around internal control processes in relation to the FPP regulations, we have added an audit of FPP regulations to the Trust's internal audit programme for this financial year.

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

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

Who/ which group has approved this report for receipt at the above meeting?		35T
Contributing authors:		35T
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
1	Register of checks – Directors
2	Assurance Framework

Directors Fit and Proper Declarations Register – 2017-18

Name	Designation	Self-Declaration completed	Register of Disqualified Directors	Insolvency/ bankrupcy Service Register (IIR)	Renewal dates
Mike Maier	Chair	Completed – no issues	No record	Completed – no issues	Registers check – May 2018 Declarations check – May 2018
Sheena Cumiskey	Chief Executive	Completed no – issues	Record found – no issues	Completed – no issues	Registers check – May 2018 Declaration check – May 2018
Tim Welch	Director of Finance and Deputy CEO	Completed – no issues	No record	Completed – no issues	Registers check – May 2018 Declarations check – May 2018
Avril Devaney	Director of Nursing	Completed – no issues	Record found – no issues	Completed – no issues	Registers check – May 2018 Declarations check – May 2018
Andy Styring	Director of Operations	Completed – no issues	No record	Completed – no issues	Registers check – May 2018 Declarations check – May 2018
Dr Anustha Sivananthan	Joint Medical Director	Completed – no issues	No record	Completed – no issues	Registers check – May 2018 Declarations check – May 2018
Dr Faouzi Alam	Joint Medical Director	Completed – no issues	No record	Completed – no issues	Registers check – May 2018 Declarations check – March 2018
David Harris	Director of HR and OD	Completed – no issues	No record	Completed – no issues	Registers check – May 2018

					Declarations check – March 2018
Dr James O'Connor	Non Executive Director	Completed – no issues	No record	Completed – no issues	Registers check – May 2018 Declarations check – May 2018
Lucy Crumplin	Non Executive Director	Completed – no issues	Record found – no issues	Completed – no issues	Registers check – May 2018 Declarations check – April 2018
Rebecca Burke-Sharples	Non Executive Director	Completed – no issues	Record found – no issues	Completed – no issues	Registers check – May 2018 Declarations check – May 2018
Sarah McKenna (nee Reier)	Non Executive Director	Completed – no issues	Record found – no issues	Completed – no issues	Registers check – May 2018 Declarations check – Sept 2017
Edward Jenner	Non Executive Director	Completed – no issues	Record found – no issues	Completed – no issues	Registers check – May 2018 Declarations check – Nov 2017
Andrea Campbell	Non Executive Director	Completed – no issues	Record found – no issues	Completed – no issues	Registers check – May 2018 Declarations check – Jan 2018

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Register of Seals 2016/17
Agenda ref. no:	17/18/38d
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	26/07/2017
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	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	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	No
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*

It is a legal requirement to place any property transactions e.g. purchase, sale, lease, under seal. Other contracts/documentation should be approved by an authorised signatory 'under hand' i.e. signed. The seal shall not be affixed except under the authority of the Board of Directors.

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

Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an officer nominated by them) and authorised and countersigned by the Chief Executive (or an officer nominated by them who shall not be within the originating division or department).

The Chief Executive keeps a register in which they, or the Head of Corporate Affairs as authorised by them enters a record of the sealing of every document.

Assessment – *analysis and considerations of options and risks*

The Sealing Report for the period April 2016 – March 2017 is set out at appendix 1.

The Register of Sealing is required to be noted by the Board of Directors on an annual basis, following Audit Committee review. The Audit Committee reviewed the register at their meeting held 2 May 2017.

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

The Board of Directors are recommended to **note** the Register of Seals 2016/17

Who/ which group has approved this report for receipt at the above meeting?	Audit Committee
Contributing authors:	N/A

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
1	Register of Seals 2016/17

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

CHAIR'S REPORT
AUDIT COMMITTEE – 4 July 2017

The following is a summary of issues discussed and any matters for escalation from the July 2017 meeting of the Audit Committee:

Internal Audit progress update
The Audit Committee was updated on the completion of recent work including the audit on incident reporting and management which attained significant assurance. An overview of forthcoming audits was provided which included pay progression policy review; activity data capture (CQUIN) review, patient cash and valuables review and locality governance assurance.

The Committee also reviewed the follow up to previous audit recommendations report and an insight update report.

External Audit update
A technical update was also provided with recent sector updates.

Mental Health Act audit action update
Following discussion at the last Audit Committee meeting, the Committee received assurance on the follow up of actions following CQC visits. Improvements in locality governance will also add further assurance on ownership of actions.

Corporate Assurance Framework and Risk Register
The Committee undertook their quarterly review of the corporate assurance framework and the risk register. A number of new risks were noted. The Committee reflected on the pace of change externally and internally and agree to refer to the Quality Committee, consideration of any potential risks arising due to the impacts of service changes.

Healthcare Quality Improvement Programme
The Committee received any update on the progress to date of the 17/18 programme. This includes patient safety improvement reviews, quality improvement projects and national clinical audits. Over the next two years, each ward and team will be taken through the programme, with priority given to those teams with the greatest potential for quality improvement as indicated by a number of qualitative measures.

NHS England Conflicts of Interest guidance
The Committee received an overview of the new guidance issued by NHS England and the Trust's ongoing work to ensure compliance. A further report will be provided to the September meeting.

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.

Edward Jenner
Chair of Audit Committee

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

CHAIR'S REPORT –
QUALITY COMMITTEE
3 MAY 2017

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

- **Strategic risk register**
  A new *risk of lack of training in respect of mandatory Autism training requirements as per the Autism Act and related guidance including MHA Code of Practice and the Care Act* was agreed at Operational Board in April 2017 and approved for inclusion on the strategic risk register. It will be led by Education CWP and the National Autism Champion, with a completion date target of the end of October 2017. Two risks have been archived on the basis that continuous quality improvement approaches are in place and are demonstrably sustaining mitigation of these risks at a tolerable level. These are the *risk of avoidable falls resulting in harm for specific vulnerable patients* and the *risk of harm to vulnerable patients in the event of failure to identify deteriorating physical health*. Both are being monitored and will be escalated back to the register as required. In relation to the latter risk, the Patient Safety & Effectiveness Sub Committee has commissioned work to understand current themes in relation to physical health (from learning from experience sources) and this will inform specific risks which might need to be modelled.
  The Board of Directors is asked to discuss, review and endorse the approval of the strategic risk register and corporate assurance framework being presented at today's meeting.

- **Annual review of effectiveness of the Quality Committee**
  The Quality Committee has undertaken an in-depth review of its effectiveness throughout 2016/17. This has resulted in an update to the terms of reference for 2017/18, which includes ensuring that the agenda is structured to ensure it seeks assurance around quality of care as per *NHS Improvement*'s Single Oversight Framework.
  The Board of Directors is asked endorse the approval of the Quality Committee's terms of reference for 2017/18.

- **Nasogastric (NG) tube misplacement**
  On behalf of the Board of Directors, the Quality Committee revisited the current controls and assurances in line with the NPSA alert: NHS/PSA/RE/2016/006 around the continuing risk of severe harm associated with misplaced NG tubes. The Board of Directors, at its previous meeting in public, noted the assurance received by the Quality Committee that sufficient support and clinical governance arrangements are in place to comply with this NPSA alert. However, subsequent to this, all NHS trusts received a letter from *NHS England* and *NHS Improvement* requesting confirmation of compliance with the alert. Whilst CWP has confirmed this, the Trust is acquiring additional assurances in relation to standardised procurement of pH test strips.
  The Board of Directors is asked to note the further assurance being sought in relation to this NPSA alert. Any gaps will be escalated on an exceptional basis.

- **Psychosis quality performance**
  A presentation was received to share CWP's performance in relation to meeting quality and access standards in each of its early intervention locality teams. The benchmarking received was based on team-led self-assessments. These show areas where all and individual teams are performing well, and areas for improvement, such as the offer of family intervention/ therapy.
  The benefits of re-instating a network meeting were discussed, that will take forward quality improvement approaches in areas where this is scope to improve or where teams can learn from each other.

- **Quality Account 2016/17**
  The Board of Directors is receiving the Quality Account as a component of CWP's annual report at today's meeting. This year the Quality Account includes locality level data based on feedback from stakeholders last year to allow for more scrutiny of the Trust's quality performance at the level of the different communities that the Trust serves. Overall CWP is performing well in relation to the mandated areas of quality that it is required to report on, including significant improvements made against its own quality improvement priorities.
  The Board of Directors is asked to endorse the Quality Account (as a component of the annual report) at today's meeting.

Jim O'Connor
Non Executive Director/ Chair, Quality Committee