Meeting of the Foundation Trust Board of Directors

Wednesday 25th March 2015 at 1.00pm

Boardroom, Romero Centre, Macclesfield

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
14/15/109	Apologies for absence	Receive apologies	Verbal	Chair	1 min (1300)
14/15/110	Declarations of interest	Identify and avoid conflicts of interest	Verbal	Chair	1 min (1301)
14/15/111	Minutes of the previous meeting held 28th January 2015	Confirm as an accurate record the minutes of the previous meetings	Written minutes	Chair	3 mins (1302)
14/15/112	Matters arising and action points	Provide an update in respect of ongoing and outstanding items to ensure progress	Written action schedule and verbal update	Chair	5 mins (1305)
14/15/113	Board Business Cycles • 2014/15 Business Cycle • Draft Business Cycle 2015/16	Confirm that agenda items provide assurance that the Board is undertaking its duties	Written Report	Chair	2 mins (1310)
14/15/114	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	5 mins (1312)

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Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
14/15/115	Chief Executive’s announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	5 mins (1317)
Assurance: Quality/ Effectiveness/ Experience/ Safety					
14/15/116	Corporate Assurance Framework and Risk Register	To note current Corporate Assurance Framework and Risk Register	Written Report	Medical Director	15 mins (1322)
14/15/117	Daily Ward Staffing Levels report (February 2015)	To approve the comprehensive staffing review report	Written Report	Director of Nursing, Therapies and Patient Partnership	10 mins (1337)
14/15/118	Zero Harm Implementation Plan update	To update on the Zero Harm implementation	Written Report	Medical Director	10 mins (1347)
14/15/119	Trust response to Francis report 'Freedom to Speak up'	To note the Trust response	Written Report	Director of Nursing, Therapies and Patient Partnership	10 mins (1357)
14/15/120	Learning from Morecombe Bay inquiry	To note the Trust response	Written Report	Medical Director	10mins (1407)
Performance					
14/15/121	Board Performance Dashboard- February 2015	Review Trust performance	Written Report	Director of Finance	10 mins (1417)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
Strategy					
14/15/122	Update on Operational Plan 2015/16 and Clinical Strategies	To update on Operational Plan 2015/16 sign off	Written Report	Director of Finance	10 mins (1427)
14/15/123	Research Strategy 2015/18	To approve the Research Strategy	Written Report	Medical Director	15 mins (1437)
14/15/124	People and Organisational Development Strategy	To approve the People and OD strategy	Written Report	Director of Human Resources and OD	15 mins (1452)
Assurance: Governance					
14/15/125	Amendment to the Standing Financial Instructions (SFIs)	To approve the amendment to the SFIs	Written Report	Director of Finance	5 mins (1507)
14/15/126	Mental Health Act- Updated Code of Practice	To receive a report on the updated Code of Practice	Written Report	Medical Director	10 mins (1512)
14/15/127	Information Governance Annual Report (2014/15)	To approve the Information Governance Annual Report 14/15	Written Report	Medical Director	10 mins (1522)
14/15/128	Division of Responsibilities: CEO and Chair	To approve the division of responsibilities in line with the code of governance	Written Report	Head of Corporate Affairs	5 mins (1532)
14/15/129	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	5 mins (1537)
14/15/130	Any other business	Consider any urgent items of other business	Verbal or written	Chair/ All	5 mins (1542)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
14/15/131	Review of meeting	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair/All	2 mins (1544)
14/15/132	Date, time and place of next meeting: **Wednesday 27th May 2015 1.00pm at Redesmere Boardroom.**	Confirm arrangements for next meeting	Verbal	Chair	2 mins (1546)

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Minutes of the Board of Directors Meeting
Wednesday 28th January 2015,
Boardroom, Redesmere, commencing at 1.00pm

PRESENT	David Eva, Chair Sheena Cumiskey, Chief Executive Dr Faouzi Alam, Medical Director Fiona Clark, Non-Executive Director Julie Critchley, Acting Director of Operations Dr Jim O'Connor, Non-Executive Director Lucy Crumplin, Non-Executive Director Avril Devaney, Director of Nursing Ron Howarth, Non-Executive Director Mike Maier, Non-Executive Director Rebecca Burke Sharples, Non-Executive Director Dr Anushta Sivananthan - Medical Director Tim Welch, Director of Finance	
IN ATTENDANCE	Louise Brereton, Head of Corporate Affairs (inc.CoSec) Maria Nelligan, Deputy Director of Nursing, Director of Infection, Prevention and Control (14/15/94 &14/15/95) Derek Bosomworth, Member of the public Anna McGrath Public Governor Rob Robertson, Public Governor Peter Wilkinson, Public Governor	
APOLOGIES	David Harris, Director of Workforce and Organisational Development	
	MINUTES	**ACTION**
14/15/86	**WELCOMES AND APOLOGIES FOR ABSENCE** The Chair welcomed everyone to the meeting and all were asked to introduce themselves for the benefit of those in public attendance. The meeting was quorate.	
14/15/87	**DECLARATIONS OF INTEREST** There were no interests declared.	
14/15/88	**BOARD MINUTES- MEETING OF 26TH NOVEMBER 2014** An amendment was required to page 7 of the minutes to reflect that seven local shelters benefited from the care-wash pack campaign. Subject to the amendment, the minutes of the meeting held on **26th November 2014** were **approved** as a correct record.	

14/15/89	**MATTERS ARISING AND ACTION POINTS** The action points were reviewed. There were no outstanding actions.	
14/15/90	**BOARD MEETING BUSINESS CYCLE 2014/15** The business cycle for 2014/15 was noted.	
14/15/91	**CHAIR'S ANNOUNCEMENTS** The Chair announced that: **IAPT Sefton** The Trust is pleased to have been awarded the contract to provide Improving Access to Psychological Therapies (IAPT) Services in Sefton, Southport and Formby from 1st April 2015. From now until April, CWP will be working with NHS South Sefton CCG and NHS Southport & Formby CCG to map out an implementation plan to ensure seamless care for the existing caseload whilst improving access to therapies for common mental health problems such as anxiety, stress, feeling low in mood or depression. This service will be delivered in partnership with Insight Plus and Ki Group. **Friends and Family.** Patients accessing CWP's services are now able to give their feedback on their experiences of care and treatment via the friends and family test (FFT). People who use our services will be able to use the FFT to provide anonymous feedback by answering a single question that asks them to rate the service and then add free-text comments to explain their views or make suggestions. The test is intended to capture positive comments as well as to identify areas for improvement. All service users will be offered the opportunity to complete a questionnaire on review of care, transfer or discharge. **Zero Suicide Ambition** Norman Lamb and Nick Clegg have recently called on all NHS mental health trusts to commit to a new ambition for zero suicides in order reduce suicides in the health service. This approach aligns to the CWP zero harm strategy already adopted and under implementation by the Trust, demonstrating our commitment to the approach.	
13/14/92	**CHIEF EXECUTIVE'S ANNOUNCEMENTS** Sheena Cumiskey announced: <u>CQC</u> The Trust will undergo a CQC comprehensive inspection w/c 22nd June 2015. This is an opportunity for the Trust to showcase our services and to provide external input into the Trust's continuous improvement programme we have in place. Jo Watts is the Trust lead for the inspection. Governors as well as other key Trust stakeholders will have a full opportunity to be involved in the inspection. Further details will be available once the programme for the inspection is finalised.	

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	<u>Mutuals</u> As previously reported, the Trust has been successful in being involved in a Mutuals pilot with the Cabinet Office. Consultancy support, funded by the Cabinet Office is being provided to supply expertise in exploring mutualisation. Locally, workshops are being set up to look at the CWP services with the most potential for being involved in the mutual partnership. The Trust is initially looking at drug and alcohol services and CAMHS services (focussing on IAPT) in east Cheshire. Sheena Cumiskey clarified that the project is a pilot and is not about adapting the foundation trust (FT) model into a mutual; moreover, this is about enabling the freedoms that the mutual model allows within the FT framework. <u>King's Fund Well-led development session</u> Executive and Non-Executive Board members recently attended a North West Leadership academy session delivered by the King's Fund to look at the cultures needed for a successful board. The session also looked at collective leadership roles focussing on continuous improvement and enabling staff to understand their responsibility and control of this. Board members will take forward further work on this as this is an ensuring effective leadership and continuous improvement is an ongoing programme.	
14/15/93	**CORPORATE ASSURANCE FRAMEWORK AND RISK REGISTER** Dr Anushta Sivananthan introduced the report and reminded Board members that the Quality Committee undertake an in-depth scrutiny of the risk register at each meeting and the key points are brought to the attention of the Board. Dr Anushta Sivananthan drew the Board's attention to the following key points: • In November 2014, 3 new risks were added - the impact of tender losses, workforce capacity and skills and fragmentation of clinical pathways. These risks are currently being modelled and risk treatment plans are in development. It was noted that the clinical pathways risk has implications outside of CWP control. • Audit Committee continue to undertake in-depth review of individual risks for additional assurance. They will review the SUI risk at the March 2015 meeting. • That the Board recommend that the Quality Committee review the risk descriptions of the ligature risk and the safeguarding risk in detail at the March meeting to ensure they are fully reflective of recent emerging issues. The Board **resolved** to: • **approve** the amendments that have been made to the strategic risk register and corporate assurance framework as recommended by the Quality Committee,	

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	• **approve** the recommendation that the Quality Committee reviews the risk description of the ligature risk, the safeguarding risk and the staffing risk in light of the ward staffing review; and • **note** that the corporate assurance framework is under review and will reflect recommended inclusions for review at the March 2015 meeting.	
14/15/94	**COMPREHENSIVE REVIEW OF STAFFING LEVELS** (Maria Nelligan joined the meeting) Maria Nelligan introduced the report which is the first six monthly review of ward staffing establishments in line with NHS England and National Quality Board (NQB) requirements. A Programme Board is in place to oversee the work and monitor the recommendations. This is the first in a series of six monthly reviews and is provided to the Board in addition to the monthly staffing report which the Board have been receiving since May 2014. In highlighting key points, Maria Nelligan identified that the report indicates areas with below a 90% fill rate. This has been mitigated by looking at daily workloads and prioritising work to maintain safe care levels. The system for recording fill rates is currently manual but this is moving to be an automated system. The Resource Managers are also having a positive impact in enabling ward managers to focus on delivering direct and indirect care. Education CWP is also improving ways of meeting the needs of clinical services by delivering training at clinical settings to save significant time spent on travel to training sessions. Maria Nelligan reported that with regard to recruitment, the crucial issue is staff turnover which is leading to a neutral impact of recruiting new staff. Since January 2014, 80.81 Registered Nurses and Clinical Support Workers left. This is mainly due to promotional moves or retirement. There has been a 20% reduction in usage of bank staff. Looking ahead, further reviews will be undertaken on a six monthly basis from this point, in line with NQB standards. Reports will also update on the implementation of previous recommendations. Referring to the point in the report regarding the length of time to recruit a non-qualified member of staff can take up to six months, it was noted that David Harris is taking forward improvements and efficiencies to the recruitment process which will improve the time taken to bring people into post. The Programme Board is also considering proactive initiatives, particularly around return to practice to encourage people to consider CWP as a potential employer for clinical roles. Ron Howarth commented that Board have high visibility of staffing levels and receive monthly assurance that services are always maintained safely, however requested further assurance on the low points on wards occurring day to day. Maria Nelligan advised that from 1st February 2015, new escalation points will be in place to record any incidents of staffing shortages. In the case of instances when there is only one registered nurse on shift or where they are more than 5 vacancies on a ward, these occurrences will be recorded on Datix as an incident.	

	A discussion ensued on recruitment, succession planning and adjustments to ensure the appropriate skills mix. The need to ensure that those receiving uplift have the appropriate skills for the role was noted. Julie Critchley on behalf of David Harris provided an overview of the planned improvements to recruitment processes. This included plans for rolling recruitment which will enable a more proactive approach to recruitment. Rebecca Burke Sharples commented on the need to give consideration to the headroom of establishments and requested assurance on the permanency of ward staffing. The Board were advised that the ward staffing Programme Board are looking at building a staffing figure for each ward around recruitment and turnover to inform their own individual ward recruitment plan. This will include headroom. Dr Jim O'Connor commended the significant amount of work that has gone into this review, however reminded that future reviews need to reflect quality impacts where there are staffing issues. It was also clarified that the 1:8 ratio of staff to patient was still in place. The Board **resolved** to: • **approve** the report and recommendations including that the Operational Board take these forward and monitor the progress; and • **note** the progress in meeting the NQB standards.	
14/15/95	**Q3 INFECTION, PREVENTION AND CONTROL REPORT** Maria Nelligan introduced the report and highlighted the key issues. • Delivery of the new IPC contract for health and social care services in west Cheshire and Vale Royalbegan on 1st October 2014. This is progressing well and is strengthening relationships in the areas. • The IPC audit programme was completed ahead of schedule, and is working closely with Estates to pick up any areas for improvement. • A full report on the flu campaign is due next quarter and will looking at recommendations to take forward into the 2015 programme. There was an outbreak on influenza A on a CWP ward in Q3 however this was well managed by the ward and IPC staff. The Board **resolved** to **note** the Infection, Prevention and Control Quarter 3 report. (Maria Nelligan left the meeting)	

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14/15/96	**Q3 QUALITY REPORT** Dr Anushta Sivananthan introduced the report and highlighted some key areas. These included: • All the quality priorities against the three domains of patient safety, experience and effectiveness are on track. • IAPT services for children and young people in east Cheshire have been co-designed with young people in partnership with Catch22 and are outcomes focused from the outset. • Wirral CAMHS have been awarded a judgement of 'outstanding' during a recent Ofsted inspection for the work they do with Wirral Hospitals School and Home Education Service. • CWP and SLaM jointly hosted a Smoke Free Conference recently in conjunction with Public Health England. • The Young Advisers take over day was again a highly successful day. Dr Anushta Sivananthan also drew attention to the special edition quality report on the Big Book of Best Practice event held in September 2015 to showcase best practice across the Trust. The Board **resolved** to **note** the report.	
14/15/97	**SADDLEBRIDGE INVESTIGATION REPORT- MANAGEMENT RESPONSE** Julie Critchley introduced the report. The Board were advised that the report was presented to the Council of Governors prior to the Board meeting due to meeting timings. The report had been well received by Governors. The Board were informed that the report sets out the recommendations from the investigation report and provides an update on the implementation of the recommendations. Most are in progress or have been completed. Some key areas that are being looked at include gatekeeping processes, risk assessment, compatibility of services users and staff relationships. There are also recommendations on environmental changes in progress. At this point, some staff training is still to be completed. Benchmarking information will also be reviewed in April 2015. David Eva commented on the issue of the compatibility of service users. Dr Jim O'Connor commented that the Trust had not always been good at identifying any potential issues with compatibility of service users taking in account of the length of time patients generally spend at Saddlebridge. In future there will be a closer assessment of individual patient needs, particularly those with personality disorders due to the impact they can have on the wider unit. Dr Faouzi Alam commented on an error in the document pertaining to section 17 leave and requested that this be amended. **Action:** Julie Critchley to make the amendment as requested.	**JC**

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	Sheena Cumiskey reminded that Board members received the full investigation report at the November 2014 Board meeting and that the report provided today sets out the management response and an update on the progress of the recommendations. The recommendations will now be monitored by the Operational Board and any exceptions to this will be reported back to the Board. The Board **resolved** to **approve** the report.	
14/15/98	**LEARNING FROM EXPERIENCE REPORT** Avril Devaney introduced the report and advised that this provides a summary of the triangulated learning from incidents and complaints. The Quality Committee undertakes in-depth scrutiny of the full Learning from Experience report looking at reporting and whether there are any particular themes or variations particularly around category A incidents. Avril Devaney advised that a piece of work is current ongoing to explore the quality of investigations, the learning from these and what is expected from the CCG perspective. A meeting is due to be held shortly with commissioners to look at this further. Avril Devaney drew the Board's attention to restraint which continues to be area of concern, though this has recently improved. There is a need to further build on the work on the use of prone restraint. Dr Anushta Sivananthan will be leading a piece of work on this to gather more learning to further improve practice in this area. Dr Anushta Sivananthan commented that national benchmarking tells us that our number of restraints has reduced compared to other Trusts; however we are a high reporting Trust. There is a need to understand exactly what it is that we are reporting and what has happened to bring about the need for a prone restraint situation when they occur with a focus on looking to eliminate the need for the use of this restraint. Avril Devaney reminded that the recommendations of the Learning from Experience report are approved at the Quality Committee so the Board are to endorse this approval. The Board **resolved** to **endorse** and **approve** the recommendations identified by the Quality Committee. .	
14/15/99	**BOARD DASHBOARD (CORPORATE PERFORMANCE REPORT)** Tim Welch introduced the report and highlighted key issues for the Board's attention. The current financial position includes some exceptional items including the current insurance shortfall from the Saddlebridge incident. This is due to ongoing negotiation with the insurers who say that the unit was operational from the October open day however some environmental works were not completed by this time and therefore the unit was not fully operational and not ready for patients. There are also some exceptional costs included for redundancy payments. The Board also noted that sickness absence targets are still off track and that work is being progressed by the task and finish group instigated by	

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	David Harris. Ron Howarth queried the black-light implementation and whether this is now trust-wide. Tim Welch advised that is not trust-wide as yet. It has been used in CWP West for some time and the impact appears to be positive. The trust-wide rollout is now underway. The Board **resolved** to **approve** the report.	
14/15/100	**Q3 QUALITY GOVERNANCE ASSESSMENT** Dr Anushta Sivananthan introduced the report and reminded the Board members that the full quality governance framework assessment is undertaken on a quarterly basis and feeds into the quarterly report for Monitor reporting. Dr Anushta Sivananthan highlighted the 4 domains of the quality governance framework and advised that for additional assurance and good practice, the scoring methodology has also been applied to the framework to support any early identification of risk. The Board **resolved** to **approve** the report.	
14/15/101	**Q3 MONITOR SUBMISSION** Tim Welch introduced the report and reminded the Board that as part of the quarterly submissions to Monitor, the Board are required to provide two governance declarations and one for finance - the continuity of risk rating (CoSRR) declaration. The Board are also required to declare any other exceptional matters that may have arisen in quarter. The Board **resolved** to **approve** all declarations, to include the two declarations in relation to governance and the continuity of services risk rating declaration. There were no exceptional items to report.	
14/15/102	**5 YEAR FORWARD VIEW** Tim Welch introduced the report and informed the Board that the updated guidance reflected the changes Monitor have built into the planning framework. The new mental health targets around IAPT and early intervention for psychosis will be part of the risk assessment framework so work is progressing to ensure our compliance with these and ensuring that the needs of patients are being met. It was noted that this needs to focus on patient outcomes and patient experience not just waiting times. Work is ongoing with local partners across the locality areas to progress the new care models initiatives. Referring to the Operational Plan submissions, a draft of the Operational Plan financial projections is required for submission to Monitor by 27th February 2015. This will be approved by the February Board meeting. The final Operational Plan has to be provided to Monitor by 10th April 2015, therefore this will be approved by the March Board of Directors.	

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	Work is continuing with Governors to enable them to influence and inform Trust plans. A seminar was held before Christmas and a further session is planned in March. Tim Welch informed that the Board will be required to provide specific declarations on the availability of resources and in line with the 2014/15 submission, ongoing Trust sustainability. The Board **resolved** to **approve** the report.	
14/15/103	**FIT AND PROPER PERSONS REGULATIONS** Louise Brereton updated the Board on the recently issued CQC Fit and Proper Persons requirements. These are largely in line with the requirements set out in the Monitor licence however these have been extended to include any instances or evidence of mis-management in previous roles. The report sets out the CQC requirements, the current levels of assurance on meeting the requirements with any gaps and appropriate actions identified. Ron Howarth commented on the changes needed to the recruitment process to ensure that part of the interview process includes focus on the aspects of character which are to be tested. It was noted that for all senior appointments, the interview process includes a values activity, however for Board appointments, the output from this would need to be formally recorded. Dr Faouzi Alam commented on the potential to use the criteria for other senior staff appointments that fall outside of the requirements (i.e. Associate Directors or Service Directors). The Board **resolved** to **approve** the report.	
14/15/104	**CQC REGISTERED LOCATIONS** Dr Anushta Sivananthan introduced the report and advised that it is a CQC requirement to provide an updated list of registered locations. It was noted that there is a need to ensure that we are clear on which locations are CWP locations and those other areas that we may use to provide services but are not our registered locations. The Board **resolved** to **approve** the report.	
14/15/105	**REVIEW OF RISK IMPACTS OF ITEMS DISCUSSED** It was agreed that there were no outstanding areas of risk to cover.	
14/15/106	**ANY OTHER BUSINESS** Dr Anushta Sivananthan reported that a recent CQC mental health act inspection of Eastway and Limewalk House had been undertaken and there were no actions for improvement which is an excellent result.	

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	David Eva asked Governors present in the public gallery for any comments they wished to make.	
14/15/107	**REVIEW OF MEETING** All agreed the meeting had been effective.	
14/15/108	**DATE, TIME AND PLACE OF NEXT MEETING** **Wednesday 26th March 2015, 9.30am, Boardroom, Redesmere.**	

Action points from Board of Directors Meetings
25th March 2015

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
28/11/2014	14/15/78	**RESEARCH ANNUAL REPORT 2014/15** Research strategy is in development alongside the Clinical Strategy refresh. To report to the January 2015 Board	Jan 2015	FA	This will come to the March Board for approval in order to align to the locality clinical strategies	Completed
28.1.2015	14/15/97	**SADDLEBRIDGE INVESTIGATION REPORT - MANAGEMENT RESPONSE** Dr Faouzi Alam commented on an error in the document pertaining to section 17 leave and requested that this be amended. **Action:** Julie Critchley to make the amendment as requested.	Jan 2015	JC		

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

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

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

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

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

No:	Agenda Item	Executive Lead	Responsible Committee/ Subcommittee	29/04/2015 Seminar	27/05/2015	24/06/2015 Seminar	29/07/2015	30/09/2015	28/10/2015 Seminar	25/11/2015	17/12/2015 Seminar	27/01/2016	24/02/2016 Seminar	30/03/2016
1	**Chair's announcements**	Chair	N/A		✓		✓	✓		✓		✓		✓
2	**Chief Executive announcements**	Chief Executive	N/A		✓		✓	✓		✓		✓		✓
							Well Led Domain 1: Strategy							
3	**Operational Plan 2016-17approval of submission**	Director of Finance	Operational Board											✓
4	**Trust Clinical Strategies 2016/17**	Director of Operations	Operational Board											✓
5	**Monitoring implementation of Clinical Strategies/ Operational Plan 15/16**	Director of Operations	Operational Board				✓			✓		✓		✓
6	**Strategic Plan 2014-2019 monitoring**	Director of Finance	Operational Board					✓						
							Well Led Domain 2: Capability and Culture							
7	**National Annual Patient Survey Report 2014/15 and Action Plan**	Director of Nursing, Therapies and Patient Partnership	Operational Board					✓						
8	**Single Equality Scheme and Equality Act Compliance**	Director of Nursing, Therapies and Patient Partnership	Operational Board					✓						
9	**Avoidable Harm / Zero Harm strategy reporting**	Medical Director Compliance Quality and Regulation	Quality Committee					✓						✓
10	**Staff survey 2014/15**	Director of HR and OD	People and OD subcommittee (Operational Board)											✓
11	**Six monthly staffing review**	Director of Nursing, Therapies and Patient	Quality Committee				✓					✓		
							0							
12	**Receive and Approve Quarterly Monitor returns**	Director of Finance	N/A	✓			✓		✓			✓		
13	**Assessment of Quality Governance**	Medical Director Compliance Quality and Regulation	Quality Committee	✓			✓		✓			✓		
14	**Strategic Risk Register and Corporate Assurance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee		✓		✓	✓		✓		✓		✓
15	**Declarations of Interest: Directors and Governors**	Chair	Audit Committee		✓									

16	**CEO /Chair Division of Responsibilities**	Chair	N/A											✓
17	**BOD Business Cycle 2014/15**	Chair	N/A		✓		✓	✓		✓		✓		✓
18	**Approve BOD Business Cycle 2015/16**	Chair	N/A											✓
19	**Review Risk impacts of items**	Chair/All	N/A		✓		✓	✓		✓		✓		✓
20	**Care Quality Commission Registration Report**	Director of Finance	Operational Board									✓		
21	**Approve Integrated Governance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee				✓							
22	**Receive Quarterly Infection Prevention Control Reports**	Director of Infection Prevention and Control	Infection, Prevention and Control subcommittee (Quality Committee)		✓			✓		✓		✓		
23	**Director of Infection Prevention and Control Annual Report 2014/145 inc PLACE**	Director of Infection Prevention and Control	Infection, Prevention and Control subcommittee (Quality Committee)				✓							
24	**Safeguarding Children Annual Report 2014/15**	Director of Nursing, Therapies and Patient Partnership	Quality Committee				✓							
25	**Safeguarding Adults Annual Report 2014/15**	Director of Nursing, Therapies and Patient Partnership	Quality Committee				✓							
26	**Accountable Officer Annual Report inc. Medicines Management 2014/15**	Medical Director Compliance Quality and Regulation	Medicines Management Group (Quality Committee)				✓							
27	**Health and Safety Annual Report and Fire 2014/15 and link certification**	Director of Nursing, Therapies and Patient Partnership	Health, Safety and Well-being subcommittee (Operational Board)				✓							
28	**Receive Appraisal Annual Report 2014/15 and annual declaration of medical revalidation**	Medical Director of Effectiveness and Medical Workforce	People and OD subcommittee (Operational Board)				✓							
29	**Emergency Planning Annual Report 2014/15**	Director of Nursing, Therapies and Patient Partnership	Emergency Planning subcommittee (Operational Board)				✓							
30	**Monthly Ward Staffing update**	Director of Nursing, Therapies and Patient Partnership	Quality Committee		✓		✓	✓		✓		✓		✓
31	**Information Governance 14/15 Toolkit**	Medical Director	Records and Clinical Systems Group (Quality Committee)											✓

32	**Provider Licence Compliance**	Director of Finance	Audit Committee		✓					✓				
33	**Security Annual Report 2014/15**	Director of Operations	Health, Safety and Well-being subcommittee (Operational Board)					✓						
34	**Mental Health Act annual reporting**	Medical Director Compliance Quality and Regulation	Compliance, Assurance and Learning subcommittee (Quality Committee)				✓							
35	**BOD Business Cycle 2014/15**	Chair	N/A		✓		✓	✓		✓		✓		✓
36	**Approve BOD Business Cycle 2015/16**	Chair	N/A											✓
37	**Review Risk impacts of items**	Chair/All	N/A		✓		✓	✓		✓		✓		✓
38	**Receive Research Annual Report 2013/14**	Medical Director Effectiveness Medical Education	Operational Board					✓						
Monitor Well Led Domain 4: Measurement														
39	**Receive Quarterly Quality Reports**	Medical Director Compliance Quality and Regulation	Quality Committee		✓			✓		✓		✓		
40	**Board Performance Dashboard**	Director of Finance	Operational Board		✓		✓	✓		✓		✓		✓
41	**Receive Learning from Experience Report executive summary**	Director of Nursing, Therapies and Patient Partnership	Quality Committee		✓			✓				✓		

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Corporate assurance framework – update report
Agenda ref. no:	14/15/116
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	25/03/2015
Presented by:	Dr Anushta Sivananthan, Medical Director – Executive Lead for Quality

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

REPORT BRIEFING

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

Background – *contextual and background information pertinent to the situation/ purpose of the report*
The Board of Directors monitors and reviews the corporate assurance framework and receives assurances on risk via the Quality Committee. This is a key component of the Trust's integrated governance strategy which provides assurance regarding the quality and safety of the services that the Trust provides. The Quality Committee is the designated committee for risk management operationally and last reviewed the strategic risk register at its meeting on 4 March 2015. The Audit Committee undertakes in-depth reviews of strategic risks as part of its remit to review the effectiveness of integrated governance and internal control Trustwide. At its March 2015 meeting, the Audit Committee undertook an in-depth review of the 'investigation and learning from experience' risk, agreed with the risk treatment plan, and also agreed with a target risk score of nine. At its next meeting it will review a risk that it suggests be scoped around 'cyber' risk management.

Assessment – *analysis and considerations of options and risks*
New risks – none. **Amended risk scores or re-modelled risks** ▪ No risks have been re-scored. ▪ The former strategic risk 'Lack of robust ligature management programme within the Trust may result in harm to patients with associated reputational and financial impact on the organisation' has been re-modelled to 'Risk of harm to patients due to ligature points and environmental risks within the inpatient setting' to reflect that a Board approved capital programme is in place and to align this risk to the locality operational risk descriptions. ▪ The risk description of the current 'Risk of harm to patients and staff due to staffing levels across inpatient services in the three localities' is currently under review following the completion of the second comprehensive staffing review, which was received at the last meeting of the Board of Directors. The Inpatient Bed/ Ward Review Programme Board has committed to reviewing this at its next meeting on 21 April 2015. **Archived risks** – none. **Corporate assurance framework** – outlines controls and assurances and is available at appendix 1/ T drive. As reported to the January 2015 meeting of the Board of Directors, the presentation has been refined with more focused and contemporaneous content in response to Monitor's (2014) Well-led framework for governance reviews. The presentation responds to a number of recommendations that foundation trusts should include in a dynamic corporate assurance framework.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors is asked to **review**, **discuss** and **approve** the amendments that have been made to the strategic risk register and corporate assurance framework as recommended by the Quality Committee, as presented in this report.

Who/ which group has approved this report for receipt at the above meeting?		Quality Committee Chair
Contributing authors:		David Wood, Associate Director of Safe Services
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	D Wood to L Brereton for Board of Directors	12/03/2015

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1	Corporate assurance framework -available T:\01. BoD Committees\Board of Directors\Meetings\2015\150325

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Ward Daily Staffing Levels February 2015
Agenda ref. no:	14/15/117
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	25/03/2015
Presented by:	Avril Devaney

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

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*
This report details the ward daily staffing levels during the month of February 2015.The planned and actual hours for registered nurses (RN) and clinical support workers (CSWs) for February 2015 have been submitted to UNIFY using the template supplied by NHS England (appendix 1). This is the 10th monthly submission and similar themes have been reported to those that have arisen previously. These themes identify how patient safety is being maintained on a shift by shift basis.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
The monthly reporting of daily staffing levels is a requirement of NHS England and the National Quality Board in order to appraise the Board and the public of staffing levels within in-patient units. CWP undertook a comprehensive review of ward staffing levels between Oct and Dec 2013 with 6 monthly follow up reviews in May 2014 and December 2014. A programme has been established to take forward the recommendations from the review including staffing levels and a programme of continuous improvement. The Director of Operations is the lead executive for the programme supported by the Director of Nursing who has overview of the Ward Staffing work stream and reports directly to the Board of Directors in line with the NQB requirements.

Assessment – *analysis and considerations of options and risks*
During February 2015 patient safety was maintained by nurses working additional unplanned hours, nursing 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. Recruitment of both registered and non-registered nursing staff has been continual over the past 18 months. Although a significant number of nurses have been recruited, existing nurses leaving CWP has impacted on the ability to increase the overall nurse staffing numbers to the levels required. The board approval of over recruitment of nurse staffing to reflect turnover rates has been disseminated to the localities for action. There are also plans to engage with jobs fairs to promote working within CWP and further promotion of 'return to practice' opportunities for nurses who have left the profession. Additionally the identification of innovative ways to expand opportunities for high quality final placement students to be offered preceptorship within CWP is being explored.

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

Who/ which group has approved this report for receipt at the above meeting?		Ward Staffing Project Team
Contributing authors:		Maria Nelligan
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
Click here to enter text.	Click here to enter text.	Click here to enter text.

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

Appendix 1 Ward Daily Staffing February 2015

	Ward	Day				Night				Fill Rate				Comment
		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	888.1	820.1	1569.6	1452.6	667	632.5	989	954.5	92.3%	92.5%	94.8%	96.5%	The ward manager has worked in the clinical team to maintain safe staffing levels.
	Alderley Unit	675	677.5	1363	1377	609.5	575	678.5	695	100.4%	101.0%	94.3%	102.4%	Nursing staff have worked unplanned additonal hours to maintain safe staffing levels. Non-direct patient care activities were cancelled and rescheduled.
	Bollin	988.5	943	1338.5	1219	632.5	632.5	947.5	912	95.4%	91.1%	100.0%	96.3%	The ward manager has worked in the clinical team to maintain safe staffing levels.
	CARS	777	747.5	999.5	966	632.5	531	667	653.5	96.2%	96.6%	84.0%	98.0%	Nursing staff have worked unplanned additonal hours to maintain safe staffing levels. Non-direct patient care activities were cancelled and rescheduled.
	Croft	1014.6	939.1	1674.5	1520.5	644	632.5	1486.5	1445	92.6%	90.8%	98.2%	97.2%	The ward manager has worked in the clinical team to maintain safe staffing levels.
	Greenways A&T	1028.5	910.5	1837.5	1737.5	644	621	575	609.5	88.5%	94.6%	96.4%	106.0%	Nursing staff have worked unplanned additonal hours and the ward manager has worked in the clinical team to maintain safe staffing levels.
	LimeWalk Rehab	812.5	769	1269	1158	638.5	603	667.5	682	94.6%	91.3%	94.4%	102.2%	Nursing staff have worked unplanned additonal hours to maintain safe staffing levels.
	Saddlebridge	651.5	536	1219	1255	632.5	598	644	701.5	82.3%	103.0%	94.5%	108.9%	The ward manager has worked in the clinical team to maintain safe staffing levels.
Wirral	Brackendale	874	711.5	966	1100.5	644	586.5	644	638.5	81.4%	113.9%	91.1%	99.1%	Nursing staff have worked unplanned additonal hours and the ward manager has worked in the clinical team to maintain safe staffing levels.
	Lakefield	805	793.5	1000.5	966	621	598	908.5	851	98.6%	96.6%	96.3%	93.7%	Nursing staff have worked unplanned additonal hours to maintain safe staffing levels.
	Meadowbank	1176	818	1610	1808.5	644	471.5	1288	1207.5	69.6%	112.3%	73.2%	93.8%	Nursing staff have worked unplanned additonal hours and the ward manager has worked in the clinical team to maintain safe staffing levels.
	Oaktrees	1003.5	923	1217	1205.5	644	644	416	416	92.0%	99.1%	100.0%	100.0%	Nursing staff have worked unplanned additonal hours and the ward manager has worked in the clinical team to maintain safe staffing levels.
	Brooklands	858	707.5	1012	1066	644	600.5	644	704.5	82.5%	105.3%	93.2%	109.4%	The ward manager has worked in the clinical team to maintain safe staffing levels.
West	Beech	1172	1035	977.5	931.5	609.5	552	770.5	747.5	88.3%	95.3%	90.6%	97.0%	Non-direct patient care activities were cancelled and rescheduled.
	Cherry	1104	1011	781	746.5	610	564	988	919	91.6%	95.6%	92.5%	93.0%	The ward manager has worked in the clinical team to maintain safe staffing levels.
	Eastway A&T	1071.5	996.5	1162.5	1159	495.5	495.5	1026	1026	93.0%	99.7%	100.0%	100.0%	Nursing staff have worked additional unplanned hours, the ward manager has worked in the clinical team and the multi-disciplinary team have supported the ward in maintaining safe staffing levels. Non-direct patient care activities were cancelled and rescheduled.
	Juniper	989	851	1128.5	1094	552	483	770.5	770.5	86.0%	96.9%	87.5%	100.0%	Non-direct patient care activities were cancelled and rescheduled.
	Maple Ward	920	874	1173	839.5	586.5	575	701.5	759	95.0%	71.6%	98.0%	108.2%	Nursing staff have worked additional unplanned hours, the ward manager has worked in the clinical team to support the ward in maintaining safe staffing levels. Non-direct patient care activities were cancelled and rescheduled.
	Pine Lodge (YPC)	839.5	747.5	931.5	908.5	448.5	448.5	759	701.5	89.0%	97.5%	100.0%	92.4%	Nursing staff have worked additional unplanned hours, the ward manager has worked in the clinical team and the multi-disciplinary team have supported the ward in maintaining safe staffing levels. Non-direct patient care activities were cancelled and rescheduled.
	Rosewood	955.5	886.5	1303	1291.5	483	471.5	844.5	810	92.8%	99.1%	97.6%	95.9%	
	Willow PICU	681.5	748	966	839.5	644	505.9	644	724.5	109.8%	86.9%	78.6%	112.5%	Regular bank staff were booked to mitigate any shortfalls in staffing levels.
Trust Totals		19285	17446	25499	24642	12727	11821	17060	16929	90.5%	96.6%	92.9%	99.2%	

Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Zero Harm implementation – update report
Agenda ref. no:	14/15/118
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	25/03/2015
Presented by:	Dr Anushta Sivananthan, Medical Director – Executive Lead for Quality

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	Yes
▪ Risk of harm to patients due to CARSO risk assessment not being completed as per policy. ▪ Risk of harm to patients, carers and staff as well as reputational and litigation risks due to a/ unable to show consistent investigation of incidents; b/ unable to show learning from actions of incidents, claims etc. is cascaded; c/ unable to be assured investigations are carried out in a timely manner d/ inability to communicate in a timely manner with partners.	
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 provides the Board of Directors with an interim update on the progress of the Trust's strategic approach to quality, Zero Harm, following the agreement by Quality Committee and Operational Board in 2014 to endorse this approach as a "productive (long term) investment" in the delivery of quality. This demonstrates insight that cultural change takes years to influence and is a bold stance given the current climate of change accelerating further and faster in the NHS.

There will be a detailed report and presentation to the May 2015 meeting of the Board of Directors outlining overall progress and plans for future development/ acceleration of the Zero Harm programme – including further position updates to those provided in this report, but further, impacts to-date that have demonstrated continuous quality improvement.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
The Government's "Hard truths" (2013) is clear about the patient safety challenge for the NHS and CWP's Zero Harm programme is an initiative that aspires to address this challenge by continuously improving the quality of care by tackling unwarranted risks and variation. To ensure the delivery of this aspiration and to influence change in patient safety culture, an implementation plan was developed and initially shared with the Quality Committee in May 2014. Updates against the plan have been provided at each subsequent Committee meeting against the actions identified to deliver the Trust's strategic quality improvement (Quality Account) priorities to ensure a joined up approach to the Trust's quality strategy. In addition, presentations have been delivered to the Quality Committee detailing progress with meta-analytical, including statistical approaches, to understand variation in healthcare delivery to promote less variation and positive variance.

Assessment – *analysis and considerations of options and risks*
The Zero Harm implementation plan (Appendix 1) details current position updates against each strategic quality improvement priority area for patient safety, clinical effectiveness and patient experience. The Board of Directors routinely receives assurance that performance against these areas is on track within the quarterly Quality Report. The implementation plan confirms that a communications strategy is in place as a framework for staff at all levels to inform how the Board's investment in improving quality and safety is delivering. It also confirms the enabling activities in place to support staff in delivering better care. The Quality Committee, as part of its remit to identify strategic priorities in relation to quality improvement and oversight of their implementation, has during the course of 2014/15 been refocusing its approach from solely quality assurance to continuous quality improvement. This has required discussions around behaviours and patient safety culture, which in turn, via the locality Clinical Directors who attend Quality Committee, encourages teams to question their own approaches to providing safer care which creates a can-do attitude to making a difference in behaviours. A continuous quality improvement focus is essential to give the Zero Harm programme the optimal chance of being sustained. It demonstrates a commitment at all levels of the organisation to embrace and collectively overcome the challenge of designing safer systems. The Board of Director's significant investment from ultimately public funds, rightly, requires scrutiny of returns on this investment. At the inception of this programme, a number of anticipated qualitative impacts were identified; these will be reported on at the May 2015 meeting of the Board of Directors.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors is asked to **note** this interim report detailing operational progress against its strategic approach to quality and the foundations set during this first year. A report detailing the *impacts* in relation to continuous quality improvement will be reported to the May 2015.

Who/ which group has approved this report for receipt at the above meeting?		David Wood, Associate Director of Safe Services
Contributing authors:		Jo Watts David Wood
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	J Watts to D Wood	13/03/2015
2	D Wood to L Brereton for Board of Directors	17/03/2015

Appendices provided for reference and to give supporting/ contextual information:	
Appendix no.	Appendix title
1	Implementation plan for CWP Zero Harm programme – current status
2	Quality Account quality improvement priorities 2015/16
3	Three year "way points" framework

Appendix 1: Zero harm implementation plan as at 04.03.2015

Output/s	Responsibility	Date	Implementation action/s – progress update/s	Status	Trend
Ideal: ***Interventions lead to the maximum number of people achieving good outcomes and positive recovery and the smallest number of people experiencing adverse outcomes.***					
Strategic patient safety improvement priority – To achieve a continuous reduction in avoidable harm and make measurable progress to embed a culture of patient safety in CWP, including through improved reporting of incidents					
1ai. Evaluation of staff receiving training and development in safe, organisational human factors practices and the spread of the implementation of these practices. 1aii Induction and mandatory training is continuously reviewed to ensure that there is a focus on human factors principles in the workplace.	Associate Director of Safe Services/ Head of Compliance/ Associate Director of Nursing & Therapies	Ongoing	**04.03.2015:** Medical Director lead for Human Factors (HF) and Quality Committee in January 2015 agreed to continue to use the existing training provider for continuity of delivery. The HF training is being scoped and included within the current essential training programmes. The aim will be to run an additional two programmes with the external provider to staff before June 2015 in its current format and then roll out team based HF training in targeted areas. Education CWP are benchmarking this programme against the CoCH and their HF training which focuses on linking an effective service and learning from incidents – whilst Quality Committee has agreed to continue using Atrainability Ltd, this benchmarking can and will inform what is commissioned from Atrainability Ltd to enhance the current offering.		↔
Supporting operational 1aiii. Consider use of Human	Associate Director of Safe	31.07.2014 and	**04.03.2015:** HF has been introduced into a reflective review template		↔

	Action off track – will not be achieved within identified timeframe with potential impact on programme implementation and/ or other actions
	Action on track – however needs additional support to achieve timeframe and/ or delivery and/ or to ensure no impact on other actions
	Action achieved or ongoing

Output/s		Responsibility	Date	Implementation action/s – progress update/s	Status	Trend
action/s	Factors questionnaire as part of incident reporting.	Services/ Head of Clinical Governance	ongoing	that has been designed to specifically review learning from incidents involving prone position restraint. The results of this will inform how to implement HF into routine incident reporting.		
1b. Evaluation of incident reporting by staff in relation to the reported number of actual or potential harm events, and improvement actions identified to continuously increase all incident reporting and in particular the number/ proportion of (and learning from) 'no harm' incidents.		Head of Compliance/ Head of Clinical Governance	31.08.2014 and ongoing	**04.03.2015:** An updated presentation went to March 2015 Quality Committee detailing further in depth review and meta analysis of baseline figures of reported incidents of harm compared to no harm incidents and near misses.		↔
1c. Evaluation of the themes identified as recommendations following the review of serious incidents, and improvement actions identified to continuously decrease recurrent themes/ increase in new learning themes to further improve systems and processes.		Locality Quality Surveillance Support Managers (LQSSMs)	30.09.2014 and ongoing	**04.03.2015:** Learning themes have been applied to all root cause analysis (RCA) actions identified since January 2014. Further detail re breakdown of learning themes has been provided to the Quality Committee. Locality Data Packs (LDPs) have been issued to nine wards/ teams in February 2015, feedback from team/ ward managers is being collated for further development prior to Trustwide roll out of LDPs by May 2015. These themes/ sub themes will also be shared with commissioners. Meeting between Director of Nursing, Medical Director for Quality and Associate Director of Safe Services with the CCGs agreed that category B (level 1) incidents will be themed and an exception report presented to their serious incident meetings. Recurrent themes will trigger the need for a comprehensive RCA investigation; otherwise a concise review will suffice.		↔
Supporting	1ci.	Head of Clinical	30.09.2014	**04.03.2015:**		↔

	Action off track – will not be achieved within identified timeframe with potential impact on programme implementation and/ or other actions
	Action on track – however needs additional support to achieve timeframe and/ or delivery and/ or to ensure no impact on other actions
	Action achieved or ongoing

Output/s		Responsibility	Date	Implementation action/s – progress update/s	Status	Trend
operational action/s	Incorporate cognitive task analysis into serious incident investigations.	Governance		Cognitive task analysis has been introduced into a reflective review template that has been designed to specifically review learning from incidents involving prone position restraint. The results of this will inform how to implement HF into routine incident reporting and will be factored into incident investigation processes and policy post April 2015 once the NHS England framework for serious incident investigation has been developed.		
	1cii. Respond to communication as a recurrent learning theme by embedding the principles of SBAR through inclusion in policies (handovers, transfers), training and communication tools.	Head of Compliance/ Associate Director of Nursing & Therapies (Mental Health)/ Head of Communications	19.06.2014 and ongoing	**04.03.2015:** Admission, discharge and transfer policy, currently out for consultation, incorporating principles of Situation-Background-Assessment-Recommendation (SBAR) to be finalised by 23 March 2015. SBAR tool to be incorporated into this policy and the care co-ordination policy (rather than a standalone SBAR policy), as agreed by February 2015 Patient Safety & Effectiveness Sub Committee, in recognition that shift handover processes in former policy and transfers are through care co-ordination/ CPA process not SBAR process itself.		↑
	1ciii. Respond to completeness/ quality of risk assessment as a recurrent learning theme by supporting staff in understanding	Head of Compliance/ CPA/ effective lead / Head of Effective Services	Ongoing	**04.03.2015:** Education One to one training for inpatient and community staff in key areas using CARSO and HoNOS to ensure care plan reflects risk, patient safety and user perspective. This has highlighted training deficits which will be incorporated into the development of essential training to reduce avoidable harm. Staff have identified requiring support in "how to engage		↑

(red)	Action off track – will not be achieved within identified timeframe with potential impact on programme implementation and/ or other actions
(amber)	Action on track – however needs additional support to achieve timeframe and/ or delivery and/ or to ensure no impact on other actions
(green)	Action achieved or ongoing

Output/s		Responsibility	Date	Implementation action/s – progress update/s	Status	Trend
	how to use CARSO to best promote safety, quality and recovery.			service users" with regards to risk and care planning the risks. In response to this Wirral and West staff are currently piloting a risk assessment tool; outcomes are expected in March 2015. 'My Safety Plan' has been adapted and developed from AQuA and is in use alongside care plans by inpatient wards from across the Trust. A new three hour role specific CPA and effective care planning training package is in development for expected roll out in quarter 2 of 2015/16. This will be face to face training commencing for 1800 staff over a 3 year programme – i.e. 50 staff per month – commencing with all clinical inpatient staff as a priority. Reporting through Education CWP to People and Organisational Development Sub Committee (PODSC). E-learning Clinical Risk and Critical Incidents (EE3) package is being reviewed by the Clinical Education Trainer, the review is to be completed by the end of March 2015. This package is being reviewed to ensure consistency and reduce variance with effective care planning and risk management across the Trust. Policy Enhancements to CP42 CPA policy are being discussed with service user representatives on 10.03.2015. Flow charts are being developed for use in the policy and the next stage will be the policy discussion board for final comments. The enhancements are to be finalised by the end of March 2015 so that Effective Care Planning training can then commence.		

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Output/s		Responsibility	Date	Implementation action/s – progress update/s	Status	Trend
				CP5 Risk Policy has been sent to Ward Managers for review and comments, these will then be incorporated and finalised before end of March 2015 as training for Effective Care Planning will rely on an up to date policy. Paper relating to patient safety metrics (including care planning and risk management) and future developments presented to March 2015 Quality Committee.		
1d. Evaluation of the unnecessary avoidable harm identified following the review of serious incidents, and improvement actions identified to embed and sustain learning from these events.		Locality Quality Surveillance Support Managers	30.09.2014 and ongoing	**04.03.2015:** Updated presentation to March 2015 Quality Committee detailing further in depth review and meta analysis of baseline figures of reported incidents of actual harm compared to no harm incidents and near misses.	Green	↔
1e. Evaluation of the Trust's suicide prevention strategy to strengthen measures in place that aim to reduce the number of suicides and incidents of serious self-harm or harm to others, including effective crisis response.		Head of Clinical Governance	30.09.2014	**04.03.2015:** New training programme proposal is currently under review, this new training will take place from April 2015. Work programmes continue for mitigation of environmental risk factors. It has been agreed that CWP will redesign its own assurance framework to mirror that of the regional strategic zero suicide strategy. Engagement is taking place with all the leads in Public Health for suicide prevention – completion of the framework for the reduction of suicide is completed and will be refreshed.	Green	↔
2. Strategic clinical effectiveness improvement priority – To achieve a continuous improvement in health outcomes for people using the Trust's services by engaging staff to improve and innovate						
2a. Continuous improvement in the collection and reporting of outcomes from the measurement of care pathways.		Associate Director of Effective Services	19.06.2014 and ongoing	**04.03.2015:** Acute Care Pathway being tested by service users to facilitate a 'go live' date of April 2015. Revised data reporting being proposed for all pathways from April 2015 to include HoNOS outcomes. A sustainable solution to collection of PROMs data is being explored. Not all	Red	↓

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			Clinical Networks have been successfully established therefore this action is off track – mitigations to address gaps are required given care pathway focus of CQC inspection in June 2015.		
2bi Evaluation of staff receiving training and development in techniques and approaches in relation to continuous improvement. 2bii Approve the distribution of BMJ quality improvement licenses to 100 staff across the Trust to teach staff recognised improvement methodologies (e.g. SQUIRE, IHA, LEAN, Productives) to improve learning opportunities from the results of quality improvement work, to increase the options for sharing best practice, and to learn when things do not deliver hoped for improvements	AD Nursing MH / Head of Compliance/ AD Effective Services / Medical Director (Compliance, Quality & Assurance)	Ongoing	**04.03.2015:** Final draft Clinical Strategies being presented to Operational Board and Board in March 2015 with a focus on continuous improvement. There has been a lack of proactive engagement with BMJ license projects, Head of Compliance and Zero Harm Clinical Expert champion to attend locality sessions to further endorse zero harm principles. Currently contacting allocated license holders for updates with projects with a view to reallocate as appropriate. Quality Support Managers have been identified as an additional support to staff as well as current effective service managers in order to accelerate this.	(amber)	↓
2c. Continuous increase in the number of good practice stories published internally through the Trust's dedicated intranet site that celebrates and promotes good practice.	Head of Communications & Involvement	Ongoing	**04.03.2015:** The Communications Team has promoted the news of the Care Quality Commission announced inspection to CWP during the week of 22 June 2015. Staff roadshows in April will be aligned with #CWPZeroHarm/ CQC visit messages to support clinical understanding with frontline staff.	(green)	↔
2d.Continuous improvement in the number of positive	Head of Communications	Ongoing	**04.03.2015:** CWP has received positive news coverage over the last	(green)	↔

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Output/s	Responsibility	Date	Implementation action/s – progress update/s	Status	Trend
media stories published externally about the Trust.	& Involvement		few months including: - 'Street triage' approach to mental health issues; - Plans submitted for a new CAMHS new build mental health facility.		
2e. 'Innovation register' demonstrates continuous improvement in the number of innovative practices that are registered and also evidence of spread.	Associate Director of Effective Services	Ongoing	**04.03.2015:** Work is underway to further develop ideas into business plans. Innovative ideas competition will be repeated in April 2015. The Innovation Register has been developed and is updated each month, since inception it has received 17 ideas.		↔
2f. Evaluation of the outputs of clinical audit activity, through action plans, that identify recommendations to spread good practice and accelerate excellence.	Commercial Business Manager (Effective Services)/ Locality Quality Surveillance Support Managers	30.09.2014 and ongoing	**04.03.2015:** Clinical audit database is being demonstrated internally mid-February 2015 before being populated for use. Compliance, Assurance & Learning Sub Committee (CALSC) reports for March 2015 will now be presented across the 5 key domains and will be locality focused. The implementation of a virtual "Healthcare Quality Improvement team" from March 2015 will support localities to drive continuous improvement from the outputs of audit.		↔
2g. Re-audit, or equivalent monitoring, demonstrates sustained good practice and spread of excellence to other areas.	Associate Director of Effective Services/ Associate Director of Performance & Redesign/ Locality Quality Surveillance Support Managers	30.09.2014 and ongoing	**04.03.2015:** The new clinical audit database will enhance progress monitoring. Existing corporate resources from Safe & Effective Services to be combined to form a virtual "Healthcare Quality Improvement team" with a specific focus on coordinating the embedding of team/ ward learning and spread of excellence.		↔
2h. Continuous improvement in the number of publications, e.g. articles, reviews, quality	Head of Communications & Involvement	Ongoing	**04.03.2015:** As part of the communication/ engagement plan further trade features to be pitched with new angles explored.		↔

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improvement reports, research reports, developed by the Trust that are successfully published.			The team is currently supporting CWP's presence at the Mental Health: Better, Faster and Earlier Help conference (on 4 March 2015 at the Manchester Conference Centre) with CWP focus on continuous improvement/ Zero Harm.		
3. Strategic patient experience improvement priority – To achieve a continuous improvement in people's experience of healthcare by promoting the highest standards of caring through implementation of the Trust's values.					
3a. Evaluation of the outputs of the Trust's 6Cs work programme and 'values group' to review that they are supporting the workforce to have the right values, skills and training to enable excellent care and improvement actions identified to continuously improve this.	Associate Directors of Nursing/ Director of HR	Ongoing	**04.03.2015:** Progress is as stated above with the addition that the Communications and Human Resources and Organisational Development (HROD) teams are now working on a values implementation plan with a roll out commencing in April 2015.	Green	↔
Supporting operational action/s 3ai Evaluation of the outputs of the Trust's 6Cs work programme and 'values group' to review that they are supporting behaviours associated with "communication ensuring effective communication at all levels	Director of HR/ OD Practitioner	07.01.2015 (new action identified)	**04.03.2015:** Phase 1 (awareness raising) of the 6Cs programme plan is now drawing to a close and Phase 2 (embedding the 6Cs) is in place. The group will meet via virtual means to progress the values implementation action plan that the Organisational Development Practitioner is leading on. Matrix working is in progress with the communications team to implement the values into future bulletins/ briefs etc.	Green	↔
3b. Evaluation of the NHS patient survey in relation to the proportion of people, across all areas of care, who rate their experience as excellent or very good, and	Head of Communications & Involvement/ Associate Director of Effective	Ongoing	**04.03.2015:** The Communications Team is currently working with Quality Health to support the 2015 Community Mental Health survey – it is anticipated that the sample of community mental health service users (850) will start to receive the survey at the end of February/ March 2015 to	Green	↔

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improvement actions identified to improve this.	Services/ Head of Clinical Governance		find out what they think about the care they have received.		
3c. Evaluation of NHS staff survey results in relation to whether staff would recommend their place of work to a family member of friend as a high quality place to receive treatment and care, and improvement actions identified to continuously improve this.	Director of Human Resources	Ongoing	**04.03.2015:** Initial NHS Staff Survey results have been received and are to be considered at People and Organisational Development Sub Committee (PODSC) on 19 February 2015 with a presentation to follow to Operational Board in March 2015.		↔
3d. Evaluation of 'Friends and family' test for patients results for community and mental health services [by the end of December 2014] and improvement actions identified to continuously improve these.	Associate Director of Effectiveness	31.12.2014 and ongoing	**04.03.2015:** From 99 responses received since implementation, 86% of people said they were 'extremely likely' or 'likely' to recommend CWP services. Further work is being undertaken to ensure that the Friends and Family Test is embedded into routine practice to improve response rates.		↔
3e. Evaluation of local surveys, focus groups and real time experience collection conducted to measure patient/ carer/ staff experience and improvement actions identified to achieve continuous improvements in people's experiences.	Associate Director of Effectiveness/ Head of Communications & Involvement/ Director of Human Resources	Ongoing	**04.03.2015:** Identifying current real-time feedback mechanisms adopted by individual service areas to inform definition of standards for use of real-time feedback application once developed.		↔
3f. Evaluation of patient experience feedback/ complaints, including feedback from 'Care	Head of Clinical Governance	Ongoing	**04.03.2015:** The Trust has been informed that the programme Care Connect that it was part of is actually closing at the end of March 2015, this decision is part of a much wider		↔

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Connect', and improvement actions identified to improve key areas, including reports regarding the appropriateness and effectiveness of communication.			response by NHS England as part of funding reviews. There is a long term vision to develop the customer contact centre, to date it is not clear who is taking this work forward. This will be kept under review, however it is beyond CWP's control.		
4. Communications priority – A communications strategy is in place as a framework for staff at all levels to inform how the Board's investment in improving quality and safety is delivering					
4i. Ensure delivery of a communication plan for the outputs of the zero harm programme ('bronze' SMART objectives).	Head of Communications & Involvement	Ongoing	**04.03.2015:** Ongoing actions on track. Refer to the communications and engagement plan attached (updated January 2015). Stop Listen Think communications and e	Green	↔
4ii. Ensure delivery of a communication plan for the awareness raising outcomes of the zero harm programme ('silver' SMART objectives).	Head of Communications & Involvement	Ongoing	**04.03.2015:** Meeting held on the 29 January with Medical Director, Associate Director of Safe Services, Head of Compliance and Head of Communications to provide an update on a "Campaign Outline 6 Month Review" and next steps. Actions were reviewed and upcoming priorities agreed (see 4i) SMART objectives under review for next 12months.	Green	↔
5. Learning and development priority – To enable staff to deliver better care by providing them with the necessary support, training and development to proactively deliver the Trust's strategic quality improvement priorities					
5a. Learning from experience is routinely fed in to essential employee learning.	Associate Director of Nursing & Therapies (Mental Health)/ Head of Clinical Governance/ Head of	Completed	**04.03.2015:** E-Learning packages went live on the following dates: a) 22.12.2014 Investigation of Incidents, Complaints and Claims. b) 12.02.2015 Learning from Experience & Critical Updates. Both these packages have been advertised and are available on the Essentials framework.	Green	↔

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	Compliance/ Head of HR		Further plans include asking the staff, via a questionnaire and engagement as to how they would like feedback in relation to learning lessons from incidents, complaints and claims. Quality Improvement Project Plan as at 09		
5b. Skills in situational awareness are enhanced to support the management of challenging behaviour.	Associate Director of Nursing & Therapies (Mental Health)/ Head of Compliance	30.09.2014 and ongoing	**04.03.2015:** The next ward managers task and finish group is on 6 March 2015 and will be attended by Associate Director of Nursing & Therapies to determine progress with embedding patient behavioural assessments into clinical practice.		↔
5d. Review management/ leadership training to ensure there are educated and empowered teams in place across the organisation.	Associate Director of Nursing & Therapies (Mental Health)/ Head of Compliance	Completed	**04.03.2015:** CWP Leadership Development Programme commenced on 18.02.2015. Action complete.		↔
5e. Review team development programmes to ensure safer and more effective practices are embedded as accepted ways of working.	Associate Director of Nursing & Therapies (Mental Health) / Director of Human Resources	Completed	**04.03.2015:** Team development programmes are ongoing throughout the Trust and are part of the core offer of the Education CWP team. Action complete.		↔
5f. Encourage the use of rolling half days for staff learning and development	Associate Medical Director/	31.07.2014 and ongoing	**04.03.2015:** Locality progress/ issues/ numbers re the rolling half days are discussed and monitored at the Education CWP		↔

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and provide framework to improve and enhance patient safety and staff morale.	Director of Medical Education/ Director of Nursing & Therapies (Mental Health)		Training Leads Meetings (these take place bi-monthly).		
5g. Ensure risk training includes appropriate practical tools to maintain safe performance.	Head of Clinical Governance	31.07.2014 and ongoing	**04.03.2015:** This is being piloted currently via the reflective review template that has been designed to specifically review learning from incidents involving prone position restraint. The results of this will inform how to implement HF into routine incident reporting. Further work is required with the incident policy which involves developing new reporting templates to incorporate findings from above, also to develop a concise review template, learning from the development of the pressure sore peer review documentation.	(green)	↔

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Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Appendix 2: Quality Account: 2015/16 quality improvement priorities
Agenda ref. no:	14/15/119
Report to (meeting):	Quality Committee
Action required:	Discussion and Approval
Date of meeting:	04/03/2015
Presented by:	David Wood, Associate Director of Safe Services

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	No
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	No
Services that are responsive to people's needs	No
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
N/A	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

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

The National Health Service (Quality Accounts) Regulations 2010 [amended 2013] require CWP to approve Trustwide quality improvement priorities each year based on:

- Identified risks to quality in-year and reflective of what is relevant to people who use and work for the Trust's services, including feedback from people who use and work for the Trust's services and stakeholders such as work with commissioners and other scrutineers.
- National priorities, e.g. protecting people who use NHS services from avoidable harm, achieving better health outcomes for patients, and ensuring that people have a positive experience of care – as detailed in The NHS Outcomes Framework 2015/16.
- Specific feedback received in-year from the outputs of the assessment and monitoring of quality provision across all localities, and the work of the Quality Committee and the Patient Safety & Effectiveness Sub Committee.

The purpose of this report is to formally seek approval of these priorities and to also document the process for consulting on and effectively communicating these across the Trust and wider stakeholder groups, as per the requirement in Monitor's Quality Governance Framework.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
CWP recognises its accountability to people who use its services and the public for continuously improving the quality of care in the Trust's annual Quality Account and quarterly Quality Reports. The quality priorities identified for achievement in 2015/16 will be set out in the Trust's forward plans, including how they link to the Trust's corporate and locality strategic objectives and associated risks to delivery. This process of integrating the Trust's quality priorities with forward planning processes, and setting out forward milestones, allows the Trust's quality priorities to be consistently consulted on and effectively communicated across the Trust and wider stakeholder groups. It also ensures a robust audit trail to document the process of setting quality priorities, including being able to evidence feedback and constructive challenge.

Assessment – *analysis and considerations of options and risks*
This year's focus remains 'continuously improving care delivery to reduce error and harm', to focus on better care rather than quantitative targets. In January 2014, the Board of Directors endorsed the quality improvement priorities remaining unchanged for at least the next three years, with a review of progress at the end of March 2017. These priorities are: **Patient safety** – Achieve a continuous reduction in avoidable harm and make measurable progress to embed a culture of patient safety in CWP, including through improved reporting of incidents. **Clinical effectiveness** – Achieve a continuous improvement in health outcomes for people using the Trust's services by engaging staff to improve and innovate. **Patient experience** – Achieve a continuous improvement in people's experience of healthcare by promoting the highest standards of caring through implementation of the Trust's values. The Board will receive the Trust's quarterly Quality Reports to evaluate progress towards delivery of the quality priorities. Through quarterly review of the Trust's self-assessment of compliance with Monitor's Quality Governance Framework, the Board will identify on a regular basis how quality drives the overall Trust strategy. The Trust's Quality Committee includes in its business cycle a review of the quarterly Quality Report which progress against the quality priorities, and is the delegated committee that identifies any necessary action plans required to manage the risks associated with their delivery. The Quality Report is also shared widely with partner organisations, governors, members, local groups and organisations as well as the public. Since all of the quality improvement priorities link to the Trust's 'zero harm' plans, they will form part of an overarching work plan that will be monitored routinely by the Trust's Quality Committee and by exception to the Board of Directors.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
To **approve** the Quality Account quality improvement priorities for 2015/16.

Who/ which group has approved this report for receipt at the above meeting?		Quality Committee Chair
Contributing authors:		N/A
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Quality Committee	26/02/2015

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

Appendix 3

Three year 'way points' framework

This three year framework is an outline only, for those specific recommendations identified against the five priority areas that were approved by the Board of Directors in January 2014, to give an indication of some of the 'way points' during the next three years in order to provide to the Board a considered view of its 'return on investment'. In keeping with the theme of the programme, the focus is on continuous improvement across qualitative themes, not targets or quantifiable financial savings. It is not possible to accurately quantify most of the qualitative returns on investment, e.g. the exact cost of prevented harm.

Appendix 1, the implementation plan, will be monitored closely so that emerging actions as things develop iteratively inform more aspirational outputs, particularly for years 2 and 3.

	Link/s to implementation action/s	Year 1 indicators	Year 2 indicators	Year 3 indicators
A. CPA/ effective lead				
Ai. Appoint a CPA/ effective lead	1a 3b 5e	▪ CPA review outcomes reviewed in performance reviews from April 2014 for *all points of discharge* [i.e. from inpatient stay or CWP services] ▪ Baseline identified for above	▪ CPA review outcomes reviewed in performance reviews from April 2015 for *all points of reviews* ▪ Baseline identified for above ▪ Continuous improvement reviewed/ demonstrated against year one baseline for all points of discharge	▪ Continuous improvement reviewed/ demonstrated against review of outcomes for all CPA reviews ▪ Evidence of dynamic care plan reviews [reviews in addition to minimum reviews at care plan review meetings]
		Continuous increase in proportion of clinical staff and managers receiving training/ development in techniques/ approaches, e.g. team working; CPA and associated relevant training; monitoring and review; situation specific approaches [as a minimum, all staff trained in CPA, HoNOS and CARSO by end year three].		

	Link/s to implementation action/s	Year 1 indicators	Year 2 indicators	Year 3 indicators
		Continuous reduction in variable use of CPA within and between teams, including continuous improvements in national CPA targets: ▪ CPA patients receiving follow-up contact within seven days of discharge from psychiatric inpatient care ▪ The percentage of all service users on CPA who have had their care plan reviewed within the last 12 months		
		Continuous improvement in feedback from CWP compliance visits/ equivalent desktop review for essential standard of quality and safety 'care and welfare of people who use services'		
		Continuous improvement in feedback and/ or rating from the CQC for the safe and effective care components as per the "CQC action plan for safe and effective care 2010 – 15"		
		Continuous improvement in feedback from people who use CWP's services [local and national survey feedback] in relation to the co-ordination of their care		
B. Celebrating success and promoting good practice				
Bi. Delivery of the clinical effectiveness and patient experience priorities for 2013/14 with respect to the development of patient pathways	2a	Delivery of the clinical effectiveness and patient experience priorities for 2013/14 with respect to the development of patient pathways	Delivery of the clinical effectiveness and patient experience priorities for 2014/15 with respect to the development of patient pathways	Delivery of the clinical effectiveness and patient experience priorities for 2015/16 with respect to the development of patient pathways
Bii. Continue to promote what works well with respect to the delivery of NICE guidance through the work of the NICE champions	2a	Continuous improvement in the number of work plans available on the intranet detailing how the NICE champions plan to assess and improve the implementation of NICE guidance		
Biii. Establishment of an intranet site to celebrate and promote good practice	2c 2d 4ii	▪ Place "Big Book of Best Practice 2014" on a dedicated intranet site ▪ Continuous increase in the number of good practice stories ▪ Continuous	▪ Continuous increase in the number of good practice stories ▪ Continuous improvement in the number of positive media stories ▪ Continuous improvement in number of external publications	

	Link/s to implementation action/s	Year 1 indicators	Year 2 indicators	Year 3 indicators
		improvement in the number of positive media stories ▪ Continuous improvement in number of external publications		
Biv. Ensure that the outputs of clinical audit activity, through action plans, identify recommendations to spread good practice and accelerate excellence	2g	Re-audit [or equivalent monitoring] demonstrates sustained good practice and spread excellence to other areas		
C. Support for meta-analysis				
Ci. Appoint a quality surveillance function	1b 1c 1d 1e 3b	Routine avoidable harm reporting to inform baseline	Continuous reduction in comparative incidence of avoidable harm	
		Continuous reduction in recurrent learning themes from serious untoward incidents, including regulation 28 action required		
		Continuous reduction/ no contractual breaches for completion of serious incident investigatory processes		
		Continuous reduction in error provoking situations – continuous increase in ratio of harm to no harm incident reporting		
		Continuous improvement in patient experience feedback/ complaints in relation to reports of inappropriate behaviour/ more effective/ clear/ concise communication		
		Continuous reduction in litigation costs [liability for harm]		
D. Peer review of complex needs and supporting efficiency				
Di. Complex Recovery, Advice and Consultation team to support acute care and community teams to manage complex cases	2a	Continuous reduction in admissions/ need for acute beds [as ratio to aftercare – enhanced community care/ support packages]		
		Continuous improvement in successful outcomes for people using services, which demonstrate moves to greater independence		
E. Organisational development				
Ei. ▪ Fully adopt the principles of the incident decision tree	1c 1d	▪ Approved incident decision tree in place ▪ Fully adopt the principles	Approved incident decision tree in place – linked to both incident reporting and management policy and capability policy	

	Link/s to implementation action/s	Year 1 indicators	Year 2 indicators	Year 3 indicators
▪ Review the capability policy and procedure so that the Trust applies fairness where there are performance issues but these are addressed more quickly to mitigate unintended consequences for people who use the Trust's services		of the incident decision tree in the capability policy		
Eii. Commission AQuA to independently review recruitment processes, with a brief to minimise process but also to move the focus from process to flexible and sophisticated approaches to recruitment based on service needs and priorities.	3a 3e	▪ Independent review and recommendations implemented, with demonstrable decrease in process steps and timeframes and in-built flexibility ▪ MIAA re-audit to assure of significant assurance	Continue to implement revised recruitment processes according to policy standards, resulting in no *avoidable* recruitment risks on locality, specialty and strategic risk registers	
Eiii. Roll out values based recruitment to key clinical posts to ensure recruitment of staff who can best demonstrate affinity to the Trust's adopted values and behaviours	3a	Three year values based recruitment plan in place with continuous increase in the comparative number of recruits subject to assessment of values as part of interview processes		
Eiv. ▪ Review the job description template to focus on competence, knowledge, attributes, values and behaviours ▪ Review the appraisal policy and procedure so that objectives for staff are explicitly tied into Trust objectives	3a 3b 3c 3d 3e	Job description and appraisal template reviewed and implemented	–	–
		Continuous improvement in patient experience feedback/ complaints in relation to staff		
		Continuous improvement in the number of 'second tier' and above HR investigatory processes		

	Link/s to implementation action/s	Year 1 indicators	Year 2 indicators	Year 3 indicators
▪ Scope training in HR/ basic employment law for all line managers ▪ Scope training to enhance the skills of managers in having difficult conversations with staff				
Ev. Training in Human Factors principles	1a 1b 1c 1d 1e 3c 3d 3e 3f 5c	Continuous reduction in error provoking situations, indicated by continuous increase in ratio of harm to no harm incident reporting Continuous improvement in patient experience feedback/ complaints in relation to reports of inappropriate behaviour/ more effective/ clear/ concise communication Continuous reduction in litigation costs [liability for harm]		
Evi. The core responsibilities of the professional and clinical leadership roles should be captured as part of the Trust's operating/ performance management framework/ integrated governance strategy	1c 1d 1e 3b 5d	Trust's operating/ performance management framework/ integrated governance strategy continuously operating effectively as per identified monitoring arrangements Performance reviews consistently operate in accordance with a demonstrable accountability model for each action identified in relation to both good and poor variance		
Evii. Training for managers to include supporting staff in continuous improvement, celebrating good practice, and encouragement to deliver innovative solutions to complex problems	2b 2c 2e 2h	Continuous increase in the number of good practice stories Continuous increase in proportion of staff receiving training/ development in techniques/ approaches in relation to continuous improvement, e.g. PDSA 'Innovation register' demonstrates continuous improvement in the number of innovative practices that are registered and also evidence of spread		
Eviii. ▪ Training in the understanding of the importance of clinical risk assessment [CARSO]/	1a 1c 1d 1e	Continuous increase in proportion of clinical staff and managers receiving training/ development in techniques/ approaches, e.g. team working; CPA and associated relevant training; monitoring and review; situation specific approaches [as a minimum, all staff trained in CPA, HoNOS and CARSO by end year three].		

	Link/s to implementation action/s	Year 1 indicators	Year 2 indicators	Year 3 indicators
management/ formulation, care planning and HoNOS ▪ More effectively develop and deliver individual and system accountability for quality of CARSO, care planning and HoNOS	5a-g	Supervisory processes reviewed to ensure capture of CARSO, CPA and HoNOS – for caseload discussion Continuous reduction in recurrent learning themes from serious untoward incidents, including regulation 28 action required		
F. Collective continuous improvements				
Fi. Specific targets/ thresholds/ tangible outputs against these expected continuous improvements that are expected as a result of the implementation of the combined proposal will be developed as part of the three year implementation plan	All	▪ Continuous promotion of meaningful recovery ▪ Continuous improvements to the delivery of co-ordinated, patient centred outcome focussed care ▪ Better prediction and forecasting to intelligently inform service improvement, service development, inform commissioning intentions, and support early warning processes ▪ Continuous promotion of safe and effective care		

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Trust Position in respect to "Freedom to Speak Up" Febuary 2015
Agenda ref. no:	14/15/119
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	18/03/2015
Presented by:	Associate Director of Nursing and Therapies

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	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	Choose an item.
Click here to enter text.	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
Click here to enter text.	

REPORT BRIEFING

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

This report is to provide the Board with a brief summary of the Freedom to Speak Up independent review (February 2015) by Sir Robert Francis QC, to outline the Trusts current position against the recommendations, and highlight areas which require further consideration.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
Following the Mid Staffordshire Public enquiry recommendations were made to make the culture of the NHS patient focused, open and transparent. A review was set up in response to the continuing disquiet about the way in which NHS organisations deal with concerns raised by NHS staff, and the treatment of some of those who have spoken up. The review considered the complex legal and policy context in which whistleblowing takes place. The Freedom to speak up (2015) report arsing from the review makes two recommendations (appendix1) and identifies five overarching themes; culture change, improved handling of cases, measures to support good practice, particular measures for vulnerable groups and extending the legal protection. The report outlines twenty principles (appendix 2) supported by a number of actions (appendix 3) which the Trust should consider. Regulators will look for evidence of these principles being taken seriously and effectively discharged.

Assessment – *analysis and considerations of options and risks*
The report is wide reaching and the principles and actions range across many corporate and operational services. Whilst the Trust can demonstrate and provide evidence in how it is currently meeting some of the principles of the five overarching themes, additional focus is required to strengthen and embed these into everyday practice, and consider how these are monitored and evidenced. The Trust has several policies which individually address some of the operational and process aspects identified in the twenty principles, for example; how to raise and escalate concerns within work (incorporating whistleblowing), Grievance policy and procedure, Dignity at work, incident reporting and safeguarding policies. Further timely work is required to undertake a gap analysis against the actions identified in the report, (appendix 3) and consider what action should be taken to ensure that the Trust can demonstrate how it meets is responsibilities and what is required to continually improve.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
TheBoard is requested to note the position of the Trust, discuss and consider the impact of the Freedom to Speak Up Report and agree the following next steps: A working party to be convened to undertake a gap analysis, and scoping of actions required to provide assurance to the Board that the organisation is meeting its responsibilities or has a plan in place.

Who/ which group has approved this report for receipt at the above meeting?		Director of Nursing, Therapies and Patient Participation
Contributing authors:		Click here to enter text.
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
Click here to enter text.	Click here to enter text.	Click here to enter text.

Appendices provided for reference and to give supporting/ contextual information: *Provide only <u>necessary</u> detail, do <u>not</u> embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1	Freedom to Speak up – Recommendations
2	Freedom to Speak up – Principles
3	Freedom to Speak up - Actions

Appendix 1

Freedom to Speak Up February 2015

Recommendation 1

All organisations which provide NHS healthcare[5] and regulators should implement the Principles and Actions set out in this report in line with the good practice described in this report.

Recommendation 2

The Secretary of State for Health should review at least annually the progress made in the implementation of these Principles and Actions and the performance of the NHS in handling concerns and the treatment of those who raise them, and report to Parliament.

Appendix 2

Principle 1 – Culture of safety

Every organisation involved in providing NHS healthcare should actively foster a culture of safety and learning in which all staff feel safe to raise concerns.

Principle 2 – Culture of raising concerns

Raising concerns should be part of the normal routine business of any well-led NHS organisation.

Principle 3 – Culture free from bullying

Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.

Principle 4 – Culture of visible leadership

All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff.

Principle 5 – Culture of valuing staff

Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to the issues identified.

Principle 6 – Culture of reflective practice

There should be opportunities for all staff to engage in regular reflection of concerns in their work.

Principle 7 – Raising and reporting concerns

All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.

Principle 8 – Investigations

When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.

Principle 9 – Mediation and dispute resolution

Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.

Principle 10 – Training

Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.

Principle 11 – Support

All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling.

Principle 12 – Support to find alternative employment in the NHS

Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.

Principle 13 – Transparency

All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.

Principle 14 – Accountability

Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising, or receiving and handling concerns. There should be personal and organisational accountability for:

- poor practice in relation to encouraging the raising of concerns and responding to them
- the victimisation of workers for making public interest disclosures
- raising false concerns in bad faith or for personal benefit
- acting with disrespect or other unreasonable behaviour when raising or responding to concerns
- inappropriate use of confidentiality clauses.

Principle 15 – External review

There should be an Independent National Officer resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this report, namely:

- review the handling of concerns raised by NHS workers, and/or the treatment of the person or people who spoke up where there is cause for believing that this has not been in accordance with good practice
- advise NHS organisations to take appropriate action where they have failed to follow good practice, or advise the relevant systems regulator to make a direction to that effect
- act as a support for Freedom to Speak Up Guardians
- provide national leadership on issues relating to raising concerns by NHS workers
- offer guidance on good practice about handling concerns
- publish reports on the activities of this office.

Principle 16 – Coordinated Regulatory Action

There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns.

Principle 17 – Recognition of organisations

CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.

Principle 18 – Students and trainees

All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.

Principle 19 – Primary Care

All principles in this report should apply with necessary adaptation in primary care.

Principle 20 – Legal Protection should be enhanced

ACTION SUMMARY

		DH	NHS ENGLAND	SYSTEM REG	PRO REG	HEE	ALL ORGS incl. PROVIDERS
1.1	Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis						✓
1.2	System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led.			✓			
2.1	Every NHS organisation should have an integrated policy and a common procedure for employees to formally report incidents or raise concerns. In formulating that policy and procedure organisations should have regard to the descriptions of good practice in this report.						✓
2.2	NHS England, NHS TDA and Monitor should produce a standard integrated policy and procedure for reporting incidents and raising concerns to support Action 2.1.		✓	✓			
3.1	Bullying of staff should consistently be considered, and be shown to be, unacceptable. All NHS organisations should be proactive in detecting and changing behaviours which amount, collectively or individually, to bullying or any form of deterrence against reporting incidents and raising concerns; and should have regard to the descriptions of good practice in this report.						✓
3.2	Regulators should consider evidence on the prevalence of bullying in an organisation as a factor in determining whether it is well led.			✓			

3.3	Any evidence that bullying has been condoned or covered up should be taken into consideration when assessing whether someone is a fit and proper person to hold a post at director level in an NHS organisation.			✓			✓
4.1	Employers should ensure and be able to demonstrate that staff have open access to senior leaders in order to raise concerns, informally and formally.						✓
5.1	Boards should consider and implement ways in which the raising of concerns can be publically celebrated.						✓
6.1	All NHS organisations should provide the resources, support and facilities to enable staff to engage in reflective practice with their colleagues and their teams.						✓
7.1	Staff should be encouraged to raise concerns informally and work together with colleagues to find solutions.						✓
7.2	All NHS organisations should have a clear process for recording all formal reports of incidents and concerns, and for sharing that record with the person who reported the matter, in line with the good practice in this report.						✓
8.1	All NHS organisations should devise and implement systems which enable such investigations to be undertaken, where appropriate by external investigators, and have regard to the good practice suggested in this report.						✓
9.1	All NHS organisations should have access to resources to deploy alternative dispute resolution techniques, including mediation and reconciliation to: • address unresolved disputes between staff or between staff and management as a result of or associated with a report raising a concern. • repair trust and build constructive relationships.						✓
10.1	Every NHS organisation should provide training which complies with national standards, based on a curriculum devised jointly by HEE and NHS England in consultation with stakeholders. This should be in accordance with the good practice set out in this report.		✓			✓	✓

11.1	The Boards of all NHS organisations should ensure that their procedures for raising concerns offer a variety of personnel, internal and external, to support staff who raise concerns including: a) a person (a 'Freedom to Speak Up Guardian') appointed by the organisation's chief executive to act in a genuinely independent capacity. b) a nominated non-executive director to receive reports of concerns directly from employees (or from the Freedom to Speak Up Guardian) and to make regular reports on concerns raised by staff and the organisation's culture to the Board. c) at least one nominated executive director to receive and handle concerns. d) at least one nominated manager in each department to receive reports of concerns. e) a nominated independent external organisation (such as the Whistleblowing Helpline) whom staff can approach for advice and support.						✓
11.2	All NHS organisations should have access to resources to deploy counselling and other means of addressing stress and reducing the risk of resulting illness after staff have raised a concern.						✓
11.3	NHS England, NHS TDA and Monitor should issue joint guidance setting out the support required for staff who have raised a concern and others involved.		✓	✓			
12.1	NHS England, NHS TDA and Monitor should jointly devise and establish a support scheme for NHS workers and former NHS workers whose performance is sound who can demonstrate that they are having difficulty finding employment in the NHS as result of having made protected disclosures.		✓	✓			
12.2	All NHS organisations should actively support a scheme to help current and former NHS workers whose performance is sound to find alternative employment in the NHS.						✓
13.1	All NHS organisations that are obliged to publish Quality Accounts or equivalent should include in them quantitative and qualitative data describing the number of formally reported concerns in addition to incident reports, the action taken in respect of them and feedback on the outcome.						✓

13.2	All NHS organisations should be required to report to the National Learning and Reporting System (NLRS), or to the Independent National Officer described in Principle 15, their relevant regulators and their commissioners any formally reported concerns/public interest disclosures or incidences of disputed outcomes to investigations. NLRS or the Independent National Officer should publish regular reports on the performance of organisations with regard to the raising of and acting on public interest concerns; draw out themes that emerge from the reports; and identify good practice.		✓	✓			✓
13.3	a) CEOs should personally review all settlement agreements made in an employment context that contain confidentiality clauses to satisfy themselves that such clauses are genuinely in the public interest. b) All such settlement agreements should be available for inspection by the CQC as part of their assessment of whether an organisation is well-led. c) If confidentiality clauses are to be included in such settlement agreements for which Treasury approval is required, the trust should be required to demonstrate as part of the approval process that such clauses are in the public interest in that particular case. d) NHS TDA and Monitor should consider whether their role of reviewing such agreements should be delegated to the Independent National Officer recommended under Principle 15.			✓			✓
14.1	Employers should ensure that staff who are responsible for, participate in, or permit such conduct are liable to appropriate and proportionate disciplinary processes.						✓
14.2	Trust Boards, CQC, Monitor and the NHS TDA should have regard to any evidence of responsibility for, participation in or permitting such conduct in any assessment of whether a person is a fit and proper person to hold an appointment as a director or equivalent in accordance with the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 regulation 5.			✓			✓

14.3	All organisations associated with the provision, oversight or regulation of healthcare services should have regard to any evidence of poor conduct in relation to staff who have raised concerns when deciding whether it is appropriate to employ any person to a senior management or leadership position and whether the organisation is well-led.			✓			✓
15.1	CQC, Monitor, NHS TDA, and NHS England should consider and consult on how such a post of an Independent National Officer (INO) might jointly be created and resourced and submit proposals to the Secretary of State as to how it might carry out these functions in respect of existing and future concerns.		✓	✓			
16.1	CQC, Monitor, NHS TDA in consultation with the Department of Health should work together to agree procedures and define the roles to be played by each in protecting workers who raise concerns in relation to regulated activity. Where necessary they should seek amendment of the regulations to enable this to happen.	✓		✓			
16.2	Healthcare professional regulators should review their procedures and processes to ensure compliance with the good practice set out in this report and with this Principle.				✓		
17.1	CQC should consider the good practice set out in this report when assessing how organisations handle staff concerns. Good practice should be viewed as a positive factor contributing to a good or outstanding rating as part of their well-led domain.			✓			
18.1	Professional regulators and Royal Colleges, in conjunction with Health Education England should ensure that all students and trainees working towards a career in healthcare have access to policies, procedure and support compatible with the Principles and good practice in this report.				✓	✓	
18.2	All training for students and trainees working towards a career in healthcare should include training on raising and handling concerns.					✓	
19.1	NHS England should include in its contractual terms for general/primary medical services standards for empowering and protecting staff to enable them to raise concerns freely, consistent with these Principles.		✓				

19.2	NHS England and all commissioned primary care services should ensure that each has a policy and procedures consistent with these Principles which identify appropriate external points of referral which are easily accessible for all primary care staff for support and to register a concern, in accordance with this report.		✓				✓
19.3	In regulating registered primary care services CQC should have regard to these Principles and the extent to which services comply with them.			✓			
20.1	The Government should, having regard to the material contained in this report, again review the protection afforded to those who make protected disclosures, with a view to including discrimination in recruitment by employers (other than those to whom the disclosure relates) on grounds of having made that disclosure as a breach of either the Employment Rights Act 1996 or the Equality Act 2010.	✓					
20.2	The list of persons prescribed under the Employment Rights Act should be extended to include all relevant national oversight, commissioning, scrutiny and training bodies including NHS Protect, NHS England, NHS Clinical Commissioning Groups, Public Health England, Healthwatch England, local Healthwatch, Health Education England, Local Education and Training Boards and the Parliamentry and Health Services Ombudsman.	✓					
20.3	The Government should ensure that its proposal to widen the scope of the protection under the Employment Rights Act 1996 includes all students working towards a career in healthcare.	✓					

Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Learning from the Morecambe Bay Investigation
Agenda ref. no:	14/15/120
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	25/03/2015
Presented by:	Dr Anushta Sivananthan, Medical Director – Executive Lead for Quality

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

Background – *contextual and background information pertinent to the situation/ purpose of the report*
The Morecambe Bay Investigation, chaired by Dr Bill Kirkup CBE, was an independent panel established by the Secretary of State for Health in September 2013 to investigate the management, delivery and outcome of care provided by the maternity and neonatal services of the University Hospitals of Morecambe Bay NHS Foundation Trust between January 2004 and June 2013. This was following concerns over serious failures of clinical care at one of the Trust's five sites – Furness General Hospital (FGH). The report was published on 5 March, concluding that the maternity unit at FGH was 'dysfunctional', led to unnecessary deaths of mothers and babies, and made 44 recommendations for the Trust and wider NHS. This report outlines the learning pertinent to CWP and the health systems which it works within.

Assessment – *analysis and considerations of options and risks*

Areas of learning that CWP needs to take into account are:

- Clarity of roles and responsibilities of clinical leads/ managers in the delivery of high quality care.
- Clarity about skills, knowledge, training and continuing professional development for all clinical staff.
- Ensuring improved incident reporting and management.
- Use of complaints/ concerns as a way to support improvement of care.
- Duty of candour and open reporting of external investigations into clinical service delivery.

Areas that CWP needs to work with its partners are:

- The delivery of services and recruitment of staff in areas that are rural/ isolated.
- Ensuring pathways of care for mothers and babies includes their mental health and wellbeing.
- Improving joint working across hospital and community sites.
- A focus on 'quality first' emphasised within contract negotiations with commissioning organisations.
- Working to deliver any new national requirements in relation to investigations, whistleblowing and professional regulation and duties in relation to clinical leadership.

CWP has made considerable progress in the areas outlined:

- The forward planning focus on continuous quality improvement, Zero Harm and organisational development has included the above thematic areas. These enable staff to deliver high quality care and provides clarity about the roles and responsibilities of staff. This includes clinical and professional leads who have worked over the past year, and continue to do so, within each locality to influence clinical strategy including joint pathways and working.
- Workforce metrics such as essential learning is showing continuous improvement.
- Reporting of incidents has shown a positive trend of reporting low and no harm incidents. The embedding of Human Factors into investigation of incidents and training of staff will lead to improved care.
- Each locality holds joint quality meetings with its commissioners to ensure a 'quality first' emphasis.
- The Board business cycle ensures that learning from experience (this includes complaints), strategic risk management (this includes recruitment difficulties) and quality of care are reported in public to ensure accountability in these areas.

The themes from the Investigation report will be discussed with commissioners as part of ongoing contract development and negotiations to promote a focus on safe and effective care that delivers good patient experience.

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

The Board of Directors is asked to **endorse** that CWP should continue to include the broad themes for the wider NHS identified by the Morecambe Bay Investigation into its existing operational and forward strategic plans as they relate to developing a culture of learning and continuous quality improvement.

Who/ which group has approved this report for receipt at the above meeting?		Dr Anushta Sivananthan
Contributing authors:		David Wood, Associate Director of Safe Services
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	A Sivananthan to D Wood	13/03/2015
2	D Wood to L Brereton for Board of Directors	17/03/2015

Appendices provided for reference and to give supporting/ contextual information:	
Appendix no.	Appendix title
N/A	N/A

Document Reference (2014/15)	Feb-15

Date of Meeting: 18th February 2015

Title of Report: CWP Performance Dashboard

Open Version

Action sought: **DISCUSSION & APPROVAL**

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

Presented by: Tim Welch, Director of Finance/Deputy Chief Executive

The Board are asked to:

Note:

1. The Continuity of Services Risk Rating for December 2014 remains at 4.
2. Trustwide CIP performance has worsened in January to £417k behind year-to-date target. Remedial actions continue.
3. Performance for all Monitor indicators is above target.
4. Sections of this new-format dashboard remain in development and work is ongoing to provide all data. Items remaining in development (estimated dates of availability in parenthesis):

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

5. A new Clinical Strategies section is now provided in the dashboard, detailing locality performance against various proxy measures intended to assess progress in the implementation of each locality's clinical strategies. This remains in development and will evolve over time as feedback is received. Tolerance levels have now been introduced.
6. Live data from ESR is now available to the Trust, and development is underway to obtain the various Workforce and Essentials 1 indicators using real time, which will ensure that data can be provided for the most recent month, rather than a month behind as at present - this month (January's) report contains December ESR data, and not January's. Real time reporting is expected to commence by March 2015.
7. Waiting time reporting is currently being provided for the services CWP provide which are subject to 18-week RTT reporting (Allied Health Professional-led services in CWP West Physical Health Services only). Over the next months, this will be developed to provide waiting time data for all services following the addressing of data quality issues. Following the recent governmental announcement of new waiting times indicators for Mental Health, work has commenced on providing the current Trust position on these indicators, and work has commenced to ensure full implementation with clinical services.
8. Overall compliance with new Essential 1 training has improved, to 84.8% for December (from 84.1% in November), but remains slightly below the 85% compliance target. Non-renewal and three-yearly training are both performing above target; annually-renewed training is below target, at 69.0%.

Discuss:

9. The Trustwide performance for sickness continues to increase, and is now at 7.18%, compared with 6.39% for November. The Trust tolerable threshold is 4.5%, and all three localities are significantly over target. CWP East and CWP Wirral are both at 7.77%. CWP West is at 7.75%. Clinical Support Services are at 4.30%. The majority of sickness is long-term. CWP Wirral is in the process of introducing the BlackLight attendance management system which is anticipated to help the locality improve its performance.

Strategic Objective(s) that this report covers:

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

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

Executive Director

Tim Welch, Director of Finance/Deputy Chief Executive

CWP Board Dashboard

Reporting Month: January 2015

Exception Reports

	Previous month	Current month	Trend
Monitor Targets - 7			
Finance			
Income & Expenditure			
CoSRR (Monitor Target)			
Cashflow			
Cost Improvement			14/15 value - £5.3m Plan to date - £3,907k Delivered - £3,490k Gap - £417k behind

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

	Bed occupancy rate	Number of closed wards	Ward staffing levels	
Previous Month	82.99%	2	Planned Shifts 6,774 Actual 6,402	**94.51%**
Current Month	82.25%	2	Planned Shifts 7,225 Actual 6,909	**95.63%**
Trend				

Number of people waiting	Average Wait	Maximum wait (no. of people)
643	9.0 weeks	18 weeks (4 people)
508	6.4 weeks	18 weeks (2 people)
	Average wait	Max wait

CWP Board Dashboard

Reporting Month: January 2015

Exception Reports

Risks	Number of risks						Number of new risks added to register	Number of risks archived from register
	Red		Amber		Green			
	Current	Trend	Current	Trend	Current	Trend		
Strategic	10	→	5	→	0	→	0	0
Clinical Services	12	↓	42	↑	3	↑	3	0
Corporate Support	In development - being piloted by Performance and Redesign							

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

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

Infection Prevention and Control	Previous audit compliance	Current audit compliance	Trend
Infection Control	0/1 passed 91% average compliance	1/1 passed 98% average compliance	↑

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

Board Dashboard - Glossary

Back to top

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

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

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

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

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

CWP Objectives

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

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Research Strategy 2015 - 2018
Agenda ref. no:	14/15/123
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	18/03/2015
Presented by:	Dr Faouzi Alam, Medical Director

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	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*
This report sets out a proposed Research Strategy for CWP from 2015 – 2018. The strategy provides an overview of the national context to research and the current research activity at CWP. The strategy identifies a number of strategic priorities for the next three years and a delivery plan for implemtation of the strategy moving forward.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
Research is important. It can provide benefits to patients, clinicians and NHS Trusts. The UK Government is committed to developing a research led NHS culture which is world class, attracts, supports and retains the best people, provides the appropriate infrastructure and delivers evidence to support health and social care service design and delivery. To this end 15 Academic Health Science Networks (AHSNs) have been set up to work in collaboration with co-terminus Collaboration for Leadership in Applied Health Research and Care (CLAHRCs) to improve the health and wealth of the nation through research. All NHS organisations ae expected to contribute to realising this vision.

Assessment – *analysis and considerations of options and risks*
The research vision for CWP is “To develop a culture within CWP which encourages all clinicians and patients to be aware of, and have access to, the best research and evidence to facilitate the highest quality care.” As part of the wider NHS, CWP needs a clear research strategy to: • Raise the profile of CWP research internally and externally • Strengthen links with external partners • Secure external funding from academia and/or industry underpinned by objectives which focus on: • Research leadership

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
That this research strategy is approved and its implementation supported by the Board of Directors

Who/which group has approved this report for receipt at the above meeting?	Dr Faouzi Alam
Contributing authors:	Dr Faouzi Alam, Dr Pat Mottram, Claire James, Dr Chris Link

Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1.	CELF	18/02/15
2	Operational Board	18/03/15

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail* *Do not embed appendices, these should follow this report*	
Appendix number	Appendix title
1	Annual delivery Plan 2015/16

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

CWP Research Strategy 2015 – 2018

1. Introduction

Research can provide benefits to patients, clinicians and NHS Trusts.

Research is important to CWP for the following reasons:

- Research is the source of evidence for improvements and innovation. The Trust wishes to be at the forefront of implementing evidence-based practice.
- Research highlights best practice and identifies areas for improvement
- Staff retention and training; staff are up-skilled as they get involved in research.
- Research links directly with patient experience
- The Trust's reputation increases as research grows; publications and our researchers put the Trust in the public eye.
- We aim to be a centre of excellence; this is our biggest goal. We will be able to attract more commercial research and will be a point of reference for other centres.
- Research is an income-generating activity; in a time when Cost Improvement Projects are high on the agenda, grants, clinical trials and other commercial sponsored activity bring significant resources to the Trust. New models of working can also save money.

This document provides an overview of current research activity at CWP and sets out the strategic priorities for the next three years.

2. National context

"Health research matters to each and every one of us. It underpins the quality of our health and care services and makes a vital contribution to health outcomes and our quality of life. All of us have the high expectation that we will be offered cutting-edge treatment and world class care when we, or our friends, or family are ill and vulnerable. Delivering the best possible health and care relies on having the best possible research evidence".

Dame Sally Davies NIHR annual report 2011

The Government is committed to enhancing the contribution of research to health and social care. Its vision is to improve the health and wealth of the nation through research. Research is essential to the successful promotion and protection of health and wellbeing, and also to provision of modern, effective health and social care services. The Department of Health has set out a number of strategic goals to support this ambition:

- Establish the NHS as an internationally recognised centre of research excellence
- Attract, develop and retain the best research professionals to conduct people based research
- Commission research focused on improving health and care
- Strengthen and streamline systems for research management and governance
- Act as sound custodians of public money for public good.

and expects that by 2019 there will be:

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- a thriving research culture within the NHS
- Fairness of access across England for patients and health professionals to take part in multi-centre studies
- More patients and health professionals participating in health research with high-quality protocols and early access to new intervention and prevention strategies
- Increased industry investment in clinical research in the NHS
- The National Programme for IT transforming our ability to recruit patients to clinical trials and gather data to support work on the health of the population and the effectiveness of health interventions
- The best research and researchers winning grants regardless of location
- Researchers working in a supportive environment to help them through the regulatory framework and conduct research relevant to the needs of patients and the population
- The NHS recognised for taking an international lead in supporting a research-led culture for health
- Researchers and healthcare professionals proud to say that they work in a research-led and evidence-based NHS
- Health and healthcare improved by research evidence.

The NHS Constitution states that the NHS "works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most." Across the NHS staff are identifying innovations and discovering new ways of treating patients which lead to better outcomes and improve the health of the population.

Innovation Health and Wealth is the NHS Chief Executive's report on the identification, adoption and spread of innovation in the NHS. It was launched by the Prime Minister in December 2011 and sets out the contribution that the NHS can make to the Government's Plan for Growth. Innovation and research is stated to be a priority for NHS England. However *Innovation Health and Wealth* describes the gap between the invention of new ideas and identification of best practice and their adoption and spread. Great innovations are often implemented quickly in one or two places but in the NHS, as in other health care systems, diffusion is slow, often taking many years.

Innovation, health and wealth: one year on, published in December 2012, sets out how the NHS plans to encourage more innovation and better implementation. *Innovation Health and Wealth* concluded that there was the need for "a more systematic delivery mechanism for diffusion and collaboration across the NHS by building strong cross boundary networks". Thus it specifically recommended that the NHS Chief Executive and the Chief Medical Officer should work with partners to designate Academic Health Science Networks (AHSNs) that will "align education, clinical research, and informatics, training and healthcare delivery." It states "their goal will be to improve patient and population health outcomes by translating research into practice and developing and implementing integrated health care systems". The report says that "every local NHS organisation should aspire to be affiliated to its local AHSN, which would act as a high quality, high value gateway for any NHS organisation needing support or help with innovation, and provide industry with focused points of access to the NHS."

In April 2014 the NHS established 15 (AHSNs). These networks will help local NHS services find the research and informatics, services, education and training they need to be innovative. An AHSN provides a systematic delivery mechanism for the local NHS, universities, public health and social care to work with industry to transform the identification, adoption and spread of proven innovations and best practice. It is a partnership organisation in which the partners are committed to working together to improve the quality and productivity of health care resulting in better patient outcomes and population health. The AHSN aims for universal participation by bringing together a range of organisations that are primarily focused on a defined geography, including clinical commissioning groups and providers of primary, community, secondary and tertiary NHS funded services in a defined area and higher educational institutions active in health care to work with other partners, especially

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industry and local government. The AHSN will need to develop links with levers and functions that benefit from and support innovation including research, education and training, service improvement, wealth creation and information.

CWP has identified a Communication Lead and an Innovation Lead to be formal members of the North West Coast Academic Health Science Network.

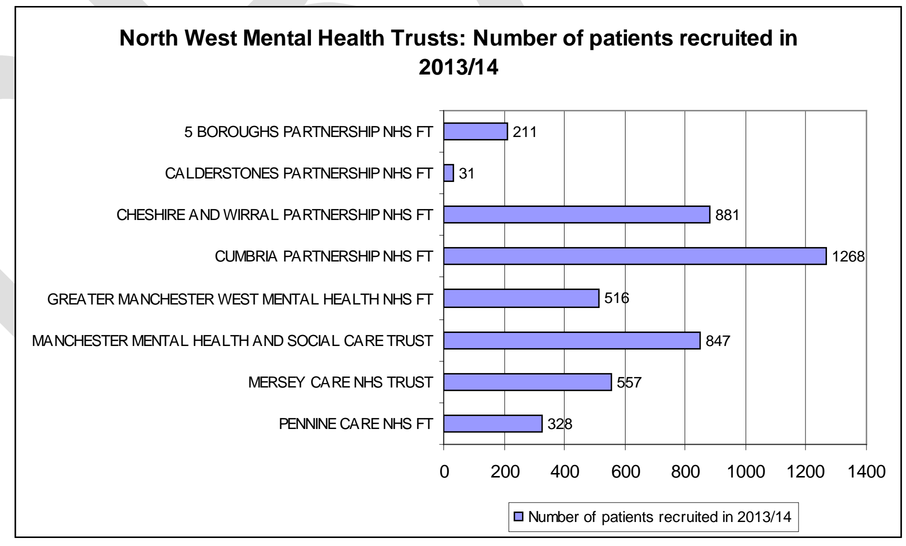
Research can involve an element of risk, both in terms of return on investment and sometimes for the safety and wellbeing of the research participants. Proper governance of research is essential to ensure that the public can have confidence in, and benefit from, quality research in health and social care. The public has a right to expect high scientific, ethical and financial standards, transparent decision making processes, clear allocation of responsibilities and robust monitoring arrangements. *Innovation Health and Wealth* describes three reasons why innovation and adoption at pace are important not just to the NHS but to society and the economy as a whole:

- Innovation transforms patient outcomes;
- Innovation can simultaneously improve quality and productivity;
- Innovation is good for economic growth.

As a Foundation Trust within the NHS, CWP needs a clear strategy to support these ambitions at a local level.

3. Current research activity in CWP

CWP is already a leading recruiter to NIHR portfolio studies (see recent annual research report approved by Board of Directors in November 2014) and will seek to enhance this position. The table below indicates the ranking of all mental health Trusts in the northwest of England in terms of contribution made to NIHR portfolio studies:

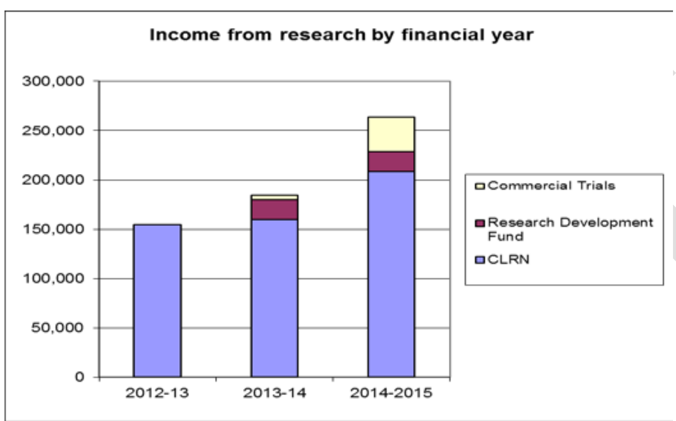


This clearly demonstrates that CWP is currently ranked 2nd. The national target for approval of NIHR studies is 30 days. On average CWP achieved approval in 15.8 days.

In addition to portfolio studies, last year CWP staff were involved in undertaking 39 non portfolio studies, the majority of which contributed to staff gaining higher degrees. A member of the CWP

Research team specialises in supporting new researchers as it is considered important that all studies reach the same standard of research governance as the larger portfolio studies as many are potential source of ideas for future research.

Research is also important as it attracts funding. The research funding to CWP is dependent on the number of subjects recruited into NIHR studies. The growth in income generated by research in CWP in recent years is indicated in the graph below:



4. Assessment of current position

The Trust has undertaken an assessment of current strengths and weaknesses, and opportunities and threats, via one to one discussion with research active staff and via the Clinical Engagement and Leadership Forum (CELF). The results have influenced the recommended goals for a new Research and Development strategy.

Strengths	Weaknesses
• Support for Research from the Trust's Board of Directors. Research is one of the Trust's strategic objectives, and is high on the agenda. An Executive Director carries research within his portfolio. • Our patient pool; large population of patients all of whom could be future recruits to clinical trials. A pool of potential research subjects has already been identified through the "consent to consent" initiative in which interested patients attending CWP services express their interest in being contacted should suitable research opportunities arise. • Motivated team of clinicians • Participation in local, regional and national research networks, which facilitates collaborations and opportunities • The provision of an Integrated Provider Hub (IPH) in Western Cheshire which affords the opportunity to exploit programme budgeting.	• Lack of current profile of research within the trust's governance structure and locality performance meetings. • Not enough time allocated for research among clinicians, managers and other staff; clinical commitments will interfere with research • Lack of interest among staff; perception that research is "something else to worry about" • The lack of an up to date research strategy. • Lack of understanding of the number of posts within the organisation which have research identified as a key element of the job description. • Lack of understanding of how the supporting programmed activities (SPAs), which form part of each consultant's job plan, are utilised.

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Opportunities	Threats
• Collaboration with the Countess of Chester Hospital and the Centre for Integrated Healthcare Science (CISH) sited at Bache Hall • The significant income from the Comprehensive Research Network (CRN) over the last few years; important at a time when funding is becoming scarce • The national push for industry-sponsored trials; we have a good track record and relationships already established with key players • Collaboration with the University of Liverpool, particularly in the area of clinical trial management • The potential to undertake studies which follow patients from acute into primary care and vice versa. • Attract and retain high quality staff via enhanced research profile • Involvement of service users and carers in research and evaluation activities	• Competition from other local Trusts for hosting clinical trials, which could impact on overall activity, reducing our research portfolio and the number of patients recruited. • Difficulty in attracting staff with relevant research experience • Targets set up by the National Institute for Health Research which are not understood or prioritised by staff • Although the research budget has been ring-fenced nationally, there is no security that it will continue after 2014 • Research regulations; although there is a trend for streamlining the research approval process, some staff prefer not to embark on research due to what they see as "bureaucracy"

5. Vision

To support this national and local context, the trust is committed:

"To develop a culture within CWP which encourages all clinicians and patients to be aware of, and have access to, the best research and evidence to facilitate the highest quality care."

6. Strategic Priorities

CWP aspires to become an increasingly strong partner in conducting and implementing research to improve outcomes in mental health and community services. CWP will build on the strong foundations identified via the SWOT analysis to raise awareness of research and develop a research culture within CWP.

Three key strategic priorities have been identified, and will be addressed during the next 3 years.

Priority 1 **Raise the profile of CWP research internally and externally**

Priority 2 **Strengthen links with external partners**

Priority 3 **Secure external funding from academia and/or industry**

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7. How are we going to get there?

Priority 1: Raise the profile of CWP research internally, and externally

Leadership

Strong leadership will be critical to success of the strategy. CWP's Research Team is part of the "Effective Services" portfolio and the team structure is currently being reviewed to ensure that there is a strong alignment between research and development and service development, business objectives and service evaluation.

Research capability and capacity

Research and development will not happen without the support of staff and service users. The Trust is committed to developing staff to have both the skills and time in order to become skilled in undertaking research, or through continuing professional development, working to implement the findings of research.

This vision is shared by the National Institute for Health Research (NIHR) which allocates Research Capability Funding (RCF) to research-active NHS organisations to enable them to maintain research capacity and capability. It does this by enabling NHS organisations to meet some, or all of the research-related component of the salary of their researchers and research support staff working on clinical and applied health research, where that component is not already provided by another funding source and to support the salaries of their researchers, particularly NIHR Faculty members, in a flexible and strategic manner. This helps NHS organisations to create and maintain a sustainable capacity for people and patient-based research. It facilitates success in attracting NIHR research grants and other funding, leading to future allocation of RCF – a virtuous circle. NIHR RCF aims to help research-active NHS organisations to act flexibly and strategically to maintain research capacity and capability and supports the appointment, development and retention of key staff undertaking patient-based research. In addition, it contributes towards the costs of hosting research funded by the NIHR, or its funding partners, that is not currently fully covered across NIHR's programmes, and that are not met in other ways. CWP receives £20K annually for recruiting more than 500 subjects into NIHR portfolio studies and funding for the research team salaries (4.6 wte) of £200k. Having staff act as Principal Investigators also attracts funding.

In addition, raising the profile of research within CWP will come from:

- Ensuring that all staff have a good knowledge of research to create a vibrant research culture across the Trust
- Working towards developing centres of excellence in research in specific Trust services
- Developing specific Trust clinical staff to become national and world class investigators with their own research profile and grants
- Working towards clearly linking Trust research activity with clinical outcomes and developments
- Embedding research capacity building into forthcoming changes to services and new initiatives in the Trust from an early stage

Research systems

The Government *Plan for Growth* published in March 2011, announced the launch of the NIHR Research Support Services (RSS) framework, a set of tools and guidelines to support a consistent and streamlined approach to managing health research studies in the NHS. The RSS framework was developed in collaboration with a wide range of stakeholders, including senior R&D managers and

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investigators, who identified research processes that could be speeded up or simplified and steered working solutions to help overcome problems.

The RSS framework can help providers of NHS services to start research studies more efficiently and is relevant for everyone who shares the government's wish to see a dramatic and sustained improvement in the performance of providers of NHS services in initiating and delivering clinical research. The aim is to increase the number of patients who have the opportunity to participate in research and to enhance the nation's attractiveness as a host for research.

Using the framework starts with the Chief Executive or Board agreeing and publishing a clear statement setting out the organisations capability to undertake research. It aims to help providers of NHS services meet the benchmark in new NHS contracts for recruiting the first patient to clinical trials and to organise themselves to have the capacity to manage trials from end to end, helping them deliver to time and target.

CWP does not currently have an operational capability statement. This will need to be developed to underpin the Trusts' commitment to becoming more active in the field of research.

Research into practice

The task of keeping up to date with the literature on a given subject can be daunting, particularly as many areas of health and social care generate hundreds of new journal articles every month. On many occasions NHS staff just want the headline, "need to know" information about a piece of research. The Trust will need an accessible overview of the most important implications and conclusions of a piece of research and provide links to further, more in-depth information and references for further reading.

Library services are essential to facilitate access to research literature and resources, including on-line journals. The Trust Library Service provides a range of services to support research, including:

- Carrying out literature searches on behalf of staff
- Provision of a range of books related to research and writing for publication
- Document supply to obtain articles, books or other material from elsewhere
- Providing information skills training, including critical appraisal skills and searching healthcare databases

The Trust will continue to provide access to a range of evidence, make this evidence available, and encourage its uptake and use, for example, through NHS Evidence (which provides clinical and non-clinical evidence and best practice), to make informed decisions.

Service User and Public involvement

CWP already has a good reputation and history of service user involvement including the consent to consent initiative through which patients regularly receive a newsletter and an invitation to the Trust's annual research conference. Involving patients and members of the public in research can lead to better research, clearer outcomes, and faster uptake of new evidence. The Trust, working with and in partnership with partners encourages patients and the public to be actively involved in all health and social care research to:

- Set research priorities;
- Identify the important questions that health and social care research needs to answer;
- Give their views on research proposals alongside clinicians, methodologists, scientists, and public health and other professionals;
- Take part in clinical trials and other health and social care research studies, not just as subjects

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but as active partners in the research process;
- Publicise the results.

Priority 2: Strengthen links with external partners

Partnership with others

CWP is actively engaged in the development of the "Centre for Integrated Healthcare Science" (CIHS), a multiprofessional and multidisciplinary research environment that promotes and supports high quality research in Chester which opened at Bache Hall on the Countess of Chester hospital site in February 2015. The aim is to deliver a centre of excellence that delivers and supports high quality healthcare research to the Countess of Chester Trust and its partners. The centre will be used for research, education and innovation with a "Partnership Board" to oversee work streams which includes support from the Local Authority. It is intended to develop and deliver undergraduate and postgraduate courses at Bache Hall and the aim is to be self-sufficient in 5 years.

The stated mission is

"To improve the health of our local population through high quality research"

The goals of CIHS are to:

- Develop the capacity to conduct high quality research that is
    - Multidisciplinary and multiprofessional
    - Locally relevant and translates into real and immediate benefits
    - Nationally and internationally significant
    - Develops and attracts the best healthcare researchers
- Create an environment that nurtures and develops research by
    - Embedding research and innovation into the core values of our trust
    - Creating the capacity for individuals to pursue high quality research
    - Encouraging partnerships and collaborations with surrounding institutions (educational, NHS, industry)
    - Recognising and rewarding high quality research
    - Benchmarking standards for research and innovation alongside other quality markers of healthcare (eg. Clinical outcomes, governance)
- Create a research environment that ensures all people are able to access research by
    - Integrating seamlessly with primary and tertiary care partners
    - Promoting healthcare promotion at a community level
    - Aligning our healthcare strategy with regional and national strategies (e.g. Connecting Care across Cheshire)

There are a number of potential partners for this endeavour, it is acknowledged that some will play a greater role than others, but all partners will support the vision to deliver high quality research to the local population (those in italics are to be confirmed):

- University of Chester
- West Cheshire Clinical Commissioning Group

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- Cheshire and Wirral Partnership NHS Foundation Trust
- National Institute for Health Research
- University of Liverpool
- Liverpool John Moores University
- Research Design Service
- Northwest Surgical Trials Unit
- North West Coast Academic Health Science Network

Identified strengths include geography (The CIHS is geographically placed at the centre of the M53 corridor, south of the Mersey River. The nearest academic medical institutes of Liverpool and Manchester are both more than 25 miles away and neighbouring trusts have not chosen to develop similar facilities) and the COCH and CWP are already established as leading recruiters for NIHR adopted trials:

Name	Trust Type	No. Recruiting Studies 12/13	No. Recruiting Studies 13/14	Interventional Recruiting Studies 13/14	Observational Recruiting Studies 13/14	Number of patients recruited
Cheshire and Wirral Partnership	Mental Health & community	28	29	9	20	881
Countess of Chester Hospital	Acute	60	70	35	35	1037

http://www.theguardian.com/healthcare-network-nihr-clinical-research-zone/table/nhs-trust-research-activity-league-table-2013-14

The CIHS will provide a range of training opportunities for those wishing to get involved in research activity including coaching, mentoring, informal and formal workshops and training courses.

In addition, CWP has a number of well-established collaborations with local academic centres. For example, plans are already underway for a joint application for research funding for a programme of research between the University of Chester and CWP and a Wellcome small Arts grant between Staffordshire University and CWP was submitted at the end of 2014. In addition the University of Chester has offered to collaborate with CWP to deliver a series of 6 monthly seminars during the first half of 2015 for CWP staff interested in research. These seminars are aimed at clinicians from CWP, the Local Authority, the University of Chester and West Cheshire Clinical Commissioning Group. The series title is *How to turn a work place 'good idea' into a Research Project and Publication!* The programme is designed to upskill staff, as follows:

1. An introduction to the research process: Is your idea really novel? What is already known about the subject, how to research it and generate a literature review, how to refine the question, what will your idea contribute to the field?
2. How to develop a research protocol: setting objectives, appropriate outcome measure etc.
3. A simple guide to statistical methods; sample size calculations, appropriateness of statistical tests etc.
4. A simple guide to qualitative methods with examples of analytical methods.
5. How to get your original research published in a peer reviewed journal.
6. How to apply for research funding; what are the national research priorities for health, how is NIHR structured, who holds the money (in the UK and Europe), what is the application cycle?

CWP research staff have also been invited to have a representative on the University's Research Committee and the University's ethics committee. This will strengthen the links between CWP and the University. The collaboration between the CISH and CWP will put structures in place that will help

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people take part in all stages of NHS research.

Working with industry

The government is determined to make the UK the best place in the world for health research, development and innovation. CWP, with our partners in health research, wants to work to turn this ambition into a reality. The Trust is working with academic and health partners to create the best possible research environment and build a reputation for excellence in research e.g. the collaboration with the Royal Liverpool Hospital Phase I clinical trials unit, work with the university, enviable record in recruiting to time and target for industry sponsored studies and undertaking feasibility studies on behalf of industry partners. There is still some way to go to realise these ambitions including capacity, capability, and vision. The NHS has a leading role to play in contributing to Britain's international competitiveness in health research. The National Institute for Health Research is aiming to develop the reputation of the NHS as a world-class environment for collaborative research in the public interest and establish the NHS as the preferred host for multi-centre clinical research in partnership with and for industry.

The NIHR is working with partners to create the best possible research environment in the NHS and build an international reputation for excellence in translational and applied research. Industry - devices, diagnostics, biotech and pharma (and associated Contract Research Organisations) - is involved at a strategic and operational level in initiatives to enhance the UK's clinical research environment.

Speeding up trial initiation and improving recruitment reliability are essential to the Trust’s status as an effective environment for industry research. Initiatives implemented to achieve these objectives include:

- The National Research Ethics Services (NRES), now part of the new Health Research Authority, which provides a single UK-wide ethical opinion and national panel of Research Ethics Committees assigned to review devices studies.
- Roll out of the Integrated Research Application System (IRAS), supported by the UKCRC partners, including the NIHR, which enables researchers to prepare and submit applications for regulatory, ethics and governance approvals using the same integrated on-line system.

Priority 3: Secure external funding from academia and/or industry

Supporting research within CWP will both generate income and require funding. Money for research is available from a variety of national and European sources. To maximise the financial impact of research within the Trust will require:

- Increasing the number of local studies and Trust-grown grant applications for funding
- Maximising research capacity and recruitment to time and target in all areas of the Trust by engaging with services and sponsors
- Implementing the principles of the National Institute for Health Research
- Maintaining and developing further links with national bodies and universities such as NIHR, academic departments within universities

This strategy will ensure that the Trust remains a strong partner in the delivery of the health service ambitions.

The proposed delivery plan for 2015/16 is detailed in Appendix 1. This plan will be refreshed on an annual basis.

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8. Evaluation, monitoring and updating

The above priorities will be the subject of regular monitoring and evaluation. Research will become an agenda item at each monthly locality Clinical Management Board (CMB). In addition an annual report will be provided to Trust board.

Appendix 1

Delivery Plan for 2015/16

Strategic priority	Focus	Action	Delivered by whom?	Delivered by when?
Raise the profile of CWP research internally, and externally	Research Leadership	To consider and make recommendation to Board of Directors about the Trust's research department structure	Claire James/Dr Chris Link/Dr Faouzi Alam/Dr Pat Mottram	April 2015
		Identify research active, motivated staff across the Trust to 'champion' research	Claire James/Dr Chris Link/Dr Faouzi Alam/Dr Pat Mottram	June 2015
	Research capability and capacity	Recruitment of 500 subjects to NIHR portfolio studies	Dr Pat Mottram	March 2016
		Evidence of involvement in 45 non portfolio studies recorded in the EDGE database	Dr Pat Mottram/Service Directors	December 2015
		Identify posts which have research included as a key element of the job description	Clinical Directors	June 2015
		Raise awareness of research during staff induction and training	Dr Pat Mottram & CWP Education	June 2015
		Gain better understanding of how the supporting programmed activities (SPAs), which form part of each consultant's job plan, are utilised	Clinical Directors	June 2015
		Increase the number of clinicians who have undertaken the training to be a principal investigator for research studies	Dr Pat Mottram/Faouzi Alam/Chris Link	March 2016
		Seek to increase the number of CWP staff involved in research year on year	Dr Faouzi Alam/Dr Chris Link/Claire James/Dr Pat Mottram	March 2016

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		Develop an operational capability statement to be agreed at Board of Directors	Dr Pat Mottram	September 2015
	Research systems	Development and implementation of systems to improve the dissemination of Trust research activity e.g. digital signage, research newsletter, computer wallpaper at log on.	Dr Pat Mottram/Chris Link/Claire James/Katherine Wright	June 2015
	Translating research into practice	Develop a quarterly e-newsletter for distribution to all staff	Dr Pat Mottram/Katherine Wright	June 2015
		Explore the potential to advertise a "study of the month" upon boot up of all Trust computers	Dr Pat Mottram	June 2015
		Communicate Trust research activity via "Sheena's blog" at regular intervals	Dr Pat Mottram	From June 2015
	Service user and public involvement	Routinely offer all service users the opportunity to "consent to consent" with a view to engaging more patients in research opportunities	Dr Pat Mottram	June 2015
		Advertise research opportunities for patients via digital signage in out patient waiting areas	Dr Pat Mottram	April 2015
		Continue to deliver an Annual Research Conference	Dr Pat Mottram	November 2015
Strengthen links with external partners	Working with industry	Commence recruitment to at least 3 industry sponsored studies	Dr Pat Mottram	December 2015
	Work in partnership with others	Ensure active involvement, including co-location of staff in the CIHS, Bache Hall, as appropriate	Dr Faouzi Alam/Dr Chris Link/Claire James/Dr Pat Mottram	June 2015
		Collaborate with the Clinical Research Unit at the Royal Liverpool Hospital on at least one phase I/II trial	Dr Pat Mottram/Dr Chris Link	December 2015 (Achieved)
		Deliver a series of workshops entitled *How to turn a*	Dr Chris Link/Prof Paul	September

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		work place 'good idea' into a Research Project and Publication! in collaboration with the University of Chester	Kingston/Sarah Carroll	2015 (Achieved)
Secure external funding from academia and/or industry	Work in partnership with others	Apply for external funding for a research programme in collaboration with the University of Chester	Dr Chris Link/Dr Sabu Oomman/Professor Paul Kingston	September 2015
		Apply for a small Arts Award from the Wellcome Trust to undertake a piece of research in the psychosexual service in collaboration with the University of Staffordshire	Dr Josie Butcher/Dr Chris Link/Dr Pat Mottram	January 2015 (Achieved)
	Monitoring	Continue to provide an annual research report to Board of Directors	Dr Pat Mottram	November 2015
		Research to become a standing item on the agenda for all locality performance reviews and clinical management boards	Pat Mottram/ Mandy Skelding Jones/Claire James	From June 2015
		Develop and roll out a feedback proforma to disseminate research findings	Claire James/Dr Chris Link	April 2015
		Annual measure of research awareness and activity amongst trust staff via survey monkey	Pat Mottram	November 2015

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References

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/139565/dh_4122427.pdf

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136579/dh_4127153.pdf

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Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	People and Organisational Development Strategy 2015-2020
Agenda ref. no:	14/15/124
Report to (meeting):	Trust Board
Action required:	Discussion and Approval
Date of meeting:	25/03/2015
Presented by:	David Harris, Director of HR 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	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	Yes
Which CQC quality of service domains this report reflects:	
Safe services	No
Effective services	No
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	No
Measurement	No
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
Click here to enter text.	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
Click here to enter text.	

REPORT BRIEFING

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

Th purpose of this report is to set out the Trust's People and Organisational Development (POD) Strategy for the next five years to the end of March 2020. It describes how the Trust will enable our people to be the best that they can be as they deliver the Trust's Strategic and Operational Plans, Zero Harm Strategy and the locality Clinical Strategies. In this way, the Trust will be the model employer for whom our people would want to work and will deliver safe, high quality and cost effective services for the population of Cheshire and Wirral.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
The document has gone through a number of iterations as a result of feedback from a variety of groups and individuals, including the Trust Board, Executive Directors, Operational Board, the People and Organisational Development Sub-Committee, Education CWP and the Communications & Engagement Team. It is based on research into high impact HR and Organisational Development interventions and on some emerging thinking within the Trust on a new integrated approach to culture change within complex systems. The 4 strategic themes and underlying areas of focus have been identified as being those aspects which could have the greatest impact on delivery of high quality, person-centred care through our people.

Assessment – *analysis and considerations of options and risks*
Like all good strategies this document will evolve as the Trust's approach to the development of its people adapts to the ever changing context. This will enable it to remain responsive to the needs of the Trust, to be sensitive to the changing landscape in which it operates, to provide clarity for people and organisational development decision-making, to respond to relevant risks and issues and to enable strategic focus for any choices to be made in relation to our people. An associated Delivery Plan will detail how the strategy will be delivered, over what timeframe, the outcomes that should be expected from each deliverable, and the evaluation methods for determining if these have been achieved. The first version of this Plan will focus on the timeframe running up to the CQC inspection.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board is asked to, i) Approve the People and OD Strategy, and ii) continue to provide input to and support for the POD Strategy as it emerges to meet the Trust's needs.

Who/ which group has approved this report for receipt at the above meeting?		Operational Board
Contributing authors:		David Harris
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	People and OD Sub Committee Operational Board	19th February 2015 18th March 2015

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

People and Organisational Development Strategy 2015 - 2020

10th March 2015
(Review by: 01/04/2016)
Version 1.0

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Introduction

The Cheshire and Wirral Partnership (CWP) NHS Foundation Trust's vision is of 'Leading in partnership to improve health and well-being by providing high quality care'.

This document sets out the Trust's People and Organisational Development (POD) Strategy for the next five years to the end of March, 2020. It describes how the Trust will enable our people to be the best that they can be as they deliver this vision for the population of Cheshire and Wirral. In this way, we will be the model employer for whom our people would want to work and will deliver safe, high quality and cost effective services for the population of Cheshire and Wirral.

Background and Context

In October 2014, the NHS published its Five Year Forward View. In this view, it is recognised that the NHS' values have not changed, but that the world in which it operates has. It *'…sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health.'*

The Forward View argues that, *'...to sustain a comprehensive, high quality NHS, action will be needed on... three fronts – demand, efficiency, and funding.'* Without this, ever-widening gaps will be created. These will be the Health and Wellbeing gap, the Care and Quality gap and the Funding and Efficiency gap. One of the actions the NHS is taking in order to support work on these three fronts is to support a modern workforce. The View states that, *'Health care depends on people…. We can design innovative new care models, but they simply won't become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it.'*

The Trust also has a clear commitment to delivering recovery oriented services that value the expertise available from service users and carers themselves. This means focusing on enabling people to be the best that they can be and, in this context, the Trust demonstrates its focus on Care, Wellbeing and Partnership. These three tenets are at the centre of everything we do.

The Trust's Vision is of:

'Leading in partnership to improve health and wellbeing by providing high quality care.'

This vision is underpinned by seven strategic objectives:

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

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Against this backdrop, the Trust is keen to demonstrate its emphasis on the quality of service to patients and carers and to highlight the qualities it looks for in its staff. For this reason, and in response to learning from the Francis public enquiry, the Trust has adopted the Department of Health's 6C's as its values in June 2013.

The Trust's Values are:

- Care
- Compassion
- Competence
- Communication
- Courage, and
- Commitment

Quality is fundamental to the Trust's vision and quality improvement priorities have been set in the domains of patient safety, clinical effectiveness and patient experience. The focus of these is on 'continuously improving care delivery to reduce error and harm'. This responds to Professor Don Berwick's review into patient safety in the NHS in which he calls for a culture of 'zero harm'. In January 2014, the Board of Directors approved continuous improvement plans to help deliver the ambitious challenge of achieving a culture of 'zero harm' and in doing so endorsed them for the following three to five years. The quality improvement priorities will therefore remain unchanged for at least the next two years. The Trust appreciates that, to enable excellent care, its people need to have the right values, skills and training.

The Trust employs approximately 3,400 staff and has 15,000 Foundation Trust members. Principally, the Trust operates across three local authority areas and works with five Clinical Commissioning Groups (CCGs) and four acute hospital trusts.

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People and Organisational Development Strategy

As an enabler of the Trust's Strategy and Operational Plan, the overall aim of the People and Organisational Development Strategy is:

'To enable our people to be the best that they can be.'

This fits directly into the Trust's third Strategic Objective (SO3) to, 'Be a model employer and have a caring, competent and motivated workforce.' This also impacts the achievement of the other strategic objectives by the way in which it supports and engages people achieving results in these areas.

To help us to achieve this objective, we have identified **four key 'strategic themes'**:

- **Our People**
  - We attract and develop skilled, knowledgeable and innovative people who live out our Values

- **Our Leaders and Our Managers**
  - We encourage all our people to lead; we enable those who manage our people to do so with confidence and ability

- **Our Environment**
  - We provide a workplace in which people can be at their best

- **Our People Services**
  - We support our people with expertise and advice they can trust

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Focus areas for the delivery of the strategic themes

For each of the key strategic themes, a number of focus areas have been identified. These will be delivered through an annual People and Organisational Development Delivery Plan, which will identify the main tasks, milestones, resource implications and requirements for achieving each area.

Our People

We attract and develop skilled, knowledgeable and innovative people who live out our Values

- Our Values are embedded throughout the organisation
- Our Education strategy ensures professional development that meets the needs of our people and supports our culture, vision and values
- Our people work effectively in partnership
- We have the right number of people with the right skills, values, and behaviours
- We have a commitment to our corporate and social responsibilities
- Performance management focuses on individual performance, behaviour and improved user experience of our services

Our Leaders and Our Managers

We encourage all our people to lead; we enable those who manage our people to do so with confidence and ability

- All our people are encouraged to be leaders and to take responsibility for helping the Trust to achieve its vision
- Opportunities are provided to strengthen the capability and confidence of our managers and to drive people management as a profession within the Trust
- Our managers identify appropriate opportunities to develop our people so that they can be the best that they can be
- Our management of people focuses on clarifying expectations and enabling them to fulfil their potential

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Our Environment

We provide a workplace in which people can be at their best

- Our systems and processes are continually reviewed to ensure they enable rather than hinder our activity
- We take account of human factors when addressing system issues
- We provide our people with the opportunity to seek continuous improvement in their activities
- Our Health & Wellbeing Strategy ensures we provide an environment that promotes the health and wellbeing of our people
- We value the diversity of our people, recognising that everyone has a unique contribution to make through their skills, knowledge and experience

Our People Services

We support our people with expertise and advice they can trust

- Our People Services' teams deliver on their commitment to meet the needs of our service users
- Appropriate and timely information is provided to enable effective planning and decision-making
- Our managers apply policies that reflect the needs of our people and the Trust, are accessible to all, and are supported by our People Services teams
- The systems we use are clear and enable self-service
- Our People Services' structure, roles and responsibilities are clear and based around users' needs

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Governance

Progress against these strategic focus areas will be monitored and evaluated through CWP's governance structure as follows:

Body	Monitors and Evaluates
Operations Board	Provides assurance on strategic workforce priorities, risks and the overall delivery of the People and Organisational Development Strategy. The key duties of this group are: • Ensuring that the decisions of the Board of Directors are implemented • Monitoring the operational performance of the Trust • Steering early development of policy, strategy and business case proposals prior to full discussions at the Board of Directors
People and Organisational Development Sub-Committee	Ensures the operational delivery of the strategic focus areas of the People and Organisational Development Strategy. Manages our People risk. Also ensures links to decision-makers across the localities and within the Trust Head Office – including Communications and Engagement, Performance and Redesign, and Safe Services
People Planning Group	Ensures that we have accurate and meaningful information from which to assess our People risk. Implementation and use of ESR, Health Roster, Blacklight and other associated systems.
Health and Safety Group	Manages health and safety risk and delivers our Health and Safety Strategy.
Equality and Diversity Group	Ensures the delivery of the Trust's Equality and Diversity objectives.
People Services Improvement Programme	Ensures that our People Services meet the needs of our people both now and in the future. Delivers the People Services Improvement Programme.

Evaluation

Core metrics will be used to assess progress in the delivery of the Strategic Plan and achievement against the strategic focus areas. These include:

- Feedback responses from the Staff Survey
- Feedback responses from the Staff Friends & Family Test
- Action taken in response to Staff Survey findings
- Actions taken against the Investors in People Recommendation Plan
- Staffing levels
- Staff sickness
- Recruitment lead times

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- Payroll accuracy
- Staff turnover
- Appraisal rates
- Mandatory training received
- Staff satisfaction with training
- Use of bank and agency staff
- Delivery of outcomes within the Education CWP Strategy, People Services Improvement Programme and Wellbeing Strategy

The exact metrics to be used will be defined in the delivery plans for the Strategy and reported against by each of the identified bodies in the governance structure.

Through the execution of this strategy, we will enable our people to be the best that they can be, we will achieve our objective of being a model employer with a caring, competent and motivated workforce and we will thereby lead in partnership to improve the health and wellbeing of the population of Cheshire and Wirral by providing high quality care.

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References

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

NICE Guidelines on Workplace Health, July 2012
http://www.nice.org.uk/advice/lgb2/chapter/introduction

The Francis Report: Public Enquiry into Mid Staffordshire NHS Foundation Trust, February 2013
http://www.midstaffspublicinquiry.com/report

CWP's three tenets of Care, Wellbeing and Partnership mean we pride ourselves on:

- Openness, respect and partnership working with all stakeholders and local communities
- A strong commitment to improving the service user experience and promotion of a recovery culture
- Encouraging creativity, innovation and challenging traditional boundaries
- Recognising the contribution of staff and aiming to provide a supportive, flexible working environment
- Embracing diversity and challenging prejudice and discrimination wherever this affects our service users, staff and communities
- Ensuring effective stewardship of public resources acting in the wider public interest

A promise to learn – a commitment to act. Improving the safety of patients in England
Professor Don Berwick, National Advisory Group on the Safety of Patients in England, August 2013
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

NICE: National Institute for Health and Care Excellence
NHS trusts failing to support staff health and mental wellbeing
http://www.nice.org.uk/news/article/nhs-trusts-failing-to-support-staff-health-and-mental-wellbeing

Keogh Mortality Review, July 2013
http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx

Working for a Healthier Tomorrow, Review of the Health of Britain's working age population, Dame Carol Black, March 2008
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209782/hwwb-working-for-a-healthier-tomorrow.pdf

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Appendix

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Cheshire and Wirral Partnership
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Appendix 1

People and Organisational Development Strategy 2015 – 2020

Leading in Partnership to improve health and well-being by providing high quality care

Be a model employer and have a caring, competent and motivated workforce

'To enable our people to be the best that they can be'

Our People
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CARE COMPASSION COMPETENCE COMMUNICATION COURAGE COMMITMENT

Care • Well-being • Partnership

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STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Changes to Standng Financial Instructions (SFIs)
Agenda ref. no:	14/15/125
Report to (meeting):	Board of Directors
Action required:	Endorse approval by other group
Date of meeting:	25/03/2015
Presented by:	Tim Welch, Director of Finance

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

REPORT BRIEFING

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

To inform the Board of Directors of a proposed amendment to the Standing Financial Instructions (SFIs) to take into account the new electronic tendering system and an amendment to the rules to waive tendering. This amendment was approved by the Audit Committee at the March 2015 meeting.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
The amendment to the Standing Finanical Orders (SFIs) will allow single tender waiver actions and will clarify when it is possible to waive tendering altogether, therefore potentially reducing the number of waivers going forward. The changes also allow for the Trust to only use electronic tendering procedures, to be known as e-procurement. The Head of Procurement, or authorised member of staff, will use e-procurement to conduct any tendering exercise or enter into any contract using e-tendering.

Assessment – *analysis and considerations of options and risks*
The Standing Financial Orders (SFIs) reflect the move from manual tendering processes to e-tendering which is in line with the governments and Trusts e- procurement strategy. The changes are set out in the Corporate Governance Manual from p.81.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors are recommended to approve the changes to Standing Finanical Instructions (SFIs)

Who/ which group has approved this report for receipt at the above meeting?		Audit Committee
Contributing authors:		Stephen Wilson, Head of Procurement. Andy Harland, Deputy Director of Finance
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
Click here to enter text.	Click here to enter text.	Click here to enter text.

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1	Corporate Governance Manual - updated March 2015 - T:\01. BoD Committees\Board of Directors\Meetings\2015\150325

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	CQC MHA and MCA Annual Reports and new MHA Code of Practice 2015
Agenda ref. no:	14/15/126
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	25/03/2015
Presented by:	Dr Anushta Sivananthan, Medical Director – Executive Lead for Quality

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	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	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	Yes
Risk of breach of Trust Provider Licence as a result of external scrutiny	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	
N/A	

REPORT BRIEFING

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

This report is to inform the Board of Directors of the:

- Key findings of the CQC Monitoring the MHA annual report 2013/14 (February 2015).
- Key findings of the CQC Deprivation of Liberty Safeguards (DoLS) annual report 2013/14 (January 2015).
- Changes in the new MHA Code of Practice 2015 to be implemented with effect from 1 April 2015.
- Recommended actions for CWP to ensure learning from these reports is disseminated Trustwide and that the changes in the new Code of Practice are implemented effectively.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
The Care Quality Commission's primary role is to provide a safeguard to individuals whose rights are restricted either by the Mental Health Act or the Mental Capacity Act/ Deprivation of Liberty Safeguards. An annual report is produced for each piece of legislation to highlight how the legal powers are being implemented and to report on any themes nationally. The findings from these reports form the basis of future CQC monitoring visits and the key lines of enquiry across their five domains. Guidance for professionals on how to undertake their roles and responsibilities under the Mental Health Act is contained within the MHA Code of Practice. Following an extensive consultation period with service users, carers, families and professionals the new MHA Code of Practice will be implemented on 1 April 2015.

Assessment – *analysis and considerations of options and risks*

- The CQC Monitoring the MHA annual report 2013/14 noted a national increase in hospital detentions from the previous year of 6% resulting in a steady increase in tribunal applications. Whilst there is a lot of good practice noted, information sharing with service users, their families and carers was highlighted as an area for concern. Feedback suggested that their views are not always being sought. Nationally it was noted Board members and Non Executive Directors of some Trusts were unfamiliar with CQC MHA reports, themes, and quality and safety issues. This is also a key line of enquiry for the impending CQC inspection of the Trust in June 2015.
- The CQC DoLS annual report noted continuing national inconsistency in the application of the Safeguards. Since the Supreme Court Judgment (March 2014) the number of DoLS applications have substantially increased, as have applications to the Court of Protection.
- The new MHA Code of Practice aims to provide stronger protection for patients, and to clarify roles, rights and responsibilities. There are five new guiding principles, new chapters, i.e. care planning, human rights, equality, physical health care, and blanket restrictions; and updated chapters on restrictive interventions, segregation, police powers, and young people.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Compliance Assurance and Learning Sub Committee has agreed the actions identified for the implementation of the new MHA Code of Practice from 1 April 2015. The Board of Directors is asked to **discuss** the main changes and **endorse** the approval of the implementation plan which will be monitored by the Compliance, Assurance and Learning Sub Committee and will report compliance and qualitative themes to the Board of Directors by exception.

Who/ which group has approved this report for receipt at the above meeting?	Jo Watts
Contributing authors:	Jan Devine David Wood

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Compliance, Assurance & Learning Sub Committee	11.03.15
2	Board of Directors	17.03.15

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

Appendix no.	Appendix title
1	Overview of CQC Monitoring MHA Report 2013/14
2	Overview of CQC Monitoring Deprivation of Liberty Safeguards Report 2013/14
3	Overview of main changes in the new Code of Practice 2015
4	CWP benchmark position for key data in MHA and MCA/ DoLS
5	Action plan for the implementation of the new Code of Practice 2015

Appendix 1

CARE QUALITY COMMISSION
MONITORING THE MENTAL HEALTH ACT 2013/14

OVERVIEW OF REPORT

Introduction

The Care Quality Commission (CQC) has a duty to monitor how services in England exercise their powers and duties in relation to patients detained in hospital or subject to community treatment orders. In the 2012/13 report five key areas of action were set out and were aligned with the CQC corporate strategy – '*Raising standards, putting people first'*. These areas will continue to be focused on until 2016.

This year, 2013/14, marked the 30th anniversary of monitoring the Mental Health Act and five years since CQC become responsible for its' review. CQC carried out 1,227 MHA monitoring visits nationally throughout this year and highlighted themes and variations in services in their annual report.

Comprehensive Inspections will include:

- Review of application of MHA
- Assessment of governance systems and processes
- Meeting a wider range of people affected by MHA
- Monitoring of how MHA is delivered, it's use and audits
- Looking for evidence that issues raised in previous visits have been actioned
- Focus on patient rights/experience
- Implementation of new MHA Code of Practice
- Look at how data is used to improve benchmarking and understanding of its use
- Provision of patient rights

MHA Reviewer visits are to be patient driven.

Issues raised in the report

National	CWP current position	Recommended action
Board members and Non Executive Directors of some Trusts were unfamiliar with CQC MHA reports, themes and quality and safety issues. This is regarded as unacceptable by CQC.	MHA reviewer visit themes are reported bi-monthly to Compliance, Assurance & Learning Sub Committee (CALSC). Non Executive Director lead for Mental Health Act and holds regular meetings with MHA Team Manager to understand themes re safety and quality issues from CQC visits. Non Executive Directors chair hospital managers' review hearings.	To supplement the overview provided in relation to the CQC Monitoring the Mental Health Act report, a MHA Annual Report is to be provided for the Board of Directors, commencing in July 2015.

Appendix 1

National	CWP current position	Recommended action
Second Opinion Appointed Doctors (SOADs) are having difficulties when carrying out assessments in accessing records, contacting named professionals, and incomplete information on treatment plans, causing delays in assessments.	No issues have been raised with the MHA Team or highlighted as an issue on CQC MHA visits	MHA Team to escalate any difficulties to Ward/Team Managers and Consultants should they be raised by visiting SOADs or CQC.
MHA complaints/enquiries to CQC have increased nationally by 62% since 2012/2013.	Formal complaints to CWP specifically regarding dissatisfaction with the MHA process has been steady, averaging 10 a year since 2011, therefore no increase has been noted internally within the Trust. Any complaints/concerns are recorded and escalated to the relevant professionals for feedback.	Continue to monitor complaints/themes relating to the MHA and report via the bi-monthly locality summary reports to localities.
There has been a reduction in the notification of deaths of detained patients, although notification for CTO patients is not required by law.	MHA Team ensure notifications of deaths of detained patients, including CTO, are sent to CQC within the required timeframes	MHA Team will continue to ensure notifications are submitted as required.
There has been an increase in the use of MHA by 6% between 2012/13 and 2013/14.	CWP has seen an increase of 7% during this period. The use of the MHA is monitored and reported to the Compliance, Assurance and Learning Sub-Committee.	MHA Team will continue to monitor the use of MHA detentions and report to the Compliance, Assurance and Learning Sub-Committee. The Annual Report for the Board of Directors will reflect annual trends broken down to localities/individual wards.
84% of records examined showed patients had received information regarding their rights. The provision of rights will be a key line of enquiry at future visits.	Evidence from CQC MHA visits since January 2014 shows that the issue of patients being informed of their rights was raised on two occasions.	The inpatient safety metrics audit will continue to monitor compliance. The MHA Team will raise issues regarding rights at the bi-monthly link nurse meetings.
It was found that awareness of IMHA services is "not good enough".	Evidence from CQC MHA visits since January 2014 shows that this has not been raised as an issue within CWP.	MHA Team to check information regarding IMHA services is available on wards as part of the ward audit programme.

Appendix 1

National review of mental health crisis care
This review looked at people who experience mental health crisis and who:

a) Go to A&E
b) Require access/support from specialist mental health services
c) Are detained under section 136

A national report is due to be published in Spring 2015.

Police powers/places of safety

- The number of reported sections 136 has increased by 2,675 nationally from 2012/13 to 2013/14.
- The use of police stations as a place of safety is declining.

Children and Young People under 18

- Small improvements but provision of, and access to, child and adolescent services is not good enough.

Learning Disability

- Services are variable and concern was raised that hospital placements are not appropriate.
- In 2013 40% of inpatients were more than 50km away from home.
- Hospital admission can exacerbate mental and behavioural issues leading to disproportionate long stays.
- In some services there were inadequate person centred care plans.

Treatment

- Over a quarter of records checked did not have evidence of assessment of capacity to consent to treatment following admission.
- Concern raised that some patients say they are having little or no discussion about their treatment.
- The MHA Code of Practice states that it is not good practice just to state consent status on a form – there should be documented evidence of the process leading to the decision, and evidence that the patient is able to give informed consent, including discussion with the patient.
- Consent to treatment will be a key line of enquiry on future visits.
- In 2013/14 there was a decline in the number of requests for ECT certification from SOADs.
- There was ‘alarm’ that emergency treatment powers were being used beyond their intended purposes in situations that were not urgent.

Safe & therapeutic responses to disturbed behaviour

- To prioritise the monitoring of restrictive practices, keeping restrictions to a minimum and to ensure they are applied to protect rights and dignity.
- New MHA Code of Practice stresses the need for debriefing and support after seclusion ends.
- In 2014/15 CQC plan to conduct focused work on issues relating to segregation.

Leaving hospital

- Providers must ensure good care planning is in place.

- CQC continue to find poor examples of care planning and engagement with patients on CTO.
- New MHA Code of Practice includes an updated chapter on care planning, including duty to inform CTO patients of their rights.

Next Steps

CQC Challenge to Providers	➢ To ensure local planning of services is completed using data available, ensuring this is accurate and routine MHA audits are carried out ➢ To help people understand their legal rights and to be involved in their treatment – Policies, training, audit to help staff understanding Share learning, make improvements and work jointly with other services ➢ Providers and commissioners should work together to prepare for the implementation of the new MHA Code of Practice
CQC will	➢ Strengthen inspection/monitoring of MHA – Increase opportunities to meet with people affected by MHA ➢ Monitor implementation of new MHA Code of Practice – Shape approaches to regulating/monitoring ➢ Evaluate how MHA is used – Collection and analysis of data Audit Look for evidence that issues raised by patients are considered by board members and are used to form local action plans

CARE QUALITY COMMISSION
MONITORING THE USE OF THE MENTAL CAPACITY ACT DEPRIVATION OF LIBERTY SAFEGUARDS 2013/14

OVERVIEW OF REPORT

Introduction
Deprivation of Liberty Safeguards (DoLS) was introduced in 2009 under the Mental Capacity Act 2005.
The Care Quality Commission is responsible for monitoring the use of DoLS by hospital and care homes. Although it does not have any enforcement powers, action can be taken under the Health & Social Care Act 2008 if it is found that the safeguards are not being used correctly. To gain a better understanding the CQC have explored difference approaches to capturing information including: an online survey for IMCA's; views of care providers, services users' experiences and relevant person's representatives.
In order to monitor the use of DoLS providers are required to notify the CQC of applications and outcomes. In addition the coroners' office has a legal duty to investigate deaths of persons subject to detention, including DoLS. The Chief Coroner issued guidance in December 2014 regarding this process.

Themes Raised in the Report

National	CWP current position	Recommended Actions
Regional variations in numbers of applications	A higher level of applications in East locality, compared to West and Wirral. Variances in application are currently monitored by the Compliance, Assurance and Learning Sub Committee.	Continue to monitor differences in applications between localities through the bi-monthly CALSC reports
Lack of understanding and awareness of MCA	Variable knowledge across localities. Essential learning currently available for clinical staff via e-learning/ MCA/DoLS training – Aftathought training delivered on 2.3.15. Trust guidance /flowcharts distributed. Z-cards distributed trustwide	Development of new MCA/DoLS e-learning package underway in conjunction with the North West Commissioning Support Unit and is expected to be available by the end of May 2015.
Notification to CQC of applications has been inconsistent	Notifications are being submitted on a timely basis by the MHA Team. Improved method of recording DoLS on	MHA Team to streamline the monitoring mechanism for submission of notifications to further enhance the current system.

	Carenotes has been developed.	
In the northwest of England 68% of applications were accompanied by an urgent authorisation	CWP is in line with this statement	The Admission policy is currently under review and includes the requirement for capacity assessment regarding consent to admission to ensure potential deprivations of liberty cases are identified. A high level of urgent authorisations accompanying standard applications will continue to be expected. Capacity assessments should be undertaken and documented prior to admission to hospital to ascertain capacity to consent to admission and treatment.
Approximately 40 – 60% or applications for standard authorisation have been granted	Data is currently not available	The improved method of recording DoLS on Carentoes commenced on 2.3.15. Reporting from Carenotes will allow future benchmarking starting in June 2015, and quarterly thereafter.
Statutory deadlines for completion of DoLS assessments are not always being met by local authorities. In 2013/14 81% of local authorities met the timescales, however,since March 2014 the delays have increased due to the significant rise in applications.	The majority of applications from CWP are for urgent authorisation, followed by standard authorisation. These are given priority by local authorities within the Trust footprint. However, a backlog in assessments has been noted.	The Trust recommends that authorisations continue to be requested from the relevant local authority as soon as it is determined that a person may be deprived of their liberty.
As a result of the Supreme Court Judgment in March 2104 there has been an increase in applications to the Court of Protection	CWP has had two cases over the last 6 months which have been taken to the Court of Protection	In November 2014 the Court of Protection introduced new measures to streamline its process for managing applications and a new group of judges were put in place to deal with non-contentious requests to authorisation. A flowchart is to be devised for CWP staff regarding the process for applications to the Court of Protection – to be completed by 30.4.15.

Developments in Legislation
March 2014 -
The House of Lords MCA post-legislative scrutiny committee published its findings highlighting that the implementation of the Act had not met expectations and reinforced that the Safeguards were over bureaucratic and complex. Thirty nine recommendations were made.

The Supreme Court handed down its judgment on the case of ‘P v Cheshire West and Chester Council and another’ and ‘P & Q v Surrey County Council’ (known as the Cheshire West case). This judgment clarified when a person is being deprived of their liberty.

June 2014 -
The Government published its response to the House of Lords committee, welcoming its findings.

Impact of the Supreme Court Judgment in March 2014
The ruling confirmed that two key questions (the ‘acid test’) need to be answered when a person lacks the capacity to consent to, or refuse, suggested arrangements, for care and treatment that is thought to be in their best interests:

- Is the person not free to leave? **And**
- Is the person subject to continuous supervision and control?

If the answer to both questions is yes, then that person is deprived of their liberty.

As a result there has been a significant change in practice. National data collected shows figures for the first two quarters of 2014/15 already exceeds the whole of the previous year.

Next Steps

What CQC will do:	➢ Listen to experiences of people with personal involvement with DoLS, and consider how the MCA is being used in our inspections of providers ➢ Use our inspections and reports to encourage improvements in practice, and where necessary take enforcement action to drive improvement ➢ Make sure that our inspectors have the confidence and competence to recognise and encourage good practice ➢ Take enforcement action where we find that providers are failing to notify us of DoLS authorisations
What CQC expects others to do:	➢ We expect local authorities to do all they can to assess the backlog of requests for authorisation and prevent its recurrence ➢ We expect providers to work within the framework of the MCA, the Supreme Court Judgment and, pending the Law Commission review, any changes that may arise ➢ We expect joint working, locally and nationally, to make sure that local authority and NHS Commissioning, training and polices take into account the need to avoid deprivation of liberty wherever possible ➢ We expect providers to examine the care and treatment plans for individuals lacking capacity, to determine if there is a deprivation of liberty.

CQC recommendations:	➢ Local authorities continue to consider using advocacy services for all those subject to DoLS ➢ Local authority leads for MCA and DoLS create good working relationships with their local coroners. ➢ Local authorities and IMCA providers work together to support the relevant person's representative ➢ Hospitals and care homes continue to request authorisations when they think people are being deprived of their liberty, based on the new 'acid test'.

Appendix 3

MENTAL HEALTH ACT 1983
CODE OF PRACTICE 2015

Introduction
Since the last MHA Code of Practice was produced in 2008 there have been substantial changes and update in legislation, policy, case law and professional practice. The new Code reflects these changes and provides guidance to professionals. This includes involving the patient and, as appropriate, their families and carers in discussions about the patient's care at every stage; providing personalised care; and minimising the use of inappropriate blanket restrictions, restrictive interventions and the use of police cells as places of safety.

The Code highlights that professionals should receive training to ensure they are familiar with its requirements, as departures from the Code could lead to legal challenges. The new Code comes into effect on 1 April 2015.

The main changes
The Government has highlighted the main changes.

Five new guiding principles:

- *Least restrictive option and maximising independence*
  Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible
- *Empowerment and involvement*
  Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.
- *Respect and dignity*
  Patients, their families and carers should be treated with respect and dignity and listened to by professionals.
- *Purpose and effectiveness*
  Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.
- *Efficiency and equity*
  Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

New Chapters on care planning, human rights, equality and health inequalities

Consideration of when to use the Mental Health Act, and when to use the Mental Capacity Act and Deprivation of Liberty Safeguards; and information to support victims.

New Sections on physical health care, blanket restrictions, duties to support patients with dementia and immigration detainees.

Significantly updated chapters on the appropriate use of restrictive interventions, particularly seclusion and long-term segregation, police powers and places of safety.

Further guidance on how to support children and young people, those with a learning disability or autism.

There are further, less obvious changes. For example:

- A new section on whistleblowing
- Further guidance on MAPPA (Multi-agency Public Protection Arrangements)
- More detail on providers' requirements to give information and support to detained patients who bring complaints
- Further guidance on the interaction between MHA and MCA/DoLS
- A new list of policies and procedures to be followed
- A new Reference Guide to accompany the Code

The CQC inspection teams will continue to use to MHA Code of Practice to help identify areas of good practice, or improvements required by services. The Code will help to establish whether services are 'safe, effective, caring, well-led and responsive to people's needs'.

A Trust wide action plan for the implementation of the new Code has been developed, including a programme to review the Trust's MHA policies to ensure the changes are reflected.

ACTION PLAN FOR THE IMPLEMENTATION OF THE NEW MHA CODE OF PRACTICE

ACTION	BY WHOM	BY WHEN	COMPLETED
Posters to be designed and circulated to all areas of the Trust	**MHA Team/ Communications Team**	**27/03/2015**	
Briefing to be circulated via CWP Essential	**MHA Team/ Communications Team**	**27/03/2015**	
Produce a document of the main changes for nursing/community staff and RCs	**MHA Team**	**27/03/2015**	
Update MHA intranet page – attach new Code and relevant guidance	**MHA Team**	**27/03/2015**	
Review of all MHA Trust policies to ensure compliance with the new Code	**MHA Team**	**01/05/2015**	
Review of MHA essential learning and role specific training	**MHA Team**	**01/06/2015**	
MHA Team to receive training on the new Code (MHA Team Manager and one administrator to attend training day on 14/04/15)	**MHA Team Manager**	**30/04/2015**	
Paper copies of the new MHA Code of Practice to be ordered and distributed to Non Executive Directors and associate hospital managers	**MHA Team Manager**		Copies ordered prior to publication on 27/02/2015. Awaiting delivery
MHA Administrators to raise awareness of new Code via locality link nurse meetings and visits to community teams	**MHA Team**	**30/04/2015**	
Safeguarding team and Security Manager to identify areas of action in respect of their specialities and update policies where required	**Val Sturgess, Safeguarding Manager Ken Edwards, Security & Safety Lead**	**30/04/2015**	
An MHA audit programme to be produced to test measure compliance with the new Code	**Healthcare Quality Improvement Team**	**01/06/2015**	

Appendix 4

BENCHMARKING

Use of Mental Health Act within CWP against national figures for 2013/14

	CWP percentage	National percentage
Use of Mental Health Act	7% ↑	6% ↑
Use of detention on admission	54%	65%
New Community Treatment Orders	24%↓	5%↓
Tribunal applications	Data not available for the period stated. However, between 2012/13 and 2014/15 there has been an increase of 61%↑	Over 5 years 27%↑
Use of Section 136	0.2%↑ from 2012/13 to 2013/14	12% ↑ from 2012/13 to 2013/14.

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Annual Information Governance Report
Agenda ref. no:	14/15/127
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	25/03/2015
Presented by:	Dr Anushta Sivananthan, Medical Director Quality Compliance & Assurance

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

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*
To brief the Board of Directors on information governance resources, governance, issues, risks and improvement plans undertaken in 2014/15 and planned for 2015/16 and to seek approval for the 2014/15 annual Information Governance Toolkit submission.

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

The planned Information Governance Toolkit (IGT) submission for 2014/15 achieves an overall score of 94%. All areas of the toolkit are compliant and level 2/3 with the exception of clinical coding which is at level 1. Information governance arrangements have been reviewed during 2014/15 firstly against the latest version of the information governance toolkit, and then against guidance released throughout the year. Whilst there has been a drop in the toolkit score for clinical coding the rest of the toolkit is at least at level 2 with many areas scoring level 3. This supports the case that current information governance arrangements within Cheshire & Wirral Partnership are appropriate and fit for purpose.

Assessment – *analysis and considerations of options and risks*

A key priority for the 2014/15 work plan was to maintain the previous improvement achieved for clinical coding. The Trust continued to temporarily employ a qualified clinical coder to quality check secondary diagnosis codes. The coder has liaised directly with clinicians when errors have been found. This focussed primarily on primary diagnosis codes. General communication has also been disseminated via the weekly data quality dashboards to improve the quality of clinical coding. MIAA undertook an audit in March 2015. The preliminary results have shown that secondary diagnosis has not met the information governance toolkit level 2 target by 1%. The Trust is undertaking an options appraisal to identify the best option to improve and sustain best practice in relation to data collection and clinical coding thus enabling the trust to make better use of the data/ information available to inform service development. This will enable the Trust to provide richer data to the commissioners.

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

a. That the Board approves the statement that current information governance arrangements are fit for purpose
b. That the Board approves the submission of the 2014/15 information governance toolkit (31/03/2015)
c. That the Board the information governance work plan for 2015/16

Who/ which group has approved this report for receipt at the above meeting?		Records & Clinical Systems Group, Dr Anushta Sivananthan, Medical Director Quality Compliance and Assurance
Contributing authors:		Gill Monteith, Trust Records Manager, Sean Capper, Head of ICT, Mandy Skelding-Jones, Associate Director Performance & Re-design
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Sean Capper, Head of ICT, Mandy Skelding Jones, Associate Director Perormance & Re-design Records & Clinical Systems Group Dr Anushta Sivananthan, Medical Director Quality Compliance and Assurance	5/02/2015 5/02/2015 23/2/2015 24/02/2015

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

Provide only necessary detail, do not embed appendices, provide as separate reports	
Appendix no.	Appendix title
A	Cheshire & Wirral Partnership NHS Foundation Trust information governance toolkit planned submission March 2015
B	Mersey Internal Audit Agency information governance toolkit assessment terms of reference
C	Information governance work plan 2015/2016

Information Governance Annual Board report March 2015.

1. Information governance briefing

Information governance is the framework of organisational culture, communication, policies and procedures which ensure the security, validity, availability and accuracy of its clinical and corporate information. It is driven by a framework of legislation, national and international standards and good practice guidelines and is particularly impacted by the rate of technological change which requires the compliance framework in which the Trust operates to be regularly updated.

Compliance with information governance standards is annually assessed through the completion of the Information Governance Toolkit, hosted by NHS Information Centre

The information governance toolkit submission is examined by the Trust's regulators: The Care Quality Commission (CQC) include the toolkit assessment in the Trust's Quality & Risk Profile (QRP), while the foundation trust regulator, Monitor, consider the toolkit when assessing the foundation trust's governance risk rating.

2. Information Governance 2014/15 and 2015/16

Review of information governance work plan 2014/15

A key priority for the 2014/15 work plan was to maintain the previous improvement achieved for clinical coding. The Trust continued to temporarily employ a qualified clinical coder to quality check diagnosis codes. The coder has liaised directly with clinicians when errors have been found. General communication has also been disseminated via the weekly data quality dashboards to improve the quality of clinical coding, this focussed primarily on primary diagnosis codes.

MIAA undertook an audit in March 2015, as part of the IG Toolkit assessment process. The preliminary results have shown that secondary diagnosis has not met the information governance toolkit level 2 target by 1%. The Trust is undertaking an options appraisal to identify the best option to improve and sustain best practice in relation to data collection and clinical coding thus enabling the trust to make better use of the data/ information available to inform service development. This will enable the Trust to provide richer data to the commissioners.

The targets in the 2014/15 information governance work plan have been met with the exception of clinical coding. Evidence uploaded to the Information Governance Toolkit has been refreshed and updated policies have been uploaded to the toolkit. The Trust scored 95% for both the baseline July 2014 and interim October 2014 IGT submissions.

The following annual audits have all been undertaken:

- Patient IG survey
- Staff IG survey
- Data protection audit (transfers of data outside of UK)
- Corporate records audit
- Health records audit

Information asset owners undertook their annual reports for the SIRO during December 2014. This included all transfers of hardcopy and digital person identifiable and sensitive information being identified, mapped and risk assessed.

The ICT Acceptable Usage Policy (AUP) has been reviewed and the following changes have been made:

- Network password length has been increased from a minimum of 6 characters to 8 characters, in line with a recent audit undertaken by MIAA.
- Client Firewalls are now activated when a Trust mobile device is connected to third party network.

In 2014/15 we have begun to review our data quality performance management processes to support decision making and the identification of areas of risk to the delivery of plans. This includes the development of appropriate and meaningful performance dashboards at team, services, locality and Trust Board levels. These dashboards will support our service line reporting processes, enabling managers to understand how the resources at their disposal are utilised and to facilitate internal benchmarking.

Information governance toolkit 2014/15

In recent years, following national guidance, Mersey Internal Audit Agency (MIAA) have completed an annual IG Toolkit review of scores and evidence uploaded to the toolkit. The last report detailed that the score could not be substantiated in 3 cases at the time of the review, this was largely due to actions being underway but not completed or reported to committee, including the clinical coding concerns. However MIAA gave a **significant assurance** opinion, for the third consecutive year, on the information governance toolkit evidence.

MIAA are undertaking a further review of the Trust's IGT scores and evidence. See appendix B for the terms of reference (appendix B outlines the requirements to be assessed).

Information governance work plan 2015/16

The focus of the Trust's work plan for 2015/16 will be to raise the level of clinical coding from level 1 to level 2. The maintenance of all level 3 information governance toolkit requirements and the improvement of scores at level 2 to level 3 will also be a priority.

Policies and procedures – policy review remains an on-going process and will be reviewed in line with clinical pathway development and in line with the clinical effectiveness strategy. Policies will also be in reviewed in line with the policy review process to ensure they are clear, concise and easily accessible to all staff.

Awareness and training – while the majority of information governance training is delivered through e-learning, requests for greater choice in delivery have been facilitated by the use of a handbook and assessment sheet which meets the requirements of the toolkit. Face to face sessions are also available for staff. A choice of training methods will continue to be offered in 2015/16.

Upgrade to ICT disaster recovery facilities and backup systems – after a review of the existing ICT Disaster Recovery (DR) facilities and Backup systems, ICT have begun to implement upgrades to those systems to strengthen DR facilities and reduce return of service recovery times. MIAA undertook an audit of the Trust ICT DR and backup facilities and have stated that proposed upgrades would deliver significant assurance for ICT service continuity. It is anticipated that the upgrades will be completed by May 2015.

Windows 7 upgrade - In April 2015 Microsoft will cease supporting Windows XP, consequently no software updates will be produced, potentially putting PC's/laptops/tablets (AKA Desktop estate) at risk. During 2014/15, ICT Services have been upgrading the Desktop estate, with approximately 2,700 Desktops now running Windows 7 / 8.1 and it is anticipated that the remainder of the estate will be upgraded by April 2015.

Windows server 2003 - In July 2015 Microsoft will cease supporting Windows Server 2003, consequently no software updates will be produced, potentially putting servers at risk. During 2014/15, ICT Services have been upgrading the Server estate, with over 50 Servers are now running Windows Server 2008 and it is anticipate that the remainder of the estate will be upgraded by July 2015.

Data quality – The Trust's quality strategy has described plans to better use data and information by increasing skills and capacity to intelligently analyse data at team, service and Trust-wide levels. This will facilitate the identification of variance – promoting positive variance and reducing/ eliminating harmful or inefficient/ unnecessary variance. This requires support for meta-analysis to facilitate checking for variance, normalised deviance, and looking at what works well.

The Trust collects a wealth of data, however, in common with many other organisations it has been less skilled at turning this into usable information that supports decision making at the appropriate level within the organisation. Many of our existing reporting models have been guided towards providing data for historic contractual currencies that do not support current clinical practice. With this comes a lack of ownership that may reduce data quality. Our approach is to break out of this vicious circle as improved data quality is essential to ensure that we have data and information that can be used to inform service and organisation redesign and development. This will be supported and provided through improved clinical systems and real time data capture.

We will invest in and develop skills in the performance and business intelligence functions within the Trust. As part of our strategy, we will be bringing these two teams together to work as one business intelligence unit. This will be supported by a development programme that will include shadowing clinical teams, working with clinicians to understand their information requirements, understanding of the data available and supporting clinical teams to utilise the wealth of data in an informed way. This will build on the established role of the locality analyst.

Developing a central team alone will not achieve the required cultural shift whereby robust data and information is at the heart of our decision making and practice. There is a value to producing high quality information that needs to be owned at every level of the Trust. Our strategy is to engage at all levels and with a supporting training and development programme, ensure that the Trust information requirements, from clinical practice through to business and strategic planning are met.

See appendix C for 2015/2016 work plan.

Review of information governance incidents 2014/15

Data on information governance incidents and near misses were provided for the first 3 quarters of 2014/15 as reported on the Trust's Datix risk and incident reporting system.

There were two serious breaches of confidentiality which were reportable to the Information Commissioner. Both were as a result of emails being sent outside of the Trust. The breaches involved:

- Spread sheet containing staff confidential information on the second and third un-named tabs

- Email containing staff confidential information intended for internal staff sent to external contact caused by email system storing all previous contacts in address book and staff selecting wrong recipient in error

A robust action plan was developed to reduce the risk of future recurrences. Both emails were sent from separate corporate services, therefore specific email confidentiality training was targeted to corporate services staff. General email confidentiality guidance was distributed to all staff via the weekly news bulletin and the key messages are displayed on computer screen saver shots. The Information Commissioner's Office investigated the breaches and it was decided that no further regulatory action was necessary due to the Trust's prompt and comprehensive action taken. The Information Commissioner's Office made the following recommendations:

1. Review your policies and procedures for handling data in this area.

2. Review your approach to staff training and awareness on an ongoing basis.

3. Implement interim technical solutions to minimise similar errors recurring, prior to the potential migration to the NHSmail2 system.

4. Avoid transferring personal data by email wherever possible. For example, shared folders with controlled access rights could be used to pass on data internally where strictly required.

5. Ensure clear written instructions are issued to staff for any tasks of this nature, so that they are fully aware of what is expected of them.

6. Where possible, use other programs such as Word or PDF when emailing attachments, to avoid the inclusion of additional tabs.

A further robust action plan has been developed to address the Information Commissioner's recommendations.

Overall, information governance incidents have increased significantly compared to the first 3 quarters of the previous year. There were 144 information governance incidents reported in 2014/15 compared to 80 the previous year which is an increase of 55%.

Of the 144 incidents reviewed, incidents of inappropriate disclosure (eg wrongly addressed, wrongly delivered, sent to wrong email, disclosure of PID in attachments) accounted for 38% of incidents (55 in total). There were also 31 incidents of lost or mis-filed records reported which is an increase of 61% compared to the previous year. This may be as a result of increased reporting. Other incidents reported were `potential breaches' or near misses, these included a lost smart card, confidential information found in redundant furniture and security officer finding unlocked office with open filing cabinet containing confidential information.

Analysis of the incidents indicates inappropriate disclosure accounted for over 38% of incidents, two of which were serious reportable incidents. As a result, the need for staff to be vigilant has been emphasied in staff briefings and information governance face to face training delivered. Incidents of lost records continue to be of concern and staff have been reminded of the need to use the case note tracking system correctly.

Information risk management approach
CWP has access to a number of sources of information, guidance and assurance concerning information governance. NHSIC (Information Centre) maintains a comprehensive library of exemplar materials supports the information governance toolkit and provides guidance on ethics and the health and social care record guarantees. The Information Commissioner's Office

provides guidance on the Data Protection and Freedom of Information Acts and the Environmental Information Regulations.

Audit opinions are provided by both external and internal audit and the Trust incorporates mandatory information governance audit within its annual audit programme.

CWP takes a risk-based approach to information governance – evaluating incidents and being appraised of potential gaps in assurance. It should be noted that compliance with the requirements of the information governance toolkit does not necessarily imply that there are no areas of risk within an organisation, the toolkit cannot accommodate every eventuality and therefore organisations are urged to consider their level of risk in collecting, processing, disclosing and disposing of data. The Patient Safety & Effectiveness Sub Committee and I.T. Enablement Board are responsible for monitoring overall compliance with Information Governance principles.

Lesson learned from investigations and reviews are incorporated into training materials, communication notices and policy as appropriate.

Assessment of information governance arrangements

Information governance arrangements have been reviewed during 2014/15 firstly against the latest version of the information governance toolkit, and then against guidance released throughout the year. Whilst there has been a drop in the toolkit score for clinical coding the rest of the toolkit is at least at level 2 with many areas scoring level 3. This supports the case that current information governance arrangements within Cheshire & Wirral Partnership are appropriate and fit for purpose.

3. Recommendations to the Board of Directors

a. That the Board approves the statement that current information governance arrangements are fit for purpose
b. That the Board approves the submission of the 2014/15 information governance toolkit.
c. That the Board the information governance work plan for 2015/16

4. References

1. Information Governance Toolkit
https://nww.igt.connectingforhealth.nhs.uk/

Information Governance Annual Report 2014/15

Appendices

A. Cheshire & Wirral Partnership information governance toolkit planned submission – March 2015

Req No	Description	Status	Attainment Level
Information Governance Management			
10-101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	Confirmed Complete	Level 3
10-105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	Confirmed Complete	Level 3
10-110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	Confirmed Complete	Level 2
10-111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	Confirmed Complete	Level 3
10-112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	Confirmed Complete	Level 3
Confidentiality and Data Protection Assurance			
10-200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	Confirmed Complete	Level 3
10-201	Staff are provided with clear guidance on keeping personal information secure and on respecting the confidentiality of service users	Confirmed Complete	Level 3
10-202	Personal information is only used in ways that do not directly contribute to the delivery of care services where there is a lawful basis to do so and objections to the disclosure of confidential personal information are appropriately respected	Confirmed Complete	Level 3
10-203	Individuals are informed about the proposed uses of their personal information	Confirmed Complete	Level 3
10-205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	Confirmed Complete	Level 3
10-206	There are appropriate confidentiality audit procedures to monitor access to confidential personal information	Confirmed Complete	Level 3
10-207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	Confirmed Complete	Level 2
10-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	Confirmed Complete	Level 3
10-210	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	Confirmed Complete	Level 3
Information Security Assurance			
10-300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	Confirmed Complete	Level 3

10-301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	Confirmed Complete	Level 3
10-302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	Confirmed Complete	Level 3
10-303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	Confirmed Complete	Level 3
10-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	Confirmed Complete	Level 3
10-305	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	Confirmed Complete	Level 3
10-307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	Confirmed Complete	Level 3
10-308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	Confirmed Complete	Level 3
10-309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	Confirmed Complete	Level 3
10-310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	Confirmed Complete	Level 3
10-311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	Confirmed Complete	Level 3
10-313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	Confirmed Complete	Level 3
10-314	Policy and procedures ensure that mobile computing and teleworking are secure	Confirmed Complete	Level 2
10-323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	Confirmed Complete	Level 2
10-324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	Confirmed Complete	Level 2
Clinical Information Assurance			
10-400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	Confirmed Complete	Level 3
10-401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	Confirmed Complete	Level 3
10-402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	Confirmed Complete	Level 3
10-404	A multi-professional audit of clinical records across all specialties has been undertaken	Confirmed Complete	Level 3
10-406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	Confirmed Complete	Level 3

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Secondary Use Assurance			
10-501	National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as standards develop	Confirmed Complete	Level 3
10-502	External data quality reports are used for monitoring and improving data quality	Confirmed Complete	Level 3
10-504	Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained	Confirmed Complete	Level 3
10-506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	Confirmed Complete	Level 3
10-507	The Completeness and Validity check for data has been completed and passed	Confirmed Complete	Level 3
10-508	Clinical/care staff are involved in validating information derived from the recording of clinical/care activity	Confirmed Complete	Level 3
10-514	An audit of clinical coding, based on national standards, has been undertaken by a NHS Classifications Service approved clinical coding auditor within the last 12 months	Confirmed Complete	Level 1
10-516	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national standards	Confirmed Complete	Level 2
Corporate Information Assurance			
10-601	Documented and implemented procedures are in place for the effective management of corporate records	Confirmed Complete	Level 3
10-603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	Confirmed Complete	Level 3
10-604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	Confirmed Complete	Level 3

B **Mersey Internal Audit Agency information governance toolkit assessment terms of reference**

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C **Information governance work plan 2015/2016**

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STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Chair and Chief Executive - Division of Responsibilities
Agenda ref. no:	14/15/128
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	25/03/2015
Presented by:	Louise Brereton, Head of Corporate Affairs

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	No
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	No
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	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	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	Yes
Process and structures	Yes
Measurement	No
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
Click here to enter text.	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
Click here to enter text.	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*
To inform the Board of the requirements in the Monitor NHS Foundation Trust Code of Governance regarding the division of responsibilities between the Chair and the Chief Executive.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
The division of responsibilities between the Chairperson and Chief Executive should be clearly established, set out in writing and agreed by the board of directors. Section 7.11.7 of The Corporate Governance Manual sets out that the division of responsibilities for the Chair and the Chief Executive to be set out in writing and approved by the Board of Directors on an annual basis.

Assessment – *analysis and considerations of options and risks*
The responsibilies of the Chair and Chief Executive are set out at appendix 2. The NHS Foundation Trust Code of Governance is available at http://www.monitor.gov.uk/FTcode

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
That the Board of Directors approves the division of responsibilities as set out in the Monitor NHS Code of Governance for Foundation Trusts and that this is reviewed on an annual basis.

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

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

Appendix 1

The responsibilities of the Chair are as follows:

- To ensure the effective operation of the Board of Directors and the Council of Governors
- To promote the highest standards of integrity, probity and corporate governance throughout the organisation and particularly at the Board of Director level
- To ensure that the Board of Directors as a whole plays a full part in the development and determination of the Foundation Trust's strategy and overall objectives, having regard to the Council of Governors
- To lead the Board of Directors, to preside and lead the Council of Governors and to be the guardian of the Board of Directors decision making processes
- To ensure that the Board of Directors and the Council of Governors work together effectively
- To set clear expectations concerning the Trust's culture, values and behaviours including setting the style and tone of discussions at Board meetings
- To ensure the Board of Directors and Council of Governors agendas take full account of the important issues facing the Trust
- To ensure that the Board of Directors and the Council of Governors receive accurate, timely and clear information
- To ensure compliance with the Board of Directors approved procedures including schedule of matters, terms of reference and other Board policies and procedures
- To facilitate the effective contribution of all members of the Board of Directors and the Council of Governors ensuring that constructive relationships exist between Directors, between Governors and between Governors and Directors themselves
- To ensure that the Non-Executive Directors understand their accountability, individually and collectively to the Council for Governors for the performance of the Board
- To preside over the Council of Governors in holding the Non-Executive Directors to account
- To ensure that accountability processes work effectively
- To Chair the Remuneration and Nominations Committees
- To initiate succession planning at Board level with the Nominations Committee to ensure appropriate Board composition and refreshment
- To ensure effective communication on the part of the foundation trust with patients, members, staff and other stakeholders
- To lead an induction programme for new Directors
- To lead in updating the skills and knowledge and in meeting the development needs of individual Directors and the Board of Directors as a whole
- To ensure that the Governors have the skills, knowledge and familiarity within the Foundation Trust to fulfil their role
- To ensure that the performance of the Board of Directors and the Council of Governors as a whole, including an externally led assessment at least once in every three years
- To ensure a good flow of information each way between the Board of Directors, committees, the Council of Governors, Non-Executive Directors and management

The responsibilities of the Chief Executive are as follows:

- To report to the Chair and the Board of Directors and lead the Executive Team ensuring high standards of performance.
- Conduct the affairs of the Foundation Trust in compliance with the highest standards of integrity, probity and corporate governance and promote continuing compliance across the organisation.
- To lead and be responsible for proposing and developing, in consultation with the Board, the Foundation Trust's strategy and overall objectives, and to lead the implementation of these, ensuring appropriate resources and control and risk management systems are in place
- As the Accountable Officer to maintain a sound system of internal control that supports the organisation's policies, aims and objectives and manages risks to a reasonable level, including responsibility for safeguarding the public funds and organisations assets ensuring the efficient and effective use of all the resources in their charge.
- To ensure the appropriate and timely flow of information to the Board that enables an assessment of risk and a level of assurance in internal control.
- To ensure the provision of information and support with the Board of Directors and the Council of Governors
- To facilitate and support effective joint working between the Board of Directors and the Council of Governors
- To communicate the expectations of the Board, concerning culture, values and behaviours to all employees
- To ensure the Chair is aware of any important issues facing the Foundation Trust and to ensure the provision of reports to the Board containing accurate, timely and clear information
- To ensure the compliance of the Executive Team with the Board of Directors procedures
- To support the Chair in facilitating effective contributions and sustaining constructive relations between Executive and Non-Executive directors of the Board. Between governors and between the Board of Directors and Council of Governors
- To provide, with Executive team, support to the Non-Executive Directors in order to facilitate the accountability relationship
- To support the Chair in delivering an effective accountability process
- To support with Board succession planning, particularly in respect of executive directors
- Lead the communication programme with members and stakeholders including staff, particularly around Trust strategy, vision and values
- Ensure that the development needs of the Executive Directors and other senior management are identified and are met
- Ensure the provision of appropriate development and training for the council of governors
- Ensure that performance reviews are carried out at least annually for each of the Executive Directors and provide input to the wider Board of Directors and Council of Governors evaluation process