Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting of the Foundation Trust Board of Directors
Wednesday 30th March 2016
Boardroom, Redesmere, Countess of Chester Health Park
1.30pm

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
15/16/128	Apologies for absence	Receive apologies	Verbal	Chair	1 min (1330)
15/16/129	Declarations of Interest	Identify and avoid conflicts of interest	Verbal	Chair	2 min (1331)
15/16/130	Minutes of the previous meeting held 27th January 2016	Confirm as an accurate record the minutes of the previous meetings	Written minutes	Chair	2 mins (1333)
15/16/131	Matters arising and action points	Provide an update in respect of ongoing and outstanding items to ensure progress	Written action schedule and verbal update	Chair	2 mins (1335)
15/16/132	Board Meeting business cycle 2015/16 and draft 2016/17 business cycle	Confirm that agenda items provide assurance that the Board is undertaking its duties	Written	Chair	3 mins (1337)
15/16/133	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	10 mins (1340)
15/16/134	Chief Executive's announcements *(including overview of items discussed in closed meeting)*	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	10 mins (1350)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
MATTERS FOR APPROVAL/ DECISION					
Strategy					
15/16/135	Learning Disability services - Transforming Care – Cheshire and Merseyside Plan	To note update on developments	Written Report	Director of Operations	15 mins (1400)
15/16/136	Corporate Assurance Framework, Risk Register and Integrated Governance Framework	To approve current Corporate Assurance Framework, Risk Register and amended Integrated Governance Framework	Written Report	Medical Director	10 mins (1415)
15/16/137	West Cheshire Healthy Living Centre closure	To note update	Written Report	Director of Operations	10 mins (1425)
Capability and Culture					
15/16/138	Response to Southern Health NHSFT report findings	To note assurance framework	Written Report	Director of Nursing, Therapies and Patient Partnership	10 mins (1435)
Process and Structures					
15/16/139	CQC Inspection - approval of final action for submission to CQC	To update on implementation of action plan and any exceptions	Written Report	Chief Executive	10 mins (1445)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
15/16/140	Daily Ward Staffing figures February 2016	To note the Daily Ward Staffing Figures	Written Report	Director of Nursing, Therapies and Patient Partnership	5 mins (1455)
Measurement					
15/16/141	Annual Information Governance report	To approve submission	Written Report	Medical Director	10 mins (1500)
15/16/142	Board Performance Dashboard – February 2016 data	To review Trust performance	Written Report	Director of Finance	10 mins (1510)
15/16/143	CAMHS Benchmarking	To review CAMHS benchmarking data	Presentation	Medical Director/ Clinical Director	30 mins (1520)
Governance					
15/16/144	Monitor Well- led governance review – draft specification	Review and approve draft specification	Written Report	Head of Corporate Affairs	10 mins (1550)
15/16/145	Committee Governance Effectiveness Review	To receive overview of annual review of committee effectiveness	Written Report	Medical Director	10 mins (1600)
15/16/146	Audit Committee reporting: • Chair's Report of meeting held 1st March 2016	Review Chair's Report and any matters for note/ escalation	Written	Chair of Audit Committee	3 mins (1610)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
15/16/147	Quality Committee reporting : • Chair's report of meeting held 2nd March 2016	Review Chair's Report and any matters for note/ escalation	Written	Chair of Quality Committee	3 mins (1613)
15/16/148	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair/ All	5 mins (1616)
15/16/149	Any other business	Consider any urgent items of other business	Verbal or written	Chair	2 mins (1621)
15/16/150	Review of meeting https://www.surveymonkey.com/s/XN5ZLNC	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair/All	2 mins (1623)
15/16/151	Date, time and place of next meeting: **Wednesday 25th May 2016, 2.00pm Boardroom, Redesmere.**	Confirm arrangements for next meeting	Verbal	Chair	1625

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Minutes of the Board of Directors Meeting
Wednesday 27th January 2016
Boardroom, Redesmere commencing at 2.00pm

PRESENT	David Eva, Chair Sheena Cumiskey, Chief Executive Dr Jim O'Connor, Non-Executive Director Stephen Scorer, Interim Director of Nursing, Therapies and Patient Partnership Sarah Reiter, Non-Executive Director Mike Maier, Deputy Chair and Non-Executive Director Dr Anushta Sivananthan, Medical Director Andy Styring, Director of Operations Rebecca Burke – Sharples, Non-Executive Director Dr Faouzi Alam, Medical Director Fiona Clark, Non-Executive Director Lucy Crumplin, Non-Executive Director Tim Welch, Director of Finance
IN ATTENDANCE	Louise Brereton, Head of Corporate Affairs David Harris, Director of People and OD Andrea Hughes, Director of Infection, Prevention and Control (for item 15/16/116) Jennie Atkins, Communications and Engagement Manager Rob Walker, Service user/ Carer Governor Fergie McQuarrie, Service user/ Carer Governor Susan Kettle, Member of the public.
APOLOGIES	None

	MINUTES	**ACTION**
15/16/104	**WELCOME AND APOLOGIES FOR ABSENCE** The Chair welcomed all to the meeting. Introductions were made for the benefit of those in the public gallery.	
15/16/105	**DECLARATIONS OF INTEREST** No Directors declared any interest in any agenda items.	
15/16/106	**MINUTES OF THE PREVIOUS MEETING HELD 27th NOVEMBER 2015** The minutes of the meeting held **27th November 2015** were **approved** as a correct record.	
15/16/107	**MATTERS ARISING AND ACTION POINTS** The actions from the previous meeting were reviewed. **15/16/34:** A Board to Board meeting was held recently with West Cheshire CCG where discussions were held regarding sharing ideas on improving outcomes for people and shaping different ways of meeting needs.	

	15/16/101: The Executive team have further reviewed the proposed statement put forward by Murdo Kennedy. The Board are in support of the principles set out in the statement; however there are some refinements to make to ensure it is fully reflective of the CWP position. A further update is due at the March 2016 Board. **Action:** SS to make arrangements for Board to receive proposed statement at March 2016 Board meeting. All other actions had been completed.	**SS**
15/16/108	**BOARD BUSINESS CYCLE 2015/16** The Board noted the business cycle for 2015/16.	
15/16/109	**CHAIR'S ANNOUCEMENTS** The Chair announced: During December and January so far, CWP achieved almost 50 pieces of coverage in newspapers with many more new stories being published online and in local newsletters. **CWP clinical psychologist appointed as national interest group lead** Dr Fiona Pender, consultant clinical psychologist and clinical director for Wirral CAMHS, has been chosen to jointly head up a special interest group that will ensure young people's mental health remains a priority in parliament. **Direct access to physiotherapy rated 'excellent' by 99% of patients** For the first time, people in West Cheshire are able to book an appointment directly with 'Physiotherapy First' - a joint initiative between CWP and the Countess of Chester Hospital. Since its launch in January 2015, 3,030 GP appointments have been freed up. **CWP partners with a Wirral based charity** CWP has team up with ARCH to provide a new, integrated model of medical care and an enhanced therapeutic recovery programme at Birchwood Residential Treatment Centre in Birkenhead. The new model of care provides enhanced clinical treatment facilities and 24 hour medical back up.	
15/16/110	**CHIEF EXECUTIVE'S ANNOUCEMENTS** The Chief Executive announced the following: **Avril Devaney New Years Honours** Avril Devaney, Director of Nursing, Therapies and Patient Partnership has been awarded an MBE in the New Years' Honours. Avril, who is currently on adoption leave for the Trust, will be returning on 7th March 2016. **Overview of discussions at closed Board meeting** Items discussed during the closed session included:	

	• Financial planning for 2016/17 and the potential impact of the STP fund. • The STP footprint to ensure the delivery of sustainable and transformational services moving forward and the use of different service delivery levels to meet needs in a different way. • The Caring Together transformation plans for east Cheshire and CWP continuing to be a partner in further improving outcomes for people of east Cheshire. • Expression of interest for pilot for new ways of commissioning and providing specialised mental health services for CAMHS, low secure and perinatal services which is part of new planning regime announced in late December 2015. • CQC action plan check – no exception were reported and delivery is on track.	
15/16/111	**CORPORATE ASSURANCE FRAMEWORK AND RISK REGISTER** Dr Anushta Sivananthan introduced the report and highlighted the recent changes to the risk register. At the recommendation of the Audit Committee, a new risk has been added around cyber threats. This has a full risk treatment plan in place. The falls management risk has been archived, following completion of the outstanding action which has resulted in a reduction in number of falls. The physical health network is considering any residual risk areas in relation to falls in the context of the wider physical health risk. The essential learning risk has been archived following completion of the risk treatment plan and a significant improvement in the completion of mandatory learning. An emerging risk around mental health act compliance has been identified, in part through the CQC inspection. This risk has been modelled and added to the risk register. A discussion followed regarding risks to the Trust around the STP footprints and how these are captured. It was noted that the commissioning and tenders risk and the finance risk covers elements of this but this would be further reviewed. The Board resolved to **approve** the amendments to the strategic risk register and corporate assurance framework.	
15/16/112	**Q3 15/16 QUALITY REPORT** Dr Anushta Sivananthan presented the report and highlighted some key achievements. • The recent young people's take over day was successful resulting in a number of pledges being made by staff to continue to raise awareness of young people's rights.	

	• David Wood, Associate Director: Safe Services recently presented at a Preventing Harm, Improving Care conference. • An increased number of compliments have been received over the period. It was noted that the development of the mental health act audit tool set out in the report forms part of the risk treatment plan for the emerging mental health act compliance risk.	
15/16/113	**EAST CHESHIRE CARING TOGETHER GOVERNANCE ARRANGEMENTS** Sheena Cumiskey presented the report and advised that the East Cheshire Caring Together transformation programme has been in progress for some time. It is linked into the Five Year Forward Vision and the need to transform services through a preventative approach. The document sets out the governance arrangements for all the stakeholders working in partnership. It was confirmed that the CWP Board of Directors are happy to sign up to memorandum of understanding, demonstrating the Trust's commitment to working with east Cheshire to transform services. Following earlier discussions, it was noted that the CWP Board are disappointed on the lack of representation of mental health services in the draft strategic and transformation plan and will be working closely with east Cheshire CCG to ensure that this is properly represented and following this work, a further iteration of the strategy will return to a future Board meeting for further consideration. The Board of Directors resolved to: • **approve** the Terms of Reference for the Caring Together Programme Board • **approve** the Terms of Reference for the Programme Executive Group	
15/16/114	**COMPREHENSIVE REVIEW OF WARD STAFFING (SIX MONTH REVIEW)** Stephen Scorer introduced the report and reminded Board members that as part of the National Quality Board reporting cycle, a full review of ward staffing is required on the six monthly basis. Highlighting some of the key review findings, Stephen Scorer advised: • the inclusion of the Hurst model in future review processes as a means of providing additional evidence base to the numbers. • Inclusion of contact time as per the Department of Health requirement within the next six monthly review. • Use of the deep dive approach to test use of e-rostering and quality of record keeping. • The 18 rolling recruitment programme has only now enabled the Trust to reach the establishment levels recommended in the 2013 staffing report. A positive impact has been reported but has resulted in a number of less experienced staff now requiring preceptorship and there is a need to balance this with more	

	experienced staff. • The process for extending the review approach to community teams and examining the interface between community and in-patients commences shortly and will be reported to the Board as part of the next six monthly report. Rebecca Burke-Sharples commended the progress made in this report. It was noted that the use of the Hurst model enables a step towards greater acuity modelling. It was also noted that use of HONOS also enables this. The Trust's approach to apprenticeships was queried. National directives will be requiring organisations of a certain size to offer a number of apprenticeships opportunities which will be in addition to those already offered in the Trust. Dr Jim O'Connor queried the links between the report recommendations and the financial position, and the need to develop a more outcome focus to the paper, to include the MDT. Stephen Scorer advised that the Trust has heavily invested in staffing since the ward staffing review process started. The focus is now about making the best of this resource, taking the MDT into account. Sarah Reiter commented on the need to take account of industry examples around rostering such as public transport which uses a highly sophisticated approach. The Board noted the recommendations specific to Adelphi ward and assurance was given around the timescales. Actions are due to complete by the end of Q4. Reporting on this will be via the Operational Board. The Board resolved to **approve** the report. (Sarah Reiter left the meeting.)	
15/16/115	**DAILY WARD STAFFING FIGURES – DECEMBER 2015** Stephen Scorer introduced the report setting out the December 2015 ward staffing figures. All fill rates were at 90% or above showing an overall increase. The Board of Directors resolved to **note** the report. (Andrea Hughes joined the meeting)	
15/16/116	**Q3 2015/16 INFECTION, PREVENTION AND CONTROL REPORT** The Chair welcomed Andrea Hughes, Director of Infection, Prevention and Control to the meeting. Andrea Hughes presented the report and advised that despite being in the middle of the winter season, there had been no virus outbreaks to date which was very positive. A recent development was the appointment of an IPC nurse to support inpatient services in liaison role between community and in patient	

	services which had been well received by staff. The flu campaign had not been as successful this year, particularly around the staff take up of the vaccine. It was noted that the campaign is entering its last phase and the Communications team are continuing to target staff to encourage them to have the vaccine, particularly since influenza E has been identified in the community and there have been incidents of staff sickness as a result It was noted that there are plans to work more closely with public health for the 2016 campaign. The Board of Directors resolved to **note** the Q3 2015/16 Infection, Prevention and Control report.	
15/16/117	**Q3 20/15/16 QUALITY GOVERNANCE ASSESSMENT** Dr Anushta Sivananthan provided an overview of the Q3 position for quality governance. The data quality domain continues to be rated as amber green. This risk area is reflected on the Trust risk register and a risk treatment plan in place which has been recently reviewed by the Quality Committee. The development of the locality data packs will support with driving up data quality but more needs to be done around using data to drive quality and financial improvement. This will be taken forward through the further development of the locality data packs and the work to ensure ward and team managers have the right information to competently run their services. The Board of Directors resolved to **note** the report and the Q3 position.	
15/16/118	**RESEARCH ANNUAL REPORT 2014/15** Dr Faouzi Alam introduced the report which provides an overview of research activity undertaken in 2014/15. The Board were reminded that the Research Strategy sets out the direction and the influence of research on practice. Highlighting some key points, Dr Alam reported that CWP were the top recruiting Trust for genetic studies for mental health with 85 patients becoming involved. CWP was also selected to facilitate phase 1 of a study around Alzheimer's disease. This is a pre-clinical study and is undertaken on healthy people without symptoms. The Board noted clinicians support to this and other research studies as many are undertaking this work on top of their substantive roles. Collaboration with local universities and the work of the research team connecting with more clinical staff is widening the exposure of research within the Trust. The Board of Directors resolved to **note** the report.	

15/16/119	**BOARD PERFORMANCE DASHBOARD: DECEMBER 2015** Tim Welch highlighted the key issues from the Board dashboard as follows: • The financial sustainability risk rating is scoring 3 with the Q3 position showing £50k ahead of the plan. • DEToC performance has improved since the sharp increase in delays reported at the November 2015 Board, however a significant challenge faces all providers about ensuring safe discharges into community in light of the significant financial pressures in social care. • IAPT 18 week target. The Trust has not maintained the improvement trajectory planned for this. This is a Monitor target but is not a weighted indicator in the risk assessment framework at this time. From Q1 2016/17 it will become a mandatory indictor therefore performance improvement is a priority in Q4. A discussion followed regarding IAPT performance. East Cheshire is the underperforming. CWP is working closely with the CCGs and NHS England to improve on the position and it is planned that the Q1 2015/16 position will see the impact of the remedial action. The Trust has called upon capacity from other localities and the position is under weekly monitoring Assurance was requested on appraisal and supervision figures as it was noted that the appraisal figures are declining and whether the Trust should be aspiring for 100% compliance. David Harris advised that the Operational Board had recently received a paper on a revised approach to appraisal and the steps need to progress this. This work is progressing but this has to be balanced alongside other priorities for the team. It was noted that Wirral locality have undertaken a sustained, targeted approach to improving their appraisal rates which has been very successful. **Action:** DH to report back on progress with appraisal review work upon conclusion. The Board of Directors resolved to **note** the report.	**DH**
15/16/120	**Q3 2015/16 MONITOR DECLARATIONS** Tim Welch presented the report and an overview of the declarations required. A discussion followed regarding the financial sustainability declaration. The Trust is achieving a FSRR of 3 at present however the forthcoming 12 month declaration is difficult to provide full assurance on at this time as this is predicated on the forthcoming financial planning period. It was agreed that based on the current position, the Board could agree the declarations, however the supporting narrative for Q3 to Monitor should make reference to the implications of the forthcoming planning period and the potential impact on the declarations. It was also noted that	

	reference to the current IAPT 18 week underperformance and the remedial action in place to ensure compliance by the time this becomes a formal mandated indicator. The Board resolved to **approve** all declarations, to include the two declarations in relation to finance and the governance declaration regarding compliance.	
15/16/121	**LEARNING FROM EXPERIENCE REPORT T2** Stephen Scorer presented the report and highlighted the following areas: • High levels of incident reporting being a positive indicator of a patient safety culture and in line with duty of candour • Continuing overall reduction in the use of prone restraint although an increasing use of de-escalating techniques. CWP continue to be a high reporting organisation of these incidents. There is no specific link to certain areas and the Trust is able to identify where any spikes in numbers are attributable to specific individuals or a small group of individuals who require changes to their care plans. Drawing attention to the report recommendations, Stephen Scorer highlighted the work being taken forward to further improve delivery plans for the effective and efficient management of SUIs, taking into account the learning from the recent Southern Health NHSFT review. The Board of Directors resolved to **approve** the report and recommendations therein.	
15/16/122	**AUDIT COMMITTEE REPORTING: MINUTES OF MEETING HELD 27TH OCTOBER (FINAL) AND CHAIR'S REPORT OF MEETING HELD 5TH JANUARY 2016** Mike Maier highlighted the key points from the Chair's report including the recent audit reports with limited assurance, the draft external audit plan and the assurance provided by the freedom to speak up presentation. Mike Maier noted that there are few issues reported to the Audit Committee from either the Operational Board or the Quality Committee. Sarah Reiter was approved as an Audit Committee member with immediate effect. The Board resolved to **receive** the minutes of this meeting.	
15/16/123	**QUALITY COMMITTEE – MEETING OF 4th NOVEMBER (FINAL) AND CHAIR'S REPORT OF MEETING HELD 6TH JANUARY 2016** Lucy Crumplin, deputy Chair of Quality Committee provided an overview of the proceedings at the last meeting. There were no exceptions for Board attention. The Board resolved to **receive** the minutes of this meeting.	

15/16/124	**REVIEW OF RISK IMPACTS OF ITEMS DISCUSSED** It was noted that the East Cheshire strategic plan and the lack of mental health representation represented some risk to the Trust and required further consideration as part of the next review of both the financial position risk and the commissioning/ tendering risk. **Action:** LB to take forward with CJ via the next review of the risk register.	**LB**
15/16/125	**ANY OTHER BUSINESS** Sheena Cumiskey raised the issue of the forthcoming junior doctors' industrial action planning for the 10th February 2016. Business continuity arrangements are in place. Sheena Cumiskey also wished to formally note the CQC outcome of 'Good' officially received in early December 2015. Although there has been a broad communication plan on this throughout the Trust, this is the first formal Board meeting since the announcement.	
15/16/126	**REVIEW OF MEETING** All agreed the meeting had been effective.	
15/16/127	**DATE, TIME AND PLACE OF NEXT MEETING** Wednesday 30th March, 2.00pm, Boardroom, Redesmere.	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Action points from Board of Directors Meetings
March 2016

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
27/11/15	15/16/101	**ANY OTHER BUSINESS** The Board discussed a question submitted by Murdo Kennedy in respect of the Trust's future approach to recovery. A statement was provided to Board members to consider further. This will be noted at a future Board meeting. **Action**: Board members to further consider recovery statement.	January 2016	SC/DE	To update at March 2016 Board meeting.	In progress
27.01.16	15/16/119	**BOARD PERFORMANCE DASHBOARD: DECEMBER 2015** DH to report back on progress with appraisal review work upon conclusion.	May 2016	DH	Report due to March Operational Board with full report in April/ May 2016	In progress
27.01.16	15/16/124	**REVIEW OF RISK IMPACTS** It was noted that the East Cheshire strategic plan and the lack of mental health representation represented some risk to the Trust and required further consideration as part of the	March 2016	LB	Rescoring of the tendering risk reporting to the March 2016 QC	Completed

		next review of both the financial position risk and the commissioning/ tendering risk. LB to take forward via the next review of the risk register				

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

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

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

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

Cheshire and Wirral Partnership NHS Foundation Trust
Board of Directors meeting Business Cycle 2016/17

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

No:	Agenda Item	Executive Lead	Responsible Committee/ Subcommittee	27/04/2016 Seminar	25/05/2016	29/06/2016 Seminar	27/07/2016	28/09/2016	26/10/2016 Seminar	30/11/2016	22/12/2016 Seminar	25/01/2017	22/02/2017 seminar	29/03/2017
Well Led Domain 1: Strategy														
1	**Operational Plan 2017-18approval of submission**	Director of Finance	Operational Board											✓
4	**Approve Integrated Governance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee					✓						
5	**Receive Quarterly Quality Reports**	Medical Director Compliance Quality and Regulation	Quality Committee		✓			✓		✓		✓		
6	**Strategic Risk Register and Corporate Assurance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee		✓		✓	✓		✓		✓		✓
Well Led Domain 2: Capability and Culture														
8	**CQC Community Patient Survey Report 2015/16 and Action Plan**	Director of Nursing, Therapies and Patient	Operational Board					✓						
9	**Equality Act Compliance**	Director of Nursing, Therapies and Patient	Operational Board					✓						
10	**Zero Harm strategy reporting**	Medical Director Compliance Quality and Regulation	Quality Committee				✓							✓
11	**Staff survey 2015/16**	Director of HR and OD	People and OD subcommittee (Operational Board)											✓
12	**Six monthly staffing review**	Director of Nursing, Therapies and Patient	Quality Committee/ Operational Board				✓					✓		
Monitor Well Led Domain 3: Process and Structures														
13	**Receive and Approve Quarterly Monitor returns**	Director of Finance	N/A	✓			✓		✓			✓		
14	**Receive Learning from Experience Report executive summary**	Director of Nursing, Therapies and Patient Partnership	Quality Committee		✓			✓				✓		
15	**Assessment of Quality Governance**	Medical Director Compliance Quality and Regulation	Quality Committee		✓		✓		✓			✓		
16	**Declarations of Interest: Directors and Governors**	Chair	Audit Committee		✓									
17	**CEO /Chair Division of Responsibilities**	Chair	N/A											✓

18	**Care Quality Commission Registration Report**	Director of Finance	Operational Board									✓		
19	**Receive Quarterly Infection Prevention Control Reports**	Director of Infection Prevention and Control	Infection, Prevention and Control subcommittee (Quality Committee)		✓			✓		✓		✓		
20	**Director of Infection Prevention and Control Annual Report 2015/16 inc PLACE**	Director of Infection Prevention and Control	Infection, Prevention and Control subcommittee (Quality Committee)				✓							
21	**Safeguarding Children Annual Report 2015/16**	Director of Nursing, Therapies and Patient Partnership	Quality Committee				✓							
22	**Safeguarding Adults Annual Report 2015/16**	Director of Nursing, Therapies and Patient Partnership	Quality Committee				✓							
23	**Accountable Officer Annual Report inc. Medicines Management 2015/16**	Medical Director Compliance Quality and Regulation	Medicines Management Group (Quality Committee)				✓							
24	**Health and Safety Annual Report and Fire 2015/16 and link certification**	Director of Nursing, Therapies and Patient Partnership	Health, Safety and Well-being subcommittee (Operational Board)				✓							
25	**Receive Appraisal Annual Report 2015/16 and annual declaration of medical revalidation**	Medical Director of Effectiveness and Medical Workforce	People and OD subcommittee (Operational Board)				✓							
26	**Emergency Planning Annual Report 2015/16**	Director of Nursing, Therapies and Patient Partnership	Emergency Planning subcommittee (Operational Board)					✓						
27	**Monthly Ward Staffing update**	Director of Nursing, Therapies and Patient Partnership	Quality Committee		✓		✓	✓		✓		✓		✓
28	**Provider Licence Compliance**	Director of Finance	Audit Committee		✓					✓				
29	**Security Annual Report 2015/16**	Director of Operations	Health, Safety and Well-being subcommittee (Operational Board)					✓						
30	**Mental Health Act compliance report**	Medical Director Compliance Quality and Regulation	Compliance, Assurance and Learning subcommittee (Quality Committee)		✓					✓				

31	**Receive Register of Sealings Report**	Director of Finance	Audit Committee					✓						
32	**Receive Research Annual Report 2015/16**	Medical Director Effectiveness Medical Education	Operational Board					✓						
	Monitor Well Led Domain 4: Measurement													
33	**Information Governance 15/16 Toolkit**	Medical Director	Records and Clinical Systems Group (Quality Committee)											✓
34	**Board Performance Dashboard**	Director of Finance	Operational Board		✓		✓	✓		✓		✓		✓
	Governance													
35	**Receive minutes and Chair's Report of the Quality Committee**	Non Executive Director	N/A		✓		✓	✓		✓		✓		✓
36	**Receive minutes and Chair's Report of the Audit Committee**	Non Executive Director	N/A		✓		✓	✓		✓		✓		✓
37	**BOD Business Cycle 2015/16**	Chair	N/A		✓		✓	✓		✓		✓		✓
38	**Approve BOD Business Cycle 2016/17**	Chair	N/A											✓
39	**Review Risk impacts of items**	Chair/All	N/A		✓		✓	✓		✓		✓		✓
40	**Chair's announcements**	Chair	N/A		✓		✓	✓		✓		✓		✓
41	**Chief Executive announcements**	Chief Executive	N/A		✓		✓	✓		✓		✓		✓

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Transforming Care - Cheshire and Mersey Plan
Agenda ref. no:	15/16/135
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	16/03/2016
Presented by:	Andy Styring, Director of Operations

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	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	
35T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	
35T	

REPORT BRIEFING

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

NHS England has compiled a report to brief Health and Wellbeing Boards and governing bodies on the implementation of the national Transforming Care programme for learning disabilities services across Cheshire and Mersey, setting out the region's transformation agenda for the life of the programme (which runs until 31st March 2019) and the progress to date.

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

The national policy 'Transforming Care for people with Learning Disabilities' requires radical transformation of services to ensure that individuals with learning disabilities and/or autism are supported to live the community with the appropriate support and where hospital admission is required, it is only for as long as strictly necessary. To ensure delivery of these priorities, a Transforming Care Partnership has been established across Cheshire and Mersey which includes representatives from CCGs, local authorities, providers, experts by experience and others. As a provider CWP is represented on the TCP by Andy Styring, Director of Operations and Tom Parry, Transformation Projects Manager. Both sit on the 'Cheshire' delivery hub alongside CWP, other health and social care colleagues. The Cheshire Hub has developed a draft plan, submitted on 8th February to NHS England. The final plan will be submitted on 11th April.

Assessment – *analysis and considerations of options and risks*

System-wide risks are identified in the report. As the major provider of LD services in Cheshire, CWP is heavily involved in Transforming Care and is able to work with commissioners to ensure CWP maintains its position as a specialist health care provider.

The board is asked to note that the national service model in non-negotiable as it has already been widely consulted on, however, local service changes will require public consultation.

CWP is committed to working with service users, carers, families and advocates in the spirit of coproduction to develop new services and support which we hope will mitigate against potential risks of judicial review or referral to the Secretary of State over changes to services.

There is financial risk as no new revenue funding is available to support the new models of care; this may be mitigated against through phased service transformation and NHS England transitional and capital funding. There is financial risk where service budgets are targeted for recurrent savings during the programme. Commissioners across Cheshire have been asked by the TCP chairman to protect LD budgets.

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

The Board of Director is asked to **note** the report and **support** CWP's role in delivering the national transformation agenda.

Who/ which group has approved this report for receipt at the above meeting?	Andy Styring, Director of Operations
Contributing authors:	Tom Parry, Project Manager

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	CWP Transforming Care Programme Board	1.3.2016

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

Appendix no.	Appendix title
1	Transforming Care: Implementation of National Plans across Cheshire and Merseyside

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Corporate assurance framework and risk register – update report
Agenda ref. no:	15/16/136
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	30/03/2016
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 undertakes individual in-depth reviews of risks, with the Audit Committee undertaking periodic reviews of risk treatment processes for individual risks on an escalation/ enquiry basis.

Assessment – *analysis and considerations of options and risks*

New risks – no new risks have been added to the risk register. However, there is ongoing work in relation to two potential emerging risks, which will be considered for inclusion in the corporate assurance framework and strategic risk register once a greater understanding of these is gained (the outputs of this scoping work will be shared with the next meeting of the Board of Directors):

- The risk of impact on cash flow for the Trust, in view of the current challenging financial climate. This will be considered with the Finance Services Department, alongside the finalising of the Operational Plan 2016/17.
- Failure to achieve mandated Monitor performance targets for IAPT services. A review of the locality risk registers with the locality service directors will be undertaken to inform this and a further update provided to Operational Board in April 2016 and Quality Committee in May 2016.

Amended risk scores or re-modelled risks

- No risks have been re-modelled. However, the March Quality Committee meeting received an update on its response to the findings of the Southern Health NHS Foundation Trust approach to learning from serious incidents. The Board of Directors is today receiving a continuous improvement plan in relation to this which presents an opportunity to remodel this risk so that it is focussed on system outcomes. Also following discussion at the March Quality Committee meeting, the physical healthcare clinical network and Safeguarding Sub Committee are in the process of reviewing the risks around safeguarding in order to update its strategic risk description and score.
- The risk score for one risk has been amended. The risk score for the risk of *loss of current services due to risks associated with the market environment and the potential for commissioners to seek further competitive tendering for clinical services* has been increased to 12 in view of the upcoming tenders for CAMHS Tier 4 and West 0-5 services. A strengthened risk treatment plan is in development to mitigate this increase in risk.

Archived risks – none.

Other notable exceptions

The data quality risk is subject to an internal review following identified gaps in assurance arising from an external data submission. A responsive remedial action plan is in place, which will inform the substantive risk description and risk treatment plan.

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

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

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	E Fergusson to L Brereton	22/03/2016
2	D Wood to L Brereton for Board of Directors	23/03/2016

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

Appendix no.	Appendix title
1	Risk register and corporate assurance framework – March 2016 (full document)

Corporate Assurance Framework

Updated:
23 March 2016

Risk no.	Current risk description	Origin/ source	Date initial risk added	Target risk score review date
1	Risk of harm to patients due to staff competency to manage changing physical health conditions	Incident report	20/01/2011	October 2016
2	Adults, children and young people are not protected through practitioners not implementing safeguarding practices and principles	External recommendations	01/12/2011	October 2016
3	Risk of cyber-attack resulting in loss of access to key systems and/ or data files with possible impacts on healthcare delivery, financial penalties and reputational damage	External climate	06/01/2016	January 2017
4	Risk of reduced provision of clinical pharmacy support services due to a number of staff vacancies within the pharmacy team and vacancy restrictions in operation, potentially impacting on patient safety and care and clinical strategic developments	Service notification (Trustwide risk)	29/08/2015	January 2017
5	Risk of harm to patients due to CARSO risk assessment not being completed as per policy	Incident report	05/07/2013	January 2017
6	Risk of harm to patients, carers and staff as well as reputational and litigation risks due to a) unable to show consistent investigation of incidents; b) unable to show learning from actions of incidents, claims etc. is cascaded; c) unable to be assured investigations are carried out in a timely manner; d) inability to communicate in a timely manner with partners	Incident report	11/05/2010	October 2016
7	Risk of harm to patients due to ligature points and environmental risks within the inpatient setting	Risk assessment/ incident report	11/05/2010	March 2017
8	Fragmentation of commissioning leading to fragmented patient pathways and therefore risks to delivery of good quality patient care and outcomes	Strategic plan 2014/19	05/11/2014	December 2016
9	Risk of adverse clinical incident due to quality of record keeping and dual record keeping systems (electronic and	Incident report	11/05/2010	August 2016

Risk no.	Current risk description	Origin/ source	Date initial risk added	Target risk score review date
	paper)			
10	Risk of breach of CQC regulation in respect of adherence to mental health legislation and lack of robust governance systems to monitor compliance	External recommendations	04/12/2015	March 2017
11	Failure to maintain (and predict the need for) the right number of staff with the right skills/ attitudes in the right place at the right time could impact on the Trust's ability to deliver a safe and effective service against changing needs	Strategic plan 2014/19	05/11/2014	March 2017
12	Data quality may have an adverse impact on external (regulatory, contractual) monitoring and governance ratings and on effective internal decision making regarding service planning and development	External/ independent recommendation	11/05/2010	February 2016
13	Loss of current services due to risks associated with the market environment and the potential for commissioners to seek further competitive tendering for clinical services	Strategic plan 2014/19	05/11/2014	December 2016
14	Risk of not being able to deliver planned financial risk rating due to weaker than planned financial performance and incomplete CIP plans, resulting in potential breach of terms of licence	Locality risk registers and Trust-wide reporting	11/05/2010	March 2017

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

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

Risk appetite: 3

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

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

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Physical healthcare network looking at areas such as physical health in mental health, falls and pressure ulcers ▪ Physical health zero harm group in CWP West (which includes review of pressure ulcer care) ▪ Physical health pathway and policy ▪ Essential learning ▪ Patient safety metrics ▪ Falls policy and pathway; falls risk assessment tool (cross reference with risk 3) ▪ Policy and pathway implementation in relation to healthcare monitoring agreed at February 2016 Patient Safety & Effectiveness Sub Committee	▪ Reports to Patient Safety & Effectiveness Sub Committee (PSESC) ▪ Safety metrics reporting ▪ Learning from Experience reporting ▪ Participation in mental health physical healthcare CQUIN ▪ Assurance Framework completed including triangulation of complaints, incidents and concerns in relation to pressure ulcers, falls and other physical health risks ▪ Healthcare quality improvement programme 2015/16 ▪ Training in Physical Health ▪ Benchmarking CWP performance against NICE Guidelines, Safety	▪ Commissioners supported the archive of the pressure ulcer specific strategic risk (05/11/2014), however ongoing assurance is required via review at physical healthcare network to ensure care being delivered is evidence based and that standards are continuously improving ▪ Falls management and reduction agenda managed by the physical healthcare network (from January 2016) and assurances needed of controls to be implemented	Undertake quality improvement projects on physical healthcare risks, e.g. falls, pressure ulcers Physical healthcare network 2015/16 and 2016/17 healthcare quality improvement programme Re-model the current strategic risk description to add emerging physical healthcare risk areas from local learning and also external learning (e.g. other trusts' Regulation 28 reports), e.g. sepsis, monitoring physical health needs, improving physical health reviews/ checks for all patients, increasing physical health training for mental health staff, particularly training in Early Warning Scores, making sure staff understand

	Thermometer etc ▪ Localities have scoped resources, training, support and equipment needed to implement the national CQUIN 2015/2016 – this was reported to PSESC in February 2015 ▪ Improvements are being demonstrated in stage 3 and stage 4 pressure ulcer reporting (trimester 1 2015/16 to-date)		and can identify clinical signs of physical health problems, Lester tool standards/ national CQUIN/ cardio metabolic syndrome, falls, pressure ulcers. Physical Healthcare Clinical Network May 2016

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

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

Risk appetite: 2

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

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

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Safeguarding policies: ▪ Adult safeguarding policy ▪ Children's safeguarding policy ▪ Mandatory Essential Learning policy ▪ Policy for management of investigations ▪ Policy for management of complaints/ concerns ▪ How to raise and escalate concerns policy including whistleblowing ▪ Health records policy ▪ Incident reporting and management policy ▪ Supervision policy ▪ Visiting of patients by children on adult wards ▪ Prevent assurance framework ▪ Audit programme 2015/16	▪ Learning from experience and incident reporting ▪ Safeguarding exception reporting to Quality Committee ▪ Contractual requirements within NHS standard contract regarding 100% access to supervision and 80% compliance with statutory and mandatory training ▪ Inspection report from CQC safeguarding and looked after children January 2014 – completion of action plan approved by designated nurse ▪ Trustwide Safeguarding Sub Committee minutes, business cycle and terms of reference ▪ Training needs analysis of compliance with intercollegiate guidance	▪ CWP current benchmarked position indicates that a review of current controls in relation to e.g. seclusion/ segregation, restraint, DoLS requires review and/ or improvement to be assured that improper/ incorrect applications are not safeguarding concerns ▪ Clinical audit plan requires close monitoring to ensure remains on track ▪ Training compliance with Prevent below requirement ▪ New guidance for Prevent required to be implemented ▪ Full impact of Care Act not known ▪ Capability and capacity within workforce in relation to front line safeguarding practice requires strengthening within localities	Ensure compliance reaches 85% across all levels of safeguarding training Service Directors End March 2016 (Deferred to May 2016) Scope adequate DoLS and MCA training via needs analysis Education CWP End January 2016 (Deferred to May 2016) Continue to work closely with LSABs and sub groups to monitor impact of Care Act Members of LSABs and sub groups Ongoing Develop the Safeguarding Practitioner Links programme across

▪ MHA visits ▪ MIAA programme ▪ Link to LSABs and LSCBs ▪ Safeguarding flow chart displayed on all wards and community teams ▪ Locality safeguarding groups ▪ Essential learning ▪ Patient safety metrics ▪ Healthcare quality improvement programme ▪ Compliance visits ▪ Practice audits ▪ CQC visits ▪ Monitoring of safeguarding performance ▪ Links in place between the Safeguarding Sub Committee and Patient Safety & Effectiveness Sub Committee	▪ Monthly tracker of safeguarding training ▪ CCG Self Assessment for Safeguarding Adults and Children ▪ Completion of Section 11 audit and feedback and action plan ▪ Monitoring of Prevent implementation – quarterly reporting to NHS England ▪ Compliance/inspection reports internal ▪ Quarterly performance reports to LSABs and LSCBs ▪ MIAA reports and action plans ▪ Benchmarking reports to Operational Board ▪ Improvements to restraint reduction and seclusion via quality improvement projects	▪ Gaps identified by the CQC Trustwide inspection in June 2015 ▪ Gaps in clinicians receiving learning from safeguarding incidents	all localities Named Nurses Safeguarding Ongoing Update this assurance framework to capture gaps in control identified as part of CQC Trustwide inspection in June 2015 Head of Safeguarding March 2016 (Deferred to May 2016) Sharing of learning with clinicians and teams to be strengthened via sharelearning bulletins – this is in addition to the role of the locality safeguarding sub-groups Head of Safeguarding Ongoing Introduce quarterly safeguarding updates to the Board of Directors in the 2016/17 business cycle for improved line of sight and receipt of assurance in relation to this assurance framework Associate Director of Nursing (Safeguarding)/ Head of Corporate Affairs [to schedule on business cycle] April 2016 onwards Trustwide Safeguarding Sub Committee to review this strategic risk. The sub committee will consider whether the risk is in a position to be archived, whether residual risk is appropriate to be placed on its operational work plan for monitoring or remains a strategic risk, or whether the risk description requires re-

			modelling and re-scoring. Safeguarding Sub Committee May 2016

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

Risk Owner: Director of Operations
Risk Lead: Head of ICT Services

Risk appetite: 3

Risk 3: Risk of cyber-attack resulting in loss of access to key systems and/ or data files with possible impacts on healthcare delivery, financial penalties and reputational damage

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
3	5	15	3	5	15	2	5	10

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ ICT Services continuing to update ICT infrastructure software to ensure latest security and anti-virus updates are applied ▪ Primary Firewall replaced in December 2015 ▪ Network Firewalls installed between CWP network and connections Internet/ N3 network, which are monitored and managed by CWP ICT ▪ Access is controlled by a unique username and password ▪ Laptops and tablets have their hard disk drives encrypted (McAfee Endpoint Encryption) ▪ When a Smartphone is reported	▪ Effective management of the following: ▪ Network Firewalls are monitored and managed by CWP ICT ▪ If a virus is detected, the Anti-Virus Server deletes the file and a notification is sent to the server	▪ Current Firewalls are going end of support in 2016 (no software fixes will be released) ▪ No Business Continuity Plan in place ▪ Current and future risks uncertain (pending audit/ scoping) ▪ Lack of access to internal cyber specialist	Implementation of secondary/ resilient firewall Head of IT February 2016 (Deferred until April 2016) Undertake further cyber essentials audit following installation of secondary firewall Head of IT April 2016 Undertake MIAA ICT network penetration audit. Consider/ implement recommendations from audit. Head of IT

lost or stolen, ICT send a remote “wipe” signal to the device and cancel the SIM ▪ USB drives supplied to staff by CWP are encrypted, in a similar fashion to hard disk drives ▪ An Anti-Virus Server automatically downloads and distributes Anti-Virus updates to all CWP devices, as and when new updates are released. If a Virus is detected it deletes the file and a notification is sent to the server. ▪ Trust working with specialist advisors in MIAA to advise on risk treatment processes			April 2016 Develop a programme of cyber security training for relevant ICT staff and consider integrating cyber security awareness as part of IG eLearning Head of IT May 2016 Consider appointment of specialist cyber security role/ professional as part of NDCC/ future IT strategy plans Head of IT May 2016

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

Risk Owner: Medical Director Quality
Risk Lead: Fiona Couper, Chief Pharmacist & Associate Director for Medicines Management

Risk appetite: 3

Risk 4: Risk of reduced provision of clinical pharmacy support services due to a number of staff vacancies within the pharmacy team and vacancy restrictions in operation, potentially impacting on patient safety and care and clinical strategic developments

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

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Prioritisation of service in line with the team business continuity plan under implementation from 01/09/2015 ▪ Supply of medicines function not affected with Lloyds pharmacy ▪ Delivery of a service which is within the capacity of the existing team i.e. BCP stating prioritisation of work ▪ Review of pharmacy service based on added value the team provides to patient care ▪ Regular engagement of	▪ Various medicine policies and procedures in place for medicines management ▪ Service lead (Chief Pharmacist) addressing the gaps	▪ Limited pharmacy staffing in place in each locality ▪ No senior pharmacist lead in post in any of the localities from 28/08/2015 ▪ No physical health pharmacist in post in West since June 2015 ▪ Unable to replace vacancies based on service need until a full service review has been undertaken in line with NDCC workplan ▪ Inability to carry out non-core strategic work of the medicines management	Implement approved business continuity plan to control existing gaps associated with this risk Chief Pharmacist Ongoing Review the health and well-being of current staff, i.e. monitor sickness levels, holiday entitlement, increased errors/ near misses by the team Chief Pharmacist December 2015 (deferred to April 2016)

pharmacy team with staff support services, including attendance at stress workshops and resilience training ▪ Use of locum staff		business cycle, which from January 2016 is having an impact on contract issues	

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

Risk Owner: Medical Director Quality
Risk Lead: Clinical Directors

Risk appetite: 3

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

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

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Clinical risk management policy ▪ Essential learning ▪ Patient safety metrics ▪ Effective Care Planning Lead in situ ▪ Zero Harm strategy implementation plan ▪ Care co-ordination policy ▪ Appointed clinical care planning lead ▪ Ward manager task and finish groups ▪ Care planning (incorporating risk assessment) meta-analysis undertaken with improvement actions ▪ Process agreed at March 2016 Operational Board re clinical standards around risk assessment documentation for people on standard care	▪ Patient safety metrics reporting ▪ Data quality/ completeness reporting to wards and teams ▪ Learning from experience and incident reporting ▪ Compliance visits ▪ Critical issues escalated to Patient Safety & Effectiveness Sub Committee ▪ Effective Care Planning training modules being facilitated to all staff groups as part of essential learning. Additional Effective Care Planning education is being facilitated on an individual team basis across both inpatient and community settings. All attendance is reported through EDCWP Governance Network to PODSC.	▪ Services not sustaining over 99% completion rates ▪ Further assurance needed on quality of CARSO assessments prior to re-modelling ▪ Care co-ordination policy approved at April 2015 Patient Safety & Effectiveness Sub Committee, agreed a further review by end of 2015 calendar year based on feedback from training, further work around advance statements and an integrated checklist for care planning needs – to better align with standards around formulation of risk and clinical risk standards ▪ Issues relating transfer and discharge of out of area patients and the effectiveness of the CPA current process to support these	In-depth review, supported by thematic analysis of learning from serious incidents and analysis of current status with respect to gap between risk assessments in standard letters and CARSO summarised view of risk, of cost and efficiency impact of achieving full adherence to current policy – to inform what is the current nature of the risk re CARSO risk assessment and what the Trust's adopted standard should be Quality Surveillance Support Managers/ Incidents Team/ Healthcare Quality Improvement Team – Reporting to Patient Safety & Effectiveness Sub Committee April 2016

▪ Advance statements guidance approved at February 2016 Patient Safety & Effectiveness Sub Committee and appended to care co-ordination policy		persons safely on transfer	Develop a Task & Finish Group to consider the recently published NHS England document entitled ‘Care and Treatment review for admission to hospital for learning disabilities patients’ and identify any additional amends to the existing policy and also to the educational programme. Education CWP May 2016

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

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

Risk appetite: 3

Risk 6: Risk of harm to patients, carers, and staff as well as reputational and litigation risks due to: a) unable to show consistent investigation of incidents; b) unable to show learning from actions of incidents, claims etc. is cascaded; c) unable to be assured investigations are carried out in a timely manner; d) inability to communicate in a timely manner with partners

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

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Incident reporting and management policy ▪ Complaints management policy ▪ Essential learning ▪ Quality assurance group with Non Executive Director review ▪ Weekly meeting of harm with senior oversight (Director of Nursing, Therapies and Patient Partnership and Medical Director) ▪ Learning from experience report ▪ Commissioner serious incident meetings ▪ Healthcare quality improvement programme ▪ SUI Board report ▪ Investment in clinical expert	▪ Learning from experience reporting ▪ Compliance, Assurance & Learning Sub Committee review of completion of serious incident investigations ▪ Quality Committee review of Regulation 28 learning ▪ Board review of level 3 investigations ▪ Audit Committee in-depth review of current assurances March 2015 ▪ The governance of ensuring duty of candour is recorded ▪ Significant assurance received from Internal Audit regarding	▪ Incident reporting and management policy does not reflect national standards (Duty of Candour) and recommendations from external independent reports (Southern Health) ▪ Agreement required on formal internal and external performance management of investigations ▪ Repeated learning themes (including from claims) ▪ Capacity in the Trust to meet contractual timeframes (as per NHS England guidance) ▪	Update the incident reporting and management policy to reflect new ways of working internally (e.g. meeting of harm, investigations review meeting), areas identified for improvement based on learning from external sources (e.g. recommendations from the Southern Health independent report), and recommendations from the CQC inspection (e.g. re regulatory Duty of Candour references) Head of Clinical Governance End April 2016 2016/17 contracts to agree performance management standards

champion for serious incidents and bank of investigation officers ▪ SUI Board exception report enhanced in January 2016 to ensure appropriate Board oversight ▪ In response to Southern Health NHS Foundation Trust independent report recommendations, CWP has strengthened its delivery plans in relation to the management of the investigation of serious incidents.	incident reporting and management		Head of Clinical Governance April 2016 and ongoing (based on iterative discussions with commissioners) Theme incomplete/ outstanding individual actions in response to investigations into serious incidents reported by the Trust and identifying how these thematic areas have been/ will be addressed through existing/ planned work programmes Service Directors March 2016 (deferred from January 2016 due to Compliance, Assurance & Learning Sub Committee focus on CQC learning. Deferred to May/ June meeting of CAL Sub Committee – no meeting in March 2016) Develop trajectories and forecasts based on the Trust's claims portal data – trial by forecasting quarters 3 and 4 Safe Services Department/ Finance Department

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

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

Risk appetite: 2

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

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

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
• Environmental clinical risk assessment policy • Seclusion and segregation policy reviewed against new MHA Code of Practice guidance, including associated education programme • Board approved capital programme in place, approved annually • Patient safety walkrounds • Process now in place for reviewing any relevant incidents and establishing the appropriate actions and communication mechanisms/ cascading of safety alerts • Suicide prevention action group meeting and Suicide Prevention	• Works completed (October 2014) regarding en-suite door top alarm systems and clinical risk management of dressing gown cords • Patient safety metrics reporting • Staff trained and guidance provided on the technical aspects of the en-suite door top alarm system • Reporting to Operational Board on locality risks • Reporting to Patient Safety & Effectiveness Sub Committee on outputs of suicide prevention strategy work • Continuous improvement of patient environment	• No formal link between HoNOS score and self-harm risk and/ or sudden new or sudden emergence of known risk factors to self • Alignment of clinical and environmental risk management to be further enhanced • Review required of the standard of rooms which being used as an emergency contingency measure for seclusion purposes	Review environmental clinical risk assessment policy to reflect new environmental risk assessment processes and reporting measures now in place Suicide Prevention Clinical Environmental Group End April 2016 (deferred from February 2016) Roll out environmental risk assessment report and a colour coded ligature map approach used across wards to areas within the inpatient setting such as receptions, corridors, café's etc. Clinical Services Manager End March 2016

Clinical & Environmental Risk work-stream in place meeting bi-monthly. • Suicide prevention strategy/ assurance framework • Zero Harm strategy • Compliance visits • Patient safety metrics • Testing protocol for door top alarm system • Operational risk registers monitor local controls • Estates network • Monthly seclusion task and finish group (from May 2015) • Peer benchmarking groups: CAMHS Secure Eating Disorder Learning Disability • New build – secure services and CAMHS Tier 4 unit • Ligature points are risk assessed by a process involving systematic examination of identified areas including external reviews of estate re ligatures • Each ward has a ligature “floor map” of all the bedrooms and bathrooms and identifies any potential ligature points – this supports staff when allocating bedrooms to facilitate clinical risk assessment and management • Each ward area now has a full environmental risk assessment report and a colour coded ligature map which RAG rates areas depending upon the associated	• Significant investment in ligature remedial work over the last 4 years		

risks. An annual review process is currently being formalised • A plan is also under development in relation to the assessment of community team areas with an assessment being piloted in February 2016 • Safeguards (flow chart setting out escalation procedures) for seclusion incidents			

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

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

Risk appetite: 4

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

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

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

• Integrated provider models and partnerships, e.g. via pathfinder model • Establishing even better strategic partnerships with commissioners and providers to maximise adverse impact upon services to citizens • Vanguard; provider partnerships • Active partner in the Vanguards in Wirral and West Cheshire • Key partner in Connecting Care and Caring Together			leaders - cascade through CWP Immediate and ongoing Development of Sustainability and Transformation Plan (STP) setting out clear alignment of LHE partners Chief Executive June 2016

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

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

Risk appetite: 4

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

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

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

			(Interim audit in place, process to review alerts audit to be developed pending confirmation from supplier) In-depth review of this strategic risk, with review of the risk description to ensure that it captures the current nature of the risk (including residual risks from CQC) to be undertaken by a task and finish group Associate Director of Performance & Redesign January 2016 (deferred to Spring 2016) Review and redesign of clinical systems training. Clinical Systems Manager & Head of Education July 2016 SOP to be developed for the transfer of patient records when new services are acquired. Clinical Systems Manager June 2016 Agreement of which forms are required to be retained on paper Trust Records Manager May 2016 Training refresh on specific requirement for recording of MH Act information and sharelearning bulletin to be produced. Trust Records Manager & MH Act Administrator April 2016

			Review of patient data stored on shared drives Trust IG lead and Head of ITC May 2016

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

Risk Owner: Medical Director Quality
Risk Lead: Associate Director of Safe Services/ Head of Compliance

Risk appetite: 2

Risk 10: Risk of breach of CQC regulation in respect of adherence to mental health legislation and lack of robust governance systems to monitor compliance

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	5	25	3	5	15	2	5	10

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Sharelearning bulletin to medics and nursing staff as reminder of key principles of MHA/ MCA and learning identified from CQC inspection ▪ Locality governance meetings monitoring completion of actions identified from CQC MHA Reviewer visits ▪ Enhanced reporting through to CALSC of MHA compliance with escalation to Quality Committee, Board and individual performance reviews ▪ MHA team undertaking ward and team audits to monitor key requirements of MHA/ MCA ▪ CSM/ MM undertaking weekly audit of clinical records to review	▪ Safety metrics reporting ▪ CQC MHA Reviewer visits noting improvements ▪ Improved outcomes from MHA team ward and team audits ▪ Incident reporting ▪ Investigatory themes ▪ Compliance visit outcomes	▪ Gaps in relation to targeted training for different levels of staff ▪ Recording of MHA/ MCA legislation in both paper and electronic health records ▪ MCA/ DoLS adherence (cross reference with risk 2) ▪ Inconsistency in escalation processes to flag poor performance, e.g. Responsible Clinician roles and responsibilities (performance and approval status), associate manager performance	MHA improvement plan developed to target MHA team specialist resource to support clinical teams with legislative requirements – this includes systems to ensure people's rights are upheld, e.g. access to independent advocates, associate manager appraisal, assurance of Responsible Clinician approval Head of Compliance with support from MHA Team, People Services, Matrons, Exec/ NED/ Associate Director lead for MHA All actions due to be completed by end of June 2016 Review outcomes of ward and team audit to identify any additional developments required for clinical

recording of assessment of capacity, referral to IMHA/ IMCA, reading of rights and consent to treatment ▪ Individual concerns/ lack of adherence to legislation being addressed through supervision, consultant and medical appraisal ▪ Datix reporting of any non-compliance with legislation to improve oversight and scrutiny of continued breaches ▪ Review of MHA team structure undertaken to consider effective use of resources. This will continue to be reviewed as required.			systems to streamline and simplify recording of MHA/ MCA Head of Compliance with support from Matrons/ Clinical leads to liaise with Clinical Systems Manager By end April 2016 (following completion of local CQC audit March 2016)

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

Risk Owner:	**Director of Human Resources and Organisational Development**	**Risk appetite: 4**
Risk Lead:	**Associate Director of Nursing & Therapies (Mental Health)/ Heads of Human Resources, Workforce Planning, Education**	

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

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

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

▪ Recruitment processes revised to ensure that they are safe and that all the necessary checks and risk assessments are carried out (in response to the Saville Inquiry) ▪ TRAC online recruitment system implementation commenced ▪ Creation of one integrated Resourcing Team commenced (at final consultation stage) ▪ Review carried out on options for strategic resourcing – report produced and to be discussed at POD Sub Committee on 11/05/2015 ▪ Task and Finish Group set up to address sick absence levels ▪ Programme of education and learning interventions designed to meet clinical and non-clinical skills and knowledge needs based on a TNA ▪ Trust workforce plan produced and submitted to Health Education England informed by clinical strategies ▪ Essential learning features as a Trust KPI and is scrutinised via Trust's governance processes ▪ Ward staffing monthly and six monthly review reports published	Project Group	"gaps in controls" in those other areas ▪ Agency spend on staffing has increased. ▪ Assurance of inpatient staffing levels being fully implemented ▪ Whilst recruitment issues are being addressed, sickness levels remain a concern	continue to deliver action plan for reducing sickness absence ▪ Revised report tools to enable increased use of triangulation ▪ Increase use and analysis of exit interviews to aid understanding of turnover ▪ People and Organisational Development Sub Committee to configure its business cycle to enable implementation of the recently approved strategy and to capture above actions. People and Organisational Development Sub Committee October 2015 (deferred to end November 2015 and then end of January 2016. Further deferred until May 2016 following overall Committee and Sub Committee effectiveness review presented to Board of Directors in March 2016)

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

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

Risk appetite: 4

Risk 12: Data quality may have an adverse impact on external (regulatory, contractual) monitoring and governance ratings and on effective internal decision making regarding service planning and development

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

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Data quality improvement framework detailing data quality roles and responsibilities ▪ Five year strategic plan re better use of information ▪ Data quality reporting from clinical systems to localities for sense check ▪ IT enabled project board – oversee the Data Quality Improvement Project ▪ Improvement plan to improve data quality/ completeness for national IAPT indicators for 2015/16 (quarter 3) as received by September 2015 Operational Board. ▪ Annual Governor selected Quality Account indicator	▪ Clinical coding and information governance audits detailing compliance ▪ Progress reported in 'measurement' section of Monitor quality governance framework self-assessment ▪ Quality Account external audit 2013/14 received no qualifications (currently in progress for 2014/15) ▪ CWP performance dashboard reporting ▪ Data Quality Project Implementation plan agreed at operational Board – March 2015	Implementation plan required for data quality improvement framework to assure that the required systems, processes, competencies and gatekeeping arrangements are in place to operationalise the framework (this will identify forward actions to address specific gaps) Data quality issues raised during preparations for and during CQC inspection June 2015 Data quality issues identified in relation to external data submission for CQC mental health survey 2015	Review of all data extracts from the data warehouse that support our contractual and mandatory reporting requirements Data Warehouse Manager Timescale November 2016 Revised data quality framework approved by Operational Board under implementation Associate Director of Performance & Redesign March 2016 – outstanding Development of Data Quality Improvement groups in East & West Localities Head of Performance & Information May 2016

▪ Wirral locality data quality improvement groups ▪ Data quality validation checks undertaken as part of national dataset submission process			Data validation SOP to be developed Head of Performance & Information April 2016 Review the strategic risk description as a result of data quality issues identified in relation to external data submissions Associate Director of Performance & Redesign May 2016 Review the scope of the Q1 2016/17 well-led governance review to use as an opportunity to strengthen systems and processes in relation to the "Measurement" domain of the well-led framework Associate Director of Performance & Redesign/ Head of Corporate Affairs April 2016

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

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

Risk appetite: 4

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

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

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Clinical and financial review and involvement throughout tender process ▪ Ability to influence commissioners via close working relationships ▪ History of good performance ▪ Robust Standard Operating procedures developed by Effective Services to respond to tender opportunities ▪ A non-direct care cost review is currently being undertaken and this will help to identify any gaps in current tendering processes and skills	▪ Clinical and financial review and involvement throughout the tender process ▪ Executive Director sponsor assigned to each tender ▪ 'Black hat' meeting undertaken in advance of tender submission ▪ Executive Director sign off of tender submission ▪ It is acknowledged that this risk score is likely to be volatile based on market environment	▪ Lack of business development strategy ▪ Bid writing constraints ▪ Contract management capacity constraints ▪ Costing and pricing capacity ▪ Current tendering exercises in the CWP West locality of value £25,000 - £100,000 ▪ Irregular quoracy of governance mechanism for monitoring above via the Business Development and Innovation Sub Committee ▪ Upcoming tenders for CAMHS Tier 4 and West 0-5 services	Monitor impact of Service Improvement Framework to address the gaps in controls, to guide localities, mitigate governance issues associated with sub contracted services, and to bring about consistency to mitigate the volatility of the risk score Business Development and Innovation Sub Committee/ Effective Services Department Ongoing Strengthen relationships with commissioners Ongoing throughout 2016 Review effectiveness of Business Development and Innovation Sub Committee as the principal sub

			committee for mitigating the impact of the risk, following identification of quoracy and attendance issues. Associate Director of Effective Services/ Head of Corporate Affairs March 2016 (Deferred until May 2016 following overall Committee and Sub Committee effectiveness review presented to Board of Directors in March 2016)

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

Risk Owner:	**Director of Finance/ Director of Operations**
Risk Lead:	**Service Directors/ Deputy Director of Finance**

Risk appetite: 4

Risk 14: Risk of not being able to deliver planned financial risk rating due to weaker than planned financial performance and incomplete CIP plans, resulting in potential breach of terms of licence

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	4	20	4	4	16	2	4	8

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Budget statements detail CIP ▪ Quarterly financial risk rating to Monitor ▪ Quarterly performance reviews address financial issues ▪ Associate Director of Performance and Redesign leading CIP management process/ tracking of CIP delivery ▪ Strengthened financial infrastructure via locality accountants ▪ Board approved operational plan including 2014/15 CIP plans ▪ Monthly reporting to Operational Board ▪ CIP forward planning events held in August 2014 to start the 2015/16 process ▪ Impact assessment process	▪ Impact assessment of service redesign as part of the annual planning processes ▪ CWP performance report monthly monitoring ▪ Regular monitoring via CIP steering group ▪ Internal audit programme mapped to financial strategy ▪ Audit Committee and Quality Committee overview ▪ Weekly reporting to Exec team ▪ Formal review in quarterly Performance Reviews with services ▪ Improvement in positions up to M8 ▪ Monthly assessment by Board of Directors	▪ Quality of CIP plans ▪ Plans off track ▪ Uncertainty of commissioning intentions ▪ Inability to influence the overall budget available to commissioners ▪ Fully understanding of issues driving expenditure	To continue to review quality of CIP plans and those off track (as part of 2015/16 efficiency targets) Associate Director of Performance and Redesign Ongoing 2015/16 Agree strategic service plans with commissioners based either on disinvestment from CWP or reinvestment to deliver wider systemic efficiencies Service Directors Ongoing 2015/16 Implementation of Financial Recovery Plan 2015/16 and monthly reporting to Operational Board/ Board of Directors Ongoing until return to Plan 2015/16

▪ Associate Director of Performance & Redesign and Director of Operations meeting with Service Directors to review progress ▪ Development of Integrated Provider/ Commissioning Hubs to manage service re-design; delivery in a more strategic manner ▪ Shared planning via emerging Vanguard model ▪ Review and redesign of non-direct clinical care services to achieve greater efficiencies ▪ Financial Recovery Plan 15/16 approved by Board of Directors, July 2015 ▪ Monthly monitoring of financial recovery plan ▪ Agreement of Contracting Strategy for 2015/16			Final Financial Plan 2016/17 to be approved Board of Directors March 2016 Develop draft and final Operational Plan and development of STP indicating clear alignment to LHE partners and contracting strategy Director of Finance January – June 2016

Appendix 1a: Strategic risk register

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
1. Risk of harm to patients due to lack of staff competency to manage changing physical conditions **Incorporating (previous risk no. 3):** *The inability of staff to manage the occurrences of slips, trips and falls of patients, resulting in patient injury*	20	20	20	↔	a) Ensure physical healthcare pathway is implemented trust wide in line with quality account targets b) Ensure that physical health management is incorporated into mandatory training review c) Ensure falls policy is ratified and implemented d) Ensure compliance with NPSA falls rapid response alert e) Review of physical healthcare pathway and discussion to take place regarding on-going funding/roll out of training f) Addition of physical healthcare training as mandatory for inpatient staff g) Confirmation of how physical healthcare training for inpatient staff is going to be delivered to be given to Trust Quality Committee h) Roll out a programme of physical healthcare training as part of mandatory training i) Develop an assurance framework to address	• The 19 June 2014 Patient Safety and Effectiveness Sub Committee received assurances on progress towards the target risk score from the physical healthcare network group and requested that it strengthen the controls and assurances in managing this strategic risk. An assurance framework has been developed and approved at the 18 June 2015 meeting of the Patient Safety & Effectiveness Sub Committee. • The September 2015 meeting of the Patient Safety & Effectiveness Sub Committee received a report on the national CQUIN scheme (2015/16) which provided significant assurance. This complements the September 2015 meeting of the Audit Committee receiving a presentation on physical health care risks, including falls, outlining the physical health network and assurance framework in place. • The Physical Health network reviews the Physical Health assurance framework submissions from localities on a bi-monthly basis. Training compliance is generally increasing in line with anticipated forecasts although there was a slight decrease

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
					listed gaps in control Associate Director of Nursing & Therapies (Physical Health) June 2015 j) Localities to scope resources, training, support and equipment needed to implement the national CQUIN 2015/16 Service Directors, February 2015 PSESC Sub Committee k) Physical healthcare assurance framework to be further reviewed to provide assurance around pressure ulcers, falls and other physical health risks Associate Director of Nursing & Therapies [Physical Health] August 2015 l) Localities to undertake gap analysis re cardiometabolic assessment national CQUIN based on previous year's performance and report to Patient Safety & Effectiveness Sub Committee [escalating to Board as appropriate] Locality Service and Clinical Directors October 2015 m) Audit via a three month trial across three wards of the proposed CWP physical health	reported in October 2015. **The Physical Healthcare clinical network considered the risk in January 2016 and agreed that the current physical health assurance framework is embedded and the escalation pathway established. The Medical Directors have met to review the clinical networks in place and have suggested a number of additions for the assurance framework, which was presented at the March 2016 Quality Committee meeting. Quality Committee agreed that the assurance framework needs to be updated to capture emerging risks which continue to reflect a risk score of 20, this risk description and assurance framework are therefore currently under review.**

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
					early warnings chart against the national chart to compare the number of false positives and gain an understanding of its points of use and practice Clinical Training Manager – Physical Health and Resuscitation April 2016	
7. Risk of harm to patients due to ligature points and environmental risks within the inpatient setting	**20**	**20**	**20**	↔	a) Ensure an action plan of how red/amber risks are going to be managed is discussed at exec directors meetings b) Ensure that ligature management programme is reported to the Trust Health Safety and Well-being meeting regularly c) Ensure that there is an on-going programme for ligature risk assessment and managed within the Trust d) A final report of priorities for 11/12 capital programme to go to July Ops Board for sign off - outlining remedial risks e) Following completion of actions relating to new policy, audit to be undertaken f) Embed clinical risk assessment and therapeutic assessment policies contained within MEL in clinical service g) Put a programme of ligature works in place for 2013, based on clinical risk	• Board approved capital programme in place, with update provided to December 2014 Operational Board. Capital programme for 2015/16 includes additional finance for Bowmere Hospital. • Works completed [October 2014] regarding en-suite door top alarm systems and clinical risk management of dressing gown cords. Learning from a peer review of a serious incident identified immediate organisational learning and this learning has been implemented – provision of training to staff and guidance on the technical aspects of the en-suite door top alarm system and testing protocol. • Suicide prevention action group meeting every two months bringing together observation and environment policies. • Risk description reviewed based on 2015/16 approved capital programme and alignment with operational risk descriptions. This extended risk description now includes wider components of the capital strategy

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
					h) Confirm progress against urgent works at Alderley and progress against ligature scheme i) Further action required regarding the door top alarm systems and anti-ligature products Operational Board received assurances that all actions on track for completion by August [for high priority works] as agreed. Progress at present with medium and low priority works [for completion by September and October respectively]. j) Receive a further environmental works report looking at ligature and falls risks - to Compliance, Assurance & Learning Sub Committee. Programme reported to December 2014 Operational Board and identified additional finances for Bowmere Hospital. k) Monthly Seclusion task and finish group to review current gaps in control in relation to standard of rooms for seclusion Patient Safety & Effectiveness Sub Committee October 2015 l) Capital plan to presented to Operational Board Associate Director Infrastructure Services	that impact on patient safety, e.g. required standards for seclusion facilities, which are currently being discussed at a monthly seclusion task and finish group. Good practice via Sharelearning bulletins are produced when emerging risks are identified. **Suicide Prevention Clinical Environmental Group review this risk at every meeting. They are reviewing the environmental clinical risk assessment policy to reflect new environmental risk assessment processes and reporting measures now in place, which is due to be completed by the end of April 2016. Additionally, the group is overseeing roll out of an environmental risk assessment report and a colour coded ligature map approach across wards to areas within the inpatient setting such as receptions, corridors, cafés etc. due to be completed by the end of March 2016.**

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
					November 2015	
10. Risk of breach of CQC regulation in respect of adherence to the Mental Health Act and lack of robust governance in relation to recommendations from CQC MHA commissioner visits	**N/A**	**20**	**20**	↔	a) Sharelearning bulletin to medics and nursing staff as reminder of key principles of MHA/ MCA and learning identified from CQC inspection b) Locality governance meetings monitoring completion of actions identified from CQC MHA Reviewer visits c) Enhanced reporting through to CALSC of MHA compliance with escalation to Quality Committee, Board and individual performance reviews d) MHA team undertaking ward and team audits to monitor key requirements of MHA/ MCA e) CSM/ MM undertaking weekly audit of clinical records to review recording of assessment of capacity, referral to IMHA/ IMCA, reading of rights and consent to treatment f) Individual concerns/ lack of adherence to legislation being addressed through supervision, consultant and medical appraisal g) Datix reporting of any non-compliance with legislation to improve oversight and scrutiny	• The Care Quality Commission Trustwide inspection June 2015 identified a number of risk areas, in relation to practice and governance, requiring a risk treatment plan. This feedback has been complemented by intelligence from incident reporting, NED observations and audit results. • The Compliance, Assurance & Learning Sub Committee is the principal forum to take forward compliance issues and will receive strengthened reports from localities and the MHA Team, reporting to Quality Committee on a key minimum data set, which will thence report to Board on a scheduled basis. **An MHA improvement plan has been developed with all actions scheduled to be completed by the end of June 2016. This forms part of the overall CQC action plan reporting to the Quality Committee.**

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
					of continued breaches h) Improved Board oversight of MHA compliance through 6 monthly reports scheduled on Board business cycle.	
12. Data quality may have an adverse impact on external (regulatory, contractual) monitoring and governance ratings and on effective internal decision making regarding service planning and development	20	20	20	↔	a) Upgrade of CareNotes System b) Develop a process for the prioritisation of clinical developments required for CareNotes and develop an action plan 10/11 to be reviewed annually c) Commission a review of CareNotes to look at fitness for purpose of the system d) Develop a plan for auditing manual and electronic data captured for key compliance targets to ensure on-going review of 2 targets/quarter e) Convene a data quality task and finish group to review findings of PWC Quality Accounts audit and report any recommendations/actions to Operational Board An audit by PricewaterhouseCoopers of the Trust's Quality Accounts has led to a task and finish group being established in relation to data quality. The group have been tasked with reviewing the mandatory 7 day follow up of all service users discharged and a regular report is	• Data quality improvement framework approved at November 2014 Operational Board; better use of information is detailed in the five year strategic plan. • Implementation plan developed to assure the Board of Directors, as part of its duties to monitor via the quarterly *Monitor* quality governance framework self-assessment, that the required systems, processes, competencies and gatekeeping arrangements are in place to operationalise the framework. This was presented to March 2015 Operational Board. • Risk was reviewed as part of Q3 2013/14 Monitor quality governance self-assessment – returned to green however has returned to Amber-Green for Q4 2014/15 to reflect pending assurances from aforementioned data quality improvement framework. • Quality Account external audit 2014/15 received no qualifications against mandated indicators. • Risk treatment plan has been reviewed and

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
					to be circulated to all CSUs. f) Following contracting round and annual planning process, review the Trust Information strategy g) Appoint to Data Quality Project Lead post to lead implementation of Data Quality Framework Associate Director of Performance & Redesign May 2015 (started 1st week in June) h) Present implementation plan to March 2015 Operational Board Associate Director of Performance & Redesign i) Present risk treatment plan to Quality Committee – August 2015 j) Review of all data extracts from the data warehouse that support our contractual and mandatory reporting requirements Data Warehouse Manager November 2016	presented to August 2015 meeting of the Quality Committee (in-depth review). Data quality is detailed as part of the "Measurement" domain of the Monitor Quality Governance Framework assessment and has been Amber-Green since Q4 2014/15. This does not impact on the Trust's overall governance rating. • Head of Performance & Information is Trust's data quality lead, currently phase two under implementation. **This risk is being treated according to the gaps identified in relation to the Trust's self-assessment in the Measurement domain of the Monitor Quality Governance Framework and as such the Q1 2016/17 well-led review will factor this risk into its planning. An emerging issue has been escalated (February 2016) by the CQC regarding sampling errors in relation to the community mental health survey 2015, whilst this requires an individual response it will inform systems and processes requiring improvement across the data quality agenda and inform the current nature of this strategic risk.**
2. Adults, children and young people are not protected through practitioners not implementing safeguarding	**16**	**16**	**16**	↔	a) Ensure that the Trust Safeguarding policy is reviewed. b) Ensure that hotspot areas are identified and	• The risk is reviewed by Quality Committee following receipt of safeguarding reporting every two months.

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
practice and principles					targeted training is arranged to enable the Trust to meet external targets on safeguarding training. c) Targets around training to be reviewed in Performance reviews and reported to Performance and Compliance Sub Committee and Operational Board. d) Pilot in the first instance a tool to evaluate the efficacy of safeguarding training to better demonstrate staff knowledge, understanding and adherence to trust policy and guidelines around safeguarding e) Each CSU to provide a training implementation plan to achieve 80% compliance by 31st March 2013 which will be monitored at Trustwide Safeguarding committee with exceptions reported to Quality Committee f) Safeguarding team to deliver bespoke training as agreed with General Managers to target services with low uptake rates. g) Learning and Development to support CSUs in the maintenance of an up to date accurate record of training achievement and compliance via ESR h) To re-model to reflect the action plan received following the CQC inspection of safeguarding that took place week commencing	• Positive outcome of the West Cheshire CQC inspection of safeguarding for looked after children w/c 20 January 2014. • Continuous monitoring of safeguarding practice through the Trust's compliance visits, safety metrics programmes, CQC visits, and practice audits. • The Trust is providing the monthly safeguarding assurance framework to each CCG for both adult and children's services. • Individual safeguarding referrals re Saddlebridge have been reviewed by Cheshire East Council and the criteria for a large scale investigation has not been triggered. Millbrook red complaints investigated by the Trust in parallel to local authority investigation. • Risk description and assurance framework has been reviewed to capture changing landscape within safeguarding across health and social care and also to scope wider determinants of the safeguarding strategic risk based on emerging national evidence and CWP benchmarked position (e.g. seclusion, segregation, restraint, DoLS). • Annual effectiveness review of Quality Committee (2014/15) has identified further

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
					20 January 2014. i) To re-model once receipt of all-year assurances from commissioners re compliance with safeguarding training targets. j) Trustwide Safeguarding Group to review risk description and develop an updated assurance framework Head of Clinical Governance/ Associate Director of Nursing (Physical Health) July 2015 (deferred from March 2015, Quality Committee Chair has written to Chair of the Trustwide Safeguarding Group to clarify actions required for completion by July 2015 Quality Committee meeting) k) Board to receive an update on review of red complaint investigations for CWP East Head of Safeguarding May 2015 l) Updated physical healthcare assurance framework reviewed and approved Patient Safety & Effectiveness Sub June 2015 m) Strengthen locality safeguarding groups through membership representation from the Safeguarding Specialist Nurses	clarity of the risk treatment plan is required and more timely escalation of issues. This has now been achieved following the May 2015 meeting of the Trustwide Safeguarding Sub Committee. • The October 2015 meeting of the Patient Safety and Effectiveness Sub Committee received an exception report from the Safeguarding Sub Committee to present recent learning outcomes for comprehensive safeguarding cases. Whilst the sub committee received assurance that the locality safeguarding groups have been strengthened to ensure a more consistent approach to monitoring actions plans developed in response to either single agency or multi-agency investigations, the practitioners at the meeting fed back that the sharing of learning at practitioner level still requires improvement. The Safeguarding Sub Committee has been asked to, upon receiving learning summaries from the Named Nurses for Children and Adults, to approve the production of Sharelearning bulletins. **Plan to introduce quarterly safeguarding updates to the Board of Directors in the 2016/17 business cycle for improved line of sight and receipt of assurance. Additionally, discussions are ongoing with MIAA to incorporate an additional aspect to the**

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
					Head of Safeguarding End September 2015 n) Implement findings from identified quality improvement projects (e.g. “accelerating restraint reduction”, seclusion audit, DoLS training gap analyses) Medical Director Quality/ Associate Director of Safe Services End September 2015 o) Implement action plan following investigations of red complaints in East locality CWP East locality management End September 2015 p) Strengthen the monitoring of action plans by locality groups with robust updates to Trustwide Safeguarding Sub Committee Locality group chairs End October 2015 q) Ensure links between Trustwide Safeguarding Sub Committee and Patient Safety and Effectiveness Sub Committee (for Mental Capacity Act) are effective Associate Director of Nursing & Therapies [Physical Health] End March 2016 (Deferred to May 2016)	**upcoming internal audit in line with the requirements of the forthcoming Goddard review. Collectively these will all be reviewed to consider the current nature of this strategic risk.**

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
5. Risk of harm to patients due to CARSO risk assessment not being completed as per policy	16	16	16	↔	a) Completion of CARSO risk assessments being considered as part of the Never/Always Events Framework, which will be approved Sept 13 at Operational Board Operational Board by 11/09/2013 Consideration given to this for inclusion in Never/ Always Events Framework. Agreed to include this in CSM as opposed to Never/ Always Event Framework. b) October PSE to receive information on 4Ps approach to risk formulation, and information from CDs on other speciality approaches to risk management and any support required - training etc. Clinical Directors will use 4Ps as an aide memoir. c) Appointment of an internal clinical advocate to act as a catalyst to help CWP achieve synergies in promoting safe and effective services through effective care planning and systems to prevent avoidable harm and unacceptable variations in healthcare experience - risk assessment to underpin this. Dr I Davidson appointed as clinical expert champion for zero harm. Initial proposals of the internal clinical advocate approved by January 2014 Quality Committee. Final proposals agreed at January 2014 Board of Directors. Recruitment to CPA/ effective lead due end	• Completion and quality of CARSO risk assessments included in community safety metrics programme. • Recruitment to CPA/ effective lead complete – comprehensive plans in place for care plan training and guidance, including risk assessment. This will be based on historic and recent serious incident reporting themes including those in relation to the standalone 'ligature management' risk. • September 2014 Quality Committee agreed a target risk score of 12 and timescale for achievement. The Audit Committee received an in-depth review of this risk at its November 2014 meeting and noted the risk treatment plan. • Care co-ordination policy was approved at April 2015 meeting of the Patient Safety & Effectiveness Sub Committee, reflecting clinical risk standards. Underpinning training programme in place. The plan is to further review/ strengthen this policy based on feedback from training, further work around advance statements and a review of care planning needs. There are currently ongoing issues, from a record keeping point of view, relating transfer and discharge of out of area patients and the effectiveness of the CPA process to support these people safely on transfer. The Trust Records

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
					June 2014 - currently outstanding. Recent data indicates >90% CARSO completion rate. Further assurance needed on quality of CARSO assessments prior to re-modelling. The main priority is ensuring services reach and sustain over 99% completion rates. Audit on a case by case basis in September 2014 (revised to end 2014/15) where no completed CARSO summary to understand what might be the individual clinician or managerial issues preventing completion. Further development of guidance on the CARSO summarised review of risk will be rolled out as feedback from frontline staff continues to come in and it becomes routinely used. This will ensure all staff are supported in understanding how to use it best to promote safety, quality and recovery in CWP services. d) Appointment of a CPA/ effective lead to implement a risk treatment plan to work towards achievement of risk score of 12 Associate Director of Nursing & Therapies Mental Health by end September 2014. Postholder has developed a work programme to end of March 2017 aligned with Board approved zero harm plans based on actions identified in (c) above and also themes from root cause analysis investigation. e) Audit on a case by case basis end of	Manager is currently reviewing this and will report to PSESC in April 2016. • The October 2015 meeting of the Patient Safety & Effectiveness Sub Committee received a desktop meta-analysis review of the current status of clinical practice in relation to care planning and risk assessment. Clinical services all signed up to the care planning model of strengths, needs and aspirations. Progress with the associated year 2 delivery plans will be provided to the Quality Committee via the routine implementation plan updates on Zero Harm. This will include updates on development of a framework to ensure an outcome focus to care planning. • NHS England has issued a new document entitled 'Care and Treatment review for admission to hospital for learning disabilities patients'. A task and finish group will be convened to identify any additional amendments to the existing policy and also to the educational programme currently being facilitated by Education CWP. • Recovery and Implementation Group [RIG] was asked to develop an advance statement which focuses on being more patient centred and recovery focused, this was approved by PSE Sub Committee in February 2016.

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
					September 2015, where no completed CARSO summary, to understand what might be the individual clinician or managerial issues preventing completion. Clinical Audit Coordinator September 2015 f) Workshops have been held to held to educate staff on effective care planning and this will be enabled through the managerial/ supervisory hierarchy February 2016. g) Further review of care co-ordination policy that was approved in April 2015 to be undertaken based on feedback from training, further work around advance statements and feedback provided to Effective Care Planning Lead via Matrons and Ward Managers to October meeting of the Patient Safety & Effectiveness Sub Committee – to better align with standards around formulation of risk and clinical risk standards Effective Care Planning Lead February 2016	• March 2016 Operational Board agreed standards for clinical risk assessment documentation for people accessing standard care. **Actions arising from the CQC inspection around gaps/ variation in care planning potentially impacting on management/ assessment of clinical risk. Target risk score is deferred pending delivery of actions within the CQC action plan and will be reconsidered at the end of March 2016. The corporate assurance framework details actions to explore the current nature of this risk in order to refresh the current risk treatment plan.**
9. Risk of adverse clinical incident due to quality of record keeping and dual	**16**	**16**	**16**	↔	a) Review Terms of Reference for Trust Records Meeting as part of the Trust	• The Records and Clinical Systems Group is correlating clinical systems priorities with the dual record keeping risk – also tying into

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
record keeping systems (electronic and paper)					governance review b) Review the Trust records policy to ensure compliance with NHSLA standards c) Clinical informatics lead to work with IM&T to promote further development of CareNotes - presentation to Quality Committee d) Undertake a review where the Trust has dual record keeping systems and where the risks may be increased so that mitigations can be put in place e) Give an update of the action plan developed to October Patient Safety & Effectiveness Sub Committee f) The policy is currently under review for NHSLA compliance purposes, and will be approved at Patient Safety & Effectiveness Sub Committee in October. g) Give an update of the dual record keeping action plan to Patient Safety & Effectiveness Sub Committee AMD Quality (Chair of Trust Records Group)/Gill Monteith, Trust Records Manager by 30/06/2013. This item was deferred from June Patient Safety & Effectiveness Sub Committee - The revised Assurance Framework deferred from August PSE and will be received at	review of system effectiveness and functionality. • A revised dual record keeping action plan was presented to the December and February 2013/ 2014 Patient Safety & Effectiveness Sub Committee meetings, for completion end March 2014. Confirmed as completed. • Escalated to risk score of 16 following CQC visits to Springview in November 2013 and Bowmere in January 2014 which highlighted minor concern in respect of outcome 21 (records). Subsequently CQC have provided full assurance on compliance at Springview and Bowmere following re-inspections. **Target risk score of 12 deferred with target date to be agreed pending confirmation of processes supporting IT enabled transformation programmes. The output of a scoping exercise to identify clinical data held on shared drives/ manually was received by the Records and Information Systems Group in August 2015. A revised training needs analysis, including additional scoping of clinical systems training, was approved the People and Organisational Development Sub Committee in September 2015. The IT enabled group is to be apprised of the findings of recent clinical**

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
					October PSE. A revised dual record keeping action plan was presented to the December 2013 Patient Safety & Effectiveness Sub Committee. Patient Safety & Effectiveness Sub Committee will continue to monitor this action plan and to report exceptions to Quality Committee. h) February Patient Safety and Effectiveness Sub Committee to monitor progress, achievement required by end March 2014 as per response to CQC.	**audits flagging dual record keeping as an issue that requires further, more detailed review. The October Audit Committee meeting asked that the Quality Committee schedule an in-depth review of the dual record keeping risk; the January 2016 meeting of Quality Committee received an update in relation to this risk. Some record keeping issues highlighted by the CQC inspection and specific actions included within the CQC action plan. A task and finish group is being established to look at reframing the risk and therefore the current risk treatment plan and the links to the data quality risk.**
6. Risk of harm to patients, carers and staff as well as reputational and litigation risks due to: a/ unable to show consistent investigation of incidents; b/ unable to show learning from actions of incidents, claims etc. is cascaded; c/ unable to be assured investigations are carried out in a timely manner d/ inability to communicate in	**16**	**16**	**16**	↔	a) Establish core group of lead investigators within CSUs to receive externally commissioned training. b) Streamline RCA process. c) To plan and implement Investigation Managers Drop-in sessions. d) To develop and implement an Investigation Toolkit for RCA Investigators. e) Establish in house RCA training programme for additional investigators by 30/09/2012- revised action due to Risk and Legal Services Managers leaving	• Learning from experience report will be monitored to inform risk treatment plan on an ongoing basis. • Service Directors have been asked to monitor the management of actions arising from root cause analysis investigations – this is routinely monitored at the Compliance, Assurance & Learning Sub Committee and now also at Quality Committee due to lack of improvement (since August 2015). • Ongoing work around improving the process around interface incidents and ensuring actions arising/ learning points are clear.

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
a timely manner with partners					f) Ensure that 4 in house RCA training session are facilitated prior to end March 2013. g) Recruit 2 RCA leads within the Clinical Governance Department on a fixed term contract to promote consistent investigation are undertaken, learning takes place and the Trust meet contractual requirements. h) Undertake a review of unexpected deaths over a period of time, report findings and develop actions as appropriate i) Identify medical leads to support RCA leads in each area whose role will be to ensure quality of reporting, adhere to timeframes and promote feedback of learning to services. j) Training programme to be developed for RCA leads and medical leads. k) Update Incident Policy and protocols in line with revised national policy and Duty of Candour legal and contractual requirements. Further work is on-going to further improve RCA processes as part of zero harm proposals (see CARSO strategic risk). l) Implement recommendations/ actions from CQC outcome 16 review. Service Directors monitor the management of actions arising from root cause analysis	• Full review of incident reporting and management policy has been completed. • Director of Nursing, Medical Director and Associate Director of Safe Services met with CCGs in February 2015 to agree new ways of working to bring about better outcomes rather than addressing this risk solely through adding process focussed capacity. There was a follow-up meeting in September 2015, which further discussed how to work with commissioners and other providers in identifying system-wide learning from incidents. • Audit Committee undertook in-depth review at the March 2015 meeting and agreed the risk target score of 9 to be achieved by March 2017. Work currently ongoing to scope appointment of clinical expert champion for serious incidents and bank of investigation officers, discussed at August 2015 Quality Committee and is now progressing. **The October 2015 meeting of the Patient Safety and Effectiveness Sub Committee considered the high volume of incomplete/ outstanding actions identified in response to investigations into serious incidents reported by the Trust. A long term solution was discussed, included identifying SMARTer thematic actions and identifying a**

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
					investigations and performance is monitored at the Compliance, Assurance and Learning Sub Committee - exceptions reported to Quality Committee. m) Full review of incident reporting and management policy (including a governance and assurance framework) post publication of NHS England guidance Head of Clinical Governance July 2015 (deferred from May 2015 with agreement of Quality Committee to allow discussion of NHS England guidance with commissioners and agree consensus) n) Scope appointment of clinical expert champion for serious incidents and bank of investigation officers Director of Nursing, Therapies & Patient Partnership/ Head of Clinical Governance End September 2015	**realistic number of achievable actions, recognising that there is not a correlation between a greater number of actions and the quality of an investigation. The localities are theming incomplete/ outstanding individual actions and identifying how these thematic areas have been/ will be addressed through existing/ planned work programmes – reporting this back to the CAL Sub Committee to agree formal closure of the actions.** **This risk description/ treatment plan and assurance framework will be reviewed following the March 2016 Board meeting's receipt of a continuous improvement framework responding to the independent recommendations in relation to Southern Health NHS Foundation Trust's management of serious incidents requiring investigation. Further, there are a number of systems improvements in train, e.g. development of an investigatory toolkit, pilot of an investigations review panel. Collectively these things will also be used to update the Trust's current incident reporting and management policy.**
14. Risk of not being able to deliver planned financial risk rating due to weaker than planned financial performance and incomplete	**16**	**16**	**16**	↔	a) Ensure achievement of CIP plans continue to be monitored at Board of Directors and Operational Board b) Development and review of annual plans to	• Financial recovery plan developed in response to weaker planned performance in Q1 15/16, strongly driven by staffing costs and IGB.

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
CIP plans, resulting in potential breach of terms of licence **Previous risk description:** *Risk of not being able to deliver planned financial risk rating due to incomplete CIP plans resulting in potential breach of terms of authorisation and reputational damage*					include CIP. c) All clinical and corporate services to submit a structured financial recovery plan. d) Strengthened financial infrastructure via recruitment of locality accountants and establishment of a performance and redesign function to support tracking of CIP delivery. e) Improved process now in place, including weekly updates on CIP plans to Executive Team and also at every Operational Board meeting. Risk re-modelled to take account of improvements to process. f) Strengthening of financial infrastructure via recruitment of divisional accountants and establishment of (equivalent to a) PMO function to support tracking of CIP delivery. g) Improved process now in place including weekly updates on CIP plans to Exec Team and also at every Operational Board meeting. Quality Committee routinely receives quality impact assessments/ ongoing outcomes of CIP implementation. h) Development and implementation of Financial Recovery Plan 2015/16 i) NDCC Programme Board in place to deliver	**End of M10 shows an in-month surplus of £98k reported with a cumulative deficit of £53k. Cumulative performance is now £31k ahead of the original Monitor plan. This performance is also broadly in line with our internal revised forecast as at the end of January. The Trust is currently scoring financial sustainability risk rating of 3. CIP gap remains challenging. Control total assigned from Monitor may impact on FSRR.**

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
					non direct care savings across corporate teams.	
4. Risk of reduced provision of clinical pharmacy support services due to a number of staff vacancies within the pharmacy team and vacancy restrictions in operation, potentially impacting on patient safety and care and clinical strategic developments	**15**	**15**	**15**	↔	a) Senior locality management staff made aware of risk to service delivery. b) Prioritisation of service to be delivered agreed with pharmacy team c) Communication of business continuity plan to be disseminated in comms bulletin 26/8/15. d) Service review commenced by chief pharmacist and timetabled to be taken to October Operational Board meeting for decision making. e) Undertake review of pharmacy service based on added value the team provides to patient care Chief Pharmacist October 2015 f) Pharmacy team have engaged with staff support and attended a stress workshop as a team.	• BCP in place to prioritise work. • Health and well-being of the existing staff is being ensured, i.e. monitoring sickness levels, holiday entitlement, increased errors/ near misses by the team. • A review of pharmacy service to be scheduled to ensure a pragmatic and responsive service based on the added value the team provides to patient care. The review process needs to be carried out quickly and not protracted to minimise the time of reduced service. • Reinvestment of the current team vacancy money back into staffing the clinical pharmacy team so that full services can be reinstated. • Quality Committee approved the addition of this risk to the strategic risk register at September 2015 meeting. Further work is ongoing to identify a risk target score and date for achievement as well as further work to the risk treatment plan. Operational Board received an update on the review of Pharmacy Services in October 2015, which set out future options for the service, focussing on recruitment to the team and refocussing of job roles to improve

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
						efficiency. **Implementation of pharmacy structure underway following approval; recruitment is in progress with first vacancies due to be filled in March 2016. Some residual risks still impacting on Pharmacy Team staffing. To retain on risk register and review by end March 2016 with Chief Pharmacist.**
3. Risk of cyber-attack resulting in loss of access to key systems and/ or data files with possible impacts on healthcare delivery, financial penalties and reputational damage	**N/A**	**15**	**15**	↔	a) Audit Committee received reviews in relation to cyber risks at meetings in September and November 2015, following which it was recommended that the risk be included on the strategic risk register and is reviewed by Quality Committee in January 2016. b) ICT Services continue to update ICT infrastructure software to ensure latest security and anti-virus updates are applied. c) Primary Firewall replaced in December 2015.	• Implementation of secondary/ resilient Firewall in February 2016. **Deferred to March 2016.** • Cyber Essentials Audit, once secondary Firewall installed. Following this, recommendations from the audit will be considered/ implemented, in April 2016. • ICT Network penetration audit by MIAA which due commence in April 2016. Following this, recommendations from the audit will be considered/ implemented. • ICT Security training for relevant ICT staff, including consideration of making ICT Security awareness as part of Information governance eLearning. • ICT have recommended the appointment of an ICT Security officer (B7 – other Trusts have this role), who would bring a focus to ICT Security and also support the Trust in

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
						the development of Business Continuity Plans, ensuring the ICT elements of those plans are developed and tested. Finance have requested a Business Case to progress this recommendation. **March 2016.** **Modelling of risk has identified few assurance measures in place. Head of IT to continue to develop framework of assurances as the implementation of the risk treatment plan progresses such as regular reporting through the governance structure for increased scrutiny and line of sight. Head of IT is developing a business continuity plan in the event of a network attack. Draft internal audit plan for 2016/17 includes audit on cyber threat preparedness.**
8. Fragmentation of commissioning leading to fragmented patient pathways and therefore risks to delivery of good quality patient care and outcomes	**12**	**12**	**12**	↔	a) Robust mechanisms around tendering ensuring capacity at senior level to respond to changes in commissioning intentions Corporate and Operational services/ Effective Services Department September 2015	• Existing discussion and engagement with commissioners and partner organisations, including across key complex patient pathways and populations and to take account of extensive change in commissioning structures. • Quality assurance, improvement and governance mechanisms in place and routinely assessed to promote delivery of good quality patient care and outcomes. • Operational Plan 2015/16 submitted to Monitor in May 2015. This details how the

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
						Trust is planning to build upon opportunities presented by Vanguard, IPH, and integration with CWaC provider services**.** • A specific area is around crisis care (Street Triage and also care/ contingency planning) as discussed at the September 2015 meeting of the Quality Committee. A clinical audit has been presented to February 2016 Patient Safety & Effectiveness Sub Committee and will in part inform the risk treatment plan. **Further consideration of this risk is being undertaken as part of strategic and operational plan review and clinical strategy update as per Trust business planning cycle.**
11. Failure to maintain (and predict the need for) the right number of staff with the right skills/ attitudes in the right place at the right time could impact on the Trust's ability to deliver a safe and effective service against changing needs	**12**	**12**	**12**	↔	a) Development of the risk treatment plan. People and Organisational Development Sub Committee - July 2015 (with initial update to Operational Board May 2015) b) Financial Recovery Plan paper (including ward staffing costs) provided to Board of Directors requires update on implementation Director of Finance September 2015 c) **People and Organisational**	• Programme of education and learning interventions designed to meet clinical and non-clinical skills and knowledge needs. • Trust Workforce Plan produced and submitted to Health Education England. • Process in place for vacancy approval and filling. • Ward staffing review identifying capacity issues and focusing recruitment activity. • Mandatory training features as a Trust key

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
					Development strategy approved following review at Operational Board and Board.	performance indicator and is scrutinised via Trust's governance processes. • Bank and Agency usage reported to Operational Board. • Investors in People assessment recognised good practice in a range of associated areas. • 6 monthly ward staffing report received at July 2015 and January 2016 Board. **In response to the risks identified as part of the CQC inspection (which was also a previous strategic risk), the People & OD Sub Committee should review the risk description to ensure that it adequately covers the right number of staff within physical health services in particular, but generally also the capacity and skills of the workforce to respond to emerging and new models of care provision and evidence based interventions.** **January 2016 meeting of People and Organisational Development Sub Committee (PODSC) recommended that the Safe Staffing Group review this risk in order to provide an update for the Quality Committee. Following the ongoing review of committee and sub committee effectiveness, the PODSC will review the terms of**

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
						reference and business cycle to enable implementation of the recently approved strategy and to capture actions necessary to mitigate the risk.
13. Loss of current services due to risks associated with the market environment and the potential for commissioners to seek further competitive tendering for clinical services	9	9	12	↑	a) Identify back fill requirements for clinical leads (on a bid by bid basis) by Locality Service Directors (on a bid by bid basis). b) Review skills and capacity at both locality and corporate level. c) Service Improvement Framework developed to bring about consistency in approach now under implementation. d) Externally facilitated strategic planning training aimed at clinicians took place at July 2015 and October CELF. e) process in place to ensure: • Ability to influence commissioners via close working relationships. • Robust Standard Operating Procedures developed by Effective Services Department to respond to tender opportunities. • Clinical and financial review and involvement throughout tender process.	• It is acknowledged that this risk score is likely to be volatile based on market environment. • Business Development and Innovation Sub Committee (BDISC) is the designated governance meeting to maintain oversight of this risk and risk treatment plan. Quoracy issues are impacting on effectiveness of the sub-committee and the ability to fully mitigate this risk which is a possible reason for risk escalation given its potential impact. **BDISC reviewed the risk at the February 2016 meeting and recommended that the scoring for consequence be amended 4 to given that we are expecting tender for CAMHS Tier 4 and West 0-5 services. This increases the overall risk score to 12. Work to further develop the risk treatment plan will report to the next BDISC meeting.**

Description of the risk	Residual risk rating Nov 2015	Residual risk rating Jan 2016	Residual risk rating March 2016	Risk score since last review	Actions completed to-date	Current summary risk treatment plan
					• Executive Director sponsor assigned to each tender. • “Black Hat” meeting undertaken in advance of tender submission. • Executive Director sign-off of tender submission.	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Healthy Living Centre – notice of contract 31.03.2016
Agenda ref. no:	15/16/137
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	30/03/2016
Presented by:	Andy Styring, Director of Operations

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

In January 2016, Public Health as part of Cheshire West and Chester Council (CWaC) gave notice to CWP that they would no longer fund services provided from the Healthy Living Centres in Blacon and Ellesmere Port from 31 March 2016. The buildings will remain however CWaC will redesign the Ellesmere Port Centre.

CWP has kept staff informed on a regular basis. A management of change process has commenced and the staff affected met formally on the 5th Febuary 2016 with HR and Staff Side representation to discuss their current employment, redeployment options and the service exit strategy. Staff will continue to support service users until the 31st March 2016 as well as signposting people to the complaints team at CWaC and CWP Patient Advice and Liaison Service if they have any concerns about their health and wellbeing.

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

The Healthy Living Centres provide information, advice and support for the local populations of Chester and Ellesmere Port. They deliver programmes and interventions that promote healthy lifestyles and wellbeing; including healthy diet, health trainer sessions on lifestyle, health MOTs. CWP has not undertaken consultation in respect of closure and is not aware of Public Health having done so.

CWP has been made aware of public and other stakeholder's concerns including a public petition to 'save' the Centre in Ellesmere Port with over 400 supporters. Justin Madders MP and local Councillor Louise Gittens have also made enquiries. CWP and CWaC communications teams have been working together to ensure that key messages are open, transparent and aligned given the sensitivities around funding.

Assessment – *analysis and considerations of options and risks*

CWP has expressed the importance to CWaC about the need to provide sufficient information to staff and the general public as well as the opportunity to be involved in service change. CWP is proceeding with an exit strategy driven by a project group that is meeting weekly to ensure that the services are ended effectively and that both staff and service users are supported during the change.

It has been confirmed that TUPE does not apply in this process so every effort is being made to redeploy staff into suitable roles. This management of change process may result in financial implications for CWP in relation to potential compulsory redundancies. CWP will need to review impact of loss of funding on other services delivered from the Healthy Living Centres, including the Recovery College.

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

The Board of Directors are asked to **note** the termination of this service, the actions taken by CWP West to mitigate the impact of closure, and the residual risks relating to withdrawal of the service.

Who/ which group has approved this report for receipt at the above meeting?	CWP West Cheshire SMT, Andy Styring, Director of Operations
Contributing authors:	Amy Padley, Head of Service

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
N/A	N/A	N/A

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

Appendix no.	Appendix title
N/A	N/A

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Response to Southern Health NHS Foundation Trust independent report recommendations
Agenda ref. no:	15/16/138
Report to (meeting):	Board of Directors – meeting in public
Action required:	Comments and/ or recommendations sought
Date of meeting:	30/03/2016
Presented by:	Avril Devaney, Director of Nursing, Therapies & Patient Partnership

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

To provide an update on how CWP is responding to the learning identified in the independent report into unexpected deaths of people accessing services at Southern Health NHS Foundation Trust over a four year period since April 2011. CWP is committed to learning from external recommendations as an opportunity to strengthen its own systems and processes further. Serious incident management is a strategic risk for the Trust and therefore this report is an opportunity to review its current controls and assurances, as well as strengthen collaborative working with commissioners and other partner organisations (including as informed by mortality reviews) within the wider care system, so that the system as a whole aspires to securing the most efficient, effective and appropriate investigation of unexpected deaths, irrespective of the service/s a person has accessed within the community. This report presents the Trust's response and continuous improvement plan.

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

An independent report, commissioned by NHS England, found that between April 2011 and March 2015, Southern Health NHS Foundation Trust failed to investigate the unexpected deaths of more than 1,000 people. Further, the likelihood of an investigation depended on the "type" of patient, and when investigations were carried out, they were poor quality and often very late. The report blames a failure of leadership at the trust, which is one of the country's largest mental health trusts, providing services to about 45,000 people. The key findings from the report are:

- The trust could not demonstrate a comprehensive systematic approach to learning from deaths.
- Despite the trust having comprehensive data on deaths, it failed to use it effectively.
- Too few deaths among those with learning disability and over-65s with mental health problems were investigated, and some cases should have been investigated further.

In nearly two-thirds of investigations, there was no family involvement.

Southern Health is receiving expert support with strengthening the above via an improvement director.

Assessment – *analysis and considerations of options and risks*

Through a focus on continuous improvement, CWP has strengthened its delivery plans for managing the investigation of serious incidents in the following ways (this list is not exhaustive):

- Piloting a new approach to the review of investigation reports prior to sign off. This will strengthen executive oversight of the quality of investigations and facilitate appropriate measures being put in place to address and learn from issues identified, locally and Trustwide.
- A new bank of Investigating Managers are currently being employed to support the quality and consistency of investigations and learning.
- Ensuring that the Trust captures conclusions from inquests in a even more robust way, and to ensure it acts on areas for improvement quickly, is also being strengthened.
- The weekly Meeting of Harm is being further developed, to ensure that there is a clear audit trail that all unexpected deaths are discussed.
- Approaches to provide every family with the opportunity to be involved in investigations relating to a death of a loved one are also being further strengthened.
- An investigations toolkit is being developed to improve the overall process, including an even better alignment of serious incident investigations where there are HR and safeguarding elements.

A joint improvement plan is currently being developed, iteratively, with all the Trust's quality leads from the CCGs and will be revisited/ completed pending further guidance from NHS England. CWP will also be committed to working with all of its other partner organisations to ensure a true system-wide response as recommended in the independent report. This includes full engagement with any system-wide mortality review processes which may emerge, and exploration of joint working with other provider trusts re reciprocal arrangements to support capacity for and independence of investigations.

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

The Board of Directors is asked to **note** and **comment** on the Trust's proposed means of responding to the recommendations in the Southern Health NHS Foundation Trust independent report.

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	23 March 2016

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

Appendix no.	Appendix title
1	Continuous improvement plan in response to Southern Health independent report recommendations

15_16_138 Appendix 1

Action plan title	Continuous improvement plan in response to Southern Health independent report recommendations
Action plan authors	Audrey Jones, Head of Clinical Governance David Wood, Associate Director of Safe Services
Executive lead	Avril Devaney, Director of Nursing, Therapies & Patient Partnership
Date of development	22 March 2016 (iteration 1)
Date/s of next scheduled reviews	17 May 2016 (iteration 2)

***Theme:* Board Leadership and Oversight**			
Action identified (for Southern Health)		**Current CWP assurance**	**Further improvement actions for CWP**
1a	The Board needs to ensure the processes of reporting and investigating unexpected deaths are consistent and robust throughout the organisation and to improve the quality of investigations and the involvement of families in those investigations. The Trust needs to prioritise the review of deaths as part of a wider mortality review process making better use of data available.	▪ The Board receives oversight of an exception report at each meeting, reporting on all serious incidents. ▪ The Board receives information about deaths via the Learning from Experience report three times per year. ▪ The Executive Team receive notifications of all serious incidents that are reported on the StEIS system on the day that they are reported. ▪ Duty of Candour compliance is recorded and monitored via the Datix system, furthermore, the engagement and involvement with family is checked by the weekly Meeting of Harm. Further, involvement is captured within the final investigation report. ▪ Incident investigator training includes coverage on the duty of candour and involving families in investigations. ▪ The Trust is appointing a Clinical Champion to support the Trust in improving the quality of investigations, action planning and embedding	i. To set up a process for all serious incident reports to be signed off by a review team meeting. This meeting will involve an Executive Director, Non Executive Director, a member from the Safe Services Department, the Investigation Manager and one other Director/ Clinical Director. Pilots to take place in March 2016, the full meeting to commence April 2016. ii. Head of Clinical Governance to undertake an audit in relation to compliance with Duty of Candour by 15 April 2016. iii. A toolkit to support a consistent approach to all “serious” investigations (including HR and safeguarding) is currently being developed by the Heads of Clinical Governance, Safeguarding and Human Resources, for completion end April 2016.

		the learning from incidents.	
1b	The Board needs to understand and make full use of the data available and the underlying information required for assurance that unexpected deaths are being properly identified and investigated.	As 1a.	i. Discussion and agreement, on an ongoing basis and upon receipt of the routine Learning from Experience report, regarding what information the Board wishes to/ should receive.
2a	2015/16 Annual Report should provide a more transparent breakdown of deaths including an analysis of the themes that occur for people with Mental Health and Learning Disability challenges.	The Trust's Annual Report and Quality Account contains high level data which currently meets the national reporting requirements and guidance.	i. The Annual Report/ Quality Account 2015/16 will be developed to include a detailed breakdown of deaths and analysis of the mortality thematic reviews that have been undertaken.
2b	Provide data on all deaths of people using a Mental Health or Learning Disability service including service users of the social care service.	▪ All Learning Disability deaths are reported within Datix, a 72 hour safety review on all deaths is submitted to the weekly Meeting of Harm. This meeting identifies the requirement for any further investigation. ▪ As 1a.	No further actions currently.
2c	Outline how many unexpected deaths there have been and in which areas.	The Board receives the number and detail of unexpected deaths which are to be investigated in line with the Trust's serious incidents policy.	As 1bi.
2d	Outline how many IMAs (equivalent to CWP 72 hour safety review) have been written as a result and how many have progressed to CIR (Critical Incident Review) and then onto being a Serious Incident under the 2015 Serious Incident Framework.	Unexpected deaths are discussed at the weekly Meeting of Harm. A decision is made as to the level of investigation that is required after reviewing the 72 hour safety review. The decisions of the meeting are captured on a spreadsheet, recorded on Datix and where appropriate StEIS is updated.	i. A quarterly report broken down by specialty will be produced to provide the Board with a summary of unexpected deaths occurring, the numbers requiring further investigations, and those not requiring further investigations. This will accompany the exception report received by Board (assurance 1a).
2e	Include a summary of how many deaths are 'pending' for the purposes of investigation with a reason why. This would make the decision-making more transparent as regards to delays in reporting to StEIS.	This is currently discussed and recorded at the weekly Meeting of Harm. This information is currently available within the Datix system.	i. The current report produced following the weekly Meeting of Harm is being developed on an ongoing basis to demonstrate transparency of decision making processes.
2f	Provide information to enable trends to be identified and for Board members to	Improved reporting of serious incidents and deaths has been incorporated into the exception	i. Ongoing work to enhance information provided in the Learning from Experience

	become familiar with the information.	report provided to the Board.	Report in relation to incidents, unexpected deaths, trends and learning themes.
2g	Provide information which includes the categorisation of all deaths reported to Datix.	As 1a.	As 1a.
2h	Provide data at least twice a year on all deaths. Themes should be reported on which covers at least the previous 6 quarters (or a sufficient number to provide a reasonable sample from which to identify themes). This is particularly important for the Learning Disability arena where numbers of deaths in each quarter will be low and in areas that may not be considered to meet Serious Incident reporting guidance e.g. non-suicide Mental Health deaths.	The Learning from Experience report contains the previous 3 trimesters for all deaths, including Learning Disability Services. The recommendations and findings from serious incidents are themed.	No further actions currently.
2i	There is clear national and Trust policy guidance on reporting and investigating deaths. Trust policy includes a full set of templates and processes – the Board should ensure these policies are being followed and templates being used.	Policy and procedures are in place and specifically relate to reporting and investigating incidents and deaths. The Trust policy is in line with the NHS England framework. An investigation toolkit is currently being developed in partnership between the Safe Services, Human Resources and Safeguarding Departments.	i. As 1aiii. ii. Compliance against Trust policy to be provided to the Quality Committee on an annual basis, commencing September 2016.
Theme: **Monitoring mortality and unexpected deaths / attrition**			
3	Unexpected deaths should be defined more clearly. We suggest the Trust uses, as a starting point, the classification outlined in this report to identify the potential need for review or investigation in each case. In particular, the definition of an 'unexpected death' needs to be refined to be more applicable to the circumstances of people with a Learning Disability regardless of setting.	The Trust's weekly Meeting of Harm monitors all unexpected deaths. A 72 hour safety review is presented by the locality and the meeting makes a decision as to the level of investigation that is required. If a decision is made not to undertake any further investigation – this will be discussed and agreed with the relevant CCG. All decisions are recorded within a spreadsheet and recorded after every meeting onto the Datix system.	i. The Trust's incident reporting and management policy will be updated immediately to include a definition of an unexpected death to incorporate the recommendations.

4	The Trust should develop a Mental Health and Learning Disability Mortality Review Group which includes reviewing unexpected deaths which do not constitute a serious incident. Clear terms of reference should be developed. This group should serve a number of purposes: a. to provide oversight of all deaths occurring amongst the Trust's Mental Health and Learning Disability service users b. develop a mortality dashboard which is provided to stakeholders and reported in the annual report, that provides a full picture of all deaths, themes, CIRs and serious incidents c. monitor causes of deaths amongst its service users by using the 2013/14 MHMDS data release to see if the ICD 10 chapters show any trend d. provide an evidence base to share with Local Authority commissioners and other providers highlighting themes that are arising relating to social care and other agencies issues e. to ensure that liaison with acute provider colleagues can take place at a clinical and managerial level where the Trust has concerns raised with it about care in acute settings should include a GP as part of its membership g. the formation and progress of this new group should be monitored at Board level h. the group must aim to improve the transparency of reporting levels of unexpected deaths in these service user	The Trust currently works with acute trusts with some joint investigations as a result of serious incidents.	i. This will be considered further as part of the iterative development of the joint improvement plan with all the Trust's quality leads from the CCGs and will be revisited/ completed pending further guidance from NHS England.

	groups.		
		***Theme:* Thematic Reviews**	
5	A template for a thematic review should be produced. All thematic reviews should be undertaken in an agreed format which meets best practice standards and includes follow up, evaluation and demonstration of lessons learned and practice change.	The Trust currently uses a format for thematic reviews.	No further actions currently.
6	There should be further work undertaken to establish whether all deaths of people over the age of 65 are being appropriately reported and investigated – in particular amongst inpatients.	Reporting of deaths takes place via Datix. As stated previously, these reported deaths are then discussed at weekly Meeting of Harm.	No further actions currently.
7	The Trust should provide staff with regular training and guidance to help them manage physical health conditions of long-term mental health service users. Diabetes management stands out as an area for greater awareness from a number of cases we reviewed.	Physical healthcare training is delivered across the Trust, the delivery and effectiveness is monitored by the physical healthcare clinical network.	i. Physical healthcare clinical network is currently updating its assurance framework to incorporate learning from external organisations and will therefore incorporate this area also.
8	The Trust should undertake thematic reviews of the issues raised in this report, including: a. Medical input and senior medical oversight b. The role of the care co-ordinator c. The need for pharmacy colleagues to be more explicitly involved in cases involving drug toxicity and polypharmacy.	These were specific issues to Southern Health. CWP identifies themes from serious incident reports and thematic reviews are undertaken when required.	No further actions currently.
9	A regular review of all sudden deaths of OPMH inpatients should be carried out. This should include a review of whether care treatment decisions are taken quickly enough, whether co- operation and liaison with acute medical staff is adequate and whether staff feel confident in managing and identifying sudden physical	All unexpected deaths within CWP inpatient settings are reported on Datix, with a 72 hour safety/ mortality review undertaken and shared with the weekly Meeting of Harm.	No further actions currently.

	deterioration including CPR.		
		Theme: **Reporting and identifying deaths**	
10	The Trust should review the way that deaths are categorised under the incident reporting policy so that: a. All relevant deaths are re-graded accurately before and after investigations have taken place. b. All relevant deaths are reported on regardless of impact grading to ensure that deaths have greater prominence in the Trust's reporting systems. c. Accurate information is provided for future Trust Mortality Reviews. d. That immediate work with the NRLS team is undertaken to ensure the changes to the local risk management system map as expected to NRLS and on to CQC.	The Trust policy includes guidance on categorisation of incidents. Deaths are graded by the reporter and quality assured by the manager, overseen by the Safe Services Department.	i. Safe Services Department is currently working through an action plan to improve the quality of reporting and data completion in relation to incident reporting, in partnership with the NRLS. This is due to be completed during the course of quarter 1 of 2016/17.
11	The Serious Incident investigation process needs a major overhaul in the Trust. a. Separation of people responsible for quality assurance and those undertaking investigations. This would enable training in review processes and quality assurance to be targeted at senior staff and in investigation techniques at a dedicated group of investigators. b. Quality assurance processes including independent review and sign off. c. Achieving high professional standards in written presentation. d. Timeliness of investigations.	▪ Bank investigators are currently being recruited. ▪ Improved training and support for investigating managers has been implemented. ▪ Corporate and Executive oversight by newly formed investigation review meetings taking place every two weeks. ▪ Independent review is achieved through CCG closure panels' scrutiny. The employment of a Clinical Champion for investigations.	No further actions currently (further actions pending feedback from the pilot of the investigation review meetings).
12	Reporting to StEIS should be undertaken within the 2 working days of notification as required by the national guidance.	The Trust is compliant of reporting to StEIS within 2 days of knowing that an incident is a serious incident.	No further action currently.
13	There should be more explicit action to	The death reporting and incident procedure is	No further action currently.

	commence investigations promptly even when a coroner conclusion is not immediately available unless there is a specific reason to delay; any delay should have senior sign off.	specific that delays do not occur in reporting or commencing an investigation unless there is a specific and recorded reason for doing so.	
		***Theme:* Involvement of families**	
14	The involvement of families in investigations requires improvement. In particular, improvements are needed in: a. developing clear guidelines for staff, including expected timescales and core standards, which recognise the need for iterative engagement when the family is ready b. ensuring that the investigation process is clearly defined and separate from the support and assistance offered by local treatment teams c. the Trust should ensure that investigators talk to families as early as possible in the process to identify any concerns and take these into account in the ensuing investigation d. provide reports to coroners in time for inquests e. explicitly demonstrating why families are not involved identifying next of kin details for all service users as part of a core assessment including where consent to share has not been provided to enable investigators to find relatives more easily f. working with primary care to identify family members g. where the Trust delays the commencement of an investigation due to	The Trust has clear guidance in place, compliance is checked at the weekly Meeting of Harm and is included in the investigation report. An audit is currently underway to establish if there are any gaps in relation to these points. This will be completed, with an action plan, by April 2016 and reported in the Learning from Experience report (see 1aii). The Trust has a system and process for allocating a Family Liaison role which is instigated as soon as the Trust is aware of an unexpected death.	i. The audit for Duty of Candour which is due April 2016 and will be undertaken twice a year will incorporate the recommendations for involvement of families. An action plan will be developed to address any gaps.

	inquests or other investigations this should be made explicit to families and the reasons explained h. the performance of divisions in involving families and securing feedback.		
		***Theme:* Multi-agency Working**	
15	The Trust Board should seek co-operation with other providers and commissioners to agree a framework for investigations in preparation for future incidents regarding escalation. Divisions should then apply this framework where the incident report suggests another organisation should review or investigate the circumstances of a death.	Collaborative working is being developed and considered within the Terms of Reference within investigations. This includes acute trusts, CCGs and GPs. This would be extended to include other social, health and voluntary organistions when appropriate.	i. See 4i (no other further actions currently).
		***Theme:* Deaths in detention and inpatient deaths**	
16	The Trust should retain a contemporaneous list of all inpatient deaths mapped to Mental Health Act status to enable Trust-wide overview of all inpatient deaths and deaths in detention.	All inpatient deaths of individuals subject to detention under the Mental Health Act are reported and also reported to the CQC.	No further action currently.
17	All deaths of service users in detention should be investigated, whether expected or not. These investigations should occur regardless of inquest conclusions. This will give assurance that the 24/7 nature of the care required has been of the highest standard. Specific issues addressed in the Terms of Reference for these investigations should include: a. to ensure that physical health care symptoms are not dismissed where challenging behaviour presents; b. that delays in seeking physical health care are not apparent; c. that service users are fully aware of decisions regarding whether to treat or	It is CWP policy to investigate all inpatient deaths of individuals subject to Mental Health Act detention.	i. The Trust's incident reporting and management policy will be updated immediately to incorporate the issues identified in the recommendations. ii. The recommendations will now be included in the training for investigating managers, within the investigatory toolkit and furthermore the new review team for investigations will be informed to consider these.

	investigate chronic or acute symptoms and that these are made in an informed manner; d. that access to full care and treatment is not restricted in any way; e. that staff are adequately supported to provide physical health care and trained to do so.		
	***Theme:* Information management**		
18	The Trust should develop an agreed RiO extract and Ulysses reporting protocol to capture all deaths of Adult Mental Health, Older People Mental Health and Learning Disability service users including community and inpatient locations to form the basis of future mortality review. *(For CWP this is CAREnotes and Datix.)*	▪ The Trust has completed a mortality review for NHS England in March 2016. ▪ The Trust will await further guidance from NHS England as to what process should be in place for all Mental Health trusts (guidance is expected to report on the development of case reviews of most deaths for mental health trusts by 2017).	i. The Safe Services Department will provide a quarterly report on all deaths of Adult Mental Health, Older People Mental Health and Learning Disability service users, including community and inpatient locations. This will commence for quarter 1 of 2016/17 and will be shared with locality Learning from Experience groups to then inform the aggregated Learning from Experience report to Quality Committee and Board.
19	The spreadsheet arrangement currently in place in TQ21 is insufficient to monitor deaths at corporate level as part of the whole Learning Disability service provision. TQ21 service users should be incorporated into Trust administration systems in a way which ensures their deaths are captured for reporting and investigation purposes.	CWP provides reports to monitor deaths for the weekly Meeting of Harm. All information is recorded onto Datix.	No further action currently.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	CQC regulatory actions update and next steps
Agenda ref. no:	15/16/139
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	30/03/2016
Presented by:	Sheena Cumiskey, Chief Executive

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	No
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	No
Capability and culture	Yes
Process and structures	Yes
Measurement	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 clinical and operational 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*

The aim of this report is to provide an update against the CQC regulatory action plan, approved by Board in December 2015, monitored through subsequent Compliance, Assurance and Learning Sub Committees and Quality Committee meetings.

The report also provides an outline of the CQC's next steps in assessing progress made and the internal response to support preparations.

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

In response to the initial feedback from the CQC following their Trustwide inspection during the week of 22 June 2015, CWP developed an initial 10-day action plan to address immediate improvements required; actions were completed and reported to the CQC. Further to the receipt of the final inspection reports, the action plan was further refined to ensure the Trust's ability to meet the additional regulatory actions identified and to assess sustainability of initial actions, a copy of the action plan was shared with Board in December 2015 and regular updates have been provided to Compliance, Assurance and Learning Sub committee and Quality Committee.

Recommendations made by the CQC during their inspection, detailed as actions that the Trust "should take" within the reports, will be reviewed during locality roadshows, initially proposed to be held in January now scheduled to be delivered during March and April, the specific actions will be developed through frontline clinical engagement to encourage ownership and focus on continuous improvement. The Trust met with the CQC on 3 March 2016 and provided an overview of progress of the action plan, the CQC will be assessing compliance with regulatory action through further site visits during Quarter 1 2016.

Assessment – *analysis and considerations of options and risks*

The action plan identifies the regulatory breaches that the Trust is required to address along with the proposed action, timescale and accountable leads and Executive Directors. All actions are expected to be completed by 31 March 2016. A progress report against the actions was provided to March Quality Committee, confirming that there were initially 21 core actions, of which 9 are complete and the outstanding 12 are on track for completion by the end of March 2016. A further update against actions is currently being collated in preparedness for submission to CQC. The actions outstanding for completion, mainly relate to the actions being monitored by the CQC locality audits. Although the initial actions have all been completed relating to Mental Health Act (MHA) application, care planning and risk assessment, the ongoing monitoring of the localised audits continue until 31 March 2016. The results of the audits show improvement across a number of key areas, however there is still further work re sustainability and ensuring that actions are embedded in everyday practice. A number of additional assurance mechanisms have been deployed to monitor progress against the action plan including LDPs, compliance visits, local audit results, MHA internal audit visits and any subsequent visits from the CQC MHA reviewer team. Feedback from these mechanisms demonstrates that progress is being made across all core areas, however the successful embedding of these actions will be an iterative process and will require continued scrutiny. To further support services with the successful implementation of local actions relating to Mental Health legislation, there are a series of Mental Health Rapid Improvement Events scheduled with members of the Executive and Locality Leadership teams during April 2016.

The CQC have confirmed that they will be undertaking follow up visits to core services where ratings were identified as "Requires Improvement" following the receipt of our completed action plan on the 8th April 2016 and in advance of the 4th June 2016 (within 6 months of report publication), this will allow a review of the domain and the rating awarded. The visits will be either short announced or unannounced and will consider all evidence across the full domain. Roadshows and Sharelearning bulletins will support staff with preparedness.

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

The Board are recommended to **note** the update provided in relation to the CQC regulatory action plan and the CQC approach outlined to assess compliance.

Who/ which group has approved this report for receipt at the above meeting?	Sheena Cumiskey
Contributing authors:	Jo Watts, Head of Compliance

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	J Watts to S Cumiskey	21/03/2016

Appendix no.	
37T	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Ward Daily Staffing Levels February 2016
Agenda ref. no:	15/16/140
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	30/03/2016
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	No
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
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 2016 following the submission of the planned and actual hours of both registered nurses (RN) and clinical support workers (CSWs) to UNIFY (appendix 1). The themes arising within these monthly submissions continue to mirror those that have arisen previously. These themes identify how patient safety is being maintained on a shift by shift basis.

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

The monthly reporting of daily staffing levels is a requirement of NHS England and the National Quality Board in order to appraise the Board and the public of staffing levels within in-patient units. CWP undertook a comprehensive review of ward staffing levels between Oct and Dec 2013 with 6 monthly follow up reviews, the most recent of which has been approved by Operations Board in Dec 2015 and to Board of Directors in January 2016. A number of recommendations were made within the latest six monthly report including consistency checking, national benchmarking, contact time and widening the consideration of the MDT role within safer staffing. These recommendations are currently being followed through and will be reported on in the next 6 monthly report due June 2016.

Assessment – *analysis and considerations of options and risks*

During February 2016 the trust achieved staffing levels of 94% for registered nurses and 92% for clinical support workers on day shifts and 94% and 97% respectively on nights.

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

Appendix 1 details how wards, who did not achieve overall staffing of 95%, maintained patient safety.

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

The Board of Directors are recommended to note the report.

Who/ which group has approved this report for receipt at the above meeting?	Avril Devaney
Contributing authors:	Julie Anne Murray

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 February 2016

15_16_140 Appendix 1 February 2016 Staffing Levels

	Ward	Day				Night				Fill Rate				Safe staffing was maintained by:
		Registered		Care Staff		Registered		Care Staff		Day		Night		
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	
East	Adelphi	1259.5	1151.5	1164.3	1134.3	678.5	667	1104	1087	91.4%	97.4%	98.3%	98.5%	Nursing staff working additional unplanned hours, the WM working in the clinical team and cancelling non-direct care activity.
	Alderley Unit	772.5	739	1298	1269	632.5	589.5	701.5	738	95.7%	97.8%	93.2%	105.2%	Altering skill mix.
	Bollin	1269.5	1263.5	1358.5	1181	721.5	710	1207.5	1096.5	99.5%	86.9%	98.4%	90.8%	Nursing staff working additional unplanned hours.
	CARS	900.5	888.5	1081.5	1059	656	623	691	677.5	98.7%	97.9%	95.0%	98.0%	*
	Croft	1280	1317.7	1649	1185	678.5	697.5	1720.5	1517	102.9%	71.9%	102.8%	88.2%	Nursing staff working additional unplanned hours, cancelling non-direct care activity and altering skill mix. Nurses also cross covered between wards.
	Greenways A&T	1216.5	1182	1776	1526.5	667	483	667	836	97.2%	86.0%	72.4%	125.3%	Nurses working additional unplanned hours, cancelling non direct care activity and altering skill mix.
	LimeWalk Rehab	900.5	888.5	1081.5	1059	656	623	691	677.5	98.7%	97.9%	95.0%	98.0%	*
	Saddlebridge	804.5	793	1395.5	1389.5	630	630	825.5	814.5	98.6%	99.6%	100.0%	98.7%	*
Wirral	Brackendale	1016.5	1134.5	859.5	813.5	667	667	690	667	111.6%	94.6%	100.0%	96.7%	Nursing staff working additional unplanned hours and altering skill mix.
	Lakefield	804.5	793	1395.5	1389.5	630	630	825.5	814.5	98.6%	99.6%	100.0%	98.7%	*
	Meadowbank	1048	897	2356	2216.5	586.5	458	1712	1553	85.6%	94.1%	78.1%	90.7%	Nursing staff working additional unplanned hours.
	Oaktrees	1200	1126.5	1310.5	1120.5	667	655.5	345	322	93.9%	85.5%	98.3%	93.3%	Nursing staff working additional unplanned hours and the WM working in the clinical team.
	Brooklands	1106	856.5	1524.5	1413	667	682.5	1298	1211	77.4%	92.7%	102.3%	93.3%	Nursing staff working additional unplanned hours, the WM working in the clinical team, cancelling non-direct care activity and altering skill mix.
West	Beech	1366.5	1134.5	1069.5	997.5	667	667	747.5	724.5	83.0%	93.3%	100.0%	96.9%	Nursing staff working additional unplanned hours, the WM working in the clinical team, cancelling non-direct care activity and altering skill mix.
	Cherry	879	810	1215	1184.5	724.5	563.5	920	908.5	92.2%	97.5%	77.8%	98.8%	Nursing staff working additional unplanned hours, the WM working in the clinical team, cancelling non-direct care activity and altering skill mix. Nurses also cross covered between wards.
	Eastway A&T	694.5	684.5	1258.5	1201	586.5	552	736	701.5	98.6%	95.4%	94.1%	95.3%	The WM working in the clinical team.
	Juniper	1416.5	1266	1000.5	918	713	701.5	722	609.5	89.4%	91.8%	98.4%	84.4%	Nursing staff working additional unplanned hours, the WM working in the clinical team, cancelling non-direct care activity and altering skill mix. Nurses also cross covered between wards.
	Maple Ward	1144	983	1357	1230.5	667	471.5	885.5	977.5	85.9%	90.7%	70.7%	110.4%	Nursing staff working additional unplanned hours, the WM working in the clinical team, cancelling non-direct care activity and altering skill mix. Nurses also cross covered between wards.
	Pine Lodge (YPC)	1040.5	1006	1046.5	908.5	667	609.5	770.5	782	96.7%	86.8%	91.4%	101.5%	Nursing staff working additional unplanned hours, the WM working in the clinical team and altering skill mix. Nurses also cross covered between wards.
	Rosewood	888	888	1233.5	1176	379.5	379.5	782	747.5	100.0%	95.3%	100.0%	95.6%	*
	Willow PICU	877.5	864.5	1007.1	992	678.5	678.5	770.5	761.5	98.5%	98.5%	100.0%	98.8%	*
	Trust wide	21885	20667.7	27437.9	25364.3	13620.5	12739	18812.5	18224	94.4%	92.4%	93.5%	96.9%	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Annual Information Governance Report (2015/16)
Agenda ref. no:	15/16/141
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	30/03/2016
Presented by:	Dr Anushta Sivananthan, Medical Director and Executive Lead for Quality (on behalf of Dr Faouzi Alam, Medical Director and Caldicott Guardian)

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

REPORT BRIEFING

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

To provide the Information Governance annual report for 2015/16. The annual report briefs the Board of Directors on the current status of information governance resources, governance systems/ processes, issues, risks over the past year and improvement plans for 2016/17. It also details the 2015/16 annual Information Governance Toolkit submission for the approval of the Board.

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

The planned Information Governance Toolkit (IGT) submission for 2015/16 achieves an overall score of 94%. The IGT for Westminster Surgery has increased from 66% to 91% within the year. All areas of the toolkits are compliant and level 2/ 3. Information governance arrangements have been reviewed during 2015/16, firstly against the latest version of the information governance toolkit, and then against guidance released throughout the year. This supports the case that current information governance arrangements within CWP are appropriate and fit for purpose.

Assessment – *analysis and considerations of options and risks*

The Board of Directors is directed to the executive summary detailed in the information governance annual report (appendix 1) for an overview of the analysis detailed in all the appendices associated with this report.

The Board of Directors is particularly asked to approve the 2015/16 IGT. In doing so it should note the following:

- A key priority for the 2015/16 information governance work plan was to maintain the previous improvement achieved for clinical coding, which has been realised.
- Westminster Surgery in Ellesmere Port became part of CWP on 1 July 2015. GP surgeries have a separate IGT with different requirements. The existing Westminster Surgery IGT score was 66% compliance. Work was undertaken to align the toolkit scores and evidence with the CWP toolkit which has resulted in an increased compliance rating to 91%.
- For Quality Account reporting purposes, the Trust will declare a 94% green/ satisfactory level for the IGT.
- Mersey Internal Audit Agency has undertaken an annual assessment of the Trust's IGT scores and supporting evidence and awarded a significant assurance rating for the fourth consecutive year.

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

The Board of Directors is asked to **approve**:

1. The statement that current information governance arrangements are fit for purpose.
2. The submission of the 2015/16 IGT (31/03/2016).
3. The information governance work plan for 2016/17.

Who/ which group has approved this report for receipt at the above meeting?	Records & Information Systems Group; Dr Faouzi Alam & Dr Anushta Sivananthan (Medical Directors); David Wood (Associate Director of Safe Services)
Contributing authors:	Gill Monteith, Records & Information Governance Manager

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Dr Faouzi Alam	07/03/2016
1	Records & Information Systems Group	11/03/2016
1	David Wood	21/03/2016
2	Louise Brereton (for meeting agenda)	21/03/2016

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

Appendix no.	Appendix title
A	CWP Information Governance annual report 2015/16
B	CWP information governance toolkit planned submissions March 2016
C	Mersey Internal Audit Agency information governance toolkit draft report
D	Mersey Internal Audit Agency Critical Application Review of CAREnotes
E	Information governance work plan 2016/17

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

15_16_141 Appendix A

Annual Information Governance Report 2015/16

1. Introduction

This and the associated appendices aim to brief the Board of Directors on the current status of information governance resources, governance systems/ processes, issues, risks over the past year, improvement plans for 2016/17, and set out the 2015/16 annual Information Governance Toolkit (IGT) submission for approval.

2. Executive Summary

A key priority for the 2015/16 work plan was to achieve compliance for clinical coding. Previous audit results had shown that secondary diagnosis had not met the information governance toolkit level 2 target by 1%. The most recent audit demonstrated a significant improvement for secondary diagnosis coding resulting in compliance with the IG toolkit.

Westminster Surgery in Ellesmere Port became part of Cheshire and Wirral Partnership NHS Trust (CWP) on 1 July 2015. GP surgeries have a separate information governance toolkit with different requirements. The existing Westminster Surgery IG toolkit score was 66% compliance. Work was undertaken to align the toolkit scores and evidence with the CWP toolkit which has resulted in an increased compliance rating to 91%.

The targets in the 2015/16 information governance work plan have all been met. Evidence uploaded to the Information Governance Toolkit has been refreshed and updated policies have been uploaded to the toolkit. The Trust scored 93% for both the baseline July 2015 and interim October 2015 IGT submissions. The planned final March 2016 IGT score will be 94% (green satisfactory) and 91% compliance for Westminster Surgery, both will be fully compliant. For the purpose of the Quality Account for Information Governance the Trust will record a 94% green/ satisfactory level for the Information Governance Toolkit.

See appendix B for the planned March 2016 IGT submissions.

Mersey Internal Audit Agency have undertaken an annual assessment of the Trust's IGT scores and supporting evidence. See appendix C for the draft report which awards significant assurance for the fourth consecutive year.

Relevant Information Governance toolkit evidence has been refreshed to ensure compliance with Caldicott 2 recommendations.

It is a requirement for the Trust to monitor staff understanding and compliance with information governance standards. A rolling programme of spot checks commenced at the beginning of 2015. Seventeen wards and departments have been visited and staff have been asked a series of information governance related questions designed to test understanding and compliance. A good overall understanding of information governance understanding and compliance has been demonstrated. Common themes where staff have not had sufficient knowledge are:

- Role of SIRO and Caldicott Guardian
- Knowledge of Caldicott 2

Ward managers and heads of departments which have been visited have received detailed feedback and have been asked to ensure that where knowledge has been lacking, that all staff are briefed

A Caldicott 2 training package has been developed and delivered at the doctor's induction on several occasions. A Caldicott 2 progress report from the Information Governance toolkit showed that the Trust was fully compliant with implementation.

Overall, information governance incidents have decreased by 22% compared to the first 3 quarters of the previous year. Analysis of information governance incidents shows that attaching documents to wrong patient's records accounted for 32% of incidents. These were not previously reported as incidents so comparison is not possilbe. Staff wil be reminded of the importance to be vigilent when attaching documents to patient's clinical records and further this will be monitored over the coming year so that learning identified can inform systems and practice improvements.

Information governance arrangements have been reviewed during 2015/16 firstly against the latest version of the information governance toolkit, and then against guidance released throughout the year. Whilst there had initially been a drop in the toolkit score for clinical coding this was increased to compliance level following an MIAA clinical coding audit in September 2015. Both toolkits will score at least at level 2 with many areas scoring level 3. This supports the case that current information governance arrangements within CWP are appropriate and fit for purpose.

3. 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 the Health & Social Care 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 Intelligent Monitoring Tool, while the foundation trust regulator, Monitor, consider the toolkit when assessing the foundation trust's governance risk rating.

4. Information Governance 2015/16 and 2016/17

Review of information governance work plan 2015/16

A key priority for the 2015/16 work plan was to achieve compliance for secondary diagnosis clinical coding. The Trust continued to temporarily employ a qualified clinical coder to quality check diagnosis codes the work plan for 2016/17 is to review the current temporary arrangements and develop an options appraisal of potential clinical coding solutions. General communication has also been disseminated via the weekly data quality dashboards to improve the quality of clinical coding. The coder has also liaised directly with clinicians when errors have been found.

Mersey Internal Audit Agency undertook a clinical coding audit in September 2015, as part of the IG Toolkit assessment process. Previous audit results had shown that secondary diagnosis had not met the information governance toolkit level 2 target by 1% (74% compliance). The most recent audit demonstrated a significant improvement (86% compliance) for secondary diagnosis coding resulting in compliance with the IG toolkit.

The Mersey Internal Audit review of CAREnotes, a community and mental health electronic patient care record system, was conducted in accordance with the requirements of the 2015/16 Internal Audit Plan, as approved by the Audit Committee. See appendix D for draft report.

Information Governance Annual Report 2015/16

The targets in the 2015/16 information governance work plan have all been met. Evidence uploaded to the Information Governance Toolkit has been refreshed and updated policies have been uploaded to the toolkit. The Trust scored 93% for both the baseline July 2015 and interim October 2015 IGT submissions. The final March 2016 IGT score will be 94% (green satisfactory) and will be fully compliant.

Westminster Surgery in Ellesmere Port became part of CWP on 1 July 2015. GP surgeries have a separate information governance toolkit with different requirements. Baseline July and interim October submissions are not required for GP practice toolkits. The existing Westminster Surgery IG toolkit score was 66% compliance and level 2 for all elements. Work was undertaken to align the toolkit scores and evidence with the CWP toolkit which has resulted in an increased compliance rating to 91% with many of the elements rising from level 2 to level 3 compliance.

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 February 2016. The information asset register was also reviewed and updated at this time.

The Mobile Policy has been reviewed and now incorporates all mobile devices including standard mobile phones, smart phones, laptops and tablets. The policy includes a revised process for ordering mobile devices with network connectivity due the change in management of the supplier contract which has transferred from Finance to ICT.

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.

Caldicott 2

Relevant Information Governance toolkit evidence has been refreshed to ensure compliance with Caldicott 2 recommendations. Caldicott 2 has been put into CWP Essential to raise awareness with all Trust staff. Caldicott 2 specific questions have also been added to the information governance spot checks. The manager then receives feedback and is asked to raise awareness with all staff in their area for any gaps in knowledge. 17 areas have been completed this financial year. A Caldicott 2 training package has been developed and delivered at the doctor's induction on several occasions. The presentation includes a Barnardo's video about young carers. At a recent North West Caldicott Guardians group CWP was asked to share the presentation to assist other organisations with implementing Caldicott 2. A Caldicott 2 progress report from the Information Governance toolkit showed that the Trust was fully compliant with implementation.

Information Governance Spot Checks

It is a requirement for the Trust to monitor staff understanding and compliance with information governance standards. A rolling programme of spot checks commenced at the beginning of 2015. Seventeen wards and departments have been visited and staff have been asked a series of information governance related questions designed to test understanding and compliance. The following are also checked:

- Induction and training of staff
- Clear desk policy
- Security of records
- Confidential waste procedures
- Confidentiality & access to information procedures
- Caldicott 2 knowledge
- Freedom of information procedures

A good overall understanding of information governance understanding and compliance has been demonstrated. Common themes where staff have not had sufficient knowledge are:

- Role of SIRO and Caldicott Guardian
- Knowledge of Caldicott 2

Staff have shown a good overall understanding of information governance requirements in terms of enquiries which may be received and information security issues. Ward managers and heads of departments which have been visited have received detailed feedback and have been asked to ensure that where knowledge has been lacking, that all staff are briefed.

Information governance toolkit audit 2015/16

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. MIAA have awarded the Trust a **significant assurance** rating for the last three consecutive years.

MIAA have undertaken a further review of the Trust's IGT scores and evidence. See appendix C for the draft report which again awards a **significant assurance** rating.

Information governance work plan 2016/17

The focus of the Trust's work plan for 2016/17 will be to:

- Undertake a feasibility study to ascertain if there is any way in which OPCS-4 procedure codes are captured, including but not solely related to electroconvulsive therapy sessions for the Central Data Submissions (CDS), with the aim to raise the level of clinical coding from level 1 to level 2.
- The development of Clinical Coding Resource web page.
- 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 2016/17.

Caldicott 2

General awareness raising for Caldicott 2 will also continue in the next financial year. The successful training package delivered at the doctor's induction will continue.

Information Governance Annual Report 2015/16

IG spot checks
The rolling programme of information governance spot checks will continue and the results will be reported to the Records & Information Systems Group.

Upgrade to ICT disaster recovery facilities and backup systems
MIAA undertook an audit of the Trust ICT disaster recovery and backup facilities and have stated that proposed upgrades would deliver significant assurance for ICT service continuity. These upgrades were completed in 2015 and further recovery testing will be undertaken in 2016. In addition, a recent test of the resilient network connect to the primary system hosting site (1829 Building, Chester) was successful.

Windows 7 upgrade
Support for Windows XP expired in 2015 and all* Windows PCs/ laptops have been upgraded to Windows 7, which Microsoft will continue to support until January 2020.

3 appliances being used by Pharmacy are still running XP and replacement devices have been procured. The supplier now needs to deploy the devices and ICT are liaising with them to complete this work, ideally by the end of May 2016.

Windows server 2008 upgrades
Support for Windows Server 2003 ceased in 2015. ICT Services have upgraded 90% of the hosted servers to Windows Server 2008(R2) which Microsoft will continue to support until January 2020. ICT are working with suppliers and the BI team to hopefully complete the remaining migrations by July 2016.

Data quality
The Trust's quality strategy has been aligned to the Trust's Zero Harm strategy and describes 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.

The key priorities for 2016/17 are:

- Development of locality led data quality improvement programmes.
- Improvement in quality of basic demographic details held for all patients (i.e. postcode/ GP/ DoB).
- Further development of data quality webpage.

See appendix E for the 2016/2017 work plan.

Review of information governance incidents 2015/16

Data on information governance incidents and near misses was reviewed for the first 3 quarters of 2015/16 as reported on the Trust's Datix risk and incident reporting system.

There was one serious breach of confidentiality which was reportable to the Information Commissioner. This was as a result of a member of staff accidentally leaving a note book in a patient's home which contained personally identifiable information for other patients. The note book was returned the following day. All patients who were affected were informed. All Trust staff were issued a reminder to safeguard confidential information. The Information Commissioner advised that the Trust had responded appropriately and that no further action was necessary.

Overall, information governance incidents have decreased compared to the first 3 quarters of the previous year. There were 113 information governance incidents reported in 2015/16 compared to 144 the previous year which is a decrease of 22%.

Of the 113 incidents reviewed, incidents of documents attached to wrong patient's records accounted for 32% of incidents (36 in total). These were not previously reported as incidents so comparison is not possilbe. Staff wil be reminded of the importance to be vigilent when attaching documents to patient's clinical records and this will be monitored over the coming year so that learning identified can inform systems and practice improvements. Incidents of missing paper records accounted for 18% (20 in total). Mis-directed post accounted for 14% (16 in total). There were also smaller numbers of incidents including information disclosed in error, mis-directed emails, mis-directed faxes, patients and families taking video recordings in ward areas, verbal disclosure, lost smart cards, lost equipment including a laptop, phone and blackberry all of which were encrypted.

Information risk management approach

CWP has access to a number of sources of information, guidance and assurance concerning information governance. HSCIC (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 2015/16 firstly against the latest version of the information governance toolkit, and then against guidance released throughout the year. Whilst there had initially been a drop in the toolkit score for clinical coding this was increased to compliance level following an MIAA clinical coding audit in September 2015. Both toolkits will score at least at level 2 with many areas scoring level 3. This supports the case that current information governance arrangements within CWP are appropriate and fit for purpose.

5. Recommendations to the Board of Directors

The Board of Directors is asked to approve the Information Governance annual report and associated appendices, including the 2015/16 annual IGT submission.

6. References

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Corporate Board Performance Report February 2016
Agenda ref. no:	15/16/142
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	30/03/2016
Presented by:	Tim Welch, Director of Finance/Deputy Chief Executive

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	
36T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	
36T	

REPORT BRIEFING

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

The Trust has a responsibility to ensure it is well led and this report intends to provide Board of Directors with an overview of performance against our KPI's and areas of concern or priority.

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

Having reviewed performance against our key KPI/priority areas, key lines of enquiry [KLOE] were identified. Operational board reviewed and discussed the KLOEs. Feedback was provided by each KLOE owner. Service Directors and Clinical Support Services provided an overview of actions being taken to understand and improve performance with indicative timescales for improvement. Further detail on actions being undertaken to improve performance is available on pages 3 and 4 of appendix 1.

Assessment – *analysis and considerations of options and risks*

Following review of the CPR at Operational Board it was agreed to exception report the following areas to the Board of Directors:

1. **IAPT 18 week waiting time standard performance** and receipt of its first formal performance trigger warning from Monitor, for IAPT following breach of the standard for 1 quarter, should the Trust breach 3 consecutive quarters this would trigger a potential governance concern, which may impact on the Trusts governance rating . The Trust has informed East Cheshire CCG ; Vale Royal and South CCGs and NHSE that we are unlikely to hit 18 week target until during Q2 2016-17 and that plan is in place to do so by then.

   At the time of writing this report the current waiting time the current position is 84.8% for 6 week and 96.4% at 18 weeks, should this position continue the trust will achieve the required performance standard and reduce the risk of receiving a second performance notice from Monitor.

   Update against action being taken to address underperformance in East:
   i) daily oversight of performance by the Associate Director of Performance/ GM and CSM
   ii) review the access policy for this service – this is ongoing,
   iii) development of a draft waiting time standard performance forecast tool - by end of March;
   iv) shared learning events with 3rd party provider to support in the attainment of the 18 week waiting time standard
   v) Develop productivity reporting to assist managers with staff performance monitoring, first to follow up ratios and discharge rates – initial reports developed and information team continue to work with IAPT teams
   vi) Purchase of CDT software for implementation in East Cheshire

2. **The reduction in performance against the 7 day follow up target** to 93.8% in February 2016; this is the first time performance has been below the 95% Monitor standard since June 2014. The Trust had five confirmed breaches in February; 2 in West, 1 in Wirral and 2 in East. The indicator is reported to Monitor quarterly and overall Q4 performance remains above standard, at 96.7%. The March performance will need to improve from the February position to ensure quarterly compliance, therefore monitoring of performance will take place three times a week effect from 17th March 2016. All three localities are aware of the reasons for their breaches and have put steps in place to mitigate them in future; for more detail please see the Monitor standards page.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors are asked to: • **Note** the content, • **Discuss** the content, • **Agree** any further action determined

Who/ which group has approved this report for receipt at the above meeting?	Tim Welch, Director of Finance/Deputy Chief Executive
Contributing authors:	Neil Griffiths, Senior Information Analyst Anne Casey, Head of Performance and Information Mandy Skelding-Jones, Associate Director of Performance and Redesign Locality Service Directors Andy Styring, Director of Operations

Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
0.1	Locality Management Teams	11 March 2016
1.0	Operational Board	16 March 2016
2.0	Andy Styring	17 March 2016

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1	Corporate Performance Report for February 2016

CWP Board Dashboard

Reporting Month: February 2016

Exception Reports

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

	Previous month	Current month	Trend
Monitor Targets - 10 [SO 1 & 5]			

Contracting [SO 4, 6 & 7]			
Contracts held			20
Contractual Targets - 330			97.42% met
Contract queries / MSA breaches			1 open 0 MSA breaches
Financial Penalties			0

Inpatient Metrics [SO 1 & 3]	Bed occupancy rate	Ward staffing levels
Previous Month	90.02%	Planned Shifts 7,769 Actual 7,250 (93.32%)
Current Month	89.77%	Planned Shifts 7,099 Actual 6,693 (94.27%)
Trend		

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

	Target	Previous month	Current month	Trend
Workforce [SO 3]				
Essentials 1	85%			
Appraisals (including medical staff)	85%			
Safeguarding	80%			
Supervisions	85%			
Sickness	< 4.5%			
Disciplinary	TBC			
Patient Experience [SO 1 & 2]				
Complaints per 1000 episodes	< 2.17			
Staff Raising Concerns	TBC			
Customer Satisfaction	80%	Process for data collection in development. Reporting expected to be in place Q3 2015/16		
Family & Friends Test *(% would recommend)*	TBC	95.50% (289 respondents)	95.02% (281 respondents)	

Waiting Times Indicators (SO 1)	Target	Previous month	Current month	Trend
Early Intervention (2 weeks)	50%	91.67%	86.67%	
IAPT (6 weeks)	75%	79.51%	80.87%	
IAPT (18 weeks)	95%	93.66%	94.39%	
Allied Health Prof'ls (18 weeks)	95%	96.12%	95.74%	

Strategic 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

CWP Board Dashboard

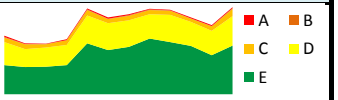
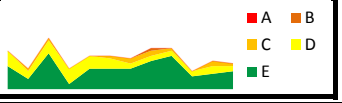
Reporting Month: February 2016

Exception Reports

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Risks [SO 1]	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	→	3	→	0	→	0	0
Clinical Services	21	↓	55	→	14	↑	6	1
Corporate Support								

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

Incidents [SO 1]	Category A&B (SUIs)		Category C&D (Mild / Moderate harm)		Category E (No harm)		Trend
	Previous month	Current month	Previous month	Current month	Previous month	Current month	
Mental Health Services (inc LD)	↓	↑	↑	↑	↑	↑	
West Physical Health Services	↓	→	↑	↓	↑	↑	
Clinical Support Services	→	→	↓	→	↑	↓	

Quality [SO 1, 2 & 3]	Previous month	Current month	Trend
Patient Safety Composite Score	→	→	
Staff Experience	Process for data collection in development. Expected to be in place Q3 2015/16		

Infection Prevention and Control [SO 1]	Previous audit compliance	Current audit compliance	Trend
Infection Control	0/4 passed 89% compliance	0/4 passed 90% compliance	↑

Incidents of Prone Restraint [SO 1]	CWP West	CWP Wirral	CWP East	Trustwide
	17 in month 102 year to date (15/16) 2.96 per 1,000 bed days:	1 in month 18 year to date (15/16) 0.68 per 1,000 bed days	2 in month 23 year to date (15/16) 0.58 per 1,000 bed days	20 in month 143 year to date (15/16) 1.42 per 1,000 bed days

Clinical Strategies [SO 1]	CWP West		CWP Wirral		CWP East	
	Previous month	Current month	Previous month	Current month	Previous month	Current month
1 (Integration)	Stable	Stable	Improving	Improving	Improving	Improving
2 (Self care)	Stable	Stable	Improving	Improving	Stable	Stable
3 (£xperience / 6Cs)	Stable	Stable	Declining	Declining	Stable	Stable

Strategic 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

Board Dashboard - Glossary

Back to top

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

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

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

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

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

CWP Objectives

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Well-led governance review: update
Agenda ref. no:	15/16/144
Report to (meeting):	Board of Directors – meeting in public
Action required:	Information and noting
Date of meeting:	30/03/2016
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	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 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	No
N/A	

REPORT BRIEFING

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

The *Monitor* Risk Assessment Framework provides guidance to NHS foundation trusts for complying with their continuity of services and governance licence conditions. It requires trusts to undertake an external review of their governance every three years. This requirement was added to the framework requirements in May 2014 thereby requiring trusts to have undertaken a review within the following three years, by May 2017. This requirement is reiterated in the foundation trust Code of Governance, compliance with which is assessed annually and reported on a 'comply or explain' basis.

Specific guidance has been issued by *Monitor* to provide a framework for trusts to shape and structure their reviews. It is recommended that an external organisation be appointed to undertake reviews, excluding the organisation providing the Trust's independent/ external audit function. Costs of "well-led" governance reviews are generally dependent on the level of specification; therefore it will require a tender process and identification of central funding.

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

A report was provided to the Board in November 2014 to inform of the launch of the new Monitor framework and to propose a timeline for when the Trust would potentially undertake a well-led governance review. This was initially proposed to commence in quarter 2 of 2015/16, however this was deferred pending the outcome of the CQC inspection undertake in June 2015.

The intended consequence of this was that the review could tailored to further test the elements of governance infrastructure that were not fully tested as part of the CQC inspection and to focus on any areas identified for improvement by CQC to inform the degree of the specification for the review.

The well-led governance review approach is tailored to Trust requirements, but will broadly include a pre-assessment process including Board self-assessment and a desk top review of documentation.

Assessment – *analysis and considerations of options and risks*

A draft specification for the well-led review is attached at appendix 1. This sets out the broad process involved. Work is currently underway on the self-assessment element and this will be considered by the Board at the April 2016 seminar.

A reminder of the timeline for the review is set out below:
March 2016: agreement of specification
April 2016: work with procurement to appoint an external reviewer. Board work on self-assessment
May 2016: Observations and interviews commence
June 2016: Conclusion of observation's and interviews. Receipt of reviewers draft report
July 2016: Final report and action plan agreed by Board of Directors. NHS Improvement notification of completion of review.

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

The Board of Directors is asked to:

- **note** the report and;
- **approve** the draft review specification

Who/ which group has approved this report for receipt at the above meeting?	David Wood, Associate Director of Safe Services
Contributing authors:	Louise Brereton, Head of Corporate Affairs David Wood, Associate Director of Safe Services

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	30/3/2016

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

Appendix no.	Appendix title
1	Monitor Well-Led Framework guidance - https://www.gov.uk/government/publications/well-led-nhs-foundation-trusts-a-framework-for-structuring-governance-reviews
2	Draft well-led specification.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

15/16/144 Appendix 1

CWP Well Led Governance Review

Draft Outline Specification

March 2016

1. Scope and purpose

The External Review Team will undertake an independent review of Cheshire and Wirral Partnership NHS Foundation Trust's governance arrangements in line with the Monitor 'Well – led' Framework. This work will include:

- A review of the Trust's governance arrangements (informed by the 2015 CQC assessment of the Well-led domain, rated 'Good') against the four domains of the Well-led Framework:
    - Strategy and Planning
    - Capability and Culture
    - Process and Structure
    - Measurement
- An appraisal of the Trust's self-assessment RAG rating (in line with the Quality Governance assessment) in respect of the four domains.
- The identification of recommendations where areas of improvement are identified to strengthen the Trust's governance arrangements.
- The identification of areas of good practice.
- The presentation of the findings to the Board of Directors, including a summary written report, following completion of the independent review.

2. Diagnostic work

2.1 Desk top review of the Trust's self-assessment

The Trust will provide the Trust's self-assessment against the four domains (Strategy and Planning, Capability and Culture, Process and Structure and Measurement) of the Well-led Framework together with access to the library of key supporting evidence/ documentation including Board and Committee agenda packs and minutes, reports, plans, policies, guidance and strategies.

The External Review Team will undertake a desk top review to validate the Trust's self-assessment assumptions based on the library of information available.

2.2 Interviews with the Board of Directors

The External Review Team will undertake an individual non- attributable interview with each member of the Board of Directors (Executive Directors and Non-Executive Directors (which includes the Chairs of the Trust's key governance Committees) to ascertain their perspective on the effectiveness of the Board and its governance arrangements.

2.3 Interviews with non-Board members

The External Review Team will undertake individual non attributable interviews or

interviews in pairs with non-Board members but who are able to comment on the effectiveness of the governance arrangements throughout the Trust. These will include:

- Director of People and OD
- Associate Director of Safe Services
- Head of Corporate Affairs
- Head of Compliance
- Deputy Director of Finance
- Service Director representative
- Clinical Director representative
- Lead Governor.

2.4 Observation of Board of Directors meeting

The External Review Team will observe one meeting of the Board of Directors (public and private) to assess the level of robustness of challenge and scrutiny, the conduct of Board meetings and the dynamic between Executive and Non-Executive Board members.

2.5 Observation of the Board's key standing Committees

The External Review Team will observe one meeting of each of the Board's key governance Committees to determine the effectiveness of challenge and debate, reporting to the Board, and the extent to which the Committee complies with their Terms of Reference. The Board's key governance Committees include:

- Audit Committee;
- Quality Committee;
- Operational Board
- Selected subcommittees

2.6 Observation of other key meetings

The External Review Team will observe one meeting of the following:

- Council of Governors;
- Clinical Engagement and Leadership Forum

2.7 Views of external stakeholders

The External Review Team will undertake a survey of relevant external stakeholders to ascertain their perceptions of the Board's effectiveness and their perceptions of the organisation as a whole.

The External Review Team will undertake a non-attributable interview with the following:

- A representative from key locality CCGs;

- A representative from locality Local Authorities

2.8 Focus Groups with staff

The External Review team will facilitate one staff focus group at each of the Trust's main sites to seek a broader insight into the effectiveness of the Trust's governance arrangements within the organisation, including for example: risk management arrangements, clarity of accountability and performance management arrangements; clarity of roles and responsibilities and the flow of information within the Trust including awareness of escalation routes.

2.9 Focus Group with involvement representatives (service users and carers)

The External Review Team will facilitate a service user focus group to ascertain their perceptions of the Board's effectiveness and their perceptions of the organisation as a whole.

2.10 Focus Group with Council of Governors

The External Review Team will facilitate a focus group with representatives from the Council of Governors to understand their perceptions of the effectiveness of the governance arrangements and the quality of the Board's engagement with the Council of Governors.

2.11 Board Development plan review

The External Review Team will review the current Board Development plan detailing current Board skills, expertise and development needs.

3. Feedback and reporting

3.1 Weekly update meetings

The Trust's External Review Co-ordinator (Head of Corporate Affairs) will be available for regular weekly meetings with the External Review Team to answer any queries, provide any information required by the Team not previously provided, resolve any practical issues and support the Team's forward planning.

Any significant concerns raised by the Team with regard to their interim findings/ feedback they receive in the course of their review will be reported immediately to the Associate Director of Safe Services.

3.2 Feedback to the Board

The External Review Team will, upon completion of the review:

- Feedback emerging themes to the Chair, Chief Executive, Medical Director (Executive Lead for Quality), Associate Director of Safe Services, and the Trust's External Review Co-ordinator (Head of Corporate Affairs).
- Provide a draft written report detailing the outcome of the review. This will be reviewed by the Trust for points of accuracy and reasonable challenge, e.g. contextual misrepresentation.
- Provide a final written report detailing the outcome of the review.
- Design and present to the Board of Directors a presentation relating to the findings and suggested action plan.

Cheshire and Wirral Partnership NHS
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STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Committee and Sub Committee meetings effectiveness review 2015/16
Agenda ref. no:	15/16/145
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	30/03/2016
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 outputs of the recent review undertaken in respect of the effectiveness of committees and sub committees within the Trust meetings structure during 2015/16. The report indicates the main findings of the review, which is based on feedback from attendees, identifies areas of good practice and details recommendations to further enhance the effectiveness of Trust meetings in order that the Trust continues to be well governed, operating within an effective integrated governance framework.

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

This report is a mechanism to provide the Board of Directors with assurance that the integrated governance meeting structures in place, as outlined within the Trust's integrated governance strategy, and in line with the principles of the Department of Health Integrated Governance Handbook, are effective in supporting the Board in providing assurance of the quality and safety of the services that the Trust provides. These assurance mechanisms are aligned to Monitor service line management and reporting principles and are designed to support the Board with essential tools to fulfil their strategic leadership roles in ensuring that CWP is well-led through appropriate focus on clinical, operational and financial matters.

Assessment – *analysis and considerations of options and risks*

This is the first time that the Trust has surveyed meeting attendees to seek their feedback on the effectiveness of the Trust's meetings. Appendix 1 details thematic analysis of the feedback (T-drive). The detailed verbatim responses will be provided to each meeting Chair to inform the development of the respective meetings during the course of 2016/17 so that they can operate even more effectively and support Board assurance even better (building on the positive feedback from the Care Quality Commission inspection of the Trust in 2015 that the Trust has sound governance structures). This, coupled with the impending well-led governance review, is an opportunity to further and continuously improve the governance of the Trust. The overall feedback received complements this, with the positive areas outlined in Appendix 1. Opportunities to improve effectiveness even further include:

- Supporting current members of meetings and reviewing membership to ensure all attendees understand their individual role and what is expected of them, in particular for instances when a deputy attends to ensure they are able to provide a meaningful contribution.
- Improving inter-meeting communication by clarifying reporting lines, in particular the escalation and cascade of information to and from other committees and sub committees.
- Meeting Chairs only accepting the standardised report briefing (i.e. this report template) to improve quality and timeliness of information received for meetings to inform even better decision making.

Next steps, in response to the findings of this review, include:

- Committees and sub committees will conduct an annual review of their terms of reference and business cycles to take account of the feedback received, for approval at their next meeting in readiness for 2016/17.
- A scoping exercise to understand what other Trustwide meetings are taking place which are not currently detailed in the Trust's meeting structure to review need.
- A review and update of the Trust's integrated governance strategy will then follow to ensure effective operation of the whole framework.
- Offer up of the meeting effectiveness questionnaire to other meetings throughout the Trust, both those within the governance structure (sub groups) and those within the localities.
- Roll out a new meetings standards approach to support improvements to administering committees and sub committees to ensure they are effective and consistent across the structure.

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

The Board of Directors is asked to:

- **Review** and **discuss** the report as an assurance mechanism that the Trust is well governed.
- **Approve** the next steps identified above to further improve the effective operation of committee and sub committee meetings within the Trust's meetings structure.

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	E Fergusson to L Brereton	18/03/2016
2	D Wood to L Brereton for Board of Directors	23/03/2016

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

Appendix no.	Appendix title
1	Committee and Sub Committee Effectiveness Review 2015/16

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CHAIR'S REPORT
AUDIT COMMITTEE
1st March 2016

The following is a summary of issues discussed and any matters for escalation from the March 2016 meeting of the Audit Committee:

Internal Audit progress update
The Audit Committee received an update on the outcomes of recent work including audits on ESR and bank and agency staff usage. Both audits received significant assurance. Some concern was raised regarding the progress of the 2015/16 audit schedule and the number of audit days that were still to be completed by the end March 2016. Assurance was provided by MIAA that the outstanding days were achievable.

The draft internal plan for 2016/17 was presented and approved by Committee members. The draft plan had been shared in advance with the finance team, safe services and the executive team.

External Audit update
KPMG provided a technical update providing recent sector updates. The final 2016/17 audit plan was presented and approved. It was noted that the Trust discontinued operations will continue to be treated as such for the 2015/16 audit. KPMG confirmed that there would be no fixed asset impairment this year, but that a full review would be required in 2016/17, when the capital expenditure on Ancora House will have been completed

Counter Fraud progress report
An update was provided on current cases. The impact of delays with disciplinary hearings was noted as an impact on the progress of counter fraud cases. Assurance would be sought on this by the counter fraud officer.

Financial Statement risks
A report on the Trust's financial statement risks was presented providing management judgements on key areas of estimation uncertainty, as identified by the Trust's external audits. There were no areas of significant risk.

Quarterly review of the strategic risk register
As agreed with the Quality Committee, the Audit Committee reviewed the current risk register. There were no specific risks for escalation; however the Committee noted that the physical health risk would be reviewed at the forthcoming Quality Committee, following the risk rescore. The Audit Committee noted the new emerging risk regarding Mental Health Act compliance.

Estates Budget control
Justin Pidcock, Interim Associate Director of Estates provided a report to the Committee to provide assurance on the recent estates budget overspend and the controls now in place to return to plan.

Governance matters
The Audit Committee noted the 2015/16 statutory Directors registers, including the gifts and hospitality register and declarations of interest. It was noted that these registers are updated with declarations in year and all directors are asked to confirm their declarations annually. Both registers are available on the CWP website.

The Audit Committee terms of reference was reviewed. No changes were requested, however it was noted that there is a need to appoint a vice chair to the Committee. This will be confirmed at the May meeting.

The Audit Committee noted the minutes and/ or chair's reports from the Quality Committee and the Operational Board. There were no specific matters for escalation.

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CHAIR'S REPORT –
QUALITY COMMITTEE
2 MARCH 2016

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

- **Strategic risk register**
  The Quality Committee referred a potential strategic risk of failure to achieve mandated Monitor performance targets for IAPT services to the Operational Board for consideration of its impacts and any support that localities require in relation to achieving the required performance – the Board will be apprised through the corporate assurance framework. The current data quality strategic risk is subject to review following escalation of gaps in assurance arising from an external data submission. A responsive remedial action plan is in place, which will inform the substantive risk description and treatment plan (for approval at the next Quality Committee meeting).
  The Board of Directors is asked to endorse the strategic risk register.

- **Implementing Human Factors**
  The Quality Committee received a presentation from the Associate Director of Safe Services to argue a case for change and propose that Human Factors be prioritised as a learning need for the organisation. A practitioner from the Chester adult community mental health team endorsed this proposal by sharing the significant impacts that Human Factors education from expert input has had on introducing and sustaining safe and effective team working procedures, including communication. It was discussed that shifting organisational focus to Human Factors makes it easier for clinicians to be accountable for and become part of the solution in relation to improving patient safety and continuously improving quality. Health Education England is scheduled to publish proposals for increasing the safety focus of education for healthcare professionals on 8 March, the Trust is in a good position to respond to this internally, and with an investment in quality improvement efforts has the potential to help other organisations to respond to the national proposals. A business case is scheduled for presentation at the April meeting of the Business Development and Innovation Sub Committee, which will set out the quantifiable and non quantifiable benefits of the preferred option to invest in a trainer skills development course.
  The Board of Directors is asked to note that the Quality Committee members will contribute to the business case and the outcome will be shared with the Board at its next meeting.

- **Strengthening clinical communications/ implementation of a best practice and outcomes portal**
  The Quality Committee endorsed the proposed development of a best practice and outcomes portal as a means of strengthening clinical communication and engaging staff with continuous improvement. This is part of the Trust's Zero Harm aspirations and is being implemented in recognition that behaviours that produce errors are often variations on the same processes that produce success, therefore a portal, to communicate the spectrum of successful practice/ 'positive deviance' and areas requiring improvement, should prove effective in improving quality and sharing learning. As such, the portal will house the Trust's successful 'sharelearning' bulletins, which will also be further strengthened by involving direct care staff in their development so that clinical messages are appropriate to the audience and written in language that clinicians can to translate to their own practice.
  The Quality Committee agreed to receive a demonstration of the portal at its next meeting.

- **Response to Southern Health NHS Foundation Trust independent report recommendations**
  The Quality Committee received an update on the Trust's approach developing its response to this independent report's findings. CWP welcomes the opportunity to learn from external recommendations and this is an opportunity to remodel this strategic risk, to focus on system outcomes rather than internal process problems. The Safe Services Department is continuing to actively work with its commissioning colleagues and other partners to ensure a systems approach to securing the best outcomes from the investigation of serious incidents.
  The Board of Directors is receiving an assurance framework in response at today's meeting.

- **Development of service level locality data packs**
  The Quality Committee agreed with the proposed format for the aggregated version of locality data packs (that currently provide an indication of ward and team quality and safety profiles) to service level. They are based on the principle of benchmarking each team with others that provide similar clinical services, to encourage use of this information to drive continuous improvements in quality, safety and care delivery.

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