Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting of the Foundation Trust Board of Directors
Wednesday 29th March 2017
Redesmere, Countess of Chester Health Park, Chester
1.30pm

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
16/17/128	Apologies for absence	Receive apologies	Verbal	Chair	1 min (1330)
16/17/129	Declarations of Interest	Identify and avoid conflicts of interest	Verbal	Chair	2 min (1331)
16/17/130	Minutes of the previous meeting held 25th January 2017	Confirm as an accurate record the minutes of the previous meetings	Written minutes	Chair	2 mins (1333)
16/17/131	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)
16/17/132	Board Meeting 2016/17 business cycle and draft 2017/18 business cycle	Confirm that agenda items provide assurance that the Board is undertaking its duties	Written	Chair	3 mins (1337)
16/17/133	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	10 mins (1340)
16/17/134	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					
16/17/135	External 'Well led' governance review	To receive review findings	Presentation	MIAA/ AQUA	45mins (1400)
16/17/136	Strategic Risk Register and Corporate Assurance Framework	To approve the risk register and assurance framework	Written Report	Medical Director	10 mins (1445)
Capability and Culture					
16/17/137	Staff survey 2016/17	To receive survey outcomes	Written report	Director of People and OD	10 mins (1455)
16/17/138	Staff absence review	To note review outcomes	Written Report	Director of People and OD	10mins (1505)
Process and Structures					
16/17/139	Safer Staffing: • Daily Ward Staffing figures: January/ February 2017	To note the ward staffing reports	Written Reports	Director of People and OD	5 mins (1515)
16/17/140	Appraisal review	To note review	Written Report	Director of People and OD	10 mins (1520)
Measurement					

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
16/17/141	Annual Information Governance toolkit report	To approve submission	Written report	Medical Director	10 mins (1530)
Governance					
16/17/142	Matters of Governance: • a. Junior Doctors quarterly declaration • b. Medical Revalidation 2016/17 declaration	To approve declarations	Presentation/ Written Report	Medical Director	15 mins (1540)
16/17/143	Audit Committee reporting: • Chair's report of meeting held 28 February 2017	Review Chair's Report and terms of reference and any matters for note/ escalation	Written Report	Chair of Audit Committee	3 mins (1555)
16/17/144	Quality Committee reporting : • Chair's report of meeting held 4 1 March 2017	Review Chair's Report and any matters for note/ escalation	Written Report	Chair of Quality Committee	3 mins (1558)
16/17/145	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair/ All	5 mins (1601)
16/17/146	Any other business	Consider any urgent items of other business	Verbal or written	Chair	2 mins (1606)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
16/17/147	Review of meeting	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair/All	2 mins (1608)
16/17/148	Date, time and place of next meeting: **Wednesday 24th May 2017, 9.30am Boardroom, Redesmere.**	Confirm arrangements for next meeting	Verbal	Chair	1610

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Minutes of the Open Board of Directors Meeting
Wednesday 25th January 2017
Board Room, Trust HQ, Redesmere commencing at 1.30pm

PRESENT	Mike Maier, Chair Sheena Cumiskey, Chief Executive Dr Faouzi Alam, Medical Director Professor Avril Devaney, Director of Nursing, Therapies and Patient Partnership Andrea Campbell, Non-Executive Director Dr Jim O'Connor, Non-Executive Director Lucy Crumplin, Non-Executive Director Edward Jenner, Non-Executive Director Sarah McKenna, Non-Executive Director Rebecca Burke – Sharples, Non-Executive Director Dr Anushta Sivananthan, Medical Director Andy Styring, Director of Operations Tim Welch, Director of Finance
IN ATTENDANCE	Louise Brereton, Head of Corporate Affairs Phil Hough, Involvement Representative Gary Flockhart, Deputy Director of Nursing (for item 16/17/116) Andrea Hughes, Director of Infection, Prevention and Control (for item 16/17/120) Emma Pool, PA to Deputy Director of Nursing David Wood, Associate Director Safe Services Jane Woods, Interim Deputy Director of People and OD (for item 16/17/119)
APOLOGIES	David Harris, Director of People and Organisational Development.

REF	MINUTES	ACTION
16/17/103	**Apologies for absence** The Chair welcomed all to the meeting. Apologies were noted from David Harris, Director of People and Organisational Development. The meeting was quorate.	
16/17/104	**Declarations of Interest** None was declared	
16/17/105	**Minutes of the previous meeting held 30th November 2016** The minutes of the meeting held 30th November 2016 were **approved** as a correct record.	
16/17/106	**Matters arising and action points** The action log was reviewed. All actions were now agreed to be closed.	
16/17/107	**Board 2016/17 Business Cycle** The business cycle was reviewed and noted.	
16/17/108	**Chair's Announcements**	

	The Chair announced the following: **Director of Nursing, Therapies and Patient Partnership** Avril Devaney has been awarded the honorary title of Visiting Professor at the University of Chester. **Senior Independent Director** Rebecca Burke Sharples was recently proposed and approved as Senior Independent Director by the Council of Governors. The Board **noted** the appointment. **Nursing Associates** CWP is leading the Cheshire and Wirral partnership to pilot the new role of Nursing Associate. The partnership is one of the original 11 pilot sites across England to pioneer the role. The NMC has also recently announced that they will regulate the nursing associate role. The Trainees will begin their 2 year training on January 20th 2017. CWP is supporting 8 trainees. **Peer support mentor funding** £30k has been awarded from Health Education England North West to recruit and train peer support volunteers to work alongside people who access services and health professionals to better support people with their mental health care and recovery. The money will be used to develop and deliver accredited training for over 30 more peer support roles by the end of 2017 **Linda Johnstone, Substance Misuse Services** Linda Johnstone, Lead Nurse and Clinical Director for Substance Misuse Services has been named 'Inspirational Leader' at the 2016 NHS North West Leadership Academy Recognition Awards. Linda has worked in substance misuse services for over 20 years.	
16/17/109	**Chief Executive Announcements** Sheena Cumiskey announced the following main points of discussion from the closed Board meeting: **Global Digital Exemplar** The Trust has recently expressed an interest in a global digital exemplar pilot project with NHS England. **Accountable Care Systems in Cheshire and Wirral** Agreement has been reached with Merseycare and Five Boroughs Foundation Trusts to form an 'Accountable Clinical Network'. This will provide an opportunity to enhance services and clinical excellence and will	

	offer an opportunity for support services to work even more efficiently. **Financial and operational planning update** The Board discussed financial and operational planning. The CWP forward view strategy is currently in development and will launch in April 2017.	
16/17/110	**Strategic Risk Register and Corporate Assurance Framework** Dr Sivananthan presented the strategic risk register and assurance framework. The risk register and assurance framework was reviewed in depth at the January 2017 Quality Committee where a number of risks were agreed for remodelling and archive. Since the Quality Committee, the Civic Way environment risk has also been archived. The Board resolved to **note** the report.	
16/17/111	**Quality Improvement Report** Dr Sivananthan introduced the report and highlighted the following issues: • Excellent performance in improving pressure care. • The development of the Suicide Prevention Strategy, this has been well received and includes broad input to meet nationally defined goals. • The roll out of the development of perinatal services led by Dr Tania Stanway. • Supporting 'John's campaign' to enable carers of relatives with dementia to have enough time with families, supporting person centred care. A discussion followed commending the report and the assurances it provided, particularly for Non-Executives when triangulated with other assurances such as compliance visits. The Board resolved to **note** the report.	
16/17/112	**Zero Harm Strategy update** David Wood introduced the report and reminded Board members that the Zero Harm strategy commenced in January 2014. A presentation was provided on strategy outcomes since inception and areas of focus for 2017/18. This included: • CQC confirmation that the foundations were in place to deliver zero harm in the Trust and there is evidence to show that the strategy is becoming embedded. • A quality improvement (QI) approach to clinical audit based on Vincent safety model has been adopted. • The identification of learning themes and subsequent identification of early warnings creating a real time response to issues before they escalate. • Zero harm is underpinned by the Person Centred Framework principles. • Simplification of the Zero Harm vision is required to enable quality	

	improvement and to aid staff understanding. A discussion followed. Good practice on QI was cited during a recent Kings Fund quality forum attended by Sheena Cumiskey and Dr Sivananthan where another trust had embedded a consistent QI methodology. This was underpinned by a business case with clear return on investment, helping to the drive toward the cessation of work of lower value. The Board resolved to **note** the progress to date and **endorsed** the areas of focus for 2017/18.	
16/17/113	**Person Centred Framework** The Chair welcomed Phil Hough to the meeting and a reminder of the Person Centred Framework journey to date was provided. This has involved: • A wide consultation on framework principles. • The development of tools and approaches • A joint meeting of Patient and Carer Experience and Patient Safety and Effectiveness sub-committees for tool validation. • Discussion and input from the Council of Governors. A discussion followed commending and endorsing the framework while recognising the challenge of measuring framework outcomes. Continued Board support to the launch and roll out of the framework was requested, including pledges and developing one page profiles which Board members agreed to. The Framework will be introduced through various activities w/c 6th March 2017. **Action**: Board members to all complete one page profiles. The Board of Directors resolved to **approve** the Person Centred Framework Overarching Principles, tools and approaches and **note** the plans to introduce the framework.date of the launch event.	**AD**
16/17/114	**CQC Learning, Candour and Accountability report (and Southern Health) : CWP response** Avril Devaney presented the report which brings together the reflective work undertaken on the Mazar's report into Southern Health NHSFT and the recent CQC Learning, Candour and Accountability report. The focus of this work has been on what the Trust can do differently and better with emphasis on continuous improvement and person centeredness. It was noted that much of the actions identified are on stream or have been completed. A mortality Task and Finish group has been established to look at gaps on quality improvement. The Board resolved to **note** the report.	

	(Gary Flockhart joined the meeting).	
16/17/115	**Benchmarking: Adult Mental Health** Dr Sivananthan gave a presentation on recently issued benchmarking data on adult mental health services. The following key findings were highlighted: • Good Trust performance despite lower levels of resources. • Comparative low bed base • Low admission rates with lower than average length of stay • Comparatively lower cost of beds (adults and older people) with lower cost per admission and occupied bed day • Increasing number of patients admitted of no fixed abode. • A higher number of readmissions – unsure if this related to a quality of care issue or a data quality issue which will be explored further. • Higher bed occupancy than national average but this is possibly linked to prevalence of older people in the area. • Occupied bed days - two thirds are used by people known to the Trust which requires further exploration. • Serious incidents, complaints and ligatures appear to be above national mean which again requires investigation and understanding. • Increase in length of stay, impacted by lack of community provision following discharge. • Increase in inpatient spend, identified as a financial risk. The Board discussed the recommendations arising from the data. These will be overseen by the Quality Committee. It was requested that Board members spend more time in seminar sessions on benchmarking to enable more flexible time on debate and discussion. The Board resolved to **note** the report.	
16/17/116	**Safer Staffing:** **a. Six monthly ward staffing report** Gary Flockhart introduced the report. It is a National Quality Board requirement that the Board reviews ward staffing on six monthly basis. The following points were highlighted: • Good general feedback from staff on their satisfaction with establishment levels, however there are issues with backfill to cover vacancies and sickness. • Adelphi ward has fluctuations due to complexity of patients and required levels of observations. • Issues with Central and East staffing are being monitored by the Operational Board. • Staffing levels are consistently above 90% fill rates. • A service improvement forum has been established, running six weekly, focusing on lean methodology and continuous improvement.	

	• The Trust is currently in the process of implementing the Hurst Tool. The report recommendations were presented and a discussion followed. The low take-up of supervision and training was noted and assurance was requested regarding addressing this issue. The Board were advised that a task and finish group had been established to consider this issue. A query was raised regarding the CAMHS wards and adapting the approach to staffing as a whole unit rather than viewing them as separate wards. The Board resolved to **approve** the report recommendations and future approaches **b. Daily Ward Staffing figures: November/ December 2016** The ward staffing figures for November and December 2016 were reviewed. The Board resolved to **note** the report.	
16/17/117	**Learning from Experience Report (T2)** Avril Devaney presented the report and reminded Board members that the comprehensive Learning from Experience report is reviewed by the Quality Committee. The Board of Directors resolved to **approve** the report and **endorse** the recommendations.	
16/17/118	**Mental Health Act (MHA) report** Dr Sivananthan introduced the report and highlighted the following issues. • The recent CQC re-inspection had provided good/ improved feedback on the application of the MHA. • An appraisal system is now in place for hospital managers. Thanks were extended to Rebecca Burke-Sharples to her support with this. • Use of s136 has reduced this year whereas nationally this has increased. • There has been an increase in revocations of CTOs, with the Trust becoming an outlier on this indicator. This is currently under review and will be considered in the improvement forum. • Lack of statutory reporting by AMPHs which has been raised formally by local authorities. (Sarah McKenna left the meeting). The Board resolved to **note** the report.	
16/17/119	**Living Wage** (Jane Woods joined the meeting.) Jane Woods, attending the meeting on behalf of David Harris, presented the report. The Board had committed to the Living Wage in 2014. There	

	has been a recent national announcement regarding an uplift of 1% to the Voluntary Living Wage (VLW) as set out by the Living Wage Foundation. The uplift would cause a £25k budget pressure. A discussion followed where the Board reiterated their commitment to upholding the Living Wage. Clarity was requested regarding the options discussed by the People and OD subcommittee. The Board resolved to **approve** to continue to adopt the VLW rate and uplift CWP salaries accordingly with effect from 1st November 2016. (Andrea Hughes joined the meeting, Jane Woods left the meeting)	
16/17/120	**Q3 2016/17 reports** **a. Infection, Prevention and Control Report** Andrea Hughes presented the Q3 report and drew attention to the following highlights: • There were no reportable infections during Q3. • Two ward closures occurred due to diarrhoea and vomiting infections. Investigation revealed no causative organisms. • A sepsis improvement programme is in place and has implemented an early warning system which has recently resulted in the early identification of a sepsis case where the patient received early interventions. A discussion followed regarding the recent outbreak of flu on Meadowbank ward. It has been found that not all staff or patients have been vaccinated which will be addressed. **b.(i) CWP Safeguarding and (ii) Strategy 2017/20** Andrea Hughes presented the Safeguarding Strategy for 2017/20 which has taken a 'plan on a page' approach. The key principles were discussed and the Board commended their support. The Board resolved to **note** the Q32016/17 report and to **approve** the 2017/20 Safeguarding Strategy.	
16/17/121	**Matters of Governance:** **• CQC statement of purpose** Dr Sivananthan advised that the CQC statement of purpose had been recently updated to reflect the opening of Ancora House and the acquisition of Westminster surgery. The Board resolved to **approve** the report and the amended Statement of Purpose.	
16/17/122	**Audit Committee reporting: Chair's report of meeting held 10 January 2017** The Audit Committee Chair summarised proceedings of the last meeting. There were no matters of exception.	

	The Board resolved to **receive** the Chair's Report.	
16/17/123	**Quality Committee reporting : Chair's report of meeting held 4 January 2017** The Quality Committee Chair provided an overview of the last meeting. There were no exceptions to note. The Board resolved to **receive** the Chair's Report.	
16/17/124	**Review of risk impact of items discussed** Items discussed posed risk to the Trust but were accounted for on assurance framework.	
16/17/125	**Any other business** It was proposed that the Accountable Care Network utilise the data highlighted in Dr Sivananthan presentation to support systems working and to use data try and to amplify outcomes. Sheena Cumiskey agreed to take this forward. Faouzi Alam advised Board members that NHS Employers have issued a directive that all NHS Boards should be reviewing junior doctor contract performance on a quarterly basis. These will begin to report to the Board from Q4.	
16/17/126	**Review of meeting** Some items, presentations in particular had run on longer than the time allocated. Consideration should be given to the number of presentations per meeting or potentially allocating seminar time to allow more flexible discussion time.	
16/17/127	**Date, time and place of the next meeting** Wednesday 29th March, Romero Centre, Macclesfield, Cheshire.1.30pm	

Signed

Chair

Date:

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Action points from Board of Directors Meetings
January 2017

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
25.1.17	16/17/115	**BENCHMARKING: ADULT MENTAL HEALTH** Circulate slides presented by Dr Sivananthan and link to FYFV dashboards	ASAP	LB	Circulated	Completed
25.1.17	1617/125	**ANY OTHER BUSINESS** Include new quarterly Junior Doctor guardian report on Board/ relevant Committee business cycle 2017/18	March 2017	LB	Reporting will start Q4 16/17.	Completed

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

Cheshire and Wirral Partnership 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											✓
2	**Receive Annual Report, Accounts and Quality Account**	Director of Finance	Audit Committee (Quality Committee for QA)		✓									
3	**Integrated Governance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee					✓						
4	**Quality Improvement Reports**	Medical Director Compliance Quality and Regulation	Quality Committee		✓			✓				✓		
5	**Strategic Risk Register and Corporate Assurance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee		✓			✓				✓		✓
Well Led Domain 2: Capability and Culture														
6	**CQC Community Patient Survey Report 2016/17 and Action Plan**	Director of Nursing, Therapies and Patient Partnership	Operational Board					✓						
7	**Equality Act Compliance**	Director of Nursing, Therapies and Patient Partnership	Operational Board					✓						
8	**Zero Harm strategy reporting**	Medical Director Compliance Quality and Regulation	Quality Committee									✓		
9	**Staff survey 2016/17**	Director of HR and OD	People and OD subcommittee (Operational Board)											✓
10	**Freedom to speak up six monthly report**	Director of Nursing, Therapies and Patient Partnership	Operational Board					✓						
11	**Six monthly staffing review**	Director of Nursing, Therapies and Patient Partnership	Quality Committee/ Operational Board				✓					✓		
Monitor Well Led Domain 3: Process and Structures														
13	**Receive and Approve Quarterly Monitor returns** (no longer required post Q2/ SOF)	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** (no longer required post Q2)	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	Safeguarding subcommittee				✓							
22	**Quartely Safeguarding Report**	Director of Nursing, Therapies and Patient Partnership	Safeguarding subcommittee				✓	✓		✓			✓	
23	**Safeguarding Adults Annual Report 2015/16**	Director of Nursing, Therapies and Patient Partnership	Safeguarding subcommittee				✓							
24	**Accountable Officer Annual Report inc. Medicines Management 2015/16**	Medical Director Compliance Quality and Regulation	Medicines Management Group (Quality Committee)				✓							
25	**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)				✓							
26	**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)				✓							
27	**Emergency Planning Annual Report 2015/16**	Director of Nursing, Therapies and Patient Partnership	Emergency Planning subcommittee (Operational Board)					✓						
28	**Monthly Ward Staffing update**	Director of Nursing, Therapies and Patient Partnership	Quality Committee		✓		✓	✓		✓			✓	✓
29	**Provider Licence Compliance**	Director of Finance	Audit Committee		✓					✓				
30	**Security Annual Report 2015/16**	Director of Operations	Health, Safety and Well-being subcommittee (Operational Board)					✓						

31	**Mental Health Act compliance report (KP90)**	Medical Director Compliance Quality and Regulation	Compliance, Assurance and Learning subcommittee (Quality Committee)		✓					✓					
32	**Receive Register of Sealings Report**	Director of Finance	Audit Committee					✓							
33	**Receive Research Annual Report 2015/16**	Medical Director Effectiveness Medical Education	Operational Board					✓							
	Monitor Well Led Domain 4: Measurement														
34	**Information Governance 16/17Toolkit**	Medical Director	Records and Clinical Systems Group (Quality Committee)												✓
35	**Board Performance Dashboard**	Director of Finance	Operational Board		✓		✓	✓		✓		✓			✓
	Governance														
36	**Receive minutes and Chair's Report of the Quality Committee**	Non Executive Director	N/A		✓		✓	✓		✓		✓			✓
37	**Receive minutes and Chair's Report of the Audit Committee**	Non Executive Director	N/A		✓		✓	✓		✓		✓			✓
38	**BOD Business Cycle 2016/17**	Chair	N/A		✓		✓	✓		✓		✓			✓
39	**Approve BOD Business Cycle 2017/18**	Chair	N/A												✓
40	**Review Risk impacts of items**	Chair/All	N/A		✓		✓	✓		✓		✓			✓
41	**Chair's announcements**	Chair	N/A		✓		✓	✓		✓		✓			✓
42	**Chief Executive announcements**	Chief Executive	N/A		✓		✓	✓		✓		✓			✓

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

Cheshire and Wirral Partnership NHS Foundation Trust

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

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

26	**Board Performance Dashboard**	Director of Finance	Operational Board		✓		✓	✓		✓		✓		✓
Governance														
27	**Receive Register of Sealings Report**	Director of Finance	Audit Committee					✓						
28	**CEO /Chair Division of Responsibilities**	Chair	N/A		✓									
29	**Integrated Governance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee					✓						
30	**Receive minutes and Chair's Report of the Quality Committee**	Non Executive Director	N/A		✓		✓	✓		✓		✓		✓
31	**Receive minutes and Chair's Report of the Audit Committee**	Non Executive Director	N/A		✓		✓	✓		✓		✓		✓
32	**Audit Committee annual effectivenes review**	Non Executive Director			✓									
33	**BOD Business Cycle 2017/18**	Chair	N/A		✓		✓	✓		✓		✓		✓
34	**Approve BOD Business Cycle 2018/19**	Chair	N/A											✓
35	**Review Risk impacts of items**	Chair/All	N/A		✓		✓	✓		✓		✓		✓

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Corporate assurance framework – update report
Agenda ref. no:	16/17/136
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/03/2017
Presented by:	Dr Anushta Sivananthan, Medical Director

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	Yes
All strategic risks	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	Yes
N/A	

REPORT BRIEFING

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

To update the Board of Directors of the current status of the corporate assurance framework to inform discussion of the current risks to the delivery of the organisational strategic objectives, and as per the requirements outlined within the Trust's integrated governance strategy. The report indicates progress against the mitigating actions identified against the Trust's strategic risks and the controls and assurances in place that act as mitigations against each strategic risk. **As at March 2017, the Trust has 3 red and 7 amber strategic risks. 2 risks are currently in scope.**

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

The Board of Directors monitors and reviews the corporate assurance framework and receives assurances on strategic risk via the Quality Committee. This is a key component of the Trust's integrated governance strategy which provides assurance regarding the quality and safety of the services that the Trust provides. The Quality Committee undertakes individual in-depth reviews of risks, with the Audit Committee undertaking periodic reviews of risk treatment processes for individual risks on an escalation/ enquiry basis.

Assessment – *analysis and considerations of options and risks*

New risks/ risks in-scope

Risk 1 – Risk of harm due to deficits in familiarity with and staff confidence in applying safety critical policies, in particular the Trust's "search" policy, to ensure CWP maintains safe environments for patients and staff. This is a new risk in response to recent incidents involving fires associated with access to ignition sources including lighters (although the risk applies to possession and access to other implements that may be harmful). Mitigating actions have been identified to focus on building staff confidence.

Risk 2 – Risk of significant operational impact resulting from the redesign of Adult & Older Persons Mental Health Services in Central and Eastern Cheshire. This risk has now been fully modelled, facilitating the Board of Directors with scrutiny of progress against mitigation of the impacts of this strategic risk.

Risk 4 – Risk of failure to achieve Trust control total due to in-achievement of cost improvement programme (CIP). This is a re-escalated risk and is in the process of being modelled. The risk interfaces are multiple and the risk score is likely to be changeable based on current CIP position at any one time.

The in-scope *Risk that the CWP workforce not having sufficient capability and resilience to deliver place-based systems of care* is currently being developed by the Deputy Director of People and Organisational Development to understand the degree and nature of the risk as it applies to CWP. This work is linked to and will be informed by the 'Aligning Capability' work that is currently being undertaken and therefore it is not yet concluded. It is proposed that *Risk 11*, *Risk 16* and the in-scope *Risk of impact on patient care due to staffing pressures in CMHTs Trustwide* be archived and any outstanding actions be captured as part of the overarching in-scope risk.

IT infrastructure risk

Following discussions at the February 2017 Board meeting, work has been undertaken with the IT department to explore the *Risk of IT infrastructure failure* to understand if this meets the integrated governance framework criteria for escalation to the strategic risk register. This is currently an in-scope risk and will report to the May 2017 meeting of the Quality Committee.

Amended risk scores or re-modelled risks – None to report.

Archived risks

Risk 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. The CQC re-inspection of mental health services report was published on 3 February 2017, which reports significant improvements in relation to governance around the Mental Health Act. There are now no regulatory actions required to be taken in relation to the MHA. CQC MHA Commissioner visits continue to take place to monitor this area, whilst this and other activity in relation to the MHA will be monitored via quarterly reports to Quality Committee commencing in the 2017/18 business cycle.

Risk 17 – Risk of non-compliance with regulatory frameworks and negative impact on patient care due to environmental/ accommodation shortcomings at Civic Way, Ellesmere Port. It was agreed at Operational Board, held 18 January 2017, to archive this risk as it has reached the agreed tolerable risk score. This was subsequently endorsed (following a near real time verbal update) by the January 2017 Board meeting.

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

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

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	22/02/2017

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

Appendix no.	Appendix title
(attachment to agenda email)	Corporate assurance framework – March 2017

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	2016 Staff Survey Results
Agenda ref. no:	16/17/137
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/03/2017
Presented by:	David Harris, Director of People and OD

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

REPORT BRIEFING

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

The staff survey was conducted September to December 2016 to gauge staff views on a range of areas to highlight to the Trust (and indeed external stakeholders such as NHSE & CQC) areas for improvement / where things are working well. The survey was distributed to 100% of staff that were employed by the Trust on 31st August 2016, with the vast majority of surveys emailed to staff; this was the first time the staff survey has been conducted in this way. Staff in roles with limited access to emails, such as estates and facilities, were provided with a paper-based copy. Staff could also opt for a paper based version of the survey if they so wished.This report aims to provide CWP Trust Board with an overview of the 2016 survey results together with plans for addressing feedback.

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

CWP commissioned Quality Health (official NHS Staff Survey provider) to conduct the staff survey. The official sample size for Cheshire and Wirral Partnership NHS Foundation Trust was a 100% census using a mix of paper and email sent to all 3440 staff in post as of 1 September 2016.

The Trust response rate to the National Staff Survey was 47%, which while is less than 2015 final rate of 49% still remains significantly higher than the 2014 response rate of 41%.

Similar sector organisations surveyed by Quality Health in 2016 had a mean overall response rate of 44%.

Assessment – *analysis and considerations of options and risks*

Of the 84 'core' questions comparable with the 2015 Staff Survey, 63 (75%) of the responses showed positive improvement; of those 21 were significant increases.

The 2016 survey also saw a decline in 10 questions responses (12%) compared to the 2015 survey, with two question responses identified as significantly decreased.

changes by 4% or more are considered significant

Please refer to Appendix1 for an overview of the findings.

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

The Board of Directors is recommended to note the content of this report.

Who/ which group has approved this report for receipt at the above meeting?		Operations Board – March 2017
Contributing authors:		Hayley Curran
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
Appendix 1	Staff Survey Results
Appendix 2	Big Conversation
Appendix 3	Big Conversation Calendar

16/17/137 Appendix 1

CWP Staff Survey 2016

1.0) Introduction

Overall 2016 Staff Survey results are positive, with a significant number of areas identified as above average when compared with sector - combined Mental Health, Learning Disability & Community Services. This report aims to provide a brief overview of highlights and areas where CWP need to focus further support and development.

The response rate to the National Staff Survey was 47%, which while is less than last year's final rate of 49% still remains significantly higher than the 2015 response rate of 41%. Similar sector organisations surveyed by Quality Health in 2016 had a mean overall response rate of 44%.

The Trust's 2016 Overall Staff Engagement score is above that for the sector (Trust 3.89, sector 3.80).

- Respondents were 80% female, 20% male, 93% of which were white British and 27% having worked for the trust for more than 15 years.
- 36% of the respondents were registered nurses and midwives
- 23% were allied health professionals
- Almost 26% wider healthcare team including corporate support
- 6% general management
- 6% nursing or healthcare assistants and
- 4% medical and dental

2.0) What

Of the 84 'core' questions comparable with 2015 Staff Survey, 63 (75%) of the responses showed positive improvement; of those 21 were significant increases. The 2016 survey also saw a decline in 10 questions responses (12%) compared to the 2015 survey, with two question responses identified as significantly decreased.
changes by 4% or more are considered significant

2.1) Please see below a table outlining the responses that have seen a significant change from 2015 survey.

Survey Results with significant change (*4% or more*) since 2015 Survey	
Positive Change	**Negative Change**
Your Job – 6% increase in respondents saying they often / always look forward to coming to work.	
Your Job – 4% increase in respondents 'strongly agreeing' that they know their work responsibilities	**Your Job** – 4% reduction in respondents 'agreeing' that they know their work responsibilities (*although this could be due to the fact that 'strongly agree' has risen by 4%)*
Your Job – 4% increase in respondents strongly agreeing that their team has shared objectives.	
Your Job – 4% increase in respondents agreeing they	

get recognition for good work.	
Your Job – 4% increase in respondents who are 'very satisfied' with the support from their immediate manager.	
Your Job – 4% increase in responses that 'strongly agree' they are trusted to do their job.	
Your Job – 4% 'strongly agree' their team members have to communicate closely with colleagues to achieve objectives.	
Your Managers – 5% increase in respondents strongly agreeing that their manager takes a positive interest into their health and wellbeing.	
Your Managers – 4% increase those who 'strongly agree' their manager is supportive in a personal crisis.	
Your Health, Wellbeing & Safety – 5% increase in respondents who believe they are treated fairly when involved in an error or near miss.	
Your Health, Wellbeing & Safety – 6% increase in staff who agree that the organisation takes action to ensure errors or near misses are avoided in future.	
Your Health, Wellbeing & Safety – 7% increase in respondents who agree they are given feedback about changes made in response to near misses/errors.	
Your Health, Wellbeing & Safety – 7% increase in respondents who agree they would feel secure about raising concerns around unsafe practise.	
Your Health, Wellbeing & Safety – 7% increase agreement that staff are confident the Trust would address their concern.	
Your Health, Wellbeing & Safety – 6% reduction in experiences of discrimination because of gender.	
Your Personal Development – 4% increase in staff who agree their training and development has helped to do their job more effectively.	**Your Personal Development** – 5% decrease in staff having any training or development in the past 12 months
Your Personal Development - 4% increase in responses agreeing that training has helped them to deliver a better patient experience.	
Your Personal Development – 4% increase in staff who agree their appraisal/reviews made clear objectives for their work.	
Your Personal Development – 7% increase in staff who found the values of the organisation were discussed during their appraisal.	
Your Organisation – 5% increase in responses agreeing patient care is organisation's top priority	
Your Organisation - 6% increase in respondents who 'strongly agree' they receive regular updates on service user feedback.	

2.2) CWP Has scored better than the sector in the following areas:

- Staff agree preventative action is taken when errors occur
- Staff are given feedback about changes made in response to reported errors

- Staff agree they would feel secure raining their concerns
- Staff agree they felt confident the org would address those concerns
- Patient / Service User care is the org's top priority
- Would recommend their org as a place to work
- Would be happy with standards of care for friends / family
- Other colleagues demonstrate values at work
- Satisfied with level of pay
- Agree that their immediate manager takes a positive interest in their health and wellbeing

3.0) So What

Areas recommended to address at Trust Wide level

3.1 Celebrate the positive responses and in particular areas in which the Trust is higher than average for sector – explore how these can be 'amplified' for further success.

3.2 Communication and engagement between senior managers and staff – with particular emphasis on involving staff in decision making process and providing feedback on outcome

3.3 Identify areas where staff have reported violence and HBA from patients, managers and other staff, cross referencing against local reporting process to drill down potential service areas. Raise awareness as to the importance of reporting incidents and process for 'Speak Up Guardian'
**NOTE: whilst this is a priority, staff reporting having experienced HBA is low, has reduced from 2015 survey and is lower than the sector.

3.4 Review the provision of non-mandatory training for staff through Training Needs Analysis.

3.5 Ensure that Patient Experience Data is regularly shared with staff to highlight areas which are positive (and should be celebrated) as well as areas for improvement.

4.0) Now What

A programme of engagement – Big Conversation - is currently being planned which will take the results of the 2016 Staff Survey directly to front line staff to gain their views on the survey results and will facilitate staff to identify priority areas for action within their locality.

Please refer to Appendix 2 for an overview of the Big Conversation programme and particularly 'Community Conversations' taking place within May 2017, in which engagement with staff re: Staff Survey Results will take place. Staff will be updated of plans via *"We Said – We're Doing"* brief attached to May payslips, and will continue to be updated via locality news letters on a quarterly basis.

16/17/137 Appendix 2

The Big Conversation 2017

1.) Introduction

Consideration has been given as to how best to engage with staff in a meaningful way, with a range of opportunities for people to have their say and get involved in shaping CWP's agenda. This proposal is not a '*catch all'* for all Trust engagement activity, but aims to address specific workforce concerns raised through 2016 Staff Survey and focus groups used to 'make sense' of survey results.

2.) Key insights from The Big Conversation focus groups:

During January and February focus groups took place across the footprint. These were held at times considered convenient for staff, i.e. at ward handover time at Millbrook, and 8am for community staff in Wirral. The key themes to emerge from this were:

Engagement with senior leads

- Strong visible leadership from team managers and CSMs, yet perceived disconnect between senior management (locality leads and Executive team) and those on 'the shop floor'.
- Limited opportunities to raise ideas, and lack of feedback when ideas are raised
- Communication needs to be two way between staff and management.
- Senior Leadership, particularly Exec's, is not visible; a number of staff have requested Exec's shadow them in post

Internal communications

- Over-reliance on email; difficult for those not at their desk or with limited / no access to email
- Internal communication needs to be more succinctly delivered – there are too many communication vehicles and messages are getting lost
- Individuals and teams are unaware of services outside of their own. Staff are unaware of the breadth of CWP services and how to refer into one another
- Staff feel that communications are not transparent, and are often '*holding information back for fear of alarming staff'*. Staff know the NHS has a funding crisis, and feel that communications need to clearly outline the impact of this upon their locality / service and ultimately what this means for them.

Health, work and wellbeing

- Staff (that are aware of them) recognise that there are lots of good initiatives, however awareness of what's available isn't across the board and therefore health and wellbeing activities need to be better communicated
- With high levels of burnout and workload pressures, resilience workshops are valued and staff want more investment like this
- Some managers don't always act in a person centred way and support their staff who are stressed or reaching burn-out
- Staff can't be released to attend wellbeing initiatives due to short notice / short staffing in teams

Recognition

- Managers don't always recognise and thank staff for their hard work and commitment
- Sense that senior managers don't value staffs contribution and don't understand the difficult circumstances they face on a daily basis
- Lots of great work taking place that isn't effectively promoted internally , sharing best practice

3.) Proposal

The Big Conversation programme aims to address the above feedback from staff by working in collaboration with colleagues from across the Trust to provide a range of opportunities that are anticipated to improve staff engagement. The Big Conversation also provides a forum by which CWP senior leadership can regularly connect with front line staff to set context for the Trust's broader operational plans and increase their visibility.

A key priority for Big Conversation is to embed a culture of recognition; this will form a key ingredient in all initiatives implemented. The following initiatives are proposed for 2017/18:

- **Community Conversations** – large scale staff '*get-togethers*' designed to bring staff together with colleagues from across their local area to network, promote and recognise best practice, engage on specific topics and access health and wellbeing initiatives. These events will take place by-annually within each locality
- **Breakfast with Sheena** –held on a monthly basis this breakfast meeting is an opportunity for staff to nominate themselves or be nominated by locality management team, to meet Sheena and discuss local issues, promote good working practices or highlight opportunities for service development. Its anticipated that they will rotate on a monthly basis, bringing Sheena into the localities and into staff environments
- **Staff Survey** – This annual survey will continue Sept-Nov 2017, however Trust-wide and locality action plans will be developed with staff through Community Conversations and progress will be reported via regular '*We Said, We Did*' campaigns; including a brochure to all staff outlining CWP's commitment to address their concerns form 2016 survey; this will be attached to May's payslips.
- **Staff FFT & Cultural Barometer** – This is an NHSE requirement that we conduct with staff on a quarterly basis. It is an opportunity to seek feedback from staff to further inform 'workforce insight data' and will be used to shape community conversations and locality plans. It is anticipated that a full census will be issued in Quarter 1 (six months post staff survey), with locality based surveys in quarters 2, 3 and 4 thereafter. Locality management teams will be provided with a copy of the results to inform their local engagement plans.
- **Staff Handbook** - All staff will receive a handbook outlining key CWP information including support and benefits of working for the trust as well as key processes and policies to support them in the workplace. There will be a feature within the handbook on engagement including how staff can get involved in shaping CWP agenda
- **CWP Staff App** – The Trust need to use different ways to connect with staff and, given that we are now in a 'd*igital world',* the app aims to connect with staff through this means. The app will have a range of functionality including features such as Freedom to Speak Up, push notifications to keep staff updated on latest developments and pulse checks to gain their reactions to proposed changes and developments. It is hoped to reach a wider audience than traditional internal comms, which is felt to be overly reliant on email.
- **Locality News Letters** – This initiative was launched in Wirral in 2016 and has proved so popular that staff in other localities have said they would also like one. The benefits of a staff newsletter is that it is about staff; enabling staff specific stories, celebrations and sharing of best practice in a way that CWP Life cannot as it is a public facing document aimed at staff and members. Work to develop one for Central and East locality is currently underway.

**Its anticipated that further initiatives for engagement will be implemented throughout the year to build upon the Big Conversation Programme

Please refer to Appendix 3 that provides an overview of implementation during the 2017/18 calendar.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

#TheBigConversation

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
What	Staff Friends and Family Test: Full consensus			Staff Friends and Family Test: West			Staff Friends and Family Test: Wirral			Staff Friends and Family Test: Central & East		
	Appraisals: Bands 7 and above			Appraisals: Bands 5 & 6			Appraisals: Bands 1-4					
						NHS Staff Survey						
So what	Exec breakfast Central & East	Exec breakfast Wirral	Exec breakfast West	Exec breakfast Central & East	Exec breakfast Wirral	Exec breakfast West	Exec breakfast Central & East	Exec breakfast Wirral	Exec breakfast West	Exec breakfast Central & East	Exec breakfast Wirral	Exec breakfast West
		Community Conversations x4						Community Conversations x4				
				Appraisal quality review			Appraisal quality review			Appraisal quality review		
Now what		Staff handbook				Staff app						
		We said, we're doing'				'We said, we did'					Staff Survey results published	Staff Survey results cascaded
		Locality newsletter: Wirral	Locality newsletter: Central & East	Locality newsletter: Wirral		Locality newsletter: Wirral		Locality newsletter: Wirral		Locality newsletter: Wirral		Locality newsletter: Wirral

So what: Exec breakfasts
monthly

Now what: Locality newsletters
Wirral – every other month
Central & East – launch in June
West - TBC

So what: Community Conversations
One in each locality, twice a year

What: Staff FFT & Cultural Barometer
Quarterly for each locality

The Big Conversation 2017-18

What: Staff Survey
Annually – Sept-Nov

Now what:'We said, we did'
September

Now what: 'We said, we're doing'
April

Now what: Staff Handbook
May

Now what: Staff app
September

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Sickness Absence Performance & Trends 2016
Agenda ref. no:	16/17/138
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/03/2017
Presented by:	David Harris, Director of People and OD Services

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	
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	
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
35T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	
35T	

REPORT BRIEFING

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

This report was commissioned in January 2017 due to increasing concerns about reported sickness absence rates and in response to the fact that rates had exceeded the threshold triggers as set out in the Operational Plan 16/17 monitoring, in three consecutive months within one quarter.

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

People Services collated sickness absence data spanning April 2012 to December 2016 and sought to correlate this with other information in order to identify and better understand any trends and factors which may be contributing to sickness absence rates. Data and information sources included - ESR, NHS Digital, Blacklight, 2016 Staff Survey, CWP managers survey, Physiomed, Occupational Health and Staff Support & Psychological Well-being Service Report (SSPWS) activity data, HR Operational Team and NICE Workplace health: management practices.

The key findings of the deep dive and a number of recommendations are set out in the report attached at appendix 1 with further supporting data and information contained at appendices 2 – 5.

Assessment – *analysis and considerations of options and risks*

The main conclusions to be drawn from the deep dive may be summarised as follows:

- CWP is not an outlier when comparing sickness rates with other mental health and community trusts in the North West
- Seasonal variation during the autumn/winter months accounted for the threshold trigger being broken
- CWP has in place all the main interventions in place set out by NICE guidance
- The Attendance Management policy is generally being used correctly and effectively
- More focused work is needed on the wider impacts of change, wellbeing promotion and ill-health prevention and use of mental health pathways

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

The Board is asked to **note** this report, in particular that the recommendations set out in Appendix 1 which will form an action plan and will be monitored by the Health & Wellbeing Group, which in turn will provide bi-monthly updates to the People and OD Sub Committee.

Who/ which group has approved this report for receipt at the above meeting?	People and OD Sub Committee
Contributing authors:	Chris Sheldon, Head of HR, Gill Kelly, Head of People Information

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	People and OD Sub Committee	13 March 2017

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

Appendix no.	Appendix title
35T	1. Sickness Absence Performance and Trends 2016 2. Data workbook 3. Physiomed information 4 Staff Support & Psychological Well-being Service (SSPWS) Report (including Mental Health Pathway) (1 April 2016 – 31 December 2016) 5 Managers survey results

Sickness Absence Performance & Trends 2016

Executive Summary

This report was commissioned in January 2017 due to increasing concerns about reported sickness absence rates and in response to the fact rates had broken the threshold triggers as set out in the annual plan in three consecutive months within one quarter.

Sickness Absence Rate	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
NHSI forecast Position	5.75%	5.68%	5.60%	5.58%	5.57%	5.50%	5.46%	5.43%	5.40%	5.36%	5.32%	5.30%
CWP Actual Position*	5.27%	5.40%	5.52%	5.45%	5.43%	5.26%	5.61%	5.91%	5.98%	5.99%		

**Rate reported at the 10th working day after month end as instructed by NHSI*

People Services have reviewed sickness absence data spanning April 2012 and December 2016 and have sought to correlate this with other information in order to identify and better understand any trends and factors which may be contributing to sickness absence rates.

The key findings of the deep dive and a number of recommendations are set out in the report.

Background

The report seeks to summarise the following:-

Context: putting the Trust's sickness absence into context with reference to what is happening elsewhere, how we're performing compared with 2015.

Analysis: looking at:-

- what the current year data/information is telling us;
- trends identified over time;
- effectiveness of the application of the Management of Attendance policy;
- the capability (capacity, competence and confidence) of line managers.

Next Steps:

- Recommendations.

Context

Since 2012 sickness absence rates in the North West of England have been the highest of all regions across the county. The current year to date (YTD) absence rate in the North West from April 2016 to December 2016 is 4.76%, the highest in the country.

Mental Health Trusts (MHTs) nationally have higher rates of absence than acute trusts. Looking at how CWP compares with other mental health and community trusts in the North West it can be

identified that CWP is not an outlier. CWP has been below the MHT average for the region for 3 consecutive months from October 2016 to December 2016. The North West MHT average for December 2016 was 6.00% compared to 5.70%for CWP.

Looking at how CWP compares with the MHT averages over a longer period of time, from April 2014 it can be seen that CWP follows a similar pattern of absence. Please see Appendix 2 for more benchmarking detail.

The environment in which the Trust operates continues to be challenging with staff facing continuous change which creates uncertainty. Occupational Health has reported staff being referred in with increasingly complex presentations.

The roll out of Blacklight Attendance Line was completed in March 2015 following a recommendation by Mersey Internal Audit Agency (MIAA). As a result, CWP can be more confident that it is now capturing and reporting sickness absence in a more effective way and all managers should be better assisted to manage sickness absence. In addition, the Management of Attendance Policy was reviewed in February 2016 with a comprehensive training programme put in place to re-launch it.

Analysis

Current Year to Date (YTD): April 2016 to December 2016

- The cumulative sickness absence rate at 31st December 2016 was 5.34%
- The cost*of sickness absence to 31st December 2016 was £3,828,068

  *(*cost is based on employee basic salary plus employer on costs for the period off work)*
- The average number of days lost per worker was 19.62 FTE days
- 1981 out of a total of 3433 substantive members of staff had at least one episode of sickness
- Of all sickness absence, the two most common reasons remain those which are linked to mental ill health issues (34.21%) and muscular skeletal conditions (21.34%)
- The next most common reasons are gastrointestinal (7.38%) and cough/cold & flu (6.36%)
- The prevalence of sickness absence rates across the Care Quality Commission (CQC) staff groups is as set out in the table below.

Staff grouping (CQC)	Absence rate per group
Inpatient	7.38%
Estates and facilities	5.52%
Community Mental Health	5.49%
Community Physical Health	4.24%
Admin/Management	3.29%

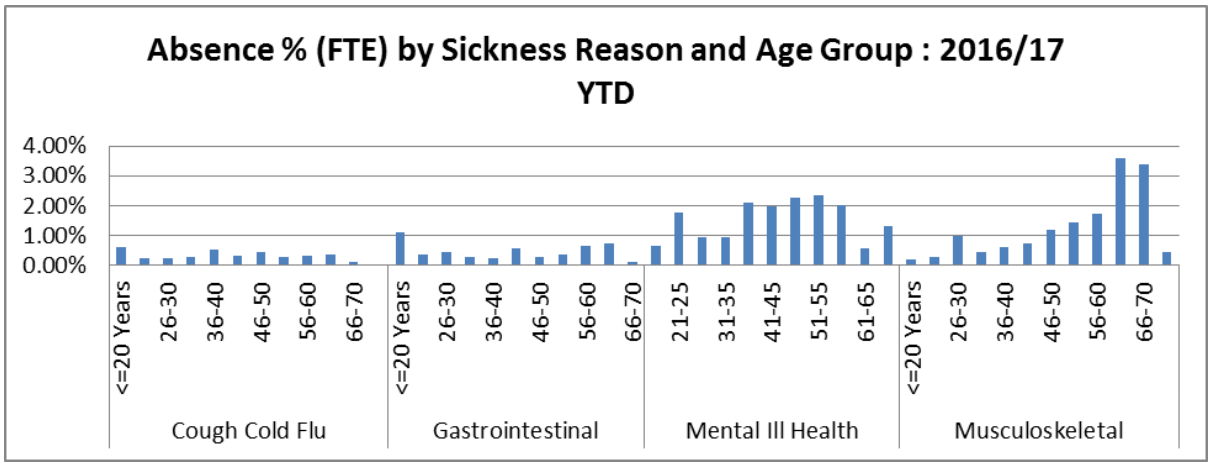
- The prevalence of the top 4 absence reasons in terms of number of episodes is as set out below.

Reason	Number of episodes
Gastrointestinal	699
Cough/Cold/ Flu	681
Musculoskeletal(MSK)	421
Anxiety/stress/depression	301

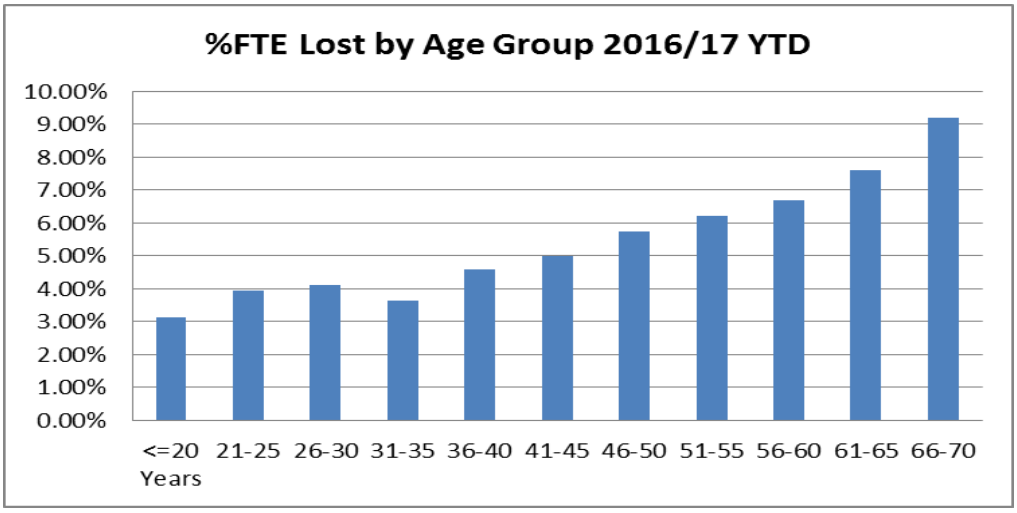
- The prevalence of the top 4 absence reasons in terms of average length of an episode is as set out below.

Reason	Av length of Episode (FTE days)
Anxiety/stress/depression	50.2
Musculoskeletal(MSK)	22.4
Gastrointestinal	4.5
Cough/Cold/ Flu	4.1

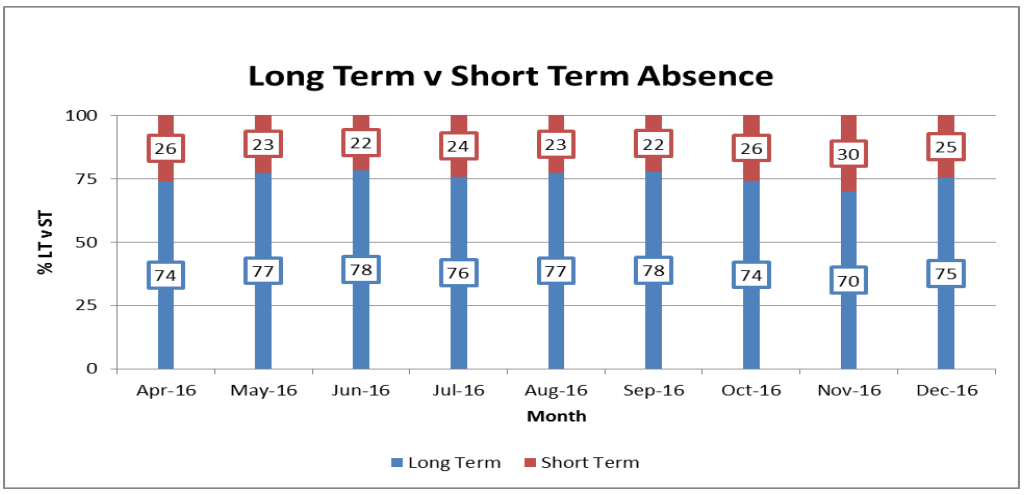
- Figures indicate that age is not generally a factor in relation to absences related to Cough/Cold/Flu or gastrointestinal but where absences relate to MSK there is a definite correlation with age. The correlation between mental health issues and age is more difficult to determine but the age groups currently experiencing the highest % are between 46 and 55.



- In overall terms, as age increases so does the percentage of time lost. See table below.



- The proportion of short term sickness to long term sickness is ordinarily around 24%, however this increases in the winter and early spring months when coughs and colds are more common. There is no discernible difference from previous years.



- Absence Related to Incidents at Work

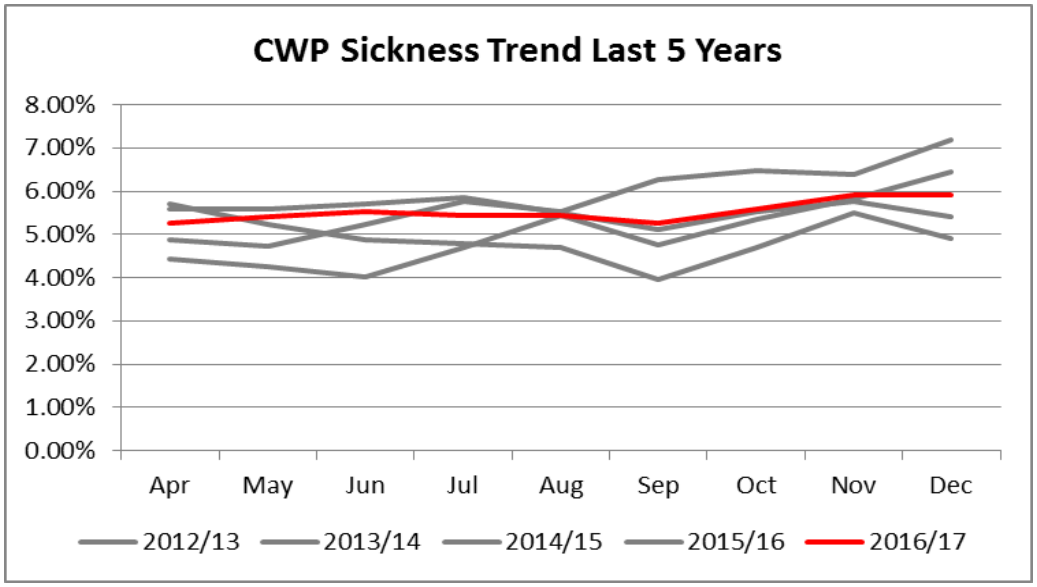
Looking at data for April to December compared to the same period in 2015 we can see that:-

- The proportion of incidents involving staff has increased from 11.2% to 23.2%;
- Of all staff related incidents, the proportion of a physical nature reduced from 72% to 65% while the proportion of a verbal nature increased from 28% to 35%;
- The number of staff who go off sick as the result of an incident reduced from 33 to 23 (ESR Data).

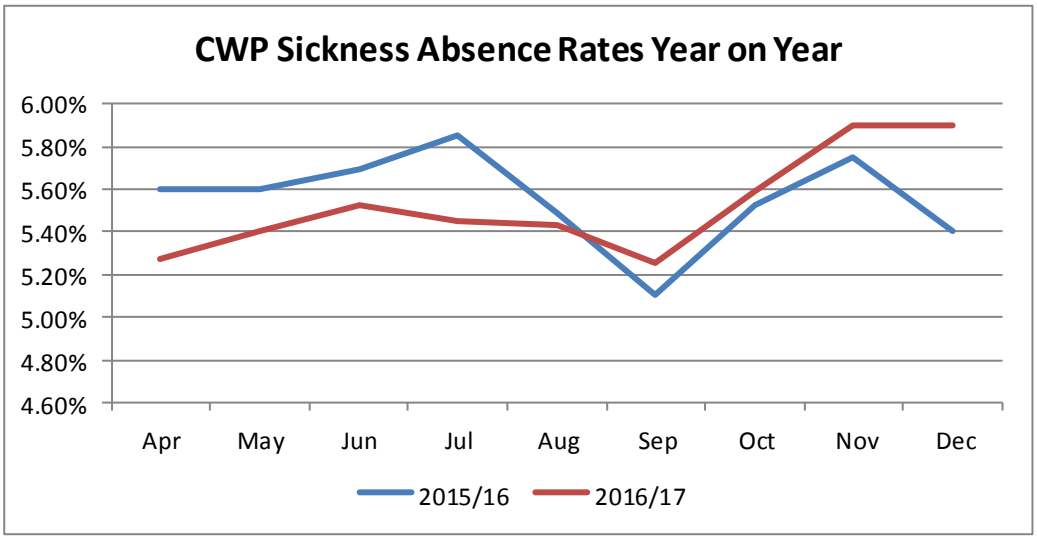
Whilst the number of reported incidents involving staff has doubled compared with the same period last year, there is no corresponding increase in absence rates. Further detail relating to incident data can be found in Appendix 2.

Trends over Time

- Looking at sickness trends within CWP over the past 5 years seasonal variations can be identified with rates increasing during autumn and winter. Peak months are from October to January (5.5% - 5.86%). The lowest averages recorded are August (4.85%) and May (4.87%).



- Comparing 2016/17 with 2015/2016 in the chart below, the figures indicate overall an improving picture up until September 2016 where performance began to drop below rates in the previous year. However, it can be seen from the chart above that 2016/17 does not compare so favourably with 3 of the previous 4 years.



Locality Trends

Performance Year on Year (April to December)

The table below shows the YTD figure from April to December for 2014, 2015 and 2016. This comparison shows that:

- West and Central and Eastern localities have both improved their performance year on year

- Wirral locality showed improvement in 2015 but 2016 now sees the poorest performance of the 3 years
- Corporate Clinical Support Services have seen the most deterioration in its performance since 2014.

Locality	2014	2015	2016
Central and East	6.64%	6.23%	6.14%
West	5.99%	5.27%	4.92%
Wirral	6.16%	5.99%	6.26%
Clinical Support Services	3.64%	3.85%	4.01%

Long Term vs. Short Term Absence

Appendix 2 provides a month by month breakdown at locality level of the proportion of long term sickness to short term sickness since April 2014. It can be seen that:-

- There is some indication of a seasonal trend during the winter and early spring months where the proportion of short term sickness increases, reflecting an increased occurrences of coughs/colds;
- On the whole the ratio of short term sickness to long term sickness is 25% to 75%;
- Short term sickness absence in Wirral locality rarely increases beyond 25% of all absence;
- The ratio of short term absence in corporate services is less stable and periodically increases above 25%.

Effectiveness of Support Packages in Place

Management of Attendance Policy

Return to Work Discussions

Blacklight Attendance Line provides information on the timeliness of return to work interviews (RTW) which in turn is an indicator of managers following the policy. Taking data from April 2016 – November 2016:-

- 56% of RTW's were completed within one week of the employee returning to work
- If we look at the proportion of RTWs being undertaken within 2 weeks of return to work this figure increases to 73%;
- 3.4% were not completed at all.

Stage Escalation Management

The ability to report on how many people have met triggers and are therefore subject to the informal and formal stages of the management of attendance procedure is still under development with an expectation that this functionality will be available from summer 2017.

Management Referrals

Of all the sickness absences attributed to mental ill health or musculoskeletal reasons for the period April 2015 to December 2016, we can see that:-

- There were 752 episodes of MIH sickness. 308 (40.96%) were referred into either the OH integrated pathway or SSPWS either during their absence or within 2 weeks of their return date. A further 9 employees were referred within the week prior to them becoming unwell;
- There were 1049 episodes of MSK related absence. Only 164 (15.63%) were referred either into the OH integrated pathway or directly to PhysioMed.

Occupational Health Service

There has been no significant change in the number of referrals made to Occupational Health (OH) for musculoskeletal and mental health related issues when comparing April to December 2016 with the same period in 2015.

The average waiting time for an appointment with an OH professional is 10.37 working days. This is based on the length of time from the receipt of the referral in OH to the first appointment offered. The OH target for this performance indicator is 7.5 working days and as such further work will have to be undertaken to establish whether performance can be improved.

PhysioMed Service

PhysioMed accept direct referrals from CWP managers so the number referred in to OH and PhysioMed will not be the same.

The total number of referral s to PhysioMed between April - December 2016 was 269. The average time to access OH physiotherapy is 1.3 days compared with 71.5 working days for an NHS referral via GP.

Work aggravated conditions were responsible for 15.7% and a further 5.6% of referrals were recorded as being due to accidents on duty.

For further detail regarding the PhysioMed service, please see Appendix 3.

Staff Support & Psychological Well-being Service (SSPWS)

Over the last 3 years the number of referrals into the service has remained fairly constant.

The total number of referrals into the service during the period April 2016 to December 2016 was 338, 193 (57%) of whom joined the Mental Health pathway.

Of the presenting issues, the most prevalent were anxiety & stress (23%), depression (14%) and interpersonal/relationship problems (12%).

The service has compelling but mainly self-reported evidence that their interventions are effective in reducing the length of time staff are off sick when comparing absences prior to referral and 4 weeks prior to final appointment.

Key work related reasons contributing to stress levels, as reported by managers and staff attending Stress Workshops were volume of work, difficult team relationships and poor communications particularly relating to organisational changes.

For further detail regarding the SSPWS service please see Appendix 4.

Locality HR interventions

Locality HR Teams provide significant support to managers and feedback from the localities indicates that this is generally valued and effective. Support is offered in slightly different ways, however all have regular meetings with managers to discuss cases and have further meetings with CSM's and/or GM's to discuss cases/hotspots/ policy compliance . All HR locality teams state that they are providing support and guidance on a daily basis and that all of the localities acknowledge that managing absence is a key priority.

People Information

In addition to a suite of sickness absence information provided to support corporate performance monitoring, People Information continues to provide hot spot reports to assist services in identifying where efforts need to be targeted and local monitoring.

Training interventions

There are a range of training activities which support staff attendance and wellbeing.

Resilience workshops - separate evaluations have been undertaken relating to the effectiveness of these sessions which have been well received by staff.

Stress workshops – throughout 2015.

Management of attendance training – courses are held throughout the year which receive generally positive evaluations.

<u>Surveys</u>

Manager Survey

Managers were recently asked to complete a short survey to test out their levels of confidence in managing attendance. 207 managers responded to the survey and the full results are attached at Appendix 5.

In overall terms the responses were encouraging. 68.7% of managers believe they have influence over absence levels. 94% of managers are confident in their understanding of the absence management policy. 78% feel confident in applying it. Managers requested greater practical training

especially around understanding the policy (which is interesting in view of the responses to the questions set out above) and more support with holding difficult conversations.

2016 Staff Survey Indicators

Looking at the responses that relate to health and wellbeing there have been a number of significant improvements in some areas. Nearly all the scores are either slightly or significantly better than the sector. For example 95% of staff say that they trust takes positive action on health and wellbeing – which is slightly higher than the sector score (91%) and a small improvement on last years' score of 93%

The % of staff saying that they have felt unwell due to work related stress has slightly decreased from 37% last year, to 36% this year.

Comparing the results from the last four surveys there has been little change in the % of staff putting themselves under pressure to come into work, however the CWP result for 2016 is now within the bottom 20% of comparator Trusts for this measure.

Further analysis of the survey data will be undertaken in due course.

Conclusions

Whilst sickness rates remain a concern when compared with other trusts of a similar type in the North West the Trust is not an outlier.

The policy is fit for purpose with a high percentage of managers indicating that they are confident in their understanding of it. However there is evidence to suggest that their application of certain elements could be improved by:

- completing return to work interviews in a timely manner, and;
- increasing the number of referrals into the integrated OH pathway and PhysioMed as currently only 40.96% of staff off sick with MIH related issues are referred in to service and only 15.93% of those absent with MSK related problems.

Managers are generally confident in using Attendance Line and HR is proactively using it to monitor activity and direct support to managers.

The staff survey does not indicate generally any points for concern but it requires further analysis particularly in relation to any trends toward increased 'presenteeism '.

Given the clear correlation of absence rates and the aging workforce, the Trust needs to identify and put measures in place to address their needs.

There is clear evidence that absences relating to MSK and mental ill health continue to account for the highest average number of days lost and that focus should remain on supporting staff with these conditions.

Inpatient and Estates & Facilities staff account for the two highest rates of absence and as such additional support needs to be directed towards these groups of staff.

There is no evidence to suggest that incidents relating to staff are having a significant effect on absence rates.

Whilst interrogating the data around incidents and staff absence from two data sources (Datix and ESR) it became evident that managers are recording more staff absence as a result of a work related incident in ESR than in Datix. Further work is needed to better align this information.

There is evidence that managers would appreciate further 'practical' training and that they would value increased administrative capacity within the teams to support the application of the policy.

There is evidence to suggest that management of change impacts on attendance rates.

Locality trends show variable patterns in relation to monthly absence rates in 2016, not following the expected seasonal variation pattern, and as such need further analysis to come to any meaningful conclusion.

There is evidence that CWP have many of the elements of good practice in place as set out in NICE guidance "*Workplace Health: management practices'',* however there is clearly scope to undertake further work across a range of factors.

Recommendations

Give resource and priority to rolling-out the Health and Wellbeing Strategy to support building a more motivated workforce (Organisational Commitment).*

Ensure that our values are reflected in our approach to managing attendance whilst balanced against the needs of the organisation (Organisational Commitment).

Look at enhancing our management of change processes to ensure that staff feel better supported through change (Leadership and Organisational Commitment).

Continue to build on staff engagement activities that ensure that management understand how staff may be supported to stay in work without feeling pressured to come in when they are not well (Participation and Trust).

Find ways of increasing the referral rate of staff off sick with MSK and MIH related issues to OH, SSPWS and PhysioMed, ensuring these services have the capacity to provide pro-active interventions which have been proven to enable staff to return to work sooner.

Ensure that manager job roles are designed in such a way that gives them adequate time to focus on managing attendance (Supporting the Role of Line Managers, Job Design).

Continue to seek ways of speeding up investigation processes so that staff are not experiencing unduly prolonged periods of stress which does impact on sickness rates (Leadership and Organisational Commitment).

Given that the majority of absence is long term consider focusing support from HR, SS and OH to mangers on supporting those people back into work in a timelier manner (Supporting the Role of Line Managers).

Ensure that managers focus on what staff can do rather that what they can't do in order to get people back into work sooner (Supporting the Role of Line Managers).

Support managers either through the formal training or coaching to apply the policy fairly but consistently particularly in relation to managers applying discretion (Training, Supporting Role of Line Managers).

Review the training/coaching to ensure that managers understand the application of reasonable adjustments in relation to people with disabilities and have the confidence to make decisions about terminating employment where appropriate (Training, Supporting Role of Line Managers).

Further develop the management of attendance toolkit to make sure that it supports managers to follow the management of attendance policy and supports the administrative processes (Supporting the Role of Line Managers).

Continue with the sickness clinics/dedicated HR links for each service as these are well received and are seen to add value (Training, Supporting the Role of Line Mangers).

Managers to give higher priority to the Stress Prevention Policy given that stress remains a significant reason for absence throughout the trust (Mental wellbeing).

Managers to consider the feedback from staff attending stress workshops by addressing some of the issues relating to the demands of the job, relationships and communication which could impact on attendance (Leadership, Job Design).

Managers to think about the local environment so that people feel they can take breaks and eat lunch away from their desk or work station (Physical environment).

Continue to use and improve the monthly data provided by People Information and available from Attendance Line to identify hot spots and trends which will help managers and support services prioritise support and shape strategy (Monitoring and Evaluation).

Enhance the functionality of attendance line so that reports can be produced on the stages people are on (Monitoring and Evaluation).

Ensure the annual plan target takes into account seasonal variation (Monitoring and Evaluation).

Consider introducing local 'stretch targets' for localities based on previous performance which may be more achievable (Monitoring and Evaluation).

Summary Recommendation

The Board is asked to note this report; in particular that the recommendations set out in Appendix 1 will be turned into an action plan and monitored by the Health & Wellbeing Group, which in turn will provide bi-monthly updates to the People and OD Sub Committee.

**headings taken from NICE guidance*

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Ward Daily Staffing Levels January and February Data 2017
Agenda ref. no:	16_17_139
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/03/2017
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

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

REPORT BRIEFING

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

This report details the ward daily staffing levels during the month of January and February 2017 following the submission of the planned and actual hours of both registered nurses (RN) and clinical support workers (CSWs) to UNIFY (appendix 1). The themes arising within these monthly submissions continue to mirror those that have arisen previously. These themes identify how patient safety is being maintained on a shift by shift basis.

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

The monthly reporting of daily staffing levels is a requirement of NHS England and the National Quality Board in order to appraise the Board and the public of staffing levels within in-patient units.
A number of recommendations were made within the latest six monthly report including consistency checking, national benchmarking, and widening the consideration of the MDT role within safer staffing. These recommendations are currently being followed through and monitored via the Safer Staffing group led by the Associate Director of Nursing [MH and LD] and are reported on in the next 6 monthly report.

Assessment – *analysis and considerations of options and risks*

During January 2017 the trust achieved staffing levels of 96.8% for registered nurses and 94.7% for clinical support workers on day shifts and 94.2% and 96.9% respectively on nights. During February 2017 the trust achieved staffing levels of 96.9% for registered nurses and 96.8% for clinical support workers on day shifts and 96.2% and 97.3% respectively on nights.

To note:

- The staffing levels on Oaktrees Ward fell below expected variation, to 85.5% and Coral ward to 78.4% for January; and
- The staffing levels on two wards fell below expected variation. Croft Ward, at 88.7% and Lakefield at 88.3%.

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

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

The Board of Directors are recommended to note the report.

Who/ which group has approved this report for receipt at the above meeting?	Avril Devaney, Director of Nursing, Therapies and Patient Partnership
Contributing authors:	Anne Casey, Head of Performance and Information

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Gary Flockhart, Associate Director of Nursing [MH and LD] Avril Devaney, Director of Nursing, Therapies and Patient Partnership	17/03/2017

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

Appendix no.	Appendix title
1	Ward Daily Staffing January 2017
2	Ward Daily Staffing February 2017

	Ward	Day				Night				Fill Rate				Safe Staffing was maintained by:
		Registered		Care Staff		Registered		Care Staff		Day		Night		
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	
East	Adelphi	1393.5	1347.5	1369.5	1152.5	717.5	728.5	1466.5	1317	96.7%	84.2%	101.5%	89.8%	Staff cross covered from other wards. Altering skill mix. Nursing staff working additional unplanned hours.
	Alderley Unit	1205	1225	1302	1186.5	747.5	747.5	713	690	101.7%	91.1%	100.0%	96.8%	*
	Bollin	1471	1392.5	1474.5	1414	724.5	713	1660.5	1476.5	94.7%	95.9%	98.4%	88.9%	Staff cross covered from other wards. Altering skill mix. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	Croft	1047	983	1651	1381.5	704.5	617	1502.5	1450.5	93.9%	83.7%	87.6%	96.5%	Staff cross covered from other wards. Altering skill mix. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	Greenways A&T	1170.5	1061.5	1630.5	1528	713	736	1403	1294	90.7%	93.7%	103.2%	92.2%	Staff cross covered from other wards. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	LimeWalk Rehab	1102	996	1022	929	672	660.5	724.5	727.5	90.4%	90.9%	98.3%	100.4%	Altering skill mix. Staff cross covered from other wards.
	Saddlebridge	1019	957.5	1620.5	1554.5	897	851	897	874	94.0%	95.9%	94.9%	97.4%	Altering skill mix. Staff cross covered from other wards. Nursing staff working additional unplanned hours.
Wirral	Brackendale	1063.5	1046.5	850	815.5	738.5	747.5	701.5	690	98.4%	95.9%	101.2%	98.4%	*
	Brooklands	1042.25	1041	1457.5	1457.5	669.5	611.25	1207.5	1207.5	99.9%	100.0%	91.3%	100.0%	*
	Lakefield	1021	961.5	928	893.5	713	655.5	713	724.5	94.2%	96.3%	91.9%	101.6%	Staff cross covered from other wards. Nursing staff working additional unplanned hours.
	Meadowbank	1160	1160	1284.5	1159	736	706.5	989	925.5	100.0%	90.2%	96.0%	93.6%	*
	Oaktrees	1139.5	1105	1363	1265	713	701.5	494.5	471.5	97.0%	92.8%	98.4%	95.3%	Altering skill mix. Staff cross covered from other wards. Nursing staff working additional unplanned hours.
	Willow PICU	1143.5	1180.5	828	793.5	766.5	755	816.5	828	103.2%	95.8%	98.5%	101.4%	*
West	Beech	1345.5	1249.5	1086	1050	678.5	678.5	724.5	715.5	92.9%	96.7%	100.0%	98.8%	*
	Cherry	1303	1305.25	1064.5	1053	713	747.5	943	931.5	100.2%	98.9%	104.8%	98.8%	*
	Eastway A&T	932.5	899	1073.9	1074	529	529	920	924	96.4%	100.0%	100.0%	100.4%	*
	Juniper	1353	1331	995	952.5	697.5	697.5	701.5	699.5	98.4%	95.7%	100.0%	99.7%	*
	Coral	1089	1085	1368.5	1364	586.5	460	1230.5	931.5	99.6%	99.7%	78.4%	75.7%	Staff cross covered from other wards. Altering skill mix. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	Indigo	1162.5	1105	1138.5	1115.5	621	586.5	1115.5	1150	95.1%	98.0%	94.4%	103.1%	*
	Rosewood	1108.5	1097	1365	1337.5	671	671	759	724.5	99.0%	98.0%	100.0%	95.5%	*
	Trustwide	22163.25	21432.25	23507.4	22139	13338	12929.75	18924	18028.5	96.7%	94.2%	96.9%	95.3%	

	Ward	Day				Night				Fill Rate				Safe Staffing was maintained by:	
		Registered		Care Staff		Registered		Care Staff		Day		Night			
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)		
East	Adelphi	1147	1052.5	1035.5	993.5	627.5	616	1166	1120	91.8%	95.9%	98.2%	96.1%	*	
	Alderley Unit	1050.5	1021	1296.85	1274	632.5	609.5	655.5	690	97.2%	98.2%	96.4%	105.3%	*	
	Bollin	1194	1117	1488.5	1432	650	638.5	1402	1375	93.6%	96.2%	98.2%	98.1%	*	
	Croft	916	885.5	1470	1304	621	544	1357	1307.5	96.7%	88.7%	87.6%	96.4%	Altering skill mix.	
	Greenways A&T	1053	892	1497	1512.5	644	609.5	1265	1184.5	84.7%	101.0%	94.6%	93.6%	Staff cross covered from other wards. Altering skill mix. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.	
	LimeWalk Rehab	970.5	934.5	937.25	910.25	644	621	644	632.5	96.3%	97.1%	96.4%	98.2%	*	
	Saddlebridge	878.5	855.5	1350	1332.25	644	632.5	713	701.5	97.4%	98.7%	98.2%	98.4%	*	
Wirral	Brackendale	1006.5	987.5	866.5	843.5	644	644	644	632.5	98.1%	97.3%	100.0%	98.2%	*	
	Brooklands	910	910	1223.5	1200.5	633	598.5	1017	1004.5	100.0%	98.1%	94.5%	98.8%	*	
	Lakefield	1024	978	784	692	644	621	655.5	621	95.5%	88.3%	96.4%	94.7%	Staff cross covered from other wards. Altering skill mix.	
	Meadowbank	1092.5	1064	1174	1141	667	644	905	801.5	97.4%	97.2%	96.6%	88.6%	*	
	Oaktrees	917.5	794.5	1548.25	1323.75	678.5	678.5	529	494.5	86.6%	85.5%	100.0%	93.5%	Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.	
	Willow PICU	1050.5	1050.5	874	875.5	644	632.5	759	770.5	100.0%	100.2%	98.2%	101.5%	*	
West	Beech	1326	1314.5	890.5	844	621	621	667	663	99.1%	94.8%	100.0%	99.4%	*	
	Cherry	1207	1184	954.5	937	632.5	632.5	920	908.5	98.1%	98.2%	100.0%	98.8%	*	
	Eastway A&T	648.25	640.75	1171	1164.5	392.5	381	887	887	98.8%	99.4%	97.1%	100.0%	*	
	Juniper	1283.5	1268	871.5	838.5	629	629	690	675.8	98.8%	96.2%	100.0%	97.9%	*	
	Coral	868.5	864.5	1359	1336	499	499	1046.5	1012	99.5%	98.3%	100.0%	96.7%	*	
	Indigo	829.2	817.7	1115	1069	517.5	517.5	920	920	98.6%	95.9%	100.0%	100.0%	*	
	Rosewood	893.5	870.5	1115.5	1115.5	537	537	747.5	722	97.4%	100.0%	100.0%	96.6%	*	
	Trustwide	20266.45	19502.45	23022.35	22139.25	12202	11906.5	17590	17123.8	96.2%	96.2%	97.6%	97.3%		

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	CWP Appraisals
Agenda ref. no:	16/17/140
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/03/2017
Presented by:	David Harris, Director of People and OD

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

REPORT BRIEFING

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

The new appraisal process and paperwork was launched in May 2016 following agreement at April Operations Board. The aim of the new process was to achieve 100% compliance (of all available staff) and to improve the quality of the appraisal discussion by focusing upon quality of discussion and placing greater emphasis on a holistic review of the individual's performance and general wellbeing as well as performance in role and achievement of objectives. This report will provide an overview of the 9-month 2016/17 implementation and will outline plans for continued implementation for 2017/18.

Ref: further details within Appendix 1

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

The new appraisal was launched in May 2016 consisting of updated paperwork and manager training together with 3 implementation cycles spread over a 9-month period: Band 7 and above May –Jul; Band 5 & 6 Aug – Oct; Bands 1-4 Nov- Jan. It was originally anticipated that implementation could be delivered over a six month period through two cycles, however April 2016 Operations Board advised that this would place considerable pressure upon services and it was therefore decided to defer for 2016/17 implementation, but to reconsider a 6-month cycle for 2017/18 implementation. The appraisal paperwork was also re-worked to provide a more holistic, person-centred review of an individual's contribution, their health and well-being needs as well as placing focus upon performance in role. Throughout implementation, a quality review of appraisals has been undertaken.

Assessment – *analysis and considerations of options and risks*

Following the implementation of all three cycles the Trust is now 98% compliant (data taken 3/3/17) which is the highest level of compliance the Trust has had in recent years.

Wirral 98%, Central and East 100%, West 95%, Corporate (in Estates and Facilities) 100%.

Compliance (less exceptions) per cycle is; 99% of bands 7 and above, 98% bands 5 & 6 and 96% Bands 1-4. Work has taken place to determine as to why non-compliant staff remain outstanding (see Appendix 1 for further details). Quality reviews undertaken post appraisal have been extremely positive with the vast majority of staff advising their appraisal was good to excellent across all cycles (see Appendix 1 for full breakdown). The revised paperwork has also received a positive response with staff feeling it is more person-centred and focused upon them as individuals.

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

The Board is asked to **note** this report, in particular the overview of plans for 2017/18 as set out in Appendix 1.

Who/ which group has approved this report for receipt at the above meeting?	Operations Board – February 2017
Contributing authors:	Hayley Curran

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1.0	People & OD Sub-Committee	23/01/2017

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

Appendix no.	Appendix title
1	Appraisal Implementation

16/17/140 Appendix 1

Appraisal Implementation

What:

1.0) Overview

The Trust took a decision to change the way appraisals were undertaken (for staff on AfC contracts) in April 2016; this work included changes to workbook, implementation process, training and also introduced quality evaluation of the appraisal discussion. This was in direct response to feedback from the 2015 Staff Survey re: quality of appraisals '*leaving staff unvalued'* and also challenge from the Trust's Scrutiny Committee that the target should be 100% as opposed to 85% for compliance.

1.1) Appraisal Workbook

The workbook was streamlined in collaboration with feedback from colleagues in Education, the Professional Advisors network and staff users, and was piloted during phase one of implementation (May-Jul 2016). Staff were also invited to provide feedback via an online questionnaire.

Feedback on the new format was overwhelmingly positive, however, further improvements were made at the end of cycle one following evaluation to reduce repetition between questions and wording amended to ensure it was inclusive of all workforce groups (as it was previously felt too nursing focused).

Two versions of the workbook were made available as some staff preferred to have a Word version that is editable to insert evidence and increase template size etc., whereas others preferred an editable PDF version. Both can be undertaken electronically and shared with a manager via email, and whilst this isn't an electronic solution it's a step change towards a culture of electronic appraisal.

1.2) Implementation Reporting

To support implementation, the People Information (PI) team produced fortnightly reports for managers broken down by locality and service (budget) line. It was recognised that a large proportion of appraisals were undertaken (or recorded) in the last 3-weeks of the appraisal cycle. People Information introduced a planned trajectory to support managers in adopting a planned approach. This had a limited impact as a large proportion of appraisals continued to be implemented in the final 3-weeks.

The PI team have worked closely with localities to ensure that information in ESR remains current and reporting accurately reflects workforce / structure changes. This work was ongoing as workforce data within ESR changes on a daily basis. The regularity of the reporting helped to resolve the majority of queries and to improve data quality, with very few queries made during cycle 3 of implementation.

So What:

2.0) Current Position

- Trust total 98% compliance (up 2% from last report dated 3/2/17)
- Corporate 100% compliant, Wirral 98% compliant, Central and East 100%, West 95%
- Bands 7+ target group is 99% compliant. Bands 5 & 6 target group is 98% compliant. Bands 1-4 target group is 96% compliant.

** The implementation of a new cyclical approach has flagged up gaps in the current policy regarding lack of exclusion periods for staff returning to work from maternity, long term sick and secondment. These will be addressed in new policy which will support improved compliance in 2017/18.

3.0) Appraisal Quality Review

A key element of the new process is quality review, providing staff the opportunity to feedback on the quality of their appraisal discussion via an anonymous online survey. This information can be used to develop and better target training where poor quality appraisals are reported and to gauge staff's reaction to the appraisal process.

	Central and East	Wirral	West	Corporate	Estates and Facilities
No of responses	160	110	232	81	13
What grade are you?	Band 7 & above – 34.5% Band 5 or 6 – 31% Band 1-4 – 34.5%	Band 7 & above – 32% Band 5 or 6 – 27% Band 1-4 – 41%	Band 7 & above – 35% Band 5 or 6 – 33% Band 1-4 – 32%	Band 7 & above – 32% Band 5 or 6 – 35% Band 1-4 – 33%	Band 7 & above – 39% Band 5 or 6 – 15% Band 1-4 – 46%
Role	Clinical – 65% Non-clinical – 35%	Clinical – 39% Non-clinical – 31%	Clinical – 67% Non-clinical – 33%	Clinical – 9% Non-clinical – 91%	Clinical – 8% Non-clinical – 92%
How prepared were you for your appraisal?	Very prepared – 35% Quite prepared – 49% Insufficiently prepared – 3% I never prepared – 1% (12% left comments)	Very prepared – 38% Quite prepared – 45% Insufficiently prepared – 4% I never prepared – 2% (11% left comments)	Very prepared – 42% Quite prepared – 44% Insufficiently prepared – 3% I never prepared – 1% (10% left comments)	Very prepared – 45% Quite prepared – 45% Insufficiently prepared – 3% I never prepared – 1% (6% left comments)	Very prepared – 30% Quite prepared – 50% Insufficiently prepared – 0% I never prepared – 10% (10% left comments)
How prepared do you feel your manager was for your appraisal?	Very prepared – 42% Quite prepared – 38% Insufficiently prepared – 3% I don't feel they prepared – 6% (11% left comments)	Very prepared – 52% Quite prepared – 34% Insufficiently prepared – 1% I don't feel they prepared – 2% (11% left comments)	Very prepared – 50% Quite prepared - 37% Insufficiently prepared – 2% I don't feel they prepared – 3% (8% left comments)	Very prepared – 45% Quite prepared – 43% Insufficiently prepared – 6% I don't feel they prepared – 1% (5% left comments)	Very prepared – 60% Quite prepared – 40% Insufficiently prepared – 0% I don't feel they prepared – 0% (0% left comments)
Rate the quality of your appraisal on a scale of 1-5 (1 = Poor and 5 = Excellent)	5* - 28% 4* - 42% 3* - 18% 2* - 6% 1* - 6%	5* - 35% 4* - 38% 3* - 19% 2* - 2% 1* - 6%	5* - 39% 4* - 34% 3* - 18% 2* - 6% 1* - 3%	5* - 35% 4* - 38% 3* - 16% 2* - 11% 1* - 0%	5* - 25% 4* - 62% 3* - 13% 2* - 0% 1* - 0%
Do you feel that your appraisal was 'person centred'?	Yes – 74% No – 7% Unsure – 7% (12% left	Yes – 75% No – 5% Unsure – 5%	Yes – 83% No – 2% Unsure – 5%	Yes – 71% No – 7% Unsure – 12%	Yes – 100% No – 0% Unsure – 0%

	comments)	(15% left comments)	(10% left comments)	(10% left comments)	(0% left comments)

Breakdown of Quality Review by Cycle Implementation

	Bands 1-4	Bands 5-6	Bands 7 and above
No of responses	206	190	200
Role	22% clinical 78% non-clinical	76% clinical 24% non-clinical	77% clinical 23% non-clinical
How prepared were you for your appraisal?	39% 'quite prepared' 46% 'very prepared' 2% 'insufficiently prepared' 3% 'I never prepared' (10% left a comment)	45% 'quite prepared' 37% 'very prepared' 5% 'insufficiently prepared' 1% 'I never prepared' (12% left a comment)	45% 'quite prepared' 42% 'very prepared' 3% 'insufficiently prepared' 0% 'I never prepared' (10% provided a comment)
How prepared do you feel your manager was for your appraisal?	55% 'quite prepared' 35% 'very prepared' 2% 'insufficiently prepared' 2% 'I don't feel they prepared at all' (6% provided a comment)	35% 'quite prepared' 48% 'very prepared' 4% 'insufficiently prepared' 2% 'I don't feel they prepared at all' (11% provided a comment)	42% 'quite prepared' 40% 'very prepared' 3% 'insufficiently prepared' 5% 'I don't feel they prepared at all' (10% provided a comment)
Rate the quality of your appraisal on a scale of 1-5 (1 = Poor and 5 = Excellent),	5* - 36% 4* - 35% 3* - 20% 2* - 3% 1* - 6%	5* - 41% 4* - 31% 3* - 18% 2* - 8% 1* - 2%	5* - 28% 4* - 47% 3* - 15% 2* - 7% 1* - 3%
Do you feel that your appraisal was 'person centred'?	80% 'yes 5% 'no' 9% 'unsure' (6% left comments)	70% 'yes' 5% 'no' 6% 'unsure' (19% left comments)	82% 'yes' 5% 'no' 3% 'unsure' (10% left comments)
Sample comments	• 'The new format is so much more person-centred and relevant to me and my post.' 'Some questions need further explaining' • 'Opportunity to discuss how I feel about working for CWP' • 'Too long, a tick box exercise' • 'Effective' • 'Given time to complete by manager ahead of	• 'Most simple and efficient appraisal' • 'Specific times for all appraisals is a good idea' • 'Like the new format and direction to reflect on' • 'Paper exercise to tick a box for compliance' • 'Very supportive appraisal, felt really valued'	• 'Like the new format' • 'Lengthy paperwork' • 'Receptive to personal and professional development needs' • 'Good work acknowledged and celebrated' • 'Tick box exercise'

	appraisal'		

Now What:

4.0) Implementation 2017/18

The following recommendations were agreed by CWP Operations Board on 15th February 2017:

- To continue with a 9-month implementation period that includes 3 cycles based upon 2016/17 banding groups.
- Continue to work with managers to address the 2% gap in compliance and target areas for development where quality conversations are reported as low
- To shift the implementation period in line with quarterly reporting periods; April – Jun, July – Sept, Oct- Dec.
- To continue to provide Appraisal reports on a monthly basis to support the culture shift and mainstream cycle process into day to day practice
- To align appraisal and management supervision processes together and revise the current appraisal policy and paperwork to robustly align staff performance (against objectives) within management supervision process
- To amend the appraisal policy to include an exception period of 3-month for maternity/adoption leave, new starters, career breaks, secondments and periods of long term sickness absence of a period longer than 3-months
  ***paperwork and guidance and training will be developed to reflect these changes*
- Scope options for an electronic system

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Annual Information Governance Board Report
Agenda ref. no:	16/17/141
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/03/2017
Presented by:	Dr Faouzi Alam, Medical Director, Effectiveness, Medical Education and Medical Workforce

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
37T	
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
37T	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*
To brief the Board of Directors on information governance resources, governance, issues, risks and improvement plans undertaken in 2016/17 and planned for 2017/18 and to seek approval for the 2016/17 annual Information Governance Toolkit submission.

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

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 (IGT), hosted by NHS Digital. The Records & Information Systems Group monitor the IGT work plan through audits, spot checks and review of incidents throughout the year.

Assessment – *analysis and considerations of options and risks*

The targets in the 2016/17 information governance work plan were to maintain the score of 94% and increase this where possible. The targets have all been met. The planned Information Governance Toolkit (IGT) submission for 2016/17 achieves an overall score of 95%, which is an increase of 1% since last year, and the IG toolkit for Westminster Surgery achieves an overall score of 91%. Mersey Internal Audit Agency have undertaken an annual assessment of the Trust's IGT scores and supporting evidence and awarded a significant assurance rating for the fifth consecutive year. This supports the case that current information governance arrangements within Cheshire & Wirral Partnership NHS Foundation Trust are appropriate and fit for purpose. The Records & Information Systems Group will continue to monitor information governance arrangements during the coming year.

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

The Board of Directors is recommended to approve:

- the submission of the 2016/17 information governance toolkit (31/03/2017)
- the information governance work plan for 2017/18
- the statement that current information governance arrangements are fit for purpose

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Records & Information Systems Group	27 January 2017

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

Appendix no.	Appendix title
1	Annual Information Governance Board Report
2	Cheshire & Wirral Partnership NHS Foundation Trust information governance toolkit planned submissions March 2017
3	Information governance work plan 2017/2018

16/17/141 Appendix 1

Annual Information Governance Board Report

1. Purpose of the report

To brief the Board of Directors on information governance resources, governance, issues, risks and improvement plans undertaken in 2016/17, those planned for 2017/18, and to seek approval for the 2016/17 annual Information Governance Toolkit (IGT) submission.

2. Summary

The targets in the 2016/17 information governance work plan were to maintain the score of 94% and increase this where possible. The targets have all been met. The Trust scored 94% for both the baseline July 2016 and interim October 2016 IGT submissions. The planned final March 2017 IGT score will be 95% (green satisfactory), which is an increase of 1% for the clinical coding element since last year, and 91% compliance for Westminster Surgery. Both toolkits will score at least at level 2 with many areas scoring level 3 and will be fully compliant.

All internal audits required by the IGT have been completed with satisfactory results which have been monitored by the Records & Information Systems Group. Mersey Internal Audit Agency have undertaken an annual assessment of the Trust's IGT scores and supporting evidence and awarded **significant assurance** for the fifth consecutive year.

It is a requirement for the Trust to monitor staff understanding and compliance with information governance standards. A rolling programme of spot checks has continued during 2016/17. 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. Spot checks of all Trust wards are now complete. Spot checks which are planned during the coming months include Substance Mis-Use East and Corporate areas. A Caldicott 2 training package has continued to be delivered at the doctor's induction.

Overall, information governance (IG) incidents have increased compared to the first 3 quarters of the previous year. There were 202 information governance incidents reported in the first three quarters of 2016 compared to 113 the previous year which is an increase of 55.9% which is due largely to the increased reporting of EMIS mobile problems. From July 2016 the IG incidents report for the Records & Information Systems Group was split into system/procedure errors and human errors. Staff have received information governance reminders based on IG incidents throughout the year. The Records & Information Systems Group will continue to monitor trends in the coming year and take rememdial action where necessary.

CWP were the first Trust in the region to invite MIAA to complete a thorough security audit on our infrastructure, the results have been analysed and the ICT work plan has been modified to include the recommendations from the auditors. The work plan will be monitored by the Records & Information Systems Group.

The Care Quality Commission (CQC) was asked to undertake a review of data security in the NHS, and in parallel Dame Fiona Caldicott the National Data Guardian (NDG) was asked to develop new data security standards and a method for testing compliance against these. The NDG was asked to recommend a new consent model for data sharing in the NHS and social care,

commonly known as Caldicott 3. CQC and the NDG have published separate reports and recommendations, but have produced a joint letter to the Secretary of State for Health outlining their joint findings and recommendations. The NDG is undertaking a national consultation for the consent model. A CWP working group consisting of Caldicott/IG/ICT and Clinical Systems Managers for the Trust met to consider the recommendations along with the Information Commissioner's recommendations for the new Data Protection regulation, due to come into force in May 2018. The working group have produced a combined action plan. The Records & Information Systems Group will monitor the action plan to ensure a state of readiness for implementation.

Information governance arrangements have been reviewed during 2016/17 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 Cheshire & Wirral Partnership are appropriate and fit for purpose.

The focus of the Trust's work plan for 2017/18 will be to:

- Implement MIAA recommendations contained in the clinical coding audit repot
- Continue to develop the Clinical Coding Resource web page
- Implement recommendations made in the MIAA cyber security audit report
- Work towards implementation of the new General Data Protection Regulation
- 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

3. Information governance briefing

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

Compliance with information governance standards is annually assessed through the completion of the Information Governance Toolkit, hosted by NHS Digital. The IGT submission is examined by the Trust's regulators: The Care Quality Commission (CQC) include the toolkit assessment in the Trust's Quality & Risk Profile (QRP), while the foundation trust regulator, Monitor, consider the toolkit when assessing the foundation trust's governance risk rating. The Records & Information Systems Group has devolved responsibility from The Patient Safety & Effectiveness Sub Committee for monitoring overall compliance with Information Governance principles.

4. Information Governance 2016/17 and 2017/18

4.1 Review of information governance work undertaken in 2016/17

The targets in the 2016/17 information governance work plan were to maintain the score of 94% and increase this where possible. The targets have all been met. Evidence uploaded to the IGT has been refreshed and updated policies have been uploaded to the toolkit. The Trust scored 94% for both the baseline July 2016 and interim October 2016 IGT submissions. The planned final March 2017 IGT score will be 95% (green satisfactory) which is an increase of 1% for the clinical coding element, and 91% compliance for Westminster Surgery, both toolkits will be fully compliant. 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

The above audits which are required by the IGT have been completed with satisfactory results which have been monitored by the Records & Information Systems Group.

4.1.1 Information Assets

Information asset owners are general managers and heads of departments. They are responsible for information held within their areas and the nature of and justification for information flows to and from each asset. All asset owners both clinical and corporate were asked to undertake an annual risk report for the Senior Information Risk Owner (SIRO) and a data flow mapping exercise in February 2017. The information asset register has been checked for accuracy by asset owners and is held centrally on the information governance page of the intranet. No new risks were identified by the information asset owners.

4.1.2 Upgrade to ICT disaster recovery facilities and backup systems

The ICT Services department have continued to work on processes in order to improve the performance and duration of each backup, the rollout of the backup software (Veeam) has nearly been completed but this task cannot be deemed as closed until the migration of Carenotes on to Windows Server 2008(R2).

4.1.3 Windows 7 upgrade

This work has been completed including the conversion of the 3 Pharmacy PC's.

4.1.4 MIAA Security Audit

CWP were the first Trust in the region to invite Mersey Internal Audit Agency (MIAA) to complete a thorough security audit on our infrastructure, the results have been analysed and the ICT work plan has been modified to include the recommendations from the auditors. The audit report was noted by the Audit Committee on 1st November 2016.

4.1.5 Data Quality

In 2014/15 we began 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 approach has resulted in 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. This approach continues to be developed and refined to meet the needs of key stakeholder.

4.1.6 Caldicott 2

A Caldicott 2 training package has continued to be delivered at the doctor's induction programme. Relevant IGT evidence has been refreshed to ensure compliance with Caldicott 2 recommendations.

4.1.7 Information Governance Spot Checks

It is a requirement for the Trust to monitor staff understanding and compliance with information governance standards. A total of thirty one wards and departments have been audited to date. 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
- Freedom of information procedures
- Whether staff are adhering to Trust policy of electronic record being the primary record
- Whether staff are aware of the requirement to record patient email addresses and consent to receive emails

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

- Role of SIRO and Caldicott Guardian
- Knowledge of Caldicott 2, although on further questioning staff are becoming more aware of this but are not necessarily familiar with the term `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. Spot checks of all Trust wards are now complete. Spot checks which are planned during the coming months include Substance Mis-Use East and Corporate areas.

4.1.8 New General Data Protection Act Rule and National Data Guardian Review

The Care Quality Commission (CQC) was asked to undertake a review of data security in the NHS, and in parallel Dame Fiona Caldicott the National Data Guardian (NDG) was asked to develop new data security standards and a method for testing compliance against these. The NDG was asked to recommend a new consent model for data sharing in the NHS and social care, commonly known as Caldicott 3. CQC and the NDG have published separate reports and recommendations, but have produced a joint letter to the Secretary of State for Health outlining their joint findings and recommendations. The NDG is undertaking a national consultation for the consent model. A CWP working group consisting of Caldicott/IG/ICT and Clinical Systems Managers for the Trust met to consider the recommendations along with the Information Commissioner's recommendations for the new Data Protection regulation, due to come into force in May 2018, and have produced a combined action plan. The Records & Information Systems Group will monitor the action plan to ensure a state of readiness for implementation.

4.1.9 Review of information governance incidents 2016/17

Data on information governance incidents and near misses was reviewed for the first 3 quarters of 2016/17 as reported on the Trust's Datix risk and incident reporting system. CWP have had one reportable security breach which resulted in a decision by the Information Commissioner's Office (ICO) that no further action was necessary. In June 2016, 39 NCMP letters were sent to parents

with other children's results. The ICO decided that no further action was necessary as it did not meet the criteria set out in their Data Protection Regulatory Action Policy. The personal data involved in the breach was limited in scope however appropriate remedial action has been taken to prevent a recurrence following the incident.

Overall, information governance (IG) incidents have increased compared to the first 3 quarters of the previous year. There were 202 information governance incidents reported in 2016 compared to 113 the previous year which is an increase of 55.9% which is due largely to the increased reporting of EMIS mobile problems. From July 2016 the IG incidents report for the Records & Information Systems Group was split into system/procedure errors and human errors. Of the 202 incidents reviewed, 33.6% (68 in total) incidents related to computer system issues e.g. computers freezing/working slowly/IPAD failing to synchronise. Mis-directed post accounted for 20.7% (42 in total) of incidents. Incidents of filing errors/missing paper records accounted for 7.9% (16 in total). Documents attached to wrong patient's records accounted for 5.9 % (12 in total) of incidents. There were also smaller numbers of incidents including care plans not being available in patient's homes, information disclosed in error, mis-directed emails, mis-directed faxes, patients and families taking video recordings in ward areas, verbal disclosure and lost smart cards. Staff have received information governance reminders based on IG incidents throughout the year. The Records & Information Systems Group will continue to monitor trends in the coming year and take rememdial action where necessary.

4.1.10 Information governance toolkit audit 2016/17

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 five consecutive years. The audit report was noted by the Audit Committee on 28th February 2017.

4.2 Information governance work plan 2017/18

The focus of the Trust's work plan for 2017/18 will be to:

- Implement MIAA recommendations contained in clinical coding audit repot
- Continue to develop the Clinical Coding Resource web page
- Implement recommendations made in the MIAA cyber security audit report
- 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.

See **appendix 3** for the 2017/2018 work plan. The work plan has been approved by the Records & Information Systems Group.

4.2.1 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.

4.2.2 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 have been reviewed and approved within the year and 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 2017/18.

4.2.3 Caldicott 2

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

4.2.4 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.

4.2.5 New General Data Protection Act Rule and National Data Guardian Review

The working group of the Records & Information systems group will continue to work towards implementation of the new GDPR and NDG review action plan. This significant piece of work will involve the review of policies and training. Consent models for young people will need to be reviewed to enable the Trust to process information for people under 13 years of age. The Trust privacy notice and the privacy impact assessment pathway will also be reviewed to ensure compliance.

4.2.6 Windows server 2008 upgrades

All bar four servers are now on an updated platform. For two of these servers ICT Services are continuing to work with Performance & Redesign to put a plan together in order to get these upgraded, the remaining two (Allocate) have been superseded by newer devices and we are working towards decommissioning these servers.

4.2.7 MIAA Cyber Security Audit

The Records & Information Systems Group will monitor ICT work plan in relation to the recommendations made in the MIAA cyber security audit report.

4.2.8 Data quality

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

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

We will invest in and develop skills in the performance and business intelligence functions within the Trust. As part of our strategy, we will be bringing these two teams together to work as one business intelligence unit. This will be supported by a development programme that will include shadowing clinical teams, working with clinicians to understand their information requirements,

understanding of the data available and supporting clinical teams to utilise the wealth of data in an informed way. This will build on the established role of the locality analyst.

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

The key priorities for 2017/18 are;

- Sustainability of locality led data quality improvement programmes
- Building on the focus in 2016/17 for the Improvement in quality of demographic ie postcode/ GP/ DoB) details, in 2017/18 the focus will extend to cover improvement in the quality of data capture for MHSMDS requirements and client waiting Times
- Further development of data quality webpage

5. Information risk management approach

CWP has access to a number of sources of information, guidance and assurance concerning information governance. NHS digital 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 Records & Information Systems Group monitors overall compliance with Information Governance principles. Lesson learned from investigations and reviews are incorporated into training materials, communication notices and policy as appropriate.

6. Assessment of information governance arrangements

Information governance arrangements have been reviewed during 2016/17 firstly against the latest version of the information governance toolkit, and then against guidance released throughout the year. 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 Cheshire & Wirral Partnership are appropriate and fit for purpose. The Records & Information Systems Group will continue to monitor information governance arrangements during the coming year.

7. Recommendations to the Board of Directors

a. That the Board approves the statement that current information governance arrangements are fit for purpose
b. That the Board approves the submissions of the 2016/17 information governance toolkit.
c. That the Board the information governance work plan for 2017/18

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Quarterly Report of the Guardian of Safe Working Hours
Agenda ref. no:	16/17/142a
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/03/2017
Presented by:	Dr Ian Porter

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 16 Risk of insufficient Junior Doctor coverage	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
36T	

REPORT BRIEFING

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

This report sets out data regarding rotas, locum/agency usage and safe working for the period December 2016 – Feb 2017 for doctors in training across the trust. It considers current areas of risk and suggested areas of future risk which should be addressed.

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

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

Assessment – *analysis and considerations of options and risks*

Detailed information can be found in the attached report as directed by NHS Employers.

In summary, to date we have 21 doctors working under the terms and conditions of the 2016 contract. There are considerable vacancies related to HENW placements not being filled, maternity and less than full time training. We have received no exception reports and there have been no concerns raised regarding safe practice or access to educational and training experiences.

Locum and agency usage appears largely related to vacancies and sickness. There have been several incidents whereby Consultants or Higher Trainees have stepped down to cover the 1st on call rota.

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

Expected/required data collection is difficult and often from disparate sources and incomplete.

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

The Trust must compile data regarding Junior Doctors completing work for other agencies or trusts in order to guarantee no breaches with the EWTD or 72hr safe working rules. It is unclear at present how this should be addressed and further guidance is awaited.

The trust should consider methods of collecting real-time data regarding working patterns and internal locum shifts worked to ensure safe working and avoid breaches and financial penalties.

Compliant rotas are possible at present with the use of internal locum and occasional agency usage. The rates however of vacant posts within core psychiatry training in particular are high and predicted to increase which is likely to create difficulty in managing on call provision in the future and should be considered early. Any increase to internal locum in particular increases the likelihood of a breach regarding safe working hours and financial penalty.

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

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1	Guardian of Safe working Hours Report to the Trust Board for the period December 2016 – February 2017

16_17_142a Appendix 1

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

Executive summary

The following report is the first of the quarterly reports to the Trust board and details the quarter from the first Doctors joining the trust on the new contract, December 2016.

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

Areas of concern for the future include the management of exceptions arising from the non-resident 2nd on call rota, management of rotas and the ability to efficiently pool data to give reassurances of safe working hours and the availability of information regarding doctors completing extra work for other trusts or agencies.

Introduction

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

High level data

Number of doctors in training (total):	43.4 WTE
	(60 placements in total with HENW and maternity/LTFT posts accounted)
Number of doctors in training on 2016 TCS (total):	21
Amount of time available in job plan for guardian to do the role:	0.5 PAs per week
Admin support provided to the guardian (if any):	No admin support
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

a) Exception reports (with regard to working hours)

We currently have 21 doctors working under the TCS of the 2016 contract. **We have had no exceptions regarding working hours reported at the time of preparation of the report.**

There is currently a mixed economy of contracts on individual rotas and this pattern will persist for several years as trainees progress onto the new contracts. For this reason there will continue to be a requirement on the trust to conduct traditional hours monitoring exercises for those rotas and trainees. The latest period of monitoring was completed between November and December 2016 with the results below:

Each CWP medical out of hours rota was monitored between the dates of the 7th November and the 4th December 2016. The following table contains information on the rota monitored and the % of returns for the doctors on that rota (total shifts in the period v forms completed and returns for that shift)

	Core trainees			Higher trainees		Consultants		
	C+E	Wi	We	C+E	Wi+We	C+E	Wi	We
% Returns	59%	21%	21%	21%	57%	57%	39%	36%

Although historically monitoring returns are low, a couple of factors could have contributed to the low returns –

- The monitoring period was over a 4 week period rather than the usual 2 and trainees were required to report on activity in 15 minute blocks
- GP's and F2's rotated in December and although the GP's and F2's were working for the Trust during those dates, they'd have left during the chase up period.
- At least half the shifts on the HT rota in Central and East are uncovered

The average % of work per hour per shift is as follows:

Core Trainee East – 88%
Core Trainee West/Wirral – 86%

Higher Trainee East – 5%
Higher Trainee West/Wirral – 32%

Consultant East – 9%
Consultant Wirral – 2%
Consultant West - 4%

Summary:

Recommended breaks under the New Deal and Working Time legislation were achieved in 100% of shifts across Wirral and West Core trainees, Higher Trainees (Trustwide) and Consultants (Trustwide), but this was the case in only 82% of shifts for Core Trainees in Central and East.

Although the core trainee shift in Central and East were recorded as being generally busy anyway, it was the nights when the core trainee were expected to cover Liaison that they were unable to take the natural breaks.

During the 4 week monitoring period, there were 2 cases of the step down procedure being implemented. A higher trainee on the Wirral covered the duties of the 1st tier on-call and a Consultant in Central and East acted as 1st on-call.

Higher trainee on-call shifts in Wirral and West during the monitoring period were busier than those in Central and East. A reason for this was the number of MHA assessments in that period (19 in Wirral/West v 0 in East)

There were no major differences between the Consultant shifts Trustwide. Consultants in Central and East were slightly busier due to less of the 2nd tier rota being populated.

The next monitoring exercise is due to take place in May 2017. There has been discussion nationally regarding all doctors in training/LAS on on-call rotas (irrespective of contract) to have access to exception reporting and this moved was backed by HEE and CQC at a recent meeting as being able to give effective real-time monitoring, highlight areas of difficulty and promote safe practice and care for patients.

b) Work schedule reviews

There have been no work schedule reviews requested or completed.

c) Locum bookings

Rota gaps are as follows:

Wirral and West 1st on-call - 1.4
(1.0 in Wirral for long term sickness and 0.4 in West due to less than full time training).

Central and East 1st on-call - 0

Wirral and West higher trainee rota - 5
(1 in 10 rota with 5 vacancies. Gaps all filled with internal locums)

Central and East higher trainee rota - technically there are no gaps as there are no 'unfilled posts'. The rota is a 1 in 8/9 and there's 4.0 WTE Higher Trainees (2 f/t, one 0.8 and two 0.6's). Whenever there isn't a Higher Trainee on the rota, the Consultant on call is 2nd on call.

i) Bank

Internal locum/bank work has varied across rota and site. Cost for the period Dec-Feb inclusive is as follows:

Higher Trainee: £21,080

1st on call rota:£10,366

It has not been possible to get an accurate reflection of the cost of each 1st on call rota for the period. The higher trainee figure above reflects cost to the Wirral/West 2nd on call rota alone as rota gaps in the Central/East 2nd on call are covered by the Consultant on call.

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

Higher Trainee: 33 shifts

1st on call rota:32 shifts

It has not been fully possible to indicate which of the core trainee shifts covered were for which locality as data was partial. It should also be noted that the above will be a partial reflection of the picture as the data provided relied upon when the doctor claiming for the extra shift completed the claim form, not when the shift was completed.

In addition to the locum usage stated above there have been 3 occasions whereby Higher Trainee/Consultant has had to step down to cover 1st on call during the 9am-9pm period on the Wirral.

In addition to the locum usage stated above there has been one occasion whereby the Consultant on call has stepped down to cover the 1st on call 9pm-9am Wirral and West rota with a Consultant covering each site.

In addition to the locum usage above there have been through this reporting period 2 occasions where a Higher Trainee has stepped down to cover the evening first on call shift in the central/east rota and one occasion whereby the Consultant on call has stepped down to cover the first on call for the central/east rota.

Reasons for locum usage and step down are not fully recorded but have included sickness, vacancy (9 shifts – Dr left part way through rotation) and emergency (3 shifts - Dr stuck abroad). As mentioned above due to gaps within the higher trainee rota in Central/East there is often no higher trainee on call and the Consultant on call would act as second on call.

ii) Agency

Total spend on out of hours agency doctors of training grades combining higher and core trainees across the quarter appears to be £4436.88.

NHS employers suggests that this section should list, in aggregated fashion, all the locum work requested and worked via an agency during the last quarter. This data should be presented by department, by grade and by reason. I have been unable to compile the data to this level of information.

d) Locum work carried out by trainees

We do not have a way currently of collecting data regarding doctors completing work for other NHS trusts or agencies outside of their normal practice within CWP. This has been raised nationally as an issue and may increase the risk of fine for a breach of the 72hr safe working limits.

e) Vacancies

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

WTE Vacancies by Month (inc LTFT and Maternity Leave)			
	December	January	February
F1	0	0	0
F2	0	0	0
GPST1/2	0	0	0.4
CT1/2/3	6.6	7.2	9.2
ST4/5/6	6.5	6.5	7
Total	13.1	13.7	16.6

- HENW placement vacancies for December and January were 8. There are currently 11 HENW placement vacancies within the trust split between Core and Higher Psychiatry training.

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

WTE Vacancies by Month (inc LTFT and Maternity Leave) Chester			
	December	January	February
F1	0	0	0
F2	0	0	0
GPST1/2	0	0	0
CT1/2/3	2.2	2.8	2.4
ST4/5/6	3	3	3
Total	5.2	5.8	5.4

WTE Vacancies by Month (inc LTFT and Maternity Leave) Wirral			
	December	January	February
F1	0	0	0
F2	0	0	0
GPST1/2	0	0	0.4
CT1/2/3	1	1	2.4
ST4/5/6	2.5	2.5	3
Total	3.5	3.5	5.8

WTE Vacancies by Month (inc LTFT and Maternity Leave) Crewe			
	December	January	February
F1	0	0	0
F2	0	0	0
GPST1/2	0	0	0
CT1/2/3	0	0	3
ST4/5/6	0.4	0.4	0.4
Total	0.4	0.4	3.4

WTE Vacancies by Month (inc LTFT and Maternity Leave) Macclesfield			
	December	January	February
F1	0	0	0
F2	0	0	0
GPST1/2	0	0	0
CT1/2/3	3.4	3.4	1.4
ST4/5/6	0.6	0.6	0.6
Total	4	4	2

f) **Fines**

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

Issues arising

- We have not as a trust received any exception reports. It is unclear thus far if that is an accurate reflection of the picture within the trust. This is to be discussed further through the Junior Doctor Forum. Initial discussion suggests that it is accurate although there is nationally a concern of a lack of engagement with the process of exception reporting and engaging with safeguards within the contract.
- There are currently more WTE vacancies from all training grades across the trust than the previous rotation. This does not appear to be reflected in the amount of locum usage over the reported period. This may be related to the gap created by a Dr in the East who left the post part way through the previous rotation and the fact that most other 1st on call locum shifts are associated with sickness.
- Most vacancies are related to HENW placement vacancies as opposed to long term sickness, less than full time training or maternity leave. This reflects the difficulty in recruiting to psychiatry at present. The new contract provides financial incentive for recruitment into psychiatric training in a bid to rectify this. This is a consideration however for longer term planning.
- We currently have only two Higher Trainees in the trust on the new contract. There is an issue with respect to their non-resident on call given the variability of intensity of out of hours work and therefore under what circumstances would an exception be reported and how would it be resolved. This hasn't been raised within the trust yet but will be more of an issue from August when the 2nd on call rota is populated with more people on the new contract. The BMA and NHS Employers are currently agreeing guidance regarding this.
- It has become increasingly apparent from the data collection for the collation of this report it is not easily clear when a doctor has either knowingly or not breached EWTD or 72hr safe working limits given the processes currently in place. I have not identified such practice as yet however given rota gaps and heavy bank/internal locum usage this increases considerably the risk of unsafe working hours, breaches and financial penalty to the trust.
- I have been unable to locate information regarding Junior Doctors working within the trust who undertake locum or agency work for other trusts in psychiatry or other specialties. I have received reassurances through temporary staffing that all doctors undertaking work for the trust through an agency have opted out of EWTD. This has also been discussed within the national forum and guidance is awaited.

- It is part of the role of the Guardian of Safe Working to chair a Junior Doctor Forum. This has met on one occasion however 2 further meetings have been cancelled due

to lack the number of apologies received. This has been resolved with agreement that the forum will take place after Postgraduate Teaching in the hope of maximizing engagement.

- There is currently 0.5PA allocated to the role of Guardian for Safe Working Hours. This is in addition to clinical duties. There is no admin support for the role. Collation of the data for the preparation of this report has been extremely difficult and time consuming. Consideration should be given to a standard framework of appropriate data collection and the manner in which it is collected.

Summary

In summary, to date we have 21 doctors working under the terms and conditions of the 2016 contract. There are considerable vacancies related to HENW placements not being filled, maternity and less than full time training. We have received no exception reports and there have been no concerns raised regarding safe practice or access to educational and training experiences.

Locum and agency usage appears largely related to vacancies and sickness. There have been several incidents whereby Consultants or Higher Trainees have stepped down to cover the 1st on call rota.

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

Expected/required data collection is difficult and often from disparate sources and incomplete.

Questions for consideration

The trust must compile data regarding Junior Doctors completing work for other agencies or trusts in order to guarantee no breaches with the EWTD or 72hr safe working rules. It is unclear at present how this should be addressed and further guidance is awaited.

The trust should consider methods of collecting real-time data regarding working patterns and internal locum shifts worked to ensure safe working and avoid breaches and financial penalties.

Compliant rotas are possible at present with the use of internal locum and occasional agency usage. The rates however of vacant posts within core psychiatry training in particular are high and predicted to increase which is likely to create difficulty in managing on call provision in the future and should be considered early. Any increase to internal locum in particular increases the likelihood of a breach regarding safe working hours and financial penalty.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	NHS England review of CWP Revalidation and Appraisal Processes
Agenda ref. no:	16/17/143b
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/03/2017
Presented by:	Faouzi Alam, Medical Director

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

To update the Board of Directors with the outcomes of the NHS England review of CWP's medical appraisal and revalidation processes carried out in November 2016, and to share the subsequent action plan.

The plan requires Board sign-off prior to return to NHS England by 31 March 2017.

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

Medical staff appraisal compliance is reported to NHS England via quarterly updates and annually in 4 categories:

- Category 1A, an appraisal meeting which took place between 9-12 months of the last and the outputs (the summary and the doctor's PDP) signed off within 28 days of the meeting;
- category 1B, an appraisal which took place between 9-15 months after the date of the last meeting and/or the outputs were not signed off within 28 days but the Responsible Officer considers a meaningful appraisal took place;
- Category 2, an appraisal which was missed for acceptable reasons (ie maternity leave, extended sick leave)
- Category 3 is a missed appraisal without an acceptable reason.

Additionally, staff with responsibility for medical appraisal are monitored on their attendance at NHS England network meetings. If the appraisal rate falls below 90% or attendance is low, an NHS England review results.

Assessment – *analysis and considerations of options and risks*

The reviewers visited CWP staff in November 2016 and were significantly assured. Several areas of good practice were noted. The team were able to offer explanations for the perceived performance reduction. As detailed in appendix 1, the appraisal rate had dropped due to long-term sick leave and three doctors being on maternity leave. With relatively low numbers, just ten doctors being away from work for long periods will tip the balance and there is no opportunity to advise NHS England of the reason for the missed appraisals.

The RO and Appraisal Lead will improve attendance at network meetings, which often conflict with other high level or clinical engagements and are often of limited value. The RO had already asked the Appraisal Team to support a reduction in Category 1B appraisals for the current appraisal year but with such pressing clinical need, preparation for timely appraisal is often sacrificed for patient care. The confusion over the definition of a Category 2 appraisal was purely a slip of the tongue by an anxious Appraisal Manager! It was immediately corrected but was still included as an action. The actions identified by the reviewers have all been put in place and are recorded in Appendix 2.

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

The Board of Directors are recommended to **approve** the action plan prior to submission to NHE England by 31 March 2017.

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
V1	PODSC	14.2.17

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

Appendix no.	Appendix title
1	Report of the higher level responsible officer review November 2016
2	Action plan for Board Approval and return to NHS England by 31 March 2017

16/17/142b Appendix 1

Higher Level Responsible Officer Quality Review (HLROQR)
Notes and Actions

Organisation: Cheshire and Wirral Partnership (CWP)		**Date:** 18th November 2016
Attendees		**Meeting Time:** 14:00-16:30
Dr Faouzi Alam	Responsible Officer (apologies due to illness)	**Location:** Boardroom Redesmere, Countess of Chester Health Park, Liverpool Road, Chester CH2 1BQ
Sarah Carroll	Medical Appraisal and Revalidation Manager	
Lauren Green	Medical Appraisal Administrator	
Dr Geraldine Swift	Associate Medical Director for Workforce and appraisal lead	
Dr Laurie van Niekerk	Director of Medical Education	
Chris Sheldon	Head of HR	
Dr Paul Twomey (Chair)	Clinical Lead for Medical Appraisal & Revalidation. NHS England(North)	
Barry Fulton	Lay Representative	
Janet Bell	Project Support Officer. NHS England (North)	

Notes and Actions
In accordance with the Framework of Quality Assurance (FQA) and in acknowledgement of the HLROQR process we completed a desktop review of CWP in July 2016. It was noted that the appraisal uptake had decreased from 95% in 2014/15 to 89% in 2015/16 prompting a visit to discuss this and any support we can provide. In addition attendance at the regional programme of networks was limited. Despite the unfortunate illness of the Responsible Officer, CWP fully supported the meeting with resources present from all sections of their revalidation and appraisal team which enabled a constructive and comprehensive discussion. CWP emphasised that they are a values based organisation which has benefited from the stability and excellent continuity provided by their executive team. This and a previously enthusiastic and charismatic Medical Director has resulted in a culture within which appraisal is viewed in an enthusiastic and positive light.

The size of the organisation and the strong well integrated appraisal and revalidation team ensures supportive personal support and enables appraisal to be progressed beyond being just a process to be complied with.

CWP keep job planning entirely separate from appraisal as they felt previously that the attempt to match objectives to specific strategies inhibited the conversation which now benefits from being aligned to the organisations core values linked to the strong culture of the organisation. Appraisal is viewed as a protected time described as a "thinking space" during which the doctor can reflect on the past year and plan their future development

CWP emphasised quality and noted that their appraisal summaries are detailed and can be onerous to write up possibly accounting for a significant number of the "1bs". Opportunities to support the timely provision of the appraisal documentation were explored.

CWP has an informal method of appointing appraisers but has encouraged participation from selected groups such as SAS doctors. The potential for this process could be formalised by identifying appraisal submissions of high quality and offering those doctors the opportunity to train as an appraiser.

Appraisers undertake a 1 day appraiser training programme which includes role play.

Quality Assurance takes place using the "Excellence" tool. CWP aim to quality assure 3 appraisals for each appraiser and the summary feedback includes strengths and weaknesses. In their drive for quality CWP would prefer a tool that allowed for more detailed narrative and less scoring. The benefits of this approach were acknowledged and highlighted as an example of good practice.

CWP have 13 trained case investigators and have signed up their trust lawyers to provide some refresher top up training. The Responsible Officer acts as the case manager for performance issues. The "Maintaining High Professional Standards" framework is used for guidance in handling concerns about the conduct, clinical performance and health of medical employees.

CWP have a defined system for pre-employment checks. The "Trak" system issues weekly emails and prompts for new recruits ensuring they are included in the system early on. The visiting team referenced the "Information flows to support medical governance and responsible officer statutory function" document (Paper 1) and drew attention in particular to the toolkit section at the end of the document (P36+)

CWP raised the fact that they would like to see workshops within Responsible Officer and Medical Appraisal Lead networks based on geographical areas rather than sectors. The regional team welcomed this feedback and will look to incorporate a mixture of by sector and geography discussions in future networking events.

Actions

1. **Reflect on the document: "Information flows to support medical governance and responsible officer statutory function**" (Paper 1) to see if any additional useful material can be incorporated into the existing process for information transfer.

2. **Reflect on the increase in Measure 1B within the Annual Organisational Audit.** Consider prompts and supporting appraisers to return documents promptly.

    - A category 1b completed annual appraisal is one in which the appraisal meeting took place in the appraisal year between 1 April and 31 March and the outputs of appraisal have been agreed and signed off by the appraiser and the doctor, but one or more of the following apply:

        - The appraisal did not take place in the window of three months preceding the appraisal due date.
        - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year;
        - The outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting.

    - However, in the judgement of the responsible officer the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.

3. **Reflect on definition of Measure 2 - Approved incomplete or missed appraisal.**

    - An approved incomplete or missed annual appraisal is one where the appraisal has not been completed according to the parameters of either a Category 1a or 1b completed annual medical appraisal, but the responsible officer has given approval to the postponement or cancellation of the appraisal.
    - The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an Approved incomplete or missed annual medical appraisal.

4. **Keep March appraisal free to allow time for slippage.**

5. **Increase participation at the Medical Appraisal leads regional programme of quarterly networks**

6. **Information Transfer**:
   Regional team to send: “Information flows to support medical governance and responsible officer statutory function” document. (Complete- Paper 1)

7. **Inputs into Medical appraisal:**
   Regional team to send “Improving the inputs to medical appraisal” document (Complete- Paper 2)

8. **Medical Appraisal Logistics:**
   Regional team to send “NHS England Medical Appraisal Logistics Handbook” (Complete- Paper 3)

Areas of Good Practice Identified

1. **SARD.**

   CWP have had a very positive experience of this IT system which they found to be intuitive and user friendly and includes a job planning module. Complaints and SUIs are immediately recorded on SARD and continually amended as situations develop. This is an area CWP have identified within their board report that they intend to develop further. The capturing of this information in real time helps to prompt reflection and is considered an example of Good Practice**.**

2. **Appraiser Feedback.**

   The appraiser would receive feedback from the doctor being appraised and from the appraisal lead. This feedback would also include reference to attendance at CWP appraisal networks. The quality and specific narrative provided by the appraisal lead is considered an example of good practice.

3. **Issues to be raised at appraisal.**

   Two months before the appraisal rakes place the Medical Appraisal and Revalidation Manager emails the relevant Clinical Director to ask for information re performance issues. The Clinical Director would inform both the doctor and the appraiser by email to prompt discussion in the appraisal. It would be expected that some reference to a discussion and/or reflection on the matter would be subsequently included in the appraisal although not necessarily detailed. This was considered to be an example of good practice.

Papers		
1:	**Information flows to support medical governance and responsible officer statutory function**	
2:	**Improving the inputs to medical appraisal**	
3:	**NHS England Medical Appraisal Logistics Handbook**	
4:	**Action plan template (APPENDIX 2)**	

16_17_142b Appendix 2

Action plan template

Please complete the below action plan and return to:
England.revalidation-north@nhs.net
By: (31/03/2017)

Name of designated body:	**Cheshire and Wirral Partnership NHS Trust**	
Name of responsible officer:	**Dr Faouzi Alam**	
Area/concern/issue identified at Review Visit	**Action**	**Timescale**
1) Information Transfer.	**Reflect on the document: "Information flows to support medical governance and responsible officer statutory function" (Paper 1) to see if any additional useful material can be incorporated into the existing process for information transfer.** CWP has good systems in place, compliant with the suggested flows. • All pre-employment checks carried out and audited 2015 by CQC. • 100% compliance obtaining RO transfer of information/ARCP documents on appointment. • On appointment doctors provide a copy of their most recent (and often previous appraisal summaries) for review by the RO/Appraisal Manager & the new appraiser, providing information on most recent performance. • Clinical governance information provided to the doctor in real time to allow timely reflections	**By March 2017** 8.2.17

	rather than waiting until appraisal. • Annual assurances of satisfactory appraisal obtained for doctors working in CWP but whose designated body is elsewhere. • Doctors with external roles required to bring assurances/activity & to confirm indemnity arrangements to support whole practice appraisal.	
2) Measure 1b.	**Reflect on the increase in Measure 1B within the Annual Organisational Audit. Consider prompts and supporting appraisers to return documents promptly.** At the request of the RO, for the 2016-17 appraisal year, the appraisal staff increased support to try to reduce the number of 1B's. • In December of 2015 we wrote to all doctors reminding them of their appraisal month during the next calendar year, and that this month was generally fixed going forwards; • Each doctor is contacted between 12-16 weeks prior to their appraisal month to ask them to book an appraisal appointment if not already done. • Fortnightly email prompts continue. • 8 weeks before their appraisal month, doctors are notified that the Trust-provided information has been uploaded to their portfolio and confirmation of the meeting date and name of appraiser is again	**By March 31 2017 2016/17 for inclusion in the Annual Organisational Audit (AOA)**

	requested if necessary. • 5 weeks before the end of the appraisal month if no date is fixed, the Appraisal Lead/RO copied in; requesting action/response within 5 days. • Appraisal lead offers additional support to doctors who are delaying. • 2 weeks after the appraisal meeting the appraiser is reminded of the 28 day deadline for completion of the outputs. • At 28 days a further request is issued if necessary and this continues weekly. We believe this has improved compliance but as a further measure, the RO will write to those few doctors who were ill-prepared for appraisal and who required an extension, to advise them of the expectation that next year they will be on time. The majority of 1Bs this year were unavoidable due to extended sickness absence/maternity leave.	31.3.17
3) Measure 2	**Reflect on definition of Measure 2 - Approved incomplete or missed appraisal.** The Medical Appraisal Manager has reviewed the reporting of the missed appraisal discussed at the visit. This was accurately reported as a measure 2 in the AOA 2016-17. All are clear on the definitions. Apologies for the error on the day!	**By March 31 2017 2016/17 for inclusion in the Annual Organisational Audit (AOA)**

		21.11.16
4) Timing of Appraisal	**Keep March appraisal free to allow time for slippage.** Appraisals due in Feb/ March 2017 were all brought forward 2 weeks, thus beginning the process of keeping March fallow in future.	**For the Appraisal Year 2017/18.** Commenced and on-going
5) Appraisal Network Participation	**Increase participation at the Medical Appraisal leads regional programme of quarterly networks** RO & appraisal lead will prioritise attendance.	**For 2017 +**
6) Information Transfer	**Regional team to send: "Information flows to support medical governance and responsible officer statutory function" document**	**Complete.**
7) Inputs into Medical Appraisal	**Regional team to send "Improving the inputs to medical appraisal" document**	**Complete**
8) Medical Appraisal Logistics	**Regional team to send "NHS England Medical Appraisal Logistics Handbook" document**	**Complete**
As responsible officer I confirm that the information above has been discussed and agreed with my Board or equivalent	*Signature & Date*	
Date of Board sign-off	29 March 2017	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

CHAIR'S REPORT
AUDIT COMMITTEE – 28 February 2017

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

Internal Audit progress update
The Audit Committee was updated on the completion of recent work including audits on budgetary control and the information governance toolkit review. Both audits attained significant assurance.

Committee members reviewed the draft internal audit plan 2017/18. This had been compiled following a risk assessment of the Trust's position aligned to strategic objectives and through discussions with the management team. The plan is subject to some final amendments and will be finally approved at the next meeting.

The Committee also reviewed the follow up to previous audit recommendations report.

External Audit update
An update on the 2016/17 audit was provided. Pre audit work had been completed in early February 2017 successfully with no issues for escalation. Work will continue for the full audit work due to be undertaken in April 2017.

A technical update was provided with recent sector updates.

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 auditors. There were no areas of significant risk.

Anti- Fraud
A progress report was provided highlighting completion of recent work. The updated Fraud, Bribery and Corruption Policy was approved by the Committee. The draft anti-fraud plan for 2017/18 was presented and approved by the Committee.

Governance Matters
The Audit Committee noted the 2016/17 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. A number of potential changes were discussed with some requiring further qualification. It was agreed to present the Terms of Reference for final approval at the next meeting, following the annual review of committee effectiveness.

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.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

CHAIR'S REPORT –
QUALITY COMMITTEE
1 MARCH 2017

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

- **Strategic risk register**
  A new *risk of harm due to deficits in familiarity with and staff confidence in applying safety critical policies to ensure CWP maintains safe environments for patients and staff* (in response to recent incidents involving fires where the "search" policy was not used to guide practice) has been identified. The continuing in-scope *risk that the CWP workforce not having sufficient capability (capacity, confidence, competence) and resilience to deliver place-based systems of care* is still outstanding; therefore the Quality Committee has asked for an in-depth review of this at the next meeting for assurance purposes. An in-depth review of the *risk of harm to patients due to ligature points and environmental risks within the inpatient setting* was received, demonstrating the quality improvement approach taken by the Estates Department, in conjunction with clinical services, and through the Suicide Prevention Clinical Environmental Group.
  The Board of Directors is asked to note the exceptions to the strategic risk register highlighted above.

- **Championing autism**
  The Royal College of Psychiatrists' Championing Autism programme aims to contribute to improving the quality of the lives of people with autism (particularly with due regard to the quality domains of accessibility, affordability and sustainability). The Quality Committee discussed options for how CWP can move forward in addressing current (nationally reported) gaps and the current local risks to the Trust (based on incidents and complaints reported in relation to ASD services). There are a number of commissioning, effectiveness and training issues to consider. It was agreed that the workstreams associated with the Trust's work in relation to the local Transforming Care Partnership being reported to Operational Board would be tasked with contributing to a gap analysis, to mitigate the risk of duplication of effort and to ensure system clarity. Any care and quality impacts that this identifies will be referred to the Quality Committee for consideration.
  The Board of Directors is asked to note referral of this gap analysis, to outline tactical steps for taking key areas of work forward (including leads, timeframes and operational reporting), to Operational Board.

- **Nasogastric (NG) tube misplacement**
  Referred by the Patient Safety & Effectiveness Sub Committee, and on behalf of the Board of Directors, the Quality Committee discussed current controls and assurances in line with the NPSA alert: NHS/PSA/RE/2016/006 around the continuing risk of severe harm associated with misplaced NG tubes.
  The Board of Directors is asked to note the assurance received by the Quality Committee that sufficient support and clinical governance arrangements are in place to comply with this NPSA alert.

- **Regulation 28 Trustwide action plans**
  Following receipt of Regulation 28 reports dated 02/12/2016 and 14/12/2016, CWP has responded within the statutory timeframes. The two action plans associated with these reports were discussed by the Quality Committee. The Quality Committee will receive updates from the two nominated Associate Director leads until sufficient assurance of Trustwide compliance with the actions is secured. Further, the Quality Committee revisited previous Regulation 28/ Rule 43 learning themes. In line with CWP's safety management system, the Trust is committed to ensuring that it learns from "past harm" and is "integrating and learning". As such, the learning from these past reports will be revisited as part of the "learning themes" and "national benchmarking" work currently being overseen as quality improvement projects through the Quality Committee's business cycle.
  The Board of Directors is asked to note the assurance received by the Quality Committee regarding current assurances in response to open actions associated with Regulation 28 reports and the assurance work planned to ensure integration of past learning from Regulation 28/ Rule 43 reports.

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